AMENDED IN ASSEMBLY MAY 5, 2009

AMENDED IN ASSEMBLY APRIL 16, 2009

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 1540

Introduced by Committee on Health (Jones (Chair), Adams, Ammiano, Block, Carter, De La Torre, Hall, Hayashi, Hernandez, Bonnie Lowenthal, Nava, V. Manuel Perez, and Salas)

March 4, 2009

An act to amend Section 6276.24 of the Government Code, to amend Sections 1344, 1366.4, 1367.46, 1374.64, 1375.4, 1376.1, 1377, 1399, 116283, 116286, 116380, 116540, 116650, 116725, 121360.5, 127662, 127664, 127665, 128730, and 128745 of the Health and Safety Code, to amend Section 10123.91 of the Insurance Code, and to amend Sections 14043.26, 14043.28, 14043.29, and ~~14115~~ *14115.8* of the Welfare and Institutions Code, relating to health.

LEGISLATIVE COUNSEL'S DIGEST

AB 1540, as amended, Committee on Health. Health.

Existing law, the California Public Records Act, requires certain public records to be made available for public inspection.

Existing law, the Health Data and Advisory Council Consolidation Act, requires every organization that operates, conducts, or maintains a health facility to make and file with the Office of Statewide Health Planning and Development, specified reports containing various financial and patient data. Existing law requires the office to publish risk-adjusted outcome reports for coronary artery bypass graft surgeries, as specified.

This bill would provide, with respect to the above provisions, that patient medical record numbers and any other data elements that the office believes could be used to determine the identity of an individual patient shall be exempt from the disclosure requirements of the California Public Records Act.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. ~~The act authorizes the director of the department to adopt, amend, and rescind any rules necessary to carry out the act and requires health care service plans to provide certain notices.~~ *Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plans and health insurers to provide human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.*

This bill would provide that the HIV testing requirement does not apply to specialized health care service plan contracts or specialized health insurance policies, Medicare supplement contracts or policies, and other specified insurance policies.

The Knox-Keene Health Care Service Plan Act of 1975 authorizes the director of the department to adopt, amend, and rescind any rules necessary to carry out the act and requires health care service plans to provide certain notices.

This bill would authorize the director to, by regulation, modify the wording of any notice required by the act for purposes of clarity, readability, and accuracy.

The bill would make other technical, nonsubstantive changes to related provisions governing health care service plans.

Existing law, known as the California Safe Drinking Water Act, requires the State Department of Public Health to administer provisions relating to the regulation of drinking water to protect public health.

Existing law requires the department to adopt regulations it determines to be necessary to carry out the purposes of the California Safe Drinking Water Act. Existing law requires regulations adopted by the department to include requirements governing the use of point-of-entry treatment by public water systems in lieu of centralized treatment, as specified.

This bill would require regulations adopted by the department to include requirements governing the use of point-of-entry and point-of-use treatment by public water systems in lieu of centralized treatment, as specified.

Existing law provides that the department may issue a citation to a public water system that violates the California Safe Drinking Water Act. Existing law provides that for noncontinuing violations of primary drinking standards, other than turbidity, the department may assess a civil penalty in the citation, as specified.

This bill would delete the exemption for turbidity.

This bill would make other technical, nonsubstantive changes to related provisions governing the issuance of citations for violations of the California Safe Drinking Water Act.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits. Existing law requires that health care providers apply to, and be certified by, the department prior to their participation in the Medi-Cal program.

Existing law allows the department to grant provisional provider status or preferred provisional provider status to an applicant or provider, and requires the department to terminate that status if any specified grounds exist.

This bill would correct obsolete references in the above provisions.

Under existing law, the Medi-Cal program is partially governed and funded as part of the federal Medicaid Program. Existing law requires the department to amend the Medicaid state plan with respect to the billing option for services by local education agencies to ensure that schools are reimbursed for all eligible services that they provide that are not precluded by federal requirements. Existing law would repeal these provisions on January 1, 2010.

This bill would delete the provision repealing these provisions on January 1, 2010, thereby extending the operation of those provisions, indefinitely.

Existing law establishes the Local Education Agency Medi-Cal Recovery Account in the Special Deposit Fund, to be used only to support the department in meeting the requirements of the above provisions, and specifies a formula for funding and staffing activities provided for under these provisions.

Existing law provides that as of January 1, 2010, unless the Legislature enacts a new statute or extends the date beyond January 1, 2010, all funds in the Local Education Agency Medi-Cal Recovery Account shall be returned proportionately to all local education agencies whose federal Medicaid funds were used to create the account.

This bill would rename the account ~~to be~~ the Local Educational Agency Medi-Cal Recovery Fund.

This bill would also provide that if the Legislature enacts a new statute that ends the billing option, all funds in the Local Educational Agency Medi-Cal Recovery Fund shall be returned proportionally to all local educational agencies whose federal Medicaid funds were used to create the ~~account~~ *fund*.

~~Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the regulation of health care service plans by the Department of Managed Health Care. Existing law provides that a willful violation of the act is a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plans and health insurers to provide human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.~~

~~This bill would provide that the HIV testing requirement does not apply to specialized health care service plan contracts or specialized health insurance policies, Medicare supplement contracts or policies, and other specified insurance policies.~~

Existing law, until January 1, 2011, requests the University of California to establish the California Health Benefit Review Program to assess legislation proposing a mandated health benefit or service, as defined, to be provided by health care service plans and health insurers, and to prepare a written analysis in accordance with specified criteria.

This bill would extend the repeal date of the above provisions to June 30, 2015.

Existing law requests the University of California to submit a report to the Governor and the Legislature no later than January 1, 2010, regarding the implementation of the above provisions.

This bill would, instead, request the University of California to submit a report no later than January 1, 2014.

Existing law, for fiscal years 2006–07 to 2009–10, inclusive, provides funding for the University of California's implementation of the above provisions from a fee imposed upon health care service plans and health insurers, which would not exceed a total of $2,000,000, and is to be deposited in the Health Care Benefits Fund.

This bill, instead, provides for the imposition of that fee for fiscal years 2010–11 to 2014–15, inclusive.

Existing *law requires the State Department of Public Health to maintain a program for the control of tuberculosis. Existing* law

~~establishes the Omnibus tuberculosis control and Prevention Act of 2002, which, among other things~~, until January 1, 2011, ~~permits~~ *requires* a local health department *that elects to participate in the program* to provide for certification *for one year*, by the local health officer, of tuberculin skin test technicians.

This bill would delete the repeal date of these provisions, *thereby extending the operation of these provisions indefinitely*.

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

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

SECTION 1. Section 6276.24 of the Government Code is amended to read:

6276.24. Harmful matter, distribution, confidentiality of certain recipients, Section 313.1, Penal Code.

Hazardous substance tax information, prohibition against disclosure, Section 43651, Revenue and Taxation Code.

Hazardous waste control, business plans, public inspection, Section 25506, Health and Safety Code.

Hazardous waste control, notice of unlawful hazardous waste disposal, Section 25180.5, Health and Safety Code.

Hazardous waste control, trade secrets, disclosure of information, Sections 25511 and 25538, Health and Safety Code.

Hazardous waste control, trade secrets, procedures for release of information, Section 25358.2, Health and Safety Code.

Hazardous waste generator report, protection of trade secrets, Sections 25244.21 and 25244.23, Health and Safety Code.

Hazardous waste licenseholder disclosure statement, confidentiality of, Section 25186.5, Health and Safety Code.

Hazardous waste management facilities on Indian lands, confidentiality of privileged or trade secret information, Section 25198.4, Health and Safety Code.

Hazardous waste recycling, duties of department, Section 25170, Health and Safety Code.

Hazardous waste recycling, list of specified hazardous wastes, trade secrets, Section 25175, Health and Safety Code.

Hazardous waste recycling, trade secrets, confidential nature, Sections 25173 and 25180.5, Health and Safety Code.

Healing arts licensees, central files, confidentiality, Section 800, Business and Professions Code.

Health authorities, special county, protection of trade secrets, Sections 14087.35, 14087.36, and 14087.38, Welfare and Institutions Code.

Health Care Provider Central Files, confidentiality of, Section 800, Business and Professions Code.

Health care provider disciplinary proceeding, confidentiality of documents, Section 805.1, Business and Professions Code.

Health care service plans, review of quality of care, privileged communications, Sections 1370 and 1380, Health and Safety Code.

Health commissions, special county, protection of trade secrets, Section 14087.31, Welfare and Institutions Code.

Health facilities, patient's rights of confidentiality, subdivision (c) of Section 128745 and Sections 128735, 128736, 128737, 128755, and 128765, Health and Safety Code.

Health facility and clinic, consolidated data and reports, confidentiality of, Section 128730, Health and Safety Code.

Health personnel, data collection by the Office of Statewide Health Planning and Development, confidentiality of information on individual licentiates, Sections 127775 and 127780, Health and Safety Code.

Health planning and development pilot projects, confidentiality of data collected, Section 128165, Health and Safety Code.

Hereditary Disorders Act, legislative finding and declaration, confidential information, Sections 124975 and 124980, Health and Safety Code.

Hereditary Disorders Act, rules, regulations, and standards, breach of confidentiality, Section 124980, Health and Safety Code.

Higher Education Employee-Employer Relations, findings of fact and recommended terms of settlement, Section 3593, Government Code.

Higher Education Employee-Employer Relations, access by Public Employment Relations Board to employer's or employee organization's records, Section 3563, Government Code.

HIV, disclosures to blood banks by department or county health officers, Section 1603.1, Health and Safety Code.

Home address of public employees and officers in Department of Motor Vehicles, records, confidentiality of, Sections 1808.2 and 1808.4, Vehicle Code.

Horse racing, horses, blood or urine test sample, confidentiality, Section 19577, Business and Professions Code.

Hospital district and municipal hospital records relating to contracts with insurers and service plans, subdivision (t), Section 6254, Government Code.

Hospital final accreditation report, subdivision (s), Section 6254, Government Code.

Housing authorities, confidentiality of rosters of tenants, Section 34283, Health and Safety Code.

Housing authorities, confidentiality of applications by prospective or current tenants, Section 34332, Health and Safety Code.

SEC. 2. Section 1344 of the Health and Safety Code is amended to read:

1344. (a) The director may from time to time adopt, amend, and rescind any rules, forms, and orders that are necessary to carry out the provisions of this chapter, including rules governing applications and reports, and defining any terms, whether or not used in this chapter, insofar as the definitions are not inconsistent with the provisions of this chapter. For the purpose of rules and forms, the director may classify persons and matters within the director's jurisdiction, and may prescribe different requirements for different classes. The director may waive any requirement of any rule or form in situations where in the director's discretion that requirement is not necessary in the public interest or for the protection of the public, subscribers, enrollees, or persons or plans subject to this chapter. The director may adopt rules consistent with federal regulations and statutes to regulate health care coverage supplementing Medicare.

(b) The director may, by regulation, modify the wording of any notice required by this chapter for purposes of clarity, readability, and accuracy.

(c) The director may honor requests from interested parties for interpretive opinions.

(d) No provision of this chapter imposing any liability applies to any act done or omitted in good faith in conformity with any rule, form, order, or written interpretive opinion of the director, or any opinion of the Attorney General, notwithstanding that the rule, form, order, or written interpretive opinion may later be

amended or rescinded or be determined by judicial or other authority to be invalid for any reason.

SEC. 3. Section 1366.4 of the Health and Safety Code is amended to read:

1366.4. (a) A medical group, physician, or independent practice association that contracts with a health care service plan may enter into contracts with licensed nonphysician providers to provide services, as defined in Section 1300.67(a)(1) of Title 28 of the California Code of Regulations, to plan enrollees covered by the contract between the plan and the group, physician, or association.

(b) The licensed nonphysician provider described in subdivision (a) that contracts with a medical group, physician, or independent practice association may directly bill, if direct billing is otherwise permitted by law, a health care service plan for covered services pursuant to a contract with the health care service plan that specifies direct billing. Direct billing pursuant to this subdivision is permitted only to the extent that the same services are not billed for by the medical group, physician, or independent practice association.

(c) A health care service plan may require the nonphysician provider to complete an appropriate credentialing process.

(d) Every health care service plan may either list licensed nonphysician providers that contract with medical groups, physicians, and independent practice associations pursuant to subdivision (b) in any listing or directory of plan health care providers that is provided to enrollees or to the public, or may include a notification in the plan's evidence of coverage or provider list that the health care service plan has contracts with nonphysician providers, pursuant to subdivision (b), and may list the types of contracted nonphysician providers. The notification may inform an enrollee that he or she may obtain a list of the nonphysician providers by contacting his or her primary or specialist medical group. The listing may indicate whether licensed nonphysician providers may be accessed directly by enrollees.

(e) Nothing in this section shall be construed to authorize, or otherwise require the director to approve, a risk-sharing arrangement between a plan and a provider.

SEC. 4. Section 1367.46 of the Health and Safety Code is amended to read:

1367.46. (a) Every individual or group health care service plan contract that is issued, amended, or renewed on or after January 1, 2009, that covers hospital, medical, or surgery expenses shall provide coverage for human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.

(b) This section shall not apply to specialized health care service plan contracts or Medicare supplement contracts.

SEC. 5. Section 1374.64 of the Health and Safety Code is amended to read:

1374.64. (a) Only a plan that has been licensed under this chapter and in operation in this state for a period of five years or more, or a plan licensed under this chapter and operating in this state for a period of five or more years under a combination of (1) licensure under this chapter and (2) pursuant to a certificate of authority issued by the Department of Insurance may offer a point-of-service contract. A specialized health care service plan shall not offer a point-of-service plan contract unless this plan was formerly registered under the Knox-Mills Health Plan Act (Article 2.5 (commencing with Section 12530) of Chapter 6 of Part 2 of Division 3 of Title 2 of the Government Code), as repealed by Chapter 941 of the Statutes of 1975, and offered point-of-service plan contracts previously approved by the director on July 1, 1976, and on September 1, 1993.

(b) A plan may offer a point-of-service plan contract only if the director has not found the plan to be in violation of any requirements, including administrative capacity, under this chapter or the rules adopted thereunder and the plan meets, at a minimum, the following financial criteria:

(1) The minimum financial criteria for a plan that maintains a minimum net worth of at least five million dollars ($5,000,000) shall be:

(A) (i) Initial tangible net equity so that the plan is not required to file monthly reports with the director as required by Section 1300.84.3(d)(1)(G) of Title 28 of the California Code of Regulations and then have and maintain adjusted tangible net equity to be determined pursuant to either of the following:

(I) In the case of a plan that is required to have and maintain a tangible net equity as required by Section 1300.76(a)(1) or (2) of Title 28 of the California Code of Regulations, multiply 130 percent times the sum resulting from the addition of the plan's

tangible net equity required by Section 1300.76(a)(1) or (2) of Title 28 of the California Code of Regulations and the number that equals 10 percent of the plan's annualized health care expenditures for out-of-network services for point-of-service enrollees.

(II) In the case of a plan that is required to have and maintain a tangible net equity as required by Section 1300.76(a)(3) of Title 28 of the California Code of Regulations, recalculate the plan's tangible net equity under Section 1300.76(a)(3) of Title 28 of the California Code of Regulations excluding the plan's annualized health care expenditures for out-of-network services for point-of-service enrollees, add together the number resulting from this recalculation and the number that equals 10 percent of the plan's annualized health care expenditures for out-of-network services for point of services enrollees, and multiply this sum times 130 percent, provided that the product of this multiplication must exceed 130 percent of the tangible net equity required by Section 1300.76(a)(3) of Title 28 of the California Code of Regulations so that the plan is not required to file monthly reports to the director as required by Section 1300.84.3(d)(1)(G) of Title 28 of the California Code of Regulations.

(ii) The failure of a plan offering a point-of-service plan contract under this article to maintain adjusted tangible net equity as determined by this subdivision shall require the filing of monthly reports with the director pursuant to Section 1300.84.3(d) of Title 28 of the California Code of Regulations, in addition to any other requirements that may be imposed by the director on a plan under this article and chapter.

(iii) The calculation of tangible net equity under any report to be filed by a plan offering a point-of-service plan contract under this article and required of a plan pursuant to Section 1384, and the regulations adopted thereunder, shall be on the basis of adjusted tangible net equity as determined under this subdivision.

(B) Demonstrates adequate working capital, including (i) a current ratio (current assets divided by current liabilities) of at least 1:1, after excluding obligations of officers, directors, owners, or affiliates, or (ii) evidence that the plan is now meeting its obligations on a timely basis and has been doing so for at least the preceding two years. Short-term obligations of affiliates for goods or services arising in the normal course of business that are payable on the same terms as equivalent transactions with nonaffiliates

shall not be excluded. For purposes of this subdivision, an obligation is considered short term if the repayment schedule is 30 days or fewer.

(C) Demonstrates a trend of positive earnings over the previous eight fiscal quarters.

(2) The minimum financial criteria for a plan that maintains a minimum net worth of at least one million five hundred thousand dollars ($1,500,000) but less than five million dollars ($5,000,000) shall be:

(A) (i) Initial tangible net equity so that the plan is not required to file monthly reports with the director as required by Section 1300.84.3(d)(1)(G) of Title 28 of the California Code of Regulations and then have and maintain adjusted tangible net equity to be determined pursuant to either of the following:

(I) In the case of a plan that is required to have and maintain a tangible net equity as required by Section 1300.76(a)(1) or (2) of Title 28 of the California Code of Regulations, multiply 130 percent times the sum resulting from the addition of the plan's tangible net equity required by Section 1300.76(a)(1) or (2) of Title 28 of the California Code of Regulations and the number that equals 10 percent of the plan's annualized health care expenditures for out-of-network services for point-of-service enrollees.

(II) In the case of a plan that is required to have and maintain a tangible net equity as required by Section 1300.76(a)(3) of Title 28 of the California Code of Regulations, recalculate the plan's tangible net equity under Section 1300.76(a)(3) excluding the plan's annualized health care expenditures for out-of-network services for point-of-service enrollees, add together the number resulting from this recalculation and the number that equals 10 percent of the plan's annualized health care expenditures for out-of-network services for point-of-services enrollees, and multiply this sum times 130 percent, provided that the product of this multiplication must exceed 130 percent of the tangible net equity required by Section 1300.76(a)(3) of Title 28 of the California Code of Regulations so that the plan is not required to file monthly reports to the director as required by Section 1300.84.3(d)(1)(G) of Title 28 of the California Code of Regulations.

(ii) The failure of a plan offering a point-of-service plan contract under this article to maintain adjusted tangible net equity as

determined by this subdivision shall require the filing of monthly reports with the director pursuant to Section 1300.84.3(d) of Title 28 of the California Code of Regulations, in addition to any other requirements that may be imposed by the director on a plan under this article and chapter.

(iii) The calculation of tangible net equity under any report to be filed by a plan offering a point-of-service plan contract under this article and required of a plan pursuant to Section 1384, and the regulations adopted thereunder, shall be on the basis of adjusted tangible net equity as determined under this subdivision.

(B) Demonstrates adequate working capital, including (i) a current ratio (current assets divided by current liabilities) of at least 1:1, after excluding obligations of officers, directors, owners, or affiliates or (ii) evidence that the plan is now meeting its obligations on a timely basis and has been doing so for at least the preceding two years. Short-term obligations of affiliates for goods or services arising in the normal course of business that are payable on the same terms as equivalent transactions with nonaffiliates shall not be excluded. For purposes of this subdivision, an obligation is considered short term if the repayment schedule is 30 days or fewer.

(C) Demonstrates a trend of positive earnings over the previous eight fiscal quarters.

(D) Demonstrates to the director that it has obtained insurance for the cost of providing any point-of-service enrollee with out-of-network covered health care services, the aggregate value of which exceeds five thousand dollars ($5,000) in any year. This insurance shall obligate the insurer to continue to provide care for the period in which a premium was paid in the event a plan becomes insolvent. Where a plan cannot obtain insurance as required by this subparagraph, then a plan may demonstrate to the director that it has made other arrangements, acceptable to the director, for the cost of providing enrollees out-of-network health care services; but in this case the expenditure for total out-of-network costs for all enrollees in all point-of-service contracts shall be limited to a percentage, acceptable to the director, not to exceed 15 percent of total health care expenditures for all its enrollees.

(c) Within 30 days of the close of each month a plan offering point-of-service plan contracts under paragraph (2) of subdivision

(b) shall file with the director a monthly financial report consisting of a balance sheet and statement of operations of the plan, which need not be certified, and a calculation of the adjusted tangible net equity required under subparagraph (A). The financial statements shall be prepared on a basis consistent with the financial statements furnished by the plan pursuant to Section 1300.84.2 of Title 28 of the California Code of Regulations. A plan shall also make special reports to the director as the director may from time to time require. Each report to be filed by a plan pursuant to this subdivision shall be verified by a principal officer of the plan as set forth in Section 1300.84.2(e) of Title 28 of the California Code of Regulations.

(d) If it appears to the director that a plan does not have sufficient financial viability, or organizational and administrative capacity to assure the delivery of health care services to its enrollees, the director may, by written order, direct the plan to discontinue the offering of a point-of-service plan contract. The order shall be effective immediately.

SEC. 6. Section 1375.4 of the Health and Safety Code is amended to read:

1375.4. (a) Every contract between a health care service plan and a risk-bearing organization that is issued, amended, renewed, or delivered in this state on or after July 1, 2000, shall include provisions concerning the following, as to the risk-bearing organization's administrative and financial capacity, which shall be effective as of January 1, 2001:

(1) A requirement that the risk-bearing organization furnish financial information to the health care service plan or the plan's designated agent and meet any other financial requirements that assist the health care service plan in maintaining the financial viability of its arrangements for the provision of health care services in a manner that does not adversely affect the integrity of the contract negotiation process.

(2) A requirement that the health care service plan disclose information to the risk-bearing organization that enables the risk-bearing organization to be informed regarding the financial risk assumed under the contract.

(3) A requirement that the health care service plans provide payments of all risk arrangements, excluding capitation, within 180 days after close of the fiscal year.

(b) In accordance with subdivision (a) of Section 1344, the director shall adopt regulations on or before June 30, 2000, to implement this section which shall, at a minimum, provide for the following:

(1) (A) A process for reviewing or grading risk-bearing organizations based on the following criteria:

(i) The risk-bearing organization meets criterion 1 if it reimburses, contests, or denies claims for health care services it has provided, arranged, or for which it is otherwise financially responsible in accordance with the timeframes and other requirements described in Section 1371 and in accordance with any other applicable state and federal laws and regulations.

(ii) The risk-bearing organization meets criterion 2 if it estimates its liability for incurred but not reported claims pursuant to a method that has not been held objectionable by the director, records the estimate at least quarterly as an accrual in its books and records, and appropriately reflects this accrual in its financial statements.

(iii) The risk-bearing organization meets criterion 3 if it maintains at all times a positive tangible net equity, as defined in subdivision (e) of Section 1300.76 of Title 28 of the California Code of Regulations.

(iv) The risk-bearing organization meets criterion 4 if it maintains at all times a positive level of working capital (excess of current assets over current liabilities).

(B) A risk-bearing organization may reduce its liabilities for purposes of calculating tangible net equity, pursuant to clause (iii) of subparagraph (A), and working capital, pursuant to clause (iv) of subparagraph (A), by the amount of any liabilities the payment of which is guaranteed by a sponsoring organization pursuant to a qualified guarantee. A sponsoring organization is one that has a tangible net equity of a level to be established by the director that is in excess of all amounts that it has guaranteed to any person or entity. A qualified guarantee is one that meets all of the following:

(i) It is approved by a board resolution of the sponsoring organization.

(ii) The sponsoring organization agrees to submit audited annual financial statements to the plan within 120 days of the end of the sponsoring organization's fiscal year.

(iii) The guarantee is unconditional except for a maximum monetary limit.

(iv) The guarantee is not limited in duration with respect to liabilities arising during the term of the guarantee.

(v) The guarantee provides for six months' advance notice to the plan prior to its cancellation.

(2) The information required from risk-bearing organizations to assist in reviewing or grading these risk-bearing organizations, including balance sheets, claims reports, and designated annual, quarterly, or monthly financial statements prepared in accordance with generally accepted accounting principles, to be used in a manner, and to the extent necessary, provided to a single external party as approved by the director to the extent that it does not adversely affect the integrity of the contract negotiation process between the health care service plan and the risk-bearing organizations.

(3) Audits to be conducted in accordance with generally accepted auditing standards and in a manner that avoids duplication of review of the risk-bearing organization.

(4) A process for corrective action plans, as mutually agreed upon by the health care service plan and the risk-bearing organization and as approved by the director, for cases where the review or grading indicates deficiencies that need to be corrected by the risk-bearing organization, and contingency plans to ensure the delivery of health care services if the corrective action fails. The corrective action plan shall be approved by the director and standardized, to the extent possible, to meet the needs of the director and all health care service plans contracting with the risk-bearing organization. If the health care service plan and the risk-bearing organization are unable to determine a mutually agreeable corrective action plan, the director shall determine the corrective action plan.

(5) The disclosure of information by health care service plans to the risk-bearing organization that enables the risk-bearing organization to be informed regarding the risk assumed under the contract, including:

(A) Enrollee information monthly.

(B) Risk arrangement information, information pertaining to any pharmacy risk assumed under the contract, information regarding incentive payments, and information on income and expenses assigned to the risk-bearing organization quarterly.

(6) Periodic reports from each health care service plan to the director that include information concerning the risk-bearing organizations and the type and amount of financial risk assumed by them, and, if deemed necessary and appropriate by the director, a registration process for the risk-bearing organizations.

(7) The confidentiality of financial and other records to be produced, disclosed, or otherwise made available, unless as otherwise determined by the director.

(c) The failure by a health care service plan to comply with the contractual requirements pursuant to this section shall constitute grounds for disciplinary action. The director shall, as appropriate, within 60 days after receipt of documented violation from a risk-bearing organization, investigate and take enforcement action against a health care service plan that fails to comply with these requirements and shall periodically evaluate contracts between health care service plans and risk-bearing organizations to determine if any audit, evaluation, or enforcement actions should be undertaken by the department.

(d) The Financial Solvency Standards Board established in Section 1347.15 shall study and report to the director on or before January 1, 2001, regarding all of the following:

(1) The feasibility of requiring that there be in force insurance coverage commensurate with the financial risk assumed by the risk-bearing organization to protect against financial losses.

(2) The appropriateness of different risk-bearing arrangements between health care service plans and risk-bearing organizations.

(3) The appropriateness of the four criteria specified in paragraph (1) of subdivision (b).

(e) This section shall not apply to specialized health care service plans.

(f) For purposes of this section, “provider organization” means a medical group, independent practice association, or other entity that delivers, furnishes, or otherwise arranges for or provides health care services, but does not include an individual or a plan.

(g) (1) For the purposes of this section, a “risk-bearing organization” means a professional medical corporation, other form of corporation controlled by physicians and surgeons, a medical partnership, a medical foundation exempt from licensure pursuant to subdivision (*l*) of Section 1206, or another lawfully organized group of physicians that delivers, furnishes, or otherwise

arranges for or provides health care services, but does not include an individual or a health care service plan, and that does all of the following:

(A) Contracts directly with a health care service plan or arranges for health care services for the health care service plan's enrollees.

(B) Receives compensation for those services on any capitated or fixed periodic payment basis.

(C) Is responsible for the processing and payment of claims made by providers for services rendered by those providers on behalf of a health care service plan that are covered under the capitation or fixed periodic payment made by the plan to the risk-bearing organization. Nothing in this subparagraph in any way limits, alters, or abrogates any responsibility of a health care service plan under existing law.

(2) Notwithstanding paragraph (1), risk-bearing organizations shall not be deemed to include a provider organization that meets either of the following requirements:

(A) The health care service plan files with the department consolidated financial statements that include the provider organization.

(B) The health care service plan is the only health care service plan with which the provider organization contracts for arranging or providing health care services and, during the previous and current fiscal years, the provider organization's maximum potential expenses for providing or arranging for health care services did not exceed 115 percent of its maximum potential revenue for providing or arranging for those services.

(h) For purposes of this section, "claims" include, but are not limited to, contractual obligations to pay capitation or payments on a managed hospital payment basis.

SEC. 7. Section 1376.1 of the Health and Safety Code is amended to read:

1376.1. The deposit requirements of Section 1300.76.1 of Title 28 of the California Code of Regulations shall not apply to any plan operated by a county, or city and county, if both of the following apply:

(a) All of the evidence of indebtedness of the county, or city and county, has been rated "A" or better by Moody's Investors Service, Inc. or Standard & Poor's Corporation, based on a rating conducted during the immediately preceding 12 months.

(b) The county, or city and county, has cash or cash equivalents in an amount equal to fifty million dollars ($50,000,000) or more, based on its audited financial statements for the immediately preceding fiscal year. For purposes of this subdivision, the term "equivalents" shall have the same meaning as in Section 1300.77 of Title 28 of the California Code of Regulations.

SEC. 8. Section 1377 of the Health and Safety Code is amended to read:

1377. (a) Every plan which reimburses providers of health care services that do not contract in writing with the plan to provide health care services, or which reimburses its subscribers or enrollees for costs incurred in having received health care services from providers that do not contract in writing with the plan, in an amount which exceeds 10 percent of its total costs for health care services for the immediately preceding six months, shall comply with the requirements set forth in either paragraph (1) or (2):

(1) (A) Place with the director, or with any organization or trustee acceptable to the director through which a custodial or controlled account is maintained, a noncontracting provider insolvency deposit consisting of cash or securities that are acceptable to the director that at all times have a fair market value in an amount at least equal to 120 percent of the sum of the following:

(i) All claims for noncontracting provider services received for reimbursement, but not yet processed.

(ii) All claims for noncontracting provider services denied for reimbursement during the previous 45 days.

(iii) All claims for noncontracting provider services approved for reimbursement, but not yet paid.

(iv) An estimate of claims for noncontracting provider services incurred, but not reported.

(B) Each plan licensed pursuant to this chapter prior to January 1, 1991, shall, upon that date, make a deposit of 50 percent of the amount required by subparagraph (A), and shall maintain additional cash or cash equivalents as defined by rule of the director, in the amount of 50 percent of the amount required by subparagraph (A), and shall make a deposit of 100 percent of the amount required by subparagraph (A) by January 1, 1992.

(C) The amount of the deposit shall be reasonably estimated as of the first day of the month and maintained for the remainder of the month.

(D) The deposit required by this paragraph is in addition to the deposit that may be required by rule of the director and is an allowable asset of the plan in the determination of tangible net equity as defined in subdivision (b) of Section 1300.76 of Title 28 of the California Code of Regulations. All income from the deposit shall be an asset of the plan and may be withdrawn by the plan at any time.

(E) A health care service plan that has made a deposit may withdraw that deposit or any part of the deposit if (i) a substitute deposit of cash or securities of equal amount and value is made, (ii) the fair market value exceeds the amount of the required deposit, or (iii) the required deposit under this paragraph is reduced or eliminated. Deposits, substitutions, or withdrawals may be made only with the prior written approval of the director, but approval shall not be required for the withdrawal of earned income.

(F) The deposit required under this section is in trust and may be used only as provided by this section. The director or, if a receiver has been appointed, the receiver shall use the deposit of an insolvent health care service plan, as defined in Sections 1394.7 and 1394.8, for payment of covered claims for services rendered by noncontracting providers under circumstances covered by the plan. All claims determined by the director or receiver, in his or her discretion, to be eligible for reimbursement under this section shall be paid on a pro rata basis based on assets available from the deposit to pay the ultimate liability for incurred expenditures. Partial distribution may be made pending final distribution. Any amount of the deposit remaining shall be paid into the liquidation or receivership of the health care service plan. The director may also use the deposit of an insolvent health care service plan for payment of any administrative costs associated with the administration of this section. The department, the director, and any employee of the department shall not be liable, as provided by Section 820.2 of the Government Code, for an injury resulting from an exercise of discretion pursuant to this section. Nothing in this section shall be construed to provide immunity for the acts of a receiver, except when the director is acting as a receiver.

(G) The director may, by regulation, prescribe the time, manner, and form for filing claims.

(H) The director may permit a plan to meet a portion of this requirement by a deposit of tangible assets acceptable to the director, the fair market value of which shall be determined on at least an annual basis by the director. The plan shall bear the cost of any appraisal or valuations required hereunder by the director.

(2) Maintain adequate insurance, or a guaranty arrangement approved in writing by the director, to pay for any loss to providers, subscribers, or enrollees claiming reimbursement due to the insolvency of the plan.

(b) Whenever the reimbursements described in this section exceed 10 percent of the plan's total costs for health care services over the immediately preceding six months, the plan shall file a written report with the director containing the information necessary to determine compliance with subdivision (a) no later than 30 business days from the first day of the month. Upon an adequate showing by the plan that the requirements of this section should be waived or reduced, the director may waive or reduce these requirements to an amount as the director deems sufficient to protect subscribers and enrollees of the plan consistent with the intent and purpose of this chapter.

(c) Every plan which reimburses providers of health care service on a fee-for-services basis; or which directly reimburses its subscribers or enrollees, to an extent exceeding 10 percent of its total payments for health care services, shall estimate and record in the books of account a liability for incurred and unreported claims. Upon a determination by the director that the estimate is inadequate, the director may require the plan to increase its estimate of incurred and unreported claims. Every plan shall promptly report to the director whenever these reimbursables exceed 10 percent of its total expenditures for health care services.

As used herein, the term "fee-for-services" refers to the situation where the amount of reimbursement paid by the plan to providers of service is determined by the amount and type of service rendered by the provider of service.

(d) In the event an insolvent plan covered by this section fails to pay a noncontracting provider sums for covered services owed, the provider shall first look to the uncovered expenditures insolvency deposit or the insurance or guaranty arrangement

maintained by the plan for payment. When a plan becomes insolvent, in no event shall a noncontracting provider, or agent, trustee, or assignee thereof, attempt to collect from the subscriber or enrollee sums owed for covered services by the plan or maintain any action at law against a subscriber or enrollee to collect sums owed by the plan for covered services without having first attempted to obtain reimbursement from the plan.

SEC. 9. Section 1399 of the Health and Safety Code is amended to read:

1399. (a) Surrender of a license as a health plan becomes effective 30 days after receipt of an application to surrender the license or within a shorter period of time as the director may determine, unless a revocation or suspension proceeding is pending when the application is filed or a proceeding to revoke or suspend or to impose conditions upon the surrender is instituted within 30 days after the application is filed. If this proceeding is pending or instituted, surrender becomes effective at the time and upon the conditions as the director by order determines.

(b) If the director finds that any plan is no longer in existence, or has ceased to do business or has failed to initiate business activity as a licensee within six months after licensure, or cannot be located after reasonable search, the director may by order summarily revoke the license of the plan.

(c) The director may summarily suspend or revoke the license of a plan upon (1) failure to pay any fee required by this chapter within 15 days after notice by the director that the fee is due and unpaid, (2) failure to file any amendment or report required under this chapter within 15 days after notice by the director that the report is due, (3) failure to maintain any bond or insurance pursuant to Section 1376, (4) failure to maintain a deposit, insurance, or guaranty arrangement pursuant to Section 1377, or (5) failure to maintain a deposit pursuant to Section 1300.76.1 of Title 28 of the California Code of Regulations.

SEC. 10. Section 116283 of the Health and Safety Code, as added by Section 4 of Chapter 874 of the Statutes of 1996, is amended to read:

116283. This chapter shall apply to a food facility that is regulated pursuant to the California Retail Food Code only if the human consumption includes drinking of water.

SEC. 11. Section 116283 of the Health and Safety Code, as added by Section 4 of Chapter 875 of the Statutes of 1996, is amended to read:

116283. This chapter shall apply to a food facility that is regulated pursuant to the California Retail Food Code only if the human consumption includes drinking of water.

SEC. 12. Section 116286 of the Health and Safety Code is amended to read:

116286. (a) A water district, as defined in subdivision (b), in existence prior to May 18, 1994, that provides primarily agricultural services through a piped water system with only incidental residential or similar uses shall not be considered to be a public water system if the department determines that either of the following applies:

(1) The system certifies that it is providing alternative water for residential or similar uses for drinking water and cooking to achieve the equivalent level of public health protection provided by the applicable primary drinking water regulations.

(2) The water provided for residential or similar uses for drinking, cooking, and bathing is centrally treated or treated at the point of entry by the provider, a passthrough entity, or the user to achieve the equivalent level of protection provided by the applicable primary drinking water regulations.

(b) For purposes of this section, "water district" means any district or other political subdivision, other than a city or county, a primary function of which is irrigation, reclamation, or drainage of land.

SEC. 13. Section 116380 of the Health and Safety Code is amended to read:

116380. In addition to the requirements set forth in Section 116375, the regulations adopted by the department pursuant to Section 116375 shall include requirements governing the use of point-of-entry and point-of-use treatment by public water systems in lieu of centralized treatment where it can be demonstrated that centralized treatment is not economically feasible.

SEC. 14. Section 116540 of the Health and Safety Code is amended to read:

116540. Following completion of the investigation and satisfaction of the requirements of subdivisions (a) and (b), the department shall issue or deny the permit. The department may

impose permit conditions, requirements for system improvements, and time schedules as it deems necessary to assure a reliable and adequate supply of water at all times that is pure, wholesome, potable, and does not endanger the health of consumers.

(a) No public water system that was not in existence on January 1, 1998, shall be granted a permit unless the system demonstrates to the department that the water supplier possesses adequate financial, managerial, and technical capability to assure the delivery of pure, wholesome, and potable drinking water. This section shall also apply to any change of ownership of a public water system that occurs after January 1, 1998.

(b) No permit under this chapter shall be issued to an association organized under Title 3 (commencing with Section 18000) of Division 3 of the Corporations Code. This section shall not apply to unincorporated associations that as of December 31, 1990, are holders of a permit issued under this chapter.

SEC. 15. Section 116650 of the Health and Safety Code is amended to read:

116650. (a) If the department determines that a public water system is in violation of this chapter or any regulation, permit, standard, or order issued or adopted thereunder, the department may issue a citation to the public water system. The citation shall be served upon the public water system personally or by registered mail.

(b) Each citation shall be in writing and shall describe with particularity the nature of the violation, including a reference to the statutory provision, standard, order, or regulation alleged to have been violated.

(c) For continuing violations, the citation shall fix the earliest feasible time for elimination or correction of the condition constituting the violation where appropriate. If the public water system fails to correct a violation within the time specified in the citation, the department may assess a civil penalty as specified in subdivision (e).

(d) For a noncontinuing violation of primary drinking standards, the department may assess in the citation a civil penalty as specified in subdivision (e).

(e) Citations issued pursuant to this section shall be classified according to the nature of the violation or the failure to comply.

The department shall specify the classification in the citation and may assess civil penalties for each classification as follows:

(1) For violation of a primary drinking standard, an amount not to exceed one thousand dollars ($1,000) per day for each day that the violation occurred, including each day that the violation continues beyond the date specified for correction in the citation *or order*.

(2) For failure to comply with any citation or order issued for violation of a secondary drinking water standard that the director determines may have a direct or immediate relationship to the welfare of the users, an amount not to exceed one thousand dollars ($1,000) for each day that the violation continues beyond the date specified for correction in the citation *or order*.

(3) For failure to comply with any citation or order issued for noncompliance with any department regulation or order, other than a primary or secondary drinking water standard, an amount not to exceed two hundred dollars ($200) per day for each day the violation continues beyond the date specified for correction in the citation.

SEC. 16. Section 116725 of the Health and Safety Code is amended to read:

116725. (a) Any person who knowingly makes any false statement or representation in any application, record, report, or other document submitted, maintained, or used for purposes of compliance with this chapter, may be liable, as determined by the court, for a civil penalty not to exceed five thousand dollars ($5,000) for each separate violation or, for continuing violations, for each day that violation continues.

(b) Any person who violates a citation schedule of compliance for a primary drinking water standard or any order regarding a primary drinking water standard or the requirement that a reliable and adequate supply of pure, wholesome, healthful, and potable water be provided may be liable, as determined by the court, for a civil penalty not to exceed twenty-five thousand dollars ($25,000) for each separate violation or, for continuing violations, for each day that violation continues.

(c) Any person who violates any order, other than one specified in subdivision (b), issued pursuant to this chapter may be liable, as determined by the court, for a civil penalty not to exceed five

thousand dollars ($5,000) for each separate violation or, for continuing violations, for each day that violation continues.

(d) Any person who operates a public water system without a permit issued by the department pursuant to this chapter may be liable, as determined by the court, for a civil penalty not to exceed twenty-five thousand dollars ($25,000) for each separate violation or, for continuing violations, for each day that violation continues.

(e) Each civil penalty imposed for any separate violation pursuant to this section shall be separate and in addition to any other civil penalty imposed pursuant to this section or any other provision of law.

SEC. 17. Section 121360.5 of the Health and Safety Code is amended to read:

121360.5. (a) Any city or county health department that elects to participate in this program shall provide for one-year certification of tuberculin skin test technicians by local health officers.

(b) For purposes of this section, a "certified tuberculin skin test technician" is an unlicensed public health tuberculosis worker employed by, or under contract with, a local public health department, and who is certified by a local health officer to place and measure skin tests in the local health department's jurisdiction.

(c) A certified tuberculin skin test technician may perform the functions for which he or she is certified only if he or she meets all of the following requirements:

(1) The certified tuberculin skin test technician is working under the direction of the local health officer or the tuberculosis controller.

(2) The certified tuberculin skin test technician is working under the supervision of a licensed health professional. For purposes of this section, "supervision" means the licensed health professional is immediately available for consultation with the tuberculin skin test technician through telephonic or electronic contact.

(d) A certified tuberculin skin test technician may perform intradermal injections only for the purpose of placing a tuberculin skin test and measuring the test result.

(e) A certified tuberculin skin test technician may not be certified to interpret, and may not interpret, the results of a tuberculin skin test.

(f) In order to be certified as a tuberculin skin test technician by a local health officer, a person shall meet all of the following requirements, and provide to the local health officer appropriate documentation establishing that he or she has met those requirements:

(1) The person has a high school diploma, or its equivalent.

(2) (A) The person has completed a standardized course approved by the California Tuberculosis Controllers Association (CTCA), which shall include at least 24 hours of instruction in all of the following areas: Didactic instruction on tuberculosis control principles and instruction on the proper placement and measurement of tuberculin skin tests, equipment usage, basic infection control, universal precautions, and appropriate disposal of sharps, needles, and medical waste, client preparation and education, safety, communication, professional behavior, and the importance of confidentiality.

(B) A certification of satisfactory completion of this CTCA-approved course shall be dated and signed by the local health officer, and shall contain the name and social security number of the tuberculin skin test technician, and the printed name, the jurisdiction, and the telephone number of the certifying local health officer.

(3) The person has completed practical instruction including placing at least 30 successful intradermal tuberculin skin tests, supervised by a licensed physician or registered nurse at the local health department, and 30 correct measurements of intradermal tuberculin skin tests, at least 15 of which are deemed positive by the licensed physician or registered nurse supervising the practical instruction. A certification of the satisfactory completion of this practical instruction shall be dated and signed by the licensed physician or registered nurse supervising the practical instruction.

(g) The certification may be renewed, and the local health department shall provide a certificate of renewal, if the certificate holder has completed in-service training, including all of the following:

(1) At least three hours of a CTCA-approved standardized training course to assure continued competency. This training shall include, but not be limited to, fundamental principles of tuberculin skin testing.

(2) Practical instruction, under the supervision of a licensed physician or registered nurse at the local health department, including the successful placement and correct measurement of 10 tuberculin skin tests, at least five of which are deemed positive by the licensed physician or registered nurse supervising the practical instruction.

(h) The local health officer or the tuberculosis controller may deny or revoke the certification of a tuberculin skin test technician if the local health officer or the tuberculosis controller finds that the technician is not in compliance with this section.

(i) Each county or city participating in the program under this section using tuberculin skin test technicians, that elects to participate on or after January 1, 2005, shall submit to the CTCA a survey and an evaluation of its findings, including a review of the aggregate report, by July 1, 2006, and by July 1 of each year thereafter to, and including, July 1, 2011. The report shall include the following:

(1) The number of persons trained and certified as tuberculin skin test technicians in that city or county.

(2) The estimated number of tuberculin skin tests placed by tuberculin skin test technicians in that city or county.

(j) By July 1, 2008, the CTCA shall submit a summary of barriers to implementing the tuberculosis technician program in the state to the department and to the appropriate policy and fiscal committees of the Legislature.

(k) The local health officer of each participating city or county shall report to the Tuberculosis Control Branch within the department any adverse event that he or she determines has resulted from improper tuberculin skin test technician training or performance.

SEC. 18. Section 127662 of the Health and Safety Code is amended to read:

127662. (a) In order to effectively support the University of California and its work in implementing this chapter, there is hereby established in the State Treasury, the Health Care Benefits Fund. The university’s work in providing the bill analyses shall be supported from the fund.

(b) For fiscal years 2010–11 to 2014–15, inclusive, each health care service plan, except a specialized health care service plan, and each health insurer, as defined in Section 106 of the Insurance

Code, shall be assessed an annual fee in an amount determined through regulation. The amount of the fee shall be determined by the Department of Managed Health Care and the Department of Insurance in consultation with the university and shall be limited to the amount necessary to fund the actual and necessary expenses of the university and its work in implementing this chapter. The total annual assessment on health care service plans and health insurers shall not exceed two million dollars ($2,000,000).

(c) The Department of Managed Health Care and the Department of Insurance, in coordination with the university, shall assess the health care service plans and health insurers, respectively, for the costs required to fund the university's activities pursuant to subdivision (b).

(1) Health care service plans shall be notified of the assessment on or before June 15 of each year with the annual assessment notice issued pursuant to Section 1356. The assessment pursuant to this section is separate and independent of the assessments in Section 1356.

(2) Health insurers shall be noticed of the assessment in accordance with the notice for the annual assessment or quarterly premium tax revenues.

(3) The assessed fees required pursuant to subdivision (b) shall be paid on an annual basis no later than August 1 of each year. The Department of Managed Health Care and the Department of Insurance shall forward the assessed fees to the Controller for deposit in the Health Care Benefits Fund immediately following their receipt.

(4) "Health insurance," as used in this subdivision, does not include Medicare supplement, vision-only, dental-only, or CHAMPUS supplement insurance, or hospital indemnity, accident-only, or specified disease insurance that does not pay benefits on a fixed benefit, cash payment only basis.

SEC. 19. Section 127664 of the Health and Safety Code is amended to read:

127664. The Legislature requests the University of California to submit a report to the Governor and the Legislature by January 1, 2014, regarding the implementation of this chapter.

SEC. 20. Section 127665 of the Health and Safety Code is amended to read:

127665. This chapter shall remain in effect until June 30, 2015, and shall be repealed as of that date, unless a later enacted statute that becomes operative on or before June 30, 2015, deletes or extends that date.

SEC. 21. Section 128730 of the Health and Safety Code is amended to read:

128730. (a) Effective January 1, 1986, the office shall be the single state agency designated to collect the following health facility or clinic data for use by all state agencies:

(1) That data required by the office pursuant to Section 127285.

(2) That data required in the Medi-Cal cost reports pursuant to Section 14170 of the Welfare and Institutions Code.

(3) Those data items formerly required by the California Health Facilities Commission that are listed in Sections 128735 and 128740. Information collected pursuant to subdivision (g) of Section 128735 and Sections 128736 and 128737 shall be made available to the State Department of Health Care Services and the State Department of Public Health. The departments shall ensure that the patient's rights to confidentiality shall not be violated in any manner. The departments shall comply with all applicable policies and requirements involving review and oversight by the State Committee for the Protection of Human Subjects.

(b) The office shall consolidate any and all of the reports listed under this section or Sections 128735 and 128740, to the extent feasible, to minimize the reporting burdens on hospitals. Provided, however, that the office shall neither add nor delete data items from the Hospital Discharge Abstract Data Record or the quarterly reports without prior authorizing legislation, unless specifically required by federal law or regulation or judicial decision.

SEC. 22. Section 128745 of the Health and Safety Code is amended to read:

128745. (a) Commencing July 1993, and annually thereafter, the office shall publish risk-adjusted outcome reports in accordance with the following schedule:

Publication Date	Period Covered	Procedures and Conditions Covered
July 1993	1988–90	3
July 1994	1989–91	6

Publication Date	Period Covered	Procedures and Conditions Covered
July 1995	1990–92	9

Reports for subsequent years shall include conditions and procedures and cover periods as appropriate.

(b) The procedures and conditions required to be reported under this chapter shall be divided among medical, surgical and obstetric conditions or procedures and shall be selected by the office, based on the recommendations of the commission and the advice of the technical advisory committee set forth in subdivision (j) of Section 128725. The office shall publish the risk-adjusted outcome reports for surgical procedures by individual hospital and individual surgeon unless the office in consultation with the technical advisory committee and medical specialists in the relevant area of practice determines that it is not appropriate to report by individual surgeon. The office, in consultation with the technical advisory committee and medical specialists in the relevant area of practice, may decide to report nonsurgical procedures and conditions by individual physician when it is appropriate. The selections shall be in accordance with all of the following criteria:

(1) The patient discharge abstract contains sufficient data to undertake a valid risk adjustment. The risk adjustment report shall ensure that public hospitals and other hospitals serving primarily low-income patients are not unfairly discriminated against.

(2) The relative importance of the procedure and condition in terms of the cost of cases and the number of cases and the seriousness of the health consequences of the procedure or condition.

(3) Ability to measure outcome and the likelihood that care influences outcome.

(4) Reliability of the diagnostic and procedure data.

(c) (1) In addition to any other established and pending reports, on or before July 1, 2002, the office shall publish a risk-adjusted outcome report for coronary artery bypass graft surgery by hospital for all hospitals opting to participate in the report. This report shall be updated on or before July 1, 2003.

(2) In addition to any other established and pending reports, commencing July 1, 2004, and every year thereafter, the office

shall publish risk-adjusted outcome reports for coronary artery bypass graft surgery for all coronary artery bypass graft surgeries performed in the state. In each year, the reports shall compare risk-adjusted outcomes by hospital, and in every other year, by hospital and cardiac surgeon. Upon the recommendation of the technical advisory committee based on statistical and technical considerations, information on individual hospitals and surgeons may be excluded from the reports.

(3) Unless otherwise recommended by the clinical panel established by Section 128748, the office shall collect the same data used for the most recent risk-adjusted model developed for the California Coronary Artery Bypass Graft Mortality Reporting Program. Upon recommendation of the clinical panel, the office may add any clinical data elements included in the Society of Thoracic Surgeons' database. Prior to any additions from the Society of Thoracic Surgeons' database, the following factors shall be considered:

(A) Utilization of sampling to the maximum extent possible.

(B) Exchange of data elements as opposed to addition of data elements.

(4) Upon recommendation of the clinical panel, the office may add, delete or revise clinical data elements, but shall add no more than a net of six elements not included in the Society of Thoracic Surgeons' database, to the data set over any five-year period. Prior to any additions or deletions, all of the following factors shall be considered:

(A) Utilization of sampling to the maximum extent possible.

(B) Feasibility of collecting data elements.

(C) Costs and benefits of collection and submission of data.

(D) Exchange of data elements as opposed to addition of data elements.

(5) The office shall collect the minimum data necessary for purposes of testing or validating a risk-adjusted model for the coronary artery bypass graft report.

(6) Patient medical record numbers and any other data elements that the office believes could be used to determine the identity of an individual patient shall be exempt from the disclosure requirements of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(d) The annual reports shall compare the risk-adjusted outcomes experienced by all patients treated for the selected conditions and procedures in each California hospital during the period covered by each report, to the outcomes expected. Outcomes shall be reported in the five following groupings for each hospital:

(1) "Much higher than average outcomes," for hospitals with risk-adjusted outcomes much higher than the norm.

(2) "Higher than average outcomes," for hospitals with risk-adjusted outcomes higher than the norm.

(3) "Average outcomes," for hospitals with average risk-adjusted outcomes.

(4) "Lower than average outcomes," for hospitals with risk-adjusted outcomes lower than the norm.

(5) "Much lower than average outcomes," for hospitals with risk-adjusted outcomes much lower than the norm.

(e) For coronary artery bypass graft surgery reports and any other outcome reports for which auditing is appropriate, the office shall conduct periodic auditing of data at hospitals.

(f) The office shall publish in the annual reports required under this section the risk-adjusted mortality rate for each hospital and for those reports that include physician reporting, for each physician.

(g) The office shall either include in the annual reports required under this section, or make separately available at cost to any person requesting it, risk-adjusted outcomes data assessing the statistical significance of hospital or physician data at each of the following three levels: 99 percent confidence level (0.01 p-value), 95 percent confidence level (0.05 p-value), and 90 percent confidence level (.10 p-value). The office shall include any other analysis or comparisons of the data in the annual reports required under this section that the office deems appropriate to further the purposes of this chapter.

SEC. 23. Section 10123.91 of the Insurance Code is amended to read:

10123.91. (a) On or after January 1, 2009, every insurer that issues, amends, or renews an individual or group policy of health insurance that covers hospital, medical, or surgical expenses shall provide coverage for human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.

(b) It shall remain within the sole discretion of the health insurer as to the provider of the testing with which it chooses to contract. Reimbursement shall be provided according to the respective principles and policies of the health insurer.

(c) This section shall not apply to specialized health insurance policies, Medicare supplement policies, CHAMPUS-supplement insurance policies, or to hospital indemnity, accident-only, and specified disease insurance policies.

SEC. 24. Section 14043.26 of the Welfare and Institutions Code is amended to read:

14043.26. (a) (1) On and after January 1, 2004, an applicant that currently is not enrolled in the Medi-Cal program, or a provider applying for continued enrollment, upon written notification from the department that enrollment for continued participation of all providers in a specific provider of service category or subgroup of that category to which the provider belongs will occur, or, except as provided in subdivisions (b) and (e), a provider not currently enrolled at a location where the provider intends to provide services, goods, supplies, or merchandise to a Medi-Cal beneficiary, shall submit a complete application package for enrollment, continuing enrollment, or enrollment at a new location or a change in location.

(2) Clinics licensed by the department pursuant to Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(3) Health facilities licensed by the department pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(4) Adult day health care providers licensed pursuant to Chapter 3.3 (commencing with Section 1570) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(5) Home health agencies licensed pursuant to Chapter 8 (commencing with Section 1725) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(6) Hospices licensed pursuant to Chapter 8.5 (commencing with Section 1745) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(b) A physician and surgeon licensed by the Medical Board of California or the Osteopathic Medical Board of California practicing in an individual physician practice, who is enrolled and in good standing in the Medi-Cal program, and who is changing locations of that individual physician practice within the same county, shall be eligible to continue enrollment at the new location by filing a change of location form to be developed by the department. The form shall comply with all minimum federal requirements related to Medicaid provider enrollment. Filing this form shall be in lieu of submitting a complete application package pursuant to subdivision (a).

(c) (1) Except as provided in paragraph (2), within 30 days after receiving an application package submitted pursuant to subdivision (a), the department shall provide written notice that the application package has been received and, if applicable, that there is a moratorium on the enrollment of providers in the specific provider of service category or subgroup of the category to which the applicant or provider belongs. This moratorium shall bar further processing of the application package.

(2) Within 15 days after receiving an application package from a physician, or a group of physicians, licensed by the Medical Board of California or the Osteopathic Medical Board of California, or a change of location form pursuant to subdivision (b), the department shall provide written notice that the application package or the change of location form has been received.

(d) (1) If the application package submitted pursuant to subdivision (a) is from an applicant or provider who meets the criteria listed in paragraph (2), the applicant or provider shall be considered a preferred provider and shall be granted preferred provisional provider status pursuant to this section and for a period of no longer than 18 months, effective from the date on the notice from the department. The ability to request consideration as a preferred provider and the criteria necessary for the consideration shall be publicized to all applicants and providers. An applicant or provider who desires consideration as a preferred provider pursuant to this subdivision shall request consideration from the

department by making a notation to that effect on the application package, by cover letter, or by other means identified by the department in a provider bulletin. Request for consideration as a preferred provider shall be made with each application package submitted in order for the department to grant the consideration. An applicant or provider who requests consideration as a preferred provider shall be notified within 60 days whether the applicant or provider meets or does not meet the criteria listed in paragraph (2). If an applicant or provider is notified that the applicant or provider does not meet the criteria for a preferred provider, the application package submitted shall be processed in accordance with the remainder of this section.

(2) To be considered a preferred provider, the applicant or provider shall meet all of the following criteria:

(A) Hold a current license as a physician and surgeon issued by the Medical Board of California or the Osteopathic Medical Board of California, which license shall not have been revoked, whether stayed or not, suspended, placed on probation, or subject to other limitation.

(B) Be a current faculty member of a teaching hospital or a children's hospital, as defined in Section 10727, accredited by the Joint Commission or the American Osteopathic Association, or be credentialed by a health care service plan that is licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) or county organized health system, or be a current member in good standing of a group that is credentialed by a health care service plan that is licensed under the Knox-Keene Act.

(C) Have full, current, unrevoked, and unsuspended privileges at a Joint Commission or American Osteopathic Association accredited general acute care hospital.

(D) Not have any adverse entries in the federal Healthcare Integrity and Protection Data Bank.

(3) The department may recognize other providers as qualifying as preferred providers if criteria similar to those set forth in paragraph (2) are identified for the other providers. The department shall consult with interested parties and appropriate stakeholders to identify similar criteria for other providers so that they may be considered as preferred providers.

(e) (1) If a Medi-Cal applicant meets the criteria listed in paragraph (2), the applicant shall be enrolled in the Medi-Cal program after submission and review of a short form application to be developed by the department. The form shall comply with all minimum federal requirements related to Medicaid provider enrollment. The department shall notify the applicant that the department has received the application within 15 days of receipt of the application. The department shall issue the applicant a provider number or notify the applicant that the applicant does not meet the criteria listed in paragraph (2) within 90 days of receipt of the application.

(2) Notwithstanding any other provision of law, an applicant or provider who meets all of the following criteria shall be eligible for enrollment in the Medi-Cal program pursuant to this subdivision, after submission and review of a short form application:

(A) The applicant's or provider's practice is based in one or more of the following: a general acute care hospital, a rural general acute care hospital, or an acute psychiatric hospital, as defined in subdivisions (a) and (b) of Section 1250 of the Health and Safety Code.

(B) The applicant or provider holds a current, unrevoked, or unsuspended license as a physician and surgeon issued by the Medical Board of California or the Osteopathic Medical Board of California. An applicant or provider shall not be in compliance with this subparagraph if a license revocation has been stayed, the licensee has been placed on probation, or the license is subject to any other limitation.

(C) The applicant or provider does not have an adverse entry in the federal Healthcare Integrity and Protection Data Bank.

(3) An applicant shall be granted provisional provider status under this subdivision for a period of 12 months.

(f) Except as provided in subdivision (g), within 180 days after receiving an application package submitted pursuant to subdivision (a), or from the date of the notice to an applicant or provider that the applicant or provider does not qualify as a preferred provider under subdivision (d), the department shall give written notice to the applicant or provider that any of the following applies, or shall on the 181st day grant the applicant or provider provisional

provider status pursuant to this section for a period no longer than 12 months, effective from the 181st day:

(1) The applicant or provider is being granted provisional provider status for a period of 12 months, effective from the date on the notice.

(2) The application package is incomplete. The notice shall identify additional information or documentation that is needed to complete the application package.

(3) The department is exercising its authority under Section 14043.37, 14043.4, or 14043.7, and is conducting background checks, preenrollment inspections, or unannounced visits.

(4) The application package is denied for any of the following reasons:

(A) Pursuant to Section 14043.2 or 14043.36.

(B) For lack of a license necessary to perform the health care services or to provide the goods, supplies, or merchandise directly or indirectly to a Medi-Cal beneficiary, within the applicable provider of service category or subgroup of that category.

(C) The period of time during which an applicant or provider has been barred from reapplying has not passed.

(D) For other stated reasons authorized by law.

(g) Notwithstanding subdivision (f), within 90 days after receiving an application package submitted pursuant to subdivision (a) from a physician or physician group licensed by the Medical Board of California or the Osteopathic Medical Board of California, or from the date of the notice to that physician or physician group that does not qualify as a preferred provider under subdivision (d), or within 90 days after receiving a change of location form submitted pursuant to subdivision (b), the department shall give written notice to the applicant or provider that either paragraph (1), (2), (3), or (4) of subdivision (f) applies, or shall on the 91st day grant the applicant or provider provisional provider status pursuant to this section for a period no longer than 12 months, effective from the 91st day.

(h) (1) If the application package that was noticed as incomplete under paragraph (2) of subdivision (f) is resubmitted with all requested information and documentation, and received by the department within 60 days of the date on the notice, the department shall, within 60 days of the resubmission, send a notice that any of the following applies:

(A) The applicant or provider is being granted provisional provider status for a period of 12 months, effective from the date on the notice.

(B) The application package is denied for any other reasons provided for in paragraph (4) of subdivision (f).

(C) The department is exercising its authority under Section 14043.37, 14043.4, or 14043.7 to conduct background checks, preenrollment inspections, or unannounced visits.

(2) (A) If the application package that was noticed as incomplete under paragraph (2) of subdivision (f) is not resubmitted with all requested information and documentation and received by the department within 60 days of the date on the notice, the application package shall be denied by operation of law. The applicant or provider may reapply by submitting a new application package that shall be reviewed de novo.

(B) If the failure to resubmit is by a provider applying for continued enrollment, the failure shall make the provider also subject to deactivation of the provider's number and all of the business addresses used by the provider to provide services, goods, supplies, or merchandise to Medi-Cal beneficiaries.

(C) Notwithstanding subparagraph (A), if the notice of an incomplete application package included a request for information or documentation related to grounds for denial under Section 14043.2 or 14043.36, the applicant or provider shall not reapply for enrollment or continued enrollment in the Medi-Cal program or for participation in any health care program administered by the department or its agents or contractors for a period of three years.

(i) (1) If the department exercises its authority under Section 14043.37, 14043.4, or 14043.7 to conduct background checks, preenrollment inspections, or unannounced visits, the applicant or provider shall receive notice, from the department, after the conclusion of the background check, preenrollment inspection, or unannounced visit of either of the following:

(A) The applicant or provider is granted provisional provider status for a period of 12 months, effective from the date on the notice.

(B) Discrepancies or failure to meet program requirements, as prescribed by the department, have been found to exist during the preenrollment period.

(2) (A) The notice shall identify the discrepancies or failures, and whether remediation can be made or not, and if so, the time period within which remediation must be accomplished. Failure to remediate discrepancies and failures as prescribed by the department, or notification that remediation is not available, shall result in denial of the application by operation of law. The applicant or provider may reapply by submitting a new application package that shall be reviewed de novo.

(B) If the failure to remediate is by a provider applying for continued enrollment, the failure shall make the provider also subject to deactivation of the provider's number and all of the business addresses used by the provider to provide services, goods, supplies, or merchandise to Medi-Cal beneficiaries.

(C) Notwithstanding subparagraph (A), if the discrepancies or failure to meet program requirements, as prescribed by the director, included in the notice were related to grounds for denial under Section 14043.2 or 14043.36, the applicant or provider shall not reapply for three years.

(j) If provisional provider status or preferred provisional provider status is granted pursuant to this section, a provider number shall be used by the provider for each business address for which an application package has been approved. This provider number shall be used exclusively for the locations for which it was approved, unless the practice of the provider's profession or delivery of services, goods, supplies, or merchandise is such that services, goods, supplies, or merchandise are rendered or delivered at locations other than the provider's business address and this practice or delivery of services, goods, supplies, or merchandise has been disclosed in the application package approved by the department when the provisional provider status or preferred provisional provider status was granted.

(k) Except for providers subject to subdivision (c) of Section 14043.47, a provider currently enrolled in the Medi-Cal program at one or more locations who has submitted an application package for enrollment at a new location or a change in location pursuant to subdivision (a), or filed a change of location form pursuant to subdivision (b), may submit claims for services, goods, supplies, or merchandise rendered at the new location until the application package or change of location form is approved or denied under this section, and shall not be subject, during that period, to

deactivation, or be subject to any delay or nonpayment of claims as a result of billing for services rendered at the new location as herein authorized. However, the provider shall be considered during that period to have been granted provisional provider status or preferred provisional provider status and be subject to termination of that status pursuant to Section 14043.27. A provider that is subject to subdivision (c) of Section 14043.47 may come within the scope of this subdivision upon submitting documentation in the application package that identifies the physician providing supervision for every three locations. If a provider submits claims for services rendered at a new location before the application for that location is received by the department, the department may deny the claim.

(*l*) An applicant or a provider whose application for enrollment, continued enrollment, or a new location or change in location has been denied pursuant to this section, may appeal the denial in accordance with Section 14043.65.

(m) (1) Upon receipt of a complete and accurate claim for an individual nurse provider, the department shall adjudicate the claim within an average of 30 days.

(2) During the budget proceedings of the 2006–07 fiscal year, and each fiscal year thereafter, the department shall provide data to the Legislature specifying the timeframe under which it has processed and approved the provider applications submitted by individual nurse providers.

(3) For purposes of this subdivision, "individual nurse providers" are providers authorized under certain home- and community-based waivers and under the state plan to provide nursing services to Medi-Cal recipients in the recipients' own homes rather than in institutional settings.

(n) The amendments to subdivision (b), which implement a change of location form, and the addition of paragraph (2) to subdivision (c), the amendments to subdivision (e), and the addition of subdivision (g), which prescribe different processing timeframes for physicians and physician groups, as contained in Chapter 693 of the Statutes of 2007, shall become operative on July 1, 2008.

SEC. 25. Section 14043.28 of the Welfare and Institutions Code is amended to read:

14043.28. (a) (1) If an application package is denied under Section 14043.26 or provisional provider status or preferred

provisional provider status is terminated under Section 14043.27, the applicant or provider is prohibited from reapplying for enrollment or continued enrollment in the Medi-Cal program or for participation in any health care program administered by the department or its agents or contractors for a period of three years from the date the application package is denied or the provisional provider status is terminated, or from the date of the final decision following an appeal from that denial or termination, except as provided otherwise in paragraph (2) of subdivision (h), or paragraph (2) of subdivision (i), of Section 14043.26 and as set forth in this section.

(2) If the application is denied under paragraph (2) of subdivision (h) of Section 14043.26 because the applicant failed to resubmit an incomplete application package or is denied under paragraph (2) of subdivision (i) of Section 14043.26 because the applicant failed to remediate discrepancies, the applicant may resubmit an application in accordance with paragraph (2) of subdivision (h) or paragraph (2) of subdivision (i), respectively.

(3) If the denial of the application package is based upon a conviction for any offense or for any act included in Section 14043.36 or termination of the provisional provider status or preferred provisional provider status is based upon a conviction for any offense or for any act included in paragraph (1) of subdivision (c) of Section 14043.27, the applicant or provider may not reapply for enrollment or continued enrollment in the Medi-Cal program or for participation in any health care program administered by the department or its agents or contractors for a period of 10 years from the date the application package is denied or the provisional provider status or preferred provisional provider status is terminated or from the date of the final decision following an appeal from that denial or termination.

(4) If the denial of the application package is based upon two or more convictions for any offense or for any two or more acts included in Section 14043.36 or termination of the provisional provider status or preferred provisional provider status is based upon two or more convictions for any offense or for any two acts included in paragraph (1) of subdivision (c) of Section 14043.27, the applicant or provider shall be permanently barred from enrollment or continued enrollment in the Medi-Cal program or

for participation in any health care program administered by the department or its agents or contractors.

(5) The prohibition in paragraph (1) against reapplying for three years shall not apply if the denial of the application or termination of provisional provider status or preferred provisional provider status is based upon any of the following:

(A) The grounds provided for in paragraph (4), or subparagraph (B) of paragraph (7), of subdivision (c) of Section 14043.27.

(B) The grounds provided for in subdivision (d) of Section 14043.27, if the investigation is closed without any adverse action being taken.

(C) The grounds provided for in paragraph (6) of subdivision (c) of Section 14043.27. However, the department may deny reimbursement for claims submitted while the provider was noncompliant with CLIA.

(b) (1) If an application package is denied under subparagraph (A), (B), or (D) of paragraph (4) of subdivision (f) of Section 14043.26, or with respect to a provider described in subparagraph (B) of paragraph (2) of subdivision (h), or subparagraph (B) of paragraph (2) of subdivision (i), of Section 14043.26, or provisional provider status or preferred provisional provider status is terminated based upon any of the grounds stated in subparagraph (A) of paragraph (7), or paragraphs (1), (2), (3), (5), and (8) to (12), inclusive, of subdivision (c) of Section 14043.27, all business addresses of the applicant or provider shall be deactivated and the applicant or provider shall be removed from enrollment in the Medi-Cal program by operation of law.

(2) If the termination of provisional provider status is based upon the grounds stated in subdivision (d) of Section 14043.27 and the investigation is closed without any adverse action being taken, or is based upon the grounds in subparagraph (B) of paragraph (7) of subdivision (c) of Section 14043.27 and the applicant or provider obtains the appropriate license, permits, or approvals covering the period of provisional provider status, the termination taken pursuant to subdivision (c) of Section 14043.27 shall be rescinded, the previously deactivated provider numbers shall be reactivated, and the provider shall be reenrolled in the Medi-Cal program, unless there are other grounds for taking these actions.

(c) Claims that are submitted or caused to be submitted by an applicant or provider who has been suspended from the Medi-Cal program for any reason or who has had its provisional provider status terminated or had its application package for enrollment or continued enrollment denied and all business addresses deactivated may not be paid for services, goods, merchandise, or supplies rendered to Medi-Cal beneficiaries during the period of suspension or termination or after the date all business addresses are deactivated.

SEC. 26. Section 14043.29 of the Welfare and Institutions Code is amended to read:

14043.29. (a) If, at the end of the period for which provisional provider status or preferred provisional provider status was granted under Section 14043.26, all of the following conditions are met, the provisional status shall cease and the provider shall be enrolled in the Medi-Cal program without designation as a provisional provider:

(1) The provider has demonstrated an appropriate volume of business.

(2) The provisional provider status or preferred provisional provider status has not been terminated or if it has been terminated, the act of termination was rescinded.

(3) The provider continues to meet the standards for enrollment in the Medi-Cal program as set forth in this article and Section 51000 and following of Title 22 of the California Code of Regulations.

(b) (1) An applicant or a provider who applied for enrollment or continued enrollment in the Medi-Cal program, prior to May 1, 2003, and for whom the application has not been approved or denied, or who has not received a notice on or before January 1, 2004, that the department is exercising its authority under Section 14043.37, 14043.4, or 14043.7 to conduct background checks, preenrollment inspections, or unannounced visits, shall be granted provisional provider status effective on January 1, 2004. Applications from applicants or providers who have been so noticed prior to January 1, 2004, shall be processed in accordance with subdivision (h) of Section 14043.26.

(2) Applications from applicants or providers that have been received by the department after May 1, 2003, but prior to January 1, 2004, shall be processed in accordance with Section 14043.26,

except that these application packages shall be deemed to have been received by the department on January 1, 2004.

SEC. 27. Section 14115.8 of the Welfare and Institutions Code is amended to read:

14115.8. (a) (1) The department shall amend the Medicaid state plan with respect to the billing option for services by local educational agencies, to ensure that schools shall be reimbursed for all eligible services that they provide that are not precluded by federal requirements.

(2) The department shall examine methodologies for increasing school participation in the Medi-Cal billing option for local educational agencies so that schools can meet the health care needs of their students.

(3) The department, to the extent possible shall simplify claiming processes for local educational agency billing.

(4) The department shall eliminate and modify state plan and regulatory requirements that exceed federal requirements when they are unnecessary.

(b) If a rate study for the LEA Medi-Cal billing option is completed pursuant to Section 52 of Chapter 171 of the Statutes of 2001, the department, in consultation with the entities named in subdivision (c), shall implement the recommendations from the study, to the extent feasible and appropriate.

(c) In order to assist the department in formulating the state plan amendments required by subdivisions (a) and (b), the department shall regularly consult with the State Department of Education, representatives of urban, rural, large and small school districts, and county offices of education, the local education consortium, local educational agencies, and the local educational agency technical assistance project. It is the intent of the Legislature that the department also consult with staff from Region IX of the federal Centers for Medicare and Medicaid Services, experts from the fields of both health and education, and state legislative staff.

(d) Notwithstanding any other provision of law, or any other contrary state requirement, the department shall take whatever action is necessary to ensure that, to the extent there is capacity in its certified match, a local educational agency shall be reimbursed retroactively for the maximum period allowed by the federal government for any department change that results in an increase in reimbursement to local educational agency providers.

(e) The department may undertake all necessary activities to recoup matching funds from the federal government for reimbursable services that have already been provided in the state's public schools. The department shall prepare and take whatever action is necessary to implement all regulations, policies, state plan amendments, and other requirements necessary to achieve this purpose.

(f) The department shall file an annual report with the Legislature that shall include at least all of the following:

(1) A copy of the annual comparison required by subdivision (i).

(2) A state-by-state comparison of school-based Medicaid total and per eligible child claims and federal revenues. The comparison shall include a review of the most recent two years for which completed data is available.

(3) A summary of department activities and an explanation of how each activity contributed toward narrowing the gap between California's per eligible student federal fund recovery and the per student recovery of the top three states.

(4) A listing of all school-based services, activities, and providers approved for reimbursement by the federal Centers for Medicare and Medicaid Services in other state plans that are not yet approved for reimbursement in California's state plan and the service unit rates approved for reimbursement.

(5) The official recommendations made to the department by the entities named in subdivision (c) and the action taken by the department regarding each recommendation.

(6) A one-year timetable for state plan amendments and other actions necessary to obtain reimbursement for those items listed in paragraph (4).

(7) Identify any barriers to local educational agency reimbursement, including those specified by the entities named in subdivision (c), that are not imposed by federal requirements, and describe the actions that have been, and will be, taken to eliminate them.

(g) (1) These activities shall be funded and staffed by proportionately reducing federal Medicaid payments allocable to local educational agencies for the provision of benefits funded by the federal Medicaid program under the billing option for services by local educational agencies specified in this section. Moneys

collected as a result of the reduction in federal Medicaid payments allocable to local educational agencies shall be deposited into the Local Educational Agency Medi-Cal Recovery Fund, which is hereby established in the Special Deposit Fund established pursuant to Section 16370 of the Government Code. These funds shall be used, upon appropriation by the Legislature, only to support the department to meet all the requirements of this section. If the Legislature enacts a new statute that ends this program, all funds in the Local Educational Agency Medi-Cal Recovery Fund shall be returned proportionally to all local educational agencies whose federal Medicaid funds were used to create this fund. The annual amount funded shall not exceed one million five hundred thousand dollars ($1,500,000).

(2) Funding received pursuant to paragraph (1) shall derive only from federal Medicaid funds that exceed the baseline amount of local educational agency Medicaid billing option revenues for the 2000-01 fiscal year.

(h) (1) The department may enter into a contract to comply with the requirements of this section.

(2) The level of additional staff to comply with the requirements of this section, including, but not limited to, staff for which the department has contracted for pursuant to paragraph (1), shall be limited to that level that can be funded with revenues derived pursuant to subdivision (g).

(i) The activities of the department shall include all of the following:

(1) An annual comparison of the school-based Medicaid systems in comparable states.

(2) Efforts to improve communications with the federal government, the State Department of Education, and local educational agencies.

(3) The development and updating of written guidelines to local educational agencies regarding best practices to avoid audit exceptions, as needed.

(4) The establishment and maintenance of a local educational agency friendly interactive Web site.

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