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, Padilla, Pavley, Romero, Steinberg, Wiggins, and Yee)
(Coauthors: Assembly Members Bass, Beall, Block, Blumenfield, Brownley, Chesbro, Coto, Davis, De La Torre, Eng, Evans, Feuer, Hayashi, Jones, Bonnie Lowenthal, Ma, Mendoza, Nava, Price, Ruskin, 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 introduced, 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, 2011, 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, 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:

SECTION 1. Division 114 (commencing with Section 140000) is added to the Health and Safety Code, to read:

DIVISION 114. CALIFORNIA UNIVERSAL HEALTHCARE ACT

Chapter 1. General Provisions

140000. There is hereby established in state government the California Healthcare System, which shall be administered by the California Healthcare Agency, an independent agency under the control of the Healthcare Commissioner.

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

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

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

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

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

(a) The Healthcare Policy Board.

(b) The Office of Patient Advocacy.

(c) The Office of Health Planning.

(d) The Office of Health Care Quality.

(e) The Healthcare Fund.

(f) The Public Advisory Committee.

(g) The Payments Board.

(h) Partnerships for Health.

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

(a) An estimated 6.6 million Californians were uninsured in 2006, representing over 20 percent of the nonelderly population.

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

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

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

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

(f) On average, the United States spends more than twice as much as all other industrial nations on health care, both per person and as a percentage of its gross domestic product. Additionally, the rate of health care inflation significantly outpaces other industrial nations.

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

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

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

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

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

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

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

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

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

(p) According to these reports and numerous other studies, by simplifying administration, achieving bulk purchase discounts on pharmaceuticals, reducing the use of emergency facilities for

primary care, and better managing health care resources, California could divert billions of dollars toward direct health care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) "Agency" means the California Healthcare Agency.

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

(c) "Commissioner" means the Healthcare Commissioner.

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

(e) "Essential community provider" means a health facility that has served as part of the state's health care safety net for low income and traditionally underserved populations in California and that is one of the following:

(1) A "community clinic" as defined under subparagraph (A) of paragraph (1) of subdivision (a) of Section 1204.

(2) A "free clinic" as defined under subparagraph (B) of paragraph (1) of subdivision (a) of Section 1204.

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

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

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

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

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

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

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

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

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

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

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

(k) "Premium Commission" means the California Healthcare Premium Commission.

(*l*) "Primary care provider" means a direct care provider that is a family physician, internist, general practitioner, pediatrician, an obstetrician-gynecologist, or a family nurse practitioner or

physician assistant practicing under supervision as defined in California codes or essential community providers who employ primary care providers.

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

(n) "System" means the California Healthcare System.

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

Chapter 2. Governance

140100. (a) (1) The commissioner shall be appointed by the Governor on or before March 1, 2010, subject to confirmation by the Senate. If in session, the Senate shall act on the appointment within 30 days of the appointment date. If the Senate does not act on the appointment within that period, the nominee shall be deemed confirmed and may take office. If the Senate is not in session at the time of the appointment, the Senate shall act on the appointment within 30 days of the commencement of the next legislative session. If the Senate does not act on the appointment within that period, the appointee shall be deemed confirmed and may take office.

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

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

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

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

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

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

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

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

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

(c) The commissioner shall appoint a deputy commissioner, the Director of the Healthcare Fund, the patient advocate of the Office of Patient Advocacy, the chief medical officer, the Director of the Payments Board, the Director of the Office of Health Planning, the Director of the Partnerships for Health, the regional health

planning directors, the chief enforcement counsel, and legal counsel in any action brought by or against the commissioner under or pursuant to any provision of any law under the commissioner's jurisdiction, or in which the commissioner joins or intervenes as to a matter within the commissioner's jurisdiction, as a friend of the court or otherwise, and stenographic reporters to take and transcribe the testimony in any formal hearing or investigation before the commissioner or before a person authorized by the commissioner.

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

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

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

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

(h) The commissioner, as a general rule, shall publish or make available for public inspection any information filed with or obtained by the agency, unless the commissioner finds that this availability or publication is contrary to law. No provision of this division authorizes the commissioner or any of the commissioner's assistants, clerks, or deputies to disclose any information withheld from public inspection except among themselves or when necessary or appropriate in a proceeding or investigation under this division or to other federal or state regulatory agencies. No provision of this division either creates or derogates from any privilege that exists at common law or otherwise when documentary or other

evidence is sought under a subpoena directed to the commissioner or any of his or her assistants, clerks, and deputies.

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

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

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

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

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

140102. The commissioner shall do all of the following:

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

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

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

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

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

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

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

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

(8) Partnerships for Health.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) The commissioner.

(2) The deputy commissioner.

(3) The Director of the Healthcare Fund.

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

(5) The chief medical officer.

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

(7) The Director of the Partnerships for Health.

(8) The Director of the Payments Board.

(9) The State Public Health Officer.

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

(11) Two representatives from regional planning boards.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) The commissioner.

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

(3) The chief medical officer.

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

(5) The Director of the Healthcare Fund.

(6) The State Public Health Officer.

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

(8) Direct care providers.

(9) Representatives of retirement boards.

(10) Employer and employee representatives.

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

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

(13) Representatives of counties.

(14) Consumers of health care services.

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

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

(1) The State Department of Health Care Services.

(2) The Department of Managed Health Care.

(3) The Department of Aging.

(4) The Department of Developmental Services.

(5) The Health and Welfare Data Center.

(6) The State Department of Mental Health.

(7) The State Department of Alcohol and Drug Programs.

(8) The Department of Rehabilitation.

(9) The Emergency Medical Services Authority.

(10) The Managed Risk Medical Insurance Board.

(11) The Office of Statewide Health Planning and Development.

(12) The Department of Insurance.

(13) The State Department of Public Health.

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

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

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

(1) Patterns of utilization of health care services.

(2) Health care resources, including workforce resources.

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

(4) Geography.

(5) Population and demographic characteristics.

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

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

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

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

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

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

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

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

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

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

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

of Partnerships for Health pursuant to the priorities and goals of the system established by the commissioner.

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

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

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

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

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

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

(10) Implement procedures established by the commissioner for the resolution of disputes.

(11) Implement processes established by the commissioner and recommend needed changes to permit the public to share concerns, provide ideas, opinions, and recommendations regarding all aspects of the system's policies.

(12) Report regularly to the public and, at intervals determined by the commissioner and pursuant to this division, to the commissioner on the status of the regional planning system, including evaluating access to care, quality of care delivered, and provider performance, and other issues related to regional health care needs, and recommending needed improvements.

(13) Identify or establish guidelines for providers to identify, maintain, and provide to the regional planning director inventories of regional health care assets.

(14) Establish and maintain regional health care databases that are coordinated with other regional and statewide databases.

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

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

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

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

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

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

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

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

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

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

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

(d) Assure the evaluation and measurement of the quality of care delivered in the region, including assessment of the performance of individual providers, pursuant to standards and methods established by the chief medical officer to ensure a single standard of high quality care is delivered to all state residents.

(e) In collaboration with the chief medical officer and regional providers, evaluate standards of care in use at the time the system becomes operative.

(f) Ensure a smooth transition toward use of standards based on clinical efficacy that guide clinical decisionmaking. Identify areas of medical practice where standards have not been established and collaborated with the chief medical officer and health care providers, to establish priorities in developing needed standards.

(g) Support the development and distribution of user-friendly software for use by providers in order to support the delivery of high quality care.

(h) Provide feedback to, and support and supervision of, health care providers to ensure the delivery of high quality care pursuant to standards established by the system.

(i) Collaborate with the regional Partnerships for Health to develop patient education to assist consumers in evaluating and appropriately utilizing health care providers and facilities.

(j) Collaborate with regional public health officers to establish regional health policies that support the public health.

(k) Establish a regional program to monitor and decrease medical errors and their causes pursuant to standards and methods established by the chief medical officer.

(*l*) Support the development and implementation of innovative means to provide high quality care and assist providers in securing funds for innovative demonstration projects that seek to improve care quality.

(m) Establish means to assess the impact of the system's policies intended to assure the delivery of high quality care.

(n) Collaborate with the chief medical officer, the Director of the Office of Health Planning, the regional planning director, and health care providers in the development and maintenance of regional health care databases.

(o) Ensure the enforcement of, and recommend needed changes in, the system's reporting requirements.

(p) Support providers in developing regional budget requests.

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

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

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

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

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

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

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

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

(4) One expert in health care financing.

(5) One expert in health care planning.

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

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

(8) One member representing hospitals in the region.

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

(10) One member representing the public.

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

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

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

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

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

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

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

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

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

Chapter 3. Funding

Article 1. General Provisions

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

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

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

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

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

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

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

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

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

(2) A reserve account.

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

(c) The system shall at all times hold an actuarially sound reserve that is consistent with appropriate risk-based capital standards to assure financial solvency of the system.

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

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

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

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

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

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

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

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

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

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

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

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

(5) Postponement of planned capital expenditures.

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

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

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

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

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

(10) Deferred funding of the reserve account.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Transition budget.

(2) Providers and managers budget.

(3) Capitated operating budgets.

(4) Noncapitated operating budgets.

(5) Capital investment budget.

(6) Purchasing budget, including prescription drugs and durable and nondurable medical equipment pursuant to Section 140220.

(7) Research and innovation budget pursuant to Section 140221.

(8) Workforce training and development budget pursuant to Section 140222.

(9) Reserve account pursuant to Section 140223.

(10) System administration budget pursuant to Section 140224.

(11) Regional budgets.

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

(1) Costs of transition to the new system.

(2) Projections regarding the health care services anticipated to be used by California residents.

(3) Differences in cost of living between the regions, including the overhead costs of maintaining medical practices.

(4) Health risk of enrollees.

(5) Scope of services provided.

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

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

(8) Costs of workforce training and development.

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

(10) Relative usage of different health care providers.

(11) Needed improvements in access to care.

(12) Projected savings in administrative costs.

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

(14) Projected savings from improvements in care quality.

(15) Projected savings from decreases in medical errors.

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

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

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

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

(20) Costs of new technology.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Article 2. California Healthcare Premium Commission

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

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

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

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

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

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

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

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

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

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

(9) The Director of the Employment Development Department.

(10) The Legislative Analyst.

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

(12) The Director of the Department of Finance.

(13) The Controller.

(14) The Treasurer.

(15) The Lieutenant Governor.

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

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

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

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

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

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

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

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

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

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

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

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

(7) Comply with federal requirements.

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

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

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

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

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

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

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

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

140235. (a) On or before January 1, 2011, the Premium Commission shall submit to the Governor and the Legislature a detailed recommendation for a premium structure.

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

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

Article 3. Governmental Payments

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

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

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

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

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

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

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

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

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

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

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

Article 4. Federal Preemption

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

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

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

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

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

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

(e) To the extent permitted by federal law, a health care provider shall first seek payment from the contract or plan, before submitting 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

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

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

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

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

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

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

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

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

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

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

Chapter 4. Eligibility

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Chapter 5. Benefits

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

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

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

(a) Inpatient and outpatient health facility services.

(b) Inpatient and outpatient professional health care provider services by licensed health care professionals.

(c) Diagnostic imaging, laboratory services, and other diagnostic and evaluative services.

(d) Durable medical equipment, appliances, and assistive technology, including prosthetics, eyeglasses, and hearing aids and their repair.

(e) Rehabilitative care.

(f) Emergency transportation and necessary transportation for health care services for disabled and indigent persons.

(g) Language interpretation and translation for health care services, including sign language for those unable to speak, or

hear, or who are language impaired, and Braille translation or other services for those with no or low vision.

(h) Child and adult immunizations and preventive care.

(i) Health education.

(j) Hospice care.

(k) Home health care.

(*l*) Prescription drugs that are listed on the system's formulary. Nonformulary prescription drugs may be included if standards and criteria established by the commissioner are met.

(m) Mental and behavioral health care.

(n) Dental care.

(o) Podiatric care.

(p) Chiropractic care.

(q) Acupuncture.

(r) Blood and blood products.

(s) Emergency care services.

(t) Vision care.

(u) Adult day care.

(v) Case management and coordination to ensure services necessary to enable a person to remain safely in the least restrictive setting.

(w) Substance abuse treatment.

(x) Care of up to 100 days in a skilled nursing facility following hospitalization.

(y) Dialysis.

(z) Benefits offered by a bona fide church, sect, denomination, or organization whose principles include healing entirely by prayer or spiritual means provided by a duly authorized and accredited practitioner or nurse of that bona fide church, sect, denomination, or organization.

(aa) Chronic disease management.

(ab) Family planning services and supplies.

(ac) For persons under 21 years of age, early and periodic screening, diagnosis, and treatment services, as defined in Section 1396d(r) of Title 42 of the United States Code, whether or not those services are covered benefits for persons who are 21 years of age or older.

140502. The commissioner may expand benefits beyond the minimum benefits described in this chapter when expansion meets

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Chapter 6. Delivery of Care

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

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

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

undertaken to assist health care providers to return to practice and to resolve complaints made by patients.

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

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

(f) Choice of health care provider:

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

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

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

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

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

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

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

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

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

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

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

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

(5) Where referral processes 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 needed changes are implemented so that all Californians receive the same standards of care quality and access to specialty care.

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

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

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

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

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

(c) The director shall do all the following:

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

(2) Serve on the Healthcare Policy Board.

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

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

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

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

(B) Identify disparities in health outcomes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(h) Establish electronic initiatives that reduce administration costs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Promote efficient care delivery.

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

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

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

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

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

(1) Administer all aspects of the office.

(2) Serve on the Healthcare Policy Board.

(3) Collaborate with regional medical officers, regional planning directors, health care providers, consumers, the Director of the Office of Health Planning, the patient advocate of the Office of Patient Advocacy, and directors of Partnerships for Health to develop community-based networks of solo providers, small group practices, essential community providers, and providers of patient care support services in order to offer comprehensive, 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 others institutions that have had a positive impact on care quality, such as the Centers for Disease Control, 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 delivered in the system. Monitoring systems shall include, but shall not be limited to, peer and patient performance reviews.

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

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

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

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

(1) Identify safe and effective treatments.

(2) Evaluate and draw on existing benefit packages.

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

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

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

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

(7) Recommend to the commissioner and update as appropriate, pharmaceutical and durable and nondurable medical equipment formularies based on clinical efficacy. In establishing the formularies, the chief medical officer shall establish a Pharmacy

and Therapeutics Committee composed of pharmacy and health care providers, representatives of health facilities and organizations having system formularies in place at the time the system is implemented, and other experts that shall do all the following:

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

(B) Draw on existing standards and formularies.

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

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

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

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

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

(A) Where such processes are in place when the system is initiated, the chief medical officer shall review those 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.

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

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

medical providers to patients in order to meet the health care needs of the population and the goals of the system.

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

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

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

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

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

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

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

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

(1) Personal maintenance of health.

(2) Prevention of disease.

(3) Improvement in communication between patients and providers.

(4) Improving quality of care.

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

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

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

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

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

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

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

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

(i) That the grievance has been received.

(ii) The date of receipt.

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

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

(i) The date of the call.

(ii) The name of the enrollee.

(iii) The enrollee's system identification number.

(iv) The nature of the grievance.

(v) The nature of the resolution.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) For purposes of this section, "life-threatening" means either or both of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) The enrollee's medical condition.

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

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

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

(2) A copy of all information provided to the enrollee by the system and any of its contracting providers concerning their decisions regarding the enrollee's condition and care, and a copy of any materials the enrollee or the enrollee's health care provider submitted to the system and to the system's contracting providers in support of the enrollee's request for disputed health care service. This documentation shall include the written response to the enrollee's grievance. The confidentiality of any enrollee medical information shall be maintained pursuant to applicable state and 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 medical necessity of the disputed health care services and shall not include any consideration of coverage decisions or other issues.

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

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

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

(1) The system.

(2) Any officer or employee of the system.

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

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

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

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

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

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

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

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

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

(2) Nationally recognized professional standards.

(3) Expert opinion.

(4) Generally accepted standards of medical practice.

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

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

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

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

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

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

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

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

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

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

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

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

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

Chapter 7. Other Provisions

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

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

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

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

O