

**ASSEMBLY BILL**

**No. 1400**

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**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

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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:*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

30

31 TITLE 23. THE CALIFORNIA GUARANTEED HEALTH  
32 CARE FOR ALL ACT

33

34 CHAPTER 1. GENERAL PROVISIONS

35

36 100600. This title shall be known, and may be cited, as the  
37 California Guaranteed Health Care for All Act.

38 100601. There is hereby established in state government the  
39 California Guaranteed Health Care for All program, or CalCare,

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

3 100602. For the purposes of this title, the following definitions  
4 apply:

5 (a) “Activities of daily living” means basic personal everyday  
6 activities including eating, toileting, grooming, dressing, bathing,  
7 and transferring.

8 (b) “Advisory commission” means the Advisory Commission  
9 on Long-Term Services and Supports established pursuant to  
10 Section 100614.

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

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

26 (e) “Board” means the CalCare Board described in Section  
27 100610.

28 (f) “CalCare” or “California Guaranteed Health Care for All”  
29 means the California Guaranteed Health Care for All program  
30 established in Section 100601.

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

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

- 1 (i) “Committee” means the CalCare Public Advisory Committee  
2 established pursuant to Section 100611.
- 3 (j) “County organized health system” means a health system  
4 implemented pursuant to Part 4 (commencing with Section 101525)  
5 of Division 101 of the Health and Safety Code, and Article 2.8  
6 (commencing with Section 14087.5) of Chapter 7 of Part 3 of  
7 Division 9 of the Welfare and Institutions Code.
- 8 (k) “Essential community provider” means a provider, as defined  
9 in Section 156.235(c) of Title 45 of the Code of Federal  
10 Regulations, as published February 27, 2015, in the Federal  
11 Register (80 FR 10749), that serves predominantly low-income,  
12 medically underserved individuals and that is one of the following:
- 13 (1) A community clinic, as defined in subparagraph (A) of  
14 paragraph (1) of subdivision (a) of Section 1204 of the Health and  
15 Safety Code.
- 16 (2) A free clinic, as defined in subparagraph (B) of paragraph  
17 (1) of subdivision (a) of Section 1204 of the Health and Safety  
18 Code.
- 19 (3) A federally qualified health center, as defined in Section  
20 1395x(aa)(4) or Section 1396d(l)(2)(B) of Title 42 of the United  
21 States Code.
- 22 (4) A rural health clinic, as defined in Section 1395x(aa)(2) or  
23 1396d(l)(1) of Title 42 of the United States Code.
- 24 (5) An Indian Health Service Facility, as defined in subdivision  
25 (v) of Section 2699.6500 of Title 10 of the California Code of  
26 Regulations.
- 27 (l) “Federally matched public health program” means the state’s  
28 Medi-Cal program under Title XIX of the federal Social Security  
29 Act (42 U.S.C. Sec. 1396 et seq.) and the federal Children’s Health  
30 Insurance Program under Title XXI of the federal Social Security  
31 Act (42 U.S.C. Sec. 1397aa et seq.).
- 32 (m) “Fund” means the CalCare Trust Fund established pursuant  
33 to Article 2 (commencing with Section 100665) of Chapter 7.
- 34 (n) “Global budget” means the payment negotiated between an  
35 institutional provider and the board pursuant to Section 100641.
- 36 (o) “Group practice” means a professional corporation under  
37 the Moscone-Knox Professional Corporation Act (Part 4  
38 (commencing with Section 13400) of Division 3 of Title 1 of the  
39 Corporations Code) that is a single corporation or partnership  
40 composed of licensed doctors of medicine, doctors of osteopathy,



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

5 (p) “Health care professional” means a health care professional  
6 licensed pursuant to Division 2 (commencing with Section 500)  
7 of the Business and Professions Code, or licensed pursuant to the  
8 Osteopathic Act or the Chiropractic Act, who, in accordance with  
9 the professional’s scope of practice, may provide health care items  
10 and services under this title.

11 (q) “Health care item or service” means a health care item or  
12 service that is included as a benefit under CalCare.

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

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

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

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

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

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

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

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

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

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

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

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

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

16 (10) A mental health care provider licensed pursuant to Division  
17 4 (commencing with Section 4000) of the Welfare and Institutions  
18 Code.

19 (11) A federally qualified health center, as defined in Section  
20 1395x(aa)(4) or 1396d(l)(2)(B) of Title 42 of the United States  
21 Code.

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

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

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

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

5 (y) “Medicaid” or “medical assistance” means a program that  
6 is one of the following:

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

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

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

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

23 (ab) “Member” means an individual who is enrolled in CalCare.

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

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

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

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

1 (ae) “Prescription drugs” means prescription drugs as defined  
 2 in subdivision (n) of Section 130501 of the Health and Safety  
 3 Code.

4 (af) “Resident” means an individual whose primary place of  
 5 abode is in this state, without regard to the individual’s immigration  
 6 status, who meets the California residence requirements adopted  
 7 by the board pursuant to subdivision (k) of Section 100610. The  
 8 board shall be guided by the principles and requirements set forth  
 9 in the Medi-Cal program under Article 7 (commencing with  
 10 Section 50320) of Chapter 2 of Subdivision 1 of Division 3 of Title  
 11 22 of the California Code of Regulations.

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

15 100603. This title does not preempt a city, county, or city and  
 16 county from adopting additional health care coverage for residents  
 17 in that city, county, or city and county that provides more  
 18 protections and benefits to California residents than this title.

19 100604. To the extent any law is inconsistent with this title or  
 20 the legislative intent of the California Guaranteed Health Care for  
 21 All Act, this title shall apply and prevail, except when explicitly  
 22 provided otherwise by this title.

23  
 24  
 25

CHAPTER 2. GOVERNANCE

26 100610. (a) CalCare shall be governed by an executive board,  
 27 known as the CalCare Board, consisting of nine voting members  
 28 who are residents of California. The CalCare Board shall be an  
 29 independent public entity not affiliated with an agency or  
 30 department. Of the members of the board, five shall be appointed  
 31 by the Governor, two shall be appointed by the Senate Committee  
 32 on Rules, and two shall be appointed by the Speaker of the  
 33 Assembly. The Secretary of California Health and Human Services  
 34 or the secretary’s designee shall serve as a nonvoting, ex officio  
 35 member of the board.

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

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

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

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

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

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

18 (A) Two health care professionals who practice medicine.

19 (B) One registered nurse.

20 (C) One public health professional.

21 (D) One mental health professional.

22 (E) One member with an institutional provider background.

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

25 (G) One representative of a labor organization.

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

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

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

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

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

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

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

26 (1) Any source of income, other than gifts and other than loans  
27 by a commercial lending institution in the regular course of  
28 business on terms available to the public without regard to official  
29 status aggregating two hundred fifty dollars (\$250) or more in  
30 value provided to, received by, or promised to the member within  
31 12 months before the decision is made.

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

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

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

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

7 (j) The board shall be subject to the Bagley-Keene Open Meeting  
8 Act (Article 9 (commencing with Section 11120) of Chapter 1 of  
9 Part 1 of Division 3 of Title 2), except that the board may hold  
10 closed sessions when considering matters related to litigation,  
11 personnel, contracting, and provider rates.

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

16 100611. (a) The board shall convene a CalCare Public  
17 Advisory Committee to advise the board on all matters of policy  
18 for CalCare. The committee shall consist of members who are  
19 residents of California.

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

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

24 (1) Four health care professionals.

25 (2) One registered nurse.

26 (3) One representative of a licensed health facility.

27 (4) One representative of an essential community provider

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

30 (6) One behavioral health provider.

31 (7) One dentist or oral care specialist.

32 (8) One representative of private hospitals.

33 (9) One representative of public hospitals.

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

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

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

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

7 (e) Members of the committee shall serve without compensation,  
8 but shall be reimbursed for actual and necessary expenses incurred  
9 in the performance of their duties to the extent that reimbursement  
10 for those expenses is not otherwise provided or payable by another  
11 public agency or agencies, and shall receive one hundred fifty  
12 dollars (\$150) for each full day of attending meetings of the  
13 committee. For purposes of this section, “full day of attending a  
14 meeting” means presence at, and participation in, not less than 75  
15 percent of the total meeting time of the committee during any  
16 particular 24-hour period.

17 (f) The committee shall meet at least once every quarter, and  
18 shall solicit input on agendas and topics set by the board. All  
19 meetings of the committee shall be open to the public, pursuant to  
20 the Bagley-Keene Open Meeting Act (Article 9 (commencing with  
21 Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2).

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

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

28 100612. (a) The board shall have all powers and duties  
29 necessary to establish and implement CalCare. The board shall  
30 provide, under CalCare, comprehensive universal single-payer  
31 health care coverage and a health care cost control system for the  
32 benefit of all residents of the state.

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



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

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

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

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

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

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

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

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

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

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

38 (7) Establish an enrollment system that ensures all eligible  
39 California residents, including those who travel out of state, those  
40 who have disabilities that limit their mobility, hearing, vision or

1 mental or cognitive capacity, those who cannot read, and those  
2 who do not speak or write English, are aware of their right to health  
3 care and are formally enrolled in CalCare.

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

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

11 (10) Implement policies to ensure that all Californians receive  
12 culturally, linguistically, and structurally competent care, pursuant  
13 to Chapter 6 (commencing with Section 100650), ensure that all  
14 disabled Californians receive care in accordance with the federal  
15 Americans with Disabilities Act (42 U.S.C. Sec. 12101 et seq.)  
16 and Section 504 of the federal Rehabilitation Act of 1973 (29  
17 U.S.C. Sec. 794), and develop mechanisms and incentives to  
18 achieve these purposes and a means to monitor the effectiveness  
19 of efforts to achieve these purposes.

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

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

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

28 (14) Meet regularly with the committee.

29 (15) Determine an appropriate level of, and provide support  
30 during the transition for, training and job placement for persons  
31 who are displaced from employment as a result of the initiation of  
32 CalCare pursuant to Section 100615.

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

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

- 1 (18) Establish a process that is accessible to all Californians for  
2 CalCare to receive the concerns, opinions, ideas, and  
3 recommendations of the public regarding all aspects of CalCare.
- 4 (19) (A) Annually prepare a written report on the  
5 implementation and performance of CalCare functions during the  
6 preceding fiscal year, that includes, at a minimum:
- 7 (i) The manner in which funds were expended.
  - 8 (ii) The progress toward and achievement of the requirements  
9 of this title.
  - 10 (iii) CalCare's fiscal condition.
  - 11 (iv) Recommendations for statutory changes.
  - 12 (v) Receipt of payments from the federal government and other  
13 sources.
  - 14 (vi) Whether current year goals and priorities have been met.
  - 15 (vii) Future goals and priorities.
- 16 (B) The report shall be transmitted to the Legislature and the  
17 Governor, on or before October 1 of each year and at other times  
18 pursuant to this division, and shall be made available to the public  
19 on the internet website of CalCare.
- 20 (C) A report made to the Legislature pursuant to this subdivision  
21 shall be submitted pursuant to Section 9795 of the Government  
22 Code.
- 23 (f) The board may do or delegate to the executive director all  
24 of the following:
- 25 (1) Negotiate and enter into any necessary contracts, including  
26 contracts with health care providers and health care professionals.
  - 27 (2) Sue and be sued.
  - 28 (3) Receive and accept gifts, grants, or donations of moneys  
29 from any agency of the federal government, any agency of the  
30 state, and any municipality, county, or other political subdivision  
31 of the state.
  - 32 (4) Receive and accept gifts, grants, or donations from  
33 individuals, associations, private foundations, and corporations,  
34 in compliance with the conflict-of-interest provisions to be adopted  
35 by the board by regulation.
  - 36 (5) Share information with relevant state departments, consistent  
37 with the confidentiality provisions in this title, necessary for the  
38 administration of CalCare.
- 39 (g) A carrier may not offer benefits or cover health care items  
40 or services for which coverage is offered to individuals under

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

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

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

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

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

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

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

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

27 100613. The board may contract with not-for-profit  
28 organizations to provide both of the following:

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

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

35 100614. (a) There is hereby established in state government  
36 an Advisory Commission on Long-Term Services and Supports,  
37 to advise the board on matters of policy related to long-term  
38 services and supports for CalCare.

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

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

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

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

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

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

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

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

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

17 (c) In making appointments pursuant to this section, the  
18 Governor, the Senate Committee on Rules, and the Speaker of the  
19 Assembly shall make good faith efforts to ensure that their  
20 appointments, as a whole, reflect, to the greatest extent feasible,  
21 the diversity of the population of people who use long-term services  
22 and supports, including their race, ethnicity, national origin,  
23 primary language use, age, disability, sex, including gender identity  
24 and sexual orientation, geographic location, and socioeconomic  
25 status.

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

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

35 (3) Vacancies that occur shall be filled within 30 days after the  
36 occurrence of the vacancy, and shall be filled in the same manner  
37 in which the vacating member was initially selected or appointed.  
38 The Secretary of California Health and Human Services shall notify  
39 the appropriate appointing authority of any expected vacancies on  
40 the long-term services and supports advisory commission.

1 (e) Members of the advisory commission shall serve without  
2 compensation, but shall be reimbursed for actual and necessary  
3 expenses incurred in the performance of their duties to the extent  
4 that reimbursement for those expenses is not otherwise provided  
5 or payable by another public agency or agencies. Members shall  
6 also receive one hundred fifty dollars (\$150) for each full day of  
7 attending meetings of the advisory commission. For purposes of  
8 this section, “full day of attending a meeting” means presence at,  
9 and participation in, not less than 75 percent of the total meeting  
10 time of the advisory commission during any particular 24-hour  
11 period.

12 (f) The advisory commission shall meet at least six times per  
13 year in a place convenient to the public. All meetings of the  
14 advisory commission shall be open to the public, pursuant to the  
15 Bagley-Keene Open Meeting Act (Article 9 (commencing with  
16 Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2).

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

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

24 100615. (a) The board shall provide funds from the CalCare  
25 Trust Fund or funds otherwise appropriated for this purpose to the  
26 Secretary of Labor and Workforce Development for program  
27 assistance to individuals employed or previously employed in the  
28 fields of health insurance, health care service plans, or other  
29 third-party payments for health care, individuals providing services  
30 to health care providers to deal with third-party payers for health  
31 care, individuals who may be affected by and who may experience  
32 economic dislocation as a result of the implementation of this title,  
33 and individuals whose jobs may be or have been ended as a result  
34 of the implementation of CalCare, consistent with otherwise  
35 applicable law.

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

39 100616. (a) The board shall utilize the data collected pursuant  
40 to Chapter 1 (commencing with Section 128675) of Part 5 of

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

30 (1) The number of patients served.

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

34 (A) Patients receiving charity care.

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

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

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



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

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

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

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

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

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

23 100617. (a) The board shall establish and use a process to  
24 enter into participation agreements with health care providers and  
25 other contracts with contractors. A contract entered into pursuant  
26 to this title shall be exempt from Part 2 (commencing with Section  
27 10100) of Division 2 of the Public Contract Code, and shall be  
28 exempt from the review or approval of the Department of General  
29 Services. The board shall adopt a CalCare Contracting Manual  
30 incorporating procurement and contracting policies and procedures  
31 that shall be followed by CalCare. The policies and procedures in  
32 the manual shall be substantially similar to the provisions contained  
33 in the State Contracting Manual.

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

1 100618. (a) Notwithstanding any other law, CalCare, a state  
 2 or local agency, or a public employee acting under color of law  
 3 shall not provide or disclose to anyone, including the federal  
 4 government, any personally identifiable information obtained,  
 5 including a person’s religious beliefs, practices, or affiliation,  
 6 national origin, ethnicity, or immigration status, for law  
 7 enforcement or immigration purposes.

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

17  
 18  
 19

CHAPTER 3. ELIGIBILITY AND ENROLLMENT

20  
 21

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

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

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

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

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

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

35 100621. (a) All residents of this state, no matter what their  
 36 sex, race, color, religion, ancestry, national origin, disability, age,  
 37 previous or existing medical condition, genetic information, marital  
 38 status, familial status, military or veteran status, sexual orientation,  
 39 gender identity or expression, pregnancy, pregnancy-related  
 40 medical condition, including termination of pregnancy, citizenship,

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

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

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

11 (1) Exclusion of a person from participation in or denial of the  
12 benefits of CalCare, except as expressly authorized by this title  
13 for the purposes of enforcing eligibility standards in Section  
14 100620.

15 (2) Reduction of a person's benefits.

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

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

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

26  
27 CHAPTER 4. BENEFITS  
28

29 100625. (a) Individuals enrolled for benefits under CalCare  
30 are entitled to have payment made by CalCare to a participating  
31 provider for the health care items and services in subdivision (c),  
32 if medically necessary or appropriate for the maintenance of health  
33 or for the prevention, diagnosis, treatment, or rehabilitation of a  
34 health condition.

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

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

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

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

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

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

11 (4) Prescription drugs and biological products.

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

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

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

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

19 (9) Pediatrics.

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

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

23 (12) Emergency services and transportation.

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

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

29 (15) Long-term services and supports described in Section  
30 100626, including long-term services and supports covered under  
31 Medi-Cal (Chapter 7 (commencing with Section 14000) of Part 3  
32 of Division 9 of the Welfare and Institutions Code) or the federal  
33 Children's Health Insurance Program (Title XXI of the federal  
34 Social Security Act (42 U.S.C. Sec. 1397aa et seq.))

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

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

- 1 (1) Prosthetics, eyeglasses, and hearing aids and the repair,  
2 technical support, and customization needed for their use by an  
3 individual.
- 4 (2) Child and adult immunizations.
- 5 (3) Hospice care.
- 6 (4) Care in a skilled nursing facility.
- 7 (5) Home health care, including health care provided in an  
8 assisted living facility.
- 9 (6) Prenatal and postnatal care.
- 10 (7) Podiatric care.
- 11 (8) Blood and blood products.
- 12 (9) Dialysis.
- 13 (10) Community-based adult services as defined under Chapter  
14 7 (commencing with Section 14000) of Part 3 of Division 9 of the  
15 Welfare and Institutions Code as of January 1, 2021.
- 16 (11) Dietary and nutritional therapies determined appropriate  
17 by the board.
- 18 (12) Therapies that are shown by the National Center for  
19 Complementary and Integrative Health in the National Institutes  
20 of Health to be safe and effective, including chiropractic care and  
21 acupuncture.
- 22 (13) Health care items and services previously covered by  
23 county integrated health and human services programs pursuant  
24 to Chapter 12.96 (commencing with Section 18990) and Chapter  
25 12.991 (commencing with Section 18991) of Part 6 of Division 9  
26 of the Welfare and Institutions Code.
- 27 (14) Health care items and services previously covered by a  
28 regional center for persons with developmental disabilities pursuant  
29 to Chapter 5 (commencing with Section 4620) of Division 4.5 of  
30 the Welfare and Institutions Code.
- 31 (15) Language interpretation and translation for health care  
32 items and services, including sign language and braille or other  
33 services needed for individuals with communication barriers.
- 34 (e) Covered health care items and services under CalCare  
35 include all health care items and services required to be covered  
36 under the following provisions, without regard to whether the  
37 member would be eligible for or covered by the source referred  
38 to:
  - 39 (1) The federal Children’s Health Insurance Program (Title XXI  
40 of the federal Social Security Act (42 U.S.C. Sec. 1397aa et seq.)).

- 1 (2) Medi-Cal (Chapter 7 (commencing with Section 14000) of
- 2 Part 3 of Division 9 of the Welfare and Institutions Code).
- 3 (3) The federal Medicare program pursuant to Title XVIII of
- 4 the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).
- 5 (4) Health care service plans pursuant to the Knox-Keene Health
- 6 Care Service Plan Act of 1975 (Chapter 2.2 (commencing with
- 7 Section 1340) of Division 2 of the Health and Safety Code).
- 8 (5) Health insurers, as defined in Section 106 of the Insurance
- 9 Code, pursuant to Part 2 (commencing with Section 10110) of
- 10 Division 2 of the Insurance Code.
- 11 (6) All essential health benefits mandated by the federal Patient
- 12 Protection and Affordable Care Act as of January 1, 2017.
- 13 (f) Health care items and services covered under CalCare shall
- 14 not be subject to prior authorization or a limitation applied through
- 15 the use of step therapy protocols.
- 16 100626. (a) Subject to the other provisions of this title,
- 17 individuals enrolled for benefits under CalCare are entitled to have
- 18 payment made by CalCare to an eligible provider for long-term
- 19 services and supports, in accordance with the standards established
- 20 in this title, for care, services, diagnosis, treatment, rehabilitation,
- 21 or maintenance of health related to a medically determinable
- 22 condition, whether physical or mental, of health, injury, or age,
- 23 that either:
  - 24 (1) Causes a functional limitation in performing one or more
  - 25 activities of daily living or in instrumental activities of daily living.
  - 26 (2) Is a disability, as defined in Section 12102(1)(A) of Title
  - 27 42 of the United States Code, that substantially limits one or more
  - 28 of the member's major life activities.
- 29 (b) The board shall adopt regulations that provide for the
- 30 following:
  - 31 (1) The determination of individual eligibility for long-term
  - 32 services and supports under this section.
  - 33 (2) The assessment of the long-term services and supports
  - 34 needed for an eligible individual.
  - 35 (3) The automatic entitlement of an individual who receives or
  - 36 is approved to receive disability benefits from the federal Social
  - 37 Security Administration under the federal Social Security Disability
  - 38 Insurance program established in Title II or Title XVI of the federal
  - 39 Social Security Act to the long-term services and supports under
  - 40 this section.

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

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

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

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

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

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

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

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

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

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

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

36 100627. (a) (1) The board shall, on a regular basis and at least  
37 annually, evaluate whether the benefits under CalCare should be  
38 expanded or adjusted to promote the health of members and  
39 California residents, account for changes in medical practice or

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

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

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

9 (c) The board shall establish a process by which individuals  
10 may bring a disputed health care item or service or a coverage  
11 decision for review to the Independent Medical Review System  
12 established in the Department of Managed Health Care pursuant  
13 to Article 5.55 (commencing with Section 1374.30) of Chapter  
14 2.2 of Division 2 of the Health and Safety Code.

15 (d) For the purposes of this chapter:

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

25 (2) “Disputed health care item or service” means a health care  
26 item or service eligible for coverage and payment under CalCare  
27 that has been denied, modified, or delayed by a decision of a  
28 participating provider or a health care professional who is  
29 employed by or otherwise receives compensation or payment for  
30 health care items and services furnished under CalCare from a  
31 participating provider, in whole or in part, due to a finding that the  
32 service is not medically necessary or appropriate. A decision  
33 regarding a disputed health care item or service relates to the  
34 practice of medicine, including early discharge from an institutional  
35 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

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

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

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

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

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

21 100631. (a) A health care provider shall enter into a  
22 participation agreement with the board to qualify as a participating  
23 provider under CalCare.

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

27 (1) Health care items and services to members shall be furnished  
28 by the provider without discrimination, as required by Section  
29 100621. This paragraph does not require the provision of a type  
30 or class of health care items or services that are outside the scope  
31 of the provider's normal practice.

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

37 (3) The provider shall follow the policies and procedures in the  
38 CalCare Contracting Manual established pursuant to Section  
39 100617.

1 (4) The provider shall furnish information reasonably required  
2 by the board and shall meet the reporting requirements of Sections  
3 100616 and 100651 for at least the following:

4 (A) Quality review by designated entities.

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

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

10 (D) Other purposes specified by the board.

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

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

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

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

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

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

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

- 1 (i) Use proprietary case mix indexes, diagnosis coding software,  
2 procedure coding software, or other coding system for the purposes  
3 of meeting payment, global budget, or other disclosure  
4 requirements under this title.
- 5 (ii) Require another health care professional to apply case mix  
6 indexes, diagnosis coding software, procedure coding software,  
7 or other coding system in a manner that limits the clinical  
8 diagnosis, treatment process, or a treating health care professional’s  
9 judgment in determining a diagnosis or treatment process, including  
10 the use of leading queries or prohibitions on using certain codes.
- 11 (iii) Provide financial incentives or disincentives to physicians,  
12 registered nurses, or other health care professionals for particular  
13 coding query results or code selections.
- 14 (iv) Use case mix indexes, diagnosis coding software, procedure  
15 coding software, or other coding system that make suggestions for  
16 higher severity diagnoses or higher cost procedure coding.
- 17 (9) The provider shall comply with the duty of patient advocacy  
18 and reporting requirements described in Section 100651.
- 19 (10) If the provider is not an individual, the provider shall ensure  
20 that a board member, executive, or administrator of the provider  
21 shall not receive compensation from, own stock or have other  
22 financial investments in, or receive services as a board member of  
23 an entity that contracts with or provides health care items or  
24 services, including pharmaceutical products and medical devices  
25 or equipment, to the provider.
- 26 (11) If the provider is a not-for-profit hospital subject to Article  
27 2 (commencing with Section 127340) of Chapter 2 of Part 2 of  
28 Division 107 of the Health and Safety Code, the hospital shall  
29 submit to the board the community benefits plan developed  
30 pursuant to Article 2 (commencing with Section 127340) of the  
31 Health and Safety Code.
- 32 (12) Health care items and services to members shall be  
33 furnished by a health care professional while the professional is  
34 physically present within the State of California.
- 35 (13) The provider shall not enter into risk-bearing, risk-sharing,  
36 or risk-shifting agreements with other health care providers or  
37 entities other than CalCare.
- 38 (c) This section does not limit the formation of group practices.

1 100632. (a) A participation agreement may be terminated with  
2 appropriate notice by the board for failure to meet the requirements  
3 of this title or may be terminated by a provider.

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

8 (c) The procedures and penalties under the Medi-Cal program  
9 for fraud or abuse pursuant to Sections 14107, 14107.11, 14107.12,  
10 14107.13, 14107.2, 14107.3, 14107.4, 14107.5, and 14108 of the  
11 Welfare and Institutions Code shall apply to an applicant or  
12 provider under CalCare.

13 (d) For purposes of this section:

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

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

26 100633. (a) A person shall not discharge or otherwise  
27 discriminate against an employee on account of the employee or  
28 a person acting pursuant to a request of the employee for any of  
29 the following:

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

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

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

- 1 (4) Testifying before or otherwise providing information relevant  
2 for a state or federal proceeding regarding this title or a proposed  
3 amendment to this title.
- 4 (5) Commencing, causing to be commenced, or being about to  
5 commence or cause to be commenced a proceeding under this title.
- 6 (6) Testifying or being about to testify in a proceeding.
- 7 (7) Assisting or participating, or being about to assist or  
8 participate, in a proceeding or other action to carry out the purposes  
9 of this title.
- 10 (8) Objecting to, or refusing to participate in, an activity, policy,  
11 practice, or assigned task that the employee or representative  
12 reasonably believes to be in violation of this title or any order,  
13 rule, regulation, standard, or ban under this title.
- 14 (b) An employee covered by this section who alleges  
15 discrimination by an employer in violation of subdivision (a) may  
16 bring an action governed by the rules and procedures, legal burdens  
17 of proof, and remedies applicable under the False Claims Act  
18 (Article 9 (commencing with Section 12650) of Chapter 6 of Part  
19 2 of Division 3 of Title 2) or Section 12990, or an action against  
20 unfair competition pursuant to Chapter 5 (commencing with  
21 Section 17200) of Part 2 of Division 7 of the Business and  
22 Professions Code.
- 23 (c) (1) This section does not diminish the rights, privileges, or  
24 remedies of an employee under any other law, regulation, or  
25 collective bargaining agreement. The rights and remedies in this  
26 section shall not be waived by an agreement, policy, form, or  
27 condition of employment.
- 28 (2) This section does not preempt or diminish any other law or  
29 regulation against discrimination, demotion, discharge, suspension,  
30 threats, harassment, reprimand, retaliation, or any other manner  
31 of discrimination.
- 32 (d) For purposes of this section:
- 33 (1) “Employer” means a person engaged in profit or  
34 not-for-profit business or industry, including one or more  
35 individuals, partnerships, associations, corporations, trusts,  
36 professional membership organization including a certification,  
37 disciplinary, or other professional body, unincorporated  
38 organizations, nongovernmental organizations, or trustees, and  
39 who is subject to liability for violating this title.

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

3 100634. (a) This section shall be effective on the date the  
4 implementation period ends pursuant to paragraph (6) of  
5 subdivision (e) of Section 100612.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

- 5 (A) A contract described in paragraph (1) shall be void.
- 6 (B) A payment shall not be made under CalCare for a health  
7 care item or service furnished by the provider during the two-year  
8 period beginning on the date the affidavit was signed or the date  
9 the claim was submitted, whichever is later. A payment made by  
10 CalCare to the provider during that two-year period shall be  
11 remitted to CalCare, plus interest.
- 12 (C) A payment received by the provider from the member,  
13 CalCare program, or other payer for a health care item or service  
14 furnished during the period described in subparagraph (B) shall  
15 be remitted to the payer, and damages shall be available to the  
16 payer pursuant to Section 3294 of the Civil Code.
- 17 (5) An institutional or individual provider without a participation  
18 agreement in effect may bill or enter into a private contract with  
19 an individual for a health care item or service that is not a benefit  
20 under CalCare.

21  
22 Article 2. Payment for Health Care Items and Services

23  
24 100640. (a) The board shall adopt regulations regarding  
25 contracting for, and establishing payment methodologies for,  
26 covered health care items and services provided to members under  
27 CalCare by participating providers. All payment rates under  
28 CalCare shall be reasonable and reasonably related to all of the  
29 following:

- 30 (1) The cost of efficiently providing the health care items and  
31 services.
- 32 (2) Ensuring availability and accessibility of CalCare health  
33 care services, including compliance with state requirements  
34 regarding network adequacy, timely access, and language access.
- 35 (3) Maintaining an optimal workforce and the health care  
36 facilities necessary to deliver quality, equitable health care.
- 37 (b) (1) Payment for health care items and services shall be  
38 considered payment in full.
- 39 (2) A participating provider shall not charge a rate in excess of  
40 the payment established through CalCare for a health care item or

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

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

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

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

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

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

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

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

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

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

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

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

16 100641. (a) An institutional provider’s global budget shall be  
17 determined before the start of a fiscal year through negotiations  
18 between the provider and the board. The global budget shall be  
19 negotiated annually based on the payment factors described in  
20 subdivision (d).

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

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

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

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

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

- 1 (A) The expenditures of other comparable institutional providers  
2 in the state.
- 3 (B) The normative payment rates established under the  
4 comparative payment rate systems pursuant to Section 100643,  
5 including permissible adjustments to the rates for the health care  
6 items and services.
- 7 (C) Projected changes in the volume and type of health care  
8 items and services to be furnished.
- 9 (D) Employee wages.
- 10 (E) The provider's maximum capacity to provide the health care  
11 items and services.
- 12 (F) Education and prevention programs.
- 13 (G) Permissible adjustments to the provider's operating budget  
14 from the previous fiscal year due to factors including an increase  
15 in primary or specialty care access, efforts to decrease health care  
16 disparities in rural or medically underserved areas, a response to  
17 emergent conditions, and proposed changes to patient care  
18 programs at the institutional level.
- 19 (H) Any other factor determined appropriate by the board.
- 20 (3) In a rural or medically underserved area, the need to mitigate  
21 the impact of the availability and accessibility of health care  
22 services through increased global budget payment.
- 23 (e) A payment negotiated pursuant to subdivision (a) or payment  
24 methodology shall not do any of the following:
- 25 (1) Take into account capital expenditures of the provider or  
26 any other expenditure not directly associated with furnishing health  
27 care items and services under CalCare.
- 28 (2) Be used by a provider for capital expenditures or other  
29 expenditures associated with capital projects.
- 30 (3) Exceed the provider's capacity to furnish health care items  
31 and services covered under CalCare.
- 32 (4) Be used to pay or otherwise compensate a board member,  
33 executive, or administrator of the institutional provider who has  
34 an interest or relationship prohibited under paragraph (10) of  
35 subdivision (b) of Section 100631 or paragraph (3) of subdivision  
36 (c) of Section 100651.
- 37 (f) The board may negotiate changes to an institutional  
38 provider's global budget based on factors not prohibited under  
39 subdivision (e) or any other provision of this title.

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

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

19 (i) For the purposes of this section, “operating expenses” of a  
20 provider include the following:

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

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

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

28 (C) Purchasing supplies.

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

34 (E) Incidental services necessary for safe patient care.

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

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

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

5 (2) Administrative costs of the institutional provider.

6 100642. (a) The board shall consider an appeal of payments  
7 and the global budget, filed by an institutional provider that is  
8 subject to the payments or global budget, based on the following:

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

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

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

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

21 (A) Natural disasters.

22 (B) Outbreaks of epidemics or infectious diseases.

23 (C) Unanticipated facility or equipment repairs or purchases.

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

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

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

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

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

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

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

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

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

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

22 100643. (a) The board shall use existing Medicare prospective  
23 payment systems to establish and serve as the comparative payment  
24 rate system in global budget negotiations described in subparagraph  
25 (B) of paragraph (2) of subdivision (d) of Section 100641. The  
26 board shall update the comparative payment rate system annually.

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

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

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



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

3 100644. (a) The board shall engage in good faith negotiations  
4 with health care providers' representatives under Chapter 8  
5 (commencing with Section 100800) to determine rates of  
6 fee-for-service payment for health care items and services furnished  
7 under CalCare.

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

12 (c) Payments to individual providers under this article shall not  
13 include payments to individual providers in salaried positions at  
14 institutional providers receiving global budgets under Section  
15 100641 or individual health care professionals who are employed  
16 by or otherwise receive compensation or payment for health care  
17 items and services furnished under CalCare from group practices,  
18 county organized health systems, or local initiatives that receive  
19 payment under CalCare on a salaried basis.

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

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

27 100645. (a) (1) The board shall adopt, by regulation, payment  
28 methodologies for the payment of capital expenditures for  
29 specifically identified capital projects incurred by not-for-profit  
30 or governmental entities that are health facilities pursuant to  
31 Chapter 2 (commencing with Section 1250) of Division 2 of the  
32 Health and Safety Code.

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

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

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

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

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

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

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

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

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

26 100646. (a) (1) A margin generated by a participating provider  
27 receiving a global budget under CalCare may be retained and used  
28 to meet the health care needs of CalCare members.

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

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

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

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

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

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

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

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

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

20 (7) State political contributions.

21 (c) (1) The board shall establish and enforce penalties for  
22 violations of this section, consistent with the Administrative  
23 Procedure Act (Chapter 3.5 (commencing with Section 11340) of  
24 Part 1 of Division 3 of Title 2).

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

27 100647. (a) The board shall, in consultation with the  
28 Department of General Services, the Department of Health Care  
29 Services, and other relevant state agencies, negotiate prices to be  
30 paid for pharmaceuticals, medical supplies, medical technology,  
31 and medically necessary assistive equipment covered through  
32 CalCare. Negotiations by the board shall be on behalf of the entire  
33 CalCare program. A state agency shall cooperate to provide data  
34 and other information to the board.

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

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

- 3 (1) Promote the use of generic and biosimilar medications.
- 4 (2) Consider the clinical efficacy of medications.
- 5 (3) Update the formulary frequently and allow health care  
6 professionals, other clinicians, and members to petition the board  
7 to add new pharmaceuticals or to remove ineffective or dangerous  
8 medications from the formulary.
- 9 (4) Consult with patient advocacy organizations, physicians,  
10 nurses, pharmacists, and other health care professionals to  
11 determine the clinical efficacy and need for the inclusion of specific  
12 medications in the formulary.

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

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

19

20 CHAPTER 6. PROGRAM STANDARDS

21

22 100650. CalCare shall establish a single standard of safe,  
23 therapeutic, and effective care for all residents of the state by the  
24 following means:

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

- 33 (1) The scope, quality, and accessibility of health care items  
34 and services.
- 35 (2) Relations between participating providers and members.
- 36 (3) Relations between institutional providers, group practices,  
37 and individual health care organizations, including credentialing  
38 for participation in CalCare and clinical and admitting privileges,  
39 and terms, methods, and rates of payment.

- 1 (b) The board shall establish requirements and standards, by  
2 regulation, under CalCare that include provisions to promote all  
3 of the following:
- 4 (1) Simplification, transparency, uniformity, and fairness in the  
5 following:
- 6 (A) Health care provider credentialing for participation in  
7 CalCare.
- 8 (B) Health care provider clinical and admitting privileges in  
9 health care facilities.
- 10 (C) Clinical placement for educational purposes, including  
11 clinical placement for prelicensure registered nursing students  
12 without regard to degree type, that prioritizes nursing students in  
13 public education programs.
- 14 (D) Payment procedures and rates.
- 15 (E) Claims processing.
- 16 (2) In-person primary and preventive care, efficient and effective  
17 health care items and services, quality assurance, and promotion  
18 of public, environmental, and occupational health.
- 19 (3) Elimination of health care disparities.
- 20 (4) Nondiscrimination pursuant to Section 100621.
- 21 (5) Accessibility of health care items and services, including  
22 accessibility for people with disabilities and people with limited  
23 ability to speak or understand English.
- 24 (6) Providing health care items and services in a culturally,  
25 linguistically, and structurally competent manner.
- 26 (c) The board shall establish requirements and standards, to the  
27 extent authorized by federal law, by regulation, for replacing and  
28 merging with CalCare health care items and services and ancillary  
29 services currently provided by other programs, including Medicare,  
30 the Affordable Care Act, and federally matched public health  
31 programs.
- 32 (d) A participating provider shall furnish information as required  
33 by the Office of Statewide Health Planning and Development  
34 pursuant to Sections 100616 and 100631, and to Division 107  
35 (commencing with Section 127000) of the Health and Safety Code,  
36 and permit examination of that information by the board as  
37 reasonably required for purposes of reviewing accessibility and  
38 utilization of health care items and services, quality assurance,  
39 cost containment, the making of payments, and statistical or other

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

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

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

13 100651. (a) (1) As part of a health care practitioner’s duty to  
14 advocate for medically appropriate health care for their patients  
15 pursuant to Sections 510 and 2056 of the Business and Professions  
16 Code, a participating provider has a duty to act in the exclusive  
17 interest of the patient.

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

22 (b) Consistent with subdivision (a) and with Sections 510 and  
23 2056 of the Business and Professions Code:

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

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

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

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

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

10 (A) A patient's utilization of services.

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

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

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

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

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

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

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

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

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

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

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

19 100652. (a) An individual’s treating physician, nurse, or other  
20 health care professional, in implementing a patient’s medical or  
21 nursing care plan and in accordance with their scope of practice  
22 and licensure, may override health information technology or  
23 clinical practice guidelines, including standards and guidelines  
24 implemented by a participating provider through the use of health  
25 information technology, including electronic health record  
26 technology, clinical decision support technology, and computerized  
27 order entry programs.

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

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

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

36 (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.

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

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

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

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

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

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

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

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

3 (C) Is in the interest of CalCare.

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

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

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

17 (i) The board shall provide premium assistance for all members  
18 enrolling in a Medicare Part D drug coverage plan under Section  
19 1860D of Title XVIII of the federal Social Security Act (42 U.S.C.  
20 Sec. 1395w-101 et seq.), limited to the low-income benchmark  
21 premium amount established by the federal Centers for Medicare  
22 and Medicaid Services and any other amount the federal agency  
23 establishes under its de minimis premium policy, except that those  
24 payments made on behalf of members enrolled in a Medicare  
25 Advantage plan may exceed the low-income benchmark premium  
26 amount if determined to be cost effective to CalCare.

27 (j) If the board has reasonable grounds to believe that a member  
28 may be eligible for an income-related subsidy under Section  
29 1860D-14 of Title XVIII of the federal Social Security Act (42  
30 U.S.C. Sec. 1395w-114), the member shall provide, and authorize  
31 CalCare to obtain, any information or documentation required to  
32 establish the member’s eligibility for that subsidy. The board shall  
33 attempt to obtain as much of the information and documentation  
34 as possible from records that are available to it.

35 (k) The board shall make a reasonable effort to notify members  
36 of their obligations under this section. After a reasonable effort  
37 has been made to contact the member, the member shall be notified  
38 in writing that the member has 60 days to provide the required  
39 information. If the required information is not provided within the  
40 60-day period, the member’s coverage under CalCare may be

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

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

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8

Article 2. CalCare Trust Fund

9 100665. (a) The CalCare Trust Fund is hereby created in the  
10 State Treasury for the purposes of this title to be administered by  
11 the CalCare Board. Notwithstanding Section 13340, all moneys  
12 in the fund shall be continuously appropriated without regard to  
13 fiscal year for the purposes of this title. Any moneys in the fund  
14 that are unexpended or unencumbered at the end of a fiscal year  
15 may be carried forward to the next succeeding fiscal year.

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

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

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

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

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

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

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

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

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

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

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

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

23 100667. (a) The board annually shall prepare a budget for  
24 CalCare that specifies a budget for all expenditures to be made for  
25 covered health care items and services and shall establish  
26 allocations for each of the budget components under subdivision  
27 (b) that shall cover a three-year period.

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

- 30 (1) An operating budget.
- 31 (2) A capital expenditures budget.
- 32 (3) A special projects budget.
- 33 (4) Program standards activities.
- 34 (5) Health professional education expenditures.
- 35 (6) Administrative costs.
- 36 (7) Prevention and public health activities.

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

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

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

3 (3) A fair allocation for program standards activities.

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

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

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

17 (f) (1) The special projects budget shall be used for the payment  
18 to not-for-profit or governmental entities that are health facilities  
19 pursuant to Chapter 2 (commencing with Section 1250) of Division  
20 2 of the Health and Safety Code for the construction or renovation  
21 of health care facilities, major equipment purchases, staffing in a  
22 rural or medically underserved area, and to address health  
23 disparities, including those based on race, ethnicity, national origin,  
24 primary language use, age, disability, sex, including gender identity  
25 and sexual orientation, geography, and socioeconomic status.

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

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

34

35 Article 3. CalCare Financing

36

37 100670. (a) It is the intent of the Legislature to enact legislation  
38 that would develop a revenue plan, taking into consideration  
39 anticipated federal revenue available for CalCare. In developing

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

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

7  
8 CHAPTER 8. COLLECTIVE NEGOTIATION BY HEALTH CARE  
9 PROVIDERS WITH CALCARE

10  
11 Article 1. Definitions

12  
13 100675. For purposes of this chapter, the following definitions  
14 apply:

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

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

22 (B) An owner, officer, shareholder, or proprietor of a health  
23 care group practice that has elected to receive fee-for-service  
24 payments from CalCare pursuant to subdivision (d) of Section  
25 100640.

26 (2) A health care provider licensed, certified, registered, or  
27 authorized to practice a health care profession pursuant to Division  
28 2 (commencing with Section 500) of the Business and Professions  
29 Code who practices as an employee of a health care provider is  
30 not a health care provider for purposes of this chapter.

31 (b) “Health care provider’s representative” means a third party  
32 that is authorized by a health care provider to negotiate on their  
33 behalf with CalCare over terms and conditions affecting those  
34 health care providers.

35  
36 Article 2. Authorized Collective Negotiation

37  
38 100676. (a) Health care providers may meet and communicate  
39 for the purpose of collectively negotiating with CalCare on any  
40 matter relating to CalCare fee-for-service rates of payment for

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

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

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

8

9

Article 3. Collective Negotiation Requirements

10

11 100677. (a) Collective negotiation under this chapter shall  
12 meet all of the following requirements:

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

16 (2) A health care provider may communicate with a health care  
17 provider’s representative.

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

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

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

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

30 100678. (a) Before engaging in collective negotiations with  
31 CalCare on behalf of health care providers, a health care provider’s  
32 representative shall file with the board, in the manner prescribed  
33 by the board, information identifying the representative, the  
34 representative’s plan of operation, and the representative’s  
35 procedures to ensure compliance with this chapter.

36 (b) A person who acts as the representative of negotiating parties  
37 under this chapter shall pay a fee to the board to act as a  
38 representative. The board, by regulation, shall set fees in amounts  
39 deemed reasonable and necessary to cover the costs incurred by  
40 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:

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

O