

CALIFORNIA HEALTH AND SAFETY CODE
DIVISION 107
STATEWIDE HEALTH PLANNING AND DEVELOPMENT
PART 5
HEALTH DATA
CHAPTER 1
HEALTH FACILITY DATA

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128675.

This chapter shall be known as the Health Data and Advisory Council Consolidation Act.

(Added by Stats. 1995, Ch. 415, Sec. 9. Effective January 1, 1996.)

128680.

The Legislature hereby finds and declares that:

(a) Significant changes have taken place in recent years in the health care marketplace and in the manner of reimbursement to health facilities by government and private third-party payers for the services they provide.

(b) These changes have permitted the state to reevaluate the need for, and the manner of data collection from health facilities by the various state agencies and commissions.

(c) It is the intent of the Legislature that as a result of this reevaluation that the data collection function be consolidated in a single state agency. It is the further intent of the Legislature that the single state agency only collect that data from health facilities that are essential. The data should be collected, to the extent practical on consolidated, multipurpose report forms for use by all state agencies.

(d) It is the further intent of the Legislature to eliminate the California Health Facilities Commission, the State Advisory Health Council, and the California Health Policy and Data Advisory Commission, and to consolidate data collection and planning functions within the office.

(e) It is the Legislature's further intent that the review of the data that the state collects be an ongoing function. The office shall annually review this data for need and shall revise, add, or delete items as necessary. The office shall consult with affected state agencies and the affected industry when adding or eliminating data items. However, the office shall neither add nor delete data items to the Hospital Discharge Abstract Data Record or the quarterly reports without prior authorizing legislation, unless specifically required by federal law or judicial decision.

(f) The Legislature recognizes that the authority for the California Health Facilities Commission is scheduled to expire January 1, 1986. It is the intent of the Legislature, by the enactment of this chapter, to continue the uniform system of accounting and reporting established by the commission and required for use by health facilities. It is also the intent of the Legislature to continue an appropriate, cost-disclosure program.

(Amended by Stats. 2011, Ch. 32, Sec. 20. Effective June 29, 2011. Operative January 1, 2012, by Sec. 73 of Stats. 2011, Ch. 32.)

128681.

The office shall conduct, under contract with a qualified consulting firm, a comprehensive review of the financial and utilization reports that hospitals are required to file with the office and similar reports

required by other departments of state government, as appropriate. The contracting consulting firm shall have a strong commitment to public health and health care issues, and shall demonstrate fiscal management and analytical expertise. The purpose of the review is to identify opportunities to eliminate the collection of data that no longer serve any significant purpose, to reduce the redundant reporting of similar data to different departments, and to consolidate reports wherever practical. The contracting consulting firm shall evaluate specific reporting requirements, exceptions to and exemptions from the requirements, and areas of duplication or overlap within the requirements. The contracting consulting firm shall consult with a broad range of data users, including, but not limited to, consumers, payers, purchasers, providers, employers, employees, and the organizations that represent the data users. It is expected that the review will result in greater efficiency in collecting and disseminating needed hospital information to the public and will reduce hospital costs and administrative burdens associated with reporting the information.

(Added by Stats. 1998, Ch. 735, Sec. 4. Effective January 1, 1999.)

128685.

Intermediate care facilities/developmentally disabled-habilitative, as defined in subdivision (e) of Section 1250, are not subject to this chapter.

(Added by Stats. 1995, Ch. 415, Sec. 9. Effective January 1, 1996.)

128690.

Intermediate care facilities/developmentally disabled—nursing, as defined in subdivision (h) of Section 1250, are not subject to this chapter.

(Added by Stats. 1995, Ch. 415, Sec. 9. Effective January 1, 1996.)

128700.

As used in this chapter, the following terms mean:

(a) “Ambulatory surgery procedures” mean those procedures performed on an outpatient basis in the general operating rooms, ambulatory surgery rooms, endoscopy units, or cardiac catheterization laboratories of a hospital or a freestanding ambulatory surgery clinic.

(b) “Emergency department” means, in a hospital licensed to provide emergency medical services, the location in which those services are provided.

(c) “Encounter” means a face-to-face contact between a patient and the provider who has primary responsibility for assessing and treating the condition of the patient at a given contact and exercises independent judgment in the care of the patient.

(d) “Freestanding ambulatory surgery clinic” means a surgical clinic that is licensed by the state under paragraph (1) of subdivision (b) of Section 1204.

(e) "Health facility" or "health facilities" means all health facilities required to be licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2.

(f) "Hospital" means all health facilities except skilled nursing, intermediate care, and congregate living health facilities.

(g) "Office" means the Office of Statewide Health Planning and Development.

(h) "Risk-adjusted outcomes" means the clinical outcomes of patients grouped by diagnoses or procedures that have been adjusted for demographic and clinical factors.

(Amended by Stats. 2011, Ch. 32, Sec. 22. Effective June 29, 2011. Operative January 1, 2012, by Sec. 73 of Stats. 2011, Ch. 32.)

128705.

On and after January 1, 1986, any reference in this code to the Advisory Health Council or the California Health Policy and Data Advisory Commission shall be deemed a reference to the office.

(Amended by Stats. 2011, Ch. 32, Sec. 23. Effective June 29, 2011. Operative January 1, 2012, by Sec. 73 of Stats. 2011, Ch. 32.)

128730.

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

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

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

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

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

(Amended by Stats. 2010, Ch. 328, Sec. 138. Effective January 1, 2011.)

128735.

An organization that operates, conducts, owns, or maintains a health facility, and the officers thereof, shall make and file with the office, at the times as the office shall require, all of the following reports on forms specified by the office that shall be in accord, if applicable, with the systems of accounting and uniform reporting required by this part, except that the reports required pursuant to subdivision (g) shall be limited to hospitals:

(a) A balance sheet detailing the assets, liabilities, and net worth of the health facility at the end of its fiscal year.

(b) A statement of income, expenses, and operating surplus or deficit for the annual fiscal period, and a statement of ancillary utilization and patient census.

(c) A statement detailing patient revenue by payer, including, but not limited to, Medicare, Medi-Cal, and other payers, and revenue center, except that hospitals authorized to report as a group pursuant to subdivision (d) of Section 128760 are not required to report revenue by revenue center.

(d) A statement of cashflows, including, but not limited to, ongoing and new capital expenditures and depreciation.

(e) A statement reporting the information required in subdivisions (a), (b), (c), and (d) for each separately licensed health facility operated, conducted, or maintained by the reporting organization, except those hospitals authorized to report as a group pursuant to subdivision (d) of Section 128760.

(f) Data reporting requirements established by the office shall be consistent with national standards, as applicable.

(g) A Hospital Discharge Abstract Data Record that includes all of the following:

(1) Date of birth.

(2) Sex.

(3) Race.

(4) ZIP Code.

(5) Principal language spoken.

(6) Patient social security number, if it is contained in the patient's medical record.

(7) Prehospital care and resuscitation, if any, including all of the following:

(A) "Do not resuscitate" (DNR) order at admission.

(B) "Do not resuscitate" (DNR) order after admission.

- (8) Admission date.
- (9) Source of admission.
- (10) Type of admission.
- (11) Discharge date.
- (12) Principal diagnosis and whether the condition was present at admission.
- (13) Other diagnoses and whether the conditions were present at admission.
- (14) External cause of injury.
- (15) Principal procedure and date.
- (16) Other procedures and dates.
- (17) Total charges.
- (18) Disposition of patient.
- (19) Expected source of payment.
- (20) Elements added pursuant to Section 128738.

(h) It is the intent of the Legislature that the patient's rights of confidentiality shall not be violated in any manner. Patient social security numbers and other data elements that the office believes could be used to determine the identity of an individual patient shall be exempt from the disclosure requirements of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(i) A person reporting data pursuant to this section shall not be liable for damages in an action based on the use or misuse of patient-identifiable data that has been mailed or otherwise transmitted to the office pursuant to the requirements of subdivision (g).

(j) A hospital shall use coding from the International Classification of Diseases in reporting diagnoses and procedures.

(Amended by Stats. 2008, Ch. 179, Sec. 163. Effective January 1, 2009.)

128736.

(a) Each hospital shall file an Emergency Care Data Record for each patient encounter in a hospital emergency department. The Emergency Care Data Record shall include all of the following:

- (1) Date of birth.
- (2) Sex.

- (3) Race.
- (4) Ethnicity.
- (5) Principal language spoken.
- (6) ZIP Code.
- (7) Patient social security number, if it is contained in the patient's medical record.
- (8) Service date.
- (9) Principal diagnosis.
- (10) Other diagnoses.
- (11) Principal external cause of injury.
- (12) Other external cause of injury.
- (13) Principal procedure.
- (14) Other procedures.
- (15) Disposition of patient.
- (16) Expected source of payment.
- (17) Elements added pursuant to Section 128738.

(b) It is the expressed intent of the Legislature that the patient's rights of confidentiality shall not be violated in any manner. Patient social security numbers and any other data elements that the office believes could be used to determine the identity of an individual patient shall be exempt from the disclosure requirements of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(c) No person reporting data pursuant to this section shall be liable for damages in any action based on the use or misuse of patient-identifiable data that has been mailed or otherwise transmitted to the office pursuant to the requirements of subdivision (a).

(d) Data reporting requirements established by the office shall be consistent with national standards as applicable.

(e) This section shall become operative on January 1, 2004.

(Amended by Stats. 2002, Ch. 351, Sec. 2. Effective January 1, 2003.)

128737.

(a) Each general acute care hospital and freestanding ambulatory surgery clinic shall file an Ambulatory Surgery Data Record for each patient encounter during which at least one ambulatory surgery procedure is performed. The Ambulatory Surgery Data Record shall include all of the following:

- (1) Date of birth.
- (2) Sex.
- (3) Race.
- (4) Ethnicity.
- (5) Principal language spoken.
- (6) ZIP Code.
- (7) Patient social security number, if it is contained in the patient's medical record.
- (8) Service date.
- (9) Principal diagnosis.
- (10) Other diagnoses.
- (11) Principal procedure.
- (12) Other procedures.
- (13) Principal external cause of injury, if known.
- (14) Other external cause of injury, if known.
- (15) Disposition of patient.
- (16) Expected source of payment.
- (17) Elements added pursuant to Section 128738.

(b) It is the expressed intent of the Legislature that the patient's rights of confidentiality shall not be violated in any manner. Patient social security numbers and any other data elements that the office believes could be used to determine the identity of an individual patient shall be exempt from the disclosure requirements of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(c) No person reporting data pursuant to this section shall be liable for damages in any action based on the use or misuse of patient-identifiable data that has been mailed or otherwise transmitted to the office pursuant to the requirements of subdivision (a).

(d) Data reporting requirements established by the office shall be consistent with national standards as applicable.

(e) This section shall become operative on January 1, 2004.

(Amended by Stats. 2006, Ch. 259, Sec. 12. Effective January 1, 2007.)

128738.

(a) The office shall allow and provide for, in accordance with appropriate regulations, additions or deletions to the patient level data elements listed in subdivision (g) of Section 128735, Section 128736, and Section 128737, to meet the purposes of this chapter.

(b) Prior to any additions or deletions, all of the following shall be considered:

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

(2) Feasibility of collecting data elements.

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

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

(c) The office shall add no more than a net of 15 elements to each data set over any five-year period. Elements contained in the uniform claims transaction set or uniform billing form required by the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Sec. 300gg) shall be exempt from the 15-element limit.

(d) The office, in order to minimize costs and administrative burdens, shall consider the total number of data elements required from hospitals and freestanding ambulatory surgery clinics, and optimize the use of common data elements.

(Amended by Stats. 2011, Ch. 32, Sec. 28. Effective June 29, 2011. Operative January 1, 2012, by Sec. 73 of Stats. 2011, Ch. 32.)

128740.

(a) Commencing with the first calendar quarter of 1992, the following summary financial and utilization data shall be reported to the office by each hospital within 45 days of the end of every calendar quarter. Adjusted reports reflecting changes as a result of audited financial statements may be filed within four months of the close of the hospital's fiscal or calendar year. The quarterly summary financial and utilization data shall conform to the uniform description of accounts as contained in the Accounting and Reporting Manual for California Hospitals and shall include all of the following:

(1) Number of licensed beds.

(2) Average number of available beds.

- (3) Average number of staffed beds.
 - (4) Number of discharges.
 - (5) Number of inpatient days.
 - (6) Number of outpatient visits.
 - (7) Total operating expenses.
 - (8) Total inpatient gross revenues by payer, including Medicare, Medi-Cal, county indigent programs, other third parties, and other payers.
 - (9) Total outpatient gross revenues by payer, including Medicare, Medi-Cal, county indigent programs, other third parties, and other payers.
 - (10) Deductions from revenue in total and by component, including the following: Medicare contractual adjustments, Medi-Cal contractual adjustments, and county indigent program contractual adjustments, other contractual adjustments, bad debts, charity care, restricted donations and subsidies for indigents, support for clinical teaching, teaching allowances, and other deductions.
 - (11) Total capital expenditures.
 - (12) Total net fixed assets.
 - (13) Total number of inpatient days, outpatient visits, and discharges by payer, including Medicare, Medi-Cal, county indigent programs, other third parties, self-pay, charity, and other payers.
 - (14) Total net patient revenues by payer including Medicare, Medi-Cal, county indigent programs, other third parties, and other payers.
 - (15) Other operating revenue.
 - (16) Nonoperating revenue net of nonoperating expenses.
- (b) Hospitals reporting pursuant to subdivision (d) of Section 128760 may provide the items in paragraphs (7), (8), (9), (10), (14), (15), and (16) of subdivision (a) on a group basis, as described in subdivision (d) of Section 128760.
- (c) The office shall make available at cost, to any person, a hard copy of any hospital report made pursuant to this section and in addition to hard copies, shall make available at cost, a computer tape of all reports made pursuant to this section within 105 days of the end of every calendar quarter.
- (d) The office shall adopt by regulation guidelines for the identification, assessment, and reporting of charity care services. In establishing the guidelines, the office shall consider the principles and practices recommended by professional health care industry accounting associations for differentiating between charity services and bad debts. The office shall further conduct the onsite validations of health facility

accounting and reporting procedures and records as are necessary to assure that reported data are consistent with regulatory guidelines.

This section shall become operative January 1, 1992.

(Amended by Stats. 2011, Ch. 32, Sec. 29. Effective June 29, 2011. Operative January 1, 2012, by Sec. 73 of Stats. 2011, Ch. 32.)

128745.

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

		Procedures and
Publication	Period	Conditions
Date	Covered	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. The office shall publish the risk-adjusted outcome reports for surgical procedures by individual hospital and individual surgeon unless the office in consultation with medical specialists in the relevant area of practice determines that it is not appropriate to report by individual surgeon. The office, in consultation with the clinical panel established by Section 128748 and medical specialists in the relevant area of practice, may decide to report nonsurgical procedures and conditions by individual physician when it is appropriate. The selections shall be in accordance with all of the following criteria:

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

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

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

(4) Reliability of the diagnostic and procedure data.

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

(2) In addition to any other established and pending reports, commencing July 1, 2004, and every year thereafter, the office shall publish risk-adjusted outcome reports for coronary artery bypass graft surgery for all coronary artery bypass graft surgeries performed in the state. In each year, the reports shall compare risk-adjusted outcomes by hospital, and in every other year, by hospital and cardiac surgeon. Upon the recommendation of the clinical panel established by Section 128748 based on statistical and technical considerations, information on individual hospitals and surgeons may be excluded from the reports.

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

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

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

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

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

(B) Feasibility of collecting data elements.

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

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

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

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

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

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

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

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

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

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

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

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

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

(Amended by Stats. 2011, Ch. 32, Sec. 30. Effective June 29, 2011. Operative January 1, 2012, by Sec. 73 of Stats. 2011, Ch. 32.)

128747.

Commencing July 1, 2002, and biennially thereafter, the office shall evaluate the impact of the office's published risk-adjusted outcome reports required by Sections 128745 and 128746 on mortality rates in California and on any other measure of quality the office deems appropriate. The office shall also coordinate with other state agencies in promoting prevention and educational initiatives on those reported procedures and conditions.

(Added by Stats. 2001, Ch. 898, Sec. 7. Effective January 1, 2002.)

128748.

(a) This section shall apply to any risk-adjusted outcome report that includes reporting of data by an individual physician.

(b) (1) The office shall obtain data necessary to complete a risk-adjusted outcome report from hospitals. If necessary data for an outcome report is available only from the office of a physician and not the hospital where the patient received treatment, then the hospital shall make a reasonable effort to obtain the data from the physician's office and provide the data to the office. In the event that the office finds any errors, omissions, discrepancies, or other problems with submitted data, the office shall contact either the hospital or physician's office that maintains the data to resolve the problems.

(2) The office shall collect the minimum data necessary for purposes of testing or validating a risk-adjusted model. Except for data collected for purposes of testing or validating a risk-adjusted model, the office shall not collect data for an outcome report nor issue an outcome report until the clinical panel established pursuant to this section has approved the risk-adjusted model.

(c) For each risk-adjusted outcome report on a medical, surgical, or obstetric condition or procedure that includes reporting of data by an individual physician, the office director shall appoint a clinical panel, which shall have nine members. Three members shall be appointed from a list of three or more names submitted by the physician specialty society that most represents physicians performing the medical, surgical, and obstetric procedure for which data is collected. Three members shall be appointed from a list of three or more names submitted by the California Medical Association. Three members shall be appointed from lists of names submitted by consumer organizations. At least one-half of the appointees from the lists submitted by the physician specialty society and the California Medical Association, and at least one appointee from the lists submitted by consumer organizations, shall be experts in collecting and reporting outcome measurements for physicians or hospitals. The panel may include physicians from another state. The panel shall review and approve the development of the risk-adjustment model to be used in preparation of the outcome report.

(d) For the clinical panel authorized by subdivision (c) for coronary artery bypass graft surgery, three members shall be appointed from a list of three or more names submitted by the California Chapter of the American College of Cardiology. Three members shall be appointed from list of three or more names submitted by the California Medical Association. Three members shall be appointed from lists of names submitted by consumer organizations. At least one-half of the appointees from the lists submitted by the California Chapter of the American College of Cardiology, and the California Medical Association, and at least one appointee from the lists submitted by consumer organizations, shall be experts in collecting and reporting outcome measurements for physicians and surgeons or hospitals. The panel may include physicians from another state. The panel shall review and approve the development of the risk-adjustment model to be used in preparation of the outcome report.

(e) Any report that includes reporting by an individual physician shall include, at a minimum, the risk-adjusted outcome data for each physician. The office may also include in the report, after consultation with the clinical panel, any explanatory material, comparisons, groupings, and other information to facilitate consumer comprehension of the data.

(f) Members of a clinical panel shall serve without compensation, but shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the clinical panel.

(Added by Stats. 2001, Ch. 898, Sec. 8. Effective January 1, 2002.)

128750.

(a) Prior to the public release of the annual outcome reports, the office shall furnish a preliminary report to each hospital that is included in the report. The office shall allow the hospital and chief of staff 60 days to review the outcome scores and compare the scores to other California hospitals. A hospital or its chief of staff that believes that the risk-adjusted outcomes do not accurately reflect the quality of care provided by the hospital may submit a statement to the office, within the 60 days, explaining why the outcomes do not accurately reflect the quality of care provided by the hospital. The statement shall be included in an appendix to the public report, and a notation that the hospital or its chief of staff has submitted a statement shall be displayed wherever the report presents outcome scores for the hospital.

(b) (1) Prior to the public release of any outcome report that includes data by a physician, the office shall furnish a preliminary report to each physician that is included in the report. The office shall allow the physician 30 days from the date the office sends the report to the physician to review the outcome scores and compare the scores to other California physicians. A physician who believes that the risk-adjusted outcome does not accurately reflect the quality of care provided by the physician may submit a statement to the office within the 30 days, explaining why the outcomes do not accurately reflect the quality of care provided by the physician.

(2) The office shall promptly review the physician's statement and shall respond to the physician with one of the following conclusions:

(A) The physician's statement reveals a flaw in the accuracy of the reported data relating to the physician that materially diminishes the validity of the report. If this finding is made, the data for that physician shall not be included in the report until the flaw in the physician's data is corrected.

(B) The physician's statement reveals a flaw in the risk-adjustment model that materially diminishes the value of the report for all physicians. If this finding is made, the report using that risk-adjustment model shall not be issued until the flaw is corrected.

(C) The physician's statement does not reveal a flaw in either the accuracy of the reported data relating to the physician or the risk-adjustment model in which case the report shall be used, unless the physician chooses to use the procedure set forth in paragraph (3).

(3) If a physician is not satisfied with the conclusion reached by the office, the physician shall notify the office of that fact. Upon receipt of the notice, the office shall forward the physician's statement to the appropriate clinical panel appointed pursuant to Section 128748. The office shall forward the physician's statement with any information identifying the physician or the physician's hospital redacted, or shall adopt other means to ensure the physician's identity is not revealed to the panel. The clinical panel shall promptly review the physician statement and the conclusion of the office and shall respond by either upholding the conclusion or reaching one of the other conclusions set forth in this subdivision. The panel decision shall be the final determination regarding the physician's statement. The process set forth in this subdivision shall be completed within 60 days from the date the office sends the report to each physician included in the report. If a decision by either the office or the clinical panel cannot be reached within the 60-day period, then the outcome report may be issued but shall not include data for the physician submitting the statement.

(c) The office shall, in addition to public reports, provide hospitals and the chiefs of staff of the medical staffs with a report containing additional detailed information derived from data summarized in the public outcome reports as an aid to internal quality assurance.

(d) If, pursuant to the recommendations of the office, the Legislature subsequently amends Section 128735 to authorize the collection of additional discharge data elements, then the outcome reports for conditions and procedures for which sufficient data is not available from the current abstract record will be produced following the collection and analysis of the additional data elements.

(e) The recommendations of the office for the addition of data elements to the discharge abstract should take into consideration the technical feasibility of developing reliable risk-adjustment factors for additional procedures and conditions as determined by the office with the advice of the research community, physicians and surgeons, hospitals, consumer or patient advocacy groups, and medical records personnel.

(f) The office at a minimum shall identify a limited set of core clinical data elements to be collected for all of the added procedures and conditions and unique clinical variables necessary for risk adjustment of specific conditions and procedures selected for the outcomes report program. In addition, the committee should give careful consideration to the costs associated with the additional data collection and the value of the specific information to be collected.

(g) The office shall also engage in a continuing process of data development and refinement applicable to both current and prospective outcome studies.

(Amended by Stats. 2011, Ch. 32, Sec. 31. Effective June 29, 2011. Operative January 1, 2012, by Sec. 73 of Stats. 2011, Ch. 32.)

128755.

(a) (1) Hospitals shall file the reports required by subdivisions (a), (b), (c), and (d) of Section 128735 with the office within four months after the close of the hospital's fiscal year except as provided in paragraph (2).

(2) If a licensee relinquishes the facility license or puts the facility license in suspense, the last day of active licensure shall be deemed a fiscal year end.

(3) The office shall make the reports filed pursuant to this subdivision available no later than three months after they were filed.

(b) (1) Skilled nursing facilities, intermediate care facilities, intermediate care facilities/developmentally disabled, hospice facilities, and congregate living facilities, including nursing facilities certified by the department to participate in the Medi-Cal program, shall file the reports required by subdivisions (a), (b), (c), and (d) of Section 128735 with the office within four months after the close of the facility's fiscal year, except as provided in paragraph (2).

(2) (A) If a licensee relinquishes the facility license or puts the facility licensure in suspense, the last day of active licensure shall be deemed a fiscal year end.

(B) If a fiscal year end is created because the facility license is relinquished or put in suspense, the facility shall file the reports required by subdivisions (a), (b), (c), and (d) of Section 128735 within two months after the last day of active licensure.

(3) The office shall make the reports filed pursuant to paragraph (1) available not later than three months after they are filed.

(4) (A) Effective for fiscal years ending on or after December 31, 1991, the reports required by subdivisions (a), (b), (c), and (d) of Section 128735 shall be filed with the office by electronic media, as determined by the office.

(B) Congregate living health facilities are exempt from the electronic media reporting requirements of subparagraph (A).

(c) A hospital shall file the reports required by subdivision (g) of Section 128735 as follows:

(1) For patient discharges on or after January 1, 1999, through December 31, 1999, the reports shall be filed semiannually by each hospital or its designee not later than six months after the end of each semiannual period, and shall be available from the office no later than six months after the date that the report was filed.

(2) For patient discharges on or after January 1, 2000, through December 31, 2000, the reports shall be filed semiannually by each hospital or its designee not later than three months after the end of each semiannual period. The reports shall be filed by electronic tape, diskette, or similar medium as approved by the office. The office shall approve or reject each report within 15 days of receiving it. If a report does

not meet the standards established by the office, it shall not be approved as filed and shall be rejected. The report shall be considered not filed as of the date the facility is notified that the report is rejected. A report shall be available from the office no later than 15 days after the date that the report is approved.

(3) For patient discharges on or after January 1, 2001, the reports shall be filed by each hospital or its designee for report periods and at times determined by the office. The reports shall be filed by online transmission in formats consistent with national standards for the exchange of electronic information. The office shall approve or reject each report within 15 days of receiving it. If a report does not meet the standards established by the office, it shall not be approved as filed and shall be rejected. The report shall be considered not filed as of the date the facility is notified that the report is rejected. A report shall be available from the office no later than 15 days after the date that the report is approved.

(d) The reports required by subdivision (a) of Section 128736 shall be filed by each hospital for report periods and at times determined by the office. The reports shall be filed by online transmission in formats consistent with national standards for the exchange of electronic information. The office shall approve or reject each report within 15 days of receiving it. If a report does not meet the standards established by the office, it shall not be approved as filed and shall be rejected. The report shall be considered not filed as of the date the facility is notified that the report is rejected. A report shall be available from the office no later than 15 days after the report is approved.

(e) The reports required by subdivision (a) of Section 128737 shall be filed by each hospital or freestanding ambulatory surgery clinic for report periods and at times determined by the office. The reports shall be filed by online transmission in formats consistent with national standards for the exchange of electronic information. The office shall approve or reject each report within 15 days of receiving it. If a report does not meet the standards established by the office, it shall not be approved as filed and shall be rejected. The report shall be considered not filed as of the date the facility is notified that the report is rejected. A report shall be available from the office no later than 15 days after the report is approved.

(f) Facilities shall not be required to maintain a full-time electronic connection to the office for the purposes of online transmission of reports as specified in subdivisions (c), (d), and (e). The office may grant exemptions to the online transmission of data requirements for limited periods to facilities. An exemption may be granted only to a facility that submits a written request and documents or demonstrates a specific need for an exemption. Exemptions shall be granted for no more than one year at a time, and for no more than a total of five consecutive years.

(g) The reports referred to in paragraph (2) of subdivision (a) of Section 128730 shall be filed with the office on the dates required by applicable law and shall be available from the office no later than six months after the date that the report was filed.

(h) The office shall post on its Internet Web site and make available to any person a copy of any report referred to in subdivision (a), (b), (c), (d), or (g) of Section 128735, subdivision (a) of Section 128736, subdivision (a) of Section 128737, Section 128740, and, in addition, shall make available in electronic formats reports referred to in subdivision (a), (b), (c), (d), or (g) of Section 128735, subdivision (a) of

Section 128736, subdivision (a) of Section 128737, Section 128740, and subdivisions (a) and (c) of Section 128745, unless the office determines that an individual patient's rights of confidentiality would be violated. The office shall make the reports available at cost.

(Amended by Stats. 2012, Ch. 673, Sec. 11. Effective January 1, 2013.)

128760.

(a) On and after January 1, 1986, those systems of health facility accounting and auditing formerly approved by the California Health Facilities Commission shall remain in full force and effect for use by health facilities but shall be maintained by the office.

(b) The office shall allow and provide, in accordance with appropriate regulations, for modifications in the accounting and reporting systems for use by health facilities in meeting the requirements of this chapter if the modifications are necessary to do any of the following:

(1) To correctly reflect differences in size of, provision of, or payment for, services rendered by health facilities.

(2) To correctly reflect differences in scope, type, or method of provision of, or payment for, services rendered by health facilities.

(3) To avoid unduly burdensome costs for those health facilities in meeting the requirements of differences pursuant to paragraphs (1) and (2).

(c) Modifications to discharge data reporting requirements. The office shall allow and provide, in accordance with appropriate regulations, for modifications to discharge data reporting format and frequency requirements if these modifications will not impair the office's ability to process the data or interfere with the purposes of this chapter. This modification authority shall not be construed to permit the office to administratively require the reporting of discharge data items not specified pursuant to Section 128735.

(d) Modifications to emergency care data reporting requirements. The office shall allow and provide, in accordance with appropriate regulations, for modifications to emergency care data reporting format and frequency requirements if these modifications will not impair the office's ability to process the data or interfere with the purposes of this chapter. This modification authority shall not be construed to permit the office to require administratively the reporting of emergency care data items not specified in subdivision (a) of Section 128736.

(e) Modifications to ambulatory surgery data reporting requirements. The office shall allow and provide, in accordance with appropriate regulations, for modifications to ambulatory surgery data reporting format and frequency requirements if these modifications will not impair the office's ability to process the data or interfere with the purposes of this chapter. The modification authority shall not be construed to permit the office to require administratively the reporting of ambulatory surgery data items not specified in subdivision (a) of Section 128737.

(f) Reporting provisions for health facilities. The office shall establish specific reporting provisions for health facilities that receive a preponderance of their revenue from associated comprehensive group practice prepayment health care service plans. These health facilities shall be authorized to utilize established accounting systems, and to report costs and revenues in a manner that is consistent with the operating principles of these plans and with generally accepted accounting principles. When these health facilities are operated as units of a coordinated group of health facilities under common management, they shall be authorized to report as a group rather than as individual institutions. As a group, they shall submit a consolidated income and expense statement.

(g) Hospitals authorized to report as a group under this subdivision may elect to file cost data reports required under the regulations of the Social Security Administration in its administration of Title XVIII of the federal Social Security Act in lieu of any comparable cost reports required under Section 128735. However, to the extent that cost data is required from other hospitals, the cost data shall be reported for each individual institution.

(h) The office shall adopt comparable modifications to the financial reporting requirements of this chapter for county hospital systems consistent with the purposes of this chapter.

(Amended by Stats. 2011, Ch. 32, Sec. 32. Effective June 29, 2011. Operative January 1, 2012, by Sec. 73 of Stats. 2011, Ch. 32.)

128765.

(a) The office shall maintain a file of all the reports filed under this chapter at its Sacramento office. Subject to any rules the office may prescribe, these reports shall be produced and made available for inspection upon the demand of any person, and shall also be posted on its Web site, with the exception of discharge and encounter data that shall be available for public inspection unless the office determines, pursuant to applicable law, that an individual patient's rights of confidentiality would be violated.

(b) The reports published pursuant to Section 128745 shall include an executive summary, written in plain English to the maximum extent practicable, that shall include, but not be limited to, a discussion of findings, conclusions, and trends concerning the overall quality of medical outcomes, including a comparison to reports from prior years, for the procedure or condition studied by the report. The office shall disseminate the reports as widely as practical to interested parties, including, but not limited to, hospitals, providers, the media, purchasers of health care, consumer or patient advocacy groups, and individual consumers. The reports shall be posted on the office's Internet Web site.

(c) Copies certified by the office as being true and correct copies of reports properly filed with the office pursuant to this chapter, together with summaries, compilations, or supplementary reports prepared by the office, shall be introduced as evidence, where relevant, at any hearing, investigation, or other proceeding held, made, or taken by any state, county, or local governmental agency, board, or commission that participates as a purchaser of health facility services pursuant to the provisions of a publicly financed state or federal health care program. Each of these state, county, or local

governmental agencies, boards, and commissions shall weigh and consider the reports made available to it pursuant to the provisions of this subdivision in its formulation and implementation of policies, regulations, or procedures regarding reimbursement methods and rates in the administration of these publicly financed programs.

(d) The office shall compile and publish summaries of individual facility and aggregate data that do not contain patient-specific information for the purpose of public disclosure. The summaries shall be posted on the office's Internet Web site. The office may initiate and conduct studies as it determines will advance the purposes of this chapter.

(e) In order to assure that accurate and timely data are available to the public in useful formats, the office shall establish a public liaison function. The public liaison shall provide technical assistance to the general public on the uses and applications of individual and aggregate health facility data and shall provide the director with an annual report on changes that can be made to improve the public's access to data.

(Amended by Stats. 2011, Ch. 32, Sec. 33. Effective June 29, 2011. Operative January 1, 2012, by Sec. 73 of Stats. 2011, Ch. 32.)

128766.

(a) Notwithstanding Section 128765 or any other provision of law, the office, upon request, shall disclose information collected pursuant to subdivision (g) of Section 128735 and Sections 128736 and 128737, to any California hospital and any local health department or local health officer in California as set forth in Part 3 (commencing with Section 101000) of Division 101. The office shall disclose this same information to the National Center for Health Statistics or any other unit of the Centers for Disease Control and Prevention, or the Agency for Healthcare Research and Quality of the United States Department of Health and Human Services, for the purposes of conducting a statutorily authorized activity. All disclosures made pursuant to this section shall be consistent with the standards and limitations applicable to the disclosure of limited data sets as provided in Section 164.514 of Part 164 of Title 45 of the Code of Federal Regulations, relating to the privacy of health information.

(b) Any hospital that receives information pursuant to this section shall not disclose that information to any person or entity, except in response to a court order, search warrant, or subpoena, or as otherwise required or permitted by the federal medical privacy regulations contained in Parts 160 and 164 of Title 45 of the Code of Federal Regulations. In no case shall a hospital, contractor, or subcontractor reidentify or attempt to reidentify any information received pursuant to this section.

(c) No disclosure shall be made pursuant to this section if the director of the office has determined that the disclosure would create an unreasonable risk to patient privacy. The director shall provide a written explanation of the determination to the requester within 60 days.

(Added by Stats. 2004, Ch. 434, Sec. 1. Effective January 1, 2005.)

128770.

(a) Any health facility or freestanding ambulatory surgery clinic that does not file any report as required by this chapter with the office is liable for a civil penalty of one hundred dollars (\$100) a day for each day the filing of any report is delayed. No penalty shall be imposed if an extension is granted in accordance with the guidelines and procedures established by the office.

(b) Any health facility that does not use an approved system of accounting pursuant to the provisions of this chapter for purposes of submitting financial and statistical reports as required by this chapter shall be liable for a civil penalty of not more than five thousand dollars (\$5,000).

(c) Civil penalties are to be assessed and recovered in a civil action brought in the name of the people of the State of California by the office. Assessment of a civil penalty may, at the request of any health facility or freestanding ambulatory surgery clinic, be reviewed on appeal, and the penalty may be reduced or waived for good cause.

(d) Any money that is received by the office pursuant to this section shall be paid into the General Fund.

(Amended by Stats. 2011, Ch. 32, Sec. 34. Effective June 29, 2011. Operative January 1, 2012, by Sec. 73 of Stats. 2011, Ch. 32.)

128775.

(a) Any health facility or freestanding ambulatory surgery clinic affected by any determination made under this part by the office may petition the office for review of the decision. This petition shall be filed with the office within 15 business days, or within a greater time as the office may allow, and shall specifically describe the matters which are disputed by the petitioner.

(b) A hearing shall be commenced within 60 calendar days of the date on which the petition was filed. The hearing shall be held before an employee of the office, or an administrative law judge employed by the Office of Administrative Hearings. If held before an employee of the office, the hearing shall be held in accordance with any procedures as the office shall prescribe. If held before an administrative law judge employed by the Office of Administrative Hearings, the hearing shall be held in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. The employee or administrative law judge shall prepare a recommended decision including findings of fact and conclusions of law and present it to the office for its adoption. The decision of the office shall be in writing and shall be final. The decision of the office shall be made within 60 calendar days after the conclusion of the hearing and shall be effective upon filing and service upon the petitioner.

(c) Judicial review of any final action, determination, or decision may be had by any party to the proceedings as provided in Section 1094.5 of the Code of Civil Procedure. The decision of the office shall be upheld against a claim that its findings are not supported by the evidence unless the court determines that the findings are not supported by substantial evidence.

(d) The employee of the office, or the administrative law judge employed by the Office of Administrative Hearings or the Office of Administrative Hearings, may issue subpoenas and subpoenas duces tecum in a manner and subject to the conditions established by Article 11 (commencing with Section 11450.10) of Chapter 4.5 of Part 1 of Division 3 of Title 2 of the Government Code.

(e) This section shall become operative on July 1, 1997.

(Amended by Stats. 2011, Ch. 32, Sec. 35. Effective June 29, 2011. Operative January 1, 2012, by Sec. 73 of Stats. 2011, Ch. 32.)

128780.

Notwithstanding any other provision of law, the disclosure aspects of this chapter shall be deemed complete with respect to district hospitals, and no district hospital shall be required to report or disclose any additional financial or utilization data to any person or other entity except as is required by this chapter.

(Added by Stats. 1995, Ch. 415, Sec. 9. Effective January 1, 1996.)

128782.

Notwithstanding any other provision of law, upon the request of a small and rural hospital, as defined in Section 124840, the office shall do all of the following:

(a) If the hospital did not file financial reports with the office by electronic media as of January 1, 1993, the office shall, on a case-by-case basis, do one of the following:

(1) Exempt the small and rural hospital from any electronic filing requirements of the office regarding annual or quarterly financial disclosure reports specified in Sections 128735 and 128740.

(2) Provide a one-time reduction in the fee charged to the small and rural hospital not to exceed the maximum amount assessed pursuant to Section 127280 by an amount equal to the costs incurred by the small and rural hospital to purchase the computer hardware and software necessary to comply with any electronic filing requirements of the office regarding annual or quarterly financial disclosure reports specified in Sections 128735 and 128740.

(b) The office shall provide a one-time reduction in the fee charged to the small and rural hospital not to exceed the maximum amount assessed pursuant to Section 127280 by an amount equal to the costs incurred by the small and rural hospital to purchase the computer software and hardware necessary to comply with any electronic filing requirements of the office regarding reports specified in Sections 128735, 128736, and 128737.

(c) The office shall provide the hospital with assistance in meeting the requirements specified in paragraphs (1) and (2) of subdivision (c) of Section 128755 that the reports required by subdivision (g) of Section 128735 be filed by electronic media or by online transmission. The assistance shall include the provision to the hospital by the office of a computer program or computer software to create an

electronic file of patient discharge abstract data records. The program or software shall incorporate validity checks and edit standards.

(d) The office shall provide the hospital with assistance in meeting the requirements specified in subdivision (d) of Section 128755 that the reports required by subdivision (a) of Section 128736 be filed by online transmission. The assistance shall include the provision to the hospital by the office of a computer program or computer software to create an electronic file of emergency care data records. The program or software shall incorporate validity checks and edit standards.

(e) The office shall provide the hospital with assistance in meeting the requirements specified in subdivision (e) of Section 128755 that the reports required by subdivision (a) of Section 128737 be filed by online transmission. The assistance shall include the provision to the hospital by the office of a computer program or computer software to create an electronic file of ambulatory surgery data records. The program or software shall incorporate validity checks and edit standards.

(Amended by Stats. 1998, Ch. 735, Sec. 14. Effective January 1, 1999.)

128785.

On January 1, 1986, all regulations previously adopted by the California Health Facilities Commission that relate to functions vested in the office and that are in effect on that date, shall remain in effect and shall be fully enforceable to the extent that they are consistent with this chapter, as determined by the office, unless and until readopted, amended, or repealed by the office.

(Amended by Stats. 2011, Ch. 32, Sec. 36. Effective June 29, 2011. Operative January 1, 2012, by Sec. 73 of Stats. 2011, Ch. 32.)

128790.

Pursuant to Section 16304.9 of the Government Code, the Controller shall transfer to the office the unexpended balance of funds as of January 1, 1986, in the California Health Facilities Commission Fund, available for use in connection with the performance of the functions of the California Health Facilities Commission to which it has succeeded pursuant to this chapter.

(Added by Stats. 1995, Ch. 415, Sec. 9. Effective January 1, 1996.)

128795.

All officers and employees of the California Health Facilities Commission who, on December 31, 1985, are serving the state civil service, other than as temporary employees, and engaged in the performance of a function vested in the office by this chapter shall be transferred to the office. The status, positions, and rights of persons shall not be affected by the transfer and shall be retained by them as officers and employees of the office, pursuant to the State Civil Service Act except as to positions exempted from civil service.

(Added by Stats. 1995, Ch. 415, Sec. 9. Effective January 1, 1996.)

128800.

The office shall have possession and control of all records, papers, offices, equipment, supplies, moneys, funds, appropriations, land, or other property, real or personal, held for the benefit or use of the California Health Facilities Commission for the performance of functions transferred to the office by this chapter.

(Added by Stats. 1995, Ch. 415, Sec. 9. Effective January 1, 1996.)

128805.

The office may enter into agreements and contracts with any person, department, agency, corporation, or legal entity as are necessary to carry out the functions vested in the office by this chapter or any other law.

(Added by Stats. 1995, Ch. 415, Sec. 9. Effective January 1, 1996.)

128810.

The office shall administer this chapter and shall make all regulations necessary to implement the provisions and achieve the purposes stated herein.

(Amended by Stats. 2011, Ch. 32, Sec. 37. Effective June 29, 2011. Operative January 1, 2012, by Sec. 73 of Stats. 2011, Ch. 32.)

HSCHealth and Safety Code - HSC

127280.

(a) Every health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2, except a health facility owned and operated by the state, shall each year be charged a fee established by the office consistent with the requirements of this section.

(b) Commencing in calendar year 2004, every freestanding ambulatory surgery clinic as defined in Section 128700, shall each year be charged a fee established by the office consistent with the requirements of this section.

(c) The fee structure shall be established each year by the office to produce revenues equal to the appropriation made in the annual Budget Act or another statute to pay for the functions required to be performed by the office pursuant to this chapter, Article 2 (commencing with Section 127340) of Chapter 2, or Chapter 1 (commencing with Section 128675) of Part 5, and to pay for any other health-related programs administered by the office. The fee shall be due on July 1 and delinquent on July 31 of each year.

(d) The fee for a health facility that is not a hospital, as defined in subdivision (c) of Section 128700, shall be not more than 0.035 percent of the gross operating cost of the facility for the provision of health care services for its last fiscal year that ended on or before June 30 of the preceding calendar year.

(e) The fee for a hospital, as defined in subdivision (c) of Section 128700, shall be not more than 0.035 percent of the gross operating cost of the facility for the provision of health care services for its last fiscal year that ended on or before June 30 of the preceding calendar year.

(f) (1) The fee for a freestanding ambulatory surgery clinic shall be established at an amount equal to the number of ambulatory surgery data records submitted to the office pursuant to Section 128737 for encounters in the preceding calendar year multiplied by not more than fifty cents (\$0.50).

(2) (A) For the calendar year 2004 only, a freestanding ambulatory surgery clinic shall estimate the number of records it will file pursuant to Section 128737 for the calendar year 2004 and shall report that number to the office by March 12, 2004. The estimate shall be as accurate as possible. The fee in the calendar year 2004 shall be established initially at an amount equal to the estimated number of records reported multiplied by fifty cents (\$0.50) and shall be due on July 1 and delinquent on July 31, 2004.

(B) The office shall compare the actual number of records filed by each freestanding clinic for the calendar year 2004 pursuant to Section 128737 with the estimated number of records reported pursuant to subparagraph (A). If the actual number reported is less than the estimated number reported, the office shall reduce the fee of the clinic for calendar year 2005 by the amount of the difference multiplied by fifty cents (\$0.50). If the actual number reported exceeds the estimated number reported, the office shall increase the fee of the clinic for calendar year 2005 by the amount of the difference multiplied by fifty cents (\$0.50) unless the actual number reported is greater than 120 percent of the estimated number reported, in which case the office shall increase the fee of the clinic for calendar year 2005 by the amount of the difference, up to and including 120 percent of the estimated number, multiplied by fifty cents (\$0.50), and by the amount of the difference in excess of 120 percent of the estimated number multiplied by one dollar (\$1).

(g) There is hereby established the California Health Data and Planning Fund within the office for the purpose of receiving and expending fee revenues collected pursuant to this chapter.

(h) Any amounts raised by the collection of the special fees provided for by subdivisions (d), (e), and (f) that are not required to meet appropriations in the Budget Act for the current fiscal year shall remain in the California Health Data and Planning Fund and shall be available to the office in succeeding years when appropriated by the Legislature in the annual Budget Act or another statute, for expenditure under the provisions of this chapter, Article 2 (commencing with Section 127340) of Chapter 2, and Chapter 1 (commencing with Section 128675) of Part 5, or for any other health-related programs administered by the office, and shall reduce the amount of the special fees that the office is authorized to establish and charge.

(i) (1) No health facility liable for the payment of fees required by this section shall be issued a license or have an existing license renewed unless the fees are paid. A new, previously unlicensed, health facility shall be charged a pro rata fee to be established by the office during the first year of operation.

(2) The license of any health facility, against which the fees required by this section are charged, shall be revoked, after notice and hearing, if it is determined by the office that the fees required were not paid within the time prescribed by subdivision (c).

(j) This section shall become operative on January 1, 2002.

(Amended by Stats. 2011, Ch. 32, Sec. 17. Effective June 29, 2011. Operative January 1, 2012, by Sec. 73 of Stats. 2011, Ch. 32.)