

AMENDED IN SENATE JANUARY 13, 2010

AMENDED IN SENATE APRIL 23, 2009

SENATE BILL

No. 810

**Introduced by Senator Leno
(Principal coauthor: Senator Alquist)**

(Principal coauthors: Assembly Members Ammiano, Huffman, and Yamada)

(Coauthors: Senators Cedillo, Corbett, DeSaulnier, Florez, Hancock, Lowenthal, Oropeza, Padilla, Pavley, Price, Romero, Steinberg, Wiggins, and Yee)

(Coauthors: Assembly Members Bass, Beall, Block, Blumenfield, *Bradford*, Brownley, Chesbro, Coto, Davis, De La Torre, Eng, Evans, Feuer, Fong, Hayashi, Jones, Lieu, Bonnie Lowenthal, Ma, Mendoza, Monning, Nava, ~~Price~~, Ruskin, Salas, Skinner, Solorio, Swanson, Torlakson, and Torrico)

February 27, 2009

An act to add Division 114 (commencing with Section 140000) to the Health and Safety Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 810, as amended, Leno. 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 the Legislature on or before January 1, ~~2012~~ 2013, 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, ~~2010~~ 2011, 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 114 (commencing with Section 140000)
2 is added to the Health and Safety Code, to read:

3
4 DIVISION 114. 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 6.6 million Californians were uninsured in
24 2006, representing over 20 percent of the nonelderly population.

25 (b) In California, 763,000 children are currently uninsured, and
26 an additional 300,000 are significantly at risk for losing their
27 coverage.

28 (c) Health care spending has continuously grown two to three
29 times faster than California's economy, while health insurance
30 premiums have grown significantly faster than overall health care
31 spending.

32 (d) Since 2000, health care costs have outpaced increases in
33 wages by a ratio of four to one.

34 (e) One-third of California's State Budget is devoted to health
35 care, including direct public programs as well as employee health
36 benefits. The imbalanced growth in health spending relative to
37 economic growth which drives public revenues greatly hinders
38 California's ability to maintain a balanced budget.

39 (f) On average, the United States spends more than twice as
40 much as all other industrial nations on health care, both per person

1 and as a percentage of its gross domestic product. Additionally,
2 the rate of health care inflation significantly outpaces other
3 industrial nations.

4 (g) Despite this high spending, United States healthcare
5 outcomes consistently rank at the bottom of all industrial nations
6 and the United States Institute of Medicine has declared an
7 epidemic of substandard health-care throughout the nation.

8 (h) Instead of effectively containing costs, costs have been
9 increasingly shifted to working Californians in the form of a
10 continual decline in employer-offered coverage, dramatic increases
11 in premiums, copayments, and deductibles, declining clinical
12 quality, overall reductions in benefits, and inappropriate utilization
13 review procedures that deny patients access to needed care.

14 (i) As a result, one-half of all bankruptcies in the United States
15 now relate to medical costs, though three-fourths of bankrupted
16 families had health care coverage at the time of sustaining the
17 injury or illness.

18 (j) More than one-half of all Americans report forgoing
19 recommended health care because of the cost, and Americans are
20 more likely to report difficulty seeing a doctor on the day they
21 sought.

22 (k) Health plans and insurers compete to construct patient pools
23 consisting of the healthiest segments of the population, leaving
24 higher risk patients to public programs or uninsured.

25 (l) Segregating patients into groups based on actuarial
26 assessments of their medical risk guarantees the continuation of
27 entrenched health care disparities in access and quality, and drives
28 health care resources toward healthier populations who least need
29 it for whom more care often does more harm than good.

30 (m) The Institute of Medicine estimates that 18,000 people die
31 annually in the United States because of lack of access to care and
32 that 30,000 die from overtreatment.

33 (n) The RAND Institute estimates that one-third of clinical
34 procedures performed are of questionable clinical benefit.

35 (o) Quantitative analyses performed by the Congressional
36 Budget Office, the General Accounting Office, the Lewin Group,
37 and the Legislative Analyst's Office indicate that under a single
38 payer health care coverage system, the amount currently spent for
39 health care is adequate to finance comprehensive high quality
40 health care coverage for every resident of the state.

1 (p) According to these reports and numerous other studies, by
2 simplifying administration, achieving bulk purchase discounts on
3 pharmaceuticals, reducing the use of emergency facilities for
4 primary care, and better managing health care resources, California
5 could divert billions of dollars toward direct health care.

6 (q) Enactment of a single payer universal health care system
7 would create 2.6 million jobs in the United States, while infusing
8 three hundred seventeen billion dollars (\$317,000,000,000) in new
9 business and public revenues and one hundred billion dollars
10 (\$100,000,000,000) in wages into the United States economy
11 according to a recent study by the Institute for Health and
12 Socioeconomic Policy.

13 (r) Single payer health care, exhibited by Medicare and the
14 Veterans Administration, along with virtually every other industrial
15 nation in the world, is a well tested model that has been proven to
16 contain the growth in health care spending while promoting quality
17 improvements and maintaining comprehensive coverage.

18 140005.1. (a) It is the intent of the Legislature to establish a
19 system of universal health care coverage in this state that provides
20 all residents with comprehensive health care benefits, guarantees
21 a single standard of care for all residents, stabilizes the growth in
22 health care spending, and improves the quality of health care for
23 all residents.

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

34 140006. This division shall have all of the following purposes:

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

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

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

1 (d) To prevent disease and disability and to improve or maintain
2 health and functionality.

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

5 (f) To implement policies that strengthen and improve culturally
6 and linguistically sensitive care and sensitive care provided to
7 disabled persons.

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

10 (h) To provide information and care in an appropriate and
11 accessible format.

12 140007. As used in this division, the following terms have the
13 following meanings:

14 (a) “Agency” means the California Healthcare Agency.

15 (b) “Clinic” means an organized outpatient health facility that
16 provides direct medical, surgical, dental, optometric, or podiatric
17 advice, services, or treatment to patients who remain less than 24
18 hours, and that may also provide diagnostic or therapeutic services
19 to patients in the home as an alternative to care provided at the
20 clinic facility, and includes those facilities defined under Sections
21 1200 and 1200.1.

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

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

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

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

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

36 (3) A “federally qualified health center” as defined under Section
37 1395x (aa)(4) or 1396d (l)(2) of Title 42 of the United States Code.

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

1 (5) Any clinic conducted, maintained, or operated by a federally
2 recognized Indian tribe or tribal organization, as defined in Section
3 1603 of Title 25 of the United States Code.

4 (6) Any clinic exempt from licensure under subdivision (h) of
5 Section 1206.

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

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

18 (h) “Hospital” means all health facilities to which persons may
19 be admitted for a 24-hour stay or longer, as defined in Section
20 1250, with the exception of nursing, skilled nursing, intermediate
21 care, and congregate living health facilities.

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

24 (1) Is fully integrated operationally and clinically to provide a
25 broad range of health care services, including preventative care,
26 prenatal and well-baby care, immunizations, screening diagnostics,
27 emergency services, hospital and medical services, surgical
28 services, and ancillary services.

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

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

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

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

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

16 (n) “System” means the California Healthcare System.

17 140008. The definitions contained in Section 140007 shall
18 govern the construction of this division, unless the context requires
19 otherwise.

20
21 CHAPTER 2. GOVERNANCE
22

23 140100. (a) (1) The commissioner shall be appointed by the
24 Governor on or before ~~March 1, 2010~~ *July 1 of the fiscal year*
25 *following the date that this section becomes operative pursuant to*
26 *Section 140700*, subject to confirmation by the Senate. If in session,
27 the Senate shall act on the appointment within 30 days of the
28 appointment date. If the Senate does not act on the appointment
29 within that period, the nominee shall be deemed confirmed and
30 may take office. If the Senate is not in session at the time of the
31 appointment, the Senate shall act on the appointment within 30
32 days of the commencement of the next legislative session. If the
33 Senate does not act on the appointment within that period, the
34 appointee shall be deemed confirmed and may take office.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

40 (2) The Office of Patient Advocacy, pursuant to Section 140105.

1 (3) The Office of Health Planning, pursuant to Section 140602.

2 (4) The Office of Healthcare Quality, pursuant to Section
3 140605.

4 (5) The Healthcare Fund, pursuant to Section 140200.

5 (6) The Public Advisory Committee, pursuant to Section 140104.

6 (7) The Payments Board, pursuant to Section 140208.

7 (8) Partnerships for Health.

8 (b) Determine goals, standards, guidelines, and priorities for
9 the system.

10 (c) Establish health planning regions, pursuant to Section
11 140112.

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

24 (e) Annually assess projected revenues and expenditures and
25 assure financial solvency of the system pursuant to Section 140203.

26 (f) Develop the system's budget pursuant to Section 140206 to
27 ensure adequate funding to meet the health care needs of the
28 population. Review all budgets and locations annually to ensure
29 they address disparities in service availability and health care
30 outcomes and for sufficiency of rates, fees, and prices.

31 (g) Establish a capital management framework for the system
32 pursuant to Section 140216, including, but not limited to, a
33 standardized process and format for the development and
34 submission of regional operating and regional capital budget
35 requests and ensure a smooth transition to system oversight.

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

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

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

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

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

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

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

27 (o) Establish standards based on clinical efficacy to guide
28 delivery of care and a process to identify areas where no such
29 standards exist, set priorities and a timetable for their development,
30 and ensure a smooth transition to clinical decisionmaking under
31 statewide standards.

32 (p) Implement policies to ensure that all Californians receive
33 culturally and linguistically sensitive care, pursuant to Section
34 140604, and that all disabled Californians receive care in
35 accordance with the federal Americans with Disabilities Act (42
36 U.S.C. Sec. 12101 et seq.) and Section 504 of the Rehabilitation
37 Act of 1973 (29 U.S.C. Sec. 794) and develop mechanisms and
38 incentives to achieve these purposes and a means to monitor the
39 effectiveness of efforts to achieve these purposes.

1 (q) Create a systematic approach to the measurement,
2 management, and accountability for care quality and access,
3 including a system of performance contracts that contain
4 measurable goals and outcomes and appropriate statewide and
5 regional health care databases to assure the delivery of quality care
6 to all patients.

7 (r) Establish standards for mandatory reporting by health care
8 providers and penalties for failure to report.

9 (s) Develop methods and a framework to measure the
10 performance of health care coverage and health delivery system
11 upper level managers, including a system of performance contracts
12 that contain measurable goals and outcomes.

13 (t) Implement policies to ensure that all residents of this state
14 have access to medically appropriate, coordinated mental health
15 services.

16 (u) Ensure the establishment of policies that support the public
17 health.

18 (v) Meet regularly with the chief medical officer, the patient
19 advocate for the Office of Patient Advocacy, the Public Advisory
20 Committee, the Director of the Office of Health Planning, the
21 Director of the Payments Board, the Director of the Partnerships
22 for Health, regional planning directors, and regional medical
23 officers to review the impact of the agency and its policies on the
24 health of the population and on satisfaction with the system.

25 (w) Negotiate for or set rates, fees, and prices involving any
26 aspect of the system and establish procedures thereto.

27 (x) Establish a formulary based on clinical efficacy for all
28 prescription drugs and durable and nondurable medical equipment
29 for use by the system.

30 (y) Establish guidelines for prescribing medications and durable
31 medical equipment that are not included in the system's
32 formularies.

33 (z) Utilize the purchasing power of the state to negotiate price
34 discounts for prescription drugs and durable and nondurable
35 medical equipment for use by the system.

36 (aa) Ensure that use of state purchasing power achieves the
37 lowest possible prices for the system without adversely affecting
38 needed pharmaceutical research.

1 (ab) Create incentives and guidelines for research needed to
2 meet the goals of the system and disincentives for research that
3 does not achieve the system goals.

4 (ac) Implement eligibility standards for the system, including
5 guidelines to prevent an influx of persons to the state for the
6 purpose of obtaining medical care.

7 (ad) Determine an appropriate level of, and provide support
8 during the transition for, training and job placement for persons
9 who are displaced from employment as a result of the initiation of
10 the system.

11 (ae) Oversee the establishment of a system for resolution of
12 disputes pursuant to Sections 140608 and 140610.

13 (af) Investigate the costs and benefits to the health of the
14 population of advances in information technology, including those
15 that support data collection, analysis, and distribution.

16 (ag) Ensure that consumers of health care have access to
17 information needed to support their choice of a physician.

18 (ah) Collaborate with the licensing entities of health facilities
19 to ensure that facility performance is monitored and that deficient
20 practices are recognized and corrected in a timely fashion and that
21 consumers and providers of health care have access to information
22 needed to support their choice of facility.

23 (ai) Establish an Internet Web site that provides information to
24 the public about the system that includes, but is not limited to,
25 information that supports choice of providers and facilities, informs
26 the public about meetings of state and regional health planning
27 boards and activities of the Partnerships for Health.

28 (aj) Procure funds, including loans, for the system, enter into
29 leases, and obtain insurance for the system and its employees and
30 agents.

31 (ak) Collaborate with state and local authorities, including
32 regional planning directors, to plan for needed earthquake retrofits
33 in a manner that does not disrupt patient care.

34 (al) Establish a process that is accessible to all Californians for
35 the system to receive the concerns, opinions, ideas, and
36 recommendation of the public regarding all aspects of the system.

37 (am) Annually report to the Legislature and the Governor, on
38 or before October of each year and at other times pursuant to this
39 division, on the performance of the system, its fiscal condition and
40 need for rate adjustments, consumer copayments or consumer

1 deductible payments, recommendations for statutory changes,
2 receipt of payments from the federal government and other sources,
3 whether current year goals and priorities are met, future goals, and
4 priorities, and major new technology or prescription drugs or other
5 circumstances that may affect the cost of health care.

6 140103. (a) The commissioner shall establish a Healthcare
7 Policy Board and shall serve as the president of the board.

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

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

11 (2) Establish the scope of services to be provided to the
12 population in accordance with Chapter 5 (commencing with Section
13 140500).

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

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

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

20 (1) The commissioner.

21 (2) The deputy commissioner.

22 (3) The Director of the Healthcare Fund.

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

24 (5) The chief medical officer.

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

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

27 (8) The Director of the Payments Board.

28 (9) The State Public Health Officer.

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

32 (11) Two representatives from regional planning boards.

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

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

38 (d) It is unlawful for the board members or any of their
39 assistants, clerks, or deputies to use for personal benefit any

1 information that is filed with or obtained by the board and that is
2 not then generally available to the public.

3 140104. (a) The commissioner shall establish the Public
4 Advisory Committee to advise the Healthcare Policy Board on all
5 matters of policy for the system.

6 (b) Members of the Public Advisory Committee shall include
7 all of the following:

8 (1) Four physicians all of whom shall be board certified in their
9 field and at least one of whom shall be a psychiatrist. The Senate
10 Committee on Rules and the Governor shall each appoint one
11 member. The Speaker of the Assembly shall appoint two of these
12 members, both of whom shall be primary care providers.

13 (2) One registered nurse, to be appointed by the Senate
14 Committee on Rules.

15 (3) One licensed vocational nurse, to be appointed by the Senate
16 Committee on Rules.

17 (4) One licensed allied health practitioner, to be appointed by
18 the Speaker of the Assembly.

19 (5) One mental health care provider, to be appointed by the
20 Senate Committee on Rules.

21 (6) One dentist, to be appointed by the Governor.

22 (7) One representative of private hospitals, to be appointed by
23 the Governor.

24 (8) One representative of public hospitals, to be appointed by
25 the Governor.

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

28 (10) Four consumers of health care. The Governor shall appoint
29 two of these members, one of whom shall be a member of the
30 disability community. The Senate Committee on Rules shall
31 appoint a member who is 65 years of age or older. The Speaker
32 of the Assembly shall appoint the fourth member.

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

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

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

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

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

3 (16) One pharmacist, to be appointed by the Speaker of the
4 Assembly.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

34 (6) Receive, evaluate, and respond to consumer complaints
35 about the system.

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

1 (8) Develop educational and informational guides for consumers
2 describing their rights and responsibilities and informing them
3 about effective ways to exercise their rights to secure health care
4 services and to participate in the system. The guides shall be easy
5 to read and understand, available in English and other languages,
6 including Braille and formats suitable for those with hearing
7 limitations, and shall be made available to the public by the agency,
8 including access on the agency's Internet Web site and through
9 public outreach and educational programs, and displayed in
10 provider offices and health care facilities.

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

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

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

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

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

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

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

1 (c) The Inspector General shall investigate allegations of
2 misconduct on the part of an employee or appointee of the agency
3 and on the part of any health care provider of services that are
4 reimbursed by the system and shall report any findings of
5 misconduct to the Attorney General.

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

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

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

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

24 (h) The Inspector General shall annually report
25 recommendations for improvements to the system or the agency
26 to the Governor, the Legislature, and the commissioner.

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

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

39 (b) All federal legislation and regulations governing referral
40 fees and fee-splitting, including, but not limited to, Sections

1 1320a-7b and 1395nn of Title 42 of the United States Code, shall
2 be applicable to all health care providers of services reimbursed
3 under this division, whether or not the health care provider is paid
4 with funds coming from the federal government.

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

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

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

20 140111. (a) The commissioner shall appoint a transition
21 advisory group, which shall include, but not be limited to, the
22 following members:

- 23 (1) The commissioner.
- 24 (2) The patient advocate of the Office of Patient Advocacy.
- 25 (3) The chief medical officer.
- 26 (4) The Director of the Office of Health Planning.
- 27 (5) The Director of the Healthcare Fund.
- 28 (6) The State Public Health Officer.
- 29 (7) Experts in health care financing and health care
30 administration.
- 31 (8) Direct care providers.
- 32 (9) Representatives of retirement boards.
- 33 (10) Employer and employee representatives.
- 34 (11) Hospital, integrated health care delivery system, essential
35 community provider, and long-term care facility representatives.
- 36 (12) Representatives from state departments and regulatory
37 bodies that shall or may relinquish some or all parts of their
38 delivery of health care services to the system.
- 39 (13) Representatives of counties.
- 40 (14) Consumers of health care services.

1 (b) The transition advisory group shall advise the commissioner
2 on all aspects of the implementation of this division.

3 (c) The transition advisory group shall make recommendations
4 to the commissioner, the Governor, and the Legislature on how to
5 integrate health care delivery services and responsibilities relating
6 to the delivery of the services of the following departments and
7 agencies into the system:

- 8 (1) The State Department of Health Care Services.
- 9 (2) The Department of Managed Health Care.
- 10 (3) The Department of Aging.
- 11 (4) The Department of Developmental Services.
- 12 (5) The Health and Welfare Data Center.
- 13 (6) The State Department of Mental Health.
- 14 (7) The State Department of Alcohol and Drug Programs.
- 15 (8) The Department of Rehabilitation.
- 16 (9) The Emergency Medical Services Authority.
- 17 (10) The Managed Risk Medical Insurance Board.
- 18 (11) The Office of Statewide Health Planning and Development.
- 19 (12) The Department of Insurance.
- 20 (13) The State Department of Public Health.

21 (d) The transition advisory group shall make recommendations
22 to the Governor, the Legislature, and the commissioner regarding
23 research needed to support transition to the system.

24 140112. (a) The transition advisory group shall make
25 recommendations to the commissioner relative to how the system
26 shall be regionalized for the purposes of local and
27 community-based planning for the delivery of high quality
28 cost-effective care and efficient service delivery.

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

- 33 (1) Patterns of utilization of health care services.
- 34 (2) Health care resources, including workforce resources.
- 35 (3) Health needs of the population, including public health
36 needs.
- 37 (4) Geography.
- 38 (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
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 CHAPTER 3. FUNDING

35 Article 1. General Provisions

36
37
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 an actuarially sound
30 reserve that is consistent with appropriate risk-based capital
31 standards to assure financial solvency of the system.

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

36 (e) Moneys currently held in reserve by state health programs,
37 city and county contributions as determined by the commissioner
38 pursuant to subdivision (c) of Section 140240, and federal moneys
39 for health care held in reserve in federal trust accounts shall be
40 transferred to the reserve account when the state assumes financial

1 responsibility for health care under this division that is currently
2 provided by those programs.

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

9 (g) Funds held in the reserve account and other Healthcare Fund
10 accounts may be prudently invested to increase their value
11 according to the Department of Managed Health Care's standards
12 for financial solvency.

13 140203. (a) The Director of the Healthcare Fund shall
14 immediately notify the commissioner when regional or statewide
15 revenue and expenditure trends indicate that expenditures may
16 exceed revenues.

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

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

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

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

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

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

32 (5) Postponement of planned capital expenditures.

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

39 (7) Adjustments to the compensation of managerial employees
40 and upper level managers under contract with the system to correct

1 for deficiencies in management and failure to meet contract
2 performance goals.

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

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

8 (10) Deferred funding of the reserve account.

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

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

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

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

24 (D) Waivers shall not affect the reimbursement of health care
25 providers.

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

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

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

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

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

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

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

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

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

(3) Postponement of planned regional capital expenditures.

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

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

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

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

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

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

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

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

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

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

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

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

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

38 140206. (a) The commissioner annually shall prepare a budget
39 for the system that includes all expenditures, specifies a limit on
40 total annual state expenditures, and establishes allocations for each

1 health care region that shall cover a three-year period and that shall
2 be disbursed on a quarterly basis.

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

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

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

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

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

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

- 34 (1) Costs of transition to the new system.
- 35 (2) Projections regarding the health care services anticipated to
36 be used by California residents.
- 37 (3) Differences in cost of living between the regions, including
38 the overhead costs of maintaining medical practices.
- 39 (4) Health risk of enrollees.
- 40 (5) Scope of services provided.

1 (6) Innovative programs that improve care quality,
2 administrative efficiency, and workplace safety.

3 (7) Unrecovered cost of providing care to persons who are not
4 enrollees of the system. The commissioner shall seek to recover
5 the costs of care provided to persons who are not enrollees of the
6 system.

7 (8) Costs of workforce training and development.

8 (9) Costs of correcting health outcome disparities and the unmet
9 needs of previously uninsured and underinsured enrollees.

10 (10) Relative usage of different health care providers.

11 (11) Needed improvements in access to care.

12 (12) Projected savings in administrative costs.

13 (13) Projected savings due to provision of primary and
14 preventive care to the population, including savings from decreases
15 in preventable emergency room visits and hospitalizations.

16 (14) Projected savings from improvements in care quality.

17 (15) Projected savings from decreases in medical errors.

18 (16) Projected savings from systemwide management of capital
19 expenditures.

20 (17) Cost of incentives and bonuses to support the delivery of
21 high quality care, including incentives and bonuses needed to
22 recruit and retain an adequate supply of needed providers and
23 managers and to attract health care providers to medically
24 underserved areas.

25 (18) Costs of treating complex illnesses, including disease
26 management programs.

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

29 (20) Costs of new technology.

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

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

36 140207. The commissioner shall annually establish the total
37 funds to be allocated for provider and manager compensation
38 pursuant to this section. In establishing the provider and manager
39 budgets, the commissioner shall allot sufficient funds to assure
40 that California can attract and retain those providers and managers

1 needed to meet the health care needs of the population. In
2 establishing provider and manager budgets, the commissioner shall
3 allocate funds for both salaries, incentives, bonuses, and benefits
4 to be provided to officers and upper level managers of the system
5 who are exempt from state civil service statutes.

6 140208. (a) The commissioner shall establish the Payments
7 Board and shall appoint a director and members of the board.

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

11 (c) The Payments Board shall be composed of experts in health
12 care finance and insurance systems, a designated representative
13 of the commissioner, a designated representative of the Healthcare
14 Fund, and a representative of the regional planning directors. The
15 position of regional representative shall rotate among the directors
16 of the regional planning boards every two years.

17 (d) The board shall establish and supervise a uniform payments
18 system for health care providers and managers and shall maintain
19 a compensation plan for all of the following health care providers
20 and managers pursuant to the provider and manager budget
21 established by the commissioner:

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

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

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

35 (4) Compensation for employees of the system that was
36 determined through employer-union negotiations before
37 implementation of this division shall be determined by negotiations
38 between the system and the unions after implementation of this
39 division.

1 (5) Health care providers licensed and accredited to provide
2 services in California may choose to be compensated for their
3 services either by the system or by a person to whom they provide
4 services.

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

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

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

14 (e) Health care providers licensed or accredited to provide
15 services in California, who choose to be compensated by the system
16 instead of by patients to whom they provide services, may choose
17 how they wish to be compensated under this division, as
18 fee-for-service providers or as providers employed by, or under
19 contract with, health care systems that provide comprehensive,
20 coordinated services.

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

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

33 (1) Actuarially sound payments that include a just and fair return
34 for health care providers in the fee-for-service sector and for health
35 care providers working in health systems where comprehensive
36 and coordinated services are provided, including the actuarial basis
37 for the payment.

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

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

1 (A) Bonus payments for health care providers and upper level
2 managers who, in providing services and managing facilities,
3 practices, and integrated health systems pursuant to this division,
4 meet performance standards and outcome goals established by the
5 system.

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

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

12 (D) Incentive payments required to recruit and retain nurse
13 practitioners and physician assistants in order to provide primary
14 and preventive care to the population.

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

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

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

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

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

30 140209. (a) Fee-for-service health care providers shall choose
31 representatives of their specialties to negotiate reimbursement rates
32 with the Payments Board on their behalf.

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

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

37 (d) Payment schedules shall be in effect for three years, at which
38 time payment schedules may be renegotiated. Payment adjustments
39 may be made at the discretion of the Payments Board to meet the
40 goals of the system.

1 (e) In establishing a uniform system of payments, the Payments
2 Board shall collaborate with regional planning directors and health
3 care providers and shall take into consideration regional differences
4 in the cost of living and the need to recruit and retain skilled health
5 care providers in the region.

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

10 140210. (a) Compensation for health care providers and upper
11 level managers employed by, or under contract with, integrated
12 health care delivery systems, group medical practices, and essential
13 community providers that provide comprehensive, coordinated
14 services shall be determined according to the following guidelines:

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

20 (c) In negotiating reimbursement with systems providing
21 comprehensive, coordinated services, the Payments Board shall
22 take into consideration the need for comprehensive systems to
23 have flexibility in establishing health care provider and upper level
24 manager reimbursement.

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

28 (e) The Payments Board shall take into consideration regional
29 differences in the cost of living and the need to recruit and retain
30 skilled health care providers and upper level managers to the
31 regions.

32 (f) The Payments Board shall establish a timetable for
33 reimbursement for fee-for-service health care provider's
34 negotiations. If an agreement on reimbursement is not reached
35 according to the timetable established by the Payments Board, the
36 Payments Board shall establish reimbursement rates, which shall
37 be binding.

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

1 140211. (a) The Payments Board shall annually report to the
2 commissioner on the status of health care provider and upper level
3 manager reimbursement, including satisfaction with reimbursement
4 levels and the sufficiency of funds allocated by the commissioner
5 for provider and upper level manager reimbursement. The
6 Payments Board shall recommend needed adjustments in the
7 allocation for health care provider payments.

8 (b) The Office of Health Care Quality shall annually report to
9 the commissioner on the impact of the bonus payments in
10 improving quality of care, health outcomes, and management
11 effectiveness. The Payments Board shall recommend needed
12 adjustments in bonus allocations.

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

20 140212. (a) The commissioner shall establish an allocation
21 for each region to fund regional operating and capital budgets for
22 a period of three years. Allocations shall be disbursed to the regions
23 on a quarterly basis.

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

30 (c) Health care providers choosing to function on the basis of
31 a capitated or a noncapitated system operating budget shall submit
32 three-year operating budget requests to the regional planning
33 director, pursuant to standards and guidelines established by the
34 commissioner.

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

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

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

4 (e) Operating and capitated budgets shall include health care
5 workforce labor costs other than those described in paragraphs
6 (1), (2), and (3) of subdivision (d) of Section 140208. If unions
7 represent employees working in systems functioning under
8 capitated or noncapitated budgets, unions shall represent those
9 employees in negotiations with the regional planning director and
10 the Payments Board for the purpose of establishing their
11 reimbursement.

12 140213. (a) Health systems and medical practices functioning
13 under capitated and noncapitated operating budgets shall
14 immediately report any projected operating deficit to the regional
15 planning director. The regional planning director shall determine
16 whether projected deficits reflect appropriate increases in
17 expenditures, in which case the director shall make an adjustment
18 to the operating budget. If the director determines that deficits are
19 not justifiable, no adjustment shall be made.

20 (b) If a regional planning director determines that adjustments
21 to operating budgets will cause a regional revenue shortfall and
22 that cost control measures may be required, the regional planning
23 director shall report the possible revenue shortfall to the
24 commissioner and take actions required pursuant to Section
25 140203.

26 140215. (a) Margins generated by a facility operating under
27 a system operating budget may be retained and used to meet the
28 health care needs of the population.

29 (b) No margin may be retained if that margin was generated
30 through inappropriate limitations on access to health care or
31 compromises in the quality of care or in any way that adversely
32 affected or is likely to adversely affect the health of the persons
33 receiving services from a facility, integrated health care delivery
34 system, group medical practice, or essential community provider
35 functioning under a system operating budget.

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

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

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

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

9 140216. (a) During the transition, the commissioner shall
10 develop a capital management plan that shall include
11 conflict-of-interest standards and that shall govern all capital
12 investments and acquisitions undertaken in the system. The plan
13 shall include a framework, standards, and guidelines for all of the
14 following:

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

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

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

23 (4) Development by the commissioner of a multiyear system
24 capital development plan that supports the system's goals,
25 priorities, and performance standards and meets the health care
26 needs of the population.

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

29 (6) Evaluation of, and support for, noninvestment means to
30 meet health care needs, including, but not limited to, improvements
31 in administrative efficiency, care quality, and innovative service
32 delivery, use, adaptation or refurbishment of existing land and
33 property, and identification of publicly owned land or property
34 that may be available to the system and that may meet a capital
35 need.

36 (7) Development and maintenance of capital inventories on a
37 regional basis, including the condition, utilization capacity,
38 maintenance plan and costs, deferred maintenance of existing
39 capital inventory, and excess capital capacity.

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

10 (9) Standards and a process whereby the regional planning
11 directors shall evaluate, accept, reject, or modify a business plan
12 for a capital investment or acquisition. Decisions of a regional
13 planning director may be appealed through a dispute resolution
14 process established by the commissioner.

15 (10) Standards for binding project contracts between the system
16 and the party developing a capital project or making a capital
17 acquisition that shall govern all terms and conditions of capital
18 investments and acquisitions, including terms and conditions for
19 grants, loans, lines of credit, and lease-purchase arrangements by
20 the system.

21 (11) A process and standards whereby the Director of the
22 Healthcare Fund shall negotiate terms and conditions of the liens,
23 grants, lines of credit, and lease-purchase arrangements for capital
24 investments and acquisitions by the system. Terms and conditions
25 negotiated by the Director of the Healthcare Fund shall be included
26 in project contracts.

27 (12) A plan for the commissioner and for the regional planning
28 directors to issue requests for proposals and to oversee a process
29 of competitive bidding for the development of capital projects that
30 meet the needs of the system and to fund, partially fund, or
31 participate in seeking funding for, those capital projects.

32 (13) Responses to requests for proposals and competitive bids
33 shall include a description of how a project meets the service needs
34 of the region and addresses the environmental impact report and
35 shall include the full life cycle costs of a capital asset.

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

1 (15) A process and standards for periodic revisions in the capital
2 management plan, including annual meetings in each region to
3 discuss the plan and make recommendations for improvements in
4 the plan.

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

8 (b) No registered lobbyist shall participate in or in any way
9 attempt to influence the request for proposals or competitive bid
10 process.

11 (c) Development of performance standards and a process to
12 monitor and measure performance of those making capital health
13 care investments and acquisitions, including those making capital
14 investments pursuant to a state competitive bidding process.

15 (d) A process for earned autonomy from state capital investment
16 oversight for those who demonstrate the ability to manage capital
17 investment and capital assets effectively in accordance with the
18 system's standards, and standards for loss of earned autonomy
19 when capital management is ineffective.

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

28 (f) In general, no capital investment may be made from an
29 operating budget. However, guidelines shall be established for the
30 types and levels of small capital investments that may be
31 undertaken from an operating budget without the approval of the
32 regional planning director.

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

37 140217. (a) Regional planning directors shall develop a
38 regional capital development plan pursuant to the system's capital
39 management plan established by the commissioner. In developing

1 the regional capital development plan, the regional planning
2 director shall do all of the following:

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

5 (2) Develop a multiyear regional capital health management
6 plan that supports regional goals and the state capital management
7 plan.

8 (3) Assist regional health care providers to develop capital
9 budget requests pursuant to the regional capital budget plan and
10 the system's capital management plan established by the
11 commissioner.

12 (4) Receive and evaluate capital budget requests from regional
13 health care providers.

14 (5) Establish ranking criteria to assess competing demands for
15 capital.

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

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

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

25 140218. (a) Assets financed by state grants, loans, lines of
26 credit, and lease-purchase arrangements shall be owned, operated,
27 and maintained by the recipient of the grant, loan, line of credit,
28 or lease-purchase arrangement, according to terms established at
29 the time of issuance of the grant, loan, line of credit, or
30 lease-purchase arrangement.

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

36 (c) When an asset, which was in whole or in part financed by
37 the system, is to be sold or transferred by a party that received
38 financing from the system for purchase, lease, or construction of
39 the asset, an impartial estimate of the fair market value of the asset
40 shall be undertaken. The system shall receive a share of the fair

1 market value of the asset at the time of its sale or transfer that is
2 in proportion to the system's original investment. The system may
3 elect to postpone receipt of its share of the value of the asset if the
4 commissioner determines that the postponement meets the needs
5 of the system.

6 140219. The regional planning directors shall make financial
7 information available to the public when the system's contribution
8 to a capital project is greater than twenty-five million dollars
9 (\$25,000,000). Information shall include the purpose of the project
10 or acquisition, its relation to the system's goals, the project budget
11 and the timetable for completion, environmental impact reports,
12 any terms-related conflicts of interest, and performance standards
13 and benchmarks.

14 140220. (a) The commissioner shall establish a budget for the
15 purchase of prescription drugs and durable and nondurable medical
16 equipment for the system.

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

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

26 140221. (a) The commissioner shall establish a budget to
27 support research and innovation that has been recommended by
28 the chief medical officer, the Director of the Office of Health
29 Planning, the patient advocates, the Partnerships for Health, and
30 others as required by the commissioner.

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

33 140222. (a) The commissioner shall establish a budget to
34 support the training, development, and continuing education of
35 health care providers and the health care workforce needed to meet
36 the health care needs of the population and the goals and standards
37 of the system.

38 (b) During the transition, the commissioner shall determine an
39 appropriate level and duration of spending to support the retraining

1 and job placement of persons who have been displaced from
2 employment as a result of the transition to the system.

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

6 140223. (a) The commissioner shall establish a reserve account
7 pursuant to this section.

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

10 140224. (a) The commissioner shall establish a budget that
11 covers all costs of administering the system.

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

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

18 (d) The commissioner shall ensure that the percentage of the
19 budget allocated to support system administration stays within the
20 allowable limits and shall continually seek means to lower system
21 administrative costs.

22 (e) The commissioner shall report to the public, the regional
23 planning directors, and others attending the annual system revenue
24 and expenditure conference pursuant to Section 140206 on the
25 costs of administering the system and the regions and shall make
26 recommendations for reducing administrative costs and receive
27 recommendations for reducing administrative costs.

28 29 Article 2. California Healthcare Premium Commission 30

31 140230. (a) There is hereby created the California Healthcare
32 Premium Commission, referred to in this division as the Premium
33 Commission.

34 (b) The Premium Commission shall be composed of the
35 following members:

36 (1) Three health economists with experience relevant to the
37 functions of the Premium Commission. One shall be appointed by
38 the Speaker of the Assembly, one shall be appointed by the Senate
39 Committee on Rules, and one shall be appointed by the Governor.

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

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

8 (4) Two representatives of nonprofit organizations whose
9 principal purpose includes promoting the establishment of a system
10 of universal health care in California. One shall be appointed by
11 the Senate Committee on Rules and one shall be appointed by the
12 Speaker of the Assembly.

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

17 (6) Two members of the Legislature. One shall be appointed by
18 the Senate Committee on Rules and one shall be appointed by the
19 Speaker of the Assembly.

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

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

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

23 (10) The Legislative Analyst.

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

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

26 (13) The Controller.

27 (14) The Treasurer.

28 (15) The Lieutenant Governor.

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

37 140231. (a) The Premium Commission shall perform the
38 following functions:

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

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

5 (b) The Premium Commission shall perform the functions
6 described in this section by considering existing financial
7 simulations and analyses of universal health care proposals,
8 including, but not limited to, the analysis completed by the Lewin
9 Group in January 2005, of Senate Bill 921 of the 2003–04 Regular
10 Session.

11 140232. (a) The premium structure developed by the Premium
12 Commission shall satisfy the following criteria:

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

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

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

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

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

26 (6) Be consistent with state and federal requirements governing
27 financial contributions for persons eligible for existing public
28 programs.

29 (7) Comply with federal requirements.

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

34 (b) The Premium Commission shall seek expert and legal advice
35 regarding the best method to structure premium payments
36 consistent with existing employer-employee health care financing
37 structures.

38 140233. The Premium Commission may take all of the
39 following actions:

1 (a) Obtain grants from, and contract with, individuals and
2 private, local, state, and federal agencies, organizations, and
3 institutions, including institutions of higher education.

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

6 140234. (a) The Premium Commission may consult with
7 additional persons, advisory entities, governmental agencies,
8 Members of the Legislature, and legislative staff as it deems
9 necessary to perform its functions.

10 (b) The Premium Commission shall seek structured input from
11 representatives of stakeholder organizations, policy institutes, and
12 other persons with expertise in health care, health care financing,
13 or universal health care models in order to ensure that it has the
14 necessary information, expertise, and experience to perform its
15 functions.

16 (c) The Premium Commission shall be supported by a reasonable
17 amount of staff time, which shall be provided by the state agencies
18 with membership on the Premium Commission. The Premium
19 Commission may request data from, and utilize the technical
20 expertise of, other state agencies.

21 140235. (a) On or before January 1, ~~2012~~ 2013, the Premium
22 Commission shall submit to the Governor and the Legislature a
23 detailed recommendation for a premium structure.

24 (b) The Premium Commission shall submit a draft
25 recommendation to the Governor, Legislature, and the public at
26 least 90 days prior to submission of the final recommendation
27 described in subdivision (a). The Premium Commission shall seek
28 input from the public on the draft recommendation.

29 140236. The Premium Commission shall be funded upon an
30 appropriation by the Legislature in the Budget Act of ~~2010~~ 2011.

31 32 Article 3. Governmental Payments 33

34 140240. (a) (1) The commissioner shall seek all necessary
35 waivers, exemptions, agreements, or legislation, so that all current
36 federal payments to the state for health care services be paid
37 directly to the system, which shall then assume responsibility for
38 all benefits and services previously paid for by the federal
39 government with those funds.

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

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

11 (2) In obtaining the waivers, exemptions, agreements, or
12 legislation, the commissioner shall seek from the Legislature a
13 contribution for health care services that shall not decrease in
14 relation to state government expenditures for health care services
15 in the year that this division was enacted, except that it may be
16 corrected for change in state gross domestic product, the size and
17 age of population, and the number of residents living below the
18 federal poverty level.

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

22 (d) The commissioner shall seek all necessary waivers,
23 exemptions, agreements, or legislation, so that all county or other
24 local government agency payments shall be paid directly to the
25 system.

26 140241. The system's responsibility for providing health care
27 services shall be secondary to existing federal, state, or local
28 governmental programs for health care services to the extent that
29 funding for these programs is not transferred to the Healthcare
30 Fund or that the transfer is delayed beyond the date on which initial
31 benefits are provided under the system.

32 140242. In order to minimize the administrative burden of
33 maintaining eligibility records for programs transferred to the
34 system, the commissioner shall strive to reach an agreement with
35 federal, state, and local governments in which their contributions
36 to the Healthcare Fund shall be fixed to the rate of change of the
37 state gross domestic product, the size and age of population, and
38 the number of residents living below the federal poverty level.

39 140243. If and to the extent that federal law and regulations
40 allow the transfer of Medi-Cal program funding to the system, the

1 commissioner shall pay from the Healthcare Fund all premiums,
2 deductible payments, and coinsurance for qualified beneficiaries
3 who are receiving benefits pursuant to Chapter 3 (commencing
4 with Section 12000) of Part 3 of Division 9 of the Welfare and
5 Institutions Code.

6 140244. If and to the extent that the commissioner obtains
7 authorization to incorporate Medicare revenues into the Healthcare
8 Fund, Medicare Part B payments that previously were made by
9 individuals or the commissioner shall be paid by the system for
10 all individuals eligible for both the system and the Medicare
11 Program.

12 Article 4. Federal Preemption

13
14
15 140300. (a) The commissioner shall pursue all reasonable
16 means to secure a repeal or a waiver of any provision of federal
17 law that preempts any provision of this division.

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

23 140301. (a) To the extent permitted by federal law, an
24 employee entitled to health or related benefits under a contract or
25 plan that, under federal law, preempts provisions of this division,
26 shall first seek benefits under that contract or plan before receiving
27 benefits from the system under this division.

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

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

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

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

Article 5. Subrogation

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

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

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

(2) Health care service plans and pension plans.

(3) Employers.

(4) Employee benefit contracts.

(5) Government benefit programs.

(6) A judgment for damages for personal injury.

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

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

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

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

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

140303. Whenever an individual receives health care services under the system and he or she is entitled to coverage, reimbursement, indemnity, or other compensation from a collateral source, he or she shall notify the health care provider and provide information identifying the collateral source, the nature and extent of coverage or entitlement, and other relevant information. The

1 health care provider shall forward this information to the
2 commissioner. The individual entitled to coverage, reimbursement,
3 indemnity, or other compensation from a collateral source shall
4 provide additional information as requested by the commissioner.

5 140304. (a) The system shall seek reimbursement from the
6 collateral source for services provided to the individual and may
7 institute appropriate action, including suit, to recover the
8 reimbursement. Upon demand, the collateral source shall pay to
9 the Healthcare Fund the sums it would have paid or expended on
10 behalf of the individual for the health care services provided by
11 the system.

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

18 140305. (a) If a collateral source is exempt from subrogation
19 or the obligation to reimburse the system as provided in this article,
20 the commissioner may require that an individual who is entitled
21 to health care services from the source first seek those services
22 from that source before seeking those services from the system.

23 (b) To the extent permitted by federal law, contractual retiree
24 health benefits provided by employers shall be subject to the same
25 subrogation as other contracts, allowing the system to recover the
26 cost of health care services provided to individuals covered by the
27 retiree benefits, unless and until arrangements are made to transfer
28 the revenues of the benefits directly to the system.

29 140306. (a) Default, underpayment, or late payment of any
30 tax or other obligation imposed by this division shall result in the
31 remedies and penalties provided by law, except as provided in this
32 section.

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

37 140307. The agency and the commissioner shall be exempt
38 from the regulatory oversight and review of the Office of
39 Administrative Law pursuant to Chapter 3.5 (commencing with
40 Section 11340) of Part 1 of Division 3 of Title 2 of the Government

1 Code. Actions taken by the agency, including, but not limited to,
2 the negotiating or setting of rates, fees, or prices, and the
3 promulgation of any and all regulations, shall be exempt from any
4 review by the Office of Administrative Law, except for Sections
5 11344.1, 11344.2, 11344.3, and 11344.6 of the Government Code,
6 addressing the publication of regulations.

7 140308. The agency shall adopt regulations to implement the
8 provisions of this division. The regulations may initially be adopted
9 as emergency regulations in accordance with the Administrative
10 Procedure Act (Chapter 3.5 (commencing with Section 11340) of
11 Part 1 of Division 3 of Title 2 of the Government Code), but those
12 emergency regulations shall be in effect only from the effective
13 date of this division until the conclusion of the transition period.

14
15 CHAPTER 4. ELIGIBILITY
16

17 140400. All California residents shall be eligible for the system.
18 Residency shall be based upon physical presence in the state with
19 the intent to reside. The commissioner shall establish standards
20 and a simplified procedure to demonstrate proof of residency.

21 140401. The commissioner shall establish a procedure to enroll
22 eligible residents and provide each eligible individual with
23 identification that can be used by health care providers to determine
24 eligibility for services.

25 140402. (a) It is the intent of the Legislature for the system to
26 provide health care coverage to California residents who are
27 temporarily out of the state. The commissioner shall determine
28 eligibility standards for residents temporarily out of state for longer
29 than 90 days who intend to return and reside in California and for
30 nonresidents temporarily employed in California. The
31 commissioner may establish financial arrangements with medical
32 providers in other states and foreign countries in order to facilitate
33 coverage for California residents who are temporarily out of the
34 state.

35 (b) Coverage for emergency care obtained out of state shall be
36 at prevailing local rates. Coverage for nonemergency care obtained
37 out of state shall be according to rates and conditions established
38 by the commissioner. The commissioner may require that a resident
39 be transported back to California when prolonged treatment of an

1 emergency condition is necessary and when that transport will not
2 adversely affect a patient's care or condition.

3 140403. Visitors to California shall be billed for all services
4 received under the system. The commissioner may establish
5 intergovernmental arrangements with other states and countries
6 to provide reciprocal coverage for temporary visitors.

7 140404. All persons eligible for health care benefits from
8 California employers but who are working in another jurisdiction
9 shall be eligible for health care benefits under this division
10 providing that they make payments equivalent to the payments
11 they would be required to make if they were residing in California.

12 140404.1. All persons who under an employer-employee
13 contract or under statute are eligible for retiree health care benefits,
14 including retirees who elect to reside outside of California, shall
15 remain eligible for those benefits in accordance with the contract
16 or the statute.

17 140405. Unmarried, unemancipated minors shall be deemed
18 to have the residency of their parent or guardian. If a minor's
19 parents are deceased and a legal guardian has not been appointed,
20 or if a minor has been emancipated by court order, the minor may
21 establish his or her own residency.

22 140406. (a) An individual shall be presumed to be eligible if
23 he or she arrives at a health facility and is unconscious, comatose,
24 or otherwise unable, because of his or her physical or mental
25 condition, to document eligibility or to act on his or her own behalf,
26 or if the patient is a minor, the patient shall be presumed to be
27 eligible, and the health facility shall provide care as if the patient
28 were eligible.

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

32 (c) Any individual involuntarily committed to an acute
33 psychiatric facility or to a hospital with psychiatric beds pursuant
34 to any provision of Section 5150 of the Welfare and Institutions
35 Code, providing for involuntary commitment, shall be presumed
36 eligible.

37 (d) All health facilities subject to state and federal provisions
38 governing emergency medical treatment shall continue to comply
39 with those provisions.

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

5
6 CHAPTER 5. BENEFITS
7

8 140500. Any eligible individual may choose to receive services
9 under the system from any willing professional health care provider
10 participating in the system. No health care provider may refuse to
11 care for a patient solely on any basis that is specified in the
12 prohibition of employment discrimination contained in the Fair
13 Employment and Housing Act (Part 2.8 (commencing with Section
14 12900) of Division 3 of Title 2 of the Government Code).

15 140500.01. A resident of the state in a family with an annual
16 or monthly net nonexempt household income equal to or less than
17 200 percent of the federal poverty level is eligible for no-cost
18 Medi-Cal and shall be entitled to not less than the full scope of
19 benefits available under the Medi-Cal program, pursuant to Section
20 14021 of, and Article 4 (commencing with Section 14131) of
21 Chapter 7 of Division 9 of, the Welfare and Institutions Code, as
22 provided on January 1, ~~2009~~ 2010.

23 140501. Covered benefits under this chapter shall include all
24 medical care determined to be medically appropriate by the
25 individual's health care provider, but are subject to limitations set
26 forth in Section 140503. Covered benefits include, but are not
27 limited to, all of the following:

- 28 (a) Inpatient and outpatient health facility services.
29 (b) Inpatient and outpatient professional health care provider
30 services by licensed health care professionals.
31 (c) Diagnostic imaging, laboratory services, and other diagnostic
32 and evaluative services.
33 (d) Durable medical equipment, appliances, and assistive
34 technology, including prosthetics, eyeglasses, and hearing aids
35 and their repair.
36 (e) Rehabilitative care.
37 (f) Emergency transportation and necessary transportation for
38 health care services for disabled and indigent persons.
39 (g) Language interpretation and translation for health care
40 services, including sign language for those unable to speak, or

- 1 hear, or who are language impaired, and Braille translation or other
2 services for those with no or low vision.
- 3 (h) Child and adult immunizations and preventive care.
- 4 (i) Health education.
- 5 (j) Hospice care.
- 6 (k) Home health care.
- 7 (l) Prescription drugs that are listed on the system's formulary.
- 8 Nonformulary prescription drugs may be included if standards and
9 criteria established by the commissioner are met.
- 10 (m) Mental and behavioral health care.
- 11 (n) Dental care.
- 12 (o) Podiatric care.
- 13 (p) Chiropractic care.
- 14 (q) Acupuncture.
- 15 (r) Blood and blood products.
- 16 (s) Emergency care services.
- 17 (t) Vision care.
- 18 (u) Adult day care.
- 19 (v) Case management and coordination to ensure services
20 necessary to enable a person to remain safely in the least restrictive
21 setting.
- 22 (w) Substance abuse treatment.
- 23 (x) Care of up to 100 days in a skilled nursing facility following
24 hospitalization.
- 25 (y) Dialysis.
- 26 (z) Benefits offered by a bona fide church, sect, denomination,
27 or organization whose principles include healing entirely by prayer
28 or spiritual means provided by a duly authorized and accredited
29 practitioner or nurse of that bona fide church, sect, denomination,
30 or organization.
- 31 (aa) Chronic disease management.
- 32 (ab) Family planning services and supplies.
- 33 (ac) For persons under 21 years of age, early and periodic
34 screening, diagnosis, and treatment services, as defined in Section
35 1396d(r) of Title 42 of the United States Code, whether or not
36 those services are covered benefits for persons who are 21 years
37 of age or older.
- 38 140502. The commissioner may expand benefits beyond the
39 minimum benefits described in this chapter when expansion meets

1 the intent of this division and when there are sufficient funds to
2 cover the expansion.

3 140503. The following health care services shall be excluded
4 from coverage by the system:

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

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

13 (c) Private rooms in inpatient health facilities where appropriate
14 nonprivate rooms are available, unless determined to be medically
15 necessary by a qualified, licensed health care provider in the
16 system.

17 (d) Services of a health care provider or facility that is not
18 licensed or accredited by the state except for approved services
19 provided to a California resident who is temporarily out of the
20 state.

21 140504. (a) During the initial two years of the system's
22 operation, the commissioner shall not impose a deductible payment
23 or copayment other than for treatment by a specialist if no referral
24 was made by the primary care provider pursuant to Section 140601.
25 The commissioner shall determine the amount of the copayment
26 or deductible imposed pursuant to this subdivision. The
27 commissioner and the Healthcare Policy Board shall review the
28 deductible and copayment provisions annually, commencing in
29 the third year of the system's operation, to determine whether they
30 should be included in the system.

31 (b) Commencing in the third year of the system's operation, the
32 commissioner may impose a deductible payment and copayment
33 pursuant to the determination made under subdivision (a), except
34 as specified under subdivisions (c) and (d). The amount of the
35 deductible payment and the copayment combined shall not exceed
36 two hundred fifty dollars (\$250) per person each year and five
37 hundred dollars (\$500) per family each year, except the deductible
38 payment and copayment for treatment by a specialist without a
39 referral from the primary care provider pursuant to Section 140601

1 shall not be subject to this limitation and shall be established by
2 the commissioner.

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

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

8 (e) No deductible payments or copayments may be imposed on
9 a person who is eligible for benefits under the Medi-Cal program
10 (Chapter 7 (commencing with Section 14000) of Part 3 of Division
11 9 of the Welfare and Institutions Code), except for treatment by a
12 specialist without a referral from the primary care provider pursuant
13 to Section 140601.

14 (f) The commissioner shall establish standards and procedures
15 for waiving copayments or deductible payments for a person who
16 demonstrates, to the commissioner's satisfaction, that the person
17 lacks the financial means to pay the copayment or deductible.
18 Waivers of copayments or deductible payments shall not affect
19 the reimbursement of health care providers.

20 (g) Any copayments established pursuant to this section and
21 collected by health care providers shall be transmitted to the
22 Treasurer to be deposited to the credit of the Healthcare Fund.

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

26 (i) Nothing in this division shall preclude employees from
27 receiving benefits available to them under a collective bargaining
28 agreement or other employee-employer agreement that are superior
29 to benefits under this division.

30 CHAPTER 6. DELIVERY OF CARE

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33 140600. (a) All health care providers licensed or accredited
34 to practice in California may participate in the system.

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

37 (c) If a health care provider is on probation, the licensing or the
38 accrediting agency shall monitor the health care provider in
39 question, pursuant to applicable California law. The licensing or
40 accrediting agency shall report to the chief medical officer at

1 intervals established by the chief medical officer, on the status of
2 health care providers who are on probation and on measures
3 undertaken to assist health care providers to return to practice and
4 to resolve complaints made by patients.

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

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

16 (f) Choice of health care provider:

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

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

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

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

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

34 (B) Persons who want to withdraw after the initial three-month
35 period shall request a withdrawal pursuant to dispute resolution
36 procedures established by the commissioner and may request
37 assistance from the patient advocate in the dispute process. The
38 dispute shall be resolved in a timely fashion and shall have no
39 adverse effect on the care a patient receives.

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

4 140601. (a) Primary care providers shall coordinate the care
5 a patient receives or shall ensure that a patient's care is coordinated.

6 (b) (1) Patients shall have a referral from their primary care
7 provider, or from a health care provider rendering care to them in
8 the emergency room or other accredited emergency setting, or
9 from a health care provider treating a patient for an emergency
10 condition in any setting, or from their obstetrician-gynecologist,
11 to see a physician or nonphysician specialist whose services are
12 covered by this division, unless the patient agrees to assume the
13 costs of care or pay a copayment, if implemented by the
14 commissioner pursuant to Section 140504. A referral shall not be
15 required to see a dentist or to see an ophthalmologist or optometrist
16 for a routine vision examination.

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

20 (3) Referrals shall not be restricted or provided solely because
21 of financial considerations. The chief medical officer shall monitor
22 referral patterns and intervene as necessary to assure that referrals
23 are neither restricted nor provided solely because of financial
24 considerations.

25 (4) For the first six months of the system's operation, no
26 specialist referral or copayment shall be required for patients who
27 had been receiving care from a specialist prior to the initiation of
28 the system. Beginning with the seventh month of the system's
29 operation, all patients shall be required to obtain a referral from a
30 primary or emergency care provider for specialty care if the care
31 is to be paid for by the system. No referral is required if a patient
32 pays the full cost of the specialty care and the specialist accepts
33 that payment arrangement.

34 (5) Where referral processes are in place prior to the initiation
35 of the system, the chief medical officer shall review the referral
36 processes to assure that they meet the system's standards for care
37 quality and shall assure needed changes are implemented so that
38 all Californians receive the same standards of care quality and
39 access to specialty care.

1 (6) A specialist may serve as the primary care provider if the
2 patient and the provider agree to this arrangement and if the
3 provider agrees to coordinate the patient's care or to ensure that
4 the care the patient receives is coordinated.

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

9 (8) A patient may appeal the denial of a referral through the
10 dispute resolution procedures established by the commissioner
11 and may request the assistance of the patient advocate during the
12 dispute resolution process.

13 140602. (a) The purpose of the Office of Health Planning is
14 to plan for the short- and long-term health care needs of the
15 population pursuant to the health care and finance standards
16 established by the commissioner and by this division.

17 (b) The office shall be headed by a director appointed by the
18 commissioner. The director shall serve pursuant to provisions of
19 subdivisions (c), (d), and (e) of Section 140100 and subdivisions
20 (j) and (k) of Section 140101.

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

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

23 (2) Serve on the Healthcare Policy Board.

24 (3) Establish performance criteria in measurable terms for health
25 care goals in consultation with the chief medical officer, the
26 regional planning directors, and regional medical officers and
27 others with experience in health care outcomes measurement and
28 evaluation.

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

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

35 (A) Identify medically underserved areas and health care service
36 and asset shortages.

37 (B) Identify disparities in health outcomes.

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

1 (D) Establish electronic systems that support dissemination of
2 information to health care providers and patients about integrated
3 health network and integrated health care delivery systems and
4 community-based health care resources.

5 (E) Support establishment of comprehensive health care
6 databases using uniform methodology that is compatible among
7 the regions and between the regions and the agency.

8 (F) Provide information to support effective regional planning
9 and innovation.

10 (G) Provide information to support interregional planning,
11 including planning for access to specialized centers that perform
12 a high volume of procedures for conditions requiring highly
13 specialized treatments, including emergency and trauma, and other
14 interregional access to needed care, and planning for coordinated
15 interregional capital investment.

16 (H) Provide information for, and participate in, earthquake
17 retrofit planning.

18 (I) Evaluate regional budget requests and make
19 recommendations to the commissioner about regional revenue
20 allocations.

21 (6) Estimate the health care workforce required to meet the
22 health care needs of the population pursuant to the standards and
23 goals established by the commissioner, the costs of providing the
24 needed workforce, and, in collaboration with regional planners,
25 educational institutions, the Governor, and the Legislature, develop
26 short- and long-term plans to meet those needs, including a plan
27 to finance needed training.

28 (7) Estimate the number and types of health facilities required
29 to meet the short- and long-term health care needs of the population
30 and the projected costs of needed facilities. In collaboration with
31 the commissioner, regional planning directors and regional medical
32 officers, the chief medical officer, the Governor, and the
33 Legislature, develop plans to finance and build needed facilities.

34 140603. The Technology Advisory Group shall explore the
35 feasibility and the value to the health of the population of the
36 following electronic initiatives:

37 (a) Establish integrated statewide health care databases to
38 support health care planning and determine which databases should
39 be established on a statewide basis and which should be established
40 on a regional basis.

1 (b) Assure that databases have uniform methodology and formats
2 that are compatible among the regions and between the regions
3 and the agency.

4 (c) Establish mandatory database reporting requirements and
5 penalties for noncompliance. Monitor the effectiveness of reporting
6 and make needed improvements.

7 (d) Establish means for anonymous reporting to the chief
8 medical officer and regional medical officers of medical errors
9 and other related problems, and for anonymous reporting to the
10 commissioner and regional planning directors of problems related
11 to ineffective management, and establish guidelines for the
12 protection of persons coming forward to report these problems.

13 (e) In collaboration with the chief medical officer, the Office
14 of Patient Advocacy, and regional patient advocates, investigate
15 the costs and benefits of electronic and online scheduling systems
16 and means of health care provider-patient communication that
17 allow for electronic visits, and make recommendations to the chief
18 medical officer regarding the use of these concepts in the system.

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

23 (g) In collaboration with the chief medical officer, support the
24 development of disease management programs and their use in
25 the system.

26 (h) Establish electronic initiatives that reduce administration
27 costs.

28 (i) Collaborate with the chief medical officer and regional
29 medical officers to assure the development of software systems
30 that link clinical guidelines to individual patient conditions, and
31 guide clinicians through diagnosis and treatment algorithms derived
32 from research based on clinical efficacy and best medical practices.

33 (j) Collaborate with the chief medical officer and regional
34 medical officers to assure the development of software systems
35 that offer health care providers access to guidelines that are
36 appropriate for their specialty and that include current information
37 on prevention and treatment of disease.

38 (k) In collaboration with the Partnerships for Health and regional
39 medical officers, establish Web-based, patient-centered information
40 systems that assist people to promote and maintain health and

1 provide information on health conditions and recent developments
2 in treatment.

3 (l) Establish electronic systems and other means to provide
4 patients with easily understandable information about the
5 performance of health care providers. This shall include, but not
6 be limited to, information about the experience that health care
7 providers have in the field or fields in which they deliver care, the
8 number of years they have practiced in their field and, in the case
9 of medical and surgical procedures, the number of procedures they
10 have performed in their area or areas of specialization.

11 (m) Establish electronic systems that facilitate health care
12 provider continuing medical education that meets licensure
13 requirements.

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

16 140604. (a) The Director of the Office of Health Planning
17 shall establish standards for culturally and linguistically competent
18 care, which shall include, but not be limited to, all of the following:

19 (1) State Department of Health Care Services and the
20 Department of Managed Care guidelines for culturally and
21 linguistically sensitive care.

22 (2) Medi-Cal Managed Care Division (MMCD) Policy Letters
23 99-01 to 99-04 and MMCD All Plan Letter 99005.

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

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

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

35 (b) The director shall annually evaluate the effectiveness of
36 standards for culturally and linguistically competent care and make
37 recommendations to the commissioner, the Office of Patient
38 Advocacy, and the chief medical officer for needed improvements.
39 In evaluating the standards for culturally and linguistically sensitive

1 care, the director shall establish a process to receive concerns and
2 comments from consumers.

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

6 140605. (a) Within the agency, the commissioner shall
7 establish the Office of Health Care Quality.

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

12 (c) The purpose of the Office of Health Care Quality is the
13 following:

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

18 (2) Promote efficient care delivery.

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

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

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

26 (6) Assist regional planning directors and medical officers in
27 the development and evaluation of regional operating and capital
28 budget requests.

29 140606. (a) In supporting the goals of the Office of Health
30 Care Quality, the chief medical officer shall do all of the following:

31 (1) Administer all aspects of the office.

32 (2) Serve on the Healthcare Policy Board.

33 (3) Collaborate with regional medical officers, regional planning
34 directors, health care providers, consumers, the Director of the
35 Office of Health Planning, the patient advocate of the Office of
36 Patient Advocacy, and directors of Partnerships for Health to
37 develop community-based networks of solo providers, small group
38 practices, essential community providers, and providers of patient
39 care support services in order to offer comprehensive,
40 multidisciplinary, coordinated services to patients.

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

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

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

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

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

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

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

(c) In collaboration with the Director of the Office of Health Planning and regional medical officers, the chief medical officer shall implement means to measure and monitor the quality of care

1 delivered in the system. Monitoring systems shall include, but
2 shall not be limited to, peer and patient performance reviews.

3 (d) The chief medical officer shall establish means to support
4 individual health care providers and health systems in correcting
5 quality of care problems, including timeframes for making needed
6 improvements and means to evaluate the effectiveness of
7 interventions.

8 (e) In collaboration with regional medical officers, regional
9 planning directors, and the Director of the Office of Health
10 Planning, the chief medical officer shall establish means to identify
11 medical errors and their causes and develop plans to prevent them.
12 Means shall include a process for anonymous reporting of errors
13 and guidelines to protect those who report the errors against
14 recrimination, including job demotion, promotion discrimination,
15 or job loss.

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

20 (g) The chief medical officer shall recommend to the
21 commissioner a benefits package based on clinical efficacy for the
22 system, including priorities for needed benefit improvements. In
23 making recommendations, the chief medical officer shall do all of
24 the following:

25 (1) Identify safe and effective treatments.

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

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

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

31 (5) Identify and recommend to the commissioner and the
32 Healthcare Policy Board innovative approaches to health
33 promotion, disease and injury prevention, education, research, and
34 care delivery for possible inclusion in the benefit package.

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

39 (7) Recommend to the commissioner and update as appropriate,
40 pharmaceutical and durable and nondurable medical equipment

1 formularies based on clinical efficacy. In establishing the
2 formularies, the chief medical officer shall establish a Pharmacy
3 and Therapeutics Committee composed of pharmacy and health
4 care providers, representatives of health facilities and organizations
5 having system formularies in place at the time the system is
6 implemented, and other experts that shall do all the following:

7 (A) Identify safe and effective pharmaceutical agents for use in
8 the system.

9 (B) Draw on existing standards and formularies.

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

12 (D) Review formularies in a timely fashion to ensure that safe
13 and effective drugs are available and that unsafe drugs are removed
14 from use.

15 (E) Assure the timely dissemination of information needed to
16 prescribe safely and effectively to all California health care
17 providers and the development and utilization of electronic
18 dispensing systems that decrease pharmaceutical dispensing errors.

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

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

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

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

38 (10) In collaboration with the Director of the Office of Health
39 Planning, regional planning directors and regional medical officers,
40 identify on a regional basis appropriate ratios of general medical

1 providers to specialty medical providers and appropriate ratios of
2 medical providers to patients in order to meet the health care needs
3 of the population and the goals of the system.

4 (11) Recommend to the commissioner and to the Payments
5 Board, financial and nonfinancial incentives and other means to
6 achieve recommended provider ratios.

7 (12) Collaborate with the Director of the Office of Health
8 Planning and regional medical officers and patient advocates in
9 the development of electronic initiatives, pursuant to Section
10 140603.

11 (13) Collaborate with the commissioner, the regional medical
12 officers, and the directors of the Payments Board and the
13 Healthcare Fund to formulate a health care provider reimbursement
14 model that promotes the delivery of coordinated, high quality
15 health care services in all sectors of the system and creates financial
16 and other incentives for the delivery of high quality health care.

17 (14) Establish or assure the establishment of continuing medical
18 education programs about advances in the delivery of high quality
19 health care.

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

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

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

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

40 (1) Personal maintenance of health.

1 (2) Prevention of disease.

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

4 (4) Improving quality of care.

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

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

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

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

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

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

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

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

38 (i) That the grievance has been received.

39 (ii) The date of receipt.

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

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

6 (i) The date of the call.

7 (ii) The name of the enrollee.

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

9 (iv) The nature of the grievance.

10 (v) The nature of the resolution.

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

13 (5) Provide enrollees of the system with written responses to
14 grievances, with a clear and concise explanation of the reasons for
15 the system's response. The system response shall describe the
16 criteria used and the clinical reasons for its decision, including all
17 criteria and clinical reasons related to medical necessity.

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

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

23 (b) In any case determined by the patient advocate to be a case
24 involving an imminent and serious threat to the health of the
25 enrollee, including, but not limited to, severe pain or the potential
26 loss of life, limb, or major bodily function, or in any other case
27 where the patient advocate determines that an earlier review is
28 warranted, an enrollee shall not be required to complete the
29 grievance process.

30 (c) If the enrollee is a minor, or is incompetent or incapacitated,
31 the parent, guardian, conservator, relative, or other designee of the
32 enrollee, as appropriate, may submit the grievance to the patient
33 advocate as a designated agent of the enrollee. Further, a health
34 care provider may join with, or otherwise assist, an enrollee, or
35 the agent, to submit the grievance to the patient advocate. In
36 addition, following submission of the grievance to the patient
37 advocate, the enrollee, or the agent, may authorize the health care
38 provider to assist, including advocating on behalf of the enrollee.
39 For purposes of this section, a "relative" includes the parent,

1 stepparent, spouse, domestic partner, adult son or daughter,
2 grandparent, brother, sister, uncle, or aunt of the enrollee.

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

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

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

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

32 (3) If the enrollee's grievance is sustained in whole or in part,
33 information about any corrective action taken.

34 (f) The patient advocate's order shall be binding on the system.

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

39 (h) The grievance or resolution procedures authorized by this
40 section shall be in addition to any other procedures that may be

1 available to any person, and failure to pursue, exhaust, or engage
2 in the procedures described in this section shall not preclude the
3 use of any other remedy provided by law.

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

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

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

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

38 (d) Coverage decisions regarding experimental or investigational
39 therapies for individual enrollees who meet all of the following

1 criteria are eligible for review by the independent medical review
2 system:

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

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

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

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

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

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

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

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

1 (5) The specific drug, device, procedure, or other therapy
2 recommended pursuant to paragraph (3) would be a covered
3 service, except for the system's determination that the therapy is
4 experimental or investigational.

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

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

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

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

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

36 (h) The office of the patient advocate shall prominently display
37 in every relevant informational brochure, on copies of the system's
38 procedures for resolving grievances, on letters of denials issued
39 by either the system or its contracting providers, on the grievance
40 forms, and on all written responses to grievances, information

1 concerning the right of an enrollee to request an independent
2 medical review in cases where the enrollee believes that health
3 care services have been improperly denied, modified, or delayed
4 by the system, or by one of its contracting providers.

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

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

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

12 (C) The enrollee seeks coverage for experimental or
13 investigational therapies.

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

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

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

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

1 advocate may extend the application deadline beyond six months
2 if the circumstances of a case warrant the extension.

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

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

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

15 (i) The enrollee's medical condition.

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

18 (iii) The disputed health care services requested by the enrollee
19 for the condition.

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

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

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

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

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

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

(c) An independent medical review organization shall conduct the review in accordance with a process approved by the patient advocate. The review shall be limited to an examination of the

1 medical necessity of the disputed health care services and shall
2 not include any consideration of coverage decisions or other issues.

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

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

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

21 (1) The system.

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

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

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

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

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

34 (g) In order to contract with the patient advocate for purposes
35 of this section, an independent medical review organization shall
36 meet all of the requirements pursuant to subdivision (d) of Section
37 1374.32.

38 140616. (a) Upon receipt of information and documents related
39 to a case, the medical professional reviewer or reviewers selected
40 to conduct the review by the independent medical review

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

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

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

15 (2) Nationally recognized professional standards.

16 (3) Expert opinion.

17 (4) Generally accepted standards of medical practice.

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

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

37 (d) The medical professionals' analyses and determinations
38 shall state whether the disputed health care service is medically
39 appropriate. Each analysis shall cite the enrollee's medical
40 condition, the relevant documents in the record, and the relevant

1 findings associated with the provisions of subdivision (b) to support
2 the determination. If more than one medical professional reviews
3 the case, the recommendation of the majority shall prevail. If the
4 medical professionals reviewing the case are evenly split as to
5 whether the disputed health care service should be provided, the
6 decision shall be in favor of providing the service.

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

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

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

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

1 and shall inform the enrollee and health care provider of the
2 authorization.

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

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

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

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

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

25
26 CHAPTER 7. OTHER PROVISIONS
27

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

35 No state entity shall incur any transition or planning costs prior
36 to that date. However, this prohibition shall not apply to activities
37 of the California Healthcare Premium Commission, and Article 2
38 (commencing with Section 140230) of Chapter 3 of this division
39 shall become operative on January 1, ~~2010~~ 2011.

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

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