ASSEMBLY BILL No. 1400

Introduced by Assembly Members Kalra, Lee, and Santiago
(Principal coauthors: Assembly Members Chiu and Ting)
(Principal coauthors: Senators Gonzalez, McGuire, and Wiener)
(Coauthors: Assembly Members Friedman, Kamlager, McCarty, Nazarian, Luz Rivas, and Wicks)
(Coauthors: Senators Becker, Cortese, Laird, and Wieckowski)

February 19, 2021

An act to add Title 23 (commencing with Section 100600) to the Government Code, relating to health care coverage, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 1400, as introduced, Kalra. Guaranteed Health Care for All.

Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. PPACA defines a "qualified health plan" as a plan that, among other requirements, provides an essential health benefits package. Existing state law creates the California Health Benefit Exchange, also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.

This bill, the California Guaranteed Health Care for All Act, would create the California Guaranteed Health Care for All program, or CalCare, to provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state. The bill, among other things, would provide that CalCare cover a wide range of medical benefits and other services and would incorporate the health care benefits and standards of other existing federal and state provisions, including the federal Children's Health Insurance Program, Medi-Cal, ancillary health care or social services covered by regional centers for persons with developmental disabilities, Knox-Keene, and the federal Medicare program. The bill would require the board to seek all necessary waivers, approvals, and agreements to allow various existing federal health care payments to be paid to CalCare, which would then assume responsibility for all benefits and services previously paid for with those funds.

This bill would create the CalCare Board to govern CalCare, made up of 9 voting members with demonstrated and acknowledged expertise in health care, and appointed as provided, plus the Secretary of California Health and Human Services or their designee as a nonvoting, ex officio member. The bill would provide the board with all the powers and duties necessary to establish CalCare, including determining when individuals may start enrolling into CalCare, employing necessary staff, negotiating pricing for covered pharmaceuticals and medical supplies, establishing a prescription drug formulary, and negotiating and entering into necessary contracts. The bill would require the board to convene a CalCare Public Advisory Committee with specified members to advise the board on all matters of policy for CalCare. The bill would establish an 11-member Advisory Commission on Long-Term Services and Supports to advise the board on matters of policy related to long-term services and supports.

This bill would provide for the participation of health care providers in CalCare, including the requirements of a participation agreement between a health care provider and the board, provide for payment for health care items and services, and specify program participation standards. The bill would prohibit a participating provider from

discriminating against a person by, among other things, reducing or denying a person's benefits under CalCare because of a specified characteristic, status, or condition of the person.

This bill would prohibit a participating provider from billing or entering into a private contract with an individual eligible for CalCare benefits regarding a covered benefit, but would authorize contracting for a health care item or service that is not a covered benefit if specified criteria are met. The bill would authorize health care providers to collectively negotiate fee-for-service rates of payment for health care items and services using a 3rd-party representative, as provided. The bill would require the board to annually determine an institutional provider's global budget, to be used to cover operating expenses related to covered health care items and services for that fiscal year, and would authorize payments under the global budget.

This bill would state the intent of the Legislature to enact legislation that would develop a revenue plan, taking into consideration anticipated federal revenue available for CalCare. The bill would create the CalCare Trust Fund in the State Treasury, as a continuously appropriated fund, consisting of any federal and state moneys received for the purposes of the act. Because the bill would create a continuously appropriated fund, it would make an appropriation.

This bill would prohibit specified provisions of this act from becoming operative until the Secretary of California Health and Human Services gives written notice to the Secretary of the Senate and the Chief Clerk of the Assembly that the CalCare Trust Fund has the revenues to fund the costs of implementing the act. The California Health and Human Services Agency would be required to publish a copy of the notice on its internet website.

Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

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

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

SECTION 1. (a) The Legislature finds and declares all of the following:

(1) Although the federal Patient Protection and Affordable Care Act (PPACA) brought many improvements in health care and health care coverage, PPACA still leaves many Californians without coverage or with inadequate coverage.

(2) Californians, as individuals, employers, and taxpayers, have experienced a rise in the cost of health care and health care coverage in recent years, including rising premiums, deductibles, and copayments, as well as restricted provider networks and high out-of-network charges.

(3) Businesses have also experienced increases in the costs of health care benefits for their employees, and many employers are shifting a larger share of the cost of coverage to their employees or dropping coverage entirely.

(4) Individuals often find that they are deprived of affordable care and choice because of decisions by health benefit plans guided by the plan's economic needs rather than patients' health care needs.

(5) To address the fiscal crisis facing the health care system and the state, and to ensure Californians get the health care they need, comprehensive health care coverage needs to be provided.

(6) Billions of dollars that could be spent on providing equal access to health care are wasted on administrative costs necessary in a multipayer health care system. Resources and costs spent on administration would be dramatically reduced in a single-payer system, allowing health care professionals and hospitals to focus on patient care instead.

(7) It is the intent of the Legislature to establish a comprehensive universal single-payer health care coverage program and a health care cost control system for the benefit of all residents of the state.

(b) (1) It is further the intent of the Legislature to establish the California Guaranteed Health Care for All program to provide universal health coverage for every Californian, funded by broad-based revenue.

(2) It is the intent of the Legislature to work to obtain waivers and other approvals relating to Medi-Cal, the federal Children's Health Insurance Program, Medicare, PPACA, and any other

federal programs pertaining to the provision of health care so that any federal funds and other subsidies that would otherwise be paid to the State of California, Californians, and health care providers would be paid by the federal government to the State of California and deposited in the CalCare Trust Fund.

(3) Under those waivers and approvals, those funds would be used for health care coverage that provides health care benefits equal to or exceeded by those programs as well as other program modifications, including elimination of cost sharing and insurance premiums.

(4) Those programs would be replaced and merged into CalCare, which will operate as a true single-payer program.

(5) If any necessary waivers or approvals are not obtained, it is the intent of the Legislature that the state use state plan amendments and seek waivers and approvals to maximize, and make as seamless as possible, the use of funding from federally matched public health programs and other federal health programs in CalCare.

(6) Even if other programs, including Medi-Cal or Medicare, may contribute to paying for care, it is the goal of this act that the coverage be delivered by CalCare, and, as much as possible, that the multiple sources of funding be pooled with other CalCare program funds.

(c) This act does not create an employment benefit, nor does the act require, prohibit, or limit providing a health care employment benefit.

(d) (1) It is not the intent of the Legislature to change or impact in any way the role or authority of a licensing board or state agency that regulates the standards for or provision of health care and the standards for health care providers as established under current law, including the Business and Professions Code, the Health and Safety Code, the Insurance Code, and the Welfare and Institutions Code.

(2) This act would in no way authorize the CalCare Board, the California Guaranteed Health Care for All program, or the Secretary of California Health and Human Services to establish or revise licensure standards for health care professionals or providers.

(e) It is the intent of the Legislature that neither health information technology nor clinical practice guidelines limit the

effective exercise of the professional judgment of physicians, registered nurses, and other licensed health care professionals. Physicians, registered nurses, and other licensed health care professionals shall be free to override health information technology and clinical practice guidelines if, in their professional judgment and in accordance with their scope of practice and licensure, it is in the best interest of the patient and consistent with the patient's wishes.

(f) (1) It is the intent of the Legislature to prohibit CalCare, a state agency, a local agency, or a public employee acting under color of law from providing or disclosing to anyone, including the federal government, any personally identifiable information obtained, including a person's religious beliefs, practices, or affiliation, national origin, ethnicity, or immigration status, for law enforcement or immigration purposes.

(2) This act would also prohibit law enforcement agencies from using CalCare's funds, facilities, property, equipment, or personnel to investigate, enforce, or assist in the investigation or enforcement of a criminal, civil, or administrative violation or warrant for a violation of any requirement that individuals register with the federal government or any federal agency based on religion, national origin, ethnicity, immigration status, or other protected category as recognized in the Unruh Civil Rights Act (Part 2 (commencing with Section 51) of Division 1 of the Civil Code).

(g) It is the further intent of the Legislature to address the high cost of prescription drugs and ensure they are affordable for patients.

SEC. 2. Title 23 (commencing with Section 100600) is added to the Government Code, to read:

TITLE 23. THE CALIFORNIA GUARANTEED HEALTH CARE FOR ALL ACT

Chapter 1. General Provisions

100600. This title shall be known, and may be cited, as the California Guaranteed Health Care for All Act.

100601. There is hereby established in state government the California Guaranteed Health Care for All program, or CalCare,

to be governed by the CalCare Board pursuant to Chapter 2 (commencing with Section 100610).

100602. For the purposes of this title, the following definitions apply:

(a) "Activities of daily living" means basic personal everyday activities including eating, toileting, grooming, dressing, bathing, and transferring.

(b) "Advisory commission" means the Advisory Commission on Long-Term Services and Supports established pursuant to Section 100614.

(c) "Affordable Care Act" or "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments to, or regulations or guidance issued under, those acts.

(d) "Allied health practitioner" means a group of health professionals who apply their expertise to prevent disease transmission and diagnose, treat, and rehabilitate people of all ages and in all specialties, together with a range of technical and support staff, by delivering direct patient care, rehabilitation, treatment, diagnostics, and health improvement interventions to restore and maintain optimal physical, sensory, psychological, cognitive, and social functions. Examples include audiologists, occupational therapists, social workers, and radiographers.

(e) "Board" means the CalCare Board described in Section 100610.

(f) "CalCare" or "California Guaranteed Health Care for All" means the California Guaranteed Health Care for All program established in Section 100601.

(g) "Capital expenditures" means expenses for the purchase, lease, construction, or renovation of capital facilities, health information technology, artificial intelligence, and major equipment, including costs associated with state grants, loans, lines of credit, and lease-purchase arrangements.

(h) "Carrier" means either a private health insurer holding a valid outstanding certificate of authority from the Insurance Commissioner or a health care service plan, as defined under subdivision (f) of Section 1345 of the Health and Safety Code, licensed by the Department of Managed Health Care.

(i) "Committee" means the CalCare Public Advisory Committee established pursuant to Section 100611.

(j) "County organized health system" means a health system implemented pursuant to Part 4 (commencing with Section 101525) of Division 101 of the Health and Safety Code, and Article 2.8 (commencing with Section 14087.5) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code.

(k) "Essential community provider" means a provider, as defined in Section 156.235(c) of Title 45 of the Code of Federal Regulations, as published February 27, 2015, in the Federal Register (80 FR 10749), that serves predominantly low-income, medically underserved individuals and that is one of the following:

(1) A community clinic, as defined in subparagraph (A) of paragraph (1) of subdivision (a) of Section 1204 of the Health and Safety Code.

(2) A free clinic, as defined in subparagraph (B) of paragraph (1) of subdivision (a) of Section 1204 of the Health and Safety Code.

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

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

(5) An Indian Health Service Facility, as defined in subdivision (v) of Section 2699.6500 of Title 10 of the California Code of Regulations.

(*l*) "Federally matched public health program" means the state's Medi-Cal program under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.) and the federal Children's Health Insurance Program under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.).

(m) "Fund" means the CalCare Trust Fund established pursuant to Article 2 (commencing with Section 100665) of Chapter 7.

(n) "Global budget" means the payment negotiated between an institutional provider and the board pursuant to Section 100641.

(o) "Group practice" means a professional corporation under the Moscone-Knox Professional Corporation Act (Part 4 (commencing with Section 13400) of Division 3 of Title 1 of the Corporations Code) that is a single corporation or partnership composed of licensed doctors of medicine, doctors of osteopathy,

or other licensed health care professionals, and that provides health care items and services primarily directly through physicians or other health care professionals who are either employees or partners of the organization.

(p) "Health care professional" means a health care professional licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Act or the Chiropractic Act, who, in accordance with the professional's scope of practice, may provide health care items and services under this title.

(q) "Health care item or service" means a health care item or service that is included as a benefit under CalCare.

(r) "Health professional education expenditures" means expenditures in hospitals and other health care facilities to cover costs associated with teaching and related research activities.

(s) "Home- and community-based services" means an integrated continuum of service options available locally for older individuals and functionally impaired persons who seek to maximize self-care and independent living in the home or a home-like environment, which includes the home- and community-based services that are available through Medi-Cal pursuant to the home- and-community based waiver program under Section 1915 of the federal Social Security Act (42 U.S.C. Sec. 1396n) as of January 1, 2019.

(t) "Implementation period" means the period under paragraph (6) of subdivision (e) of Section 100612 during which CalCare is subject to special eligibility and financing provisions until it is fully implemented under that section.

(u) "Institutional provider" means an entity that provides health care items and services and is licensed pursuant to any of the following:

(1) A health facility, as defined in Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

(2) A clinic licensed pursuant to Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code.

(3) A long-term health care facility, as defined in Section 1418 of the Health and Safety Code, or a program developed pursuant to paragraph (1) of subdivision (i) of Section 100612.

(4) A county medical facility licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code.

(5) A residential care facility for persons with chronic, life-threatening illness licensed pursuant to Chapter 3.01 (commencing with Section 1568.01) of Division 2 of the Health and Safety Code.

(6) An Alzheimer's day care resource center licensed pursuant to Chapter 3.1 (commencing with Section 1568.15) of Division 2 of the Health and Safety Code.

(7) A residential care facility for the elderly licensed pursuant to Chapter 3.2 (commencing with Section 1569) of Division 2 of the Health and Safety Code.

(8) A hospice licensed pursuant to Chapter 8.5 (commencing with Section 1745) of Division 2 of the Health and Safety Code.

(9) A pediatric day health and respite care facility licensed pursuant to Chapter 8.6 (commencing with Section 1760) of Division 2 of the Health and Safety Code.

(10) A mental health care provider licensed pursuant to Division 4 (commencing with Section 4000) of the Welfare and Institutions Code.

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

(v) "Instrumental activities of daily living" means activities related to living independently in the community, including meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community.

(w) "Local initiative" means a prepaid health plan that is organized by, or designated by, a county government or county governments, or organized by stakeholders, of a region designated by the department to provide comprehensive health care to eligible Medi-Cal beneficiaries, including the entities established pursuant to Sections 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, and 14087.96 of the Welfare and Institutions Code.

(x) "Long-term services and supports" means long-term care, treatment, maintenance, or services related to health conditions, injury, or age, that are needed to support the activities of daily living and the instrumental activities of daily living for a person with a disability, including all long-term services and supports as defined in Section 14186.1 of the Welfare and Institutions Code,

home- and community-based services, additional services and supports identified by the board to support people with disabilities to live, work, and participate in their communities, and those as defined by the board.

(y) "Medicaid" or "medical assistance" means a program that is one of the following:

(1) The state's Medi-Cal program under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(2) The federal Children's Health Insurance Program under Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.).

(z) "Medically necessary or appropriate" means the health care items, services, or supplies needed or appropriate to prevent, diagnose, or treat an illness, injury, condition, or disease, or its symptoms, and that meet accepted standards of medicine as determined by a patient's treating physician or other individual health care professional who is treating the patient, and, according to that health care professional's scope of practice and licensure, is authorized to establish a medical diagnosis and has made an assessment of the patient's condition.

(aa) "Medicare" means Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.) and the programs thereunder.

(ab) "Member" means an individual who is enrolled in CalCare.

(ac) "Out-of-state health care service" means a health care item or service provided in person to a member while the member is temporarily, for no more than 90 days, and physically located out of the state under either of the following circumstances:

(1) It is medically necessary or appropriate that the health care item or service be provided while the member physically is out of the state.

(2) It is medically necessary or appropriate, and cannot be provided in the state, because the health care item or service can only be provided by a particular health care provider physically located out of the state.

(ad) "Participating provider" means an individual or entity that is a health care provider qualified under Section 100630 that has a participation agreement pursuant to Section 100631 in effect with the board to furnish health care items or services under CalCare.

(ae) "Prescription drugs" means prescription drugs as defined in subdivision (n) of Section 130501 of the Health and Safety Code.

(af) "Resident" means an individual whose primary place of abode is in this state, without regard to the individual's immigration status, who meets the California residence requirements adopted by the board pursuant to subdivision (k) of Section 100610. The board shall be guided by the principles and requirements set forth in the Medi-Cal program under Article 7 (commencing with Section 50320) of Chapter 2 of Subdivision 1 of Division 3 of Title 22 of the California Code of Regulations.

(ag) "Rural or medically underserved area" has the same meaning as a "health professional shortage area" in Section 254e of Title 42 of the United States Code.

100603. This title does not preempt a city, county, or city and county from adopting additional health care coverage for residents in that city, county, or city and county that provides more protections and benefits to California residents than this title.

100604. To the extent any law is inconsistent with this title or the legislative intent of the California Guaranteed Health Care for All Act, this title shall apply and prevail, except when explicitly provided otherwise by this title.

Chapter 2. Governance

100610. (a) CalCare shall be governed by an executive board, known as the CalCare Board, consisting of nine voting members who are residents of California. The CalCare Board shall be an independent public entity not affiliated with an agency or department. Of the members of the board, five shall be appointed by the Governor, two shall be appointed by the Senate Committee on Rules, and two shall be appointed by the Speaker of the Assembly. The Secretary of California Health and Human Services or the secretary's designee shall serve as a nonvoting, ex officio member of the board.

(b) (1) A member of the board, other than an ex officio member, shall be appointed for a term of four years, except that the initial appointment by the Senate Committee on Rules shall be for a term of five years, and the initial appointment by the Speaker of the

Assembly shall be for a term of two years. These members may be reappointed for succeeding four-year terms.

(2) Appointments by the Governor shall be subject to confirmation by the Senate. A member of the board may continue to serve until the appointment and qualification of the member's successor. Vacancies shall be filled by appointment for the unexpired term. The board shall elect a chairperson on an annual basis.

(c) (1) Each person appointed to the board shall have demonstrated and acknowledged expertise in health care policy or delivery.

(2) Appointing authorities shall also consider the expertise of the other members of the board and attempt to make appointments so that the board's composition reflects a diversity of expertise in the various aspects of health care and the diversity of various regions within the state.

(3) Appointments to the board shall be made as follows:

(A) Two health care professionals who practice medicine.

(B) One registered nurse.

(C) One public health professional.

(D) One mental health professional.

(E) One member with an institutional provider background.

(F) One representative of a not-for-profit organization that advocates for individuals who use health care in California

(G) One representative of a labor organization.

(H) One member of the committee established pursuant to Section 100611, who shall serve on a rotating basis to be determined by the committee.

(d) Each member of the board shall have the responsibility and duty to meet the requirements of this title and all applicable state and federal laws and regulations, to serve the public interest of the individuals, employers, and taxpayers seeking health care coverage through CalCare, and to ensure the operational well-being and fiscal solvency of CalCare.

(e) In making appointments to the board, the appointing authorities shall take into consideration the racial, ethnic, gender, and geographical diversity of the state so that the board's composition reflects the communities of California.

(f) (1) A member of the board or of the staff of the board shall not be employed by, a consultant to, a member of the board of

directors of, affiliated with, or otherwise a representative of, a health care professional, institutional provider, or group practice while serving on the board or on the staff of the board, except board members who are practicing health care professionals may be employed by an institutional provider or group practice. A member of the board or of the staff of the board shall not be a board member or an employee of a trade association of health professionals, institutional providers, or group practices while serving on the board or on the staff of the board. A member of the board or of the staff of the board may be a health care professional if that member does not have an ownership interest in an institutional provider or a professional health care practice.

(2) Notwithstanding Section 11009, a board member shall receive compensation for service on the board. A board member may receive a per diem and reimbursement for travel and other necessary expenses, as provided in Section 103 of the Business and Professions Code, while engaged in the performance of official duties of the board.

(g) A member of the board shall not make, participate in making, or in any way attempt to use the member's official position to influence the making of a decision that the member knows, or has reason to know, will have a reasonably foreseeable material financial effect, distinguishable from its effect on the public generally, on the member or a person in the member's immediate family, or on either of the following:

(1) Any source of income, other than gifts and other than loans by a commercial lending institution in the regular course of business on terms available to the public without regard to official status aggregating two hundred fifty dollars ($250) or more in value provided to, received by, or promised to the member within 12 months before the decision is made.

(2) Any business entity in which the member is a director, officer, partner, trustee, employee, or holds any position of management.

(h) There shall not be liability in a private capacity on the part of the board or a member of the board, or an officer or employee of the board, for or on account of an act performed or obligation entered into in an official capacity, when done in good faith, without intent to defraud, and in connection with the

administration, management, or conduct of this title or affairs related to this title.

(i) The board shall hire an executive director to organize, administer, and manage the operations of the board. The executive director shall be exempt from civil service and shall serve at the pleasure of the board.

(j) The board shall be subject 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), except that the board may hold closed sessions when considering matters related to litigation, personnel, contracting, and provider rates.

(k) The board may adopt rules and regulations as necessary to implement and administer this title in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2).

100611. (a) The board shall convene a CalCare Public Advisory Committee to advise the board on all matters of policy for CalCare. The committee shall consist of members who are residents of California.

(b) Members of the committee shall be appointed by the board for a term of two years. These members may be reappointed for succeeding two-year terms.

(c) The members of the committee shall be as follows:

(1) Four health care professionals.

(2) One registered nurse.

(3) One representative of a licensed health facility.

(4) One representative of an essential community provider

(5) One representative of a physician organization or medical group.

(6) One behavioral health provider.

(7) One dentist or oral care specialist.

(8) One representative of private hospitals.

(9) One representative of public hospitals.

(10) One individual who is enrolled in and uses health care items and services under CalCare.

(11) Two representatives of organizations that advocate for individuals who use health care in California, including at least one representative of an organization that advocates for the disabled community.

(12) Two representatives of organized labor, including at least one labor organization representing registered nurses.

(d) In convening the committee pursuant to this section, the board shall make good faith efforts to ensure that their appointments, as a whole, reflect, to the greatest extent feasible, the social and geographic diversity of the state.

(e) Members of the 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 fifty dollars ($150) 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.

(f) The committee shall meet at least once every quarter, and shall solicit input on agendas and topics set by the board. All meetings of the committee 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).

(g) The committee shall elect a chairperson who shall serve for two years and who may be reelected for an additional two years.

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

100612. (a) The board shall have all powers and duties necessary to establish and implement CalCare. The board shall provide, under CalCare, comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state.

(b) The board shall, to the maximum extent possible, organize, administer, and market CalCare and services as a single-payer program under the name "CalCare" or any other name as the board determines, regardless of which law or source the definition of a benefit is found, including, on a voluntary basis, retiree health benefits. In implementing this title, the board shall avoid jeopardizing federal financial participation in the programs that

are incorporated into CalCare and shall take care to promote public understanding and awareness of available benefits and programs.

(c) The board shall consider any matter to effectuate the provisions and purposes of this title. The board shall not have executive, administrative, or appointive duties except as otherwise provided by law.

(d) The board shall designate the executive director to employ necessary staff and authorize reasonable, necessary expenditures from the CalCare Trust Fund to pay program expenses and to administer CalCare. The executive director shall hire or designate another to hire staff, who shall not be exempt from civil service, to implement fully the purposes and intent of CalCare. The executive director, or the executive director's designee, shall give preference in hiring to all individuals displaced or unemployed as a direct result of the implementation of CalCare, including as set forth in Section 100615.

(e) The board shall do or delegate to the executive director all of the following:

(1) Determine goals, standards, guidelines, and priorities for CalCare.

(2) Annually assess projected revenues and expenditures and assure financial solvency of CalCare.

(3) Develop CalCare's budget pursuant to Section 100667 to ensure adequate funding to meet the health care needs of the population, and review all budgets annually to ensure they address disparities in service availability and health care outcomes and for sufficiency of rates, fees, and prices to address disparities.

(4) Establish standards and criteria for the development and submission of provider operating and capital expenditure requests pursuant to Article 2 (commencing with Section 100640) of Chapter 5.

(5) Establish standards and criteria for the allocation of funds from the CalCare Trust Fund pursuant to Section 100667.

(6) Determine when individuals may begin enrolling in CalCare. There shall be an implementation period that begins on the date that individuals may begin enrolling in CalCare and ends on a date determined by the board.

(7) 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, vision or

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 CalCare.

(8) Negotiate payment rates, set payment methodologies, and set prices involving aspects of CalCare and establish procedures thereto, including procedures for negotiating fee-for-service payment to certain participating providers pursuant to Chapter 8 (commencing with Section 100675).

(9) Oversee the establishment, as part of the administration of CalCare, of the committee pursuant to Section 100611.

(10) Implement policies to ensure that all Californians receive culturally, linguistically, and structurally competent care, pursuant to Chapter 6 (commencing with Section 100650), ensure 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 federal 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.

(11) Establish standards for mandatory reporting by participating providers and penalties for failure to report, including reporting of data pursuant to Section 100616 and to Section 100631.

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

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

(14) Meet regularly with the committee.

(15) 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 CalCare pursuant to Section 100615.

(16) In consultation with the Department of Managed Health Care, oversee the establishment of a system for resolution of disputes pursuant to Section 100627 and a system for independent medical review pursuant to Section 100627.

(17) Establish and maintain an internet website that provides information to the public about CalCare that includes information that supports choice of providers and facilities and informs the public about meetings of the board and the committee.

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

(19) (A) Annually prepare a written report on the implementation and performance of CalCare functions during the preceding fiscal year, that includes, at a minimum:

(i) The manner in which funds were expended.

(ii) The progress toward and achievement of the requirements of this title.

(iii) CalCare's fiscal condition.

(iv) Recommendations for statutory changes.

(v) Receipt of payments from the federal government and other sources.

(vi) Whether current year goals and priorities have been met.

(vii) Future goals and priorities.

(B) The report shall be transmitted to the Legislature and the Governor, on or before October 1 of each year and at other times pursuant to this division, and shall be made available to the public on the internet website of CalCare.

(C) A report made to the Legislature pursuant to this subdivision shall be submitted pursuant to Section 9795 of the Government Code.

(f) The board may do or delegate to the executive director all of the following:

(1) Negotiate and enter into any necessary contracts, including contracts with health care providers and health care professionals.

(2) Sue and be sued.

(3) Receive and accept gifts, grants, or donations of moneys from any agency of the federal government, any agency of the state, and any municipality, county, or other political subdivision of the state.

(4) Receive and accept gifts, grants, or donations from individuals, associations, private foundations, and corporations, in compliance with the conflict-of-interest provisions to be adopted by the board by regulation.

(5) Share information with relevant state departments, consistent with the confidentiality provisions in this title, necessary for the administration of CalCare.

(g) A carrier may not offer benefits or cover health care items or services for which coverage is offered to individuals under

CalCare, but may, if otherwise authorized, offer benefits to cover health care items or services that are not offered to individuals under CalCare. However, this title does not prohibit a carrier from offering either of the following:

(1) Benefits to or for individuals, including their families, who are employed or self-employed in the state, but who are not residents of the state.

(2) Benefits during the implementation period to individuals who enrolled or may enroll as members of CalCare.

(h) After the end of the implementation period, a person shall not be a board member unless the person is a member of CalCare, except the ex officio member.

(i) No later than two years after the effective date of this section, the board shall develop proposals for both of the following:

(1) Accommodating employer retiree health benefits for people who have been members of the Public Employees' Retirement System, but live as retirees out of the state.

(2) Accommodating employer retiree health benefits for people who earned or accrued those benefits while residing in the state before the implementation of CalCare and live as retirees out of the state.

(j) The board shall develop a proposal for CalCare coverage of health care items and services currently covered under the workers' compensation system, including whether and how to continue funding for those item and services under that system and how to incorporate experience rating.

100613. The board may contract with not-for-profit organizations to provide both of the following:

(a) Assistance to CalCare members with respect to selection of a participating provider, enrolling, obtaining health care items and services, disenrolling, and other matters relating to CalCare.

(b) Assistance to a health care provider providing, seeking, or considering whether to provide health care items and services under CalCare.

100614. (a) There is hereby established in state government an Advisory Commission on Long-Term Services and Supports, to advise the board on matters of policy related to long-term services and supports for CalCare.

(b) The advisory commission shall consist of eleven members who are residents of California. Of the members of the advisory

commission, five shall be appointed by the Governor, three shall be appointed by the Senate Committee on Rules, and three shall be appointed by the Speaker of the Assembly. The members of the advisory commission shall include all of the following:

(1) At least two people with disabilities who use long-term services and supports.

(2) At least two older adults who use long-term services and supports.

(3) At least two providers of long-term services and supports, including one family attendant or family caregiver.

(4) At least one representative of a disability rights organization.

(5) At least one representative or member of a labor organization representing workers who provide long-term services and supports.

(6) At least one representative of a group representing seniors.

(7) At least one researcher or academic in long-term services and supports.

(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 ensure that their appointments, as a whole, reflect, to the greatest extent feasible, the diversity of the population of people who use long-term services and supports, including their race, ethnicity, national origin, primary language use, age, disability, sex, including gender identity and sexual orientation, geographic location, and socioeconomic status.

(d) (1) A member of the board may continue to serve until the appointment and qualification of that member's successor. Vacancies shall be filled by appointment for the unexpired term.

(2) Members of the advisory commission shall be appointed for a term of four years, except that the initial appointment by the Senate Committee on Rules shall be for a term of five years, and the initial appointment by the Speaker of the Assembly shall be for a term of two years. These members may be reappointed for succeeding four-year terms.

(3) 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 Secretary of California Health and Human Services shall notify the appropriate appointing authority of any expected vacancies on the long-term services and supports advisory commission.

(e) Members of the advisory commission 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. Members shall also receive one hundred fifty dollars ($150) for each full day of attending meetings of the advisory commission. 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 advisory commission during any particular 24-hour period.

(f) The advisory commission shall meet at least six times per year in a place convenient to the public. All meetings of the advisory commission 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).

(g) The advisory commission shall elect a chairperson who shall serve for two years and who may be reelected for an additional two years.

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

100615. (a) The board shall provide funds from the CalCare Trust Fund or funds otherwise appropriated for this purpose to the Secretary of Labor and Workforce Development for program assistance to individuals employed or previously employed in the fields of health insurance, health care service plans, or other third-party payments for health care, individuals providing services to health care providers to deal with third-party payers for health care, individuals who may be affected by and who may experience economic dislocation as a result of the implementation of this title, and individuals whose jobs may be or have been ended as a result of the implementation of CalCare, consistent with otherwise applicable law.

(b) Assistance described in subdivision (a) shall include job training and retraining, job placement, preferential hiring, wage replacement, retirement benefits, and education benefits.

100616. (a) The board shall utilize the data collected pursuant to Chapter 1 (commencing with Section 128675) of Part 5 of

Division 107 of the Health and Safety Code to assess patient outcomes and to review utilization of health care items and services paid for by CalCare.

(b) As applicable to the type of provider, the board shall require and enforce the collection and availability of all of the following data to promote transparency, assess quality of care, compare patient outcomes, and review utilization of health care items and services paid for by CalCare, which shall be reported to the board and, as applicable, the Office of Statewide Health Planning and Development or the Medical Board of California:

(1) Inpatient discharge data, including severity of illness and risk of mortality, with respect to each discharge.

(2) Emergency department, ambulatory surgical center, and other outpatient department data, including cost data, charge data, length of stay, and patients' unit of observation with respect to each individual receiving health care items and services.

(3) For hospitals and other providers receiving global budgets, annual financial data, including all of the following:

(A) Community benefit activities, including charity care, to which Section 501(r) of Title 26 of the United States Code applies, provided by the provider in dollar value at cost.

(B) Number of employees by employee classification or job title and by patient care unit or department.

(C) Number of hours worked by the employees in each patient care unit or department.

(D) Employee wage information by job title and patient care unit or department.

(E) Number of registered nurses per staffed bed by patient care unit or department.

(F) A description of all information technology, including health information technology and artificial intelligence, used by the provider and the dollar value of that information technology.

(G) Annual spending on information technology, including health information technology, artificial intelligence, purchases, upgrades, and maintenance.

(4) Risk-adjusted and raw outcome data, including:

(A) Risk-adjusted outcome reports for medical, surgical, and obstetric procedures selected by the Office of Statewide Health Planning and Development pursuant to Sections 128745 to 128750, inclusive, of the Health and Safety Code.

(B) Any other risk-adjusted outcome reports that the board may require for medical, surgical, and obstetric procedures and conditions as it deems appropriate.

(5) A disclosure made by a provider as set forth in Article 6 (commencing with Section 650) of Chapter 1 of Division 2 of the Business and Professions Code.

(c) (1) The Medical Board of California shall collect data for the outpatient surgery settings that the medical board regulates that meets the Ambulatory Surgery Data Record requirements of Section 128737 of the Health and Safety Code, and shall submit that data to the CalCare board.

(2) The CalCare board shall make that data available as required pursuant to subdivision (d).

(d) The board shall make all disclosed data collected under this section publicly available and searchable through an internet website and through the Office of Statewide Health Planning and Development public data sets.

(e) Consistent with state and federal privacy laws, the board shall make available data collected through CalCare to the Office of Statewide Health Planning and Development and the California Health and Human Services Agency, consistent with this title and otherwise applicable law, to promote and protect public, environmental, and occupational health.

(f) Before full implementation of CalCare, and, for providers seeking to receive global budgets or salaried payments under Article 2 (commencing with Section 100640) of Chapter 5, as applicable, before the negotiation of initial payments, the board shall provide for the collection and availability of the following data:

(1) The number of patients served.

(2) The dollar value of the care provided, at cost, for all of the following categories of Office of Statewide Health Planning and Development data items:

(A) Patients receiving charity care.

(B) Contractual adjustments of county and indigent programs, including traditional and managed care.

(C) Bad debts or any other unpaid charges for patient care that the provider sought, but was unable to collect.

(g) The board shall regularly analyze information reported under this section and shall establish rules and regulations to allow

researchers, scholars, participating providers, and others to access and analyze data for purposes consistent with this title, without compromising patient privacy.

(h) (1) The board shall establish regulations for the collection and reporting of data to promote transparency, assess patient outcomes, and review utilization of services provided by physicians and other health care professionals, as applicable, and paid for by CalCare.

(2) In implementing this section, the board shall utilize data that is already being collected pursuant to other state or federal laws and regulations whenever possible.

(3) Data reporting required by participating providers under this section shall supplement the data collected by the Office of Statewide Health Planning and Development and shall not modify or alter other reporting requirements to governmental agencies.

(i) The board shall not utilize quality or other review measures established under this section for the purposes of establishing payment methods to providers.

(j) The board may coordinate and cooperate with the Office of Statewide Health Planning and Development or other health planning agencies of the state to implement the requirements of this section.

100617. (a) The board shall establish and use a process to enter into participation agreements with health care providers and other contracts with contractors. A contract entered into pursuant to this title shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and shall be exempt from the review or approval of the Department of General Services. The board shall adopt a CalCare Contracting Manual incorporating procurement and contracting policies and procedures that shall be followed by CalCare. The policies and procedures in the manual shall be substantially similar to the provisions contained in the State Contracting Manual.

(b) The adoption, amendment, or repeal of a regulation by the board to implement this section, including the adoption of a manual pursuant to subdivision (a) and any procurement process conducted by CalCare in accordance with the manual, is exempt from the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

100618. (a) Notwithstanding any other law, CalCare, a state or local agency, or a public employee acting under color of law shall not provide or disclose to anyone, including the federal government, any personally identifiable information obtained, including a person's religious beliefs, practices, or affiliation, national origin, ethnicity, or immigration status, for law enforcement or immigration purposes.

(b) Notwithstanding any other law, law enforcement agencies shall not use CalCare moneys, facilities, property, equipment, or personnel to investigate, enforce, or assist in the investigation or enforcement of a criminal, civil, or administrative violation or warrant for a violation of a requirement that individuals register with the federal government or a federal agency based on religion, national origin, ethnicity, immigration status, or other protected category as recognized in the Unruh Civil Rights Act (Section 51 of the Civil Code).

Chapter 3. Eligibility and Enrollment

100620. (a) Every resident of the state shall be eligible and entitled to enroll as a member of CalCare.

(b) (1) A member shall not be required to pay a fee, payment, or other charge for enrolling in or being a member of CalCare.

(2) A member shall not be required to pay a premium, copayment, coinsurance, deductible, or any other form of cost sharing for all covered benefits under CalCare.

(c) A college, university, or other institution of higher education in the state may purchase coverage under CalCare for a student, or a student's dependent, who is not a resident of the state.

(d) An individual entitled to benefits through CalCare may obtain health care items and services from any institution, agency, or individual participating provider.

(e) The board shall establish a process for automatic CalCare enrollment at the time of birth in California.

100621. (a) All residents of this state, no matter what their sex, race, color, religion, ancestry, national origin, disability, age, previous or existing medical condition, genetic information, marital status, familial status, military or veteran status, sexual orientation, gender identity or expression, pregnancy, pregnancy-related medical condition, including termination of pregnancy, citizenship,

primary language, or immigration status, are entitled to full and equal accommodations, advantages, facilities, privileges, or services in all health care providers participating in CalCare.

(b) Subdivision (a) prohibits a participating provider, or an entity conducting, administering, or funding a health program or activity pursuant to this title, from discriminating based upon the categories described in subdivision (a) in the provision, administration, or implementation of health care items and services through CalCare.

(c) Discrimination prohibited under this section includes the following:

(1) Exclusion of a person from participation in or denial of the benefits of CalCare, except as expressly authorized by this title for the purposes of enforcing eligibility standards in Section 100620.

(2) Reduction of a person's benefits.

(3) Any other discrimination by any participating provider or any entity conducting, administering, or funding a health program or activity pursuant to this title.

(d) Section 52 of the Civil Code shall apply to discrimination under this section.

(e) Except as otherwise provided in this section, a participating provider or entity is in violation of subdivision (b) if the complaining party demonstrates that any of the categories listed in subdivision (a) was a motivating factor for any health care practice, even if other factors also motivated the practice.

Chapter 4. Benefits

100625. (a) Individuals enrolled for benefits under CalCare are entitled to have payment made by CalCare to a participating provider for the health care items and services in subdivision (c), if medically necessary or appropriate for the maintenance of health or for the prevention, diagnosis, treatment, or rehabilitation of a health condition.

(b) The determination of medical necessity or appropriateness shall be made by the member's treating physician or by a health care professional who is treating that individual and is authorized to make that determination in accordance with the scope of practice, licensing, the program standards established in Chapter 6

(commencing with Section 100650) and by the board, and other laws of the state.

(c) Covered health care benefits for members include all of the following categories of health care items and services:

(1) Inpatient and outpatient medical and health facility services, including hospital services and 24-hour-a-day emergency services.

(2) Inpatient and outpatient health care professional services and other ambulatory patient services.

(3) Primary and preventive services, including chronic disease management.

(4) Prescription drugs and biological products.

(5) Medical devices, equipment, appliances, and assistive technology.

(6) Mental health and substance abuse treatment services, including inpatient and outpatient care.

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

(8) Comprehensive reproductive, maternity, and newborn care.

(9) Pediatrics.

(10) Oral health, audiology, and vision services.

(11) Rehabilitative and habilitative services and devices, including inpatient and outpatient care.

(12) Emergency services and transportation.

(13) Early and periodic screening, diagnostic, and treatment services as defined in Section 1396d(r) of Title 42 of the United States Code.

(14) Necessary transportation for health care items and services for persons with disabilities or who may qualify as low income.

(15) Long-term services and supports described in Section 100626, including long-term services and supports covered under Medi-Cal (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code) or the federal Children's Health Insurance Program (Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.))

(16) Any additional health care items and services the board authorizes to be added to CalCare benefits.

(d) The categories of covered health care items and services under subdivision (c) include all the following:

(1) Prosthetics, eyeglasses, and hearing aids and the repair, technical support, and customization needed for their use by an individual.

(2) Child and adult immunizations.

(3) Hospice care.

(4) Care in a skilled nursing facility.

(5) Home health care, including health care provided in an assisted living facility.

(6) Prenatal and postnatal care.

(7) Podiatric care.

(8) Blood and blood products.

(9) Dialysis.

(10) Community-based adult services as defined under Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code as of January 1, 2021.

(11) Dietary and nutritional therapies determined appropriate by the board.

(12) Therapies that are shown by the National Center for Complementary and Integrative Health in the National Institutes of Health to be safe and effective, including chiropractic care and acupuncture.

(13) Health care items and services previously covered by county integrated health and human services programs pursuant to Chapter 12.96 (commencing with Section 18990) and Chapter 12.991 (commencing with Section 18991) of Part 6 of Division 9 of the Welfare and Institutions Code.

(14) Health care items and services previously covered by a regional center for persons with developmental disabilities pursuant to Chapter 5 (commencing with Section 4620) of Division 4.5 of the Welfare and Institutions Code.

(15) Language interpretation and translation for health care items and services, including sign language and braille or other services needed for individuals with communication barriers.

(e) Covered health care items and services under CalCare include all health care items and services required to be covered under the following provisions, without regard to whether the member would be eligible for or covered by the source referred to:

(1) The federal Children’s Health Insurance Program (Title XXI of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.)).

(2) Medi-Cal (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).

(3) The federal Medicare program pursuant to Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).

(4) Health care service plans pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(5) Health insurers, as defined in Section 106 of the Insurance Code, pursuant to Part 2 (commencing with Section 10110) of Division 2 of the Insurance Code.

(6) All essential health benefits mandated by the federal Patient Protection and Affordable Care Act as of January 1, 2017.

(f) Health care items and services covered under CalCare shall not be subject to prior authorization or a limitation applied through the use of step therapy protocols.

100626. (a) Subject to the other provisions of this title, individuals enrolled for benefits under CalCare are entitled to have payment made by CalCare to an eligible provider for long-term services and supports, in accordance with the standards established in this title, for care, services, diagnosis, treatment, rehabilitation, or maintenance of health related to a medically determinable condition, whether physical or mental, of health, injury, or age, that either:

(1) Causes a functional limitation in performing one or more activities of daily living or in instrumental activities of daily living.

(2) Is a disability, as defined in Section 12102(1)(A) of Title 42 of the United States Code, that substantially limits one or more of the member's major life activities.

(b) The board shall adopt regulations that provide for the following:

(1) The determination of individual eligibility for long-term services and supports under this section.

(2) The assessment of the long-term services and supports needed for an eligible individual.

(3) The automatic entitlement of an individual who receives or is approved to receive disability benefits from the federal Social Security Administration under the federal Social Security Disability Insurance program established in Title II or Title XVI of the federal Social Security Act to the long-term services and supports under this section.

(c) Long-term services and supports provided pursuant to this section shall do all of the following:

(1) Include long-term nursing services for a member, whether provided in an institution or in a home- and community-based setting.

(2) Provide coverage for a broad spectrum of long-term services and supports, including home- and community-based services, other care provided through noninstitutional settings, and respite care.

(3) Provide coverage that meets the physical, mental, and social needs of a member while allowing the member the member's maximum possible autonomy and the member's maximum possible civic, social, and economic participation.

(4) Prioritize delivery of long-term services and supports through home- and community-based services over institutionalization.

(5) Unless a member chooses otherwise, ensure that the member receives home- and community-based long-term services and supports regardless of the recipient's type or level of disability, service need, or age.

(6) Have the goal of enabling persons with disabilities to receive services in the least restrictive and most integrated setting appropriate to the member's needs.

(7) Be provided in a manner that allows persons with disabilities to maintain their independence, self-determination, and dignity.

(8) Provide long-term services and supports that are of equal quality and equitably accessible across geographic regions.

(9) Ensure that long-term services and supports provide recipients the option of self-direction of service, including under the Self-Directed Services Program described in Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code, from either the recipient or care coordinators of the recipient's choosing.

(d) In developing regulations to implement this section, the board shall consult the advisory commission established pursuant to Section 100614.

100627. (a) (1) The board shall, on a regular basis and at least annually, evaluate whether the benefits under CalCare should be expanded or adjusted to promote the health of members and California residents, account for changes in medical practice or

new information from medical research, or respond to other relevant developments in health science.

(2) In implementing this section, the board shall not remove or eliminate covered health care items and services under CalCare that are listed in this chapter.

(b) The board shall establish a process by which health care professionals, other clinicians, and members may petition the board to add or expand benefits to CalCare.

(c) The board shall establish a process by which individuals may bring a disputed health care item or service or a coverage decision for review to the Independent Medical Review System established in the Department of Managed Health Care pursuant to Article 5.55 (commencing with Section 1374.30) of Chapter 2.2 of Division 2 of the Health and Safety Code.

(d) For the purposes of this chapter:

(1) "Coverage decision" means the approval or denial of health care items or services by a participating provider or a health care professional who is employed by or otherwise receives compensation or payment for items and services furnished under CalCare from a participating provider, substantially based on a finding that the provision of a particular service is included or excluded as a covered item or service under CalCare. A "coverage decision" does not encompass a decision regarding a disputed health care item or service.

(2) "Disputed health care item or service" means a health care item or service eligible for coverage and payment under CalCare that has been denied, modified, or delayed by a decision of a participating provider or a health care professional who is employed by or otherwise receives compensation or payment for health care items and services furnished under CalCare from a participating provider, in whole or in part, due to a finding that the service is not medically necessary or appropriate. A decision regarding a disputed health care item or service relates to the practice of medicine, including early discharge from an institutional provider, and is not a coverage decision.

Chapter 5. Delivery of Care

Article 1. Health Care Providers

100630. (a) (1) A health care provider or entity is qualified to participate as a provider in CalCare if the health care provider furnishes health care items and services while the provider, or, if the provider is an entity, the individual health care professional of the entity furnishing the health care items and services, is physically present within the State of California, and if the provider meets all of the following:

(A) The provider or entity is a health care professional, group practice, or institutional health care provider licensed to practice in California.

(B) The provider or entity agrees to accept CalCare rates as payment in full for all covered health care items and services.

(C) The provider or entity has filed with the board a participation agreement described in Section 100631.

(D) The provider or entity is otherwise in good standing.

(2) The board shall establish and maintain procedures and standards for recognizing health care providers located out of the state for purposes of providing coverage under CalCare for members who require out-of-state health care services while the member is temporarily located out of the state.

(b) A provider or entity shall not be qualified to furnish health care items and services under CalCare if the provider or entity does not provide health care items or services directly to individuals, including the following:

(1) Entities or providers that contract with other entities or providers to provide health care items and services shall not be considered a qualified provider for those contracted items and services.

(2) Entities that are approved to coordinate care plans under the Medicare Advantage program established in Part C of Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1851 et seq.) as of January 1, 2020, but do not directly provide health care items and services.

(c) A health care provider qualified to participate under this section may provide covered health care items or services under CalCare, as long as the health care provider is legally authorized

to provide the health care item or service for the individual and under the circumstances involved.

(d) The board shall establish and maintain procedures for members and individuals eligible to enroll in CalCare to enroll onsite at a participating provider.

(e) The board shall establish and maintain procedures and standards for members to select a primary care physician, which may be an internist, a pediatrician, a physician who practices family medicine, a gynecologist, a physician who practices geriatric medicine, or, at the option of a member who has a chronic condition that requires specialty care, a specialist health care professional who regularly and continually provides treatment to the member for that condition.

(f) A referral from a primary care provider is not required for a member to see a participating provider.

(g) A member may choose to receive health care items and services under CalCare from a participating provider, subject to the willingness or availability of the provider, and consistent with the provisions of this title relating to discrimination, and the appropriate clinically relevant circumstances and standards.

100631. (a) A health care provider shall enter into a participation agreement with the board to qualify as a participating provider under CalCare.

(b) A participation agreement between the board and a health care provider shall include provisions for at least the following, as applicable to each provider:

(1) Health care items and services to members shall be furnished by the provider without discrimination, as required by Section 100621. This paragraph does not require the provision of a type or class of health care items or services that are outside the scope of the provider's normal practice.

(2) A charge shall not be made to a member for a covered health care item or service, other than for payment authorized by this title. Except as described in Section 100634, a contract shall not be entered into with a patient for a covered health care item or service.

(3) The provider shall follow the policies and procedures in the CalCare Contracting Manual established pursuant to Section 100617.

(4) The provider shall furnish information reasonably required by the board and shall meet the reporting requirements of Sections 100616 and 100651 for at least the following:

(A) Quality review by designated entities.

(B) Making payments, including the examination of records as necessary for the verification of information on which those payments are based.

(C) Statistical or other studies required for the implementation of this title.

(D) Other purposes specified by the board.

(5) If the provider is not an individual, the provider shall not employ or use an individual or other provider that has had a participation agreement terminated for cause to provide covered health care items and services.

(6) If the provider is paid on a fee-for-service basis for covered health care items and services, the provider shall submit bills and required supporting documentation relating to the provision of covered health care items or services within 30 days after the date of providing those items or services.

(7) The provider shall submit information and any other required supporting documentation reasonably required by the board on a quarterly basis that relates to the provision of covered health care items and services and describes health care items and services furnished with respect to specific individuals.

(8) (A) If the provider receives payment based on provider data on diagnosis-related coding, procedure coding, or other coding system or data, the provider shall disclose the following to the board:

(i) Any case mix indexes, diagnosis coding software, procedure coding software, or other coding system utilized by the provider for the purposes of meeting payment, global budget, or other disclosure requirements under this title.

(ii) Any case mix indexes, diagnosis coding guidelines, procedure coding guidelines, or coding tip sheets used by the provider for the purposes of meeting payment or disclosure requirements under this title.

(B) If the provider receives payment based on provider data on diagnosis-related coding, procedure coding, or other coding system or data, the provider shall not do the following:

(i) Use proprietary case mix indexes, diagnosis coding software, procedure coding software, or other coding system for the purposes of meeting payment, global budget, or other disclosure requirements under this title.

(ii) Require another health care professional to apply case mix indexes, diagnosis coding software, procedure coding software, or other coding system in a manner that limits the clinical diagnosis, treatment process, or a treating health care professional's judgment in determining a diagnosis or treatment process, including the use of leading queries or prohibitions on using certain codes.

(iii) Provide financial incentives or disincentives to physicians, registered nurses, or other health care professionals for particular coding query results or code selections.

(iv) Use case mix indexes, diagnosis coding software, procedure coding software, or other coding system that make suggestions for higher severity diagnoses or higher cost procedure coding.

(9) The provider shall comply with the duty of patient advocacy and reporting requirements described in Section 100651.

(10) If the provider is not an individual, the provider shall ensure that a board member, executive, or administrator of the provider shall not receive compensation from, own stock or have other financial investments in, or receive services as a board member of an entity that contracts with or provides health care items or services, including pharmaceutical products and medical devices or equipment, to the provider.

(11) If the provider is a not-for-profit hospital subject to Article 2 (commencing with Section 127340) of Chapter 2 of Part 2 of Division 107 of the Health and Safety Code, the hospital shall submit to the board the community benefits plan developed pursuant to Article 2 (commencing with Section 127340) of the Health and Safety Code.

(12) Health care items and services to members shall be furnished by a health care professional while the professional is physically present within the State of California.

(13) The provider shall not enter into risk-bearing, risk-sharing, or risk-shifting agreements with other health care providers or entities other than CalCare.

(c) This section does not limit the formation of group practices.

100632. (a) A participation agreement may be terminated with appropriate notice by the board for failure to meet the requirements of this title or may be terminated by a provider.

(b) A participating provider shall be provided notice and a reasonable opportunity to correct deficiencies before the board terminates an agreement, unless a more immediate termination is required for public safety or similar reasons.

(c) The procedures and penalties under the Medi-Cal program for fraud or abuse pursuant to Sections 14107, 14107.11, 14107.12, 14107.13, 14107.2, 14107.3, 14107.4, 14107.5, and 14108 of the Welfare and Institutions Code shall apply to an applicant or provider under CalCare.

(d) For purposes of this section:

(1) "Applicant" means an individual, including an ordering, referring, or prescribing individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, owners, managing employees, or agents thereof, that apply to the board to participate as a provider in CalCare.

(2) "Provider" means an individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, owners, managing employees, or agents of a partnership, group association, corporation, institution, or entity, that provides services, goods, supplies, or merchandise, directly or indirectly, including all ordering, referring, and prescribing, to CalCare program members.

100633. (a) A person shall not discharge or otherwise discriminate against an employee on account of the employee or a person acting pursuant to a request of the employee for any of the following:

(1) Notifying the board, executive director, or employee's employer of an alleged violation of this title, including communications related to carrying out the employee's job duties.

(2) Refusing to engage in a practice made unlawful by this title, if the employee has identified the alleged illegality to the employer.

(3) Providing, causing to be provided, or being about to provide or cause to be provided to the provider, the federal government, or the Attorney General information relating to a violation of, or an act or omission the provider or representative reasonably believes to be a violation of, this title.

(4) Testifying before or otherwise providing information relevant for a state or federal proceeding regarding this title or a proposed amendment to this title.

(5) Commencing, causing to be commenced, or being about to commence or cause to be commenced a proceeding under this title.

(6) Testifying or being about to testify in a proceeding.

(7) Assisting or participating, or being about to assist or participate, in a proceeding or other action to carry out the purposes of this title.

(8) Objecting to, or refusing to participate in, an activity, policy, practice, or assigned task that the employee or representative reasonably believes to be in violation of this title or any order, rule, regulation, standard, or ban under this title.

(b) An employee covered by this section who alleges discrimination by an employer in violation of subdivision (a) may bring an action governed by the rules and procedures, legal burdens of proof, and remedies applicable under the False Claims Act (Article 9 (commencing with Section 12650) of Chapter 6 of Part 2 of Division 3 of Title 2) or Section 12990, or an action against unfair competition pursuant to Chapter 5 (commencing with Section 17200) of Part 2 of Division 7 of the Business and Professions Code.

(c) (1) This section does not diminish the rights, privileges, or remedies of an employee under any other law, regulation, or collective bargaining agreement. The rights and remedies in this section shall not be waived by an agreement, policy, form, or condition of employment.

(2) This section does not preempt or diminish any other law or regulation against discrimination, demotion, discharge, suspension, threats, harassment, reprimand, retaliation, or any other manner of discrimination.

(d) For purposes of this section:

(1) “Employer” means a person engaged in profit or not-for-profit business or industry, including one or more individuals, partnerships, associations, corporations, trusts, professional membership organization including a certification, disciplinary, or other professional body, unincorporated organizations, nongovernmental organizations, or trustees, and who is subject to liability for violating this title.

(2) "Employee" means an individual performing activities under this title on behalf of an employer.

100634. (a) This section shall be effective on the date the implementation period ends pursuant to paragraph (6) of subdivision (e) of Section 100612.

(b) (1) An institutional or individual provider with a participation agreement in effect shall not bill or enter into a private contract with an individual eligible for benefits through CalCare for a health care item or service that is a covered benefit through CalCare.

(2) An institutional or individual provider with a participation agreement in effect may bill or enter into a private contract with an individual eligible for benefits through CalCare for a health care item or service that is not a covered benefit through CalCare if the following requirements are met:

(A) The contract and provider meet the requirements specified in paragraphs (3) and (4).

(B) The health care item or service is not payable or available through CalCare.

(C) The provider does not receive reimbursement, directly or indirectly, from CalCare for the health care item or service, and does not receive an amount for the health care item or service from an organization that receives reimbursement, directly or indirectly, for the health care item or service from CalCare.

(3) (A) A contract described in paragraph (2) shall be in writing and signed by the individual, or authorized representative of the individual, receiving the health care item or service before the health care item or service is furnished pursuant to the contract, and shall not be entered into at a time when the individual is facing an emergency health care situation.

(B) A contract described in paragraph (2) shall clearly indicate to the individual receiving the health care item or service that by signing the contract, the individual agrees to all of the following:

(i) The individual shall not submit a claim or request that the provider submit a claim to CalCare for the health care item or service.

(ii) The individual is responsible for payment of the health care item or service and understands that reimbursement shall not be provided under CalCare for the health care item or service.

(iii) The individual understands that the limits under CalCare do not apply to amounts that may be charged for the health care item or service.

(iv) The individual understands that the provider is providing services outside the scope of CalCare.

(4) A participating provider that enters into a contract described in paragraph (2) shall have in effect, during the period a health care item or service is to be provided pursuant to the contract, an affidavit, which shall be filed with the board no later than 10 days after the first contract to which the affidavit applies is entered into. The affidavit shall identify the provider who is to furnish the noncovered health care item or service, state that the provider will not submit a claim to CalCare for a noncovered health care item or service provided to a member, and be signed by the provider.

(5) If a provider signing an affidavit described in paragraph (4) knowingly and willfully submits a claim to CalCare for a noncovered health care item or service or receives reimbursement or an amount for a health care item or service provided pursuant to a private contract, all of the following apply:

(A) A contract described in paragraph (2) shall be void.

(B) A payment shall not be made under CalCare for a health care item or service furnished by the provider during the two-year period beginning on the date the affidavit was signed or the date the claim was submitted, whichever is later. A payment made by CalCare to the provider during that two-year period shall be remitted to CalCare, plus interest.

(C) A payment received by the provider from the member, CalCare, or other payer for a health care item or service furnished during the period described in subparagraph (B) shall be remitted to the payer, and damages shall be available to the payer pursuant to Section 3294 of the Civil Code.

(6) An institutional or individual provider with a participation agreement in effect may bill or enter into a private contract with an individual ineligible for benefits under CalCare for a health care item or service. Consistent with Section 100618, the institutional or individual provider shall report to the board, on an annual basis, aggregate information regarding services furnished to ineligible individuals.

(c) (1) An institutional or individual provider without a participation agreement in effect may bill or enter into a private

contract with an individual eligible for benefits under CalCare for a health care item or service that is a covered benefit through CalCare only if the contract and provider meet the requirements specified in paragraphs (2) and (3).

(2) (A) A contract described in paragraph (1) shall be in writing and signed by the individual, or authorized representative of the individual, receiving the health care item or service before the item or service is furnished pursuant to the contract, and shall not be entered into at a time when the individual is facing an emergency health care situation.

(B) A contract described in paragraph (1) shall clearly indicate to the individual receiving the health care item or service that by signing the contract, the individual agrees to all of the following:

(i) The individual understands that the individual has the right to have the health care item or service provided by another provider for which payment would be made under CalCare.

(ii) The individual shall not submit a claim or request that the provider submit a claim to CalCare for the health care item or service, even if the health care item or service is otherwise covered under CalCare.

(iii) The individual is responsible for payment of the health care item or service and understands that reimbursement shall not be provided under CalCare for the health care item or service.

(iv) The individual understands that the limits under CalCare do not apply to amounts that may be charged for the health care item or service.

(v) The individual understands that the provider is providing services outside the scope of CalCare.

(3) A provider that enters into a contract described in paragraph (1) shall have in effect, during the period a health care item or service is to be provided pursuant to the contract, an affidavit, which shall be filed with the board no later than 10 days after the first contract to which the affidavit applies is entered into. The affidavit shall identify the provider who is to furnish the health care item or service, state that the provider will not submit a claim to CalCare for a health care item or service provided to a member during a two-year period beginning on the date the affidavit was signed, and be signed by the provider.

(4) If a provider who signed an affidavit described in paragraph (3) knowingly and willfully submits a claim to CalCare for a health

care item or service or receives reimbursement or an amount for a health care item or service provided pursuant to a private contract described in an affidavit signed pursuant to paragraph (3), all of the following apply:

(A) A contract described in paragraph (1) shall be void.

(B) A payment shall not be made under CalCare for a health care item or service furnished by the provider during the two-year period beginning on the date the affidavit was signed or the date the claim was submitted, whichever is later. A payment made by CalCare to the provider during that two-year period shall be remitted to CalCare, plus interest.

(C) A payment received by the provider from the member, CalCare program, or other payer for a health care item or service furnished during the period described in subparagraph (B) shall be remitted to the payer, and damages shall be available to the payer pursuant to Section 3294 of the Civil Code.

(5) An institutional or individual provider without a participation agreement in effect may bill or enter into a private contract with an individual for a health care item or service that is not a benefit under CalCare.

Article 2. Payment for Health Care Items and Services

100640. (a) The board shall adopt regulations regarding contracting for, and establishing payment methodologies for, covered health care items and services provided to members under CalCare by participating providers. All payment rates under CalCare shall be reasonable and reasonably related to all of the following:

(1) The cost of efficiently providing the health care items and services.

(2) Ensuring availability and accessibility of CalCare health care services, including compliance with state requirements regarding network adequacy, timely access, and language access.

(3) Maintaining an optimal workforce and the health care facilities necessary to deliver quality, equitable health care.

(b) (1) Payment for health care items and services shall be considered payment in full.

(2) A participating provider shall not charge a rate in excess of the payment established through CalCare for a health care item or

service furnished under CalCare and shall not solicit or accept payment from any member or third party for a health care item or service furnished under CalCare, except as provided under a federal program.

(3) This section does not preclude CalCare from acting as a primary or secondary payer in conjunction with another third-party payer when permitted by a federal program.

(c) Not later than the beginning of each fiscal quarter during which an institutional provider of care, including a hospital, skilled nursing facility, and chronic dialysis clinic, is to furnish health care items and services under CalCare, the board shall pay to each institutional provider a lump sum to cover all operating expenses under a global budget as set forth in Section 100641. An institutional provider receiving a global budget payment shall accept that payment as payment in full for all operating expenses for health care items and services furnished under CalCare, whether inpatient or outpatient, by the institutional provider.

(d) (1) A group practice, county organized health system, or local initiative may elect to be paid for health care items and services furnished under CalCare either on a fee-for-service basis under Section 100644 or on a salaried basis.

(2) A group practice, county organized health system, or local initiative that elects to be paid on a salaried basis shall negotiate salaried payment rates with the board annually, and the board shall pay the group practice, county organized health system, or local initiative at the beginning of each month.

(e) Health care items and services provided to members under CalCare by individual providers or any other providers not paid under subdivision (c) or (d) shall be paid for on a fee-for-service basis under Section 100644.

(f) Capital-related expenses for specifically identified capital expenditures incurred by participating providers shall meet the requirements under Section 100645.

(g) Payment methodologies and payment rates shall include a distinct component of reimbursement for direct and indirect costs incurred by the institutional provider for graduate medical education, as applicable.

(h) The board shall adopt, by regulation, payment methodologies and procedures for paying for out-of-state health care services.

(i) (1) This article does not regulate, interfere with, diminish, or abrogate a collective bargaining agreement, established employee rights, or the right, obligation, or authority of a collective bargaining representative under state or local law.

(2) This article does not compel, regulate, interfere with, or duplicate the provisions of an established training program that is operated under the terms of a collective bargaining agreement or unilaterally by an employer or bona fide labor union.

(j) The board shall determine the appropriate use and allocation of the special projects budget for the construction, renovation, or staffing of health care facilities in rural, underserved, or health professional or medical shortage areas, and to address health disparities, including those based on race, ethnicity, national origin, primary language use, age, disability, sex, including gender identity and sexual orientation, geography, and socioeconomic status.

100641. (a) An institutional provider's global budget shall be determined before the start of a fiscal year through negotiations between the provider and the board. The global budget shall be negotiated annually based on the payment factors described in subdivision (d).

(b) An institutional provider's global budget shall be used only to cover operating expenses associated with direct care for patients for health care items and services covered under CalCare. An institutional provider's global budget shall not be used for capital expenditures, and capital expenditures shall not be included in the global budget.

(c) The board, on a quarterly basis, shall review whether requirements of the institutional provider's participation agreement and negotiated global budget have been performed and shall determine whether adjustment to the institutional provider's payment is warranted.

(d) A payment negotiated pursuant to subdivision (a) shall take into account, with respect to each provider, all of the following:

(1) The historical volume of services provided for each health care item and service in the previous three-year period.

(2) The actual expenditures of a provider in the provider's most recent Medicare cost report for each health care item and service, or other cost report that may otherwise be adopted by the board, compared to the following:

(A) The expenditures of other comparable institutional providers in the state.

(B) The normative payment rates established under the comparative payment rate systems pursuant to Section 100643, including permissible adjustments to the rates for the health care items and services.

(C) Projected changes in the volume and type of health care items and services to be furnished.

(D) Employee wages.

(E) The provider's maximum capacity to provide the health care items and services.

(F) Education and prevention programs.

(G) Permissible adjustments to the provider's operating budget from the previous fiscal year due to factors including an increase in primary or specialty care access, efforts to decrease health care disparities in rural or medically underserved areas, a response to emergent conditions, and proposed changes to patient care programs at the institutional level.

(H) Any other factor determined appropriate by the board.

(3) In a rural or medically underserved area, the need to mitigate the impact of the availability and accessibility of health care services through increased global budget payment.

(e) A payment negotiated pursuant to subdivision (a) or payment methodology shall not do any of the following:

(1) Take into account capital expenditures of the provider or any other expenditure not directly associated with furnishing health care items and services under CalCare.

(2) Be used by a provider for capital expenditures or other expenditures associated with capital projects.

(3) Exceed the provider's capacity to furnish health care items and services covered under CalCare.

(4) Be used to pay or otherwise compensate a board member, executive, or administrator of the institutional provider who has an interest or relationship prohibited under paragraph (10) of subdivision (b) of Section 100631 or paragraph (3) of subdivision (c) of Section 100651.

(f) The board may negotiate changes to an institutional provider's global budget based on factors not prohibited under subdivision (e) or any other provision of this title.

(g) Subject to subdivision (i) of Section 100640, compensation costs for an employee, contractor employee, or subcontractor employee of an institutional provider receiving a global budget shall meet the compensation cap established in Section 4304(a)(16) of Title 41 of the United States Code and its implementing regulations, except that the board may establish one or more narrowly targeted exceptions for scientists, engineers, or other specialists upon a determination that those exceptions are needed to ensure CalCare continued access to needed skills and capabilities.

(h) A payment to an institutional provider pursuant to this section shall not allow a participating provider to retain revenue generated from outsourcing health care items and services covered under CalCare, unless that revenue was considered part of the global budget negotiation process. This subdivision shall apply to revenue from outsourcing health care items and services that were previously furnished by employees of the participating provider who were subject to a collective bargaining agreement.

(i) For the purposes of this section, "operating expenses" of a provider include the following:

(1) The costs associated with covered health care items and services under CalCare, including the following:

(A) Compensation for health care professionals, ancillary staff, and services employed or otherwise paid by an institutional provider.

(B) Pharmaceutical products administered by health care professionals at the institutional provider's facility or facilities.

(C) Purchasing supplies.

(D) Maintenance of medical devices and health care technologies, including diagnostic testing equipment, except that health information technology and artificial intelligence shall be considered capital expenditures, unless otherwise determined by the board.

(E) Incidental services necessary for safe patient care.

(F) Patient care, education, and preventive health programs, and necessary staff to implement those programs.

(G) Occupational health and safety programs and public health programs, and necessary staff to implement those programs for the continued education and health and safety of clinicians and other individuals employed by the institutional provider.

(H) Infectious disease response preparedness, including the maintenance of a one-year or 365-day stockpile of personal protective equipment, occupational testing and surveillance, and contact tracing.

(2) Administrative costs of the institutional provider.

100642. (a) The board shall consider an appeal of payments and the global budget, filed by an institutional provider that is subject to the payments or global budget, based on the following:

(1) The overall financial condition of the institutional provider, including bankruptcy or financial solvency.

(2) Excessive risks to the ongoing operation of the institutional provider.

(3) Justifiable differences in costs among providers, including providing a service not available from other providers in the region, or the need for health care services in rural areas with a shortage of health professionals or medically underserved areas and populations.

(4) Factors that led to increased costs for the institutional provider that can reasonably be considered to be unanticipated and out of the control of the provider. Those factors may include:

(A) Natural disasters.

(B) Outbreaks of epidemics or infectious diseases.

(C) Unanticipated facility or equipment repairs or purchases.

(D) Significant and unanticipated increases in pharmaceutical or medical device prices.

(5) Changes in state or federal laws that result in a change in costs.

(6) Reasonable increases in labor costs, including salaries and benefits, and changes in collective bargaining agreements, prevailing wage, or local law.

(b) (1) The payments set and global budget negotiated by the board to be paid to the institutional provider shall stay in effect during the appeal process, subject to interim relief provisions.

(2) The board shall have the power to grant interim relief based on fairness. The board shall develop regulations governing interim relief. The board shall establish uniform written procedures for the submission, processing, and consideration of an interim relief appeal by an institutional provider. A decision on interim relief shall be granted within one month of the filing of an interim relief appeal. An institutional provider shall certify in its interim relief

appeal that the request is made on the basis that the challenged amount is arbitrary and capricious, or that the institutional provider has experienced a bona fide emergency based on unanticipated costs or costs outside the control of the entity, including those described in paragraph (4) of subdivision (a).

(c) (1) In accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2), the board may delegate the conduct of a hearing to an administrative law judge, who shall issue a proposed decision with findings of fact and conclusions of law.

(2) The administrative law judge may hold evidentiary hearings and shall issue a proposed decision with findings of fact and conclusions of law, including a recommended adjusted payment or global budget, within four months of the filing of the appeal.

(3) Within 30 days of receipt of the proposed decision by the administrative law judge, the board may approve, disapprove, or modify the decision, and shall issue a final decision for the appealing institutional provider.

(d) A final determination by the commission shall be subject to judicial review pursuant to Section 1094.5 of the Code of Civil Procedure.

100643. (a) The board shall use existing Medicare prospective payment systems to establish and serve as the comparative payment rate system in global budget negotiations described in subparagraph (B) of paragraph (2) of subdivision (d) of Section 100641. The board shall update the comparative payment rate system annually.

(b) To develop the comparative payment rate system, the board shall use only the operating base payment rates under each Medicare prospective payment system with applicable adjustments.

(c) The comparative rate system shall not include value-based purchasing adjustments or capital expenses base payment rates that may be included in Medicare prospective payment systems.

(d) In the first year that global budget payments are available to institutional providers, and for purposes of selecting a comparative payment rate system used during initial global budget negotiations for an institutional provider, the board shall take into account the appropriate Medicare prospective payment system from the most recent year to determine what operating base payment the institutional provider would have been paid for covered health care items and services furnished the preceding

year with applicable adjustments, excluding value-based purchasing adjustments, based on the prospective payment system.

100644. (a) The board shall engage in good faith negotiations with health care providers' representatives under Chapter 8 (commencing with Section 100800) to determine rates of fee-for-service payment for health care items and services furnished under CalCare.

(b) There shall be a rebuttable presumption that the Medicare fee-for-service rates of reimbursement constitute reasonable fee-for-service payment rates. The fee schedule shall be updated annually.

(c) Payments to individual providers under this article shall not include payments to individual providers in salaried positions at institutional providers receiving global budgets under Section 100641 or individual health care professionals who are employed by or otherwise receive compensation or payment for health care items and services furnished under CalCare from group practices, county organized health systems, or local initiatives that receive payment under CalCare on a salaried basis.

(d) To establish the fee-for-service payment rates, the board shall ensure that the fee schedule compensates physicians and other health care professionals at a rate that reflects the value for health care items and services furnished.

(e) In a rural or medically underserved area, the board may mitigate the impact of the availability and accessibility of health care services through increased individual provider payment.

100645. (a) (1) The board shall adopt, by regulation, payment methodologies for the payment of capital expenditures for specifically identified capital projects incurred by not-for-profit or governmental entities that are health facilities pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

(2) The board shall prioritize allocation of funding under this subdivision to projects that propose to use the funds to improve service in a rural or medically underserved area, or to address health disparities, including those based on race, ethnicity, national origin, primary language use, age, disability, sex, including gender identity and sexual orientation, geography, and socioeconomic status. The board shall consider the impact of any prior reduction

in services or facility closure by a not-for-profit or governmental entity as part of the application review process.

(3) For the purposes of funding capital expenditures under this section, health care facilities and governmental entities shall apply to the board in a time and manner specified by the board. All capital-related expenses generated by a capital project shall have received prior approval from the board to be paid under CalCare.

(b) Approval of an application for capital expenditures shall be based on achievement of the program standards described in Chapter 6 (commencing with Section 100650).

(c) The board shall not grant funding for capital expenditures for capital projects that are financed directly or indirectly through the diversion of private or other non-CalCare program funding that results in reductions in care to patients, including reductions in registered nursing staffing patterns and changes in emergency room or primary care services or availability.

(d) A participating provider shall not use operating funds or payments from CalCare for the operating expenses associated with a capital asset that was not funded by CalCare without the approval of the board.

(e) A participating provider shall not do either of the following:

(1) Use funds from CalCare designated for operating expenses or payments for capital expenditures.

(2) Use funds from CalCare designated for capital expenditures or payments for operating expenses.

100646. (a) (1) A margin generated by a participating provider receiving a global budget under CalCare may be retained and used to meet the health care needs of CalCare members.

(2) A participating provider shall not retain a margin if that margin was generated through inappropriate limitations on access to health care, compromises in the quality of care, or actions that adversely affected or are likely to adversely affect the health of the persons receiving services from an institutional provider, group practice, or other participating provider under CalCare.

(3) The board shall evaluate the source of margin generation.

(b) A payment under CalCare, including provider payments for operating expenses or capital expenditures, shall not take into account, include a process for the funding of, or be used by a provider for any of the following:

(1) Marketing, which does not include education and prevention programs paid under a global budget.

(2) The profit or net revenue, or increasing the profit, net revenue, or financial result of the provider.

(3) An incentive payment, bonus, or compensation based on patient utilization of health care items or services or any financial measure applied with respect to the provider or a group practice or other entity that contracts with or provides health care items or services, including pharmaceutical products and medical devices or equipment, to the provider.

(4) A bonus, incentive payment, or incentive adjustment from CalCare to a participating provider.

(5) A bonus, incentive payment, or compensation based on the financial results of any other health care provider with which the provider has a pecuniary interest or contractual relationship, including employment or other compensation-based relationship.

(6) A bonus, incentive payment, or compensation based on the financial results of an integrated health care delivery system, group practice, or other provider.

(7) State political contributions.

(c) (1) The board shall establish and enforce penalties for violations of this section, consistent with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 1l340) of Part 1 of Division 3 of Title 2).

(2) Penalty payments collected for violations of this section shall be remitted to the CalCare Trust Fund for use in CalCare.

100647. (a) The board shall, in consultation with the Department of General Services, the Department of Health Care Services, and other relevant state agencies, negotiate prices to be paid for pharmaceuticals, medical supplies, medical technology, and medically necessary assistive equipment covered through CalCare. Negotiations by the board shall be on behalf of the entire CalCare program. A state agency shall cooperate to provide data and other information to the board.

(b) The board shall, in consultation with the Department of General Services, the Department of Health Care Services, the CalCare Public Advisory Committee, patient advocacy organizations, physicians, registered nurses, pharmacists, and other health care professionals, establish a prescription drug formulary

system. To establish the prescription drug formulary system, the board shall do all of the following:

(1) Promote the use of generic and biosimilar medications.

(2) Consider the clinical efficacy of medications.

(3) Update the formulary frequently and allow health care professionals, other clinicians, and members to petition the board to add new pharmaceuticals or to remove ineffective or dangerous medications from the formulary.

(4) Consult with patient advocacy organizations, physicians, nurses, pharmacists, and other health care professionals to determine the clinical efficacy and need for the inclusion of specific medications in the formulary.

(c) The prescription drug formulary system shall not require a prior authorization determination for coverage under CalCare and shall not apply treatment limitations through the use of step therapy protocols.

(d) The board shall promulgate regulations regarding the use of off-formulary medications that allow for patient access.

Chapter 6. Program Standards

100650. CalCare shall establish a single standard of safe, therapeutic, and effective care for all residents of the state by the following means:

(a) The board shall establish requirements and standards, by regulation, for CalCare and health care providers, consistent with this title and consistent with the applicable professional practice and licensure standards of health care providers and health care professionals established pursuant to the Business and Professions Code, the Health and Safety Code, the Insurance Code, and the Welfare and Institutions Code, including requirements and standards for, as applicable:

(1) The scope, quality, and accessibility of health care items and services.

(2) Relations between participating providers and members.

(3) Relations between institutional providers, group practices, and individual health care organizations, including credentialing for participation in CalCare and clinical and admitting privileges, and terms, methods, and rates of payment.

(b) The board shall establish requirements and standards, by regulation, under CalCare that include provisions to promote all of the following:

(1) Simplification, transparency, uniformity, and fairness in the following:

(A) Health care provider credentialing for participation in CalCare.

(B) Health care provider clinical and admitting privileges in health care facilities.

(C) Clinical placement for educational purposes, including clinical placement for prelicensure registered nursing students without regard to degree type, that prioritizes nursing students in public education programs.

(D) Payment procedures and rates.

(E) Claims processing.

(2) In-person primary and preventive care, efficient and effective health care items and services, quality assurance, and promotion of public, environmental, and occupational health.

(3) Elimination of health care disparities.

(4) Nondiscrimination pursuant to Section 100621.

(5) Accessibility of health care items and services, including accessibility for people with disabilities and people with limited ability to speak or understand English.

(6) Providing health care items and services in a culturally, linguistically, and structurally competent manner.

(c) The board shall establish requirements and standards, to the extent authorized by federal law, by regulation, for replacing and merging with CalCare health care items and services and ancillary services currently provided by other programs, including Medicare, the Affordable Care Act, and federally matched public health programs.

(d) A participating provider shall furnish information as required by the Office of Statewide Health Planning and Development pursuant to Sections 100616 and 100631, and to Division 107 (commencing with Section 127000) of the Health and Safety Code, and permit examination of that information by the board as reasonably required for purposes of reviewing accessibility and utilization of health care items and services, quality assurance, cost containment, the making of payments, and statistical or other

studies of the operation of CalCare or for protection and promotion of public, environmental, and occupational health.

(e) The board shall use the data furnished under this title to ensure that clinical practices meet the utilization, quality, and access standards of CalCare. The board shall not use a standard developed under this chapter for the purposes of establishing a payment incentive or adjustment under CalCare.

(f) To develop requirements and standards and making other policy determinations under this chapter, the board shall consult with representatives of members, health care providers, health care organizations, labor organizations representing health care employees, and other interested parties.

100651. (a) (1) As part of a health care practitioner's duty to advocate for medically appropriate health care for their patients pursuant to Sections 510 and 2056 of the Business and Professions Code, a participating provider has a duty to act in the exclusive interest of the patient.

(2) The duty described in paragraph (1) applies to a health care professional who may be employed by a participating provider or otherwise receive compensation or payment for health care items and services furnished under CalCare.

(b) Consistent with subdivision (a) and with Sections 510 and 2056 of the Business and Professions Code:

(1) An individual's treating physician, or other health care professional who is authorized to diagnose the individual in accordance with all applicable scope of practice and other license requirements and is treating the individual, is responsible for the determination of the medically necessary or appropriate care for the individual.

(2) A participating provider or health care professional who may be employed by CalCare or otherwise receive compensation or payment for health care items and services furnished under CalCare from a participating provider or other person participating in CalCare shall use reasonable care and diligence in safeguarding an individual under the care of the provider or professional and shall not impair an individual's treating physician or other health care provider treating the individual from advocating for medically necessary or appropriate care under this section.

(c) A health care provider or health care professional described in subdivision (a) violates the duty established under this section for any of the following:

(1) Having a pecuniary interest or relationship, including an interest or relationship disclosed under subdivision (d), that impairs the provider's ability to provide medically necessary or appropriate care.

(2) Accepting a bonus, incentive payment, or compensation based on any of the following:

(A) A patient's utilization of services.

(B) The financial results of another health care provider with which the participating provider has a pecuniary interest or contractual relationship, including employment or other compensation-based relationship, or of a person that contracts with or provides health care items or services, including pharmaceutical products and medical devices or equipment, to the provider.

(C) The financial results of an institutional provider, group practice, or person that contracts with, provides health care items or services under, or otherwise receives payment from CalCare.

(3) Having a board member, executive, or administrator that receives compensation from, owns stock or has other financial investments in, or serves as a board member of an entity that contracts with or provides health care items or services, including pharmaceutical products and medical devices or equipment, to the provider.

(d) To evaluate and review compliance with this section, a participating provider shall report, at least annually, to the Office of Statewide Health Planning and Development all of the following:

(1) A beneficial interest required to be disclosed to a patient pursuant to Section 654.2 of the Business and Professions Code.

(2) A membership, proprietary interest, coownership, or profit-sharing arrangement, required to be disclosed to a patient pursuant to Section 654.1 of the Business and Professions Code.

(3) A subcontract entered into that contains incentive plans that involve general payments, including capitation payments or shared risk agreements, that are not tied to specific medical decisions involving specific members or groups of members with similar medical conditions.

(4) Bonus or other incentive arrangements used in compensation agreements with another health care provider or an entity that contracts with or provides health care items or services, including pharmaceutical products and medical devices or equipment, to the provider.

(5) An offer, delivery, receipt, or acceptance of rebates, refunds, commission, preference, patronage dividend, discount, or other consideration for a referral made in exception to Section 650 of the Business and Professions Code.

(e) The board may adopt regulations as necessary to implement and enforce this section and may adopt regulations to expand reporting requirements under this section.

(f) For purposes of this section, "person" means an individual, partnership, corporation, limited liability company, or other organization, or any combination thereof, including a medical group practice, independent practice association, preferred provider organization, foundation, hospital medical staff and governing body, or payer.

100652. (a) An individual's treating physician, nurse, or other health care professional, in implementing a patient's medical or nursing care plan and in accordance with their scope of practice and licensure, may override health information technology or clinical practice guidelines, including standards and guidelines implemented by a participating provider through the use of health information technology, including electronic health record technology, clinical decision support technology, and computerized order entry programs.

(b) An override described in subdivision (a) shall, in the independent professional judgment of the treating physician, nurse or other health care professional, meet all of the following requirements:

(1) The override is consistent with the treating physician's, nurse's or other health care professional's determination of medical necessity or appropriateness or nursing assessment.

(2) The override is in the best interest of the patient.

(3) The override is consistent with the patient's wishes.

Chapter 7. Funding

Article 1. Federal Health Programs and Funding

100660. (a) (1) The board is authorized to and shall seek all federal waivers and other federal approvals and arrangements and submit state plan amendments as necessary to operate CalCare consistent with this title.

(2) The board is authorized to apply for a federal waiver or federal approval as necessary to receive funds to operate CalCare pursuant to paragraph (1), including a waiver under Section 18052 of Title 42 of the United States Code.

(3) The board shall apply for federal waivers or federal approval pursuant to paragraph (1) by January 1, 2023.

(b) (1) The board shall apply to the United States Secretary of Health and Human Services or other appropriate federal official for all waivers of requirements, and make other arrangements, under Medicare, any federally matched public health program, the Affordable Care Act, and any other federal programs or laws, as appropriate, that are necessary to enable all CalCare members to receive all benefits under CalCare through CalCare, to enable the state to implement this title, and to allow the state to receive and deposit all federal payments under those programs, including funds that may be provided in lieu of premium tax credits, cost-sharing subsidies, and small business tax credits, in the State Treasury to the credit of the CalCare Trust Fund, created pursuant to Section 100665, and to use those funds for CalCare and other provisions under this title.

(2) To the fullest extent possible, the board shall negotiate arrangements with the federal government to ensure that federal payments are paid to CalCare in place of federal funding of, or tax benefits for, federally matched public health programs or federal health programs. To the extent any federal funding is not paid directly to CalCare, the state shall direct the funding and moneys to CalCare.

(3) The board may require members or applicants to provide information necessary for CalCare to comply with any waiver or arrangement under this title. Information provided by members to the board for the purposes of this subdivision shall not be used for any other purpose.

(4) The board may take any additional actions necessary to effectively implement CalCare to the maximum extent possible as an independent single-payer program consistent with this title. It is the intent of the legislature to establish CalCare, to the fullest extent possible, as an independent agency.

(c) The board may take actions consistent with this article to enable CalCare to administer Medicare in California. CalCare shall be a provider of supplemental insurance coverage and shall provide premium assistance for drug coverage under Medicare Part D for eligible members of CalCare.

(d) The board may waive or modify the applicability of any provisions of this title relating to any federally matched public health program or Medicare, as necessary, to implement any waiver or arrangement under this section or to maximize the federal benefits to CalCare under this section.

(e) The board may apply for coverage for, and enroll, any eligible member under any federally matched public health program or Medicare. Enrollment in a federally matched public health program or Medicare shall not cause a member to lose a health care item or service provided by CalCare or diminish any right the member would otherwise have.

(f) (1) Notwithstanding any other law, the board, by regulation, shall increase the income eligibility level, increase or eliminate the resource test for eligibility, simplify any procedural or documentation requirement for enrollment, and increase the benefits for any federally matched public health program and for any program in order to reduce or eliminate an individual's coinsurance, cost-sharing, or premium obligations or increase an individual's eligibility for any federal financial support related to Medicare or the Affordable Care Act.

(2) The board may act under this subdivision, upon a finding approved by the Director of Finance and the board that the action does all of the following:

(A) Will help to increase the number of members who are eligible for and enrolled in federally matched public health programs, or for any program to reduce or eliminate an individual's coinsurance, cost-sharing, or premium obligations or increase an individual's eligibility for any federal financial support related to Medicare or the Affordable Care Act.

(B) Will not diminish any individual's access to a health care item or service or right the individual would otherwise have.

(C) Is in the interest of CalCare.

(D) Does not require or has received any necessary federal waivers or approvals to ensure federal financial participation.

(g) To enable the board to apply for coverage for, and enroll, any eligible member under any federally matched public health program or Medicare, the board may require that every member or applicant provide the information necessary to enable the board to determine whether the applicant is eligible for a federally matched public health program or for Medicare, or any program or benefit under Medicare.

(h) As a condition of continued eligibility for health care items and services under CalCare, a member who is eligible for benefits under Medicare shall enroll in Medicare, including Parts A, B, and D.

(i) The board shall provide premium assistance for all members enrolling in a Medicare Part D drug coverage plan under Section 1860D of Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395w-101 et seq.), limited to the low-income benchmark premium amount established by the federal Centers for Medicare and Medicaid Services and any other amount the federal agency establishes under its de minimis premium policy, except that those payments made on behalf of members enrolled in a Medicare Advantage plan may exceed the low-income benchmark premium amount if determined to be cost effective to CalCare.

(j) If the board has reasonable grounds to believe that a member may be eligible for an income-related subsidy under Section 1860D-14 of Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395w-114), the member shall provide, and authorize CalCare to obtain, any information or documentation required to establish the member's eligibility for that subsidy. The board shall attempt to obtain as much of the information and documentation as possible from records that are available to it.

(k) The board shall make a reasonable effort to notify members of their obligations under this section. After a reasonable effort has been made to contact the member, the member shall be notified in writing that the member has 60 days to provide the required information. If the required information is not provided within the 60-day period, the member's coverage under CalCare may be

suspended until the issue is resolved. Information provided by a member to the board for the purposes of this section shall not be used for any other purpose.

(*l*) The board shall assume responsibility for all benefits and services paid for by the federal government with those funds.

Article 2. CalCare Trust Fund

100665. (a) The CalCare Trust Fund is hereby created in the State Treasury for the purposes of this title to be administered by the CalCare Board. Notwithstanding Section 13340, all moneys in the fund shall be continuously appropriated without regard to fiscal year for the purposes of this title. Any moneys in the fund that are unexpended or unencumbered at the end of a fiscal year may be carried forward to the next succeeding fiscal year.

(b) Notwithstanding any other law, moneys deposited in the fund shall not be loaned to, or borrowed by, any other special fund or the General Fund, a county general fund or any other county fund, or any other fund.

(c) The board shall establish and maintain a prudent reserve in the fund to enable it to respond to costs including those of an epidemic, pandemic, natural disaster, or other health emergency, or market-shift adjustments related to patient volume.

(d) The board or staff of the board shall not utilize any funds intended for the administrative and operational expenses of the board for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative or regulatory modifications.

(e) Notwithstanding Section 16305.7, all interest earned on the moneys that have been deposited into the fund shall be retained in the fund and used for purposes consistent with the fund.

(f) The fund shall consist of all of the following:

(1) All moneys obtained pursuant to legislation enacted as proposed under Section 100670.

(2) Federal payments received as a result of any waiver of requirements granted or other arrangements agreed to by the United States Secretary of Health and Human Services or other appropriate federal officials for health care programs established under Medicare, any federally matched public health program, or the Affordable Care Act.

(3) The amounts paid by the State Department of Health Care Services that are equivalent to those amounts that are paid on behalf of residents of this state under Medicare, any federally matched public health program, or the Affordable Care Act for health benefits that are equivalent to health benefits covered under CalCare.

(4) Federal and state funds for purposes of the provision of services authorized under Title XX of the federal Social Security Act (42 U.S.C. Sec. 1397 et seq.) that would otherwise be covered under CalCare.

(5) State moneys that would otherwise be appropriated to any governmental agency, office, program, instrumentality, or institution that provides health care items or services for services and benefits covered under CalCare. Payments to the fund pursuant to this section shall be in an amount equal to the money appropriated for those purposes in the fiscal year beginning immediately preceding the effective date of this title.

(g) All federal moneys shall be placed into the CalCare Federal Funds Account, which is hereby created within the CalCare Trust Fund.

(h) Moneys in the CalCare Trust Fund shall only be used for the purposes established in this title.

100667. (a) The board annually shall prepare a budget for CalCare that specifies a budget for all expenditures to be made for covered health care items and services and shall establish allocations for each of the budget components under subdivision (b) that shall cover a three-year period.

(b) The CalCare budget shall consist of at least the following components:

(1) An operating budget.

(2) A capital expenditures budget.

(3) A special projects budget.

(4) Program standards activities.

(5) Health professional education expenditures.

(6) Administrative costs.

(7) Prevention and public health activities.

(c) The board shall allocate the funds received among the components described in subdivision (b) to ensure the following:

(1) The operating budget allows for participating providers to meet the health care needs of the population.

(2) A fair allocation to the special projects budget to meet the purposes described in subdivision (f) in a reasonable timeframe.

(3) A fair allocation for program standards activities.

(4) The health professional education expenditures component is sufficient to meet the need for covered health care items and services.

(d) The operating budget described in paragraph (1) of subdivision (b) shall be used for payments to providers for health care items and services furnished by participating providers under CalCare.

(e) The capital expenditures budget described in paragraph (2) of subdivision (b) shall be used for the construction or renovation of health care facilities, excluding congregate or segregated facilities for individuals with disabilities who receive long-term services and supports under CalCare, and other capital expenditures.

(f) (1) The special projects budget shall be used for the payment to not-for-profit or governmental entities that are health facilities pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code for the construction or renovation of health care facilities, major equipment purchases, staffing in a rural or medically underserved area, and to address health disparities, including those based on race, ethnicity, national origin, primary language use, age, disability, sex, including gender identity and sexual orientation, geography, and socioeconomic status.

(2) To mitigate the impact of the payments on the availability and accessibility of health care services, the special projects budget may be used to increase payment to providers in a rural or medically underserved area.

(g) For up to five years following the date on which benefits first become available under CalCare, at least 1 percent of the budget shall be allocated to programs providing transition assistance pursuant to Section 100615.

Article 3. CalCare Financing

100670. (a) It is the intent of the Legislature to enact legislation that would develop a revenue plan, taking into consideration anticipated federal revenue available for CalCare. In developing

the revenue plan, it is the intent of the Legislature to consult with appropriate officials and stakeholders.

(b) It is the intent of the Legislature to enact legislation that would require all state revenues from CalCare to be deposited in an account within the CalCare Trust Fund to be established and known as the CalCare Trust Fund Account.

Chapter 8. Collective Negotiation by Health Care Providers with CalCare

Article 1. Definitions

100675. For purposes of this chapter, the following definitions apply:

(a) (1) "Health care provider" means a person who is licensed, certified, registered, or authorized to practice a health care profession pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code and who is either of the following:

(A) An individual who practices that profession as a health care professional or as an independent contractor.

(B) An owner, officer, shareholder, or proprietor of a health care group practice that has elected to receive fee-for-service payments from CalCare pursuant to subdivision (d) of Section 100640.

(2) A health care provider licensed, certified, registered, or authorized to practice a health care profession pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code who practices as an employee of a health care provider is not a health care provider for purposes of this chapter.

(b) "Health care provider's representative" means a third party that is authorized by a health care provider to negotiate on their behalf with CalCare over terms and conditions affecting those health care providers.

Article 2. Authorized Collective Negotiation

100676. (a) Health care providers may meet and communicate for the purpose of collectively negotiating with CalCare on any matter relating to CalCare fee-for-service rates of payment for

health care items and services or procedures related to fee-for-service payment under CalCare.

(b) This chapter does not allow a strike of CalCare by health care providers related to the collective negotiations.

(c) This chapter does not allow or authorize terms or conditions that would impede the ability of CalCare to comply with applicable state or federal law.

Article 3. Collective Negotiation Requirements

100677. (a) Collective negotiation under this chapter shall meet all of the following requirements:

(1) A health care provider may communicate with other health care providers regarding the terms and conditions to be negotiated with CalCare.

(2) A health care provider may communicate with a health care provider's representative.

(3) A health care provider's representative is the only party authorized to negotiate with CalCare on behalf of the health care providers as a group.

(4) A health care provider can be bound by the terms and conditions negotiated by the health care provider's representative.

(b) This chapter does not affect or limit the right of a health care provider or group of health care providers to collectively petition a governmental entity for a change in a law, rule, or regulation.

(c) This chapter does not affect or limit collective action or collective bargaining on the part of a health care provider with the health care provider's employer or any other lawful collective action or collective bargaining.

100678. (a) Before engaging in collective negotiations with CalCare on behalf of health care providers, a health care provider's representative shall file with the board, in the manner prescribed by the board, information identifying the representative, the representative's plan of operation, and the representative's procedures to ensure compliance with this chapter.

(b) A person who acts as the representative of negotiating parties under this chapter shall pay a fee to the board to act as a representative. The board, by regulation, shall set fees in amounts deemed reasonable and necessary to cover the costs incurred by the board in administering this chapter.

Article 4. Prohibited Collective Action

100679. (a) This chapter does not authorize competing health care providers to act in concert in response to a health care provider's representative's discussions or negotiations with CalCare, except as authorized by other law.

(b) A health care provider's representative shall not negotiate an agreement that excludes, limits the participation or reimbursement of, or otherwise limits the scope of services to be provided by a health care provider or group of health care providers with respect to the performance of services that are within the health care provider's scope of practice, license, registration, or certificate.

Chapter 9. Operative Date

100680. (a) Notwithstanding any other law, this title, except for Chapter 1 (commencing with Section 100600) and Chapter 2 (commencing with Section 100610), shall not become operative until the date the Secretary of California Health and Human Services notifies the Secretary of the Senate and the Chief Clerk of the Assembly in writing that the secretary has determined that the CalCare Trust Fund has the revenues to fund the costs of implementing this title.

(b) The California Health and Human Services Agency shall publish a copy of the notice on its internet website.

SEC. 3. The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 4. The Legislature finds and declares that Section 2 of this act, which adds Sections 100610, 100616, and 100618 to the Government Code, imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

In order to protect private, confidential, and proprietary information, it is necessary for that information to remain confidential.

O