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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 1250, 1344, 1366.4, 1374.64, 1375.4, 1376.1, 1377, 1399, 116283, 116286, 116380, ~~116450~~, 116540, 116650, 116725, 121360.5, 127662, 127664, 127665, 128730, and 128745 of, and to add ~~Section~~ *Sections 116451 and 116552* to, the Health and Safety Code, and to amend Sections 14043.26, 14043.28, 14043.29, and 14115.8 of the Welfare and Institutions Code, relating to health.

LEGISLATIVE COUNSEL'S DIGEST

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

(1) 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.

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

(3) 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. The bill would also prohibit the department from issuing or amending a permit to allow the use of point-of-use treatment unless the department determines, after a public hearing, that there is no substantial community opposition. It would also limit the issuance of that permit to the lesser of 3 years or until funding for centralized treatment is available.

(4) Under existing law, when a primary drinking water standard is not complied with, when a monitoring requirement is not performed, or when a water purveyor fails to comply with the conditions of a variance or exception, a public water system is required to notify the department and users, as specified.

This bill would, if user notification is required pursuant to this provision, require the department to make a reasonable effort to ensure that notification is given.

(5) 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.

(6) 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.

(7) 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~~ *educational* 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 change the repeal date to January 1, 2013.

(8) 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 the Local Educational Agency Medi-Cal Recovery Fund.

This bill would also provide that, as of January 1, 2013, unless the Legislature enacts a new statute or extends the repeal date, 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 fund.

(9) 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.

(10) 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.

(11) 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.

(12) Existing law requires the State Department of Public Health to maintain a program for the control of tuberculosis. Existing law, until January 1, 2011, 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.

(13) This bill would incorporate additional changes to Section 6276.24 of the Government Code proposed by SB 359, that would become operative only if SB 359 and this bill are both chaptered and become effective on or before January 1, 2010, and this bill is chaptered last. ~~The bill would incorporate additional changes to Section 116450 of the Health and Safety Code proposed by AB 737, that would become operative only if AB 737 and this bill are both chaptered and become effective on or before January 1, 2010, and this bill is chaptered last.~~ The bill would incorporate additional changes to Section 14043.28 of the Welfare and Institutions Code proposed by AB 839, that would become operative only if AB 839 and this bill are both chaptered and become effective on or before January 1, 2010, and this bill is chaptered last.

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

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

1 SECTION 1. Section 6276.24 of the Government Code is
2 amended to read:
3 6276.24. Harmful matter, distribution, confidentiality of certain
4 recipients, Section 313.1, Penal Code.
5 Hazardous substance tax information, prohibition against
6 disclosure, Section 43651, Revenue and Taxation Code.
7 Hazardous waste control, business plans, public inspection,
8 Section 25506, Health and Safety Code.
9 Hazardous waste control, notice of unlawful hazardous waste
10 disposal, Section 25180.5, Health and Safety Code.
11 Hazardous waste control, trade secrets, disclosure of information,
12 Sections 25511 and 25538, Health and Safety Code.
13 Hazardous waste control, trade secrets, procedures for release
14 of information, Section 25358.2, Health and Safety Code.

1 Hazardous waste generator report, protection of trade secrets,
2 Sections 25244.21 and 25244.23, Health and Safety Code.
3 Hazardous waste licenseholder disclosure statement,
4 confidentiality of, Section 25186.5, Health and Safety Code.
5 Hazardous waste management facilities on Indian lands,
6 confidentiality of privileged or trade secret information, Section
7 25198.4, Health and Safety Code.
8 Hazardous waste recycling, duties of department, Section 25170,
9 Health and Safety Code.
10 Hazardous waste recycling, list of specified hazardous wastes,
11 trade secrets, Section 25175, Health and Safety Code.
12 Hazardous waste recycling, trade secrets, confidential nature,
13 Sections 25173 and 25180.5, Health and Safety Code.
14 Healing arts licensees, central files, confidentiality, Section 800,
15 Business and Professions Code.
16 Health authorities, special county, protection of trade secrets,
17 Sections 14087.35, 14087.36, and 14087.38, Welfare and
18 Institutions Code.
19 Health Care Provider Central Files, confidentiality of, Section
20 800, Business and Professions Code.
21 Health care provider disciplinary proceeding, confidentiality of
22 documents, Section 805.1, Business and Professions Code.
23 Health care service plans, review of quality of care, privileged
24 communications, Sections 1370 and 1380, Health and Safety Code.
25 Health commissions, special county, protection of trade secrets,
26 Section 14087.31, Welfare and Institutions Code.
27 Health facilities, patient's rights of confidentiality, subdivision
28 (c) of Section 128745 and Sections 128735, 128736, 128737,
29 128755, and 128765, Health and Safety Code.
30 Health facility and clinic, consolidated data and reports,
31 confidentiality of, Section 128730, Health and Safety Code.
32 Health personnel, data collection by the Office of Statewide
33 Health Planning and Development, confidentiality of information
34 on individual licentiates, Sections 127775 and 127780, Health and
35 Safety Code.
36 Health planning and development pilot projects, confidentiality
37 of data collected, Section 128165, Health and Safety Code.
38 Hereditary Disorders Act, legislative finding and declaration,
39 confidential information, Sections 124975 and 124980, Health and
40 Safety Code.

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

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

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

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

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

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

16 Hospital district and municipal hospital records relating to
17 contracts with insurers and service plans, subdivision (t), Section
18 6254, Government Code.

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

21 Housing authorities, confidentiality of rosters of tenants, Section
22 34283, Health and Safety Code.

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

26 SEC. 1.5. Section 6276.24 of the Government Code is amended
27 to read:

28 ~~6276.24. Hazardous~~

29 *6276.24. Hazardous* substance tax information, prohibition
30 against disclosure, Section 43651, Revenue and Taxation Code.

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

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

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

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

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

1 Hazardous waste licenseholder disclosure statement,
2 confidentiality of, Section 25186.5, Health and Safety Code.
3 Hazardous waste recycling, information—~~clearing house~~
4 *clearinghouse*, confidentiality of trade secrets, Section 25170,
5 Health and Safety Code.
6 Hazardous waste recycling, list of specified hazardous wastes,
7 trade secrets, Section 25175, Health and Safety Code.
8 Hazardous waste recycling, trade secrets, confidential nature,
9 Sections 25173 and 25180.5, Health and Safety Code.
10 Healing arts licensees, central files, confidentiality, Section 800,
11 Business and Professions Code.
12 Health authorities, special county, confidentiality of records,
13 Sections 14087.35, 14087.36, and 14087.38, Welfare and
14 Institutions Code.
15 Health care provider disciplinary proceeding, confidentiality of
16 documents, Section 805.1, Business and Professions Code.
17 Health care service plans, review of quality of care, privileged
18 communications, Sections 1370 and 1380, Health and Safety Code.
19 Health commissions, special county, confidentiality of peer
20 review proceedings, rates of payment, and trade secrets, Section
21 14087.31, Welfare and Institutions Code.
22 Health facilities, patient's rights of confidentiality, subdivision
23 (c) of Section 128745 and Sections 128735, 128736, 128737,
24 128755, and 128765, Health and Safety Code.
25 Health personnel, data collection by the Office of Statewide
26 Health Planning and Development, confidentiality of information
27 on individual licentiates, Section 127780, Health and Safety Code.
28 Health plan governed by a county board of supervisors,
29 exemption from disclosure for records relating to provider rates
30 or payments for a three-year period after execution of the provider
31 contract, Sections 6254.22 and 54956.87.
32 Hereditary Disorders Act, legislative finding and declaration,
33 confidential information, Sections 124975 and 124980, Health and
34 Safety Code.
35 Hereditary Disorders Act, rules, regulations, and standards,
36 breach of confidentiality, Section 124980, Health and Safety Code.
37 HIV, disclosures to blood banks by department or county health
38 officers, Section 1603.1, Health and Safety Code.

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

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

6 Hospital district and municipal hospital records relating to
7 contracts with insurers and service plans, subdivision (t), Section
8 6254.

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

10 Housing authorities, confidentiality of rosters of tenants, Section
11 34283, Health and Safety Code.

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

15 SEC. 2. Section 1250 of the Health and Safety Code is amended
16 to read:

17 1250. As used in this chapter, “health facility” means any
18 facility, place, or building that is organized, maintained, and
19 operated for the diagnosis, care, prevention, and treatment of
20 human illness, physical or mental, including convalescence and
21 rehabilitation and including care during and after pregnancy, or
22 for any one or more of these purposes, for one or more persons,
23 to which the persons are admitted for a 24-hour stay or longer, and
24 includes the following types:

25 (a) “General acute care hospital” means a health facility having
26 a duly constituted governing body with overall administrative and
27 professional responsibility and an organized medical staff that
28 provides 24-hour inpatient care, including the following basic
29 services: medical, nursing, surgical, anesthesia, laboratory,
30 radiology, pharmacy, and dietary services. A general acute care
31 hospital may include more than one physical plant maintained and
32 operated on separate premises as provided in Section 1250.8. A
33 general acute care hospital that exclusively provides acute medical
34 rehabilitation center services, including at least physical therapy,
35 occupational therapy, and speech therapy, may provide for the
36 required surgical and anesthesia services through a contract with
37 another acute care hospital. In addition, a general acute care
38 hospital that, on July 1, 1983, provided required surgical and
39 anesthesia services through a contract or agreement with another
40 acute care hospital may continue to provide these surgical and

1 anesthesia services through a contract or agreement with an acute
2 care hospital. The general acute care hospital operated by the State
3 Department of Developmental Services at Agnews Developmental
4 Center may, until June 30, 2007, provide surgery and anesthesia
5 services through a contract or agreement with another acute care
6 hospital. Notwithstanding the requirements of this subdivision, a
7 general acute care hospital operated by the Department of
8 Corrections and Rehabilitation or the Department of Veterans
9 Affairs may provide surgery and anesthesia services during normal
10 weekday working hours, and not provide these services during
11 other hours of the weekday or on weekends or holidays, if the
12 general acute care hospital otherwise meets the requirements of
13 this section.

14 A “general acute care hospital” includes a “rural general acute
15 care hospital.” However, a “rural general acute care hospital” shall
16 not be required by the department to provide surgery and anesthesia
17 services. A “rural general acute care hospital” shall meet either of
18 the following conditions:

19 (1) The hospital meets criteria for designation within peer group
20 six or eight, as defined in the report entitled Hospital Peer Grouping
21 for Efficiency Comparison, dated December 20, 1982.

22 (2) The hospital meets the criteria for designation within peer
23 group five or seven, as defined in the report entitled Hospital Peer
24 Grouping for Efficiency Comparison, dated December 20, 1982,
25 and has no more than 76 acute care beds and is located in a census
26 dwelling place of 15,000 or less population according to the 1980
27 federal census.

28 (b) “Acute psychiatric hospital” means a health facility having
29 a duly constituted governing body with overall administrative and
30 professional responsibility and an organized medical staff that
31 provides 24-hour inpatient care for mentally disordered,
32 incompetent, or other patients referred to in Division 5
33 (commencing with Section 5000) or Division 6 (commencing with
34 Section 6000) of the Welfare and Institutions Code, including the
35 following basic services: medical, nursing, rehabilitative,
36 pharmacy, and dietary services.

37 (c) “Skilled nursing facility” means a health facility that provides
38 skilled nursing care and supportive care to patients whose primary
39 need is for availability of skilled nursing care on an extended basis.

1 (d) “Intermediate care facility” means a health facility that
2 provides inpatient care to ambulatory or nonambulatory patients
3 who have recurring need for skilled nursing supervision and need
4 supportive care, but who do not require availability of continuous
5 skilled nursing care.

6 (e) “Intermediate care facility/developmentally disabled
7 habilitative” means a facility with a capacity of 4 to 15 beds that
8 provides 24-hour personal care, habilitation, developmental, and
9 supportive health services to 15 or fewer persons with
10 developmental disabilities who have intermittent recurring needs
11 for nursing services, but have been certified by a physician and
12 surgeon as not requiring availability of continuous skilled nursing
13 care.

14 (f) “Special hospital” means a health facility having a duly
15 constituted governing body with overall administrative and
16 professional responsibility and an organized medical or dental staff
17 that provides inpatient or outpatient care in dentistry or maternity.

18 (g) “Intermediate care facility/developmentally disabled” means
19 a facility that provides 24-hour personal care, habilitation,
20 developmental, and supportive health services to persons with
21 developmental disabilities whose primary need is for
22 developmental services and who have a recurring but intermittent
23 need for skilled nursing services.

24 (h) “Intermediate care facility/developmentally
25 disabled-nursing” means a facility with a capacity of 4 to 15 beds
26 that provides 24-hour personal care, developmental services, and
27 nursing supervision for persons with developmental disabilities
28 who have intermittent recurring needs for skilled nursing care but
29 have been certified by a physician and surgeon as not requiring
30 continuous skilled nursing care. The facility shall serve medically
31 fragile persons with developmental disabilities or who demonstrate
32 significant developmental delay that may lead to a developmental
33 disability if not treated.

34 (i) (1) “Congregate living health facility” means a residential
35 home with a capacity, except as provided in paragraph (4), of no
36 more than 12 beds, that provides inpatient care, including the
37 following basic services: medical supervision, 24-hour skilled
38 nursing and supportive care, pharmacy, dietary, social, recreational,
39 and at least one type of service specified in paragraph (2). The
40 primary need of congregate living health facility residents shall

1 be for availability of skilled nursing care on a recurring,
2 intermittent, extended, or continuous basis. This care is generally
3 less intense than that provided in general acute care hospitals but
4 more intense than that provided in skilled nursing facilities.

5 (2) Congregate living health facilities shall provide one of the
6 following services:

7 (A) Services for persons who are mentally alert, persons with
8 physical disabilities, who may be ventilator dependent.

9 (B) Services for persons who have a diagnosis of terminal
10 illness, a diagnosis of a life-threatening illness, or both. Terminal
11 illness means the individual has a life expectancy of six months
12 or less as stated in writing by his or her attending physician and
13 surgeon. A “life-threatening illness” means the individual has an
14 illness that can lead to a possibility of a termination of life within
15 five years or less as stated in writing by his or her attending
16 physician and surgeon.

17 (C) Services for persons who are catastrophically and severely
18 disabled. A person who is catastrophically and severely disabled
19 means a person whose origin of disability was acquired through
20 trauma or nondegenerative neurologic illness, for whom it has
21 been determined that active rehabilitation would be beneficial and
22 to whom these services are being provided. Services offered by a
23 congregate living health facility to a person who is catastrophically
24 disabled shall include, but not be limited to, speech, physical, and
25 occupational therapy.

26 (3) A congregate living health facility license shall specify which
27 of the types of persons described in paragraph (2) to whom a
28 facility is licensed to provide services.

29 (4) (A) A facility operated by a city and county for the purposes
30 of delivering services under this section may have a capacity of
31 59 beds.

32 (B) A congregate living health facility not operated by a city
33 and county servicing persons who are terminally ill, persons who
34 have been diagnosed with a life-threatening illness, or both, that
35 is located in a county with a population of 500,000 or more persons
36 may have not more than 25 beds for the purpose of serving persons
37 who are terminally ill.

38 (C) A congregate living health facility not operated by a city
39 and county serving persons who are catastrophically and severely
40 disabled, as defined in subparagraph (C) of paragraph (2) that is

1 located in a county of 500,000 or more persons may have not more
2 than 12 beds for the purpose of serving persons who are
3 catastrophically and severely disabled.

4 (5) A congregate living health facility shall have a
5 noninstitutional, homelike environment.

6 (j) (1) “Correctional treatment center” means a health facility
7 operated by the Department of Corrections and Rehabilitation, the
8 Department of Corrections and Rehabilitation, Division of Juvenile
9 Facilities, or a county, city, or city and county law enforcement
10 agency that, as determined by the state department, provides
11 inpatient health services to that portion of the inmate population
12 who do not require a general acute care level of basic services.
13 This definition shall not apply to those areas of a law enforcement
14 facility that houses inmates or wards that may be receiving
15 outpatient services and are housed separately for reasons of
16 improved access to health care, security, and protection. The health
17 services provided by a correctional treatment center shall include,
18 but are not limited to, all of the following basic services: physician
19 and surgeon, psychiatrist, psychologist, nursing, pharmacy, and
20 dietary. A correctional treatment center may provide the following
21 services: laboratory, radiology, perinatal, and any other services
22 approved by the state department.

23 (2) Outpatient surgical care with anesthesia may be provided,
24 if the correctional treatment center meets the same requirements
25 as a surgical clinic licensed pursuant to Section 1204, with the
26 exception of the requirement that patients remain less than 24
27 hours.

28 (3) Correctional treatment centers shall maintain written service
29 agreements with general acute care hospitals to provide for those
30 inmate physical health needs that cannot be met by the correctional
31 treatment center.

32 (4) Physician and surgeon services shall be readily available in
33 a correctional treatment center on a 24-hour basis.

34 (5) It is not the intent of the Legislature to have a correctional
35 treatment center supplant the general acute care hospitals at the
36 California Medical Facility, the California Men’s Colony, and the
37 California Institution for Men. This subdivision shall not be
38 construed to prohibit the Department of Corrections and
39 Rehabilitation from obtaining a correctional treatment center
40 license at these sites.

1 (k) “Nursing facility” means a health facility licensed pursuant
2 to this chapter that is certified to participate as a provider of care
3 either as a skilled nursing facility in the federal Medicare Program
4 under Title XVIII of the federal Social Security Act or as a nursing
5 facility in the federal Medicaid Program under Title XIX of the
6 federal Social Security Act, or as both.

7 (l) Regulations defining a correctional treatment center described
8 in subdivision (j) that is operated by a county, city, or city and
9 county, the Department of Corrections and Rehabilitation, or the
10 Department of Corrections and Rehabilitation, Division of Juvenile
11 Facilities, shall not become effective prior to, or if effective, shall
12 be inoperative until January 1, 1996, and until that time these
13 correctional facilities are exempt from any licensing requirements.

14 (m) “Intermediate care facility/developmentally
15 disabled-continuous nursing (ICF/DD-CN)” means a home-like
16 facility with a capacity of four to eight, inclusive, beds that
17 provides 24-hour personal care, developmental services, and
18 nursing supervision for persons with developmental disabilities
19 who have continuous needs for skilled nursing care and have been
20 certified by a physician and surgeon as warranting continuous
21 skilled nursing care. The facility shall serve medically fragile
22 persons who have developmental disabilities or demonstrate
23 significant developmental delay that may lead to a developmental
24 disability if not treated. ICF/DD-CN facilities shall be subject to
25 licensure under this chapter upon adoption of licensing regulations
26 in accordance with Section 1275.3. A facility providing continuous
27 skilled nursing services to persons with developmental disabilities
28 pursuant to Section 14132.20 or 14495.10 of the Welfare and
29 Institutions Code shall apply for licensure under this subdivision
30 within 90 days after the regulations become effective, and may
31 continue to operate pursuant to those sections until its licensure
32 application is either approved or denied.

33 SEC. 3. Section 1344 of the Health and Safety Code is amended
34 to read:

35 1344. (a) The director may from time to time adopt, amend,
36 and rescind any rules, forms, and orders that are necessary to carry
37 out the provisions of this chapter, including rules governing
38 applications and reports, and defining any terms, whether or not
39 used in this chapter, insofar as the definitions are not inconsistent
40 with the provisions of this chapter. For the purpose of rules and

1 forms, the director may classify persons and matters within the
2 director's jurisdiction, and may prescribe different requirements
3 for different classes. The director may waive any requirement of
4 any rule or form in situations where in the director's discretion
5 that requirement is not necessary in the public interest or for the
6 protection of the public, subscribers, enrollees, or persons or plans
7 subject to this chapter. The director may adopt rules consistent
8 with federal regulations and statutes to regulate health care
9 coverage supplementing Medicare.

10 (b) The director may, by regulation, modify the wording of any
11 notice required by this chapter for purposes of clarity, readability,
12 and accuracy, except that a modification shall not change the
13 substantive meaning of the notice.

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

16 (d) No provision of this chapter imposing any liability applies
17 to any act done or omitted in good faith in conformity with any
18 rule, form, order, or written interpretive opinion of the director,
19 or any opinion of the Attorney General, notwithstanding that the
20 rule, form, order, or written interpretive opinion may later be
21 amended or rescinded or be determined by judicial or other
22 authority to be invalid for any reason.

23 SEC. 4. Section 1366.4 of the Health and Safety Code is
24 amended to read:

25 1366.4. (a) A medical group, physician, or independent
26 practice association that contracts with a health care service plan
27 may enter into contracts with licensed nonphysician providers to
28 provide services, as defined in Section 1300.67(a)(1) of Title 28
29 of the California Code of Regulations, to plan enrollees covered
30 by the contract between the plan and the group, physician, or
31 association.

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

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

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

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

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

21 1374.64. (a) Only a plan that has been licensed under this
22 chapter and in operation in this state for a period of five years or
23 more, or a plan licensed under this chapter and operating in this
24 state for a period of five or more years under a combination of (1)
25 licensure under this chapter and (2) pursuant to a certificate of
26 authority issued by the Department of Insurance may offer a
27 point-of-service contract. A specialized health care service plan
28 shall not offer a point-of-service plan contract unless this plan was
29 formerly registered under the Knox-Mills Health Plan Act (Article
30 2.5 (commencing with Section 12530) of Chapter 6 of Part 2 of
31 Division 3 of Title 2 of the Government Code), as repealed by
32 Chapter 941 of the Statutes of 1975, and offered point-of-service
33 plan contracts previously approved by the director on July 1, 1976,
34 and on September 1, 1993.

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

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

4 (A) (i) Initial tangible net equity so that the plan is not required
5 to file monthly reports with the director as required by Section
6 1300.84.3(d)(1)(G) of Title 28 of the California Code of
7 Regulations and then have and maintain adjusted tangible net
8 equity to be determined pursuant to either of the following:

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

17 (II) In the case of a plan that is required to have and maintain
18 a tangible net equity as required by Section 1300.76(a)(3) of Title
19 28 of the California Code of Regulations, recalculate the plan's
20 tangible net equity under Section 1300.76(a)(3) of Title 28 of the
21 California Code of Regulations excluding the plan's annualized
22 health care expenditures for out-of-network services for
23 point-of-service enrollees, add together the number resulting from
24 this recalculation and the number that equals 10 percent of the
25 plan's annualized health care expenditures for out-of-network
26 services for ~~point-of-services~~ *point-of-service* enrollees, and
27 multiply this sum times 130 percent, provided that the product of
28 this multiplication must exceed 130 percent of the tangible net
29 equity required by Section 1300.76(a)(3) of Title 28 of the
30 California Code of Regulations so that the plan is not required to
31 file monthly reports to the director as required by Section
32 1300.84.3(d)(1)(G) of Title 28 of the California Code of
33 Regulations.

34 (ii) The failure of a plan offering a point-of-service plan contract
35 under this article to maintain adjusted tangible net equity as
36 determined by this subdivision shall require the filing of monthly
37 reports with the director pursuant to Section 1300.84.3(d) of Title
38 28 of the California Code of Regulations, in addition to any other
39 requirements that may be imposed by the director on a plan under
40 this article and chapter.

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

6 (B) Demonstrates adequate working capital, including (i) a
7 current ratio (current assets divided by current liabilities) of at
8 least 1:1, after excluding obligations of officers, directors, owners,
9 or affiliates, or (ii) evidence that the plan is now meeting its
10 obligations on a timely basis and has been doing so for at least the
11 preceding two years. Short-term obligations of affiliates for goods
12 or services arising in the normal course of business that are payable
13 on the same terms as equivalent transactions with nonaffiliates
14 shall not be excluded. For purposes of this subdivision, an
15 obligation is considered short term if the repayment schedule is
16 30 days or fewer.

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

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

23 (A) (i) Initial tangible net equity so that the plan is not required
24 to file monthly reports with the director as required by Section
25 1300.84.3(d)(1)(G) of Title 28 of the California Code of
26 Regulations and then have and maintain adjusted tangible net
27 equity to be determined pursuant to either of the following:

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

36 (II) In the case of a plan that is required to have and maintain
37 a tangible net equity as required by Section 1300.76(a)(3) of Title
38 28 of the California Code of Regulations, recalculate the plan's
39 tangible net equity under Section 1300.76(a)(3) excluding the
40 plan's annualized health care expenditures for out-of-network

1 services for point-of-service enrollees, add together the number
2 resulting from this recalculation and the number that equals 10
3 percent of the plan's annualized health care expenditures for
4 out-of-network services for ~~point-of-services~~ *point-of-service*
5 enrollees, and multiply this sum times 130 percent, provided that
6 the product of this multiplication must exceed 130 percent of the
7 tangible net equity required by Section 1300.76(a)(3) of Title 28
8 of the California Code of Regulations so that the plan is not
9 required to file monthly reports to the director as required by
10 Section 1300.84.3(d)(1)(G) of Title 28 of the California Code of
11 Regulations.

12 (ii) The failure of a plan offering a point-of-service plan contract
13 under this article to maintain adjusted tangible net equity as
14 determined by this subdivision shall require the filing of monthly
15 reports with the director pursuant to Section 1300.84.3(d) of Title
16 28 of the California Code of Regulations, in addition to any other
17 requirements that may be imposed by the director on a plan under
18 this article and chapter.

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

24 (B) Demonstrates adequate working capital, including (i) a
25 current ratio (current assets divided by current liabilities) of at
26 least 1:1, after excluding obligations of officers, directors, owners,
27 or affiliates or (ii) evidence that the plan is now meeting its
28 obligations on a timely basis and has been doing so for at least the
29 preceding two years. Short-term obligations of affiliates for goods
30 or services arising in the normal course of business that are payable
31 on the same terms as equivalent transactions with nonaffiliates
32 shall not be excluded. For purposes of this subdivision, an
33 obligation is considered short term if the repayment schedule is
34 30 days or fewer.

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

37 (D) Demonstrates to the director that it has obtained insurance
38 for the cost of providing any point-of-service enrollee with
39 out-of-network covered health care services, the aggregate value
40 of which exceeds five thousand dollars (\$5,000) in any year. This

1 insurance shall obligate the insurer to continue to provide care for
2 the period in which a premium was paid in the event a plan
3 becomes insolvent. Where a plan cannot obtain insurance as
4 required by this subparagraph, then a plan may demonstrate to the
5 director that it has made other arrangements, acceptable to the
6 director, for the cost of providing enrollees out-of-network health
7 care services; but in this case the expenditure for total
8 out-of-network costs for all enrollees in all point-of-service
9 contracts shall be limited to a percentage, acceptable to the director,
10 not to exceed 15 percent of total health care expenditures for all
11 its enrollees.

12 (c) Within 30 days of the close of each month a plan offering
13 point-of-service plan contracts under paragraph (2) of subdivision
14 (b) shall file with the director a monthly financial report consisting
15 of a balance sheet and statement of operations of the plan, which
16 need not be certified, and a calculation of the adjusted tangible net
17 equity required under subparagraph (A). The financial statements
18 shall be prepared on a basis consistent with the financial statements
19 furnished by the plan pursuant to Section 1300.84.2 of Title 28 of
20 the California Code of Regulations. A plan shall also make special
21 reports to the director as the director may from time to time require.
22 Each report to be filed by a plan pursuant to this subdivision shall
23 be verified by a principal officer of the plan as set forth in Section
24 1300.84.2(e) of Title 28 of the California Code of Regulations.

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

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

33 1375.4. (a) Every contract between a health care service plan
34 and a risk-bearing organization that is issued, amended, renewed,
35 or delivered in this state on or after July 1, 2000, shall include
36 provisions concerning the following, as to the risk-bearing
37 organization's administrative and financial capacity, which shall
38 be effective as of January 1, 2001:

39 (1) A requirement that the risk-bearing organization furnish
40 financial information to the health care service plan or the plan's

1 designated agent and meet any other financial requirements that
2 assist the health care service plan in maintaining the financial
3 viability of its arrangements for the provision of health care
4 services in a manner that does not adversely affect the integrity of
5 the contract negotiation process.

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

10 (3) A requirement that the health care service plans provide
11 payments of all risk arrangements, excluding capitation, within
12 180 days after close of the fiscal year.

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

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

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

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

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

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

37 (B) A risk-bearing organization may reduce its liabilities for
38 purposes of calculating tangible net equity, pursuant to clause (iii)
39 of subparagraph (A), and working capital, pursuant to clause (iv)
40 of subparagraph (A), by the amount of any liabilities the payment

1 of which is guaranteed by a sponsoring organization pursuant to
2 a qualified guarantee. A sponsoring organization is one that has a
3 tangible net equity of a level to be established by the director that
4 is in excess of all amounts that it has guaranteed to any person or
5 entity. A qualified guarantee is one that meets all of the following:

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

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

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

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

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

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

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

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

1 agreeable corrective action plan, the director shall determine the
2 corrective action plan.

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

7 (A) Enrollee information monthly.

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

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

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

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

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

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

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

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

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

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

7 (g) (1) For purposes of this section, a “risk-bearing
8 organization” means a professional medical corporation, other
9 form of corporation controlled by physicians and surgeons, a
10 medical partnership, a medical foundation exempt from licensure
11 pursuant to subdivision (I) of Section 1206, or another lawfully
12 organized group of physicians that delivers, furnishes, or otherwise
13 arranges for or provides health care services, but does not include
14 an individual or a health care service plan, and that does all of the
15 following:

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

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

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

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

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

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

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

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

6 1376.1. The deposit requirements of Section 1300.76.1 of Title
7 28 of the California Code of Regulations shall not apply to any
8 plan operated by a county, or city and county, if both of the
9 following apply:

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

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

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

22 1377. (a) Every plan which reimburses providers of health
23 care services that do not contract in writing with the plan to provide
24 health care services, or which reimburses its subscribers or
25 enrollees for costs incurred in having received health care services
26 from providers that do not contract in writing with the plan, in an
27 amount which exceeds 10 percent of its total costs for health care
28 services for the immediately preceding six months, shall comply
29 with the requirements set forth in either paragraph (1) or (2):

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

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

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

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

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

5 (B) Each plan licensed pursuant to this chapter prior to January
6 1, 1991, shall, upon that date, make a deposit of 50 percent of the
7 amount required by subparagraph (A), and shall maintain additional
8 cash or cash equivalents as defined by rule of the director, in the
9 amount of 50 percent of the amount required by subparagraph (A),
10 and shall make a deposit of 100 percent of the amount required by
11 subparagraph (A) by January 1, 1992.

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

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

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

30 (F) The deposit required under this section is in trust and may
31 be used only as provided by this section. The director or, if a
32 receiver has been appointed, the receiver shall use the deposit of
33 an insolvent health care service plan, as defined in Sections 1394.7
34 and 1394.8, for payment of covered claims for services rendered
35 by noncontracting providers under circumstances covered by the
36 plan. All claims determined by the director or receiver, in his or
37 her discretion, to be eligible for reimbursement under this section
38 shall be paid on a pro rata basis based on assets available from the
39 deposit to pay the ultimate liability for incurred expenditures.
40 Partial distribution may be made pending final distribution. Any

1 amount of the deposit remaining shall be paid into the liquidation
2 or receivership of the health care service plan. The director may
3 also use the deposit of an insolvent health care service plan for
4 payment of any administrative costs associated with the
5 administration of this section. The department, the director, and
6 any employee of the department shall not be liable, as provided
7 by Section 820.2 of the Government Code, for an injury resulting
8 from an exercise of discretion pursuant to this section. Nothing in
9 this section shall be construed to provide immunity for the acts of
10 a receiver, except when the director is acting as a receiver.

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

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

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

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

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

1 to the director whenever these reimbursables exceed 10 percent
2 of its total expenditures for health care services.

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

7 (d) In the event an insolvent plan covered by this section fails
8 to pay a noncontracting provider sums for covered services owed,
9 the provider shall first look to the uncovered expenditures
10 insolvency deposit or the insurance or guaranty arrangement
11 maintained by the plan for payment. When a plan becomes
12 insolvent, in no event shall a noncontracting provider, or agent,
13 trustee, or assignee thereof, attempt to collect from the subscriber
14 or enrollee sums owed for covered services by the plan or maintain
15 any action at law against a subscriber or enrollee to collect sums
16 owed by the plan for covered services without having first
17 attempted to obtain reimbursement from the plan.

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

20 1399. (a) Surrender of a license as a health plan becomes
21 effective 30 days after receipt of an application to surrender the
22 license or within a shorter period of time as the director may
23 determine, unless a revocation or suspension proceeding is pending
24 when the application is filed or a proceeding to revoke or suspend
25 or to impose conditions upon the surrender is instituted within 30
26 days after the application is filed. If this proceeding is pending or
27 instituted, surrender becomes effective at the time and upon the
28 conditions as the director by order determines.

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

34 (c) The director may summarily suspend or revoke the license
35 of a plan upon (1) failure to pay any fee required by this chapter
36 within 15 days after notice by the director that the fee is due and
37 unpaid, (2) failure to file any amendment or report required under
38 this chapter within 15 days after notice by the director that the
39 report is due, (3) failure to maintain any bond or insurance pursuant
40 to Section 1376, (4) failure to maintain a deposit, insurance, or

1 guaranty arrangement pursuant to Section 1377, or (5) failure to
2 maintain a deposit pursuant to Section 1300.76.1 of Title 28 of the
3 California Code of Regulations.

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

7 116283. This chapter shall apply to a food facility that is
8 regulated pursuant to the California Retail Food Code only if the
9 human consumption includes drinking of water.

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

13 116283. This chapter shall apply to a food facility that is
14 regulated pursuant to the California Retail Food Code only if the
15 human consumption includes drinking of water.

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

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

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

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

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

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

39 116380. In addition to the requirements set forth in Section
40 116375, the regulations adopted by the department pursuant to

1 Section 116375 shall include requirements governing the use of
2 point-of-entry and point-of-use treatment by public water systems
3 in lieu of centralized treatment where it can be demonstrated that
4 centralized treatment is not immediately economically feasible,
5 limited to the following:

6 (a) Water systems with less than 200 service connections.

7 (b) Usage allowed under the federal Safe Drinking Water Act
8 and its implementing regulations and guidance.

9 (c) Water systems that have submitted preapplications with the
10 State Department of Public Health for funding to correct the
11 violations for which the point-of-use treatment is provided.

12 ~~SEC. 14. Section 116450 of the Health and Safety Code is~~
13 ~~amended to read:~~

14 ~~116450. (a) When a primary drinking water standard specified~~
15 ~~in the department's regulations is not complied with, when a~~
16 ~~monitoring requirement specified in the department's regulations~~
17 ~~is not performed, or when a water purveyor fails to comply with~~
18 ~~the conditions of any variance or exemption, the person operating~~
19 ~~the public water system shall notify the department and shall give~~
20 ~~notice to the users of that fact in the manner prescribed by the~~
21 ~~department. When a variance or an exemption is granted, the person~~
22 ~~operating the public water system shall give notice to the users of~~
23 ~~that fact.~~

24 ~~(b) When a person operating a public water system determines~~
25 ~~that a significant rise in the bacterial count of water has occurred~~
26 ~~in water he or she supplies, the person shall provide, at his or her~~
27 ~~expense, a report on the rise in bacterial count of the water, together~~
28 ~~with the results of an analysis of the water, within 24 hours to the~~
29 ~~department and, where appropriate, to the local health officer.~~

30 ~~(c) When the department receives the information described in~~
31 ~~subdivision (b) and determines that it constitutes an immediate~~
32 ~~danger to health, the department shall immediately notify the~~
33 ~~person operating the public water system to implement the~~
34 ~~emergency notification plan required by this chapter.~~

35 ~~(d) In the case of a failure to comply with a primary drinking~~
36 ~~water standard that represents an imminent danger to the health~~
37 ~~of water users, the operator shall notify each of his or her customers~~
38 ~~as provided in the approved emergency notification plan.~~

39 ~~(e) In addition, the same notification requirement shall be~~
40 ~~required in any instance in which the department or the local health~~

1 department recommends to the operator that it notify its customers
2 to avoid internal consumption of the water supply and to use bottled
3 water due to a chemical contamination problem that may pose a
4 health risk.

5 (f) The content of the notices required by this section shall be
6 approved by the department. Notice shall be repeated at intervals,
7 as required by the department, until the department concludes that
8 there is compliance with its standards or requirements. Notices
9 may be given by the department.

10 When public notification is required by this section because a
11 contaminant is present in drinking water at a level in excess of a
12 primary drinking water standard, the notification shall include
13 identification of the contaminant, information on possible effects
14 of the contaminant on human health, and information on specific
15 measures that should be taken by persons or populations who might
16 be more acutely affected than the general population.

17 (g) Whenever a school or school system, the owner or operator
18 of residential rental property, or the owner or operator of a business
19 property receives a notification from a person operating a public
20 water system under any provision of this section, the school or
21 school system shall notify school employees, students and parents
22 if the students are minors, the owner or operator of a residential
23 rental property shall notify tenants, and the owner or operator of
24 business property shall notify employees of businesses located on
25 the property.

26 (1) The operator shall provide the customer with a sample
27 notification form that may be used by the customer in complying
28 with this subdivision and that shall indicate the nature of the
29 problem with the water supply and the most appropriate methods
30 for notification that may include, but is not limited to, the sending
31 of a letter to each water user and the posting of a notice at each
32 site where drinking water is dispensed.

33 (2) The notice required by this subdivision shall be given within
34 10 days of receipt of notification from the person operating the
35 public water system.

36 (3) Any person failing to give notice as required by this
37 subdivision shall be civilly liable in an amount not to exceed one
38 thousand dollars (\$1,000) for each day of failure to give notice.

1 ~~(4) If the operator has evidence of noncompliance with this~~
2 ~~subdivision the operator shall report this information to the local~~
3 ~~health department and the department.~~

4 ~~(h) If user notification is required pursuant to this section, the~~
5 ~~department shall make a reasonable effort to ensure that notification~~
6 ~~is given.~~

7 ~~SEC. 14.5. Section 116450 of the Health and Safety Code is~~
8 ~~amended to read:~~

9 ~~116450. (a) When a primary drinking water standard specified~~
10 ~~in the department's regulations is not complied with, when a~~
11 ~~monitoring requirement specified in the department's regulations~~
12 ~~is not performed, or when a water purveyor fails to comply with~~
13 ~~the conditions of any variance or exemption, the person operating~~
14 ~~the public water system shall notify the department, shall give~~
15 ~~notice to the users of that fact, and shall, if the public water system~~
16 ~~has an Internet Web site, post that notice on the public water~~
17 ~~system's Internet Web site, in the manner prescribed by the~~
18 ~~department. When a variance or an exemption is granted, the person~~
19 ~~operating the public water system shall give notice to the users of~~
20 ~~that fact.~~

21 ~~(b) When a person operating a public water system determines~~
22 ~~that a significant rise in the bacterial count of water has occurred~~
23 ~~in water he or she supplies, the person shall provide, at his or her~~
24 ~~expense, a report on the rise in bacterial count of the water, together~~
25 ~~with the results of an analysis of the water, within 24 hours to the~~
26 ~~department and, where appropriate, to the local health officer.~~

27 ~~(c) When the department receives the information described in~~
28 ~~subdivision (b) and determines that it constitutes an immediate~~
29 ~~danger to health, the department shall immediately notify the~~
30 ~~person operating the public water system to implement the~~
31 ~~emergency notification plan required by this chapter.~~

32 ~~(d) In the case of a failure to comply with a primary drinking~~
33 ~~water standard that represents an imminent danger to the health~~
34 ~~of water users, the operator shall notify each of his or her~~
35 ~~customers, and shall, if the public water system has an Internet~~
36 ~~Web site, post that notice on that Internet Web site, as provided~~
37 ~~in the approved emergency notification plan.~~

38 ~~(e) In addition, the same notification requirement shall be~~
39 ~~required in any instance in which the department or the local health~~
40 ~~department recommends to the operator that it notify its customers~~

1 to avoid internal consumption of the water supply and to use bottled
2 water due to a chemical contamination problem that may pose a
3 health risk.

4 (f) The content of the notices required by this section shall be
5 approved by the department. Notice shall be repeated at intervals,
6 as required by the department, until the department concludes that
7 there is compliance with its standards or requirements. Notices
8 may be given by the department.

9 When public notification is required by this section because a
10 contaminant is present in drinking water at a level in excess of a
11 primary drinking water standard, the notification shall include
12 identification of the contaminant, information on possible effects
13 of the contaminant on human health, and information on specific
14 measures that should be taken by persons or populations who might
15 be more acutely affected than the general population.

16 (g) Whenever a school or school system, the owner or operator
17 of residential rental property, or the owner or operator of a business
18 property receives a notification from a person operating a public
19 water system under any provision of this section, the school or
20 school system shall notify school employees, students, and parents
21 if the students are minors, the owner or operator of a residential
22 rental property shall notify tenants, and the owner or operator of
23 business property shall notify employees of businesses located on
24 the property.

25 (1) The operator shall provide the customer with a sample
26 notification form that may be used by the customer in complying
27 with this subdivision and that shall indicate the nature of the
28 problem with the water supply and the most appropriate methods
29 for notification that may include, but are not limited to, the sending
30 of a letter to each water user and the posting of a notice at each
31 site where drinking water is dispensed.

32 (2) The notice required by this subdivision shall be given within
33 10 days of receipt of notification from the person operating the
34 public water system.

35 (3) Any person failing to give notice as required by this
36 subdivision shall be civilly liable in an amount not to exceed one
37 thousand dollars (\$1,000) for each day of failure to give notice.

38 (4) If the operator has evidence of noncompliance with this
39 subdivision the operator shall report this information to the local
40 health department and the department.

~~(h) An operator that is required to post a notice on the public water system's Internet Web site pursuant to subdivision (a) or (d) may, upon rectifying the problem of complying with the standard that required notification, do either of the following:~~

~~(1) Remove the notice from the public water system's Internet Web site.~~

~~(2) Amend the notice posted on the public water system's Internet Web site to include the date on which the problem was rectified or compliance was achieved.~~

~~(i) If user notification is required pursuant to this section, the department shall make a reasonable effort to ensure that notification is given.~~

SEC. 14. Section 116451 is added to the Health and Safety Code, to read:

116451. If user notification is required pursuant to Section 116450, the department shall make a reasonable effort to ensure that notification is given.

SEC. 15. 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. 16. Section 116552 is added to the Health and Safety Code, to read:

116552. The department shall not issue a permit to a public water system or amend a valid existing permit to allow the use of point-of-use treatment unless the department determines, after conducting a public hearing in the community served by the public water system, that there is no substantial community opposition to the installation of point-of-use treatment devices. The issuance of a permit pursuant to this section shall be limited to not more than three years or until funding for centralized treatment is available, whichever occurs first.

SEC. 17. 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. 18. 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.

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

5 SEC. 19. Section 121360.5 of the Health and Safety Code is
6 amended to read:

7 121360.5. (a) Any city or county health department that elects
8 to participate in this program shall provide for one-year
9 certification of tuberculin skin test technicians by local health
10 officers.

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

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

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

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

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

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

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

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

39 (2) (A) The person has completed a standardized course
40 approved by the California Tuberculosis Controllers Association

(CTCA), which shall include at least 24 hours of instruction in all of the following areas: ~~Didactic~~ *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~~ *ensure* 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

1 if the local health officer or the tuberculosis controller finds that
2 the technician is not in compliance with this section.

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

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

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

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

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

23 SEC. 20. Section 127662 of the Health and Safety Code is
24 amended to read:

25 127662. (a) In order to effectively support the University of
26 California and its work in implementing this chapter, there is
27 hereby established in the State Treasury, the Health Care Benefits
28 Fund. The university's work in providing the bill analyses shall
29 be supported from the fund.

30 (b) For fiscal years 2010–11 to 2014–15, inclusive, each health
31 care service plan, except a specialized health care service plan,
32 and each health insurer, as defined in Section 106 of the Insurance
33 Code, shall be assessed an annual fee in an amount determined
34 through regulation. The amount of the fee shall be determined by
35 the Department of Managed Health Care and the Department of
36 Insurance in consultation with the university and shall be limited
37 to the amount necessary to fund the actual and necessary expenses
38 of the university and its work in implementing this chapter. The
39 total annual assessment on health care service plans and health
40 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. 21. 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. 22. 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. 23. 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,~~ *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. 24. 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
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

1 technical advisory committee set forth in subdivision (j) of Section
2 128725. The office shall publish the risk-adjusted outcome reports
3 for surgical procedures by individual hospital and individual
4 surgeon unless the office in consultation with the technical advisory
5 committee and medical specialists in the relevant area of practice
6 determines that it is not appropriate to report by individual surgeon.
7 The office, in consultation with the technical advisory committee
8 and medical specialists in the relevant area of practice, may decide
9 to report nonsurgical procedures and conditions by individual
10 physician when it is appropriate. The selections shall be in
11 accordance with all of the following criteria:

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

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

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

22 (4) Reliability of the diagnostic and procedure data.

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

28 (2) In addition to any other established and pending reports,
29 commencing July 1, 2004, and every year thereafter, the office
30 shall publish risk-adjusted outcome reports for coronary artery
31 bypass graft surgery for all coronary artery bypass graft surgeries
32 performed in the state. In each year, the reports shall compare
33 risk-adjusted outcomes by hospital, and in every other year, by
34 hospital and cardiac surgeon. Upon the recommendation of the
35 technical advisory committee based on statistical and technical
36 considerations, information on individual hospitals and surgeons
37 may be excluded from the reports.

38 (3) Unless otherwise recommended by the clinical panel
39 established by Section 128748, the office shall collect the same
40 data used for the most recent risk-adjusted model developed for

1 the California Coronary Artery Bypass Graft Mortality Reporting
2 Program. Upon recommendation of the clinical panel, the office
3 may add any clinical data elements included in the Society of
4 Thoracic Surgeons' database. Prior to any additions from the
5 Society of Thoracic Surgeons' database, the following factors shall
6 be considered:

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

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

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

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

17 (B) Feasibility of collecting data elements.

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

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

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

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

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

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

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

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

1 (4) “Lower than average outcomes,” for hospitals with
2 risk-adjusted outcomes lower than the norm.

3 (5) “Much lower than average outcomes,” for hospitals with
4 risk-adjusted outcomes much lower than the norm.

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

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

12 (g) The office shall either include in the annual reports required
13 under this section, or make separately available at cost to any
14 person requesting it, risk-adjusted outcomes data assessing the
15 statistical significance of hospital or physician data at each of the
16 following three levels: ~~99-percent~~ 99-percent confidence level
17 (0.01 p-value), ~~95-percent~~ 95-percent confidence level (0.05
18 p-value), and ~~90-percent~~ 90-percent confidence level ~~(.10~~ (0.10
19 p-value). The office shall include any other analysis or comparisons
20 of the data in the annual reports required under this section that
21 the office deems appropriate to further the purposes of this chapter.

22 SEC. 25. Section 14043.26 of the Welfare and Institutions
23 Code is amended to read:

24 14043.26. (a) (1) On and after January 1, 2004, an applicant
25 that currently is not enrolled in the Medi-Cal program, or a provider
26 applying for continued enrollment, upon written notification from
27 the department that enrollment for continued participation of all
28 providers in a specific provider of service category or subgroup
29 of that category to which the provider belongs will occur, or, except
30 as provided in subdivisions (b) and (e), a provider not currently
31 enrolled at a location where the provider intends to provide
32 services, goods, supplies, or merchandise to a Medi-Cal
33 beneficiary, shall submit a complete application package for
34 enrollment, continuing enrollment, or enrollment at a new location
35 or a change in location.

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

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

6 (4) Adult day health care providers licensed pursuant to Chapter
7 3.3 (commencing with Section 1570) of Division 2 of the Health
8 and Safety Code and certified by the department to participate in
9 the Medi-Cal program shall not be subject to this section.

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

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

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

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

37 (2) Within 15 days after receiving an application package from
38 a physician, or a group of physicians, licensed by the Medical
39 Board of California or the Osteopathic Medical Board of California,
40 or a change of location form pursuant to subdivision (b), the

1 department shall provide written notice that the application package
2 or the change of location form has been received.

3 (d) (1) If the application package submitted pursuant to
4 subdivision (a) is from an applicant or provider who meets the
5 criteria listed in paragraph (2), the applicant or provider shall be
6 considered a preferred provider and shall be granted preferred
7 provisional provider status pursuant to this section and for a period
8 of no longer than 18 months, effective from the date on the notice
9 from the department. The ability to request consideration as a
10 preferred provider and the criteria necessary for the consideration
11 shall be publicized to all applicants and providers. An applicant
12 or provider who desires consideration as a preferred provider
13 pursuant to this subdivision shall request consideration from the
14 department by making a notation to that effect on the application
15 package, by cover letter, or by other means identified by the
16 department in a provider bulletin. Request for consideration as a
17 preferred provider shall be made with each application package
18 submitted in order for the department to grant the consideration.
19 An applicant or provider who requests consideration as a preferred
20 provider shall be notified within 60 days whether the applicant or
21 provider meets or does not meet the criteria listed in paragraph
22 (2). If an applicant or provider is notified that the applicant or
23 provider does not meet the criteria for a preferred provider, the
24 application package submitted shall be processed in accordance
25 with the remainder of this section.

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

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

33 (B) Be a current faculty member of a teaching hospital or a
34 children's hospital, as defined in Section 10727, accredited by the
35 Joint Commission or the American Osteopathic Association, or
36 be credentialed by a health care service plan that is licensed under
37 the Knox-Keene Health Care Service Plan Act of 1975 (Chapter
38 2.2 (commencing with Section 1340) of Division 2 of the Health
39 and Safety Code) or county organized health system, or be a current

1 member in good standing of a group that is credentialed by a health
2 care service plan that is licensed under the Knox-Keene Act.

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

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

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

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

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

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

35 (B) The applicant or provider holds a current, unrevoked, or
36 unsuspended license as a physician and surgeon issued by the
37 Medical Board of California or the Osteopathic Medical Board of
38 California. An applicant or provider shall not be in compliance
39 with this subparagraph if a license revocation has been stayed, the

1 licensee has been placed on probation, or the license is subject to
2 any other limitation.

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

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

7 (f) Except as provided in subdivision (g), within 180 days after
8 receiving an application package submitted pursuant to subdivision
9 (a), or from the date of the notice to an applicant or provider that
10 the applicant or provider does not qualify as a preferred provider
11 under subdivision (d), the department shall give written notice to
12 the applicant or provider that any of the following applies, or shall
13 on the 181st day grant the applicant or provider provisional
14 provider status pursuant to this section for a period no longer than
15 12 months, effective from the 181st day:

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

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

22 (3) The department is exercising its authority under Section
23 14043.37, 14043.4, or 14043.7, and is conducting background
24 checks, preenrollment inspections, or unannounced visits.

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

27 (A) Pursuant to Section 14043.2 or 14043.36.

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

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

34 (D) For other stated reasons authorized by law.

35 (g) Notwithstanding subdivision (f), within 90 days after
36 receiving an application package submitted pursuant to subdivision
37 (a) from a physician or physician group licensed by the Medical
38 Board of California or the Osteopathic Medical Board of California,
39 or from the date of the notice to that physician or physician group
40 that does not qualify as a preferred provider under subdivision (d),

1 or within 90 days after receiving a change of location form
2 submitted pursuant to subdivision (b), the department shall give
3 written notice to the applicant or provider that either paragraph
4 (1), (2), (3), or (4) of subdivision (f) applies, or shall on the 91st
5 day grant the applicant or provider provisional provider status
6 pursuant to this section for a period no longer than 12 months,
7 effective from the 91st day.

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

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

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

19 (C) The department is exercising its authority under Section
20 14043.37, 14043.4, or 14043.7 to conduct background checks,
21 preenrollment inspections, or unannounced visits.

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

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

34 (C) Notwithstanding subparagraph (A), if the notice of an
35 incomplete application package included a request for information
36 or documentation related to grounds for denial under Section
37 14043.2 or 14043.36, the applicant or provider shall not reapply
38 for enrollment or continued enrollment in the Medi-Cal program
39 or for participation in any health care program administered by

1 the department or its agents or contractors for a period of three
2 years.

3 (i) (1) If the department exercises its authority under Section
4 14043.37, 14043.4, or 14043.7 to conduct background checks,
5 preenrollment inspections, or unannounced visits, the applicant or
6 provider shall receive notice, from the department, after the
7 conclusion of the background check, preenrollment inspection, or
8 unannounced visit of either of the following:

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

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

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

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

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

33 (j) If provisional provider status or preferred provisional provider
34 status is granted pursuant to this section, a provider number shall
35 be used by the provider for each business address for which an
36 application package has been approved. This provider number
37 shall be used exclusively for the locations for which it was
38 approved, unless the practice of the provider's profession or
39 delivery of services, goods, supplies, or merchandise is such that
40 services, goods, supplies, or merchandise are rendered or delivered

1 at locations other than the provider's business address and this
2 practice or delivery of services, goods, supplies, or merchandise
3 has been disclosed in the application package approved by the
4 department when the provisional provider status or preferred
5 provisional provider status was granted.

6 (k) Except for providers subject to subdivision (c) of Section
7 14043.47, a provider currently enrolled in the Medi-Cal program
8 at one or more locations who has submitted an application package
9 for enrollment at a new location or a change in location pursuant
10 to subdivision (a), or filed a change of location form pursuant to
11 subdivision (b), may submit claims for services, goods, supplies,
12 or merchandise rendered at the new location until the application
13 package or change of location form is approved or denied under
14 this section, and shall not be subject, during that period, to
15 deactivation, or be subject to any delay or nonpayment of claims
16 as a result of billing for services rendered at the new location as
17 herein authorized. However, the provider shall be considered during
18 that period to have been granted provisional provider status or
19 preferred provisional provider status and be subject to termination
20 of that status pursuant to Section 14043.27. A provider that is
21 subject to subdivision (c) of Section 14043.47 may come within
22 the scope of this subdivision upon submitting documentation in
23 the application package that identifies the physician providing
24 supervision for every three locations. If a provider submits claims
25 for services rendered at a new location before the application for
26 that location is received by the department, the department may
27 deny the claim.

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

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

35 (2) During the budget proceedings of the 2006–07 fiscal year,
36 and each fiscal year thereafter, the department shall provide data
37 to the Legislature specifying the timeframe under which it has
38 processed and approved the provider applications submitted by
39 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.~~

SEC. 26. 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 is

1 prohibited from reapplying for enrollment or continued enrollment
2 in the Medi-Cal program or for participation in any health care
3 program administered by the department or its agents or contractors
4 for a period of 10 years from the date the application package is
5 denied or the provisional provider status or preferred provisional
6 provider status is terminated or from the date of the final decision
7 following an appeal from that denial or termination.

8 (4) If the denial of the application package is based upon two
9 or more convictions for any offense or for any two or more acts
10 included in Section 14043.36 or termination of the provisional
11 provider status or preferred provisional provider status is based
12 upon two or more convictions for any offense or for any two acts
13 included in paragraph (1) of subdivision (c) of Section 14043.27,
14 the applicant or provider shall be permanently barred from
15 enrollment or continued enrollment in the Medi-Cal program or
16 for participation in any health care program administered by the
17 department or its agents or contractors.

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

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

24 (B) The grounds provided for in subdivision (d) of Section
25 14043.27, if the investigation is closed without any adverse action
26 being taken.

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

31 (b) (1) If an application package is denied under subparagraph
32 (A), (B), or (D) of paragraph (4) of subdivision (f) of Section
33 14043.26, or with respect to a provider described in subparagraph
34 (B) of paragraph (2) of subdivision (h), or subparagraph (B) of
35 paragraph (2) of subdivision (i), of Section 14043.26, or provisional
36 provider status or preferred provisional provider status is terminated
37 based upon any of the grounds stated in subparagraph (A) of
38 paragraph (7), or paragraphs (1), (2), (3), (5), and (8) to (12),
39 inclusive, of subdivision (c) of Section 14043.27, all business
40 addresses of the applicant or provider shall be deactivated and the

1 applicant or provider shall be removed from enrollment in the
2 Medi-Cal program by operation of law.

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

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

24 SEC. 26.5. Section 14043.28 of the Welfare and Institutions
25 Code is amended to read:

26 14043.28. (a) (1) If an application package is denied under
27 Section 14043.26 or provisional provider status or preferred
28 provisional provider status is terminated under Section 14043.27,
29 the applicant or provider shall be prohibited from reapplying for
30 enrollment or continued enrollment in the Medi-Cal program or
31 for participation in any health care program administered by the
32 department or its agents or contractors for a period of three years
33 from the date the application package is denied or the provisional
34 provider status is terminated, except as provided otherwise in
35 paragraph (2) of subdivision (h), or paragraph (2) of subdivision
36 (i), of Section 14043.26 and as set forth in this section.

37 (2) If the application is denied under paragraph (2) of
38 subdivision (h) of Section 14043.26 because the applicant failed
39 to resubmit an incomplete application package or is denied under
40 paragraph (2) of subdivision (i) of Section 14043.26 because the

1 applicant failed to remediate discrepancies, the applicant may
2 resubmit an application in accordance with paragraph (2) of
3 subdivision (h) or paragraph (2) of subdivision (i), respectively.

4 (3) If the denial of the application package is based upon a
5 conviction for any offense or for any act included in Section
6 14043.36 or termination of the provisional provider status or
7 preferred provisional provider status is based upon a conviction
8 for any offense or for any act included in paragraph (1) of
9 subdivision (c) of Section 14043.27, the applicant or provider shall
10 be prohibited from reapplying for enrollment or continued
11 enrollment in the Medi-Cal program or for participation in any
12 health care program administered by the department or its agents
13 or contractors for a period of 10 years from the date the application
14 package is denied or the provisional provider status or preferred
15 provisional provider status is terminated.

16 (4) If the denial of the application package is based upon two
17 or more convictions for any offense or for any two or more acts
18 included in Section 14043.36 or termination of the provisional
19 provider status or preferred provisional provider status is based
20 upon two or more convictions for any offense or for any two acts
21 included in paragraph (1) of subdivision (c) of Section 14043.27,
22 the applicant or provider shall be permanently barred from
23 enrollment or continued enrollment in the Medi-Cal program or
24 for participation in any health care program administered by the
25 department or its agents or contractors.

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

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

32 (B) The grounds provided for in subdivision (d) of Section
33 14043.27, if the investigation is closed without any adverse action
34 being taken.

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

39 (b) (1) If an application package is denied under subparagraph
40 (A), (B), or (D) of paragraph (4) of subdivision (f) of Section

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

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

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

32 SEC. 27. Section 14043.29 of the Welfare and Institutions
33 Code is amended to read:

34 14043.29. (a) If, at the end of the period for which provisional
35 provider status or preferred provisional provider status was granted
36 under Section 14043.26, all of the following conditions are met,
37 the provisional status shall cease and the provider shall be enrolled
38 in the Medi-Cal program without designation as a provisional
39 provider:

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

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

6 (3) The provider continues to meet the standards for enrollment
7 in the Medi-Cal program as set forth in this article and Section
8 51000 and following of Title 22 of the California Code of
9 Regulations.

10 (b) (1) An applicant or a provider who applied for enrollment
11 or continued enrollment in the Medi-Cal program, prior to May
12 1, 2003, and for whom the application has not been approved or
13 denied, or who has not received a notice on or before January 1,
14 2004, that the department is exercising its authority under Section
15 14043.37, 14043.4, or 14043.7 to conduct background checks,
16 preenrollment inspections, or unannounced visits, shall be granted
17 provisional provider status effective on January 1, 2004.
18 Applications from applicants or providers who have been so
19 noticed prior to January 1, 2004, shall be processed in accordance
20 with subdivision (h) of Section 14043.26.

21 (2) Applications from applicants or providers that have been
22 received by the department after May 1, 2003, but prior to January
23 1, 2004, shall be processed in accordance with Section 14043.26,
24 except that these application packages shall be deemed to have
25 been received by the department on January 1, 2004.

26 SEC. 28. Section 14115.8 of the Welfare and Institutions Code
27 is amended to read:

28 14115.8. (a) (1) The department shall amend the Medicaid
29 state plan with respect to the billing option for services by local
30 educational agencies, to ensure that schools shall be reimbursed
31 for all eligible services that they provide that are not precluded by
32 federal requirements.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 (g) (1) These activities shall be funded and staffed by
22 proportionately reducing federal Medicaid payments allocable to
23 local educational agencies for the provision of benefits funded by
24 the federal Medicaid program under the billing option for services
25 by local educational agencies specified in this section. Moneys
26 collected as a result of the reduction in federal Medicaid payments
27 allocable to local educational agencies shall be deposited into the
28 Local Educational Agency Medi-Cal Recovery Fund, which is
29 hereby established in the Special Deposit Fund established pursuant
30 to Section 16370 of the Government Code. These funds shall be
31 used, upon appropriation by the Legislature, only to support the
32 department to meet all the requirements of this section. As of
33 January 1, 2013, unless the Legislature enacts a new statute or
34 extends the repeal date in subdivision (j), all funds in the Local
35 Educational Agency Medi-Cal Recovery Fund shall be returned
36 proportionally to all local educational agencies whose federal
37 Medicaid funds were used to create this fund. The annual amount
38 funded shall not exceed one million five hundred thousand dollars
39 (\$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 sole source 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~~ *user-friendly, interactive Internet Web* site.

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

SEC. 29. Section 1.5 of this bill incorporates amendments to Section 6276.24 of the Government Code proposed by both this bill and SB 359. It shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2010, (2) each bill amends Section 6276.24 of the Government Code, and (3) this bill is enacted after SB 359, in which case Section 1 of this bill shall not become operative.

~~SEC. 30. Section 14.5 of this bill incorporates amendments to Section 116450 of the Health and Safety Code proposed by both this bill and AB 737. It shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2010, (2) each bill amends Section 116450 of the Health and Safety~~

1 ~~Code, and (3) this bill is enacted after AB 737, in which case~~
2 ~~Section 14 of this bill shall not become operative.~~
3 ~~SEC. 31.~~
4 *SEC. 30.* Section 26.5 of this bill incorporates amendments to
5 Section 14043.28 of the Welfare and Institutions Code proposed
6 by both this bill and AB 839. It shall only become operative if (1)
7 both bills are enacted and become effective on or before January
8 1, 2010, (2) each bill amends Section 14043.28 of the Welfare and
9 Institutions Code, and (3) this bill is enacted after AB 839, in which
10 case Section 26 of this bill shall not become operative.