California Law Excerpts Related to Patient-Level Data Reporting

Selected California statues requiring health facilities to report patient-level data to the Department of Health Care Access and Information are listed below.

To see the official version of California statues, visit the California Legislative Information web site at: http://leginfo.legislature.ca.gov/faces/codes.xhtml.

California Health and Safety Code
Division 107. Health Care Access and Information

Part 2. Health Policy and Planning
Chapter 1. Health Planning

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 department 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 department consistent with the requirements of this section.

(c) The fee structure shall be established each year by the department 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 department 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 department. 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 (f) 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 (f) 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 department 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 department 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 department 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 department 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 department 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 department 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 department 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 department 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 department, and shall reduce the amount of the special fees that the department is authorized to establish and charge. In no event, however, shall those amounts be used for programs administered by the department pursuant to Sections 127676, 127679, 127681, 127683, and 127685, that become effective on or after January 1, 2019.

(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 department 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 department 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. 2021, Ch. 143, Sec. 73. (AB 133) Effective July 27, 2021.)

Part 5. Health Policy and Planning
Chapter 1. Health Facility Data

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. (AB 106) Effective June 29, 2011. Operative January 1, 2012, by Sec. 73 of Stats. 2011, Ch. 32.)

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, and intermediate care facilities/developmentally disabled-continuous nursing, as defined in subdivision (m) of Section 1250, are not subject to this chapter.

(Amended by Stats. 2021, Ch. 143, Sec. 195. (AB 133) Effective July 27, 2021.)

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, congregate living, and hospice health facilities.

(g) "Department" means the Department of Health Care Access and Information.

(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. 2021, Ch. 143, Sec. 196. (AB 133) Effective July 27, 2021.)

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 department.

(Amended by Stats. 2021, Ch. 143, Sec. 197. (AB 133) Effective July 27, 2021.)

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

(1) Data required by the department pursuant to Section 127285.

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

(3) 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, the State Department of Public Health, and the California Health Benefit Exchange. The departments and the Exchange shall ensure that the patient's rights to confidentiality shall not be violated in any manner. The departments and the Exchange shall comply with all applicable policies and requirements involving review and oversight by the State Committee for the Protection of Human Subjects.

(b) The department 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 department 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.

(c) The Exchange shall report to the Governor and the Legislature on or before August 1, 2023, on the impacts to the Exchange associated with paragraph (3) of subdivision (a), including the impacts on premium rates for health plans offered through the Exchange. The report shall be submitted in compliance with Section 9795 of the Government Code.

(Amended by Stats. 2021, Ch. 143, Sec. 198. (AB 133) Effective July 27, 2021.)

128735.
An organization that operates, conducts, owns, or maintains a health facility, and the officers thereof, shall make and file with the department, at the times as the department shall require, all of the following reports on forms specified by the department that are 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.

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

(e) (1) 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.

(2) Notwithstanding paragraph (1), a health facility that receives a preponderance of its revenue from associated comprehensive group practice prepayment health care service plans and that is operated as a unit of a coordinated group of health facilities under common management may report the information required pursuant to subdivisions (a) and (d) for the group and not for each separately licensed health facility.

(f) Data reporting requirements established by the department 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) Preferred 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 on 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 on admission.

(13) Other diagnoses and whether the conditions were present on admission.

(14) External causes of morbidity and whether present on admission.

(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 department 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 (Division 10 (commencing with Section 7920.000) 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 department pursuant to the requirements of subdivision (g).

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

(k) On or before July 1, 2021, the department shall promulgate regulations as necessary to implement subdivision (e). A health facility that receives a preponderance of its revenue from associated comprehensive group practice prepayment health care service plans and that is operated as a unit of a coordinated group of health facilities under common management shall comply with the reporting requirements of subdivisions (b), (c), and (e) once the department finalizes related regulations.

(Amended by Stats. 2022, Ch. 28, Sec. 109. (SB 1380) Effective January 1, 2023.)

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) Preferred 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) External causes of morbidity.

(12) Principal procedure.

(13) Other procedures.

(14) Disposition of patient.

(15) Expected source of payment.

(16) 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 department 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 (Division 10 (commencing with Section 7920.000) 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 department pursuant to the requirements of subdivision (a).

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

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

(Amended by Stats. 2022, Ch. 28, Sec. 110. (SB 1380) Effective January 1, 2023.)

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) Preferred 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) External causes of morbidity.

(14) Disposition of patient.

(15) Expected source of payment.

(16) 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 department 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 (Division 10 (commencing with Section 7920.00) 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 department shall be consistent with national standards as applicable.

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

(Amended by Stats. 2022, Ch. 28, Sec. 111. (SB 1380) Effective January 1, 2023.)

128738.
(a) The department 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 department 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 department, 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. 2021, Ch. 143, Sec. 203. (AB 133) Effective July 27, 2021.)

128740.
(a) The following summary financial and utilization data shall be reported to the department by a hospital within 45 days of the end of a 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.

(17) (A) A balance sheet detailing the assets, liabilities, and net worth at the end of the quarter, as specified by the department.

(B) The department shall allow and provide for, in accordance with appropriate regulations, additions, or deletions to the summary financial and utilization data to mee the purposes of this chapter.

(b) The department may adopt regulations, including emergency regulations, necessary to implement this section.

(Amended by Stats. 2023, Ch. 6, Sec. 2. (AB 112) Effective May 15, 2023.)

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

Publication Date	*Period Covered*	*Procedures and Conditions Covered*
July 1993	1988-90	3
July 1994	1989-91	6
July 1995	1990-92	9

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

(b) The procedures and conditions for risk-adjusted outcome reports pursuant to subdivision (a) shall be divided among medical, surgical, and obstetric conditions or procedures and shall be selected by the department. The department shall publish the risk-adjusted outcome reports for selected conditions and procedures by individual hospital, individual medical group, or individual physician as selected by the department in consultation with medical specialists in the relevant area of practice. The selections, under this subdivision, 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 department 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) The department shall publish at least one risk-adjusted outcome report for coronary artery bypass graft surgery, transcatheter aortic valve replacement, or any type of interventional cardiovascular procedure for procedures performed in the state. For any type of interventional cardiovascular procedure other than coronary artery bypass graft surgery or transcatheter aortic valve replacement, the department shall only select from interventional cardiovascular procedures recommended by the clinical panel established by Section 128748, not to exceed one additional interventional cardiovascular procedure every three years. In each year, the reports shall compare

risk-adjusted outcomes by hospital, medical group, or physician as selected by the department after consultation with the clinical panel. Upon the recommendation of the clinical panel based on statistical and technical considerations, information on individual hospitals, individual medical groups, or individual physicians may be excluded from the reports.

(3) Each hospital shall produce and file with the department, at the times as the department shall require, reports of data the department needs to prepare risk-adjusted outcome reports under this subdivision. Unless otherwise recommended by the clinical panel established by Section 128748, the department shall continue to collect the same data used for the most recent risk-adjusted model developed for the California Coronary Artery Bypass Graft Outcomes Reporting Program. Upon recommendation of the clinical panel, the department may add any clinical data elements included in the Society of Thoracic Surgeons' database or other relevant databases to be collected from hospitals. Prior to any additions from the Society of Thoracic Surgeons' database, or other relevant databases, 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 department may add, delete, or revise clinical data elements to be collected from hospitals for outcome reports under this subdivision. 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 department shall collect the minimum data necessary for purposes of testing or validating a risk-adjusted model for the outcome reports under this subdivision.

(6) Patient medical record numbers and any other data elements that the department 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 (Division 10 (commencing with Section 7920.00) 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 at least the following groupings for each hospital, medical group, or physician:

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

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

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

(e) For outcome reports under this subdivision for which auditing is appropriate, the department

shall conduct periodic auditing of data at hospitals.

(f) The department 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, medical group, 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 department shall include any other analysis or comparisons of the data in the annual reports required under this section that the department deems appropriate to further the purposes of this chapter.

(Amended by Stats. 2022, Ch. 28, Sec. 112. (SB 1380) Effective January 1, 2023.)

128747.
Commencing July 1, 2002, and biennially thereafter, the department shall evaluate the impact of the department's published risk-adjusted outcome reports required by Section 128745 on mortality rates in California and on any other measure of quality the department deems appropriate. The department shall also coordinate with other state agencies in promoting prevention and educational initiatives on those reported procedures and conditions.

(Amended by Stats. 2021, Ch. 143, Sec. 206. (AB 133) Effective July 27, 2021.)

128748.
(a) This section shall apply to any risk-adjusted outcome report under Section 128745.

(b) This subdivision applies to risk-adjusted outcome reports under subdivision (c) of Section 128745.

(1) The department 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 department 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 department. In the event that the department finds any errors, omissions, discrepancies, or other problems with submitted data, the department shall contact either the hospital or physician's office that maintains the data to resolve the problems.

(2) The department 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 department 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 or an individual medical group authorized by subdivision (b) of Section 128745, the department 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, medical groups, 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 risk-adjusted outcome reports authorized by subdivision (c) of Section 128745 the following shall apply:

(1) The California Coronary Artery Bypass Graft Outcomes Reporting Program Clinical Advisory Panel shall become the clinical panel for those outcome reports and this panel shall be renamed by the department.

(2) This clinical panel shall be comprised of at least 9 and no more than 13 members. The department director shall have the authority to appoint the members of the clinical panel. 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 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. Any additional members shall be appointed at the discretion of the department director. If, at the time the department decides to report on a procedure, the panel does not have members with expertise in that procedure, the department shall seek to appoint two new members with expertise in that procedure from a list submitted by the California Chapter of the American College of Cardiology. 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. The panel may include physicians from another state.

(3) 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 department 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.

(Amended by Stats. 2021, Ch. 143, Sec. 207. (AB 133) Effective July 27, 2021.)

128750.

(a) Prior to the public release of the annual outcome reports, the department shall furnish a preliminary report to each hospital that is included in the report. The department 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 department, 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 or medical group, the department shall furnish a preliminary report to each physician or medical group

that is included in the report. The department shall allow the physician or medical group 30 days from the date the department sends the report to the physician or medical group to review the outcome scores and compare the scores to other California physicians or medical groups, respectively. A physician or medical group that believes that the risk-adjusted outcome does not accurately reflect the quality of care provided by the physician or medical group may submit a statement to the department within the 30 days, explaining why the outcomes do not accurately reflect the quality of care provided by the physician or medical group.

(2) The department shall promptly review the statement and shall respond to the physician or medical group with one of the following conclusions:

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

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

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

(3) If a physician or medical group is not satisfied with the conclusion reached by the department, the physician or medical group shall notify the department of that fact. Upon receipt of the notice, the department shall forward the statement to the appropriate clinical panel appointed pursuant to Section 128748. The department shall forward the statement with any information identifying the physician or medical group or the hospital of the physician or medical group redacted, or shall adopt other means to ensure the physician or medical group’s identity is not revealed to the panel. The clinical panel shall promptly review the 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 statement. The process set forth in this subdivision shall be completed within 60 days from the date the department sends the report to each physician or medical group included in the report. If a decision by either the department 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 or medical group submitting the statement.

(c) The department 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 department, 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 department 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 department with

the advice of the research community, physicians and surgeons, hospitals, consumer or patient advocacy groups, and medical records personnel.

(f) The department at a minimum shall identify a limited set of core clinical data elements to be collected for all of the selected 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 department 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 department shall also engage in a continuing process of data development and refinement applicable to both current and prospective outcome studies.

(Amended by Stats. 2021, Ch. 143, Sec. 208. (AB 133) Effective July 27, 2021.)

128755.

(a) (1) Hospitals shall file the reports required by subdivisions (a), (b), (c), and (d) of Section 128735 with the department 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 department 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 State Department of Health Care Services to participate in the Medi-Cal program, shall file the reports required by subdivisions (a), (b), (c), and (d) of Section 128735 with the department 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 department 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 department by electronic media, as determined by the department.

(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 department 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 department. The department shall approve or reject each report within 15 days of receiving it. If a report does not meet the standards established by the department, 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 department 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 department. The reports shall be filed by online transmission in formats consistent with national standards for the exchange of electronic information. The department shall approve or reject each report within 15 days of receiving it. If a report does not meet the standards established by the department, 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 department 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 department. The reports shall be filed by online transmission in formats consistent with national standards for the exchange of electronic information. The department shall approve or reject each report within 15 days of receiving it. If a report does not meet the standards established by the department, 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 department 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 department. The reports shall be filed by online transmission in formats consistent with national standards for the exchange of electronic information. The department shall approve or reject each report within 15 days of receiving it. If a report does not meet the standards established by the department, 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 department 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 department 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 department on the dates required by applicable law and shall be available from the department no later than six months after the date that the report was filed.

(h) The department shall post on its internet website 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 department determines that an individual patient's rights of confidentiality would be violated. The department shall make the reports available at cost.

(Amended by Stats. 2021, Ch. 143, Sec. 209. (AB 133) Effective July 27, 2021.)

128760.

(a) On and after January 1, 1986, the 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 department.

(b) The department 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) The department 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 department's ability to process the data or interfere with the purposes of this chapter. This modification authority shall not permit the department to administratively require the reporting of discharge data items not specified pursuant to Section 128735.

(d) The department 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 department's ability to process the data or interfere with the purposes of this chapter. This modification authority shall not permit the department to require administratively the reporting of emergency care data items not specified in subdivision (a) of Section 128736.

(e) The department 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 department's ability to process the data or interfere with the purposes of this chapter. The modification authority shall not permit the department to require administratively the reporting of ambulatory surgery data items not specified in subdivision (a) of Section 128737.

(f) The department 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. 2021, Ch. 143, Sec. 210. (AB 133) Effective July 27, 2021.)

128765.
(a) The department shall maintain a file of all the reports filed under this chapter at its Sacramento office. Subject to any rules the department 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 internet website with the exception of discharge and encounter data that shall be available for public inspection unless the department 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 department 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 department's internet website.

(c) Copies certified by the department as being true and correct copies of reports properly filed with the department pursuant to this chapter, together with summaries, compilations, or supplementary reports prepared by the department, 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 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 department shall compile and publish summaries of individual facility and aggregate data that do not contain patient-specific information for the purpose of public disclosure. Upon request, these shall include summaries of observation services data, in a format prescribed by the department. The summaries shall be posted on the department's internet website. The department may initiate and conduct studies as it determines will advance the purposes of this chapter.

(e) In order to ensure that accurate and timely data are available to the public in useful formats, the department 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. 2021, Ch. 143, Sec. 211. (AB 133) Effective July 27, 2021.)

128766.
(a) Notwithstanding Section 128765 or any other provision of law, the department, 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 department shall disclose this same information to the United States Department of Health and Human Services or any of its subsidiary agencies, including the National Center for Health Statistics or any other unit of the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the Health Resources and Services Administration, the Indian Health Service, Tribal Epidemiology Centers,

which are defined as public health authorities pursuant to the federal Indian Health Care Improvement Act (25 U.S.C. Sec. 1601 et seq.), the National Institutes of Health, or the National Cancer Institute, or the Veterans Health Care Administration within the United States Department of Veterans Affairs, 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 department 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.

(Amended by Stats. 2021, Ch. 143, Sec. 212. (AB 133) Effective July 27, 2021.)

128770.
(a) Any health facility or freestanding ambulatory surgery clinic that does not file any report as required by this chapter with the department 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 department.

(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 department. 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 department pursuant to this section shall be paid into the General Fund.

(Amended by Stats. 2021, Ch. 143, Sec. 213. (AB 133) Effective July 27, 2021.)

128775.
(a) Any health facility or freestanding ambulatory surgery clinic affected by any determination made under this part by the department may petition the department for review of the decision. This petition shall be filed with the department within 15 business days, or within a greater time as the department 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 department, or an administrative law judge employed by the Office of Administrative Hearings. If held before an employee of the department, 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 department for its adoption. The decision of the department shall be in writing and shall be final. The decision of the department 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 department 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. 2021, Ch. 143, Sec. 214. (AB 133) Effective July 27, 2021.)

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 department shall do all of the following:

(a) If the hospital did not file financial reports with the department by electronic media as of January 1, 1993, the department 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 department 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 department regarding annual or quarterly financial disclosure reports specified in Sections 128735 and 128740.

(b) The department 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 department regarding reports specified in Sections 128735, 128736, and 128737.

(c) The department 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 department 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 department 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 department 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 department 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 department 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. 2021, Ch. 143, Sec. 215. (AB 133) Effective July 27, 2021.)

128785.
On January 1, 1986, all regulations previously adopted by the California Health Facilities Commission that relate to functions vested in the department 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 department, unless and until readopted, amended, or repealed by the department.

(Amended by Stats. 2021, Ch. 143, Sec. 216. (AB 133) Effective July 27, 2021.)

128790.
Pursuant to Section 16304.9 of the Government Code, the Controller shall transfer to the department 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.

(Amended by Stats. 2021, Ch. 143, Sec. 217. (AB 133) Effective July 27, 2021.)

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 department by this chapter shall be transferred to the department. 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 department, pursuant to the State Civil Service Act except as to positions exempted from civil service.

(Amended by Stats. 2021, Ch. 143, Sec. 218. (AB 133) Effective July 27, 2021.)

128800.
The department 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 department by this chapter.

(Amended by Stats. 2021, Ch. 143, Sec. 219. (AB 133) Effective July 27, 2021.)

128805.
The department 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 department by this chapter or any other law.

(Amended by Stats. 2021, Ch. 143, Sec. 220. (AB 133) Effective July 27, 2021.)

128810.
The department shall administer this chapter and shall make all regulations necessary to implement the provisions and achieve the purposes stated herein.

(Amended by Stats. 2021, Ch. 143, Sec. 221. (AB 133) Effective July 27, 2021.)