SB-1511 Health omnibus. (2023-2024)

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Senate Bill No. 1511

CHAPTER 492

An act to amend Sections 1216, 1345, 1418.22, 1649.2, 102230, 102231, 128905, 128910, and 128920 of, to amend and renumber Section 1367.34 of, and to add Section 102970 to, the Health and Safety Code, and to amend Sections 5150.05, 5250, 5350, 5350.5, 10022, and 14115.8 of the Welfare and Institutions Code, relating to health.

[Approved by Governor September 22, 2024. Filed with Secretary of State September 22, 2024.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1511, Committee on Health. Health omnibus.

(1) 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 defines a “group contract,” for purposes of the act, as a contract that by its terms limits the eligibility of subscribers and enrollees to a specified group.

This bill would clarify that reference to a “group” in the act does not include a Medi-Cal managed care contract between a health care service plan and the State Department of Health Care Services to provide benefits to beneficiaries of the Medi-Cal program.

(2) Existing law, the Compassionate Access to Medical Cannabis Act or Ryan’s Law, requires specified health care facilities to allow a terminally ill patient’s use of medicinal cannabis within the health care facility, as defined, subject to certain restrictions. Existing law requires the State Department of Public Health to enforce the act. Existing law prohibits a general acute care hospital, as specified, from permitting a patient with a chronic disease to use medicinal cannabis.

This bill would authorize a general acute care hospital to allow a terminally ill patient, as defined, to use medicinal cannabis.

(3) Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed by, and funded pursuant to, federal Medicaid program provisions. Existing law establishes the Administrative Claiming process under which the department is authorized to contract with local governmental agencies and local educational consortia for the purpose of obtaining federal matching funds to assist with the performance of administrative activities relating to the Medi-Cal program that are provided by a local governmental agency or local educational agency (LEA).

Existing law requires the department to engage in specified activities relating to the LEA Medi-Cal Billing Option, including amending the Medicaid state plan to ensure that schools are reimbursed for all eligible services, consulting with specified entities in formulating state plan amendments, examining methodologies for increasing school participation in the LEA Medi-Cal Billing Option, and conducting an audit of a Medi-Cal Billing Option claim consistent with prescribed requirements, such as generally accepted accounting principles. Existing law requires the department to issue and regularly maintain a program guide for the LEA Medi-Cal Billing Option program. Existing law requires the department to file an annual report with the Legislature that includes, among other things, a summary of department activities.

Existing law requires these activities to be funded and staffed by proportionately reducing federal Medicaid payments allocable to LEAs for the provision of benefits funded by the federal Medicaid program under the billing option for services by LEAs. Existing law directs moneys collected as a result of the reduction in federal Medicaid payments allocable to LEAs to be deposited into the Local Educational Agency Medi-Cal Recovery Fund to be used, upon appropriation by the Legislature, only to support the department to meet all the requirements of the activities described above.

This bill would instead require that the department's administration of the LEA Medi-Cal Billing Option program be funded and staffed by these funds and would require moneys in the Local Educational Agency Medi-Cal Recovery Fund to be used, upon appropriation, only to support the department to meet all the requirements of administering the program.

(4) Existing law, the Lanterman-Petris-Short Act, provides for the involuntary commitment and treatment of a person who is a danger to others or to themselves, or who is gravely disabled. Existing law, commencing January 1, 2024, defines "gravely disabled," for purposes of involuntary commitment, as either a condition in which a person, as a result of a mental health disorder, severe substance use disorder, or a cooccurring mental health disorder and a severe substance use disorder, is unable to provide for their basic personal needs for food, clothing, shelter, personal safety, or necessary medical care or who has been found mentally incompetent, as specified.

This bill would make conforming changes to related provisions for consistency with that definition of gravely disabled. The bill would also make technical changes.

(5) Existing law establishes the State Department of Public Health under the direction of the State Public Health Officer. Existing law requires a funeral director, or a person acting in lieu of a funeral director if there is no funeral director, to prepare a certificate of fetal death and register it with the local registrar. Existing law requires the funeral director to prepare and register a fetal death within 8 calendar days. Existing law requires an attending physician in attendance on the delivery of a fetus to state specified information on the certificate of fetal death concerning the time of fetal death or delivery. Existing law requires the attending physician to deposit the fetal death certificate within 15 hours after the fetal death. Existing law requires a coroner to state specified information on the certificate of fetal death concerning the time of fetal death. Existing law requires the coroner to deliver the death certificate to the attending funeral director within 3 days after examining the body.

This bill would require the department to regularly, but no less than annually, review fetal death registrations to determine compliance with existing timeframe requirements for fetal death registrations. The bill would require the department to notify the relevant licensing entity of an individual's or entity's repeated failures to timely comply with fetal death registration requirements, as specified.

(6) Existing law requires the State Registrar to administer the registration of births, deaths, fetal deaths, and marriages. Existing law requires the State Registrar to arrange and permanently preserve the certificates in a systematic manner and to prepare and maintain a comprehensive and continuous index of all certificates registered. Existing law imposes certain conditions on the release of certain birth, death, or nonconfidential marriage data files prepared and maintained by the State Registrar. Existing law requires the State Registrar to prepare and maintain noncomprehensive indices, as specified, of all California birth, death, and nonconfidential marriage records for public release. Existing law requires these indices to be kept confidential and exempt from disclosure under the California Public Records Act.

This bill would require, subject to exception, death record indices to be made available to certain entities, including health care service plans and health facilities, for the sole purpose of verifying a death, as specified. The bill would authorize the release of certain death data files to those entities.

Existing law creates the Health Statistics Special Fund for the purpose of, among other things, registration and preservation of vital event records and dissemination of vital event information to the public. Existing law requires that moneys in the fund be expended by the State Registrar, as specified, upon appropriation by the Legislature.

Existing law requires that record indices and data files be made available subject to cost recovery provisions of the California Public Records Act.

This bill, notwithstanding that requirement, would require that death record indices and death data files provided by the State Department of Public Health be made available subject to reasonable cost recovery. The bill would require that moneys collected for that cost recovery be deposited with the Treasurer for credit to the Health Statistics Special Fund.

(7) Existing law provides that a person with private health care coverage is not entitled to receive health care items or services furnished or paid for by a publicly funded health care program if those health care items or services are covered by that private health care coverage. Existing law entitles a publicly funded health care program that furnishes or pays for designated health care items or services to be subrogated to the rights that person has against the carrier of the coverage to the extent of the health care items provided or services rendered. Under existing law, an entity providing private health care coverage is required to, among

other things, respond to inquiries of, and agree not to deny claims submitted by, the state or a provider, as defined, in connection with the provision of a health care item or service, as specified.

This bill would also require the entity providing private health care coverage to respond to, and agree not to deny claims submitted by, Medi-Cal managed care plans, as defined. The bill would also require, among other things, entities providing private health care coverage to request a refund of a claim paid in error from the State Department of Health Care Services within 3 years from the date of payment.

(8) Existing law requires every clinic holding a license, on or before February 15 of each year, to file with the Department of Health Care Access and Information, a verified report describing, among other things, the number of patients served, and the number of patient visits, as specified. Existing law, commencing January 1, 2027, requires certain organizations and clinics to also report specified information on or before February 15 of each year.

This bill would instead require each of the above-described entities to file the report by March 15 of each year.

(9) Existing law provides for the licensure and regulation of health facilities, including skilled nursing facilities, by the State Department of Public Health.

Existing law requires a skilled nursing facility to have an alternative source of power to protect resident health and safety for no fewer than 96 hours during any type of power outage. Existing law imposes specific compliance requirements based on whether a skilled nursing facility uses a generator as its alternative source of power, or batteries or a combination of batteries in tandem with a renewable electrical generation facility. Existing law requires a facility to comply with these requirements by January 1, 2024.

This bill would instead require a facility to comply by January 1, 2026.

(10) This bill would make an additional technical, nonsubstantive change by renumbering a related provision.
Vote: majority Appropriation: no Fiscal Committee: yes Local Program: no

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THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1216 of the Health and Safety Code is amended to read:

1216. (a) Every clinic holding a license shall, on or before the 15th day of March each year, file with the Department of Health Care Access and Information, upon forms to be furnished by the department, a verified report showing the following information relating to the previous calendar year:

(1) Number of patients served and descriptive information, including, but not limited to, age, gender, race, and ethnic background of patients.

(2) Number of patient visits by type of service, including all of the following:

(A) Child health and disability prevention screens, treatment, and followup services.

(B) Medical services.

(C) Dental services.

(D) Other health services.

(3) Total clinic operating expenses.

(4) Gross patient charges by payer category, including Medicare, Medi-Cal, the Child Health Disability Prevention Program, county indigent programs, other county programs, private insurance, self-paying patients, nonpaying patients, and other payers.

(5) Deductions from revenue by payer category, bad debts, and charity care charges.

(6) Additional information as may be required by the Department of Health Care Access and Information or the State Department of Public Health.

(b) In the event that a clinic fails to file a timely report, the department may suspend the license of the clinic until the report is completed and filed with the Department of Health Care Access and Information.

(c) In order to promote efficient reporting of accurate data, the Department of Health Care Access and Information shall consider the unique operational characteristics of different classifications of licensed clinics, including, but not limited to, the limited scope of services provided by some specialty clinics, in its design of forms for the collection of data required by this section.

(d) For the purpose of administering funds appropriated from the Cigarette and Tobacco Products Surtax Fund for support of licensed clinics, clinics receiving those funds may be required to report any additional data the Department of Health Care Access and Information or the State Department of Public Health may determine necessary to ensure the equitable distribution and appropriate expenditure of those funds. This shall include, but not be limited to, information about the poverty level of patients served and communicable diseases reported to local health departments.

(e) This section shall apply to all primary care clinics.

(f) This section shall apply to all specialty clinics, as defined in subdivision (b) of Section 1204 that receive tobacco tax funds pursuant to Article 2 (commencing with Section 30121) of Chapter 2 of Part 13 of Division 2 of the Revenue and Taxation Code.

(g) Specialty clinics that are not required to report pursuant to subdivision (f) shall report data as directed in Section 1216 as it existed prior to the enactment of Chapter 1331 of the Statutes of 1989 and Chapter 51 of the Statutes of 1990.

(h) This section shall remain in effect only until January 1, 2027, and as of that date is repealed.

SEC. 2. Section 1345 of the Health and Safety Code is amended to read:

1345. As used in this chapter:

(a) “Advertisement” means any written or printed communication or any communication by means of recorded telephone messages or by radio, television, or similar communications media, published in connection with the offer or sale of plan contracts.

(b) “Basic health care services” means all of the following:

(1) Physician services, including consultation and referral.

(2) Hospital inpatient services and ambulatory care services.

(3) Diagnostic laboratory and diagnostic and therapeutic radiologic services.

(4) Home health services.

(5) Preventive health services.

(6) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage. “Basic health care services” includes ambulance and ambulance transport services provided through the “911” emergency response system.

(7) Hospice care pursuant to Section 1368.2.

(c) “Enrollee” means a person who is enrolled in a plan and who is a recipient of services from the plan.

(d) “Evidence of coverage” means any certificate, agreement, contract, brochure, or letter of entitlement issued to a subscriber or enrollee setting forth the coverage to which the subscriber or enrollee is entitled.

(e) “Group contract” means a contract that by its terms limits the eligibility of subscribers and enrollees to a specified group. Reference to a “group” does not include a Medi-Cal managed care contract between a health care service plan and the State Department of Health Care Services to provide benefits to beneficiaries of the Medi-Cal program.

(f) “Health care service plan” or “specialized health care service plan” means either of the following:

(1) Any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.

(2) Any person, whether located within or outside of this state, who solicits or contracts with a subscriber or enrollee in this state to pay for or reimburse any part of the cost of, or who undertakes to arrange or arranges for, the provision of health care services that are to be provided wholly or in part in a foreign country in return for a prepaid or periodic charge paid by or on behalf of the subscriber or enrollee.

(g) “License” means, and “licensed” refers to, a license as a plan pursuant to Section 1353.

(h) “Out-of-area coverage,” for purposes of paragraph (6) of subdivision (b), means coverage while an enrollee is anywhere outside the service area of the plan, and shall also include coverage for urgently needed services to prevent serious deterioration of an enrollee’s health resulting from unforeseen illness or injury for which treatment cannot be delayed until the enrollee returns to the plan’s service area.

(i) “Provider” means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

(j) “Person” means any person, individual, firm, association, organization, partnership, business trust, foundation, labor organization, corporation, limited liability company, public agency, or political subdivision of the state.

(k) “Service area” means a geographical area designated by the plan within which a plan shall provide health care services.

(l) “Solicitation” means any presentation or advertising conducted by, or on behalf of, a plan, where information regarding the plan, or services offered and charges therefor, is disseminated for the purpose of inducing persons to subscribe to, or enroll in, the plan.

(m) “Solicitor” means any person who engages in the acts defined in subdivision (l).

(n) “Solicitor firm” means any person, other than a plan, who through one or more solicitors engages in the acts defined in subdivision (l).

(o) “Specialized health care service plan contract” means a contract for health care services in a single specialized area of health care, including dental care, for subscribers or enrollees, or which pays for or which reimburses any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.

(p) “Subscriber” means the person who is responsible for payment to a plan or whose employment or other status, except for family dependency, is the basis for eligibility for membership in the plan.

(q) Unless the context indicates otherwise, “plan” refers to health care service plans and specialized health care service plans.

(r) “Plan contract” means a contract between a plan and its subscribers or enrollees or a person contracting on their behalf pursuant to which health care services, including basic health care services, are furnished; and unless the context otherwise indicates it includes specialized health care service plan contracts; and unless the context otherwise indicates it includes group contracts.

(s) All references in this chapter to financial statements, assets, liabilities, and other accounting items mean those financial statements and accounting items prepared or determined in accordance with generally accepted accounting principles, and fairly presenting the matters they purport to present, subject to any specific requirement imposed by this chapter or by the director.

SEC. 3. Section 1367.34 of the Health and Safety Code, as added by Section 1 of Chapter 641 of the Statutes of 2021, is amended and renumbered to read:

1367.39. (a) A health care service plan contract issued, amended, or renewed on or after January 1, 2022, that provides coverage for pediatric services and preventive care, as required by this chapter, including Sections 1367.002 and 1367.005, shall additionally include coverage for adverse childhood experiences screenings. This section does not prohibit a health care service plan from applying cost-sharing requirements as authorized by law.

(b) For purposes of this section, “adverse childhood experiences,” or “ACEs,” means an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual’s functioning and physical, social, emotional, or spiritual well-being.

(c) The department may adopt guidance to health care service plans to implement this section. The guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The departmental guidance shall apply the rules and regulations for screening for trauma as set forth in the Medi-Cal program as the minimum ACEs coverage requirements for health care service plans. This section does not prohibit a health care service plan from exceeding the Medi-Cal program’s rules and regulations for trauma screening.

SEC. 4. Section 1418.22 of the Health and Safety Code is amended to read:

1418.22. (a) The Legislature finds and declares that it is the public policy of this state to ensure the health and safety of highly vulnerable persons residing in skilled nursing facilities during power outages that may result from a public safety power shutoff, an emergency, a natural disaster, or other cause.

(b) (1) A skilled nursing facility shall have an alternative source of power to protect resident health and safety for no fewer than 96 hours during any type of power outage.

(2) For purposes of this section, “alternative source of power” means a source of electricity that is not received through an electric utility but is generated or stored onsite, which may include, but is not limited to, emergency generators using fuel, large capacity batteries, and renewable electrical generation facilities.

(c) For purposes of this section, “resident health and safety” includes, but is not limited to, maintaining a safe temperature for residents, maintaining availability of life-saving equipment, and maintaining availability of oxygen-generating devices.

(d) A facility that uses a generator as its alternative source of power shall maintain sufficient fuel onsite to maintain generator operation for no less than 96 hours or make arrangements for fuel delivery for an emergency event. If fuel is to be delivered during an emergency event, the facility shall ensure that fuel will be available with no delays.

(e) A facility that uses batteries or a combination of batteries in tandem with a renewable electrical generation facility as its alternative source of power shall have sufficient storage or generation capacity to maintain operation for no fewer than 96 hours. A facility shall also make arrangements for delivery of a generator and fuel in the event power is not restored within 96 hours and the generation capacity of the renewable electrical generation facility is unable to provide sufficient power to comply with state requirements for long-term care facilities.

(f) A facility shall comply with the requirements of this section by January 1, 2026.

SEC. 5. Section 1649.2 of the Health and Safety Code is amended to read:

1649.2. (a) Except as provided in subdivision (b), a health care facility shall permit patient use of medicinal cannabis, as indicated by the attending physician, as defined by Section 11362.7, in the patient’s medical record and shall do all of the following:

(1) (A) A home health agency shall prohibit smoking or vaping immediately before or while home health agency staff are present in the residence.

(B) All other health facilities shall prohibit smoking or vaping as methods to use medicinal cannabis.

(2) Include the use of medicinal cannabis within the patient’s medical records.

(3) Require a patient to provide a copy of the patient’s valid identification card, as described in Section 11362.715, or a copy of that patient’s written documentation as defined in Section 11362.7.

(4) Require a patient or a primary caregiver, as defined in Section 11362.7, to be responsible for acquiring, retrieving, administering, and removing medicinal cannabis.

(5) Require medicinal cannabis to be stored securely at all times in a locked container in the patient’s room, other designated area, or with the patient’s primary caregiver. This requirement does not apply to a home health agency.

(6) Prohibit health care professionals, health care facility staff, and home health agency staff, including, but not limited to, physicians, nurses, and pharmacists, from administering medicinal cannabis or retrieving medicinal cannabis from storage.

(7) Develop, disseminate, and train health facility staff on the written guidelines developed by the facility for the use and disposal of medicinal cannabis within the health care facility pursuant to this chapter. This requirement does not apply to a home health agency.

(8) Ensure that a patient is not denied admission to the health care facility in whole or in part because of the patient’s use of medicinal cannabis.

(b) Notwithstanding subdivision (a), a general acute care hospital specified in subdivision (a) of Section 1250 shall not permit a patient with a chronic disease to use medicinal cannabis unless the patient meets the definition of “terminally ill” in subdivision (f) of Section 1649.1.

SEC. 6. Section 102230 of the Health and Safety Code is amended to read:

102230. (a) (1) The State Registrar shall arrange and permanently preserve the certificates in a systematic manner and shall prepare and maintain comprehensive and continuous indices of all certificates registered.

(2) The birth, death, and marriage record indices prepared pursuant to paragraph (1) and all comprehensive birth, death, and marriage record indices prepared or maintained by local registrars and county recorders shall be kept confidential and shall be

exempt from disclosure under the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code).

(3) Notwithstanding paragraph (2), the State Registrar, at the registrar's discretion, may release comprehensive birth, death, and nonconfidential marriage record indices to a government agency. The comprehensive birth record indices released to the county recorder shall be subject to the same restrictions applicable to the confidential portion of a certificate of live birth, as specified in Section 102430. Local registrars and county recorders, when requested, shall release their comprehensive birth, death, and marriage record indices to the State Registrar. Local registrars may release their comprehensive birth and death record indices to the county recorder within its jurisdiction for purposes of the preparation or maintenance of the indices of the county recorder. A government agency that obtains indices pursuant to this paragraph shall not sell or release the index or a portion of its contents to another person, except as necessary for official government business, and shall not post the indices or any portion of the indices on the internet.

(b) (1) The State Registrar shall prepare and maintain separate noncomprehensive indices of all California birth, death, and nonconfidential marriage records for public release.

(2) For purposes of this section, noncomprehensive birth record indices for public release shall be comprised of first, middle, and last name, sex, date of birth, and place of birth.

(3) For purposes of this section, noncomprehensive death record indices for public release shall be comprised of first, middle, and last name, sex, date of birth, place of birth, place of death, date of death, and father's last name.

(4) For purposes of this section, noncomprehensive nonconfidential marriage record indices for public release shall be comprised of the name of each party to the marriage and the date of marriage.

(5) Requesters of the birth, death, or nonconfidential marriage record indices prepared pursuant to this subdivision shall provide proof of identity, complete a form, and sign the form under penalty of perjury. The form shall include all of the following:

(A) The proposed use of the birth, death, or nonconfidential marriage record indices.

(B) A disclaimer crediting analyses, interpretations, or conclusions reached regarding the birth, death, or nonconfidential marriage record indices to the author and not to the State Department of Public Health.

(C) Assurance that technical descriptions of the birth, death, or nonconfidential marriage record indices are consistent with those provided by the State Department of Public Health.

(D) Assurance that the requester shall not sell, assign, or otherwise transfer the birth, death, or nonconfidential marriage record indices.

(E) Assurance that the requester shall not use the birth or death record indices for fraudulent purposes.

(6) Birth, death, and nonconfidential marriage record indices obtained pursuant to this subdivision, and any portion thereof, shall not be used for fraudulent purposes.

(c) (1) The State Registrar shall prepare and maintain separate noncomprehensive indices of all California birth, death, and nonconfidential marriage records for purposes of law enforcement or preventing fraud.

(2) For purposes of this section, noncomprehensive birth record indices for the purpose of preventing fraud shall be comprised of first, middle, and last name, sex, date of birth, place of birth, and mother's maiden name.

(3) For purposes of this section, noncomprehensive death record indices for the purpose of preventing fraud shall be comprised of first, middle, and last name, place of death, mother's maiden name, sex, social security number, date of birth, place of birth, date of death, and father's last name.

(4) For purposes of this section, noncomprehensive nonconfidential marriage record indices for the purpose of preventing fraud shall be comprised of the name of each party to the marriage and the date of marriage.

(5) The birth, death, and nonconfidential marriage record indices prepared pursuant to this subdivision shall be made available to financial institutions, as defined in Section 6827(4)(A) and (B) of Title 15 of the United States Code, its representatives or contractors, consumer credit reporting agencies, as defined in subdivision (d) of Section 1785.3 of the Civil Code, its representatives or contractors, those entities providing information services for purposes of law enforcement or preventing fraud, officers of the court for the sole purpose of verifying a death, and to persons or entities acting on behalf of law enforcement agencies or the court, or pursuant to a court order.

(6) The death record indices prepared pursuant to this subdivision shall be made available to all of the following entities for the sole purpose of verifying a death to promote accuracy of patient records used for patient care, reporting, and quality improvement:

(A) A health care service plan as defined in the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2) or a Medi-Cal managed care plan contracted with the State Department of Health Care Services to provide full scope benefits to a Medi-Cal enrollee pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8.75 (commencing with Section 14591) of, Part 3 of Division 9 of the Welfare and Institutions Code.

(B) A health insurer licensed to provide health insurance as defined in Section 106 of the Insurance Code.

(C) A physician organization as defined in Section 127500.2.

(D) A health facility as defined in Section 1250, including a general acute care hospital.

(7) The birth, death, and nonconfidential marriage record indices prepared pursuant to this subdivision may be released to a government agency.

(8) Requesters of the birth, death, or nonconfidential marriage record indices prepared pursuant to this subdivision shall provide proof of identity, complete a form, and sign the form under penalty of perjury. The form shall include all of the following:

(A) An agreement not to release or allow public access to the birth, death, or nonconfidential marriage record indices, and an agreement not to post the indices on the internet, except as permitted by this subdivision.

(B) The proposed use of the birth, death, or nonconfidential marriage record indices.

(C) The names of all persons within the organization, if applicable, who will have access to the birth, death, or nonconfidential marriage record indices.

(D) A disclaimer crediting analyses, interpretations, or conclusions reached regarding the birth, death, or nonconfidential marriage record indices to the author and not to the State Department of Public Health.

(E) Assurance that technical descriptions of the birth, death, or nonconfidential marriage record indices are consistent with those provided by the State Department of Public Health.

(F) Assurance that the requester shall not sell, assign, or otherwise transfer the birth, death, or nonconfidential marriage record indices, except as permitted by this subdivision.

(G) Assurance that the requester shall not use the birth, death, or nonconfidential marriage record indices for fraudulent purposes.

(9) (A) Birth, death, and nonconfidential marriage record indices, and any portion thereof, obtained pursuant to this section, shall not be used for fraudulent purposes and shall not be posted on the internet.

(B) Notwithstanding subparagraph (A), individual information contained in birth, death, and nonconfidential marriage record indices may be posted on the internet if all of the following requirements are met:

(i) The individual information is posted on an internet website that is protected by a password.

(ii) The individual information is posted on an internet website that is available to subscribers only for a fee.

(iii) The individual information is not posted for public display.

(iv) The individual information is available to subscribers pursuant to a contractual agreement.

(v) The individual information is posted for purposes of law enforcement or preventing fraud.

(d) Mail-in requests from nongovernmental agencies for birth, death, and nonconfidential marriage record indices requested pursuant to subdivisions (b) and (c) shall include a notarized statement attesting to the identity of the requester.

(e) Noncomprehensive birth, death, and nonconfidential marriage record indices pursuant to subdivisions (b) and (c) shall be updated annually.

(f) (1) Birth, death, and nonconfidential marriage record indices provided pursuant to this section shall be made available subject to cost recovery provisions of the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code).

(2) Notwithstanding paragraph (1), death record indices provided pursuant to this section by the State Department of Public Health shall be made available subject to reasonable cost recovery. Moneys collected for cost recovery pursuant to this paragraph shall be deposited with the Treasurer for credit to the Health Statistics Special Fund.

(g) Noncomprehensive birth, death, and nonconfidential marriage record indices created by local registrars or county recorders shall be subject to the conditions for release required by this section. This subdivision does not apply to data required to be made available by paragraph (6) of subdivision (c).

(h) A person or entity that obtains a birth, death, or nonconfidential marriage record index, or any portion thereof, from a requester who has obtained the index in accordance with paragraph (7) of subdivision (c) shall not sell, assign, or otherwise transfer that index, or any portion thereof, to a third party.

(i) Paragraphs (2) and (3) of subdivision (a) and subdivisions (b) to (h), inclusive, shall be implemented only to the extent that funds for these purposes are appropriated by the Legislature in the annual Budget Act or other statute.

SEC. 7. Section 102231 of the Health and Safety Code is amended to read:

102231. (a) Notwithstanding any other law, birth data files, birth data files for public release, death data files for public release, death data files for purposes of law enforcement or preventing fraud, and nonconfidential marriage data files prepared and maintained by the State Registrar, local registrars, and county recorders shall only be released as follows:

(1) Birth data files containing personal identifiers shall be subject to the same restrictions as the confidential portion of a birth certificate and shall only be released under the terms and conditions specified in Section 102430.

(2) Birth data files for public release shall not contain the mother's maiden name.

(3) Death data files for public release shall not contain the mother's maiden name and social security number.

(4) Death data files for purposes of law enforcement or preventing fraud shall include the mother's maiden name and social security number. Death data files prepared pursuant to this subdivision may be released to governmental agencies and to those entities described in paragraphs (5) and (6) of subdivision (c) of Section 102230.

(5) Death data files containing personal identifying information may be released to persons expressing a valid scientific interest, as determined by the appropriate committee constituted for the protection of human subjects that is approved by the United States Department of Health and Human Services and has a general assurance pursuant to Part 46 (commencing with Section 46.101) of Title 45 of the Code of Federal Regulations.

(6) Nonconfidential marriage data files shall include the name of each party to the marriage and the date of the marriage. Nonconfidential marriage data files for public release shall not contain the maiden names of the mothers.

(b) Requesters of birth, death, and nonconfidential marriage data files pursuant to this section shall provide proof of identity, complete a form, and sign the form under penalty of perjury. The form shall include all of the following:

(1) An agreement not to release the birth, death, or marriage data files and not to post the files on the internet, except as permitted by this subdivision.

(2) An agreement not to provide public access to data files obtained pursuant to paragraphs (1) and (4) of subdivision (a).

(3) The proposed use of the data file.

(4) For data files obtained pursuant to paragraphs (1) and (4) of subdivision (a), the names of all persons within the organization, if applicable, who will have access to the data files.

(5) A disclaimer that credits analyses, interpretations, or conclusions reached regarding the birth or death data files to the author and not to the State Department of Public Health.

(6) Assurance that technical descriptions of the data files are consistent with those provided by the State Department of Public Health.

(7) Assurance that the requester shall not sell, assign, or otherwise transfer the data files, except as permitted by subdivision (e).

(8) Assurance that the requester shall not use the data files for fraudulent purposes.

(c) Mail-in requests for birth, death, and nonconfidential marriage data files pursuant to this section shall include a notarized statement attesting to the identity of the requester.

(d) (1) Birth, death, and nonconfidential marriage data files provided pursuant to this section shall be made available subject to cost recovery provisions of the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code).

(2) Notwithstanding paragraph (1), death data files provided pursuant to this section by the State Department of Public Health shall be made available subject to reasonable cost recovery. Moneys collected for cost recovery pursuant to this paragraph shall be deposited with the Treasurer for credit to the Health Statistics Special Fund.

(e) (1) Birth, death, and nonconfidential marriage data files, and any portion thereof, obtained pursuant to this section, shall not be used for fraudulent purposes and shall not be posted on the internet.

(2) Notwithstanding paragraph (1), individual information contained in death data files obtained pursuant to paragraph (4) of subdivision (a) may be posted on the internet if all of the following requirements are met:

(A) The information is posted on an internet website that is protected by a password.

(B) The information is posted on an internet website that is available to subscribers only for a fee.

(C) The information is not posted for public display.

(D) The information is available to subscribers pursuant to a contractual agreement.

(E) The information is posted for purposes of law enforcement or preventing fraud.

(f) A person or entity that obtains a birth, death, or nonconfidential marriage data file, or any portion thereof, from a requester who has obtained the data file in accordance with subdivision (b) shall not sell, assign, or otherwise transfer that data file, or any portion thereof, to a third party.

(g) This section shall be implemented only to the extent that funds for these purposes are appropriated by the Legislature in the annual Budget Act or other statute.

SEC. 8. Section 102970 is added to the Health and Safety Code, to read:

102970. (a) The department shall regularly, but no less than annually, review fetal death registrations completed pursuant to this chapter to determine whether there is a failure to comply with the required timeframes for fetal death registration pursuant to Section 102950. The department's review is not required to include a determination of culpability for any late registrations.

(b) If the department identifies repeated failures to comply with the timeframe required by Section 102950, the department shall electronically notify the Medical Board of California, the Cemetery and Funeral Bureau, or other relevant licensing entity of an individual's or entity's failure to timely comply with fetal death registration requirements. Notwithstanding Section 102430, the department's electronic notification shall include the information necessary for the relevant licensing entity to adequately investigate the identified untimely fetal death registration.

(c) For purposes of this section, "repeated failures" means an individual's or entity's failure to timely comply with fetal death registration requirements more than 25 percent of the time in a calendar year.

SEC. 9. Section 128905 of the Health and Safety Code is amended to read:

128905. (a) Commencing January 1, 2027, every clinic holding a license and, notwithstanding subdivision (h) of Section 1206, every intermittent clinic operated by a licensed clinic and exempt from licensure shall, on or before the 15th day of March each year, file with the department, upon forms to be furnished by the department, a verified report showing the following information relating to the previous calendar year:

(1) Number of patients served and descriptive information, including, but not limited to, age, sex, race, ethnicity, preferred language spoken, disability status, sexual orientation, gender identity, and payor category. A clinic shall not be subject to any adverse action for not providing sexual orientation and gender identity information if the patient refused to provide that information.

(2) Number of patient visits by type of service, including all of the following:

(A) Child health and disability prevention screens, treatment, and followup services.

(B) Medical services.

(C) Dental services.

(D) Other health services.

(3) Primary care clinics participating in the Medi-Cal program or county indigent programs shall include the following:

(A) Number of assigned members per Medi-Cal managed care plan and county indigent program.

(B) Number of assigned members per Medi-Cal managed care plan and county indigent program that had one or more clinic visits.

(4) Total clinic operating expenses.

(5) Gross patient charges by payer category, including Medicare, Medi-Cal, the Child Health Disability Prevention Program, county indigent programs, other county programs, private insurance, self-paying patients, nonpaying patients, and other payers.

(6) Deductions from revenue by payer category, bad debts, and charity care charges.

(7) Average weekly number of clinic operating hours and whether or not the clinic is licensed or intermittent.

(8) Additional information as may be required by the department or the State Department of Public Health.

(9) This subdivision does not apply to specialty clinics.

(b) In order to facilitate timely enforcement of this section, the department shall send a written notice of violation to every clinic that fails to file a timely report pursuant to this section or pursuant to Section 127285 or 128910, either for itself or for any intermittent clinic it operates. The department shall also provide the State Department of Public Health with a list of every clinic that receives a written notice of violation and notify the State Department of Public Health when a clinic on the list completes and files all delinquent reports. The department shall make these notices and lists, including notifications of when a clinic on the list completes and files all delinquent reports, available on its internet website.

(c) In order to promote efficient reporting of accurate data, the department shall consider the unique operational characteristics of different classifications of licensed clinics, including, but not limited to, the limited scope of services provided by some specialty clinics, in its design of forms for the collection of data required by this section.

(d) For the purpose of administering funds appropriated from the Cigarette and Tobacco Products Surtax Fund for support of licensed clinics, clinics receiving those funds may be required to report any additional data the department or the State Department of Public Health may determine necessary to ensure the equitable distribution and appropriate expenditure of those funds. This shall include, but not be limited to, information about the poverty level of patients served and communicable diseases reported to local health departments.

(e) This section shall apply to all licensed primary care clinics, and to all intermittent clinics operated by those licensed primary care clinics, notwithstanding subdivision (h) of Section 1206.

(f) Specialty clinics shall report the following:

(1) Number of patients during the preceding year.

(2) Total amount of administrative or other charges or fees collected from patients.

(3) Total amount of revenues from other sources for the previous year.

(4) Total operating cost for clinic for the previous year.

(5) Additional information as may be required by regulation of the department.

SEC. 10. Section 128910 of the Health and Safety Code is amended to read:

128910. Commencing January 1, 2027, an organization that operates, conducts, owns, or maintains a primary care clinic or intermittent clinic, and the officers thereof, shall, for every primary care clinic and every intermittent clinic that it operates, conducts, owns, or maintains, on or before the 15th day of March each year, file with the department separate reports for each primary care clinic and each intermittent clinic on forms furnished by the department, in conjunction with the forms required under Sections 127285 and 128905 that are in accord, if applicable, with the systems of accounting and uniform reporting required by this part:

(a) The Medi-Cal FQHC/RHC prospective payment system (PPS) rate, if applicable.

(b) A detailed labor report including, but not limited to, the following information:

(1) The actual number of employees and full-time equivalents, by job classification, including nonlicensed and noncredentialed positions, at the beginning and end of the reporting period.

(2) The actual number of contracted or registry staff and full-time equivalents, of contracted or registry staff by job classification, including nonlicensed and noncredentialed positions at the beginning and end of the reporting period.

(3) The number of staff vacancies by job classification.

(4) The average base hourly wages and base hourly wage ranges (minimum and maximum base hourly wage) by job classification for each job classification with three or more employees.

(5) For clinics required to file Return of Organization Exempt From Income Tax form (Form 990) with the Department of the Treasury Internal Revenue Service, information identifying job title and salary of the five highest compensated employees, who received reportable compensation of more than one hundred thousand dollars ($100,000).

(6) Aggregated workforce demographic information for each clinic site, including, but not limited to, age, gender, race, and ethnicity, languages spoken, disability status, sexual orientation, and gender identity. Workers shall not be required to provide the information in this paragraph and shall not be subject to discipline or any other adverse action for not providing the information listed.

(c) A detailed workforce development report, including, but not limited to, the following:

(1) Participation in any local, regional, or statewide labor-management cooperation committee (LMCC), and for each LMCC, the identity of all partners.

(2) Data about the nature and extent of participation in allied health care professional degrees and certificate programs, including, but not limited to, the number of clinical placements for each program.

(3) Data about the nature and extent of participation in behavioral health professional degree and certificate programs, including, but not limited to, the number of clinical placements for each program.

SEC. 11. Section 128920 of the Health and Safety Code is amended to read:

128920. The department shall administer this chapter and shall adopt all regulations necessary to implement the provisions of this chapter. The regulations shall require the first annual reports described in Section 128910 to be submitted on or before March 15, 2028, using information relating to the calendar year beginning January 1, 2027.

SEC. 12. Section 5150.05 of the Welfare and Institutions Code is amended to read:

5150.05. (a) When determining if probable cause exists to take a person into custody, or cause a person to be taken into custody, pursuant to Section 5150, a person who is authorized to take that person, or cause that person to be taken, into custody pursuant to that section shall consider available relevant information about the historical course of the person's mental disorder if the authorized person determines that the information has a reasonable bearing on the determination as to whether the person is a danger to others or to themselves, or is gravely disabled.

(b) For purposes of this section, "information about the historical course of the person's mental disorder" includes evidence presented by the person who has provided or is providing mental health or related support services to the person subject to a determination described in subdivision (a), evidence presented by one or more members of the family of that person, and evidence presented by the person subject to a determination described in subdivision (a) or anyone designated by that person.

(c) If the probable cause in subdivision (a) is based on the statement of a person other than the one authorized to take the person into custody pursuant to Section 5150, a member of the attending staff, or a professional person, the person making the statement shall be liable in a civil action for intentionally giving a statement that they know to be false.

(d) This section does not limit the application of Section 5328.

SEC. 13. Section 5250 of the Welfare and Institutions Code is amended to read:

5250. If a person is detained for 72 hours under the provisions of Article 1 (commencing with Section 5150), or under court order for evaluation pursuant to Article 2 (commencing with Section 5200) or Article 3 (commencing with Section 5225) and has received an evaluation, the person may be certified for not more than 14 days of intensive treatment related to the mental health disorder or impairment by chronic alcoholism, under the following conditions:

(a) The professional staff of the agency or facility providing evaluation services has analyzed the person's condition and has found the person is, as a result of a mental health disorder or impairment by chronic alcoholism, a danger to others or to themselves, or is gravely disabled.

(b) The facility providing intensive treatment is designated by the county to provide intensive treatment and agrees to admit the person. A facility shall not be designated to provide intensive treatment unless it complies with the certification review hearing required by this article. The procedures shall be described in the county Short-Doyle plan.

(c) The person has been advised of the need for, but has not been willing or able to accept, treatment on a voluntary basis.

(d) (1) Notwithstanding paragraph (1) of subdivision (h) of Section 5008, a person is not "gravely disabled" if that person can survive safely without involuntary detention with the help of responsible family, friends, or others who are both willing and able to help provide for the person's basic personal needs for food, clothing, or shelter.

(2) However, unless they specifically indicate in writing their willingness and ability to help, family, friends, or others shall not be considered willing or able to provide this help.

(3) The purpose of this subdivision is to avoid the necessity for, and the harmful effects of, requiring family, friends, and others to publicly state, and requiring the certification review officer to publicly find, that no one is willing or able to assist a person with a grave disability.

SEC. 14. Section 5350 of the Welfare and Institutions Code is amended to read:

5350. A conservator of the person, of the estate, or of the person and the estate may be appointed for a person who is gravely disabled or impaired by chronic alcoholism.

The procedure for establishing, administering, and terminating a conservatorship under this chapter shall be the same as that provided in Division 4 (commencing with Section 1400) of the Probate Code, except as follows:

(a) A conservator may be appointed for a gravely disabled minor.

(b) (1) Appointment of a conservator under this part, including the appointment of a conservator for a person who is gravely disabled, as defined in subparagraph (A) of paragraph (1) of subdivision (h) of Section 5008, shall be subject to the list of priorities in Section 1812 of the Probate Code unless the officer providing conservatorship investigation recommends otherwise to the superior court.

(2) In appointing a conservator for a person who is gravely disabled, as defined in subparagraph (B) of paragraph (1) of subdivision (h) of Section 5008, the court shall consider the purposes of protection of the public and the treatment of the conservatee. Notwithstanding any other provision of this section, the court shall not appoint the proposed conservator if it determines that appointment of the proposed conservator will not result in adequate protection of the public.

(c) A conservatorship of the estate pursuant to this chapter shall not be established if a conservatorship or guardianship of the estate exists under the Probate Code. When a gravely disabled person already has a guardian or conservator of the person appointed under the Probate Code, the proceedings under this chapter shall not terminate the prior proceedings but shall be concurrent with and superior thereto. The superior court may appoint the existing guardian or conservator of the person or another person as conservator of the person under this chapter.

(d) (1) The person for whom conservatorship is sought shall have the right to demand a court or jury trial on the issue of whether the person is gravely disabled. Demand for court or jury trial shall be made within five days following the hearing on the conservatorship petition. If the proposed conservatee demands a court or jury trial before the date of the hearing as provided for in Section 5365, the demand shall constitute a waiver of the hearing.

(2) The court or jury trial shall commence within 10 days of the date of the demand, except that the court shall continue the trial date for a period not to exceed 15 days upon the request of counsel for the proposed conservatee. Failure to commence the trial within that period of time is grounds for dismissal of the conservatorship proceedings.

(3) This right shall also apply in subsequent proceedings to reestablish conservatorship.

(e) (1) Notwithstanding subparagraph (A) of paragraph (1) of subdivision (h) of Section 5008, a person is not "gravely disabled" if that person can survive safely without involuntary detention with the help of responsible family, friends, or others who are both willing and able to help provide for the person's basic personal needs.

(2) However, unless they specifically indicate in writing their willingness and ability to help, family, friends, or others shall not be considered willing or able to provide this help.

(3) The purpose of this subdivision is to avoid the necessity for, and the harmful effects of, requiring family, friends, and others to publicly state, and requiring the court to publicly find, that no one is willing or able to assist a person with a grave disability.

(4) This subdivision does not apply to a person who is gravely disabled as defined in subparagraph (B) of paragraph (1) of subdivision (h) of Section 5008.

(f) Conservatorship investigation shall be conducted pursuant to this part and is not subject to Section 1826 of the Probate Code or Chapter 2 (commencing with Section 1850) of Part 3 of Division 4 of the Probate Code.

(g) Notice of proceedings under this chapter shall be given to a guardian or conservator of the person or estate of the proposed conservatee appointed under the Probate Code.

(h) As otherwise provided in this chapter.

SEC. 15. Section 5350.5 of the Welfare and Institutions Code is amended to read:

5350.5. (a) If a conservatorship has already been established under the Probate Code, the court, in a proceeding under the Probate Code, after an evidentiary hearing attended by the conservatee, unless the conservatee waives presence, and the conservatee's counsel, may refer the conservatee, in consultation with a licensed physician or licensed psychologist satisfying the conditions of subdivision (c) of Section 2032.020 of the Code of Civil Procedure providing assessment or treatment to the conservatee, for an assessment by the local mental health system or plan to determine if the conservatee has a treatable mental illness, including whether the conservatee is gravely disabled or impaired by chronic alcoholism, and is unwilling to accept, or is incapable of accepting, treatment voluntarily. If the conservatee cannot afford counsel, the court shall appoint counsel for them pursuant to Section 1471 of the Probate Code.

(b) The local mental health system or plan shall file a copy of the assessment with the court that made the referral for assessment in a proceeding under the Probate Code.

SEC. 16. Section 10022 of the Welfare and Institutions Code is amended to read:

10022. (a) Each publicly funded health care program, as defined in paragraph (1) of subdivision (b) of Section 10020, that furnishes or pays for health care items or services under this division to a person having private health care coverage shall be entitled to be subrogated to the rights that person has against the carrier of the coverage to the extent of the health care items provided or services rendered.

(b) An entity providing private health care coverage, as defined in paragraph (2) of subdivision (b) of Section 10020, shall do all of the following:

(1) Accept the state's right of recovery and the assignment to the state of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the state plan, waivers granted in accordance with Section 1315 or 1396n of Title 42 of the United States Code, or through a Medi-Cal managed care plan, as defined in subdivision (j) of Section 14184.101.

(2) Respond to an inquiry by the state or a provider, as defined in subdivision (o) of Section 14043.1, including a billing agent or a billing agent of the provider, as defined in subdivision (a) of Section 14040.1, or a Medi-Cal managed care plan, as defined in subdivision (j) of Section 14184.101, regarding a claim for payment for a health care item or service that is submitted not later than three years after the date of the provision of that health care item or service.

(3) Agree not to deny a claim submitted by the state, a provider as defined in paragraph (2), or a Medi-Cal managed care plan, as defined in subdivision (j) of Section 14184.101, solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim, or in the case of a responsible third party, a failure to obtain a prior authorization for the item or service for which the claim is being submitted if both of the following occur:

(A) The claim is submitted by the state, a provider as defined in paragraph (2), or a Medi-Cal managed care plan, as defined in subdivision (j) of Section 14184.101, within the three-year period beginning on the date on which the item or service was furnished.

(B) An action by the state, a provider as defined in paragraph (2), or a Medi-Cal managed care plan, as defined in subdivision (j) of Section 14184.101, to enforce its rights with respect to that claim is commenced within six years of the state's or provider's submission of the claim.

(4) Request a refund of a claim paid in error no later than three years from the date the payment was made to the State Department of Health Care Services. The State Department of Health Care Services shall not refund a claim paid in error if the

request for a refund is more than three years from the date the payment was made to the State Department of Health Care Services.

(5) Respond to a request for payment by the state, a provider as defined in paragraph (2), or a Medi-Cal managed care plan, as defined in paragraph (2), within 60 days by providing one of the following:

(A) Payment on the claim.

(B) A written request for additional information necessary to process the claim.

(C) A written explanation for the denial of the claim.

SEC. 17. Section 14115.8 of the Welfare and Institutions Code is amended to read:

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

(2) The department shall examine methodologies for increasing school participation in the Medi-Cal Billing Option for LEAs so that schools can meet the health care needs of their students.

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

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

(5) (A) The department shall, in consultation with the LEA Ad Hoc Workgroup established pursuant to subdivision (c), and consistent with any applicable federal requirements, issue and regularly maintain a program guide for the LEA Medi-Cal Billing Option program. The program guide shall contain a billing manual that includes, but is not limited to, an explanation of billing, auditing, costs reporting, time studies, federal and state compliance rules, fiscal and programmatic compliance information regarding processes, documentation, and guidance necessary for the proper submission of claims, and auditing of LEAs, charter schools, and community colleges, as required under the LEA Medi-Cal Billing Option program.

(B) The program guide described in subparagraph (A) shall include, but not be limited to, state plan amendments, Frequently Asked Questions, policy and procedure letters, a plain language explanation of the certified public expenditure processes used to report and reconcile program costs from interim reimbursement to final cost settlement, trainings, provider manuals, and all other types of instructional materials relevant to the LEA Medi-Cal Billing Option program.

(C) (i) The department shall distribute the program guide to all participating LEAs, charter schools, and community colleges by January 1, 2020. Distribution of the program guide may occur by electronic mail or by notification by electronic mail of the posting of the guide on the department's internet website.

(ii) The department shall distribute an updated program guide to all participating LEAs, including charter schools and community colleges, by July 1, 2024, that includes the requirements described in subparagraphs (A) and (B). The department may distribute the program guide by electronic mail or by notification by electronic mail of the posting of the guide on the department's internet website.

(D) The department shall only adopt a revision of the program guide after providing 30 calendar days' written notification of the revision, including a statement of justification, to the LEA Ad Hoc Workgroup and all other participating LEAs, charter schools, and community colleges. The department may provide written notice by electronic mail. Under extraordinary circumstances, when revisions are necessary to reflect changes required by state or federal law or otherwise mandated by the federal Centers for Medicare and Medicaid Services and those changes require immediate action, the department may provide less than 30 calendar days' written notice.

(b) The department shall conduct an audit of a Medi-Cal Billing Option claim consistent with, but not limited to, all of the following:

(1) (A) The program guide and any revisions made pursuant to paragraph (5) of subdivision (a), including any revisions that are necessary to reflect changes required by state or federal law or otherwise mandated by the federal Centers for Medicare and Medicaid Services, that are in effect at the time the service was provided.

(B) Generally accepted accounting principles.

(C) Federal audit regulations, as set forth in Part 200 (commencing with Section 200.0) of Title 2 of the Code of Federal Regulations (Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards), or its successor.

(D) Reasonable cost principles under the federal Medicare Program, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(E) The federal Centers for Medicare and Medicaid Services Provider Reimbursement Manual Part 1 (CMS Publication 15-1).

(F) Any and all applicable federal or state statutes and regulations.

(2) (A) The department shall complete an audit and notify an LEA of the audit findings within 18 months of the date that the Cost and Reimbursement Comparison Schedule (CRCS) is submitted. This timeline may be extended by no more than three months upon a determination that the LEA has not provided sufficient documentation as requested by the auditor.

(B) The department shall provide an interim settlement or final settlement of the Medi-Cal share of each LEA's costs within 12 months of the March 1 due date of the CRCS.

(C) When a final settlement is not issued within 12 months of the March 1 due date, the department shall complete final settlement no later than 18 months after the date that the CRCS is submitted.

(D) LEAs shall be reimbursed for all eligible services that meet federal requirements.

(3) For purposes of this subdivision, an audit shall refer to the audit and cost recovery process described in Section 14170.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may issue and regularly maintain the program guide described in this section without taking regulatory action.

(d) If a rate study for the LEA Medi-Cal Billing Option is completed pursuant to Section 52 of Chapter 171 of the Statutes of 2001, the department, in consultation with the entities named in paragraph (1) of subdivision (e), shall implement the recommendations from the study, to the extent feasible and appropriate.

(e) (1) In order to assist the department in formulating the state plan amendments required to implement this section, the department shall regularly consult with the LEA Ad Hoc Workgroup, consisting of, but not limited to, representatives of the State Department of Education, LEAs, including urban, rural, large and small school districts, and county offices of education, and local education consortia. It is the intent of the Legislature that the department also consult with staff from Region IX of the federal Centers for Medicare and Medicaid Services, experts from the fields of both health and education, and state legislative staff.

(2) The department shall ensure that any LEA participating in the Medi-Cal Billing Option program may participate virtually in any trainings or stakeholder meetings, including those meetings conducted pursuant to paragraph (1).

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

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

(h) The department shall, on or before December 31 of each year, file with the Legislature, and publish on its internet website, an annual report that shall include at least all of the following:

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

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

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

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

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

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

(7) Identification of any barriers to LEA reimbursement, including those specified by the entities named in subdivision (e), that are not imposed by federal requirements, and a description of the actions that have been, and will be, taken to eliminate them.

(8) (A) A statewide summary of financial findings related to the process identified in the program guide for the most recently completed audited state fiscal year. The summary of findings shall be updated in subsequent years until all filed CRCS reports have been audited.

(B) For purposes of subparagraph (A), the “most recently completed audited state fiscal year” means the most recent state fiscal year where 70 percent or more of the filed CRCSs have been audited.

(C) A description of changes to the cost settlement process that shall include all of the following:

(i) A summary of the number of audits conducted of Medi-Cal Billing Option program CRCSs.

(ii) A summary of the difference between interim reimbursement and the CRCSs.

(iii) A summary related to audit findings of noncompliance.

(i) The department shall provide semiannual Medi-Cal Billing Option billing forums to LEAs to provide guidance on appropriate billing practices.

(j) The department shall make targeted technical assistance available to LEAs that experience a 25 percent or greater difference between their submitted cost report and the final audited settlement, including assisting LEAs to understand the actions needed to reduce differences between submitted cost reports and the final audited settlement.

(k) (1) The department’s administration of the LEA Medi-Cal Billing Option program shall be funded and staffed by proportionately reducing federal Medicaid payments allocable to LEAs for the provision of benefits funded by the federal Medicaid program under the billing option for services by LEAs. Moneys collected as a result of the reduction in federal Medicaid payments allocable to LEAs shall be deposited into the Local Educational Agency Medi-Cal Recovery Fund, which is hereby established in the Special Deposit Fund established pursuant to Section 16370 of the Government Code. These funds shall be used, upon appropriation by the Legislature, only to support the department to meet all the requirements of administering the LEA Medi-Cal Billing Option program. If at any time this section is repealed, it is the intent of the Legislature that all funds in the Local Educational Agency Medi-Cal Recovery Fund be returned proportionally to all LEAs whose federal Medicaid funds were used to create this fund. The annual amount withheld pursuant to this paragraph shall not exceed 5 percent of total Medicaid payments allocable to LEAs for the provision of benefits funded by the federal Medicaid program under the billing option for services by LEAs.

(2) Moneys collected under paragraph (1) shall be proportionately reduced from federal Medicaid payments to all participating LEAs so that no one LEA loses a disproportionate share of its federal Medicaid payments.

(l) (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 (i).

(m) 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 LEAs.

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

(4) The establishment and maintenance of an LEA user-friendly, interactive internet website.

(5) Collaboration with the State Department of Education to help ensure LEA compliance with state and federal Medicaid requirements and to help improve LEA participation in the Medi-Cal Billing Option for LEAs.