

AMENDED IN ASSEMBLY JUNE 2, 2004  
AMENDED IN ASSEMBLY JUNE 27, 2003  
AMENDED IN SENATE MAY 6, 2003  
AMENDED IN SENATE APRIL 23, 2003  
AMENDED IN SENATE MARCH 25, 2003

**SENATE BILL**

**No. 260**

**Introduced by Senator Romero**  
**(Coauthor: Senator Kuehl)**  
(Coauthors: Assembly Members Berg and Maze)

February 18, 2003

---

---

An act to add Section 6534 to the Government Code, and to amend Section 1367 of the Health and Safety Code, relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

SB 260, as amended, Romero. ~~Health care service plans: contracts with public hospitals.~~

*Existing law authorizes the formation of local health care districts and the establishment of municipal hospitals for the purpose of providing needed public health care services. Existing law, the Joint Exercise of Powers Act, permits 2 or more public agencies to enter into an agreement to jointly exercise any power common to the contracting parties.*

*This bill would authorize the Department of Corrections to enter into joint powers agreements with one or more health care districts in order to establish regional inmate health service joint powers agencies.*

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law ~~provides that a violation of the act is a crime.~~

~~This bill would require a contract between a health care service plan and a public hospital to have rates for services not less than the average rate paid to private hospitals in the same county. The bill would provide that these provisions would not apply to the contracted reimbursement rates for public hospitals paid by Medi-Cal and the Healthy Families Program or health care service plans participating in Medi-Cal and the Healthy Families Program. Because the bill would impose additional requirements on health care service plans, the willful violation of which is a crime, it would impose a state-mandated local program.~~

~~The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.~~

~~This bill would provide that no reimbursement is required by this act for a specified reason *requires that all contracts with providers, and other persons furnishing services, equipment, or facilities to, or in connection with, a health care service plan be fair, reasonable, and consistent with the objectives of the act.*~~

~~This bill would require the Legislative Analyst to evaluate the contracted reimbursement rates paid to public hospitals by health care service plans to assess their compliance with the above provision requiring that contracts be fair and reasonable, and to present this evaluation to the Legislature by no later than July 1, 2005.~~

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

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

- 1 ~~SECTION 1.~~ Section 1367 of the Health and Safety Code is
- 2 *SECTION 1. The Legislature finds and declares all of the*
- 3 *following:*
- 4 *(a) California's prison inmate health care delivery system is in*
- 5 *a state of disarray.*
- 6 *(b) The cost of inmate health services has increased by more*
- 7 *than 300 percent during the past decade, and will likely exceed \$1*
- 8 *billion annually by 2006, far exceeding the rate of growth in*



1 inmate population and the general rate of private sector health  
2 care cost inflation during the same period.

3 (c) The cost of “outsourced” health care services, including  
4 payments to private hospitals, is one of the fastest growing inmate  
5 health care cost centers. Total outsourced, health care costs have  
6 increased at an average 15 percent annual rate during the past  
7 decade, and will total \$250 million in 2005.

8 (d) Health care districts operate 32 rural public hospitals in  
9 California. Many of these hospitals are located within 10 miles of  
10 a state prison facility, and are able to provide all necessary health  
11 care services for the majority of prison inmates.

12 (e) California prison administrators frequently bypass health  
13 care district hospitals when seeking care for inmates, in favor of  
14 more distant and costly private hospitals.

15 (f) Health care districts operate public hospitals that provide  
16 more than 50 percent of all hospital care in rural California.

17 (g) California’s rural district hospitals have struggled for  
18 financial survival for more than the past 10 years, posting net  
19 operating losses of more than \$22,000,000 in 2002 according to  
20 the Office of Statewide Health Planning and Development.

21 (h) More extensive utilization of the rural public hospitals  
22 operated by health care districts for delivery of inmate health  
23 services leverages state inmate health care dollars to maximum  
24 effect ensuring the long-term survival of the state’s rural health  
25 safety net while helping to reduce state General Fund expenditures  
26 for inmate health care.

27 (i) Health care district management expertise could  
28 significantly improve prison health facility management, health  
29 care utilization review, quality of care review, and health care staff  
30 recruitment. This assistance would assist Department of  
31 Corrections staff in improving health care quality, access, and cost  
32 containment.

33 (j) More effective utilization of health care district hospitals  
34 could reduce the cost of outsourced inmate care by at least  
35 \$20,000,000 annually, improve the quality of inmate health care,  
36 and improve the overall management of California’s prison health  
37 care system.

38 (k) It is in the best interests of California’s prison inmates, the  
39 State of California, and California’s rural health safety net, that  
40 the Department of Corrections and health care districts form



1 regional joint powers agencies to provide, arrange for, and assist  
2 in the provision of health care services to California prison  
3 inmates.

4 SEC. 2. Section 6534 is added to the Government Code, to  
5 read:

6 6534. (a) This section shall be known, and may be cited, as  
7 the California Prison Inmate Health Service Reform Act.

8 (b) The Department of Corrections may enter into joint powers  
9 agreements under this chapter with one or more health care  
10 districts established in accordance with Division 23 (commencing  
11 with Section 32000) of the Health and Safety Code, in order to  
12 establish regional inmate health service joint powers agencies.

13 (c) Inmate health service joint powers authorities may be  
14 utilized for any purpose related to the provision, acquisition, or  
15 coordination of inmate health care services, including, but not  
16 limited to, all of the following:

17 (1) The provision of district hospital-based surgical,  
18 diagnostic, emergency, trauma, acute care, skilled nursing,  
19 long-term, and inpatient psychiatric care.

20 (2) Health care utilization review services.

21 (3) Health facility management consultation services.

22 (4) Health care contract design, negotiation, management, and  
23 related consultation services.

24 (5) Health care quality monitoring, management, and  
25 oversight consulting services.

26 (6) Physician and health care staff recruitment services.

27 (7) The design, construction, and operation of dedicated,  
28 secure, community-based health care facilities for the provision of  
29 inmate health services.

30 SEC. 3. Section 1367 of the Health and Safety Code is  
31 amended to read:

32 1367. A health care service plan and, if applicable, a  
33 specialized health care service plan shall meet the following  
34 requirements:

35 (a) Facilities located in this state including, but not limited to,  
36 clinics, hospitals, and skilled nursing facilities to be utilized by the  
37 plan shall be licensed by the State Department of Health Services,  
38 where licensure is required by law. Facilities not located in this  
39 state shall conform to all licensing and other requirements of the  
40 jurisdiction in which they are located.



1 (b) Personnel employed by or under contract to the plan shall  
2 be licensed or certified by their respective board or agency, where  
3 licensure or certification is required by law.

4 (c) Equipment required to be licensed or registered by law shall  
5 be so licensed or registered, and the operating personnel for that  
6 equipment shall be licensed or certified as required by law.

7 (d) The plan shall furnish services in a manner providing  
8 continuity of care and ready referral of patients to other providers  
9 at times as may be appropriate consistent with good professional  
10 practice.

11 (e) (1) All services shall be readily available at reasonable  
12 times to each enrollee consistent with good professional practice.  
13 To the extent feasible, the plan shall make all services readily  
14 accessible to all enrollees consistent with Section 1367.03.

15 (2) To the extent that telemedicine services are appropriately  
16 provided through telemedicine, as defined in subdivision (a) of  
17 Section 2290.5 of the Business and Professions Code, these  
18 services shall be considered in determining compliance with  
19 Section 1300.67.2 of Title 28 of the California Code of  
20 Regulations.

21 (3) The plan shall make all services accessible and appropriate  
22 consistent with Section 1367.04.

23 (f) The plan shall employ and utilize allied health manpower  
24 for the furnishing of services to the extent permitted by law and  
25 consistent with good medical practice.

26 (g) The plan shall have the organizational and administrative  
27 capacity to provide services to subscribers and enrollees. The plan  
28 shall be able to demonstrate to the department that medical  
29 decisions are rendered by qualified medical providers, unhindered  
30 by fiscal and administrative management.

31 (h) (1) Contracts with subscribers and enrollees, including  
32 group contracts, and contracts with providers, and other persons  
33 furnishing services, equipment, or facilities to, or in connection  
34 with, the plan, shall be fair, reasonable, and consistent with the  
35 objectives of this chapter. All contracts with providers shall  
36 contain provisions requiring a fast, fair, and cost-effective dispute  
37 resolution mechanism under which providers may submit disputes  
38 to the plan, and requiring the plan to inform its providers upon  
39 contracting with the plan, or upon change to these provisions, of  
40 the procedures for processing and resolving disputes, including the



1 location and telephone number where information regarding  
2 disputes may be submitted.

3 (2) A health care service plan shall ensure that a dispute  
4 resolution mechanism is accessible to noncontracting providers  
5 for the purpose of resolving billing and claims disputes.

6 (3) On and after January 1, 2002, a health care service plan shall  
7 annually submit a report to the department regarding its dispute  
8 resolution mechanism. The report shall include information on the  
9 number of providers who utilized the dispute resolution  
10 mechanism and a summary of the disposition of those disputes.

11 (i) A health care service plan contract shall provide to  
12 subscribers and enrollees all of the basic health care services  
13 included in subdivision (b) of Section 1345, except that the  
14 director may, for good cause, by rule or order exempt a plan  
15 contract or any class of plan contracts from that requirement. The  
16 director shall by rule define the scope of each basic health care  
17 service that health care service plans are required to provide as a  
18 minimum for licensure under this chapter. Nothing in this chapter  
19 shall prohibit a health care service plan from charging subscribers  
20 or enrollees a copayment or a deductible for a basic health care  
21 service or from setting forth, by contract, limitations on maximum  
22 coverage of basic health care services, provided that the  
23 copayments, deductibles, or limitations are reported to, and held  
24 unobjectionable by, the director and set forth to the subscriber or  
25 enrollee pursuant to the disclosure provisions of Section 1363.

26 (j) A health care service plan shall not require registration  
27 under the Controlled Substances Act of 1970 (21 U.S.C. Sec. 801  
28 et seq.) as a condition for participation by an optometrist certified  
29 to use therapeutic pharmaceutical agents pursuant to Section  
30 3041.3 of the Business and Professions Code.

31 Nothing in this section shall be construed to permit the director  
32 to establish the rates charged subscribers and enrollees for  
33 contractual health care services.

34 The director's enforcement of Article 3.1 (commencing with  
35 Section 1357) shall not be deemed to establish the rates charged  
36 subscribers and enrollees for contractual health care services.

37 The obligation of the plan to comply with this section shall not  
38 be waived when the plan delegates any services that it is required  
39 to perform to its medical groups, independent practice  
40 associations, or other contracting entities.



1 (k) *The Legislative Analyst shall evaluate the contracted*  
2 *reimbursement rates paid to public hospitals by health care service*  
3 *plans to assess their compliance with paragraph (1) of subdivision*  
4 *(h) that provides that contracts be fair and reasonable. The results*  
5 *of this evaluation shall be completed and presented to the*  
6 *Legislature not later than July 1, 2005. In evaluating compliance,*  
7 *the Legislative Analyst shall examine all of the following:*

8 (1) *The contracted reimbursement rates paid to privately*  
9 *owned hospitals in California on a per-adjusted patient day basis,*  
10 *by level and type of care.*

11 (2) *The contracted reimbursement rates paid to privately*  
12 *owned hospitals in California on a per diem basis, by level and*  
13 *type of care.*

14 (3) *The comparative rates of reimbursement, by type and level*  
15 *of care, paid to public and privately owned hospitals in California.*  
16 ~~amended to read:~~

17 ~~1367. Each health care service plan and, if applicable, each~~  
18 ~~specialized health care service plan shall meet the following~~  
19 ~~requirements:~~

20 ~~(a) All facilities located in this state including, but not limited~~  
21 ~~to, clinics, hospitals, and skilled nursing facilities to be utilized by~~  
22 ~~the plan shall be licensed by the State Department of Health~~  
23 ~~Services, where licensure is required by law. Facilities not located~~  
24 ~~in this state shall conform to all licensing and other requirements~~  
25 ~~of the jurisdiction in which they are located.~~

26 ~~(b) All personnel employed by or under contract to the plan~~  
27 ~~shall be licensed or certified by their respective board or agency,~~  
28 ~~where licensure or certification is required by law.~~

29 ~~(c) All equipment required to be licensed or registered by law~~  
30 ~~shall be so licensed or registered and the operating personnel for~~  
31 ~~that equipment shall be licensed or certified as required by law.~~

32 ~~(d) The plan shall furnish services in a manner providing~~  
33 ~~continuity of care and ready referral of patients to other providers~~  
34 ~~at times as may be appropriate consistent with good professional~~  
35 ~~practice.~~

36 ~~(e) (1) All services shall be readily available at reasonable~~  
37 ~~times to each enrollee consistent with good professional practice.~~  
38 ~~To the extent feasible, the plan shall make all services readily~~  
39 ~~accessible to all enrollees consistent with Section 1367.03.~~



1 ~~(2) To the extent that telemedicine services are appropriately~~  
2 ~~provided through telemedicine, as defined in subdivision (a) of~~  
3 ~~Section 2290.5 of the Business and Professions Code, these~~  
4 ~~services shall be considered in determining compliance with~~  
5 ~~Section 1300.67.2 of Title 28 of the California Code of~~  
6 ~~Regulations.~~

7 ~~(f) The plan shall employ and utilize allied health manpower~~  
8 ~~for the furnishing of services to the extent permitted by law and~~  
9 ~~consistent with good medical practice.~~

10 ~~(g) The plan shall have the organizational and administrative~~  
11 ~~capacity to provide services to subscribers and enrollees. The plan~~  
12 ~~shall be able to demonstrate to the department that medical~~  
13 ~~decisions are rendered by qualified medical providers, unhindered~~  
14 ~~by fiscal and administrative management.~~

15 ~~(h) (1) All contracts with subscribers and enrollees, including~~  
16 ~~group contracts, and all contracts with providers, and other~~  
17 ~~persons furnishing services, equipment, or facilities to or in~~  
18 ~~connection with the plan, shall be fair, reasonable, and consistent~~  
19 ~~with the objectives of this chapter. All contracts with providers~~  
20 ~~shall contain provisions requiring a fast, fair, and cost-effective~~  
21 ~~dispute resolution mechanism under which providers may submit~~  
22 ~~disputes to the plan, and requiring the plan to inform its providers~~  
23 ~~upon contracting with the plan, or upon change to these provisions,~~  
24 ~~of the procedures for processing and resolving disputes, including~~  
25 ~~the location and telephone number where information regarding~~  
26 ~~disputes may be submitted.~~

27 ~~(2) Each health care service plan shall ensure that a dispute~~  
28 ~~resolution mechanism is accessible to noncontracting providers~~  
29 ~~for the purpose of resolving billing and claims disputes.~~

30 ~~(3) On and after January 1, 2002, each health care service plan~~  
31 ~~shall annually submit a report to the department regarding its~~  
32 ~~dispute resolution mechanism. The report shall include~~  
33 ~~information on the number of providers who utilized the dispute~~  
34 ~~resolution mechanism and a summary of the disposition of those~~  
35 ~~disputes.~~

36 ~~(i) Each health care service plan contract shall provide to~~  
37 ~~subscribers and enrollees all of the basic health care services~~  
38 ~~included in subdivision (b) of Section 1345, except that the~~  
39 ~~director may, for good cause, by rule or order exempt a plan~~  
40 ~~contract or any class of plan contracts from that requirement. The~~



1 ~~director shall by rule define the scope of each basic health care~~  
2 ~~service which health care service plans shall be required to provide~~  
3 ~~as a minimum for licensure under this chapter. Nothing in this~~  
4 ~~chapter shall prohibit a health care service plan from charging~~  
5 ~~subscribers or enrollees a copayment or a deductible for a basic~~  
6 ~~health care service or from setting forth, by contract, limitations~~  
7 ~~on maximum coverage of basic health care services, provided that~~  
8 ~~the copayments, deductibles, or limitations are reported to, and~~  
9 ~~held unobjectionable by, the director and set forth to the subscriber~~  
10 ~~or enrollee pursuant to the disclosure provisions of Section 1363.~~

11 ~~(j) No health care service plan shall require registration under~~  
12 ~~the Controlled Substances Act of 1970 (21 U.S.C. Sec. 801 et seq.)~~  
13 ~~as a condition for participation by an optometrist certified to use~~  
14 ~~therapeutic pharmaceutical agents pursuant to Section 3041.3 of~~  
15 ~~the Business and Professions Code.~~

16 ~~(k) (1) A contract with a public hospital shall provide for fair~~  
17 ~~and equitable reimbursement for covered services rendered to plan~~  
18 ~~subscribers and enrollees. Contracted reimbursement rates for~~  
19 ~~public hospitals may not be less than the average rate paid by the~~  
20 ~~plan for the same covered services to privately owned hospitals~~  
21 ~~within the county in which the public hospital is located.~~

22 ~~(2) For purposes of this subdivision, “public hospital” means~~  
23 ~~a hospital licensed to a county, a city, a city and county, a local~~  
24 ~~health care district, a local health authority, or any political~~  
25 ~~subdivision of the state.~~

26 ~~(d) Nothing in subdivision (k) of this section shall apply to the~~  
27 ~~contracted reimbursement rates for public hospitals paid by~~  
28 ~~Medi-Cal and the Healthy Families Program or to health care~~  
29 ~~service plans participating in Medi-Cal and the Healthy Families~~  
30 ~~Program.~~

31 ~~(m) Nothing in this section shall be construed to permit the~~  
32 ~~director to establish the rates charged subscribers and enrollees for~~  
33 ~~contractual health care services.~~

34 ~~The director’s enforcement of Article 3.1 (commencing with~~  
35 ~~Section 1357) shall not be deemed to establish the rates charged~~  
36 ~~subscribers and enrollees for contractual health care services.~~

37 ~~The obligation of the plan to comply with this section shall not~~  
38 ~~be waived when the plan delegates any services that it is required~~  
39 ~~to perform to its medical groups, independent practice~~  
40 ~~associations, or other contracting entities.~~



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

