City of SACRAMENTO

City Council Report

915 I Street, 1st Floor
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File ID: 2021-01357 | November 30, 2021 | **Consent Item 03**

Title: Resolution in Support of CalCare (AB 1400) and Medicare for All (H.R. 1976)

Location: Citywide

Recommendation: Adopt a Resolution: 1) supporting the California Guaranteed Health Care for All Act, Assembly Bill 1400; and 2) supporting the federal Medicare for All Act of 2021, House Resolution 1976.

Contact: Consuelo Hernandez, Director of Governmental Affairs, (916) 808-7395, Office of the City Manager

Presenter: None

Attachments:
1-Description/Analysis
2-Resolution
3-AB 1400
4-HR 1976

Description/Analysis

Issue Detail: On September 14, 2021, Councilmember Valenzuela requested that the Council consider a resolution stating the City's support of Assembly Bill 1400 (AB 1400) and House Resolution 1976 (H.R. 1976).

AB 1400, 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 healthcare or social services covered by regional centers for persons with developmental disabilities, Knox-Keene, and the federal Medicare program. AB 1400 was introduced on February 19, 2021 and is awaiting further action.

H.R. 1976, the Medicare for All Act of 2021, would establish a national health-insurance program that is administered by the Department of Health and Human Services (HHS). Among other requirements, the program must (1) cover all U.S. residents, (2) provide for automatic enrollment of individuals upon birth or residency in the United States, and (3) cover items and services that are medically necessary or appropriate to maintain health or to diagnose, treat, or rehabilitate a health condition, including hospital services, prescription drugs, mental-health and substance-abuse treatment, dental and vision services, and long-term care. The bill prohibits cost-sharing (e.g., deductibles, coinsurance, and copayments) and other charges for covered services. Additionally, private health insurers and employers may only offer coverage that is supplemental to, and not duplicative of, benefits provided under the program. H.R. 1976 was introduced into Congress on March 17, 2021 and is awaiting further action.

Policy Considerations: Staff was directed to bring to Council a resolution in support of AB 1400 and H.R. 1976 at the September 21, 2021, meeting.

Economic Impacts: Not applicable.

Environmental Considerations: This activity is not subject to CEQA because it does not involve the exercise of discretionary powers by the city, it will not result in a direct or foreseeable indirect physical change in the environment, and it is not a "project" as defined in Section 15378. (CEQA Guidelines § 15060.)

Sustainability: Not applicable.

Commission/Committee Action: Passed at Law and Legislation Committee on November 16, 2021.

Rationale for Recommendation: Staff was directed to bring to Council a resolution in support of AB 1400 and H.R. 1976 at the September 21, 2021, meeting.

Financial Considerations: None.

Local Business Enterprise (LBE): Not applicable.

RESOLUTION NO.

Adopted by the Sacramento City Council

SUPPORTING CALCARE (AB 1400) AND MEDICARE FOR ALL (H.R. 1976)

BACKGROUND

A. Every person in the City of Sacramento and everywhere deserves high-quality health care as an essential human right.

B. Despite gains made since the implementation of the Affordable Care Act, the number of U.S. residents without health insurance before the Covid-19 pandemic was still nearly 30 million, with more than 40 million underinsured, and the number of Californians without health insurance was 2.7 million, with 12 million underinsured.

C. The Covid-19 pandemic has led to record levels of unemployment, the loss of employer-sponsored health insurance, a severely strained health-care system, and widespread illness; it has taken a profound toll on our community's mental health, placing significant demands on our health-care system.

D. The pandemic further exposed the dangers of our fragmented, profit-driven health-care system, that leads many Californians to delay seeking needed health care due to an inability to pay, leading to a sicker and poorer population in the long run.

E. Such a population is significantly more likely to develop serious illness if exposed to diseases like Covid-19 and will subsequently face higher mortality rates.

F. The ever-increasing costs of health care, further elevated due to the pandemic, challenge our already-strapped state and municipal budgets.

G. In order to equitably and effectively address the health-care burden of the Covid-19 crisis, we must urge the U.S. Congress and the California Legislature to provide comprehensive health care for every resident of the United States and California, respectively, at no cost to recipients.

H. The Medicare for All Act of 2021 (H.R. 1976) and the California Guaranteed Health Care for All (CalCare) Act (AB 1400) would guarantee health care that is free at the point of service for every person in the United States and California, respectively, for all necessary medical care including prescription drugs; hospital, surgical, and

outpatient services; primary and preventive care; emergency services; reproductive care; dental and vision care; mental-health care; and long-term care.

I. The Medicare for All Act of 2021 and the California Guaranteed Health Care for All Act would provide coverage without copays, deductibles, or other out-of-pocket costs, and would slash bureaucracy, protect the doctor-patient relationship, and assure patients a free choice of doctors.

J. The California Guaranteed Health Care for All Act would establish statewide, comprehensive, universal, single-payer health care with a cost-control system for the benefit of all residents of the state.

K. The Medicare for All Act of 2021 and the California Guaranteed Health Care for All Act would both guarantee that all residents of Sacramento will be fully covered for health care without copays, deductibles, or other out-of-pocket costs, and would save millions in taxpayer dollars now spent on premiums that provide often inadequate health-insurance coverage for government employees, as well as premiums for private insurance spent by employers and individuals.

L. The quality of life for the residents of Sacramento would vastly improve because they would be able to get the ongoing care that they need instead of waiting until they have a medical emergency that could upend their lives as well as further burden local resources.

M. Recent polls show that a majority of U.S. and California residents support universal, single-payer health care.

N. The federal administration has the ability to empower states, as laboratories of democracy, to use Affordable Care Act innovation waivers to develop locally tailored approaches to health coverage, including by removing barriers to states that seek to experiment with statewide universal health-care approaches.

BASED ON THE FACTS SET FORTH IN THE BACKGROUND, THE CITY COUNCIL RESOLVES AS FOLLOWS:

Section 1. The Sacramento City Council finds and determines that the background statements A through N are true.

Section 2. The Sacramento City Council enthusiastically supports the Medicare for All Act of 2021 (H.R. 1976) and calls upon our federal legislators to work toward its immediate enactment, assuring health care for all residents of the United States.

Section 3. The Sacramento City Council enthusiastically supports the California Guaranteed Health Care for All Act (AB 1400) and calls upon our state legislators to work toward its immediate enactment.

ASSEMBLY BILL No. 1400

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

February 19, 2021

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

LEGISLATIVE COUNSEL'S DIGEST

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

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

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

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

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

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

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

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

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

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

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

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

This bill would make legislative findings to that effect.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TITLE 23. THE CALIFORNIA GUARANTEED HEALTH CARE FOR ALL ACT

Chapter 1. General Provisions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Chapter 2. Governance

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

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

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

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

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

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

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

(A) Two health care professionals who practice medicine.

(B) One registered nurse.

(C) One public health professional.

(D) One mental health professional.

(E) One member with an institutional provider background.

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

(G) One representative of a labor organization.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Four health care professionals.

(2) One registered nurse.

(3) One representative of a licensed health facility.

(4) One representative of an essential community provider

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

(6) One behavioral health provider.

(7) One dentist or oral care specialist.

(8) One representative of private hospitals.

(9) One representative of public hospitals.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(14) Meet regularly with the committee.

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

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

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

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

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

(i) The manner in which funds were expended.

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

(iii) CalCare's fiscal condition.

(iv) Recommendations for statutory changes.

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

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

(vii) Future goals and priorities.

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

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

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

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

(2) Sue and be sued.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) The number of patients served.

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

(A) Patients receiving charity care.

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

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

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

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

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

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

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

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

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

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

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

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

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

Chapter 3. Eligibility and Enrollment

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

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

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

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

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

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

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

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

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

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

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

(2) Reduction of a person's benefits.

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

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

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

Chapter 4. Benefits

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

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

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

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

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

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

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

(4) Prescription drugs and biological products.

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

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

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

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

(9) Pediatrics.

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

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

(12) Emergency services and transportation.

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

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

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

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

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

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

(2) Child and adult immunizations.

(3) Hospice care.

(4) Care in a skilled nursing facility.

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

(6) Prenatal and postnatal care.

(7) Podiatric care.

(8) Blood and blood products.

(9) Dialysis.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) For the purposes of this chapter:

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

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

Chapter 5. Delivery of Care

Article 1. Health Care Providers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) Quality review by designated entities.

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

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

(D) Other purposes specified by the board.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) For purposes of this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) For purposes of this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Article 2. Payment for Health Care Items and Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(D) Employee wages.

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

(F) Education and prevention programs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(C) Purchasing supplies.

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

(E) Incidental services necessary for safe patient care.

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

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

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

(2) Administrative costs of the institutional provider.

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

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

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

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

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

(A) Natural disasters.

(B) Outbreaks of epidemics or infectious diseases.

(C) Unanticipated facility or equipment repairs or purchases.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(7) State political contributions.

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

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

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

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

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

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

(2) Consider the clinical efficacy of medications.

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

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

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

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

Chapter 6. Program Standards

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

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

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

(2) Relations between participating providers and members.

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

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

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

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

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

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

(D) Payment procedures and rates.

(E) Claims processing.

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

(3) Elimination of health care disparities.

(4) Nondiscrimination pursuant to Section 100621.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) A patient's utilization of services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Chapter 7. Funding

Article 1. Federal Health Programs and Funding

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(C) Is in the interest of CalCare.

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

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

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

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

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

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

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

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

Article 2. CalCare Trust Fund

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) An operating budget.

(2) A capital expenditures budget.

(3) A special projects budget.

(4) Program standards activities.

(5) Health professional education expenditures.

(6) Administrative costs.

(7) Prevention and public health activities.

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

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

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

(3) A fair allocation for program standards activities.

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

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

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

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

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

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

Article 3. CalCare Financing

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

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

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

Chapter 8. Collective Negotiation by Health Care Providers with CalCare

Article 1. Definitions

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

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

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

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

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

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

Article 2. Authorized Collective Negotiation

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

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

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

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

Article 3. Collective Negotiation Requirements

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

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

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

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

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

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

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

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

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

Article 4. Prohibited Collective Action

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

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

Chapter 9. Operative Date

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

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

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

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

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

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117TH CONGRESS
1ST SESSION

H. R. 1976

To establish an improved Medicare for All national health insurance program.

IN THE HOUSE OF REPRESENTATIVES

MARCH 17, 2021

Ms. JAYAPAL (for herself, Ms. ADAMS, Ms. BARRAGÁN, Ms. BASS, Mr. BEYER, Mr. BLUMENAUER, Ms. BONAMICI, Mr. BOWMAN, Mr. BRENDAN F. BOYLE of Pennsylvania, Mr. BROWN, Ms. BUSH, Mr. CARBAJAL, Mr. CÁRDENAS, Mr. CARSON, Mr. CARTWRIGHT, Ms. CHU, Mr. CICILLINE, Ms. CLARK of Massachusetts, Ms. CLARKE of New York, Mr. CLEAVER, Mr. COHEN, Mr. DEUTCH, Mr. DANNY K. DAVIS of Illinois, Mr. DEFAZIO, Ms. DEGETTE, Mr. DESAULNIER, Mrs. DINGELL, Mr. DOGGETT, Mr. MICHAEL F. DOYLE of Pennsylvania, Ms. ESCOBAR, Mr. ESPAILLAT, Ms. LOIS FRANKEL of Florida, Mr. GALLEGO, Mr. GARCÍA of Illinois, Mr. GOMEZ, Mr. GREEN of Texas, Mr. GRIJALVA, Mr. HARDER of California, Mr. HASTINGS, Mrs. HAYES, Mr. HIGGINS of New York, Mr. HUFFMAN, Ms. JACKSON LEE, Ms. JACOBS of California, Mr. JEFFRIES, Mr. JOHNSON of Georgia, Mr. JONES, Mr. KAHELE, Mr. KEATING, Ms. KELLY of Illinois, Mr. KHANNA, Mr. KILDEE, Mrs. KIRKPATRICK, Mr. LANGEVIN, Mrs. LAWRENCE, Ms. LEE of California, Ms. LEGER FERNANDEZ, Mr. LEVIN of Michigan, Mr. LEVIN of California, Mr. LIEU, Mr. LOWENTHAL, Mrs. CAROLYN B. MALONEY of New York, Mr. MCGOVERN, Mr. MCNERNEY, Mr. MEEKS, Ms. MENG, Mr. NADLER, Mrs. NAPOLITANO, Mr. NEGUSE, Ms. NEWMAN, Ms. NORTON, Ms. OCASIO-CORTEZ, Ms. OMAR, Mr. PANETTA, Mr. PAYNE, Mr. PERLMUTTER, Ms. PINGREE, Mr. POCAN, Ms. PORTER, Ms. PRESSLEY, Mr. RASKIN, Ms. ROYBAL-ALLARD, Mr. RUSH, Mr. SABLAN, Ms. SÁNCHEZ, Mr. SARBANES, Ms. SCHAKOWSKY, Mr. SCHIFF, Mr. SCOTT of Virginia, Mr. SHERMAN, Mr. SMITH of Washington, Ms. SPEIER, Mr. SWALWELL, Mr. TAKANO, Mr. THOMPSON of Mississippi, Mr. THOMPSON of California, Ms. TITUS, Ms. TLAIB, Mr. TONKO, Mr. TORRES of New York, Mrs. TRAHAN, Mr. VARGAS, Mr. VEASEY, Ms. VELÁZQUEZ, Ms. WATERS, Mrs. WATSON COLEMAN, Mr. WELCH, Ms. WILD, Ms. WILLIAMS of Georgia, Ms. WILSON of Florida, Mr. YARMUTH, Mr. PALLONE, and Mr. PRICE of North Carolina) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Education and Labor, Rules, Oversight and Reform, Armed Services, and the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration

of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To establish an improved Medicare for All national health insurance program.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare for All Act of 2021''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

TITLE I—ESTABLISHMENT OF THE MEDICARE FOR ALL PROGRAM; UNIVERSAL COVERAGE; ENROLLMENT

SEC. 101. ESTABLISHMENT OF THE MEDICARE FOR ALL PROGRAM.

There is hereby established a national health insurance program to provide comprehensive protection against the costs of health care and health-related services, in accordance with the standards specified in, or established under, this Act.

SEC. 102. UNIVERSAL COVERAGE.

(a) IN GENERAL.—Every individual who is a resident of the United States is entitled to benefits for health care services under this Act. The Secretary shall promulgate a rule that provides criteria for determining residency for eligibility purposes under this Act.

(b) TREATMENT OF OTHER INDIVIDUALS.—The Secretary may make eligible for benefits for health care services under this Act other individuals not described in subsection (a), and regulate the eligibility of such individuals, to ensure that every person in the United States has access to health care. In regulating such eligibility, the Secretary shall ensure that individuals are not allowed to travel to the United States for the sole purpose of obtaining health care items and services provided under the program established under this Act.

SEC. 103. FREEDOM OF CHOICE.

Any individual entitled to benefits under this Act may obtain health services from any institution, agency, or individual qualified to participate under this Act.

SEC. 104. NON-DISCRIMINATION.

(a) IN GENERAL.—No person shall, on the basis of race, color, national origin, age, disability, marital status, citizenship status, primary language use, genetic conditions, previous or existing medical conditions, religion, or sex, including sex stereotyping, gender identity, sexual orientation, and pregnancy and related medical conditions (including termination of pregnancy), be excluded from participation in or be denied the benefits of the program established under this Act (except as expressly authorized by this Act for purposes of enforcing eligibility standards

described in section 102), or be subject to any reduction of benefits or other discrimination by any participating provider (as defined in section 301), or any entity conducting, administering, or funding a health program or activity, including contracts of insurance, pursuant to this Act.

(b) CLAIMS OF DISCRIMINATION.—

(1) IN GENERAL.—The Secretary shall establish a procedure for adjudication of administrative complaints alleging a violation of subsection (a).

(2) JURISDICTION.—Any person aggrieved by a violation of subsection (a) by a covered entity may file suit in any district court of the United States having jurisdiction of the parties. A person may bring an action under this paragraph concurrently as such administrative remedies as established in paragraph (1).

(3) DAMAGES.—If the court finds a violation of subsection (a), the court may grant compensatory and punitive damages, declaratory relief, injunctive relief, attorneys' fees and costs, or other relief as appropriate.

(c) CONTINUED APPLICATION OF LAWS.—Nothing in this title (or an amendment made by this title) shall be construed to invalidate or otherwise limit any of the rights,

remedies, procedures, or legal standards available to individuals aggrieved under section 1557 of the Patient Protection and Affordable Care Act (42 U.S.C. 18116), title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), or the Age Discrimination Act of 1975 (42 U.S.C. 611 et seq.). Nothing in this title (or an amendment to this title) shall be construed to supersede State laws that provide additional protections against discrimination on any basis described in subsection (a).

SEC. 105. ENROLLMENT.

(a) IN GENERAL.—The Secretary shall provide a mechanism for the enrollment of individuals eligible for benefits under this Act. The mechanism shall—

(1) include a process for the automatic enrollment of individuals at the time of birth in the United States (or upon establishment of residency in the United States);

(2) provide for the enrollment, as of the dates described in section 106, of all individuals who are eligible to be enrolled as of such dates, as applicable; and

(3) include a process for the enrollment of individuals made eligible for health care services under section 102(b).

(b) ISSUANCE OF UNIVERSAL MEDICARE CARDS.—In conjunction with an individual's enrollment for benefits under this Act, the Secretary shall provide for the issuance of a Universal Medicare card that shall be used for purposes of identification and processing of claims for benefits under this program. The card shall not include an individual's Social Security number.

SEC. 106. EFFECTIVE DATE OF BENEFITS.

(a) IN GENERAL.—Except as provided in subsection (b), benefits shall first be available under this Act for items and services furnished 2 years after the date of the enactment of this Act.

(b) COVERAGE FOR CERTAIN INDIVIDUALS.—

(1) IN GENERAL.—For any eligible individual who—

(A) has not yet attained the age of 19 as of the date that is 1 year after the date of the enactment of this Act; or

(B) has attained the age of 55 as of the date that is 1 year after the date of the enactment of this Act,

benefits shall first be available under this Act for items and services furnished as of such date.

(2) OPTION TO CONTINUE IN OTHER COVERAGE DURING TRANSITION PERIOD.—Any person who is eligible to receive benefits as described in paragraph (1) may opt to maintain any coverage described in section 901, private health insurance coverage, or coverage offered pursuant to subtitle A of title X (including the amendments made by such subtitle) until the date described in subsection (a).

SEC. 107. PROHIBITION AGAINST DUPLICATING COVERAGE.

(a) IN GENERAL.—Beginning on the effective date described in section 106(a), it shall be unlawful for—

(1) a private health insurer to sell health insurance coverage that duplicates the benefits provided under this Act; or

(2) an employer to provide benefits for an employee, former employee, or the dependents of an employee or former employee that duplicate the benefits provided under this Act.

(b) CONSTRUCTION.—Nothing in this Act shall be construed as prohibiting the sale of health insurance coverage for any additional benefits not covered by this Act, including additional benefits that an employer may provide

to employees or their dependents, or to former employees or their dependents.

TITLE II—COMPREHENSIVE BENEFITS, INCLUDING PREVENTIVE BENEFITS AND BENEFITS FOR LONG-TERM CARE

SEC. 201. COMPREHENSIVE BENEFITS.

(a) IN GENERAL.—Subject to the other provisions of this title and titles IV through IX, individuals enrolled for benefits under this Act are entitled to have payment made by the Secretary to an eligible provider for the following items and services if medically necessary or appropriate for the maintenance of health or for the diagnosis, treatment, or rehabilitation of a health condition:

(1) Hospital services, including inpatient and outpatient hospital care, including 24-hour-a-day emergency services and inpatient prescription drugs.

(2) Ambulatory patient services.

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

(4) Prescription drugs and medical devices, including outpatient prescription drugs, medical devices, and biological products.

(5) Mental health and substance use treatment services, including inpatient care.

(6) Laboratory and diagnostic services.

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

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

(9) Rehabilitative and habilitative services and devices.

(10) Emergency services and transportation.

(11) Early and periodic screening, diagnostic, and treatment services, as described in sections 1902(a)(10)(A), 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A); 1396a(a)(43); 1396d(a)(4)(B); 1396d(r)).

(12) Necessary transportation to receive health care services for persons with disabilities, older individuals with functional limitations, or low-income individuals (as determined by the Secretary).

(13) Long-term care services and support (as described in section 204).

(14) Hospice care.

(15) Services provided by a licensed marriage and family therapist or a licensed mental health counselor.

(b) REVISION.—The Secretary shall, at least annually, and on a regular basis, evaluate whether the benefits

package should be improved to promote the health of beneficiaries, account for changes in medical practice or new information from medical research, or respond to other relevant developments in health science, and shall make recommendations to Congress regarding any such improvements. Such recommendations may not include a recommendation to eliminate any benefit.

(c) HEARINGS.—

(1) IN GENERAL.—The Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives shall, not less frequently than annually, hold a hearing on the recommendations submitted by the Secretary under subsection (b).

(2) EXERCISE OF RULEMAKING AUTHORITY.—Paragraph (1) is enacted—

(A) as an exercise of rulemaking power of the House of Representatives, and, as such, shall be considered as part of the rules of the House, and such rules shall supersede any other rule of the House only to the extent that rule is inconsistent therewith; and

(B) with full recognition of the constitutional right of either House to change such rules (so far as relating to the procedure in

such House) at any time, in the same manner, and to the same extent as in the case of any other rule of the House.

(d) COMPLEMENTARY AND INTEGRATIVE MEDICINE.—

(1) IN GENERAL.—In carrying out subsection (b), the Secretary shall consult with the persons described in paragraph (2) with respect to—

(A) identifying specific complementary and integrative medicine practices that are appropriate to include in the benefits package; and

(B) identifying barriers to the effective provision and integration of such practices into the delivery of health care, and identifying mechanisms for overcoming such barriers.

(2) CONSULTATION.—In accordance with paragraph (1), the Secretary shall consult with—

(A) the Director of the National Center for Complementary and Integrative Health;

(B) the Commissioner of Food and Drugs;

(C) institutions of higher education, private research institutes, and individual researchers with extensive experience in complementary and alternative medicine and the in-

tegration of such practices into the delivery of health care;

(D) nationally recognized providers of complementary and integrative medicine; and

(E) such other officials, entities, and individuals with expertise on complementary and integrative medicine as the Secretary determines appropriate.

(e) STATES MAY PROVIDE ADDITIONAL BENEFITS.—Individual States may provide additional benefits for the residents of such States, as determined by such State, and may provide benefits to individuals not eligible for benefits under this Act, at the expense of the State, subject to the requirements specified in section 1102.

SEC. 202. NO COST-SHARING; OTHER LIMITATIONS.

(a) IN GENERAL.—The Secretary shall ensure that no cost-sharing, including deductibles, coinsurance, copayments, or similar charges, is imposed on an individual for any benefits provided under this Act.

(b) NO BALANCE BILLING.—No provider may impose a charge to an enrolled individual for covered services for which benefits are provided under this Act.

(c) NO PRIOR AUTHORIZATION.—Benefits provided under this Act shall be covered without any need for any

prior authorization determination and without any limitation applied through the use of step therapy protocols.

SEC. 203. EXCLUSIONS AND LIMITATIONS.

(a) IN GENERAL.—Benefits for items and services are not available under this Act unless the items and services meet the standards developed by the Secretary pursuant to section 201(a).

(b) TREATMENT OF EXPERIMENTAL ITEMS AND SERVICES AND DRUGS.—

(1) IN GENERAL.—In applying subsection (a), the Secretary shall make national coverage determinations with respect to items and services that are experimental in nature. Such determinations shall be consistent with the national coverage determination process as defined in section 1869(f)(1)(B) of the Social Security Act (42 U.S.C. 1395ff(f)(1)(B)).

(2) APPEALS PROCESS.—The Secretary shall establish a process by which individuals can appeal coverage decisions. The process shall, as much as is feasible, follow the process for appeals under the Medicare program described in section 1869 of the Social Security Act (42 U.S.C. 1395ff).

(c) APPLICATION OF PRACTICE GUIDELINES.—

(1) IN GENERAL.—In the case of items and services for which the Department of Health and

Human Services has recognized a national practice guideline, such items and services shall be deemed to meet the standards specified in section 201(a) if they have been provided in accordance with such guideline. For purposes of this subsection, an item or service not provided in accordance with a practice guideline shall be deemed to have been provided in accordance with the guideline if the health care provider providing the item or service—

(A) exercised appropriate professional judgment in accordance with the laws and requirements of the State in which such item or service is furnished in deviating from the guideline;

(B) acted in the best interest of the individual receiving the item or service; and

(C) acted in a manner consistent with the individual's wishes.

(2) OVERRIDE OF STANDARDS.—

(A) IN GENERAL.—An individual's treating physician or other health care professional authorized to exercise independent professional judgment in implementing a patient's medical or nursing care plan in accordance with the scope of practice, licensure, and other law of

the State where items and services are to be furnished may override practice standards established pursuant to section 201(a) or practice guidelines described in paragraph (1), including such standards and guidelines that are implemented by a provider through the use of health information technology, such as electronic health record technology, clinical decision support technology, and computerized order entry programs.

(B) LIMITATION.—An override described in subparagraph (A) shall, in the professional judgment of such physician, nurse, or health care professional, be—

(i) consistent with such physician's, nurse's, or health care professional's determination of medical necessity and appropriateness or nursing assessment;

(ii) in the best interests of the individual; and

(iii) consistent with the individual's wishes.

SEC. 204. COVERAGE OF LONG-TERM CARE SERVICES.

(a) IN GENERAL.—Subject to the other provisions of this Act, individuals enrolled for benefits under this Act

are entitled to the following long-term services and supports and to have payment made by the Secretary to an eligible provider for such services and supports if medically necessary and appropriate and in accordance with the standards established in this Act, for maintenance of health or for care, services, diagnosis, treatment, or rehabilitation that is related to a medically determinable condition, whether physical or mental, of health, injury, or age that—

(1) causes a functional limitation in performing one or more activities of daily living; or

(2) requires a similar need of assistance in performing instrumental activities of daily living.

(b) ELIGIBILITY.—An individual shall be eligible for services and supports described in this section if such individual has one or more medically determinable conditions described in subsection (a).

(c) SERVICES AND SUPPORTS.—Long-term services and supports under this section shall be tailored to an individual's needs, as determined through assessment, and shall be defined by the Secretary to—

(1) include any long-term nursing services for the enrollee, whether provided in an institution or in a home and community-based setting;

(2) provide coverage for a broad spectrum of long-term services and supports, including for home and community-based services and other care provided through non-institutional settings;

(3) provide coverage that meets the physical, mental, and social needs of recipients while allowing recipients their maximum possible autonomy and their maximum possible civic, social, and economic participation;

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

(5) unless an individual elects otherwise, ensure that recipients will receive home and community based long-term services and supports (as defined in subsection (f)(4)), regardless of the individuals's type or level of disability, service need, or age;

(6) be provided with the goal of enabling persons with disabilities to receive services in the least restrictive and most integrated setting appropriate to the individual's needs;

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

(8) provide long-term services and supports that are of equal quality and equally accessible across geographic regions; and

(9) ensure that long-term services and supports provide recipient's the option of self-direction of services from either the recipient or care coordinators of the recipient's choosing.

(d) PUBLIC CONSULTATION.—In developing regulations to implement this section, the Secretary shall consult with an advisory commission on long-term services and supports that includes—

(1) people with disabilities who use long-term services and supports and older adults who use long-term services and supports;

(2) representatives of people with disabilities and representatives of older adults;

(3) groups that represent the diversity of the population of people living with disabilities, including racial, ethnic, national origin, primary language use, age, sex, including gender identity and sexual orientation, geographical, and socioeconomic diversity;

(4) providers of long-term services and supports, including family attendants and family caregivers, and members of organized labor;

(5) disability rights organizations; and

(6) relevant academic institutions and researchers.

(e) BUDGETING AND PAYMENTS.—Budgeting and payments for long-term services and supports provided under this section shall be made in accordance with the provisions under title VI.

(f) DEFINITIONS.—In this section:

(1) The term ''long-term services and supports'' means long-term care, treatment, maintenance, or services needed to support the activities of daily living and instrumental activities of daily living, including home and community-based services and any additional services and supports identified by the Secretary to support people with disabilities to live, work, and participate in their communities.

(2) The term ''activities of daily living'' means basic personal everyday activities, including tasks such as eating, toileting, grooming, dressing, bathing, and transferring.

(3) The term ''instrumental activities of daily living'' means activities related to living independently in the community, including but not limited to, meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, com-

municating by phone or other media, and traveling around and participating in the community.

(4) The term ''home and community-based services'' means the home and community-based services that are coverable under subsections (c), (d), (i), and (k) of section 1915 of the Social Security Act (42 U.S.C. 1396n), and as defined by the Secretary, including as defined in the home and community-based services settings rule in sections 441.530 and 441.710 of title 42, Code of Federal Regulations (or a successor regulation).

TITLE III—PROVIDER PARTICIPATION

SEC. 301. PROVIDER PARTICIPATION AND STANDARDS; WHISTLEBLOWER PROTECTIONS.

(a) IN GENERAL.—An individual or other entity furnishing any covered item or service under this Act is not a qualified provider unless the individual or entity—

(1) is a qualified provider of the items or services under section 302;

(2) has filed with the Secretary a participation agreement described in subsection (b); and

(3) meets, as applicable, such other qualifications and conditions with respect to a provider of services under title XVIII of the Social Security Act

as described in section 1866 of the Social Security Act (42 U.S.C. 1395cc).

(b) REQUIREMENTS IN PARTICIPATION AGREEMENT.—

(1) IN GENERAL.—A participation agreement described in this subsection between the Secretary and a provider shall provide at least for the following:

(A) Items and services to eligible persons shall be furnished by the provider without discrimination, in accordance with section 104(a). Nothing in this subparagraph shall be construed as requiring the provision of a type or class of items or services that are outside the scope of the provider's normal practice.

(B) No charge will be made to any enrolled individual for any covered items or services other than for payment authorized by this Act.

(C) The provider agrees to furnish such information as may be reasonably required by the Secretary, in accordance with uniform reporting standards established under section 401(b)(1), for—

(i) quality review by designated entities;

(ii) making payments under this Act, including the examination of records as may be necessary for the verification of information on which such payments are based;

(iii) statistical or other studies required for the implementation of this Act; and

(iv) such other purposes as the Secretary may specify.

(D) In the case of a provider that is not an individual, the provider agrees not to employ or use for the provision of health services any individual or other provider that has had a participation agreement under this subsection terminated for cause. The Secretary may authorize such employment or use on a case-by-case basis.

(E) In the case of a provider paid under a fee-for-service basis for items and services furnished under this Act, the provider agrees to submit bills and any required supporting documentation relating to the provision of covered items and services within 30 days after the date of providing such items and services.

(F) In the case of an institutional provider paid pursuant to section 611, the provider agrees to submit information and any other required supporting documentation as may be reasonably required by the Secretary within 30 days after the date of providing such items and services and in accordance with the uniform reporting standards established under section 401(b)(1), including information on a quarterly basis that—

(i) relates to the provision of covered items and services; and

(ii) describes items and services furnished with respect to specific individuals.

(G) In the case of a provider that receives payment for items and services furnished under this Act based on diagnosis-related coding, procedure coding, or other coding system or data, the provider agrees—

(i) to disclose to the Secretary any system or index of coding or classifying patient symptoms, diagnoses, clinical interventions, episodes, or procedures that such provider utilizes for global budget negotiations under title VI or for meeting any

other payment, documentation, or data collection requirements under this Act; and

(ii) not to use any such system or index to establish financial incentives or disincentives for health care professionals, or that is proprietary, interferes with the medical or nursing process, or is designed to increase the amount or number of payments.

(H) The provider complies with the duty of provider ethics and reporting requirements described in paragraph (2).

(I) In the case of a provider that is not an individual, the provider agrees that no board member, executive, or administrator of such provider receives compensation from, owns stock or has other financial investments in, or serves as a board member of any entity that contracts with or provides items or services, including pharmaceutical products and medical devices or equipment, to such provider.

(2) PROVIDER DUTY OF ETHICS.—Each health care provider, including institutional providers, has a duty to advocate for and to act in the exclusive interest of each individual under the care of such pro-

vider according to the applicable legal standard of care, such that no financial interest or relationship impairs any health care provider's ability to furnish necessary and appropriate care to such individual. To implement the duty established in this paragraph, the Secretary shall—

(A) promulgate reasonable reporting rules to evaluate participating provider compliance with this paragraph;

(B) prohibit participating providers, spouses, and immediate family members of participating providers, from accepting or entering into any arrangement for any bonus, incentive payment, profit-sharing, or compensation based on patient utilization or based on financial outcomes of any other provider or entity; and

(C) prohibit participating providers or any board member or representative of such provider from serving as board members for or receiving any compensation, stock, or other financial investment in an entity that contracts with or provides items or services (including pharmaceutical products and medical devices or equipment) to such provider.

(3) TERMINATION OF PARTICIPATION AGREEMENT.—

(A) IN GENERAL.—Participation agreements may be terminated, with appropriate notice—

(i) by the Secretary for failure to meet the requirements of this Act;

(ii) in accordance with the provisions described in section 411; or

(iii) by a provider.

(B) TERMINATION PROCESS.—Providers shall be provided notice and a reasonable opportunity to correct deficiencies before the Secretary terminates an agreement unless a more immediate termination is required for public safety or similar reasons.

(C) PROVIDER PROTECTIONS.—

(i) PROHIBITION.—The Secretary may not terminate a participation agreement or in any other way discriminate against, or cause to be discriminated against, any covered provider or authorized representative of the provider, on account of such provider or representative—

(I) providing, causing to be provided, or being about to provide or cause to be provided to the provider, the Federal Government, or the attorney general of a State information relating to any violation of, or any act or omission the provider or representative reasonably believes to be a violation of, any provision of this title (or an amendment made by this title);

(II) testifying or being about to testify in a proceeding concerning such violation;

(III) assisting or participating, or being about to assist or participate, in such a proceeding; or

(IV) objecting to, or refusing to participate in, any activity, policy, practice, or assigned task that the provider or representative reasonably believes to be in violation of any provision of this Act (including any amendment made by this Act), or any order, rule, regulation, standard, or ban

under this Act (including any amendment made by this Act).

(ii) COMPLAINT PROCEDURE.—A provider or representative who believes that he or she has been discriminated against in violation of this section may seek relief in accordance with the procedures, notifications, burdens of proof, remedies, and statutes of limitation set forth in section 2087(b) of title 15, United States Code.

(c) WHISTLEBLOWER PROTECTIONS.—

(1) RETALIATION PROHIBITED.—No person may discharge or otherwise discriminate against any employee because the employee or any person acting pursuant to a request of the employee—

(A) notified the Secretary or the employee's employer of any alleged violation of this title, including communications related to carrying out the employee's job duties;

(B) refused to engage in any practice made unlawful by this title, if the employee has identified the alleged illegality to the employer;

(C) testified before or otherwise provided information relevant for Congress or for any

Federal or State proceeding regarding any provision (or proposed provision) of this title;

(D) commenced, caused to be commenced, or is about to commence or cause to be commenced a proceeding under this title;

(E) testified or is about to testify in any such proceeding; or

(F) assisted or participated or is about to assist or participate in any manner in such a proceeding or in any other manner in such a proceeding or in any other action to carry out the purposes of this title.

(2) ENFORCEMENT ACTION.—Any employee covered by this section who alleges discrimination by an employer in violation of paragraph (1) may bring an action, subject to the statute of limitations in the anti-retaliation provisions of the False Claims Act and the rules and procedures, legal burdens of proof, and remedies applicable under the employee protections provisions of the Surface Transportation Assistance Act.

(3) APPLICATION.—

(A) Nothing in this subsection shall be construed to diminish the rights, privileges, or remedies of any employee under any Federal or

State law or regulation, including the rights and remedies against retaliatory action under the False Claims Act (31 U.S.C. 3730(h)), or under any collective bargaining agreement. The rights and remedies in this section may not be waived by any agreement, policy, form, or condition of employment.

(B) Nothing in this subsection shall be construed to preempt or diminish any other Federal or State law or regulation against discrimination, demotion, discharge, suspension, threats, harassment, reprimand, retaliation, or any other manner of discrimination, including the rights and remedies against retaliatory action under the False Claims Act (31 U.S.C. 3730(h)).

(4) DEFINITIONS.—In this subsection:

(A) EMPLOYER.—The term ''employer'' means any person engaged in profit or nonprofit business or industry, including one or more individuals, partnerships, associations, corporations, trusts, professional membership organization including a certification, disciplinary, or other professional body, unincorporated organizations, nongovernmental organizations,

or trustees, and subject to liability for violating the provisions of this Act.

(B) EMPLOYEE.—The term ''employee'' means any individual performing activities under this Act on behalf of an employer.

SEC. 302. QUALIFICATIONS FOR PROVIDERS.

(a) IN GENERAL.—A health care provider is considered to be qualified to furnish covered items and services under this Act if the provider is licensed or certified to furnish such items and services in the State in which the individual receiving such items or services is located and meets—

(1) the requirements of such State's law to furnish such items and services; and

(2) applicable requirements of Federal law to furnish such items and services.

(b) LIMITATION.—An entity or provider shall not be qualified to furnish covered items and services under this Act if the entity or provider provides no items and services directly to individuals, including—

(1) entities or providers that contract with other entities or providers to provide such items and services; and

(2) entities that are currently approved to coordinate care plans under the Medicare Advantage

program established in part C of title XVIII of the Social Security Act (42 U.S.C. 1851 et seq.) but do not directly provide items and services of such care plans.

(c) MINIMUM PROVIDER STANDARDS.—

(1) IN GENERAL.—The Secretary shall establish, evaluate, and update national minimum standards to ensure the quality of items and services provided under this Act and to monitor efforts by States to ensure the quality of such items and services. A State may establish additional minimum standards which providers shall meet with respect to items and services provided in such State.

(2) NATIONAL MINIMUM STANDARDS.—The Secretary shall establish national minimum standards under paragraph (1) for institutional providers of services and individual health care practitioners. Except as the Secretary may specify in order to carry out this Act, a hospital, skilled nursing facility, or other institutional provider of services shall meet standards applicable to such a provider under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). Such standards also may include, where appropriate, elements relating to—

(A) adequacy and quality of facilities;

(B) mandatory minimum safe registered nurse-to-patient staffing ratios and optimal staffing levels for physicians and other health care practitioners;

(C) training and competence of personnel (including requirements related to the number of or type of required continuing education hours);

(D) comprehensiveness of service;

(E) continuity of service;

(F) patient waiting time, access to services, and preferences; and

(G) performance standards, including organization, facilities, structure of services, efficiency of operation, and outcome in palliation, improvement of health, stabilization, cure, or rehabilitation.

(3) TRANSITION IN APPLICATION.—If the Secretary provides for additional requirements for providers under this subsection, any such additional requirement shall be implemented in a manner that provides for a reasonable period during which a previously qualified provider is permitted to meet such an additional requirement.

(4) ABILITY TO PROVIDE SERVICES.—With respect to any entity or provider certified to provide items and services described in section 201(a)(7), the Secretary may not prohibit such entity or provider from participating for reasons other than such entity's or provider's ability to provide such items and services.

(d) FEDERAL PROVIDERS.—Any provider qualified to provide health care items and services through the Department of Veterans Affairs, the Indian Health Service, or the uniformed services (with respect to the direct care component of the TRICARE Program) is a qualifying provider under this section with respect to any individual who qualifies for such items and services under applicable Federal law.

SEC. 303. USE OF PRIVATE CONTRACTS.

(a) IN GENERAL.—This section shall apply beginning 2 years after the date of the enactment of this Act.

(b) PARTICIPATING PROVIDERS.—

(1) PRIVATE CONTRACTS FOR COVERED ITEMS AND SERVICES FOR ELIGIBLE INDIVIDUALS.—An institutional or individual provider with an agreement in effect under section 301 may not bill or enter into any private contract with any individual eligible for

benefits under the Act for any item or service that is a benefit under this Act.

(2) PRIVATE CONTRACTS FOR NONCOVERED ITEMS AND SERVICES FOR ELIGIBLE INDIVIDUALS.—An institutional or individual provider with an agreement in effect under section 301 may bill or enter into a private contract with an individual eligible for benefits under the Act for any item or service that is not a benefit under this Act only if—

(A) the contract and provider meet the requirements specified in paragraphs (3) and (4), respectively;

(B) such item or service is not payable or available under this Act; and

(C) the provider receives—

(i) no reimbursement under this Act directly or indirectly for such item or service, and

(ii) receives no amount for such item or service from an organization which receives reimbursement for such items or service under this Act directly or indirectly.

(3) CONTRACT REQUIREMENTS.—Any contract to provide items and services described in paragraph (2) shall—

(A) be in writing and signed by the individual (or authorized representative of the individual) receiving the item or service before the item or service is furnished pursuant to the contract;

(B) not be entered into at a time when the individual is facing an emergency health care situation; and

(C) clearly indicate to the individual receiving such items and services that by signing such a contract the individual—

(i) agrees not to submit a claim (or to request that the provider submit a claim) under this Act for such items or services;

(ii) agrees to be responsible for payment of such items or services and understands that no reimbursement will be provided under this Act for such items or services;

(iii) acknowledges that no limits under this Act apply to amounts that may be charged for such items or services; and

(iv) acknowledges that the provider is providing services outside the scope of the program under this Act.

(4) AFFIDAVIT.—A participating provider who enters into a contract described in paragraph (2) shall have in effect during the period any item or service is to be provided pursuant to the contract an affidavit that shall—

(A) identify the provider who is to furnish such noncovered item or service, and be signed by such provider;

(B) state that the provider will not submit any claim under this Act for any noncovered item or service provided to any individual enrolled under this Act; and

(C) be filed with the Secretary no later than 10 days after the first contract to which such affidavit applies is entered into.

(5) ENFORCEMENT.—If a provider signing an affidavit described in paragraph (4) knowingly and willfully submits a claim under this title for any item or service provided or receives any reimbursement or amount for any such item or service provided pursuant to a private contract described in paragraph (2) with respect to such affidavit—

(A) any contract described in paragraph (2) shall be null and void;

(B) no payment shall be made under this title for any item or service furnished by the provider during the 2-year period beginning on the date the affidavit was signed; and

(C) any payment received under this title for any item or service furnished during such period shall be remitted.

(6) PRIVATE CONTRACTS FOR INELIGIBLE INDIVIDUALS.—An institutional or individual provider with an agreement in effect under section 301 may bill or enter into a private contract with any individual ineligible for benefits under the Act for any item or service.

(c) NONPARTICIPATING PROVIDERS.—

(1) PRIVATE CONTRACTS FOR COVERED ITEMS AND SERVICES FOR ELIGIBLE INDIVIDUALS.—An institutional or individual provider with no agreement in effect under section 301 may bill or enter into any private contract with any individual eligible for benefits under the Act for any item or service that is a benefit under this Act described in title II only if the contract and provider meet the requirements specified in paragraphs (2) and (3), respectively.

(2) ITEMS REQUIRED TO BE INCLUDED IN CONTRACT.—Any contract to provide items and services described in paragraph (1) shall—

(A) be in writing and signed by the individual (or authorized representative of the individual) receiving the item or service before the item or service is furnished pursuant to the contract;

(B) not be entered into at a time when the individual is facing an emergency health care situation; and

(C) clearly indicate to the individual receiving such items and services that by signing such a contract the individual—

(i) acknowledges that the individual has the right to have such items or services provided by other providers for whom payment would be made under this Act;

(ii) agrees not to submit a claim (or to request that the provider submit a claim) under this Act for such items or services even if such items or services are otherwise covered by this Act;

(iii) agrees to be responsible for payment of such items or services and under-

stands that no reimbursement will be provided under this Act for such items or services;

(iv) acknowledges that no limits under this Act apply to amounts that may be charged for such items or services; and

(v) acknowledges that the provider is providing services outside the scope of the program under this Act.

(3) AFFIDAVIT.—A provider who enters into a contract described in paragraph (1) shall have in effect during the period any item or service is to be provided pursuant to the contract an affidavit that shall—

(A) identify the provider who is to furnish such covered item or service, and be signed by such provider;

(B) state that the provider will not submit any claim under this Act for any covered item or service provided to any individual enrolled under this Act during the 2-year period beginning on the date the affidavit is signed; and

(C) be filed with the Secretary no later than 10 days after the first contract to which such affidavit applies is entered into.

(4) ENFORCEMENT.—If a provider signing an affidavit described in paragraph (3) knowingly and willfully submits a claim under this title for any item or service provided or receives any reimbursement or amount for any such item or service provided pursuant to a private contract described in paragraph (1) with respect to such affidavit—

(A) any contract described in paragraph (1) shall be null and void; and

(B) no payment shall be made under this title for any item or service furnished by the provider during the 2-year period beginning on the date the affidavit was signed.

(5) PRIVATE CONTRACTS FOR NONCOVERED ITEMS AND SERVICES FOR ANY INDIVIDUAL.—An institutional or individual provider with no agreement in effect under section 301 may bill or enter into a private contract with any individual for a item or service that is not a benefit under this Act.

TITLE IV—ADMINISTRATION

Subtitle A—General Administration Provisions

SEC. 401. ADMINISTRATION.

(a) GENERAL DUTIES OF THE SECRETARY.—

(1) IN GENERAL.—The Secretary shall develop policies, procedures, guidelines, and requirements to carry out this Act, including related to—

(A) eligibility for benefits;

(B) enrollment;

(C) benefits provided;

(D) provider participation standards and qualifications, as described in title III;

(E) levels of funding;

(F) methods for determining amounts of payments to providers of covered items and services, consistent with subtitle B;

(G) a process for appealing or petitioning for a determination of coverage or noncoverage of items and services under this Act;

(H) planning for capital expenditures and service delivery;

(I) planning for health professional education funding;

(J) encouraging States to develop regional planning mechanisms; and

(K) any other regulations necessary to carry out the purposes of this Act.

(2) REGULATIONS.—Regulations authorized by this Act shall be issued by the Secretary in accordance with section 553 of title 5, United States Code.

(3) ACCESSIBILITY.—The Secretary shall have the obligation to ensure the timely and accessible provision of items and services that all eligible individuals are entitled to under this Act.

(b) UNIFORM REPORTING STANDARDS; ANNUAL REPORT; STUDIES.—

(1) UNIFORM REPORTING STANDARDS.—

(A) IN GENERAL.—The Secretary shall establish uniform State reporting requirements and national standards to ensure an adequate national database containing information pertaining to health services practitioners, approved providers, the costs of facilities and practitioners providing items and services, the quality of such items and services, the outcomes of such items and services, and the equity of health among population groups. Such database shall include, to the maximum extent feasible

without compromising patient privacy, health outcome measures used under this Act, and to the maximum extent feasible without excessively burdening providers, a description of the standards and qualifications, levels of finding, and methods described in subparagraphs (D) through (F) of subsection (a)(1).

(B) REQUIRED DATA DISCLOSURES.—In establishing reporting requirements and standards under subparagraph (A), the Secretary shall require a provider with an agreement in effect under section 301 to disclose to the Secretary, in a time and manner specified by the Secretary, the following (as applicable to the type of provider):

(i) Any data the provider is required to report or does report to any State or local agency, or, as of January 1, 2019, to the Secretary or any entity that is part of the Department of Health and Human Services, except data that are required under the programs terminated in section 903.

(ii) Annual financial data that includes information on employees (including

the number of employees, hours worked, and wage information) by job title and by each patient care unit or department within each facility (including outpatient units or departments); the number of registered nurses per staffed bed by each such unit or department; information on the dollar value and annual spending (including purchases, upgrades, and maintenance) for health information technology; and risk-adjusted and raw patient outcome data (including data on medical, surgical, obstetric, and other procedures).

(C) REPORTS.—The Secretary shall regularly analyze information reported to the Secretary and shall define rules and procedures to allow researchers, scholars, health care providers, and others to access and analyze data for purposes consistent with quality and outcomes research, without compromising patient privacy.

(2) ANNUAL REPORT.—Beginning 2 years after the date of the enactment of this Act, the Secretary shall annually report to Congress on the following:

(A) The status of implementation of the Act.

(B) Enrollment under this Act.

(C) Benefits under this Act.

(D) Expenditures and financing under this Act.

(E) Cost-containment measures and achievements under this Act.

(F) Quality assurance.

(G) Health care utilization patterns, including any changes attributable to the program.

(H) Changes in the per-capita costs of health care.

(I) Differences in the health status of the populations of the different States, including by racial, ethnic, national origin, primary language use, age, disability, sex, including gender identity and sexual orientation, geographical, and income characteristics;

(J) Progress on quality and outcome measures, and long-range plans and goals for achievements in such areas.

(K) Plans for improving service to medically underserved populations.

(L) Transition problems as a result of implementation of this Act.

(M) Opportunities for improvements under this Act.

(3) STATISTICAL ANALYSES AND OTHER STUDIES.—The Secretary may, either directly or by contract—

(A) make statistical and other studies, on a nationwide, regional, State, or local basis, of any aspect of the operation of this Act;

(B) develop and test methods of delivery of items and services as the Secretary may consider necessary or promising for the evaluation, or for the improvement, of the operation of this Act; and

(C) develop methodological standards for policymaking.

(c) AUDITS.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct an audit of the Department of Health and Human Services every fifth fiscal year following the effective date of this Act to determine the effectiveness of the program in carrying out the duties under subsection (a).

(2) REPORTS.—The Comptroller General of the United States shall submit a report to Congress concerning the results of each audit conducted under this subsection.

SEC. 402. CONSULTATION.

The Secretary shall consult with Federal agencies, Indian tribes and urban Indian health organizations, and private entities, such as labor organizations representing health care workers, professional societies, national associations, nationally recognized associations of health care experts, medical schools and academic health centers, consumer groups, and business organizations in the formulation of guidelines, regulations, policy initiatives, and information gathering to ensure the broadest and most informed input in the administration of this Act. Nothing in this Act shall prevent the Secretary from adopting guidelines, consistent with the provisions of section 203(c), developed by such a private entity if, in the Secretary's judgment, such guidelines are generally accepted as reasonable and prudent and consistent with this Act.

SEC. 403. REGIONAL ADMINISTRATION.

(a) COORDINATION WITH REGIONAL OFFICES.—The Secretary shall establish and maintain regional offices for purposes of carrying out the duties specified in subsection (c) and promoting adequate access to, and efficient use

of, tertiary care facilities, equipment, and services by individuals enrolled under this Act. Wherever possible, the Secretary shall incorporate regional offices of the Centers for Medicare & Medicaid Services for this purpose.

(b) APPOINTMENT OF REGIONAL DIRECTORS.—In each such regional office there shall be—

(1) one regional director appointed by the Secretary;

(2) one deputy director appointed by the regional director to represent the Indian and Alaska Native tribes in the region, if any; and

(3) one deputy direction appointed by the regional director to oversee long-term services and supports.

(c) REGIONAL OFFICE DUTIES.—Each regional director shall—

(1) provide an annual health care needs assessment with respect to the region under the director's jurisdiction to the Secretary after a thorough examination of health needs and in consultation with public health officials, clinicians, patients, and patient advocates;

(2) recommend any changes in provider reimbursement or payment for delivery of health services

determined appropriate by the regional director, subject to the provisions of title VI; and

(3) establish a quality assurance mechanism in each such region in order to minimize both underutilization and overutilization of health care items and services and to ensure that all providers meet quality standards established pursuant to this Act.

SEC. 404. BENEFICIARY OMBUDSMAN.

(a) IN GENERAL.—The Secretary shall appoint a Beneficiary Ombudsman who shall have expertise and experience in the fields of health care and education of, and assistance to, individuals enrolled under this Act.

(b) DUTIES.—The Beneficiary Ombudsman shall—

(1) receive complaints, grievances, and requests for information submitted by individuals enrolled under this Act or eligible to enroll under this Act with respect to any aspect of the Medicare for All Program;

(2) provide assistance with respect to complaints, grievances, and requests referred to in paragraph (1), including assistance in collecting relevant information for such individuals, to seek an appeal of a decision or determination made by a regional office or the Secretary; and

(3) submit annual reports to Congress and the Secretary that describe the activities of the Ombudsman and that include such recommendations for improvement in the administration of this Act as the Ombudsman determines appropriate. The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment or coverage policies.

SEC. 405. CONDUCT OF RELATED HEALTH PROGRAMS.

In performing functions with respect to health personnel education and training, health research, environmental health, disability insurance, vocational rehabilitation, the regulation of food and drugs, and all other matters pertaining to health, the Secretary shall direct the activities of the Department of Health and Human Services toward contributions to the health of the people complementary to this Act.

Subtitle B—Control Over Fraud and Abuse

SEC. 411. APPLICATION OF FEDERAL SANCTIONS TO ALL FRAUD AND ABUSE UNDER THE MEDICARE FOR ALL PROGRAM.

The following sections of the Social Security Act shall apply to this Act in the same manner as they apply to

title XVIII or State plans under title XIX of the Social Security Act:

(1) Section 1128 (relating to exclusion of individuals and entities).

(2) Section 1128A (civil monetary penalties).

(3) Section 1128B (criminal penalties).

(4) Section 1124 (relating to disclosure of ownership and related information).

(5) Section 1126 (relating to disclosure of certain owners).

(6) Section 1877 (relating to physician referrals).

TITLE V—QUALITY ASSESSMENT

SEC. 501. QUALITY STANDARDS.

(a) IN GENERAL.—All standards and quality measures under this Act shall be implemented and evaluated by the Center for Clinical Standards and Quality of the Centers for Medicare & Medicaid Services (referred to in this title as the ''Center'') or such other agency determined appropriate by the Secretary, in coordination with the Agency for Healthcare Research and Quality and other offices of the Department of Health and Human Services.

(b) DUTIES OF THE CENTER.—The Center shall perform the following duties:

(1) Review and evaluate each practice guideline developed under part B of title IX of the Public Health Service Act. In so reviewing and evaluating, the Center shall determine whether the guideline should be recognized as a national practice guideline in accordance with and subject to the provisions of section 203(c).

(2) Review and evaluate each standard of quality, performance measure, and medical review criterion developed under part B of title IX of the Public Health Service Act (42 U.S.C. 299 et seq.). In so reviewing and evaluating, the Center shall determine whether the standard, measure, or criterion is appropriate for use in assessing or reviewing the quality of items and services provided by health care institutions or health care professionals. The use of mechanisms that discriminate against people with disabilities is prohibited for use in any value or cost-effectiveness assessments. The Center shall consider the evidentiary basis for the standard, and the validity, reliability, and feasibility of measuring the standard.

(3) Adoption of methodologies for profiling the patterns of practice of health care professionals and for identifying and notifying outliers.

(4) Development of minimum criteria for competence for entities that can qualify to conduct ongoing and continuous external quality reviews in the administrative regions. Such criteria shall require such an entity to be administratively independent of the individual or board that administers the region and shall ensure that such entities do not provide financial incentives to reviewers to favor one pattern of practice over another. The Center shall ensure coordination and reporting by such entities to ensure national consistency in quality standards.

(5) Submission of a report to the Secretary annually specifically on findings from outcomes research and development of practice guidelines that may affect the Secretary's determination of coverage of services under section 401(a)(1)(G).

SEC. 502. ADDRESSING HEALTH CARE DISPARITIES.

(a) EVALUATING DATA COLLECTION APPROACHES.—The Center shall evaluate approaches for the collection of data under this Act, to be performed in conjunction with existing quality reporting requirements and programs under this Act, that allow for the ongoing, accurate, and timely collection of data on disparities in health care services and performance on the basis of race, ethnicity, national origin, primary language use, age, dis-

ability, sex (including gender identity and sexual orientation), geography, or socioeconomic status. In conducting such evaluation, the Center shall consider the following objectives:

(1) Protecting patient privacy.

(2) Minimizing the administrative burdens of data collection and reporting on providers under this Act.

(3) Improving data on race, ethnicity, national origin, primary language use, age, disability, sex (including gender identity and sexual orientation), geography, and socioeconomic status.

(b) REPORTS TO CONGRESS.—

(1) REPORT ON EVALUATION.—Not later than 18 months after the date on which benefits first become available as described in section 106(a), the Center shall submit to Congress and the Secretary a report on the evaluation conducted under subsection (a). Such report shall, taking into consideration the results of such evaluation—

(A) identify approaches (including defining methodologies) for identifying and collecting and evaluating data on health care disparities on the basis of race, ethnicity, national origin, primary language use, age, disability, sex (in-

cluding gender identity and sexual orientation), geography, or socioeconomic status under the Medicare for All Program; and

(B) include recommendations on the most effective strategies and approaches to reporting quality measures, as appropriate, on the basis of race, ethnicity, national origin, primary language use, age, disability, sex (including gender identity and sexual orientation), geography, or socioeconomic status.

(2) REPORT ON DATA ANALYSES.—Not later than 4 years after the submission of the report under subsection (b)(1), and every 4 years thereafter, the Center shall submit to Congress and the Secretary a report that includes recommendations for improving the identification of health care disparities based on the analyses of data collected under subsection (c).

(c) IMPLEMENTING EFFECTIVE APPROACHES.—Not later than 2 years after the date on which benefits first become available as described in section 106(a), the Secretary shall implement the approaches identified in the report submitted under subsection (b)(1) for the ongoing, accurate, and timely collection and evaluation of data on health care disparities on the basis of race, ethnicity, na-

tional origin, primary language use, age, disability, sex (including gender identity and sexual orientation), geography, or socioeconomic status.

TITLE VI—HEALTH BUDGET; PAYMENTS; COST CONTAINMENT MEASURES

Subtitle A—Budgeting

SEC. 601. NATIONAL HEALTH BUDGET.

(a) NATIONAL HEALTH BUDGET.—

(1) IN GENERAL.—By not later than September 1 of each year, beginning with the year prior to the date on which benefits first become available as described in section 106(a), the Secretary shall establish a national health budget, which specifies a budget for the total expenditures to be made for covered health care items and services under this Act.

(2) DIVISION OF BUDGET INTO COMPONENTS.—The national health budget shall consist of the following components:

(A) An operating budget.

(B) A capital expenditures budget.

(C) A special projects budget.

(D) Quality assessment activities under title V.

(E) Health professional education expenditures.

(F) Administrative costs, including costs related to the operation of regional offices.

(G) A reserve fund.

(H) Prevention and public health activities.

(3) ALLOCATION AMONG COMPONENTS.—The Secretary shall allocate the funds received for purposes of carrying out this Act among the components described in paragraph (2) in a manner that ensures—

(A) that the operating budget allows for every participating provider in the Medicare for All Program to meet the needs of their respective patient populations;

(B) that the special projects budget is sufficient to meet the health care needs within areas described in paragraph (2)(C) through the construction, renovation, and staffing of health care facilities in a reasonable timeframe;

(C) a fair allocation for quality assessment activities; and

(D) that the health professional education expenditure component is sufficient to provide for the amount of health professional education

expenditures sufficient to meet the need for covered health care services.

(4) REGIONAL ALLOCATION.—The Secretary shall annually provide each regional office with an allotment the Secretary determines appropriate for purposes of carrying out this Act in such region, including payments to providers in such region, capital expenditures in such region, special projects in such region, health professional education in such region, administrative expenses in such region, and prevention and public health activities in such region.

(5) OPERATING BUDGET.—The operating budget described in paragraph (2)(A) shall be used for—

(A) payments to institutional providers pursuant to section 611; and

(B) payments to individual providers pursuant to section 612.

(6) CAPITAL EXPENDITURES BUDGET.—The capital expenditures budget described in paragraph (2)(B) shall be used for—

(A) the construction or renovation of health care facilities, excluding congregate or segregated facilities for individuals with disabilities who receive long-term care services and support; and

(B) major equipment purchases.

(7) SPECIAL PROJECTS BUDGET.—The special projects budget described in paragraph (2)(C) shall be used for the purposes of allocating funds for the construction of new facilities, major equipment purchases, and staffing in rural or medically underserved areas (as defined in section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3))), including areas designated as health professional shortage areas (as defined in section 332(a) of the Public Health Service Act (42 U.S.C. 254e(a))), and to address health disparities, including racial, ethnic, national origin, primary language use, age, disability, sex (including gender identity and sexual orientation), geography, or socioeconomic health disparities.

(8) TEMPORARY WORKER ASSISTANCE.—

(A) IN GENERAL.—For up to 5 years following the date on which benefits first become available as described in section 106(a), at least 1 percent of the budget shall be allocated to programs providing assistance to workers who perform functions in the administration of the health insurance system, or related functions within health care institutions or organizations

who may be affected by the implementation of this Act and who may experience economic dislocation as a result of the implementation of this Act.

(B) CLARIFICATION.—Assistance described in subparagraph (A) shall include wage replacement, retirement benefits, job training and placement, preferential hiring, and education benefits.

(9) RESERVE FUND.—The reserve fund described in paragraph (2)(G) shall be used to respond to the costs of an epidemic, pandemic, natural disaster, or other such health emergency, or market-shift adjustments related to patient volume.

(10) SUPPLEMENTAL INDIAN HEALTH SERVICE ALLOCATION.—The Secretary shall annually determine the need to provide an allotment of supplemental funds to Indian Health Services, including payments to providers, capital expenditures, special projects, health professional education, administrative expenses, and prevention and public health activities.

(b) DEFINITIONS.—In this section:

(1) CAPITAL EXPENDITURES.—The term ''capital expenditures'' means expenses for the purchase,

lease, construction, or renovation of capital facilities and for major equipment.

(2) HEALTH PROFESSIONAL EDUCATION EXPENDITURES.—The term ''health professional education expenditures'' means expenditures in hospitals and other health care facilities to cover costs associated with teaching and related research activities, including the impact of workforce diversity on patient outcomes.

Subtitle B—Payments to Providers

SEC. 611. PAYMENTS TO INSTITUTIONAL PROVIDERS BASED ON GLOBAL BUDGETS.

(a) IN GENERAL.—Not later than the beginning of each fiscal quarter during which an institutional provider of care (including hospitals, skilled nursing facilities, Federally qualified health centers, and independent dialysis facilities) is to furnish items and services under this Act, the Secretary shall pay to such institutional provider a lump sum in accordance with the succeeding provisions of this subsection and consistent with the following:

(1) PAYMENT IN FULL.—Such payment shall be considered as payment in full for all operating expenses for items and services furnished under this Act, whether inpatient or outpatient, by such provider for such quarter, including outpatient or any

other care provided by the institutional provider or provided by any health care provider who provided items and services pursuant to an agreement paid through the global budget as described in paragraph (3).

(2) QUARTERLY REVIEW.—The regional director, on a quarterly basis, shall review whether requirements of the institutional provider's participation agreement and negotiated global budget have been performed and shall determine whether adjustments to such institutional provider's payment are warranted. This review shall include consideration for additional funding necessary for unanticipated items and services for individuals with complex medical needs or market-shift adjustments related to patient volume. The review shall also include an assessment of any adjustments made to ensure that accuracy and need for adjustment was appropriate.

(3) AGREEMENTS FOR SALARIED PAYMENTS FOR CERTAIN PROVIDERS.—Certain group practices and other health care providers, as determined by the Secretary, with agreements to provide items and services at a specified institutional provider paid a global budget under this subsection may elect to be paid through such institutional provider's global

budget in lieu of payment under section 612 of this title. Any—

(A) individual health care professional of such group practice or other provider receiving payment through an institutional provider's global budget shall be paid on a salaried basis that is equivalent to salaries or other compensation rates negotiated for individual health care professionals of such institutional provider; and

(B) any group practice or other health care provider that receives payment through an institutional provider global budget under this paragraph shall be subject to the same reporting and disclosure requirements of the institutional provider.

(4) INTERIM ADJUSTMENTS.—The regional director shall consider a petition for adjustment of any payment under this section filed by an institutional provider at any time based on the following:

(A) Factors that led to increased costs for the institutional provider that can reasonably be considered to be unanticipated and out of the control of the institutional provider, such as—

(i) natural disasters;

(ii) outbreaks of epidemics or infectious diseases;

(iii) unexpected facility or equipment repairs or purchases;

(iv) significant and unexpected increases in pharmaceutical or medical device prices; and

(v) unanticipated increases in complex or high-cost patients or care needs.

(B) Changes in Federal or State law that result in a change in costs.

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

(b) PAYMENT AMOUNT.—

(1) IN GENERAL.—The amount of each payment to a provider described in subsection (a) shall be determined before the start of each fiscal year through negotiations between the provider and the regional director with jurisdiction over such provider. Such amount shall be based on factors specified in paragraph (2).

(2) PAYMENT FACTORS.—Payments negotiated pursuant to paragraph (1) shall take into account, with respect to a provider—

(A) the historical volume of services provided for each item and services in the previous 3-year period;

(B) the actual expenditures of such provider in such provider's most recent cost report under title XVIII of the Social Security Act for each item and service compared to—

(i) such expenditures for other institutional providers in the director's jurisdiction; and

(ii) normative payment rates established under comparative payment rate systems, including any adjustments, for such items and services;

(C) projected changes in the volume and type of items and services to be furnished;

(D) wages for employees, including any necessary increases mandatory minimum safe registered nurse-to-patient ratios and optimal staffing levels for physicians and other health care workers;

(E) the provider's maximum capacity to provide items and services;

(F) education and prevention programs;

(G) permissible adjustment to the provider's operating budget due to factors such as—

(i) an increase in primary or specialty care access;

(ii) efforts to decrease health care disparities in rural or medically underserved areas;

(iii) a response to emergent epidemic conditions;

(iv) an increase in complex or high-cost patients or care needs; or

(v) proposed new and innovative patient care programs at the institutional level;

(H) whether the provider is located in a high social vulnerability index community, zip code, or census track, or is a minority-serving provider; and

(I) any other factor determined appropriate by the Secretary.

(3) LIMITATION.—Payment amounts negotiated pursuant to paragraph (1) may not—

(A) take into account capital expenditures of the provider or any other expenditure not directly associated with the provision of items and services by the provider to an individual;

(B) be used by a provider for capital expenditures or such other expenditures;

(C) exceed the provider's capacity to provide care under this Act; or

(D) be used to pay or otherwise compensate any board member, executive, or administrator of the institutional provider who has any interest or relationship prohibited under section 301(b)(2) of this Act or disclosed under section 301 of this Act.

(4) LIMITATION ON COMPENSATION.—Compensation costs for any employee or any contractor or any subcontractor employee of an institutional provider receiving global budgets under this section shall meet the compensation cap established in section 702 of the Bipartisan Budget Act of 2013 (41 U.S.C. 4304(a)(16)) and implementing regulations.

(5) REGIONAL NEGOTIATIONS PERMITTED.—Subject to section 614, a regional director may nego-

tiate changes to an institutional provider's global budget, including any adjustments to address unforeseen market-shifts related to patient volume.

(c) BASELINE RATES AND ADJUSTMENTS.—

(1) IN GENERAL.—The Secretary shall use existing prospective payment systems under title XVIII of the Social Security Act to serve as the comparative payment rate system in global budget negotiations described in subsection (b). The Secretary shall update such comparative payment rate systems annually.

(2) SPECIFICATIONS.—In developing the comparative payment rate system, the Secretary shall use only the operating base payment rates under each such prospective payment systems with applicable adjustments.

(3) LIMITATION.—The comparative rate system established under this subsection shall not include the value-based payment adjustments and the capital expenses base payment rates that may be included in such a prospective payment system.

(4) INITIAL YEAR.—In the first year that global budget payments under this Act are available to institutional providers and for purposes of selecting a comparative payment rate system used during initial

global budget negotiations for each institutional provider, the Secretary shall take into account the appropriate prospective payment system from the most recent year under title XVIII of the Social Security Act to determine what operating base payment the institutional provider would have been paid for covered items and services furnished the preceding year with applicable adjustments, excluding value-based payment adjustments, based on such prospective payment system.

(d) OPERATING EXPENSES.—For purposes of this title, ''operating expenses'' of a provider include the following:

(1) The cost of all items and services associated with the provision of inpatient care and outpatient care, including the following:

(A) Wages and salary costs for physicians, nurses, and other health care practitioners employed by an institutional provider, including mandatory minimum safe registered nurse-to-patient staffing ratios and optimal staffing levels for physicians and other healthcare workers.

(B) Wages and salary costs for all ancillary staff and services.

(C) Costs of all pharmaceutical products administered by health care clinicians at the institutional provider's facilities or through services provided in accordance with State licensing laws or regulations under which the institutional provider operates.

(D) Costs for infectious disease response preparedness, including maintenance of a 1-year or 365-day stockpile of personal protective equipment, occupational testing and surveillance, medical services for occupational infectious disease exposure, and contact tracing.

(E) Purchasing and maintenance of medical devices, supplies, and other health care technologies, including diagnostic testing equipment.

(F) Costs of all incidental services necessary for safe patient care and handling.

(G) Costs of patient care, education, and prevention programs, including occupational health and safety programs, public health programs, and necessary staff to implement such programs, for the continued education and health and safety of clinicians and other individuals employed by the institutional provider.

(2) Administrative costs for the institutional provider.

SEC. 612. PAYMENT TO INDIVIDUAL PROVIDERS THROUGH FEE-FOR-SERVICE.

(a) IN GENERAL.—In the case of a provider not described in section 611(a) (including those in group practices who are not receiving payment on a salaried basis described in section 611(a)(3) and providers of home and community-based services), payment for items and services furnished under this Act for which payment is not otherwise made under section 611 shall be made by the Secretary in amounts determined under the fee schedule established pursuant to subsection (b). Such payment shall be considered to be payment in full for such items and services, and a provider receiving such payment may not charge the individual receiving such item or service in any amount.

(b) FEE SCHEDULE.—

(1) ESTABLISHMENT.—Not later than 1 year after the date of the enactment of this Act, and in consultation with providers and regional office directors, the Secretary shall establish a national fee schedule for items and services payable under this Act. The Secretary shall evaluate the effectiveness of

the fee-for-service structure and update such fee schedule annually.

(2) AMOUNTS.—In establishing payment amounts for items and services under the fee schedule established under paragraph (1), the Secretary shall take into account—

(A) the amounts payable for such items and services under title XVIII of the Social Security Act; and

(B) the expertise of providers and value of items and services furnished by such providers.

(c) ELECTRONIC BILLING.—The Secretary shall establish a uniform national system for electronic billing for purposes of making payments under this subsection.

(d) PHYSICIAN PRACTICE REVIEW BOARD.—Each director of a regional office, in consultation with representatives of physicians practicing in that region, shall establish and appoint a physician practice review board to assure quality, cost effectiveness, and fair reimbursements for physician-delivered items and services. The use of mechanisms that discriminate against people with disabilities is prohibited for use in any value or cost-effectiveness assessments.

SEC. 613. ENSURING ACCURATE VALUATION OF SERVICES UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE.

(a) STANDARDIZED AND DOCUMENTED REVIEW PROCESS.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)) is amended by adding at the end the following new subparagraph:

''(P) STANDARDIZED AND DOCUMENTED REVIEW PROCESS.—

''(i) IN GENERAL.—Not later than one year after the date of enactment of this subparagraph, the Secretary shall establish, document, and make publicly available, in consultation with the Office of Primary Health Care, a standardized process for reviewing the relative values of physicians' services under this paragraph.

''(ii) MINIMUM REQUIREMENTS.—The standardized process shall include, at a minimum, methods and criteria for identifying services for review, prioritizing the review of services, reviewing stakeholder recommendations, and identifying additional resources to be considered during the review process.''.

(b) PLANNED AND DOCUMENTED USE OF FUNDS.—Section 1848(c)(2)(M) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(M)) is amended by adding at the end the following new clause:

"(x) PLANNED AND DOCUMENTED USE OF FUNDS.—For each fiscal year (beginning with the first fiscal year beginning on or after the date of enactment of this clause), the Secretary shall provide to Congress a written plan for using the funds provided under clause (ix) to collect and use information on physicians' services in the determination of relative values under this subparagraph.".

(c) INTERNAL TRACKING OF REVIEWS.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to Congress a proposed plan for systematically and internally tracking the Secretary's review of the relative values of physicians' services, such as by establishing an internal database, under section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)), as amended by this section.

(2) MINIMUM REQUIREMENTS.—The proposal shall include, at a minimum, plans and a timeline

for achieving the ability to systematically and internally track the following:

(A) When, how, and by whom services are identified for review.

(B) When services are reviewed or reviewed or when new services are added.

(C) The resources, evidence, data, and recommendations used in reviews.

(D) When relative values are adjusted.

(E) The rationale for final relative value decisions.

(d) FREQUENCY OF REVIEW.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)) is amended—

(1) in subparagraph (B)(i), by striking ''5'' and inserting ''4''; and

(2) in subparagraph (K)(i)(I), by striking ''periodically'' and inserting ''annually''.

(e) CONSULTATION WITH MEDICARE PAYMENT ADVISORY COMMISSION.—

(1) IN GENERAL.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)) is amended—

(A) in subparagraph (B)(i), by inserting ''in consultation with the Medicare Payment

Advisory Commission,'' after ''The Secretary,'';
and

(B) in subparagraph (K)(i)(I), as amended by subsection (d)(2), by inserting '', in coordination with the Medicare Payment Advisory Commission,'' after ''annually''.

(2) CONFORMING AMENDMENTS.—Section 1805 of the Social Security Act (42 U.S.C. 1395b–6) is amended—

(A) in subsection (b)(1)(A), by inserting the following before the semicolon at the end: ''and including coordinating with the Secretary in accordance with section 1848(c)(2) to systematically review the relative values established for physicians' services, identify potentially misvalued services, and propose adjustments to the relative values for physicians' services''; and

(B) in subsection (e)(1), in the second sentence, by inserting ''or the Ranking Minority Member'' after ''the Chairman''.

(f) PERIODIC AUDIT BY THE COMPTROLLER GENERAL.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)), as amended by subsection (a), is amended by adding at the end the following new subparagraph:

"(Q) PERIODIC AUDIT BY THE COMPTROLLER GENERAL.—

"(i) IN GENERAL.—The Comptroller General of the United States (in this subsection referred to as the 'Comptroller General') shall periodically audit the review by the Secretary of relative values established under this paragraph for physicians' services.

"(ii) ACCESS TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and data related to the activities carried out under this paragraph, in a timely manner, upon request.".

SEC. 614. PAYMENT PROHIBITIONS; CAPITAL EXPENDITURES; SPECIAL PROJECTS.

(a) SENSE OF CONGRESS.—It is the sense of Congress that tens of millions of people in the United States do not receive healthcare services while billions of dollars that could be spent on providing health care are diverted to profit. There is a moral imperative to correct the massive deficiencies in our current health system and to eliminate profit from the provision of health care.

(b) PROHIBITIONS.—Payments to providers under this Act may not take into account, include any process for the provision of funding for, or be used by a provider for—

(1) marketing of the provider;

(2) the profit or net revenue of the provider, or increasing the profit or net revenue of the provider;

(3) incentive payments, bonuses, or other compensation based on patient utilization of items and services or any financial measure applied with respect to the provider (or any group practice, integrated health care delivery system, or other provider with which the provider contracts or has a pecuniary interest), including any value-based payment or employment-based compensation;

(4) any agreement or arrangement described in section 203(a)(4) of the Labor-Management Reporting and Disclosure Act of 1959 (29 U.S.C. 433(a)(4)); or

(5) political or contributions prohibited under section 317 of the Federal Elections Campaign Act of 1971 (52 U.S.C. 30119(a)(1)).

(c) PAYMENTS FOR CAPITAL EXPENDITURES.—

(1) IN GENERAL.—The Secretary shall pay, from amounts made available for capital expendi-

tures pursuant to section 601(a)(2)(B), such sums determined appropriate by the Secretary to providers who have submitted an application to the regional director of the region or regions in which the provider operates or seeks to operate in a time and manner specified by the Secretary for purposes of funding capital expenditures of such providers.

(2) PRIORITY.—The Secretary shall prioritize allocation of funding under paragraph (1) to projects that propose to use such funds to improve service in a medically underserved area (as defined in section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3))) or to address health disparities, including racial, ethnic, national origin, primary language use, age, disability, sex (including gender identity and sexual orientation), geography, or socioeconomic health disparities.

(3) LIMITATION.—The Secretary shall not grant funding for capital expenditures under this subsection for capital projects that are financed directly or indirectly through the diversion of private or other non-Medicare for All Program funding that results in reductions in care to patients, including reductions in registered nursing staffing patterns

and changes in emergency room or primary care services or availability.

(4) CAPITAL ASSETS NOT FUNDED BY THE MEDICARE FOR ALL PROGRAM.—Operating expenses and funds shall not be used by an institutional provider receiving payment for capital expenditures under this subsection for a capital asset that was not funded by the Medicare for All program without the approval of the regional director or directors of the region or regions where the capital asset is located.

(d) PROHIBITION AGAINST CO-MINGLING OPERATING AND CAPITAL FUNDS.—Providers that receive payment under this title shall be prohibited from using, with respect to funds made available under this Act—

(1) funds designated for operating expenditures for capital expenditures or for profit; or

(2) funds designated for capital expenditures for operating expenditures.

(e) PAYMENTS FOR SPECIAL PROJECTS.—

(1) IN GENERAL.—The Secretary shall allocate to each regional director, from amounts made available for special projects pursuant to section 601(a)(2)(C), such sums determined appropriate by the Secretary for purposes of funding projects de-

scribed in such section, including the construction, renovation, or staffing of health care facilities, in rural, underserved, or health professional or medical shortage areas within such region and to address health disparities, including racial, ethnic, national origin, primary language use, age, disability, sex, including gender identity and sexual orientation, geography, or socioeconomic health disparities. Each regional director shall, prior to distributing such funds in accordance with paragraph (2), present a budget describing how such funds will be distributed to the Secretary.

(2) DISTRIBUTION.—A regional director shall distribute funds to providers operating in the region of such director's jurisdiction in a manner determined appropriate by the director.

(f) PROHIBITION ON FINANCIAL INCENTIVE METRICS IN PAYMENT DETERMINATIONS.—The Secretary may not utilize any quality metrics or standards for the purposes of establishing provider payment methodologies, programs, modifiers, or adjustments for provider payments under this title.

SEC. 615. OFFICE OF HEALTH EQUITY.

Title XVII of the Public Health Service Act (42 U.S.C. 300u et seq.) is amended by adding at the end the following:

"SEC. 1712. OFFICE OF HEALTH EQUITY.

"(a) IN GENERAL.—There is established, in the Office of the Secretary of Health and Human Services, an Office of Health Equity, to be headed by a Director, to ensure coordination and collaboration across the programs and activities of the Department of Health and Human Services with respect to ensuring health equity.

"(b) MONITORING, TRACKING, AND AVAILABILITY OF DATA.—

"(1) IN GENERAL.—In carrying out subsection (a), the Director of the Office of Health Equity shall monitor, track, and make publicly available data on—

"(A) the disproportionate burden of disease and death among people of color, disaggregated by race, major ethnic group, Tribal affiliation, national origin, primary language use, English proficiency status, immigration status, length of stay in the United States age, disability, sex (including gender identity and sexual orientation), incarceration, homelessness, geography, and socioeconomic status;

"(B) barriers to health, including such barriers relating to income, education, housing, food insecurity (including availability, access, utilization, and stability), employment status, working conditions, and conditions related to the physical environment (including pollutants and population density);

"(C) barriers to health care access, including—

"(i) lack of trust and awareness;

"(ii) lack of transportation;

"(iii) geography;

"(iv) hospital and service closures;

"(v) lack of health care infrastructure and facilities; and

"(vi) lack of health care professional staffing and recruitment;

"(D) disparities in quality of care received, including discrimination in health care settings and the use of racially-biased practice guidelines and algorithms; and

"(E) disparities in utilization of care.

"(2) ANALYSIS OF CROSS-SECTIONAL INFORMATION.—The Director of the Office of Health Equity shall ensure that the data collection and reporting

process under paragraph (1) allows for the analysis of cross-sectional information on people's identities.

"(c) POLICIES.—In carrying out subsection (a), the Director of the Office of Health Equity shall develop, coordinate, and promote policies that enhance health equity, including by—

"(1) providing recommendations on—

"(A) cultural competence, implicit bias, and ethics training with respect to health care workers;

"(B) increasing diversity in the health care workforce; and

"(C) ensuring sufficient health care professionals and facilities; and

"(2) ensuring adequate public health funding at the local and State levels to address health disparities.

"(d) CONSULTATION.—In carrying out subsection (a), the Director of the Office of Health Equity, in coordination with the Director of the Indian Health Service, shall consult with Indian Tribes and with Urban Indian organizations on data collection, reporting, and implementation of policies.

''(e) ANNUAL REPORT.—In carrying out subsection (a), the Director of the Office of Health Equity shall develop and publish an annual report on—

''(1) statistics collected by the Office;

''(2) proposed evidence-based solutions to mitigate health inequities; and

''(3) health care professional staffing levels and access to facilities.

''(f) CENTRALIZED ELECTRONIC REPOSITORY.—In carrying out subsection (a), the Director of the Office of Health Equity shall—

''(1) establish and maintain a centralized electronic repository to incorporate data collected across Federal departments and agencies on race, ethnicity, Tribal affiliation, national origin, primary language use, English proficiency status, immigration status, length of stay in the United States age, disability, sex (including gender identity and sexual orientation), incarceration, homelessness, geography, and socioeconomic status; and

''(2) make such data available for public use and analysis.

''(g) PRIVACY.—Notwithstanding any other Federal or State law, no Federal or State official or employee or other entity shall disclose, or use, for any law enforcement

or immigration purpose, any personally identifiable information (including with respect to an individual's religious beliefs, practices, or affiliation, national origin, ethnicity, or immigration status) that is collected or maintained pursuant to this section.''.

SEC. 616. OFFICE OF PRIMARY CARE.

Title XVII of the Public Health Service Act (42 U.S.C. 300u et seq.) is amended by adding at the end the following:

''SEC. 1713. OFFICE OF PRIMARY CARE.

''(a) IN GENERAL.—There is established, in the Office of Health Equity established under section 1712, an Office of Primary Health Care, to be headed by a Director, to ensure coordination and collaboration across the programs and activities of the Department of Health and Human Services with respect to increasing access to high-quality primary health care, particularly in underserved areas and for underserved populations.

''(b) NATIONAL GOALS.—Not later than 1 year after the date of enactment of this section, the Director of the Office of Primary Health Care shall publish national goals—

''(1) to increase access to high-quality primary health care, particularly in underserved areas and for underserved populations; and

''(2) to address health disparities, including with respect to race, ethnicity, national origin (disaggregated by major ethnic group and Tribal affiliation), primary language use, English proficiency status, immigration status, length of stay in the United States, age, disability, sex (including gender identity and sexual orientation), incarceration, homelessness, geography, and socioeconomic status.

''(c) OTHER RESPONSIBILITIES.—In carrying out subsections (a) and (b), the Director of the Office of Primary Health Care shall—

''(1) coordinate, in consultation with the Secretary, health professional education policies and goals to achieve the national goals published pursuant to subsection (b);

''(2) develop and maintain a system to monitor the number and specialties of individuals pursuing careers in, or practicing, primary health care through their health professional education, any postgraduate training, and professional practice;

''(3) develop, coordinate, and promote policies that expand the number of primary health care practitioners, registered nurses, mid-level practitioners, and dentists;

"(4) recommend appropriate training, technical assistance, and patient protection enhancements for primary care health professionals, including registered nurses, to achieve uniform high quality and patient safety;

"(5) provide recommendations on targeted programs and resources for Federally qualified health centers, rural health centers, community health centers, and other community-based organizations;

"(6) provide recommendations for broader patient referral to additional resources, not limited to health care, and collaboration with other organizations and sectors that influence health outcomes; and

"(7) consult with the Secretary on the allocation of the special projects budget under section 601(a)(2)(C) of the Medicare for All Act of 2021.

"(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed—

"(1) to preempt any provision of State law establishing practice standards or guidelines for health care professionals, including professional licensing or practice laws or regulations; or

''(2) to require that any State impose additional educational standards or guidelines for health care professionals.''.

SEC. 617. PAYMENTS FOR PRESCRIPTION DRUGS AND APPROVED DEVICES AND EQUIPMENT.

The prices to be paid for covered pharmaceuticals, medical supplies, medical technologies, and medically necessary equipment covered under this Act shall be negotiated annually by the Secretary.

(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary shall, for fiscal years beginning on or after the date of the enactment of this subsection, negotiate with pharmaceutical manufacturers the prices (including discounts, rebates, and other price concessions) that may be charged to the Medicare for All Program during a negotiated price period (as specified by the Secretary) for covered drugs for eligible individuals under the Medicare for All Program. In negotiating such prices under this section, the Secretary shall take into account the following factors:

(A) The comparative clinical effectiveness and cost effectiveness, when available from an impartial source, of such drug.

(B) The budgetary impact of providing coverage of such drug.

(C) The number of similarly effective drugs or alternative treatment regimens for each approved use of such drug.

(D) The total revenues from global sales obtained by the manufacturer for such drug and the associated investment in research and development of such drug by the manufacturer.

(2) FINALIZATION OF NEGOTIATED PRICE.—The negotiated price of each covered drug for a negotiated price period shall be finalized not later than 30 days before the first fiscal year in such negotiated price period.

(3) COMPETITIVE LICENSING AUTHORITY.—

(A) IN GENERAL.—Notwithstanding any exclusivity under clause (iii) or (iv) of section 505(j)(5)(F) of the Federal Food, Drug, and Cosmetic Act, clause (iii) or (iv) of section 505(c)(3)(E) of such Act, section 351(k)(7)(A) of the Public Health Service Act, or section 527(a) of the Federal Food, Drug, and Cosmetic Act, or by an extension of such exclusivity under section 505A of such Act or section 505E of such Act, and any other provision of law that

provides for market exclusivity (or extension of market exclusivity) with respect to a drug, in the case that the Secretary is unable to success fully negotiate an appropriate price for a covered drug for a negotiated price period, the Secretary shall authorize the use of any patent, clinical trial data, or other exclusivity granted by the Federal Government with respect to such drug as the Secretary determines appropriate for purposes of manufacturing such drug for sale under Medicare for All Program. Any entity making use of a competitive license to use patent, clinical trial data, or other exclusivity under this section shall provide to the manufacturer holding such exclusivity reasonable compensation, as determined by the Secretary based on the following factors:

(i) The risk-adjusted value of any Federal Government subsidies and investments in research and development used to support the development of such drug.

(ii) The risk-adjusted value of any investment made by such manufacturer in the research and development of such drug.

(iii) The impact of the price, including license compensation payments, on meeting the medical need of all patients at a reasonable cost.

(iv) The relationship between the price of such drug, including compensation payments, and the health benefits of such drug.

(v) Other relevant factors determined appropriate by the Secretary to provide reasonable compensation.

(B) REASONABLE COMPENSATION.—The manufacturer described in subparagraph (A) may seek recovery against the United States in the United States Court of Federal Claims.

(C) INTERIM PERIOD.—Until 1 year after a drug described in subparagraph (A) is approved under section 505(j) of the Federal Food, Drug, and Cosmetic Act or section 351(k) of the Public Health Service Act and is provided under license issued by the Secretary under such subparagraph, the Medicare for All Program shall not pay more for such drug than the average of the prices available, during the most recent 12-month period for which data is

available prior to the beginning of such negotiated price period, from the manufacturer to any wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity in the ten OECD (Organization for Economic Cooperation and Development) countries that have the largest gross domestic product with a per capita income that is not less than half the per capita income of the United States.

(D) AUTHORIZATION FOR SECRETARY TO PROCURE DRUGS DIRECTLY.—The Secretary may procure a drug manufactured pursuant to a competitive license under subparagraph (A) for purposes of this Act.

(4) FDA REVIEW OF LICENSED DRUG APPLICATIONS.—The Secretary shall prioritize review of applications under section 505(j) of the Federal Food, Drug, and Cosmetic Act for drugs licensed under paragraph (3)(A).

(5) PROHIBITION OF ANTICOMPETITIVE BEHAVIOR.—No drug manufacturer may engage in anticompetitive behavior with another manufacturer that may interfere with the issuance and implementation

of a competitive license or run contrary to public policy.

(6) REQUIRED REPORTING.—The Secretary may require pharmaceutical manufacturers to disclose to the Secretary such information that the Secretary determines necessary for purposes of carrying out this subsection.

TITLE VII—UNIVERSAL MEDICARE TRUST FUND

SEC. 701. UNIVERSAL MEDICARE TRUST FUND.

(a) IN GENERAL.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the Universal Medicare Trust Fund (in this section referred to as the ''Trust Fund''). The Trust Fund shall consist of such gifts and bequests as may be made and such amounts as may be deposited in, or appropriated to, such Trust Fund as provided in this Act.

(b) APPROPRIATIONS INTO TRUST FUND.—

(1) TAXES.—There are appropriated to the Trust Fund for each fiscal year beginning with the fiscal year which includes the date on which benefits first become available as described in section 106, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 percent of the net increase in revenues to the Treasury which is at-

tributable to the amendments made by sections 801 and 902. The amounts appropriated by the preceding sentence shall be transferred from time to time (but not less frequently than monthly) from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes paid to or deposited into the Treasury, and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the amounts that should have been so transferred.

(2) CURRENT PROGRAM RECEIPTS.—

(A) INITIAL YEAR.—Notwithstanding any other provision of law, there is appropriated to the Trust Fund for the fiscal year containing January 1 of the first year following the date of the enactment of this Act, an amount equal to the aggregate amount appropriated for the preceding fiscal year for the following (increased by the consumer price index for all urban consumers for the fiscal year involved):

(i) The Medicare program under title XVIII of the Social Security Act (other

than amounts attributable to any premiums under such title).

(ii) The Medicaid program under State plans approved under title XIX of such Act.

(iii) The Federal Employees Health Benefits program, under chapter 89 of title 5, United States Code.

(iv) The purchased care component of the TRICARE program, under chapter 55 of title 10, United States Code (other than amounts appropriated for the purchased care component of the TRICARE Overseas Program).

(v) The maternal and child health program (under title V of the Social Security Act), vocational rehabilitation programs, programs for drug abuse and mental health services under the Public Health Service Act, programs providing general hospital or medical assistance, and any other Federal program identified by the Secretary, in consultation with the Secretary of the Treasury, to the extent the programs provide for payment for health

services the payment of which may be made under this Act.

(B) SUBSEQUENT YEARS.—Notwithstanding any other provision of law, there is appropriated to the trust fund for the fiscal year containing January 1 of the second year following the date of the enactment of this Act, and for each fiscal year thereafter, an amount equal to the amount appropriated to the Trust Fund for the previous year, adjusted for reductions in costs resulting from the implementation of this Act, changes in the consumer price index for all urban consumers for the fiscal year involved, and other factors determined appropriate by the Secretary.

(3) RESTRICTIONS SHALL NOT APPLY.—Any other provision of law in effect on the date of enactment of this Act restricting the use of Federal funds for any reproductive health service shall not apply to monies in the Trust Fund.

(c) INCORPORATION OF PROVISIONS.—The provisions of subsections (b) through (i) of section 1817 of the Social Security Act (42 U.S.C. 1395i) shall apply to the Trust Fund under this section in the same manner as such provisions applied to the Federal Hospital Insurance Trust

Fund under such section 1817, except that, for purposes of applying such subsections to this section, the ''Board of Trustees of the Trust Fund'' shall mean the ''Secretary''.

(d) TRANSFER OF FUNDS.—Any amounts remaining in the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) or the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t) after the payment of claims for items and services furnished under title XVIII of such Act have been completed, shall be transferred into the Universal Medicare Trust Fund under this section.

TITLE VIII—CONFORMING AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

SEC. 801. PROHIBITION OF EMPLOYEE BENEFITS DUPLICATIVE OF BENEFITS UNDER THE MEDICARE FOR ALL PROGRAM; COORDINATION IN CASE OF WORKERS' COMPENSATION.

(a) IN GENERAL.—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131 et seq.) is amended by adding at the end the following new section:

"SEC. 522. PROHIBITION OF EMPLOYEE BENEFITS DUPLICATIVE OF UNIVERSAL MEDICARE PROGRAM BENEFITS; COORDINATION IN CASE OF WORKERS' COMPENSATION.

''(a) IN GENERAL.—Subject to subsection (b), no employee benefit plan may provide benefits that duplicate payment for any items or services for which payment may be made under the Medicare for All Act of 2021.

''(b) REIMBURSEMENT.—Each workers compensation carrier that is liable for payment for workers compensation services furnished in a State shall reimburse the Medicare for All Program for the cost of such services.

''(c) DEFINITIONS.—In this subsection—

''(1) the term 'workers compensation carrier' means an insurance company that underwrite workers compensation medical benefits with respect to one or more employers and includes an employer or fund that is financially at risk for the provision of workers compensation medical benefits;

''(2) the term 'workers compensation medical benefits' means, with respect to an enrollee who is an employee subject to the workers compensation laws of a State, the comprehensive medical benefits for work-related injuries and illnesses provided for under such laws with respect to such an employee; and

''(3) the term 'workers compensation services' means items and services included in workers compensation medical benefits and includes items and services (including rehabilitation services and long-term care services) commonly used for treatment of work-related injuries and illnesses.''.

(b) CONFORMING AMENDMENT.—Section 4(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1003(b)) is amended by adding at the end the following: ''Paragraph (3) shall apply subject to section 522(b) (relating to reimbursement of the Medicare for All Program by workers compensation carriers).''.

(c) CLERICAL AMENDMENT.—The table of contents in section 1 of such Act is amended by inserting after the item relating to section 521 the following new item:

''Sec. 522. Prohibition of employee benefits duplicative of Universal Medicare Program benefits; coordination in case of workers' compensation.''.

SEC. 802. APPLICATION OF CONTINUATION COVERAGE REQUIREMENTS UNDER ERISA AND CERTAIN OTHER REQUIREMENTS RELATING TO GROUP HEALTH PLANS.

(a) IN GENERAL.—Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1161 et seq.) shall apply only with respect to any employee health benefit plan that does not duplicate

payments for any items or services for which payment may be made under the this Act.

(b) CONFORMING AMENDMENT.—Section 601 of part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (19 U.S.C. 1161) is amended by adding the following subsection at the end:

''(c) Subsection (a) shall apply to any group health plan that does not duplicate payments for any items or services for which payment may be made under the Medicare for All Act of 2021.''.

SEC. 803. EFFECTIVE DATE OF TITLE.

The provisions of and amendments made by this title shall take effect on the date described in section 106(a).

TITLE IX—ADDITIONAL CONFORMING AMENDMENTS

SEC. 901. RELATIONSHIP TO EXISTING FEDERAL HEALTH PROGRAMS.

(a) MEDICARE, MEDICAID, AND STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP).—

(1) IN GENERAL.—Notwithstanding any other provision of law and with respect to an individual eligible to enroll under this Act, subject to paragraphs (2) and (3)—

(A) no benefits shall be available under title XVIII of the Social Security Act for any

item or service furnished beginning on the date that is 2 years after the date of the enactment of this Act;

(B) no individual is entitled to medical assistance under a State plan approved under title XIX of such Act for any item or service furnished on or after such date;

(C) no individual is entitled to medical assistance under a State child health plan under title XXI of such Act for any item or service furnished on or after such date; and

(D) no payment shall be made to a State under section 1903(a) or 2105(a) of such Act with respect to medical assistance or child health assistance for any item or service furnished on or after such date.

(2) TRANSITION.—In the case of inpatient hospital services and extended care services during a continuous period of stay which began before the effective date of benefits under section 106, and which had not ended as of such date, for which benefits are provided under title XVIII of the Social Security Act, under a State plan under title XIX of such Act, or under a State child health plan under title XXI of such Act, the Secretary shall provide for continu-

ation of benefits under such title or plan until the end of the period of stay.

(3) SCHOOL PROGRAMS.—All school related health programs, centers, initiatives, services, or other activities or work provided under title XIX or title XXI of the Social Security Act as of January 1, 2019, shall be continued and covered by the Medicare for All Program.

(b) FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM.—No benefits shall be made available under chapter 89 of title 5, United States Code, with respect to items and services furnished to any individual eligible to enroll under this Act.

(c) TRICARE PROGRAM.—

(1) DIRECT CARE COMPONENT.—Nothing in this Act shall affect the eligibility of beneficiaries under chapter 55 of title 10, United States Code, who are entitled to receive care furnished at facilities of the uniformed services under the TRICARE program for such care.

(2) PURCHASED CARE COMPONENT.—

(A) IN GENERAL.—Except as provided in subparagraph (B), no benefits shall be made available under the purchased care component of the TRICARE program for items or services

furnished to any individual eligible to enroll under this Act.

(B) TRICARE OVERSEAS.—During any period in which an individual is eligible for benefits under the TRICARE Overseas Program and is located in a TRICARE overseas region, the individual may receive benefits for items or services furnished to the individual under the purchased care component of such program during such period.

(d) TREATMENT OF BENEFITS FOR VETERANS AND NATIVE AMERICANS.—

(1) IN GENERAL.—Nothing in this Act shall affect the eligibility of veterans for the medical benefits and services provided under title 38, United States Code, or of Indians for the medical benefits and services provided by or through the Indian Health Service.

(2) REEVALUATION.—No reevaluation of the Indian Health Service shall be undertaken without consultation with tribal leaders and stakeholders.

SEC. 902. SUNSET OF PROVISIONS RELATED TO THE STATE EXCHANGES.

Effective on the date that is 2 years after the date of the enactment of this Act, the Federal and State Ex-

changes established pursuant to title I of the Patient Protection and Affordable Care Act (Public Law 111–148) shall terminate, and any other provision of law that relies upon participation in or enrollment through such an Exchange, including such provisions of the Internal Revenue Code of 1986, shall cease to have force or effect.

SEC. 903. SUNSET OF PROVISIONS RELATED TO PAY FOR PERFORMANCE PROGRAMS.

(a) Effective on the date described in section 106(a), the Federal programs related to pay for performance programs and value-based purchasing shall terminate, and any other provision of law that relies upon participation in or enrollment in such program shall cease to have force or effect. Programs that shall terminate include—

(1) the Merit-based Incentive Payment System established pursuant to subsection (q) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4(q));

(2) the incentives for meaningful use of certified EHR technology established pursuant to subsection (a)(7) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4(a)(7));

(3) the incentives for adoption and meaningful use of certified EHR technology established pursu-

ant to subsection (o) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4(o));

(4) alternative payment models established under section 1833(z) of the Social Security Act (42 U.S.C. 1395(z)); and

(5) the following programs as established pursuant to the following sections of the Patient Protection and Affordable Care Act:

(A) Section 2701 (adult health quality measures).

(B) Section 2702 (payment adjustments for health care acquired conditions).

(C) Section 2706 (Pediatric Accountable Care Organization Demonstration Projects for the purposes of receiving incentive payments).

(D) Section 3002(b) (42 U.S.C. 1395w–4(a)(8)) (incentive payments for quality reporting).

(E) Section 3001(a) (42 U.S.C. 1395ww(o)) (Hospital Value-Based Purchasing).

(F) Section 3006 (value-based purchasing program for skilled nursing facilities and home health agencies).

(G) Section 3007 (42 U.S.C. 1395w–4(p)) (value based payment modifier under physician fee schedule).

(H) Section 3008 (42 U.S.C. 1395ww(p)) (payment adjustments for health care-acquired condition).

(I) Section 3022 (42 U.S.C. 1395jjj) (Medicare shared savings programs).

(J) Section 3023 (42 U.S.C. 1395cc–4) (National Pilot Program on Payment Bundling).

(K) Section 3024 (42 U.S.C. 1395cc–5) (Independence at home demonstration program).

(L) Section 3025 (42 U.S.C. 1395ww(q)) (hospital readmissions reduction program).

(M) Section 10301 (plans for value-based purchasing program for ambulatory surgical centers).

TITLE X—TRANSITION

Subtitle A—Medicare for All Transition Over 2 Years and Transitional Buy-In Option

SEC. 1001. MEDICARE FOR ALL TRANSITION OVER TWO YEARS.

Title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.) is amended by adding at the end the following new section:

"SEC. 1899C. MEDICARE FOR ALL TRANSITION OVER 2 YEARS.

"(a) TRANSITION.—

"(1) IN GENERAL.—Every individual who meets the requirements described in paragraph (3) shall be eligible to enroll in the Medicare for All Program under this section during the transition period starting one year after the date of enactment of the Medicare for All Act of 2021.

"(2) BENEFITS.—An individual enrolled under this section is entitled to the benefits established under title II of the Medicare for All Act of 2021.

"(3) REQUIREMENTS FOR ELIGIBILITY.—The requirements described in this paragraph are the following:

"(A) The individual meets the eligibility requirements established by the Secretary under title I of the Medicare for All Act of 2021.

"(B) The individual has attained the applicable year of age, or is currently enrolled in Medicare at the time of the transition to Medicare for All.

"(4) APPLICABLE YEAR OF AGE DEFINED.—For purposes of this section, the term 'applicable year of age' means one year after the date of enactment of the Medicare for All Act of 2021, the age of 55 or older, the age 18 or younger.

"(b) ENROLLMENT; COVERAGE.—The Secretary shall establish enrollment periods and coverage under this section consistent with the principles for establishment of enrollment periods and coverage for individuals under other provisions of this title. The Secretary shall establish such periods so that coverage under this section shall first begin on January 1 of the year on which an individual first becomes eligible to enroll under this section.

"(c) SATISFACTION OF INDIVIDUAL MANDATE.—For purposes of applying section 5000A of the Internal Revenue Code of 1986, the coverage provided under this section constitutes minimum essential coverage under subsection (f)(1)(A)(i) of such section 5000A.

''(d) CONSULTATION.—In promulgating regulations to implement this section, the Secretary shall consult with interested parties, including groups representing beneficiaries, health care providers, employers, and insurance companies.''.

SEC. 1002. ESTABLISHMENT OF THE MEDICARE TRANSITION BUY-IN.

(a) IN GENERAL.—To carry out the purpose of this section, for the year beginning one year after the date of enactment of this Act and ending with the effective date described in section 106(a), the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid (referred to in this section as the ''Administrator''), shall establish, and provide for the offering through the Exchanges, an option to buy in to the Medicare for All Program (in this Act referred to as the ''Medicare Transition buy-in'').

(b) ADMINISTERING THE MEDICARE TRANSITION BUY-IN.—

(1) ADMINISTRATOR.—The Administrator shall administer the Medicare Transition buy-in in accordance with this section.

(2) APPLICATION OF ACA REQUIREMENTS.—Consistent with this section, the Medicare Transition buy-in shall comply with requirements under title I

of the Patient Protection and Affordable Care Act (and the amendments made by that title) and title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) that are applicable to qualified health plans offered through the Exchanges, subject to the limitation under subsection (e)(2).

(3) OFFERING THROUGH EXCHANGES.—The Medicare Transition buy-in shall be made available only through the Exchanges, and shall be available to individuals wishing to enroll and to qualified employers (as defined in section 1312(f)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 18032)) who wish to make such plan available to their employees.

(4) ELIGIBILITY TO PURCHASE.—Any United States resident may enroll in the Medicare Transition buy-in.

(c) BENEFITS; ACTUARIAL VALUE.—In carrying out this section, the Administrator shall ensure that the Medicare Transition buy-in provides—

(1) coverage for the benefits required to be covered under title II of this Act; and

(2) coverage of benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.

(d) PROVIDERS AND REIMBURSEMENT RATES.—

(1) IN GENERAL.—With respect to the reimbursement provided to health care providers for covered benefits, as described in section 201, provided under the Medicare Transition buy-in, the Administrator shall reimburse such providers at rates determined for equivalent items and services under the Medicare for All fee-for-service schedule established in section 612(b) of this Act.

(2) PRESCRIPTION DRUGS.—Any payment rate under this subsection for a prescription drug shall be at the prices negotiated under section 616 of this Act.

(3) PARTICIPATING PROVIDERS.—

(A) IN GENERAL.—A health care provider that is a participating provider of services or supplier under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) or under a State Medicaid plan under title XIX of such Act (42 U.S.C. 1396 et seq.) on the date of enactment of this Act shall be a participating provider in the Medicare Transition buy-in.

(B) ADDITIONAL PROVIDERS.—The Administrator shall establish a process to allow

health care providers not described in subparagraph (A) to become participating providers in the Medicare Transition buy-in. Such process shall be similar to the process applied to new providers under the Medicare program.

(e) PREMIUMS.—

(1) DETERMINATION.—The Administrator shall determine the premium amount for enrolling in the Medicare Transition buy-in, which—

(A) may vary according to family or individual coverage, age, and tobacco status (consistent with clauses (i), (iii), and (iv) of section 2701(a)(1)(A) of the Public Health Service Act (42 U.S.C. 300gg(a)(1)(A))); and

(B) shall take into account the cost-sharing reductions and premium tax credits which will be available with respect to the plan under section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071) and section 36B of the Internal Revenue Code of 1986, as amended by subsection (g).

(2) LIMITATION.—Variation in premium rates of the Medicare Transition buy-in by rating area, as described in clause (ii) of section 2701(a)(1)(A)(iii)

of the Public Health Service Act (42 U.S.C. 300gg(a)(1)(A)) is not permitted.

(f) TERMINATION.—This section shall cease to have force or effect on the effective date described in section 106(a).

(g) TAX CREDITS AND COST-SHARING SUBSIDIES.—

(1) PREMIUM ASSISTANCE TAX CREDITS.—

(A) CREDITS ALLOWED TO MEDICARE TRANSITION BUY-IN ENROLLEES IN NON-EXPANSION STATES.—Paragraph (1) of section 36B(c) of the Internal Revenue Code of 1986 is amended by redesignating subparagraphs (C) and (D) as subparagraphs (D) and (E), respectively, and by inserting after subparagraph (B) the following new subparagraph:

''(C) SPECIAL RULES FOR MEDICARE TRANSITION BUY-IN ENROLLEES.—

''(i) IN GENERAL.—In the case of a taxpayer who is covered, or whose spouse or dependent (as defined in section 152) is covered, by the Medicare Transition buy-in established under section 1002(a) of the Medicare for All Act of 2021 for all months in the taxable year, subparagraph

(A) shall be applied without regard to 'but does not exceed 400 percent'.

''(ii) ENROLLEES IN MEDICAID NON-EXPANSION STATES.—In the case of a taxpayer residing in a State which (as of the date of the enactment of the Medicare for All Act of 2021) does not provide for eligibility under clause (i)(VIII) or (ii)(XX) of section 1902(a)(10)(A) of the Social Security Act for medical assistance under title XIX of such Act (or a waiver of the State plan approved under section 1115) who is covered, or whose spouse or dependent (as defined in section 152) is covered, by the Medicare Transition buy-in established under section 1002(a) of the Medicare for All Act of 2021 for all months in the taxable year, subparagraphs (A) and (B) shall be applied by substituting '0 percent' for '100 percent' each place it appears.''.

(B) PREMIUM ASSISTANCE AMOUNTS FOR TAXPAYERS ENROLLED IN MEDICARE TRANSITION BUY-IN.—

(i) IN GENERAL.—Subparagraph (A) of section 36B(b)(3) of such Code is

amended—(I) by redesignating clause (ii) as clause (iii), (II) by striking ''clause (ii)'' in clause (i) and inserting ''clauses (ii) and (iii)'', and (III) by inserting after clause (i) the following new clause:

''(ii) SPECIAL RULES FOR TAXPAYERS ENROLLED IN MEDICARE TRANSITION BUY-IN.—In the case of a taxpayer who is covered, or whose spouse or dependent (as defined in section 152) is covered, by the Medicare Transition buy-in established under section 1002(a) of the Medicare for All Act of 2021 for all months in the taxable year, the applicable percentage for any taxable year shall be determined in the same manner as under clause (i), except that the following table shall apply in lieu of the table contained in such clause:

''In the case of household income (expressed as a percent of poverty line) within the following income tier:	The initial premium percentage is—	The final premium percentage is—
Up to 100 percent	2.00	2.00
100 percent up to 138 percent	2.04	2.04
138 percent up to 150 percent	3.06	4.08
150 percent and above	4.08	5.00.''.

(ii) CONFORMING AMENDMENT.—Subclause (I) of clause (iii) of section 36B(b)(3) of such Code, as redesignated

by subparagraph (A)(i), is amended by inserting ", and determined after the application of clause (ii)" after "after application of this clause".

(2) COST-SHARING SUBSIDIES.—Subsection (b) of section 1402 of the Patient Protection and Affordable Care Act (42 U.S.C. 18071(b)) is amended—

(A) by inserting ", or in the Medicare Transition buy-in established under section 1002(a) of the Medicare for All Act of 2021," after "coverage" in paragraph (1);

(B) by redesignating paragraphs (1) (as so amended) and (2) as subparagraphs (A) and (B), respectively, and by moving such subparagraphs 2 ems to the right;

(C) by striking "INSURED.—In this section" and inserting "INSURED.—

"(1) IN GENERAL.—In this section";

(D) by striking the flush language; and

(E) by adding at the end the following new paragraph:

"(2) SPECIAL RULES.—

"(A) INDIVIDUALS LAWFULLY PRESENT.—In the case of an individual described in section

36B(c)(1)(B) of the Internal Revenue Code of 1986, the individual shall be treated as having household income equal to 100 percent of the poverty line for a family of the size involved for purposes of applying this section.

''(B) MEDICARE TRANSITION BUY-IN ENROLLEES IN MEDICAID NON-EXPANSION STATES.—In the case of an individual residing in a State which (as of the date of the enactment of the Medicare for All Act of 2021) does not provide for eligibility under clause (i)(VIII) or (ii)(XX) of section 1902(a)(10)(A) of the Social Security Act for medical assistance under title XIX of such Act (or a waiver of the State plan approved under section 1115) who enrolls in such Medicare Transition buy-in, the preceding sentence, paragraph (1)(B), and paragraphs (1)(A)(i) and (2)(A) of subsection (c) shall each be applied by substituting '0 percent' for '100 percent' each place it appears.''.

(h) CONFORMING AMENDMENTS.—

(1) TREATMENT AS A QUALIFIED HEALTH PLAN.—Section 1301(a)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 18021(a)(2)) is amended—

(A) in the paragraph heading, by inserting ''THE MEDICARE TRANSITION BUY-IN,'' before ''AND''; and

(B) by inserting ''The Medicare Transition buy-in,'' before ''and a multi-State plan''.

(2) LEVEL PLAYING FIELD.—Section 1324(a) of the Patient Protection and Affordable Care Act (42 U.S.C. 18044(a)) is amended by inserting ''the Medicare Transition buy-in,'' before ''or a multi-State qualified health plan''.

Subtitle B—Transitional Medicare Reforms

SEC. 1011. ELIMINATING THE 24-MONTH WAITING PERIOD FOR MEDICARE COVERAGE FOR INDIVIDUALS WITH DISABILITIES.

(a) IN GENERAL.—Section 226(b) of the Social Security Act (42 U.S.C. 426(b)) is amended—

(1) in paragraph (2)(A), by striking '', and has for 24 calendar months been entitled to,'';

(2) in paragraph (2)(B), by striking '', and has been for not less than 24 months,'';

(3) in paragraph (2)(C)(ii), by striking '', including the requirement that he has been entitled to the specified benefits for 24 months,'';

(4) in the first sentence, by striking ''for each month beginning with the later of (I) July 1973 or (II) the twenty-fifth month of his entitlement or status as a qualified railroad retirement beneficiary described in paragraph (2), and'' and inserting ''for each month for which the individual meets the requirements of paragraph (2), beginning with the month following the month in which the individual meets the requirements of such paragraph, and''; and

(5) in the second sentence, by striking ''the 'twenty-fifth month of his entitlement' '' and all that follows through ''paragraph (2)(C) and''.

(b) CONFORMING AMENDMENTS.—

(1) SECTION 226.—Section 226 of the Social Security Act (42 U.S.C. 426) is amended by—

(A) striking subsections (e)(1)(B), (f), and (h); and

(B) redesignating subsections (g) and (i) as subsections (f) and (g), respectively.

(2) MEDICARE DESCRIPTION.—Section 1811(2) of the Social Security Act (42 U.S.C. 1395c(2)) is amended by striking ''have been entitled for not less than 24 months'' and inserting ''are entitled''.

(3) MEDICARE COVERAGE.—Section 1837(g)(1) of the Social Security Act (42 U.S.C. 1395p(g)(1)) is amended by striking ''25th month of'' and inserting ''month following the first month of''.

(4) RAILROAD RETIREMENT SYSTEM.—Section 7(d)(2)(ii) of the Railroad Retirement Act of 1974 (45 U.S.C. 231f(d)(2)(ii)) is amended—

(A) by striking ''has been entitled to an annuity'' and inserting ''is entitled to an annuity'';

(B) by striking '', for not less than 24 months''; and

(C) by striking ''could have been entitled for 24 calendar months, and''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to insurance benefits under title XVIII of the Social Security Act with respect to items and services furnished in months beginning after December 1 following the date of enactment of this Act, and before the date that is 2 years after the date of the enactment of such Act.

SEC. 1012. ENSURING CONTINUITY OF CARE.

(a) IN GENERAL.—The Secretary shall ensure that all persons enrolled or who seeks to enroll in a health plan during the transition period of the Medicare for All Pro-

gram are protected from disruptions in their care during the transition period, including continuity of care with such persons current health care provider teams.

(b) CONTINUITY OF COVERAGE AND CARE IN GENERAL.—During the transition period of the Medicare for All Act, group health plans and health insurance issuers offering group or individual health insurance coverage shall not end coverage for an enrollee during the transition period described in the Act until all ages are eligible to enroll in the Medicare for All Program except as expressly agreed upon under the terms of the plan.

(c) CONTINUITY OF COVERAGE AND CARE FOR PERSONS WITH COMPLEX MEDICAL NEEDS.—

(1) The Secretary shall ensure that persons with disabilities, complex medical needs, or chronic conditions are protected from disruptions in their care during the transition period, including continuity of care with such persons current health care provider teams.

(2) During the transition period of the Medicare for All Act group health plans and health insurance issuers offering group or individual health insurance coverage shall not—

(A) end coverage for an enrollee who has a disability, complex medical need, or chronic

condition during the transition period described in the Act until all ages are eligible to enroll in the Medicare for All Program; or

(B) impose any exclusion with respect to such plan or coverage on the basis of a person's disability, complex medical need, or chronic condition during the transition period described under this Act until all ages are eligible to enroll in the Medicare for All Program.

(d) PUBLIC CONSULTATION DURING TRANSITION.—The Secretary shall consult with communities and advocacy organizations of persons living with disabilities as well as other patient advocacy organizations to ensure that the transition buy-in takes into account the continuity of care for persons with disabilities, complex medical needs, or chronic conditions.

TITLE XI—MISCELLANEOUS

SEC. 1101. DEFINITIONS.

In this Act—

(1) the term ''global budget'' means the payment negotiated between an institutional provider and as described in section 611(b);

(2) the term ''group practice'' has the meaning given such term in section 1877(h)(4) of the Social Security Act (42 U.S.C. 1395nn(h)(4));

(3) the term ''individual provider'' means a supplier (as defined in section 1861(d) of such Act (42 U.S.C. 1395x(d)));

(4) the term ''institutional provider'' means—

(A) providers of services described in section 1861(u) of such Act (42 U.S.C. 1395x(u));

(B) hospitals as defined in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e)), and any outpatient settings or clinics operating within a hospital license or any setting or clinic that provides outpatient hospital services;

(C) psychiatric hospitals (as defined in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(f)));

(D) rehabilitation hospitals (as defined by the Secretary of Health and Human Services under section 1886(d)(1)(B)(ii) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(ii)));

(E) long-term care hospitals as defined in section 1861 of the Social Security Act (42 U.S.C. 1395x(ccc)); and

(F) independent dialysis facilities and independent end-stage renal disease facilities as described in 42 CFR 413.174(b);

(5) the term ''medically necessary or appropriate'' means the health care items and services or supplies that are needed or appropriate to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms for an individual and are determined to be necessary or appropriate for such individual by the physician or other health care professional treating such individual, after such professional performs an assessment of such individual's condition, in a manner that meets—

(A) the scope of practice, licensing, and other law of the State in which the individual receiving such items and services is located; and

(B) appropriate standards established by the Secretary for purposes of carrying out this Act;

(6) the term ''provider'' means an institutional provider or a supplier (as defined in section 1861(d) of such Act (42 U.S.C. 1395x(d)) if the reference to ''this title'' were a reference to the Medicare for All Program);

(7) the term ''Secretary'' means the Secretary of Health and Human Services;

(8) the term ''State'' means a State, the District of Columbia, or a territory of the United States;

(9) the term ''TRICARE Overseas Program'' means the element of the TRICARE program administered by International SOS (or such successor administrator) under which care and health benefits are furnished to TRICARE beneficiaries located in a TRICARE overseas region;

(10) the term ''TRICARE program'' has the meaning given such term in section 1072 of title 10, United States Code;

(11) the term ''uniformed services'' has the meaning given such term in section 101 of title 10, United States Code; and

(12) the term ''United States'' shall include the States, the District of Columbia, and the territories of the United States.

SEC. 1102. RULES OF CONSTRUCTION.

(a) IN GENERAL.—A State or local government may set additional standards or apply other State or local laws with respect to eligibility, benefits, and minimum provider standards, only if such State or local standards—

(1) provide equal or greater eligibility than is available under this Act;

(2) provide equal or greater in-person access to benefits under this Act;

(3) do not reduce access to benefits under this Act;

(4) allow for the effective exercise of the professional judgment of physicians or other health care professionals; and

(5) are otherwise consistent with this Act.

(b) RELATION TO STATE LICENSING LAW.—Nothing in this Act shall be construed to preempt State licensing, practice, or educational laws or regulations with respect to health care professionals and health care providers, for such professionals and providers who practice in that State.

(c) APPLICATION TO STATE AND FEDERAL LAW ON WORKPLACE RIGHTS.—Nothing in this Act shall be construed to diminish or alter the rights, privileges, remedies, or obligations of any employee or employer under any Federal or State law or regulation or under any collective bargaining agreement.

(d) RESTRICTIONS ON PROVIDERS.—With respect to any individuals or entities certified to provide items and services covered under section 201(a)(7), a State may not prohibit an individual or entity from participating in the

program under this Act for reasons other than the ability of the individual or entity to provide such services.

SEC. 1103. NO USE OF RESOURCES FOR LAW ENFORCEMENT OF CERTAIN REGISTRATION REQUIREMENTS.

Notwithstanding any provision of Federal or State law, no Federal or State law enforcement official or employee shall use any funds, facilities, property, equipment, or personnel made available pursuant to this Act (or any amendment made thereby) to investigate, enforce, or assist in the investigation or enforcement of any criminal, civil, or administrative violation or warrant for a violation of any requirement that individuals register with the Federal Government based on religion, national origin, ethnicity, immigration status, or other protected category.

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