AMENDED IN SENATE MAY 10, 2011

# SENATE BILL No. 946

**Introduced by Committee on Health (Senators Hernandez (Chair), Alquist, Anderson, Blakeslee, De León, DeSaulnier, Rubio, Strickland, and Wolk)**

March 31, 2011

An act to amend Sections 2028.5, 2290.5, 3041, 4980.43, and 4999.90 of the Business and Professions Code, to amend Section 78910.10 of the Education Code, to amend Sections 1367, 1374.13, 1375.1, 1797.98b, 113953.3, 113973, 121022, 123149.5, 127620, 130302, and 130307 of, to add ~~Section~~ *Sections 113807 and* 113975 to, and to repeal Sections 130304 and 130309 of, the Health and Safety Code, to amend Section 10123.13, 10123.147, 10123.85, 10181.11, 10198.7, 10953, and 10959 of the Insurance Code, and to amend Sections 5705, 5708, 5710, 5716, 5724, 5750.1, 14132.72, 14132.725, and 14132.73 of the Welfare and Institutions Code, relating to public health.

LEGISLATIVE COUNSEL'S DIGEST

SB 946, as amended, Committee on Health. Public health.

(1) Existing law defines "telemedicine" for purposes of various provisions of existing law relating to the practice of medicine, among other things.

This bill would replace the term with "telehealth."

(2) Existing law authorizes a county to establish an emergency medical services fund for reimbursement of emergency medical services (EMS)-related costs, and requires an annual report to the Legislature on the implementation and status of the fund, including the fund balance and the amount of moneys disbursed to physicians and surgeons, for hospitals, and for other emergency medical services purposes.

This bill would require the report to provide additional information regarding the moneys collected and disbursed, including, but not limited to, a description of the other emergency medical services purposes, and the total amount of allowable claims submitted, if the moneys are disbursed to hospitals on a claims basis, and the names and contact information of the entity responsible for the collection and disbursement of prescribed funds. By increasing the duties of local officials, this bill would impose a state-mandated local program.

(3) Existing law, the California Retail Food Code, establishes uniform health and sanitation standards for retail food facilities, as defined. The law requires the State Department of Public Health to adopt regulations to implement and administer those provisions, and delegates primary enforcement duties to local health agencies. A violation of any of these provisions is punishable as a misdemeanor.

The code requires food employees to report to the person in charge of a food facility when a food employee has a lesion or wound that is open or draining unless specified conditions to cover or protect the lesion are met. The code requires all employees to wash their hands in specified instances, including before donning gloves for working with food. The code also requires gloves to be worn when contacting food and food-contact surfaces under specified conditions, including when the employee has any cuts, sores, or rashes. Gloves are required to be changed, replaced, or washed as often as hand washing is required.

This bill would require hands to be washed before initially donning gloves and before donning gloves after specified instances where gloves were required to be changed or replaced. The bill would prohibit single-use gloves from being washed. The bill would also prohibit an employee who has a lesion or wound that is open or draining from handling food and would require a food employee who has any cuts, sores, rashes, lesions, or wounds to cover or protect the lesion, as specified. ~~By~~

*This bill would define "hotdog" for purposes of the code.*

*By* changing the definition of a crime and increasing the duties of local enforcement officials, this bill would impose a state-mandated local program.

(4) Existing law establishes various communicable disease prevention and control programs. Existing law requires the State Department of Public Health to establish a list of reportable diseases and conditions and requires health care providers and laboratories to report cases of HIV infection to the local health officer using patient names and sets

guidelines regarding these reports. Existing law requires the local health officers to report unduplicated HIV cases by name to the department.

This bill would authorize the department to revise the HIV reporting form without the adoption of a regulation, as specified.

(5) Existing law, the Health Insurance Portability and Accountability Implementation Act of 2001, provides, until January 1, 2013, for an office in the California Health and Human Services Agency to assume statewide leadership and perform related activities for the implementation of the federal Health Insurance Portability and Accountability Act (HIPAA). Under existing law, the director of the office is required to establish an advisory committee to obtain information on statewide activities to implement HIPAA that is required to meet, at a minimum, twice each year. Existing law required that, during 2002, state entities subject to HIPAA assess its impact on their operations and that the office report that information to the Legislature.

This bill would transfer responsibility for the statewide implementation of HIPAA to the Office of Health Information Integrity in the California Health and Human Services Agency. The bill would delete the requirement of 2 annual meetings for the advisory committee, providing for meetings as required for coordination purposes. The bill would also delete the assessment and reporting requirements for state entities and the office, which were required to be completed in 2002.

(6) Existing law, the federal Patient Protection and Affordable Care Act, prohibits a health insurance issuer offering group or individual health insurance coverage from imposing any preexisting condition for children with respect to plan years beginning on or after September 23, 2010, and for adults with respect to plan years beginning on or after January 1, 2014.

Existing law prohibits the exclusion or limitation of health care coverage for children due to any preexisting condition, except as specified. Existing law requires a carrier to fairly and affirmatively offer, market, and sell all of the carrier's health benefit plans that are offered and sold to a child in each service area in which the plan provides or arranges for health care coverage during any open enrollment period, as specified. Existing law imposes specified requirements on a carrier or solicitor when offering, marketing, or selling those plans.

This bill would make necessary technical changes to these provisions and correct erroneous cross-references. The bill would revise provisions that reference "solicitor" to instead refer to an agent or broker, as specified.

(7) Under the Bronzan-McCorquodale Act, the State Department of Mental Health administers the provision of funds to counties for community mental health services programs. Existing law also permits counties to receive, under certain circumstances, Medi-Cal reimbursement for mental health services. Under existing law, negotiated net amounts or rates are used as the cost of services in contracts between the state and the county and between the county and a subprovider of services. Existing law establishes the method for computing negotiated rates. Existing law prohibits the charges for the care and treatment of each patient receiving service from a county mental health program from exceeding the actual or negotiated cost of the services.

This bill would only allow the use of negotiated net amounts as the cost of services in a contract between the state and a county and the county and a subprovider of services, and would eliminate the use of negotiated rates. The bill would also specify that the charges for the care and treatment of each patient receiving a service from a county mental health program shall not exceed the actual cost of the service.

(8) Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which basic health care services are provided to qualified low-income persons. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions. Under existing law, the State Department of Health Care Services promulgates regulations for determining reimbursement of Short-Doyle mental health services allowable under the Medi-Cal program. Existing law requires the State Department of Mental Health and the State Department of Health Care Services to jointly develop a ratesetting methodology for use in the Short-Doyle Medi-Cal system that maximizes federal funding and utilizes, as much as practicable, federal Medicare reimbursement principles. Existing law requires that this ratesetting methodology contain incentives relating to economy and efficiency.

The bill would delete the requirement that the ratesetting methodology in the Short-Doyle Medi-Cal system include incentives relating to economy and efficiency.

(9) The bill would also, with respect to the State Department of Health Care Services, delete an obsolete reporting requirement.

(10) 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.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

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

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

SECTION 1. Section 2028.5 of the Business and Professions Code is amended to read:

2028.5. (a) The board may establish a pilot program to expand the practice of telemedicine, as defined in Section 2290.5, as it read on January 1, 2011, in this state.

(b) To implement this pilot program, the board may convene a working group of interested parties from the public and private sectors, including, but not limited to, state health-related agencies, health care providers, health plan administrators, information technology groups, and groups representing health care consumers.

(c) The purpose of the pilot program shall be to develop methods, using a telemedicine model, to deliver throughout the state health care to persons with chronic diseases as well as information on the best practices for chronic disease management services and techniques and other health care information as deemed appropriate.

(d) The board shall make a report with its recommendations regarding its findings to the Legislature within one calendar year of the commencement date of the pilot program. The report shall include an evaluation of the improvement and affordability of health care services and the reduction in the number of complications achieved by the pilot program.

SEC. 2. Section 2290.5 of the Business and Professions Code is amended to read:

2290.5. (a) (1) For the purposes of this section, "telehealth" means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Neither a telephone conversation nor an electronic mail message between a health care

practitioner and patient constitutes “telehealth” for purposes of this section.

(2) For purposes of this section, “interactive” means an audio, video, or data communication involving a real time (synchronous) or near real time (asynchronous) two-way transfer of medical data and information.

(b) For the purposes of this section, “health care practitioner” has the same meaning as “licentiate” as defined in paragraph (2) of subdivision (a) of Section 805 and also includes a person licensed as an optometrist pursuant to Chapter 7 (commencing with Section 3000).

(c) Prior to the delivery of health care via telehealth, the health care practitioner who has ultimate authority over the care or primary diagnosis of the patient shall obtain verbal and written informed consent from the patient or the patient’s legal representative. The informed consent procedure shall ensure that at least all of the following information is given to the patient or the patient’s legal representative verbally and in writing:

(1) The patient or the patient’s legal representative retains the option to withhold or withdraw consent at any time without affecting the right to future care or treatment nor risking the loss or withdrawal of any program benefits to which the patient or the patient’s legal representative would otherwise be entitled.

(2) A description of the potential risks, consequences, and benefits of telehealth.

(3) All existing confidentiality protections apply.

(4) All existing laws regarding patient access to medical information and copies of medical records apply.

(5) Dissemination of any patient identifiable images or information from the telehealth interaction to researchers or other entities shall not occur without the consent of the patient.

(d) A patient or the patient’s legal representative shall sign a written statement prior to the delivery of health care via telehealth, indicating that the patient or the patient’s legal representative understands the written information provided pursuant to subdivision (a), and that this information has been discussed with the health care practitioner, or his or her designee.

(e) The written consent statement signed by the patient or the patient’s legal representative shall become part of the patient’s medical record.

(f) The failure of a health care practitioner to comply with this section shall constitute unprofessional conduct. Section 2314 shall not apply to this section.

(g) All existing laws regarding surrogate decisionmaking shall apply. For purposes of this section, "surrogate decisionmaking" means any decision made in the practice of medicine by a parent or legal representative for a minor or an incapacitated or incompetent individual.

(h) Except as provided in paragraph (3) of subdivision (c), this section shall not apply when the patient is not directly involved in the telehealth interaction, for example when one health care practitioner consults with another health care practitioner.

(i) This section shall not apply in an emergency situation in which a patient is unable to give informed consent and the representative of that patient is not available in a timely manner.

(j) This section shall not apply to a patient under the jurisdiction of the Department of Corrections or any other correctional facility.

(k) This section shall not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law.

SEC. 3. Section 3041 of the Business and Professions Code is amended to read:

3041. (a) The practice of optometry includes the prevention and diagnosis of disorders and dysfunctions of the visual system, and the treatment and management of certain disorders and dysfunctions of the visual system, as well as the provision of rehabilitative optometric services, and is the doing of any or all of the following:

(1) The examination of the human eye or eyes, or its or their appendages, and the analysis of the human vision system, either subjectively or objectively.

(2) The determination of the powers or range of human vision and the accommodative and refractive states of the human eye or eyes, including the scope of its or their functions and general condition.

(3) The prescribing or directing the use of, or using, any optical device in connection with ocular exercises, visual training, vision training, or orthoptics.

(4) The prescribing of contact and spectacle lenses for, or the fitting or adaptation of contact and spectacle lenses to, the human eye, including lenses that may be classified as drugs or devices by any law of the United States or of this state.

(5) The use of topical pharmaceutical agents for the purpose of the examination of the human eye or eyes for any disease or pathological condition.

(b) (1) An optometrist who is certified to use therapeutic pharmaceutical agents, pursuant to Section 3041.3, may also diagnose and treat the human eye or eyes, or any of its or their appendages, for all of the following conditions:

(A) Through medical treatment, infections of the anterior segment and adnexa, excluding the lacrimal gland, the lacrimal drainage system, and the sclera in patients under 12 years of age.

(B) Ocular allergies of the anterior segment and adnexa.

(C) Ocular inflammation, nonsurgical in cause except when comanaged with the treating physician and surgeon, limited to inflammation resulting from traumatic iritis, peripheral corneal inflammatory keratitis, episcleritis, and unilateral nonrecurrent nongranulomatous idiopathic iritis in patients over 18 years of age. Unilateral nongranulomatous idiopathic iritis recurring within one year of the initial occurrence shall be referred to an ophthalmologist. An optometrist shall consult with an ophthalmologist or appropriate physician and surgeon if a patient has a recurrent case of episcleritis within one year of the initial occurrence. An optometrist shall consult with an ophthalmologist or appropriate physician and surgeon if a patient has a recurrent case of peripheral corneal inflammatory keratitis within one year of the initial occurrence.

(D) Traumatic or recurrent conjunctival or corneal abrasions and erosions.

(E) Corneal surface disease and dry eyes.

(F) Ocular pain, nonsurgical in cause except when comanaged with the treating physician and surgeon, associated with conditions optometrists are authorized to treat.

(G) Pursuant to subdivision (f), glaucoma in patients over 18 years of age, as described in subdivision (j).

(2) For purposes of this section, “treat” means the use of therapeutic pharmaceutical agents, as described in subdivision (c), and the procedures described in subdivision (e).

(c) In diagnosing and treating the conditions listed in subdivision (b), an optometrist certified to use therapeutic pharmaceutical agents pursuant to Section 3041.3 may use all of the following therapeutic pharmaceutical agents:

(1) Pharmaceutical agents as described in paragraph (5) of subdivision (a), as well as topical miotics.

(2) Topical lubricants.

(3) Antiallergy agents. In using topical steroid medication for the treatment of ocular allergies, an optometrist shall consult with an ophthalmologist if the patient's condition worsens 21 days after diagnosis.

(4) Topical and oral antiinflammatories. In using steroid medication for:

(A) Unilateral nonrecurrent nongranulomatous idiopathic iritis or episcleritis, an optometrist shall consult with an ophthalmologist or appropriate physician and surgeon if the patient's condition worsens 72 hours after the diagnosis, or if the patient's condition has not resolved three weeks after diagnosis. If the patient is still receiving medication for these conditions six weeks after diagnosis, the optometrist shall refer the patient to an ophthalmologist or appropriate physician and surgeon.

(B) Peripheral corneal inflammatory keratitis, excluding Moorens and Terriens diseases, an optometrist shall consult with an ophthalmologist or appropriate physician and surgeon if the patient's condition worsens 72 hours after diagnosis.

(C) Traumatic iritis, an optometrist shall consult with an ophthalmologist or appropriate physician and surgeon if the patient's condition worsens 72 hours after diagnosis and shall refer the patient to an ophthalmologist or appropriate physician and surgeon if the patient's condition has not resolved one week after diagnosis.

(5) Topical antibiotic agents.

(6) Topical hyperosmotics.

(7) Topical and oral antiglaucoma agents pursuant to the certification process defined in subdivision (f).

(A) The optometrist shall refer the patient to an ophthalmologist if requested by the patient or if angle closure glaucoma develops.

(B) If the glaucoma patient also has diabetes, the optometrist shall consult with the physician treating the patient's diabetes in developing the glaucoma treatment plan and shall inform the

physician in writing of any changes in the patient's glaucoma medication.

(8) Nonprescription medications used for the rational treatment of an ocular disorder.

(9) Oral antihistamines.

(10) Prescription oral nonsteroidal antiinflammatory agents.

(11) Oral antibiotics for medical treatment of ocular disease.

(A) If the patient has been diagnosed with a central corneal ulcer and the central corneal ulcer has not improved 48 hours after diagnosis, the optometrist shall refer the patient to an ophthalmologist.

(B) If the patient has been diagnosed with preseptal cellulitis or dacryocystitis and the condition has not improved 48 hours after diagnosis, the optometrist shall refer the patient to an ophthalmologist.

(12) Topical and oral antiviral medication for the medical treatment of the following: herpes simplex viral keratitis, herpes simplex viral conjunctivitis, and periocular herpes simplex viral dermatitis; and varicella zoster viral keratitis, varicella zoster viral conjunctivitis, and periocular varicella zoster viral dermatitis.

(A) If the patient has been diagnosed with herpes simplex keratitis or varicella zoster viral keratitis and the patient's condition has not improved seven days after diagnosis, the optometrist shall refer the patient to an ophthalmologist. If a patient's condition has not resolved three weeks after diagnosis, the optometrist shall refer the patient to an ophthalmologist.

(B) If the patient has been diagnosed with herpes simplex viral conjunctivitis, herpes simplex viral dermatitis, varicella zoster viral conjunctivitis, or varicella zoster viral dermatitis, and if the patient's condition worsens seven days after diagnosis, the optometrist shall consult with an ophthalmologist. If the patient's condition has not resolved three weeks after diagnosis, the optometrist shall refer the patient to an ophthalmologist.

(13) Oral analgesics that are not controlled substances.

(14) Codeine with compounds and hydrocodone with compounds as listed in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) and the United States Uniform Controlled Substances Act (21 U.S.C. Sec. 801 et seq.). The use

of these agents shall be limited to three days, with a referral to an ophthalmologist if the pain persists.

(d) In any case where this chapter requires that an optometrist consult with an ophthalmologist, the optometrist shall maintain a written record in the patient's file of the information provided to the ophthalmologist, the ophthalmologist's response, and any other relevant information. Upon the consulting ophthalmologist's request and with the patient's consent, the optometrist shall furnish a copy of the record to the ophthalmologist.

(e) An optometrist who is certified to use therapeutic pharmaceutical agents pursuant to Section 3041.3 may also perform all of the following:

(1) Corneal scraping with cultures.

(2) Debridement of corneal epithelia.

(3) Mechanical epilation.

(4) Venipuncture for testing patients suspected of having diabetes.

(5) Suture removal, with prior consultation with the treating physician and surgeon.

(6) Treatment or removal of sebaceous cysts by expression.

(7) Administration of oral fluorescein to patients suspected as having diabetic retinopathy.

(8) Use of an auto-injector to counter anaphylaxis.

(9) Ordering of smears, cultures, sensitivities, complete blood count, mycobacterial culture, acid fast stain, urinalysis, and X-rays necessary for the diagnosis of conditions or diseases of the eye or adnexa. An optometrist may order other types of images subject to prior consultation with an ophthalmologist or appropriate physician and surgeon.

(10) Punctal occlusion by plugs, excluding laser, diathermy, cryotherapy, or other means constituting surgery as defined in this chapter.

(11) The prescription of therapeutic contact lenses, including lenses or devices that incorporate a medication or therapy the optometrist is certified to prescribe or provide.

(12) Removal of foreign bodies from the cornea, eyelid, and conjunctiva with any appropriate instrument other than a scalpel or needle. Corneal foreign bodies shall be nonperforating, be no deeper than the midstroma, and require no surgical repair upon removal.

(13) For patients over 12 years of age, lacrimal irrigation and dilation, excluding probing of the nasal lacrimal tract. The board shall certify any optometrist who graduated from an accredited school of optometry before May 1, 2000, to perform this procedure after submitting proof of satisfactory completion of 10 procedures under the supervision of an ophthalmologist as confirmed by the ophthalmologist. Any optometrist who graduated from an accredited school of optometry on or after May 1, 2000, shall be exempt from the certification requirement contained in this paragraph.

(f) The board shall grant a certificate to an optometrist certified pursuant to Section 3041.3 for the treatment of glaucoma, as described in subdivision (j), in patients over 18 years of age after the optometrist meets the following applicable requirements:

(1) For licensees who graduated from an accredited school of optometry on or after May 1, 2008, submission of proof of graduation from that institution.

(2) For licensees who were certified to treat glaucoma under this section prior to January 1, 2009, submission of proof of completion of that certification program.

(3) For licensees who have substantially completed the certification requirements pursuant to this section in effect between January 1, 2001, and December 31, 2008, submission of proof of completion of those requirements on or before December 31, 2009. "Substantially completed" means both of the following:

(A) Satisfactory completion of a didactic course of not less than 24 hours in the diagnosis, pharmacological, and other treatment and management of glaucoma.

(B) Treatment of 50 glaucoma patients with a collaborating ophthalmologist for a period of two years for each patient that will conclude on or before December 31, 2009.

(4) For licensees who completed a didactic course of not less than 24 hours in the diagnosis, pharmacological, and other treatment and management of glaucoma, submission of proof of satisfactory completion of the case management requirements for certification established by the board pursuant to Section 3041.10.

(5) For licensees who graduated from an accredited school of optometry on or before May 1, 2008, and not described in paragraph (2), (3), or (4), submission of proof of satisfactory

completion of the requirements for certification established by the board pursuant to Section 3041.10.

(g) Other than for prescription ophthalmic devices described in subdivision (b) of Section 2541, any dispensing of a therapeutic pharmaceutical agent by an optometrist shall be without charge.

(h) The practice of optometry does not include performing surgery. "Surgery" means any procedure in which human tissue is cut, altered, or otherwise infiltrated by mechanical or laser means. "Surgery" does not include those procedures specified in subdivision (e). Nothing in this section shall limit an optometrist's authority to utilize diagnostic laser and ultrasound technology within his or her scope of practice.

(i) An optometrist licensed under this chapter is subject to Section 2290.5 for purposes of practicing telehealth.

(j) For purposes of this chapter, "glaucoma" means either of the following:

(1) All primary open-angle glaucoma.

(2) Exfoliation and pigmentary glaucoma.

(k) In an emergency, an optometrist shall stabilize, if possible, and immediately refer any patient who has an acute attack of angle closure to an ophthalmologist.

SEC. 4. Section 4980.43 of the Business and Professions Code is amended to read:

4980.43. (a) Prior to applying for licensure examinations, each applicant shall complete experience that shall comply with the following:

(1) A minimum of 3,000 hours completed during a period of at least 104 weeks.

(2) Not more than 40 hours in any seven consecutive days.

(3) Not less than 1,700 hours of supervised experience completed subsequent to the granting of the qualifying master's or doctoral degree.

(4) Not more than 1,300 hours of supervised experience obtained prior to completing a master's or doctoral degree.

The applicant shall not be credited with more than 750 hours of counseling and direct supervisor contact prior to completing the master's or doctoral degree.

(5) No hours of experience may be gained prior to completing either 12 semester units or 18 quarter units of graduate instruction and becoming a trainee except for personal psychotherapy.

(6) No hours of experience may be gained more than six years prior to the date the application for examination eligibility was filed, except that up to 500 hours of clinical experience gained in the supervised practicum required by subdivision (c) of Section 4980.37 and subparagraph (B) of paragraph (1) of subdivision (d) of Section 4980.36 shall be exempt from this six-year requirement.

(7) Not more than a combined total of 1,250 hours of experience in the following:

(A) Direct supervisor contact.

(B) Professional enrichment activities. For purposes of this chapter, "professional enrichment activities" include the following:

(i) Workshops, seminars, training sessions, or conferences directly related to marriage and family therapy attended by the applicant that are approved by the applicant's supervisor. An applicant shall have no more than 250 hours of verified attendance at these workshops, seminars, training sessions, or conferences.

(ii) Participation by the applicant in personal psychotherapy, which includes group, marital or conjoint, family, or individual psychotherapy by an appropriately licensed professional. An applicant shall have no more than 100 hours of participation in personal psychotherapy. The applicant shall be credited with three hours of experience for each hour of personal psychotherapy.

(C) Client centered advocacy.

(8) Not more than 500 hours of experience providing group therapy or group counseling.

(9) Not more than 250 hours of experience administering and evaluating psychological tests, writing clinical reports, writing progress notes, or writing process notes.

(10) Not less than 500 total hours of experience in diagnosing and treating couples, families, and children. For up to 150 hours of treating couples and families in conjoint therapy, the applicant shall be credited with two hours of experience for each hour of therapy provided.

(11) Not more than 375 hours of experience providing personal psychotherapy, crisis counseling, or other counseling services via telehealth in accordance with Section 2290.5.

(12) It is anticipated and encouraged that hours of experience will include working with elders and dependent adults who have physical or mental limitations that restrict their ability to carry out normal activities or protect their rights.

This subdivision shall only apply to hours gained on and after January 1, 2010.

(b) All applicants, trainees, and registrants shall be at all times under the supervision of a supervisor who shall be responsible for ensuring that the extent, kind, and quality of counseling performed is consistent with the training and experience of the person being supervised, and who shall be responsible to the board for compliance with all laws, rules, and regulations governing the practice of marriage and family therapy. Supervised experience shall be gained by interns and trainees either as an employee or as a volunteer. The requirements of this chapter regarding gaining hours of experience and supervision are applicable equally to employees and volunteers. Experience shall not be gained by interns or trainees as an independent contractor.

(1) If employed, an intern shall provide the board with copies of the corresponding W-2 tax forms for each year of experience claimed upon application for licensure.

(2) If volunteering, an intern shall provide the board with a letter from his or her employer verifying the intern's employment as a volunteer upon application for licensure.

(c) Supervision shall include at least one hour of direct supervisor contact in each week for which experience is credited in each work setting, as specified:

(1) A trainee shall receive an average of at least one hour of direct supervisor contact for every five hours of client contact in each setting.

(2) An individual supervised after being granted a qualifying degree shall receive at least one additional hour of direct supervisor contact for every week in which more than 10 hours of client contact is gained in each setting. No more than five hours of supervision, whether individual or group, shall be credited during any single week.

(3) For purposes of this section, "one hour of direct supervisor contact" means one hour per week of face-to-face contact on an individual basis or two hours per week of face-to-face contact in a group.

(4) Direct supervisor contact shall occur within the same week as the hours claimed.

(5) Direct supervisor contact provided in a group shall be provided in a group of not more than eight supervisees and in segments lasting no less than one continuous hour.

(6) Notwithstanding paragraph (3), an intern working in a governmental entity, a school, a college, or a university, or an institution that is both nonprofit and charitable may obtain the required weekly direct supervisor contact via two-way, real-time videoconferencing. The supervisor shall be responsible for ensuring that client confidentiality is upheld.

(7) All experience gained by a trainee shall be monitored by the supervisor as specified by regulation.

(d) (1) A trainee may be credited with supervised experience completed in any setting that meets all of the following:

(A) Lawfully and regularly provides mental health counseling or psychotherapy.

(B) Provides oversight to ensure that the trainee's work at the setting meets the experience and supervision requirements set forth in this chapter and is within the scope of practice for the profession as defined in Section 4980.02.

(C) Is not a private practice owned by a licensed marriage and family therapist, a licensed psychologist, a licensed clinical social worker, a licensed physician and surgeon, or a professional corporation of any of those licensed professions.

(2) Experience may be gained by the trainee solely as part of the position for which the trainee volunteers or is employed.

(e) (1) An intern may be credited with supervised experience completed in any setting that meets both of the following:

(A) Lawfully and regularly provides mental health counseling or psychotherapy.

(B) Provides oversight to ensure that the intern's work at the setting meets the experience and supervision requirements set forth in this chapter and is within the scope of practice for the profession as defined in Section 4980.02.

(2) An applicant shall not be employed or volunteer in a private practice, as defined in subparagraph (C) of paragraph (1) of subdivision (d), until registered as an intern.

(3) While an intern may be either a paid employee or a volunteer, employers are encouraged to provide fair remuneration to interns.

(4) Except for periods of time during a supervisor's vacation or sick leave, an intern who is employed or volunteering in private practice shall be under the direct supervision of a licensee that has satisfied the requirements of subdivision (g) of Section 4980.03. The supervising licensee shall either be employed by and practice at the same site as the intern's employer, or shall be an owner or shareholder of the private practice. Alternative supervision may be arranged during a supervisor's vacation or sick leave if the supervision meets the requirements of this section.

(5) Experience may be gained by the intern solely as part of the position for which the intern volunteers or is employed.

(f) Except as provided in subdivision (g), all persons shall register with the board as an intern in order to be credited for postdegree hours of supervised experience gained toward licensure.

(g) Except when employed in a private practice setting, all postdegree hours of experience shall be credited toward licensure so long as the applicant applies for the intern registration within 90 days of the granting of the qualifying master's or doctoral degree and is thereafter granted the intern registration by the board.

(h) Trainees, interns, and applicants shall not receive any remuneration from patients or clients, and shall only be paid by their employers.

(i) Trainees, interns, and applicants shall only perform services at the place where their employers regularly conduct business, which may include performing services at other locations, so long as the services are performed under the direction and control of their employer and supervisor, and in compliance with the laws and regulations pertaining to supervision. Trainees and interns shall have no proprietary interest in their employers' businesses and shall not lease or rent space, pay for furnishings, equipment or supplies, or in any other way pay for the obligations of their employers.

(j) Trainees, interns, or applicants who provide volunteered services or other services, and who receive no more than a total, from all work settings, of five hundred dollars ($500) per month as reimbursement for expenses actually incurred by those trainees, interns, or applicants for services rendered in any lawful work setting other than a private practice shall be considered an employee and not an independent contractor. The board may audit applicants who receive reimbursement for expenses, and the

applicants shall have the burden of demonstrating that the payments received were for reimbursement of expenses actually incurred.

(k) Each educational institution preparing applicants for licensure pursuant to this chapter shall consider requiring, and shall encourage, its students to undergo individual, marital or conjoint, family, or group counseling or psychotherapy, as appropriate. Each supervisor shall consider, advise, and encourage his or her interns and trainees regarding the advisability of undertaking individual, marital or conjoint, family, or group counseling or psychotherapy, as appropriate. Insofar as it is deemed appropriate and is desired by the applicant, the educational institution and supervisors are encouraged to assist the applicant in locating that counseling or psychotherapy at a reasonable cost.

SEC. 5. Section 4999.90 of the Business and Professions Code is amended to read:

4999.90. The board may refuse to issue any registration or license, or may suspend or revoke the registration or license of any intern or licensed professional clinical counselor, if the applicant, licensee, or registrant has been guilty of unprofessional conduct. Unprofessional conduct includes, but is not limited to, the following:

(a) The conviction of a crime substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. The record of conviction shall be conclusive evidence only of the fact that the conviction occurred. The board may inquire into the circumstances surrounding the commission of the crime in order to fix the degree of discipline or to determine if the conviction is substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter. A plea or verdict of guilty or a conviction following a plea of nolo contendere made to a charge substantially related to the qualifications, functions, or duties of a licensee or registrant under this chapter shall be deemed to be a conviction within the meaning of this section. The board may order any license or registration suspended or revoked, or may decline to issue a license or registration when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal, or, when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under Section 1203.4 of the Penal Code allowing the person to withdraw a plea of guilty and enter a plea of not

guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment.

(b) Securing a license or registration by fraud, deceit, or misrepresentation on any application for licensure or registration submitted to the board, whether engaged in by an applicant for a license or registration, or by a licensee in support of any application for licensure or registration.

(c) Administering to himself or herself any controlled substance or using any of the dangerous drugs specified in Section 4022, or any alcoholic beverage to the extent, or in a manner, as to be dangerous or injurious to the person applying for a registration or license or holding a registration or license under this chapter, or to any other person, or to the public, or, to the extent that the use impairs the ability of the person applying for or holding a registration or license to conduct with safety to the public the practice authorized by the registration or license, or the conviction of more than one misdemeanor or any felony involving the use, consumption, or self-administration of any of the substances referred to in this subdivision, or any combination thereof. The board shall deny an application for a registration or license or revoke the license or registration of any person, other than one who is licensed as a physician and surgeon, who uses or offers to use drugs in the course of performing licensed professional clinical counseling services.

(d) Gross negligence or incompetence in the performance of licensed professional clinical counseling services.

(e) Violating, attempting to violate, or conspiring to violate any of the provisions of this chapter or any regulation adopted by the board.

(f) Misrepresentation as to the type or status of a license or registration held by the person, or otherwise misrepresenting or permitting misrepresentation of his or her education, professional qualifications, or professional affiliations to any person or entity.

(g) Impersonation of another by any licensee, registrant, or applicant for a license or registration, or, in the case of a licensee or registrant, allowing any other person to use his or her license or registration.

(h) Aiding or abetting, or employing, directly or indirectly, any unlicensed or unregistered person to engage in conduct for which a license or registration is required under this chapter.

(i) Intentionally or recklessly causing physical or emotional harm to any client.

(j) The commission of any dishonest, corrupt, or fraudulent act substantially related to the qualifications, functions, or duties of a licensee or registrant.

(k) Engaging in sexual relations with a client, or a former client within two years following termination of therapy, soliciting sexual relations with a client, or committing an act of sexual abuse, or sexual misconduct with a client, or committing an act punishable as a sexually related crime, if that act or solicitation is substantially related to the qualifications, functions, or duties of a licensed professional clinical counselor.

(*l*) Performing, or holding oneself out as being able to perform, or offering to perform, or permitting any clinical counselor trainee or intern under supervision to perform, any professional services beyond the scope of the license authorized by this chapter.

(m) Failure to maintain confidentiality, except as otherwise required or permitted by law, of all information that has been received from a client in confidence during the course of treatment and all information about the client which is obtained from tests or other means.

(n) Prior to the commencement of treatment, failing to disclose to the client or prospective client the fee to be charged for the professional services, or the basis upon which that fee will be computed.

(o) Paying, accepting, or soliciting any consideration, compensation, or remuneration, whether monetary or otherwise, for the referral of professional clients. All consideration, compensation, or remuneration shall be in relation to professional clinical counseling services actually provided by the licensee. Nothing in this subdivision shall prevent collaboration among two or more licensees in a case or cases. However, no fee shall be charged for that collaboration, except when disclosure of the fee has been made in compliance with subdivision (n).

(p) Advertising in a manner that is false, fraudulent, misleading, or deceptive, as defined in Section 651.

(q) Reproduction or description in public, or in any publication subject to general public distribution, of any psychological test or other assessment device, the value of which depends in whole or

in part on the naivete of the subject, in ways that might invalidate the test or device.

(r) Any conduct in the supervision of a registered intern, associate clinical social worker, or clinical counselor trainee by any licensee that violates this chapter or any rules or regulations adopted by the board.

(s) Performing or holding oneself out as being able to perform professional services beyond the scope of one's competence, as established by one's education, training, or experience. This subdivision shall not be construed to expand the scope of the license authorized by this chapter.

(t) Permitting a clinical counselor trainee or intern under one's supervision or control to perform, or permitting the clinical counselor trainee or intern to hold himself or herself out as competent to perform, professional services beyond the clinical counselor trainee's or intern's level of education, training, or experience.

(u) The violation of any statute or regulation of the standards of the profession, and the nature of the services being rendered, governing the gaining and supervision of experience required by this chapter.

(v) Failure to keep records consistent with sound clinical judgment, the standards of the profession, and the nature of the services being rendered.

(w) Failure to comply with the child abuse reporting requirements of Section 11166 of the Penal Code.

(x) Failing to comply with the elder and dependent adult abuse reporting requirements of Section 15630 of the Welfare and Institutions Code.

(y) Repeated acts of negligence.

(z) (1) Engaging in an act described in Section 261, 286, 288a, or 289 of the Penal Code with a minor or an act described in Section 288 or 288.5 of the Penal Code regardless of whether the act occurred prior to or after the time the registration or license was issued by the board. An act described in this subdivision occurring prior to the effective date of this subdivision shall constitute unprofessional conduct and shall subject the licensee to refusal, suspension, or revocation of a license under this section.

(2) The Legislature hereby finds and declares that protection of the public, and in particular minors, from sexual misconduct by a

licensee is a compelling governmental interest, and that the ability to suspend or revoke a license for sexual conduct with a minor occurring prior to the effective date of this section is equally important to protecting the public as is the ability to refuse a license for sexual conduct with a minor occurring prior to the effective date of this section.

(aa) Engaging in any conduct that subverts or attempts to subvert any licensing examination or the administration of an examination as described in Section 123.

(ab) Revocation, suspension, or restriction by the board of a license, certificate, or registration to practice as a clinical social worker, educational psychologist, or marriage and family therapist.

(ac) Failing to comply with the procedures set forth in Section 2290.5 when delivering health care via telehealth.

SEC. 6. Section 78910.10 of the Education Code is amended to read:

78910.10. (a) (1) The California Virtual Campus, pursuant to funding provided to the Board of Governors of the California Community Colleges for this purpose in the annual Budget Act, may pursue all of the following purposes, to the extent funding is available:

(A) To enrich formal and informal educational experiences and improve students' academic performance by supporting the development of highly engaging, research-based innovations in teaching and learning in K-12 public schools and the California Community Colleges, the California State University, and the University of California.

(B) To enhance the awareness of, and access to, highly engaging online courses of study, emphasizing courses of study that support a diverse and highly skilled science, technology, engineering, and mathematics workforce.

(C) To support education research, the implementation of research-based practices, and promote economic development through the use of next generation advanced network infrastructure, services, and network technologies that enable collaboration and resource sharing between formal and informal educators in K-12 public schools, the California Community Colleges, the California State University, the University of California, independent colleges and universities, public libraries, and community-based organizations at locations across the state.

(D) To increase access to next generation Internet services, 21st century workforce development programs, and e-government services for students and staff served or employed by education entities and students served primarily online through partnerships with public libraries and community-based organizations.

(E) To enhance access to health care education and training programs to current or future health care workers.

(F) To manage digital assets and develop contracts for services necessary to provide the technical and management support needed to maximize the benefits of the high-speed, high-bandwidth network infrastructure available to public higher education entities in California.

(G) Through the aggregation of demand for network enabled technologies and related services from public education entities, and through partnerships with the private sector, to provide education entities with access to technical support and staff who can facilitate statewide efforts that support innovations in teaching and learning that are necessary to provide for a well-educated citizenry, and economic and 21st century workforce development.

(2) To accomplish the purposes of paragraph (1), the California Virtual Campus may partner with local educational agencies, the State Department of Education, the 11 regional California Technology Assistance Projects, the California Community Colleges, the California State University, the University of California, independent colleges and universities, public libraries, and community-based organizations to facilitate ongoing collaboration and joint efforts relating to the use of technology resources and high-speed Internet connectivity to support teaching, learning, workforce development, and research.

(3) Efforts conducted as a result of this chapter shall not prohibit or otherwise exclude the ability of existing or new educational technology programs from being developed, expanded, or enhanced.

(b) For purposes of this article, the following terms have the following meanings:

(1) "Online courses of study" means any of the following:

(A) Online teaching, learning, and research resources, including, but not necessarily limited to, books, course materials, video materials, interactive lessons, tests, or software, the copyrights of which have expired, or have been released with an intellectual

property license that permits their free use or repurposing by others without the permission of the original authors or creators of the learning materials or resources.

(B) Professional development opportunities for formal and informal educators who desire to use the resources in subparagraph (A).

(C) Online instruction.

(2) "Online instruction" means technology enabled online real time (synchronous) interaction between the instructor and the student, near time (asynchronous) interaction between the instructor and the student, or any combination thereof.

(c) The California Virtual Campus grant recipient may accomplish all of the following:

(1) Convene at least four leadership stakeholder group meetings annually comprised of representatives from the State Department of Education, the California Technology Assistance Project, and other related programs administered through the department, local education agencies, including adult education, the California Community Colleges, the California State University, the University of California, independent colleges and universities, the California State Library, and representatives from community-based organizations to ensure the efforts affecting segments represented are appropriately meeting the needs of those segments. The leadership stakeholder group shall also coordinate and obtain assistance with the implementation of efforts delineated in this article, to identify and maintain an up-to-date list of the technology resources and tools that are necessary to support innovation in teaching and learning, and to identify opportunities for leveraging resources and expertise for meeting those needs in an efficient and cost-effective manner.

(2) Lead efforts to make online courses of study available across the state that include, but are not limited to, the following:

(A) Developing online courses of study that are pedagogically sound and fully accessible, in compliance with the federal Americans with Disabilities Act (Public Law 101-336), by students with varying learning styles and disabilities.

(i) The development of K-12 online courses pursuant to this subparagraph shall be achieved in partnership with local education agencies and the California Technology Assistance Project.

(ii) Online courses developed for grades K-12 pursuant to this subparagraph shall be aligned to the California academic content standards and guidelines for online courses.

(B) Overseeing the development of at least 12 model online courses of study that, collectively, would allow students to meet the requirements of the Intersegmental General Education Transfer Curriculum (IGETC) and at least two courses that support basic skills education courses in English, English as a second language, or mathematics.

(C) Encouraging the entities listed in paragraph (1) to do both of the following:

(i) Make accessible to each other their courses of study that are funded by the state.

(ii) Allow their courses of study to be accessible to the general public if they determine access would not inhibit their ability to provide appropriate protection of the state's intellectual property rights.

(3) Ensure that the learning objects created as part of the California Virtual Campus online courses of study with state General Fund revenues are linked to digital content libraries that include information about course content freely available to California educators and students.

(4) Develop formal partnership agreements between the entities listed in paragraph (1) and the California Virtual Campus, including course articulation agreements that allow qualified high school students to accelerate the completion of requirements for a high school diploma and a two-year or four-year degree and agreements that provide opportunities for part-time faculty teaching online to obtain full-time employment teaching online.

(5) Develop formal partnership agreements with the entities listed in paragraph (1) and others to enhance access to professional development courses that introduce faculty, teachers, staff, and college course developers to the conceptual development, creation, and production methodologies that underlie the development of online courses of study and support students' successful completion of those courses. The professional development opportunities may include, but not necessarily be limited to, all of the following:

(A) Addressing issues relating to copyright, permission for the use or reuse of material, use of resources in the public domain, and other intellectual property concepts.

(B) Accessibility for students with disabilities.

(C) Factors to ensure that content is culturally relevant to a diverse student body.

(D) Delivery options that incorporate multiple learning styles and strategies.

(6) Develop formal partnership agreements with entities, including, but not limited to, those listed in paragraph (1), to ensure access to online professional learning communities that incorporate the use of Internet-based collaboration tools and to support joint discussions between K-12 educators, higher education faculty and staff, and others to examine student performance data, student learning objectives, curriculum, and other issues that relate to students' academic success and preparation for the workforce.

(7) In partnership with entities, including those listed in paragraph (1), develop an e-portfolio system that allows participating students to demonstrate their attainment of academic learning objectives, skills and knowledge that relate to their career interests, and completion of prerequisites for participation in courses or training programs. The e-portfolio system may do all of the following:

(A) Ensure that student privacy is protected in accordance with existing law.

(B) Comply with accessibility laws for students with disabilities.

(C) Be designed in a manner that supports the use of e-portfolio content in the accreditation requirements of schools, colleges, and universities.

(8) In partnership with entities, including those listed in paragraph (1), identify opportunities to enhance students' access to medical education and medical services through the use of high-speed Internet connections to the campuses, and opportunities for education programs and services to support the telehealth efforts taking place within the state.

(d) The lead agency for the California Virtual Campus, in consultation with the leadership stakeholder group described in paragraph (1) of subdivision (c) if that group is convened by the California Virtual Campus grant recipient, shall contract with an independent third party with expertise in online teaching, learning, and the development of online courses of study, as approved by the board, to evaluate the California Virtual Campus. The evaluation shall include, but not be limited to, an assessment of

the number of faculty, teachers, consortia, informal educators, and students that use the online courses of study, the quality of students' experiences, student grades earned, and the cost of the online course content, comparing the online course content with traditional textbooks. The board may require additional information that it determines to be necessary to evaluate the effectiveness and viability of the California Virtual Campus. This evaluation shall be submitted to the Legislature no later than three years of the enactment of this act.

SEC. 7. Section 1367 of the Health and Safety Code is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) A health care service plan contract shall provide to subscribers and enrollees all of the basic health care services included in subdivision (b) of Section 1345, except that the director may, for good cause, by rule or order exempt a plan contract or any class of plan contracts from that requirement. The director shall by rule define the scope of each basic health care service that health care service plans are required to provide as a minimum for licensure under this chapter. Nothing in this chapter shall prohibit a health care service plan from charging subscribers or enrollees a copayment or a deductible for a basic health care service or from setting forth, by contract, limitations on maximum coverage of basic health care services, provided that the copayments,

deductibles, or limitations are reported to, and held unobjectionable by, the director and set forth to the subscriber or enrollee pursuant to the disclosure provisions of Section 1363.

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

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

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

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

SEC. 8. Section 1374.13 of the Health and Safety Code is amended to read:

1374.13. (a) It is the intent of the Legislature to recognize the practice of telehealth as a legitimate means by which an individual may receive medical services from a health care provider without person-to-person contact with the provider.

(b) For the purposes of this section, the meaning of "telehealth" is as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code.

(c) On and after January 1, 1997, no health care service plan contract that is issued, amended, or renewed shall require face-to-face contact between a health care provider and a patient for services appropriately provided through telehealth, subject to all terms and conditions of the contract agreed upon between the enrollee or subscriber and the plan. The requirement of this subdivision shall be operative for health care service plan contracts with the Medi-Cal managed care program only to the extent that both of the following apply:

(1) Telehealthservices are covered by, and reimbursed under, the Medi-Cal fee-for-service program, as provided in subdivision (c) of Section 14132.72.

(2) Medi-Cal contracts with health care service plans are amended to add coverage of telehealth services and make any appropriate capitation rate adjustments.

(d) Health care service plans shall not be required to pay for consultation provided by the health care provider by telephone or facsimile machines.

SEC. 9. Section 1375.1 of the Health and Safety Code is amended to read:

1375.1. (a) Every plan shall have and shall demonstrate to the director that it has all of the following:

(1) A fiscally sound operation and adequate provision against the risk of insolvency.

(2) Assumed full financial risk on a prospective basis for the provision of covered health care services, except that a plan may obtain insurance or make other arrangements for the cost of providing to any subscriber or enrollee covered health care services, the aggregate value of which exceeds five thousand dollars ($5,000) in any year, for the cost of covered health care services provided to its members other than through the plan because medical necessity required their provision before they could be secured through the plan, and for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for that fiscal year.

(3) A procedure for prompt payment or denial of provider and subscriber or enrollee claims, including those telehealth services, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, covered by the plan. Except as provided in Section 1371, a procedure meeting the requirements of Subchapter G of the regulations (29 C.F.R. Part 2560) under Public Law 93-406 (88 Stats. 829-1035, 29 U.S.C. Secs. 1001 et seq.) shall satisfy this requirement.

(b) In determining whether the conditions of this section have been met, the director shall consider, but not be limited to, the following:

(1) The financial soundness of the plan's arrangements for health care services and the schedule of rates and charges used by the plan.

(2) The adequacy of working capital.

(3) Agreements with providers for the provision of health care services.

(c) For the purposes of this section, "covered health care services" means health care services provided under all plan contracts.

SEC. 10. Section 1797.98b of the Health and Safety Code is amended to read:

1797.98b. (a) Each county establishing a fund, on January 1, 1989, and on each April 15 thereafter, shall report to the Legislature on the implementation and status of the Emergency Medical Services Fund. The report shall cover the preceding fiscal year, and shall include, but not be limited to, all of the following:

(1) The total amount of fines and forfeitures collected, the total amount of penalty assessments collected, and the total amount of penalty assessments deposited into the Emergency Medical Services Fund, or, if no moneys were deposited into the fund, the reason or reasons for the lack of deposits. The total amounts of penalty assessments shall be listed on the basis of each statute that provides the authority for the penalty assessment, including Sections 76000, 76000.5, and 76104 of the Government Code, and Section 42007 of the Vehicle Code.

(2) The amount of penalty assessment funds collected under Section 76000.5 of the Government Code that are used for the purposes of subdivision (e) of Section 1797.98a.

(3) The fund balance and the amount of moneys disbursed under the program to physicians and surgeons, for hospitals, and for other emergency medical services purposes, and the amount of money disbursed for actual administrative costs. If funds were disbursed for other emergency medical services, the report shall provide a description of each of those services.

(4) The number of claims paid to physicians and surgeons, and the percentage of claims paid, based on the uniform fee schedule, as adopted by the county.

(5) The amount of moneys available to be disbursed to physicians and surgeons, descriptions of the physician and surgeon claims payment methodologies, the dollar amount of the total allowable claims submitted, and the percentage at which those claims were reimbursed.

(6) A statement of the policies, procedures, and regulatory action taken to implement and run the program under this chapter.

(7) The name of the physician and surgeon and hospital administrator organization, or names of specific physicians and

surgeons and hospital administrators, contacted to review claims payment methodologies.

(8) A description of the process used to solicit input from physicians and surgeons and hospitals to review payment distribution methodology as described in subdivision (a) of Section 1797.98e.

(9) An identification of the fee schedule used by the county pursuant to subdivision (e) of Section 1797.98c.

(10) (A) A description of the methodology used to disburse moneys to hospitals pursuant to subparagraph (B) of paragraph (5) of subdivision (b) of Section 1797.98a.

(B) The amount of moneys available to be disbursed to hospitals.

(C) If moneys are disbursed to hospitals on a claims basis, the dollar amount of the total allowable claims submitted and the percentage at which those claims were reimbursed to hospitals.

(11) The name and contact information of the entity responsible for each of the following:

(A) Collection of fines, forfeitures, and penalties.

(B) Distribution of penalty assessments into the Emergency Medical Services Fund.

(C) Distribution of moneys to physicians and surgeons.

(b) (1) Each county, upon request, shall make available to any member of the public the report required under subdivision (a).

(2) Each county, upon request, shall make available to any member of the public a listing of physicians and surgeons and hospitals that have received reimbursement from the Emergency Medical Services Fund and the amount of the reimbursement they have received. This listing shall be compiled on a semiannual basis.

*SEC. 10.3. Section 113807 is added to the Health and Safety Code, to read:*

*113807. "Hot dog" means a whole, cured, cooked sausage that is skinless or stuffed in a casing, may be served in a bun or roll, and is also known as a bologna, frank, frankfurter, furter, garlic bologna, knockwurst, red hot, Vienna, or wiener.*

SEC. 11. Section 113953.3 of the Health and Safety Code is amended to read:

113953.3. (a) Except as specified in subdivision (b), all employees shall thoroughly wash their hands and that portion, if any, of their arms exposed to direct food contact with cleanser and warm water by vigorously rubbing together the surfaces of their

lathered hands and arms for at least 10 to 15 seconds and thoroughly rinsing with clean running water followed by drying of cleaned hands and that portion, if any, of their arms exposed. Employees shall pay particular attention to the areas underneath the fingernails and between the fingers. Employees shall wash their hands in all of the following instances:

(1) Immediately before engaging in food preparation, including working with nonprepackaged food, clean equipment and utensils, and unwrapped single-use food containers and utensils.

(2) After touching bare human body parts other than clean hands and clean, exposed portions of arms.

(3) After using the toilet room.

(4) After caring for or handling any animal allowed in a food facility pursuant to this part.

(5) After coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking.

(6) After handling soiled equipment or utensils.

(7) During food preparation, as often as necessary to remove soil and contamination and to prevent cross-contamination when changing tasks.

(8) When switching between working with raw food and working with ready-to-eat food.

(9) Before dispensing or serving food or handling clean tableware and serving utensils in the food service area.

(10) After engaging in other activities that contaminate the hands.

(11) Before initially donning gloves for working with food and before donning gloves to replace gloves that were changed or replaced due to the circumstances described in paragraphs (2) to (10), inclusive.

(b) If approved and capable of removing the types of soils encountered in the food operations involved, an automatic handwashing facility may be used by food employees to clean their hands.

SEC. 12. Section 113973 of the Health and Safety Code is amended to read:

113973. (a) Gloves shall be worn when contacting food and food-contact surfaces if the employee has any cuts, sores, rashes, artificial nails, nail polish, rings (other than a plain ring, such as

a wedding band), uncleanable orthopedic support devices, or fingernails that are not clean, smooth, or neatly trimmed.

(b) Whenever gloves, except single-use gloves, are worn, they shall be changed, replaced, or washed as often as handwashing is required by this part.

(c) If used, single-use gloves shall be used for only one task, such as working with ready-to-eat food or with raw food of animal origin, used for no other purpose, and shall be discarded when damaged or soiled, or when interruptions in the food handling occur. Single-use gloves shall not be washed.

(d) Except as specified in subdivision (e), slash-resistant gloves that are used to protect the hands during operations requiring cutting shall be used only with food that is subsequently cooked as specified in Section 114004, such as frozen food or a primal cut of meat.

(e) Slash-resistant gloves may be used with ready-to-eat food that will not be subsequently cooked if the slash-resistant gloves have a smooth, durable, and nonabsorbent outer surface or if the slash-resistant gloves are covered with a smooth, durable, nonabsorbent glove, or a single-use glove.

(f) Cloth gloves may not be used in direct contact with food unless the food is subsequently cooked.

SEC. 13. Section 113975 is added to the Health and Safety Code, to read:

113975. (a) Except as provided in subdivision (b), an employee who has a lesion or wound that is open or draining shall not handle food.

(b) In addition to wearing gloves when contacting food and food-contact surfaces, a food employee who has a cut, sore, rash, lesion, or wound shall do all of the following:

(1) If the lesion is located on the hand or wrist, an impermeable cover, such as a finger cot or stall shall protect the lesion. A single-use glove shall be worn over the impermeable cover.

(2) If the lesion is located on exposed portions of the arms, an impermeable cover shall protect the lesion.

(3) If the lesion is located on other parts of the body, a dry, durable, tight-fitting bandage shall cover the lesion.

SEC. 14. Section 121022 of the Health and Safety Code is amended to read:

121022. (a) To ensure knowledge of current trends in the HIV epidemic and to ensure that California remains competitive for federal HIV and AIDS funding, health care providers and laboratories shall report cases of HIV infection to the local health officer using patient names on a form developed by the department. Local health officers shall report unduplicated HIV cases by name to the department on a form developed by the department.

(b) (1) Health care providers and local health officers shall submit cases of HIV infection pursuant to subdivision (a) by courier service, United States Postal Service express mail or registered mail, other traceable mail, person-to-person transfer, facsimile, or electronically by a secure and confidential electronic reporting system established by the department.

(2) This subdivision shall be implemented using the existing resources of the department.

(c) The department and local health officers shall ensure continued reasonable access to anonymous HIV testing through alternative testing sites, as established by Section 120890, and in consultation with HIV planning groups and affected stakeholders, including representatives of persons living with HIV and health officers.

(d) The department shall promulgate emergency regulations to conform the relevant provisions of Article 3.5 (commencing with Section 2641.5) of Chapter 4 of Division 1 of Title 17 of the California Code of Regulations, consistent with this chapter, by April 17, 2007. Notwithstanding the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), if the department revises the form used for reporting pursuant to subdivision (a) after consideration of the reporting guidelines published by the federal Centers for Disease Control and Prevention, the revised form shall be implemented without being adopted as a regulation, and shall be filed with the Secretary of State and printed in Title 17 of the California Code of Regulations.

(e) Pursuant to Section 121025, reported cases of HIV infection shall not be disclosed, discoverable, or compelled to be produced in any civil, criminal, administrative, or other proceeding.

(f) State and local health department employees and contractors shall be required to sign confidentiality agreements developed by the department that include information related to the penalties for

a breach of confidentiality and the procedures for reporting a breach of confidentiality, prior to accessing confidential HIV-related public health records. Those agreements shall be reviewed annually by either the department or the appropriate local health department.

(g) No person shall disclose identifying information reported pursuant to subdivision (a) to the federal government, including, but not limited to, any agency, employee, agent, contractor, or anyone else acting on behalf of the federal government, except as permitted under subdivision (b) of Section 121025.

(h) (1) Any potential or actual breach of confidentiality of HIV-related public health records shall be investigated by the local health officer, in coordination with the department, when appropriate. The local health officer shall immediately report any evidence of an actual breach of confidentiality of HIV-related public health records at a city or county level to the department and the appropriate law enforcement agency.

(2) The department shall investigate any potential or actual breach of confidentiality of HIV-related public health records at the state level, and shall report any evidence of such a breach of confidentiality to an appropriate law enforcement agency.

(i) Any willful, negligent, or malicious disclosure of cases of HIV infection reported pursuant to subdivision (a) shall be subject to the penalties prescribed in Section 121025.

(j) Nothing in this section shall be construed to limit other remedies and protections available under state or federal law.

SEC. 15. Section 123149.5 of the Health and Safety Code is amended to read:

123149.5. (a) It is the intent of the Legislature that all medical information transmitted during the delivery of health care via telehealth, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, become part of the patient's medical record maintained by the licensed health care provider.

(b) This section shall not be construed to limit or waive any of the requirements of Chapter 1 (commencing with Section 123100) of Part 1 of Division 106 of the Health and Safety Code.

SEC. 16. Section 127620 of the Health and Safety Code is amended to read:

127620. (a) The Office of Statewide Health Planning and Development, in conjunction with the State Department of Public Health, shall act as the coordinating agency to develop a strategic

plan that would assist rural California to prepare for health care reform. The plan shall assist in the coordination and integration of all rural health care services on the birth to death continuum and serve as an infrastructure for rural communities to establish priorities and develop appropriate programs.

(b) The office shall designate representatives from provider groups including rural hospitals, clinics, physicians, other rural providers including psychologists, counties, beneficiaries, and other entities directly affected by the plan. The office shall convene meetings with the objectives of doing all of the following:

(1) Assessing the current status of health care in rural communities.

(2) Assembling and reviewing data related to available programs and resources for rural California.

(3) Assembling and reviewing data related to other states' strategic plans for rural communities.

(4) Reviewing and integrating the office's rural work plan, as appropriate.

(5) Making assumptions about the future of health care and developing a strategic plan based on these assumptions.

(c) The rural health care strategic plan shall address all of the following:

(1) The special needs of the elderly and of ethnic populations.

(2) Elimination of barriers in planning and coordinating health services.

(3) The lack of primary and specialty providers.

(4) Access to emergency services.

(5) The role of new technologies, including, but not limited to, telehealth.

SEC. 17. Section 130302 of the Health and Safety Code is amended to read:

130302. For the purposes of this division, the following definitions apply:

(a) "Director" means the Director of the Office of Health Information Integrity.

(b) "HIPAA" means the federal Health Insurance Portability and Accountability Act.

(c) "Office" means the Office of Health Information Integrity established in the California Health and Human Services Agency pursuant to Section 130200.

(d) "State entities" means all state departments, boards, commissions, programs, and other organizational units of the executive branch of state government.

SEC. 18. Section 130304 of the Health and Safety Code is repealed.

SEC. 19. Section 130307 of the Health and Safety Code is amended to read:

130307. The director shall establish an advisory committee to obtain information on statewide HIPAA implementation activities. The advisory committee shall meet as required to coordinate statewide HIPAA implementation activities with other health care stakeholders. It is the intent of the Legislature that the committee's membership include representatives from county government, from consumers, and from a broad range of provider groups, such as physicians and surgeons, clinics, hospitals, pharmaceutical companies, health care service plans, disability insurers, long-term care facilities, facilities for the developmentally disabled, and mental health providers. The director shall invite key stakeholders from the federal government, the Judicial Council, health care advocates, nonprofit health care organizations, public health systems, and the private sector to provide information to the committee.

SEC. 20. Section 130309 of the Health and Safety Code is repealed.

SEC. 21. Section 10123.13 of the Insurance Code is amended to read:

10123.13. (a) Every insurer issuing group or individual policies of health insurance that covers hospital, medical, or surgical expenses, including those telehealth services covered by the insurer as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, shall reimburse claims or any portion of any claim, whether in state or out of state, for those expenses as soon as practical, but no later than 30 working days after receipt of the claim by the insurer unless the claim or portion thereof is contested by the insurer, in which case the claimant shall be notified, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the insurer. The notice that a claim is being contested or denied shall identify the portion of the claim that is contested or denied and the specific reasons including for each reason the factual and legal basis known at that time by

the insurer for contesting or denying the claim. If the reason is based solely on facts or solely on law, the insurer is required to provide only the factual or the legal basis for its reason for contesting or denying the claim. The insurer shall provide a copy of the notice to each insured who received services pursuant to the claim that was contested or denied and to the insured's health care provider that provided the services at issue. The notice shall advise the provider who submitted the claim on behalf of the insured or pursuant to a contract for alternative rates of payment and the insured that either may seek review by the department of a claim that the insurer contested or denied, and the notice shall include the address, Internet Web site address, and telephone number of the unit within the department that performs this review function. The notice to the provider may be included on either the explanation of benefits or remittance advice and shall also contain a statement advising the provider of its right to enter into the dispute resolution process described in Section 10123.137. The notice to the insured may also be included on the explanation of benefits.

(b) If an uncontested claim is not reimbursed by delivery to the claimant's address of record within 30 working days after receipt, interest shall accrue and shall be payable at the rate of 10 percent per annum beginning with the first calendar day after the 30-working day period.

(c) For purposes of this section, a claim, or portion thereof, is reasonably contested when the insurer has not received a completed claim and all information necessary to determine payer liability for the claim, or has not been granted reasonable access to information concerning provider services. Information necessary to determine liability for the claims includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for the insurer to determine the medical necessity for the health care services provided to the claimant. If an insurer has received all of the information necessary to determine payer liability for a contested claim and has not reimbursed a claim determined to be payable within 30 working days of receipt of that information, interest shall accrue and be payable at a rate of 10 percent per annum beginning with the first calendar day after the 30-working day period.

(d) The obligation of the insurer to comply with this section shall not be deemed to be waived when the insurer requires its contracting entities to pay claims for covered services.

SEC. 22. Section 10123.147 of the Insurance Code is amended to read:

10123.147. (a) Every insurer issuing group or individual policies of health insurance that covers hospital, medical, or surgical expenses, including those telehealth services covered by the insurer as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than 30 working days after receipt of the complete claim by the insurer. However, an insurer may contest or deny a claim, or portion thereof, by notifying the claimant, in writing, that the claim is contested or denied, within 30 working days after receipt of the complete claim by the insurer. The notice that a claim, or portion thereof, is contested shall identify the portion of the claim that is contested, by revenue code, and the specific information needed from the provider to reconsider the claim. The notice that a claim, or portion thereof, is denied shall identify the portion of the claim that is denied, by revenue code, and the specific reasons for the denial, including the factual and legal basis known at that time by the insurer for each reason. If the reason is based solely on facts or solely on law, the insurer is required to provide only the factual or legal basis for its reason to deny the claim. The insurer shall provide a copy of the notice required by this subdivision to each insured who received services pursuant to the claim that was contested or denied and to the insured's health care provider that provided the services at issue. The notice required by this subdivision shall include a statement advising the provider who submitted the claim on behalf of the insured or pursuant to a contract for alternative rates of payment and the insured that either may seek review by the department of a claim that was contested or denied by the insurer and the address, Internet Web site address, and telephone number of the unit within the department that performs this review function. The notice to the provider may be included on either the explanation of benefits or remittance advice and shall also contain a statement advising the provider of its right to enter into the dispute resolution process described in Section 10123.137. An insurer may delay payment

of an uncontested portion of a complete claim for reconsideration of a contested portion of that claim so long as the insurer pays those charges specified in subdivision (b).

(b) If a complete claim, or portion thereof, that is neither contested nor denied, is not reimbursed by delivery to the claimant's address of record within the 30 working days after receipt, the insurer shall pay the greater of fifteen dollars ($15) per year or interest at the rate of 10 percent per annum beginning with the first calendar day after the 30-working-day period. An insurer shall automatically include the fifteen dollars ($15) per year or interest due in the payment made to the claimant, without requiring a request therefor.

(c) For the purposes of this section, a claim, or portion thereof, is reasonably contested if the insurer has not received the completed claim. A paper claim from an institutional provider shall be deemed complete upon submission of a legible emergency department report and a completed UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the insurer within 30 working days of receipt of the claim. An electronic claim from an institutional provider shall be deemed complete upon submission of an electronic equivalent to the UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the insurer within 30 working days of receipt of the claim. However, if the insurer requests a copy of the emergency department report within the 30 working days after receipt of the electronic claim from the institutional provider, the insurer may also request additional reasonable relevant information within 30 working days of receipt of the emergency department report, at which time the claim shall be deemed complete. A claim from a professional provider shall be deemed complete upon submission of a completed HCFA 1500 or its electronic equivalent or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the insurer within 30 working days of receipt of the claim. The provider shall provide the insurer reasonable relevant information within 15 working days of receipt of a written request that is clear and specific regarding the information sought. If, as a result of reviewing the reasonable relevant information, the insurer requires further information, the insurer shall have an additional 15 working

days after receipt of the reasonable relevant information to request the further information, notwithstanding any time limit to the contrary in this section, at which time the claim shall be deemed complete.

(d) This section shall not apply to claims about which there is evidence of fraud and misrepresentation, to eligibility determinations, or in instances where the plan has not been granted reasonable access to information under the provider's control. An insurer shall specify, in a written notice to the provider within 30 working days of receipt of the claim, which, if any, of these exceptions applies to a claim.

(e) If a claim or portion thereof is contested on the basis that the insurer has not received information reasonably necessary to determine payer liability for the claim or portion thereof, then the insurer shall have 30 working days after receipt of this additional information to complete reconsideration of the claim. If a claim, or portion thereof, undergoing reconsideration is not reimbursed by delivery to the claimant's address of record within the 30 working days after receipt of the additional information, the insurer shall pay the greater of fifteen dollars ($15) per year or interest at the rate of 10 percent per annum beginning with the first calendar day after the 30-working-day period. An insurer shall automatically include the fifteen dollars ($15) per year or interest due in the payment made to the claimant, without requiring a request therefor.

(f) An insurer shall not delay payment on a claim from a physician or other provider to await the submission of a claim from a hospital or other provider, without citing specific rationale as to why the delay was necessary and providing a monthly update regarding the status of the claim and the insurer's actions to resolve the claim, to the provider that submitted the claim.

(g) An insurer shall not request or require that a provider waive its rights pursuant to this section.

(h) This section shall apply only to claims for services rendered to a patient who was provided emergency services and care as defined in Section 1317.1 of the Health and Safety Code in the United States on or after September 1, 1999.

(i) This section shall not be construed to affect the rights or obligations of any person pursuant to Section 10123.13.

(j) This section shall not be construed to affect a written agreement, if any, of a provider to submit bills within a specified time period.

SEC. 23. Section 10123.85 of the Insurance Code is amended to read:

10123.85. (a) It is the intent of the Legislature to recognize the practice of telehealth as a legitimate means by which an individual may receive medical services from a health care provider without person-to-person contact with the provider.

(b) For the purposes of this section, the meaning of "telehealth" is as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code.

(c) On and after January 1, 1997, no disability insurance contract that is issued, amended, or renewed for hospital, medical, or surgical coverage shall require face-to-face contact between a health care provider and a patient for services appropriately provided through telehealth, subject to all terms and conditions of the contract agreed upon between the policyholder or contractholder and the insurer.

(d) Disability insurers shall not be required to pay for consultation provided by the health care provider by telephone or facsimile machines.

SEC. 24. Section 10181.11 of the Insurance Code is amended to read:

10181.11. (a) Whenever it appears to the department that any person has engaged, or is about to engage, in any act or practice constituting a violation of this article, including the filing of inaccurate or unjustified rates or inaccurate or unjustified rate information, the department may review the rate filing to ensure compliance with the law.

(b) The department may review other filings.

(c) The department shall accept and post to its Internet Web site any public comment on a rate increase submitted to the department during the 60-day period described in subdivision (d) of Section 10181.7.

(d) The department shall report to the Legislature at least quarterly on all unreasonable rate filings.

(e) The department shall post on its Internet Web site any changes submitted by the insurer to the proposed rate increase,

including any documentation submitted by the insurer supporting those changes.

(f) If the department finds that an unreasonable rate increase is not justified or that a rate filing contains inaccurate information, the department shall post its finding on its Internet Web site.

(g) Nothing in this article shall be construed to impair or impede the department's authority to administer or enforce any other provision of this code.

SEC. 25. Section 10198.7 of the Insurance Code is amended to read:

10198.7. (a) No health benefit plan that covers three or more persons and that is issued, renewed, or written by any insurer, nonprofit hospital service plan, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity shall exclude coverage for any individual on the basis of a preexisting condition provision for a period greater than six months following the individual's effective date of coverage, nor shall limit or exclude coverage for a specific insured person by type of illness, treatment, medical condition, or accident except for satisfaction of a preexisting clause pursuant to this article. Preexisting condition provisions contained in health benefit plans may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the six months immediately preceding the effective date of coverage.

(b) No health benefit plan that covers one or two individuals and that is issued, renewed, or written by any insurer, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity shall exclude coverage on the basis of a preexisting condition provision for a period greater than 12 months following the individual's effective date of coverage, nor shall limit or exclude coverage for a specific insured person by type of illness, treatment, medical condition, or accident, except for satisfaction of a preexisting condition clause pursuant to this article. Preexisting condition provisions contained in health benefit plans may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.

(c) (1) Notwithstanding subdivision (a), a health benefit plan for group coverage shall not impose any preexisting condition provision upon any child under 19 years of age.

(2) Notwithstanding subdivision (b), a health benefit plan for individual coverage that is not a grandfathered plan within the meaning of Section 1251 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) shall not impose any preexisting condition provision upon any child under 19 years of age.

(d) A carrier that does not utilize a preexisting condition provision may impose a waiting or affiliation period not to exceed 60 days, before the coverage issued subject to this article shall become effective. During the waiting or affiliation period, the carrier is not required to provide health care services and no premium shall be charged to the subscriber or enrollee.

(e) A carrier that does not utilize a preexisting condition provision in health plans that cover one or two individuals may impose a contract provision excluding coverage for waivered conditions. No carrier may exclude coverage on the basis of a waivered condition for a period greater than 12 months following the individual's effective date of coverage. A waivered condition provision contained in health benefit plans may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.

(f) In determining whether a preexisting condition provision, a waivered condition provision, or a waiting or affiliation period applies to any person, all health benefit plans shall credit the time the person was covered under creditable coverage, provided the person becomes eligible for coverage under the succeeding health benefit plan within 62 days of termination of prior coverage, exclusive of any waiting or affiliation period, and applies for coverage under the succeeding plan within the applicable enrollment period. A health benefit plan shall also credit any time an eligible employee must wait before enrolling in the health benefit plan, including any affiliation or employer-imposed waiting period. However, if a person's employment has ended, the availability of health coverage offered through employment or sponsored by an employer has terminated or, an employer's

contribution toward health coverage has terminated, a carrier shall credit the time the person was covered under creditable coverage if the person becomes eligible for health coverage offered through employment or sponsored by an employer within 180 days, exclusive of any waiting or affiliation period, and applies for coverage under the succeeding plan within the applicable enrollment period.

(g) No health benefit plan that covers three or more persons and that is issued, renewed, or written by any insurer, nonprofit hospital service plan, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity may exclude late enrollees from coverage for more than 12 months from the date of the late enrollee's application for coverage. No insurer, nonprofit hospital service plan, self-insured employee welfare benefit plan, fraternal benefits society, or any other entity shall require any premium or other periodic charge to be paid by or on behalf of a late enrollee during the period of exclusion from coverage permitted by this subdivision.

(h) An individual's period of creditable coverage shall be certified pursuant to subdivision (e) of Section 2701 of Title XXVII of the federal Public Health Services Act, 42 U.S.C. Sec. 300gg(e).

(i) A group health benefit plan may not impose a preexisting condition exclusion to a condition relating to benefits for pregnancy or maternity care.

(j) Any entity providing aggregate or specific stop loss coverage or any other assumption of risk with reference to a health benefit plan shall provide that the plan meets all requirements of this article concerning waiting periods, preexisting condition provisions, and late enrollees.

SEC. 26. Section 10953 of the Insurance Code is amended to read:

10953. (a) Upon the effective date of this chapter, a carrier shall fairly and affirmatively offer, market, and sell all of the carrier's health benefit plans that are offered and sold to a child or the responsible party for a child in each service area in which the plan provides or arranges for health care coverage during any open enrollment period, to late enrollees, and during any other period in which state or federal law, rules, regulations, or guidance expressly provide that a carrier shall not condition offer or acceptance of coverage on any preexisting condition.

(b) No carrier, agent, or broker shall, directly or indirectly, engage in the following activities:

(1) Encourage or direct a child or responsible party for a child to refrain from filing an application for coverage with a carrier because of the health status, claims experience, industry, occupation, or geographic location, provided that the location is within the carrier's approved service area, of the child.

(2) Encourage or direct a child or responsible party for a child to seek coverage from another carrier because of the health status, claims experience, industry, occupation, or geographic location, provided that the location is within the carrier's approved service area, of the child.

(c) A carrier shall not, directly or indirectly, enter into any contract, agreement, or arrangement with an agent or broker of the carrier that provides for or results in the payment of compensation to the agent or broker for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the child. This subdivision does not apply to a compensation arrangement that provides compensation to an agent or broker of a carrier on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the child.

SEC. 27. Section 10959 of the Insurance Code is amended to read:

10959. (a) All health benefit plans offered to a child or on behalf of a child to a responsible party for a child shall conform to the requirements of Sections 10127.18, 10273.6, and 12682.1, and shall be renewable at the option of the child or responsible party for a child on behalf of the child except as permitted to be canceled, rescinded, or not renewed pursuant to Section 10273.6.

(b) Any carrier that ceases to offer for sale new individual health benefit plans pursuant to Section 10273.6 shall continue to be governed by this chapter with respect to business conducted under this chapter.

(c) Except as authorized under Section 10958, a carrier that as of the effective date of this chapter does not write new health benefit plans for children in this state or that after the effective date of this chapter ceases to write new health benefit plans for children in this state shall be prohibited from offering for sale new

individual health benefit plans or in this state for a period of five years from the date of notice to the commissioner.

SEC. 28. Section 5705 of the Welfare and Institutions Code is amended to read:

5705. (a) It is the intent of the Legislature that the use of negotiated net amounts, as provided in this section, be given preference in contracts for services under this division.

(b) Negotiated net amounts may be used as the cost of services in contracts between the state and the county or contracts between the county and a subprovider of services, or both. A negotiated net amount shall be determined by calculating the total budget for services for a program or a component of a program, less the amount of projected revenue. All participating government funding sources, except for the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9), shall be bound to that amount as the cost of providing all or part of the total county mental health program as described in the county performance contract for each fiscal year, to the extent that the governmental funding source participates in funding the county mental health programs. Where the State Department of Health Care Services promulgates regulations for determining reimbursement of Short-Doyle mental health services allowable under the Medi-Cal program, those regulations shall be controlling as to the rates for reimbursement of Short-Doyle mental health services allowable under the Medi-Cal program and rendered to Medi-Cal beneficiaries. Providers under this subdivision shall report to the State Department of Mental Health and local mental health programs any information required by the State Department of Mental Health in accordance with procedures established by the Director of Mental Health.

(c) Notwithstanding any other provision of this division or Division 9 (commencing with Section 10000), absent a finding of fraud, abuse, or failure to achieve contract objectives, no restrictions, other than any contained in the contract, shall be placed upon a provider's expenditure pursuant to this section.

SEC. 29. Section 5708 of the Welfare and Institutions Code is amended to read:

5708. To maintain stability during the transition, counties that contracted with the department during the 1990–91 fiscal year on

a negotiated net amount basis may continue to use the same funding mechanism.

SEC. 30. Section 5710 of the Welfare and Institutions Code is amended to read:

5710. (a) Charges for the care and treatment of each patient receiving service from a county mental health program shall not exceed the actual cost thereof as determined or approved by the Director of Mental Health in accordance with standard accounting practices. The director may include the amount of expenditures for capital outlay or the interest thereon, or both, in his or her determination of actual cost. The responsibility of a patient, his or her estate, or his or her responsible relatives to pay the charges and the powers of the director with respect thereto shall be determined in accordance with Article 4 (commencing with Section 7275) of Chapter 3 of Division 7.

(b) The Director of Mental Health may delegate to each county all or part of the responsibility for determining the financial liability of patients to whom services are rendered by a county mental health program and all or part of the responsibility for determining the ability of the responsible parties to pay for services to minor children who are referred by a county for treatment in a state hospital. Liability shall extend to the estates of patients and to responsible relatives, including the spouse of an adult patient and the parents of minor children. The Director of Mental Health may also delegate all or part of the responsibility for collecting the charges for patient fees. Counties may decline this responsibility as it pertains to state hospitals, at their discretion. If this responsibility is delegated by the director, the director shall establish and maintain the policies and procedures for making the determinations and collections. Each county to which the responsibility is delegated shall comply with the policy and procedures.

(c) The director shall prepare and adopt a uniform sliding scale patient fee schedule to be used in all mental health agencies for services rendered to each patient. In preparing the uniform patient fee schedule, the director shall take into account the existing charges for state hospital services and those for community mental health program services. If the director determines that it is not practicable to devise a single uniform patient fee schedule applicable to both state hospital services and services of other

mental health agencies, the director may adopt a separate fee schedule for the state hospital services which differs from the uniform patient fee schedule applicable to other mental health agencies.

SEC. 31. Section 5716 of the Welfare and Institutions Code is amended to read:

5716. Counties may contract with providers on a negotiated net amount basis in the same manner as set forth in Section 5705.

SEC. 32. Section 5724 of the Welfare and Institutions Code is amended to read:

5724. (a) The department and the State Department of Health Care Services shall jointly develop a new ratesetting methodology for use in the Short-Doyle Medi-Cal system that maximizes federal funding and utilizes, as much as practicable, federal medicare reimbursement principles. The departments shall work with the counties and the federal Health Care Financing Administration in the development of the methodology required by this section.

(b) Rates developed through the methodology required by this section shall apply only to reimbursement for direct client services.

(c) Administrative costs shall be claimed separately and shall be limited to 15 percent of the total cost of direct client services.

(d) The cost of performing utilization reviews shall be claimed separately and shall not be included in administrative cost.

(e) The rates established for direct client services pursuant to this section shall be based on increments of time for all noninpatient services.

(f) The ratesetting methodology shall not be implemented until it has received any necessary federal approvals.

SEC. 33. Section 5750.1 of the Welfare and Institutions Code is amended to read:

5750.1. Notwithstanding Section 5750, a standard, rule, or policy, not directly the result of a statutory or administrative law change, adopted by the department or county during the term of an existing county performance contract shall not apply to the negotiated net amount terms of that contract under Sections 5705 and 5716, but shall only apply to contracts established after adoption of the standard, rule, or policy.

SEC. 34. Section 14132.72 of the Welfare and Institutions Code is amended to read:

14132.72. (a) It is the intent of the Legislature to recognize the practice of telehealth as a legitimate means by which an individual may receive medical services from a health care provider without person-to-person contact with the provider.

(b) For the purposes of this section, "telehealth" and "interactive" are defined as those terms are defined in subdivision (a) of Section 2290.5 of the Business and Professions Code.

(c) Commencing July 1, 1997, face-to-face contact between a health care provider and a patient shall not be required under the Medi-Cal program for services appropriately provided through telehealth, subject to reimbursement policies developed by the Medi-Cal program to compensate licensed health care providers who provide health care services, that are otherwise covered by the Medi-Cal program, through telehealth. The audio and visual telehealth system used shall, at a minimum, have the capability of meeting the procedural definition of the Current Procedural Terminology Fourth Edition (CPT-4) codes which represent the service provided through telehealth. The telecommunications equipment shall be of a level of quality to adequately complete all necessary components to document the level of service for the CPT-4 code billed. If a peripheral diagnostic scope is required to assess the patient, it shall provide adequate resolution or audio quality for decisionmaking.

(d) The Medi-Cal program shall not be required to pay for consultation provided by the health care provider by telephone or facsimile machines.

(e) The Medi-Cal program shall pursue private or federal funding to conduct an evaluation of the cost-effectiveness and quality of health care provided through telehealth by those providers who are reimbursed for telehealth services by the program.

SEC. 35. Section 14132.725 of the Welfare and Institutions Code is amended to read:

14132.725. (a) Commencing July 1, 2006, to the extent that federal financial participation is available, face-to-face contact between a health care provider and a patient shall not be required under the Medi-Cal program for teleophthalmology and teledermatology by store and forward. Services appropriately provided through the store and forward process are subject to billing and reimbursement policies developed by the department.

(b) For purposes of this section, "teleophthalmology and teledermatology by store and forward" means an asynchronous transmission of medical information to be reviewed at a later time by a physician at a distant site who is trained in ophthalmology or dermatology or, for teleophthalmology, by an optometrist who is licensed pursuant to Chapter 7 (commencing with Section 3000) of Division 2 of the Business and Professions Code, where the physician or optometrist at the distant site reviews the medical information without the patient being present in real time. A patient receiving teleophthalmology or teledermatology by store and forward shall be notified of the right to receive interactive communication with the distant specialist physician or optometrist, and shall receive an interactive communication with the distant specialist physician or optometrist, upon request. If requested, communication with the distant specialist physician or optometrist may occur either at the time of the consultation, or within 30 days of the patient's notification of the results of the consultation. If the reviewing optometrist identifies a disease or condition requiring consultation or referral pursuant to Section 3041 of the Business and Professions Code, that consultation or referral shall be with an ophthalmologist or other appropriate physician and surgeon, as required.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, and make specific this section by means of all-county letters, provider bulletins, and similar instructions.

(d) The health care provider shall comply with the informed consent provisions of subdivisions (c) to (g), inclusive, of, and subdivisions (i) and (j) of, Section 2290.5 of the Business and Professions Code when a patient receives teleophthalmology or teledermatology by store and forward.

(e) This section shall remain in effect only until January 1, 2013, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2013, deletes or extends that date.

SEC. 36. Section 14132.73 of the Welfare and Institutions Code is amended to read:

14132.73. The State Department of Health Care Services shall allow psychiatrists to receive fee-for-service Medi-Cal reimbursement for services provided through telehealth until June

30, 2004, or until the State Department of Mental Health and mental health plans, in collaboration with stakeholders, develop a method for reimbursing psychiatric services provided through telehealth that is administratively feasible for the mental health plans, primary care providers, and psychiatrists providing the services, whichever occurs later.

SEC. 37. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution for certain costs that may be incurred by a local agency or school district because, in that regard, this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

However, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

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