

AMENDED IN ASSEMBLY MARCH 17, 2025

CALIFORNIA LEGISLATURE—2025–26 REGULAR SESSION

**ASSEMBLY BILL**

**No. 787**

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**Introduced by Assembly Member Papan**

February 18, 2025

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An act to amend Section ~~127345~~ 1367.27 of the Health and Safety Code, ~~relating to hospitals~~, and to amend Section 10133.15 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL’S DIGEST

AB 787, as amended, Papan. ~~Hospitals; community benefits. Provider directory disclosures.~~

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires specified health care service plans and health insurers to publish and maintain a provider directory or directories with information on contracting providers that deliver health care services to enrollees or insureds, and requires a health care service plan or health insurer to regularly update its printed and online provider directory or directories, as specified. Existing law requires provider directories to include specified information and disclosures.

This bill would require a full service health care service plan, specialized mental health plan, health insurer, or specialized mental health insurer to include in its provider directory or directories a statement at the top of the directory advising an enrollee or insured to contact the plan or insurer for assistance in finding an in-network

provider. The bill would require the plan or insurer to respond within 24 hours if contacted for that assistance, and to provide a list of in-network providers confirmed to be accepting new patients within 2 business days. Because a violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

~~Existing law requires a private not-for-profit acute hospital to annually adopt and update a community benefits plan that describes the activities that the hospital has undertaken to address identified community needs within its mission and financial capacity. Under existing law, “community benefit” includes, among other things, health care services rendered to vulnerable populations, including, but not limited to, charity care and the unreimbursed cost of providing services to the uninsured, underinsured, and persons eligible for specified public health care programs. Existing law requires the hospital to annually submit its community benefits plan to the Department of Health Care Access and Information.~~

~~This bill would make technical, nonsubstantive changes to certain definitions for purposes of the above-described provisions.~~

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

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

- 1     SECTION 1. Section 1367.27 of the Health and Safety Code
- 2     is amended to read:
- 3     1367.27. (a) Commencing July 1, 2016, a health care service
- 4     plan shall publish and maintain a provider directory or directories
- 5     with information on contracting providers that deliver health care
- 6     services to the plan’s enrollees, including those that accept new
- 7     patients. A provider directory shall not list or include information
- 8     on a provider that is not currently under contract with the plan.
- 9     (b) A health care service plan shall provide the directory or
- 10    directories for the specific network offered for each product using

1 a consistent method of network and product naming, numbering,  
2 or other classification method that ensures the public, enrollees,  
3 potential enrollees, the department, and other state or federal  
4 agencies can easily identify the networks and plan products in  
5 which a provider participates. By July 31, 2017, or 12 months after  
6 the date provider directory standards are developed under  
7 subdivision (k), whichever occurs later, a health care service plan  
8 shall use the naming, numbering, or classification method  
9 developed by the department pursuant to subdivision (k).

10 (c) (1) An online provider directory or directories shall be  
11 available on the plan's ~~Internet Web site~~ *internet website* to the  
12 public, potential enrollees, enrollees, and providers without any  
13 restrictions or limitations. The directory or directories shall be  
14 accessible without any requirement that an individual seeking the  
15 directory information demonstrate coverage with the plan, indicate  
16 interest in obtaining coverage with the plan, provide a member  
17 identification or policy number, provide any other identifying  
18 information, or create or access an account.

19 (2) The online provider directory or directories shall be  
20 accessible on the plan's public ~~Internet Web site~~ *internet website*  
21 through an identifiable link or tab and in a manner that is accessible  
22 and searchable by enrollees, potential enrollees, the public, and  
23 providers. By July 31, 2017, or 12 months after the date provider  
24 directory standards are developed under subdivision (k), whichever  
25 occurs later, the plan's public ~~Internet Web site~~ *internet website*  
26 shall allow provider searches by, at a minimum, name, practice  
27 address, city, ZIP Code, California license number, National  
28 Provider Identifier number, admitting privileges to an identified  
29 hospital, product, tier, provider language or languages, provider  
30 group, hospital name, facility name, or clinic name, as appropriate.

31 (d) (1) A health care service plan shall allow enrollees, potential  
32 enrollees, providers, and members of the public to request a printed  
33 copy of the provider directory or directories by contacting the plan  
34 through the plan's toll-free telephone number, electronically, or  
35 in writing. A printed copy of the provider directory or directories  
36 shall include the information required in subdivisions (h) and (i).  
37 The printed copy of the provider directory or directories shall be  
38 provided to the requester by mail postmarked no later than five  
39 business days following the date of the request and may be limited

1 to the geographic region in which the requester resides or works  
2 or intends to reside or work.

3 (2) A health care service plan shall update its printed provider  
4 directory or directories at least quarterly, or more frequently, if  
5 required by federal law.

6 (e) (1) The plan shall update the online provider directory or  
7 directories, at least weekly, or more frequently, if required by  
8 federal law, when informed of and upon confirmation by the plan  
9 of any of the following:

10 (A) A contracting provider is no longer accepting new patients  
11 for that product, or an individual provider within a provider group  
12 is no longer accepting new patients.

13 (B) A provider is no longer under contract for a particular plan  
14 product.

15 (C) A provider's practice location or other information required  
16 under subdivision (h) or (i) has changed.

17 (D) Upon completion of the investigation described in  
18 subdivision (o), a change is necessary based on an enrollee  
19 complaint that a provider was not accepting new patients, was  
20 otherwise not available, or whose contact information was listed  
21 incorrectly.

22 (E) Any other information that affects the content or accuracy  
23 of the provider directory or directories.

24 (2) Upon confirmation of any of the following, the plan shall  
25 delete a provider from the directory or directories when:

26 (A) A provider has retired or otherwise has ceased to practice.

27 (B) A provider or provider group is no longer under contract  
28 with the plan for any reason.

29 (C) The contracting provider group has informed the plan that  
30 the provider is no longer associated with the provider group and  
31 is no longer under contract with the plan.

32 (f) The provider directory or directories shall include both an  
33 email address and a telephone number for members of the public  
34 and providers to notify the plan if the provider directory  
35 information appears to be inaccurate. This information shall be  
36 disclosed prominently in the directory or directories and on the  
37 plan's ~~Internet Web site~~ *internet website*.

38 (g) The provider directory or directories shall include the  
39 following disclosures informing enrollees that they are entitled to  
40 both of the following:

1 (1) Language interpreter services, at no cost to the enrollee,  
2 including how to obtain interpretation services in accordance with  
3 Section 1367.04.

4 (2) Full and equal access to covered services, including enrollees  
5 with disabilities as required under the federal Americans with  
6 Disabilities Act of 1990 and Section 504 of the Rehabilitation Act  
7 of 1973.

8 (h) A full service health care service plan and a specialized  
9 mental health plan shall include all of the following information  
10 in the provider directory or directories:

11 (1) The provider's name, practice location or locations, and  
12 contact information.

13 (2) Type of practitioner.

14 (3) National Provider Identifier number.

15 (4) California license number and type of license.

16 (5) The area of specialty, including board certification, if any.

17 (6) The provider's office email address, if available.

18 (7) The name of each affiliated provider group currently under  
19 contract with the plan through which the provider sees enrollees.

20 (8) A listing for each of the following providers that are under  
21 contract with the plan:

22 (A) For physicians and surgeons, the provider group, and  
23 admitting privileges, if any, at hospitals contracted with the plan.

24 (B) Nurse practitioners, physician assistants, psychologists,  
25 acupuncturists, optometrists, podiatrists, chiropractors, licensed  
26 clinical social workers, marriage and family therapists, professional  
27 clinical counselors, qualified autism service providers, as defined  
28 in Section 1374.73, ~~nurse midwives~~, *nurse-midwives*, and dentists.

29 (C) For federally qualified health centers or primary care clinics,  
30 the name of the federally qualified health center or clinic.

31 (D) For any provider described in subparagraph (A) or (B) who  
32 is employed by a federally qualified health center or primary care  
33 clinic, and to the extent their services may be accessed and are  
34 covered through the contract with the plan, the name of the  
35 provider, and the name of the federally qualified health center or  
36 clinic.

37 (E) Facilities, including, but not limited to, general acute care  
38 hospitals, skilled nursing facilities, urgent care clinics, ambulatory  
39 surgery centers, inpatient hospice, residential care facilities, and  
40 inpatient rehabilitation facilities.

1 (F) Pharmacies, clinical laboratories, imaging centers, and other  
2 facilities providing contracted health care services.

3 (9) The provider directory or directories may note that  
4 authorization or referral may be required to access some providers.

5 (10) Non-English language, if any, spoken by a health care  
6 provider or other medical professional as well as non-English  
7 language spoken by a qualified medical interpreter, in accordance  
8 with Section 1367.04, if any, on the provider's staff.

9 (11) Identification of providers who no longer accept new  
10 patients for some or all of the plan's products.

11 (12) The network tier to which the provider is assigned, if the  
12 provider is not in the lowest tier, as applicable. ~~Nothing in this~~  
13 ~~section shall be construed to~~ *This section does not* require the use  
14 of network tiers other than contract and noncontracting tiers.

15 *(13) A statement at the top of the directory advising an enrollee*  
16 *to contact the health care service plan for assistance in finding an*  
17 *in-network provider.*

18 ~~(13)~~

19 (14) All other information necessary to conduct a search  
20 pursuant to paragraph (2) of subdivision (c).

21 (i) A vision, dental, or other specialized health care service plan,  
22 except for a specialized mental health plan, shall include all of the  
23 following information for each provider directory or directories  
24 used by the plan for its networks:

25 (1) The provider's name, practice location or locations, and  
26 contact information.

27 (2) Type of practitioner.

28 (3) National Provider Identifier number.

29 (4) California license number and type of license, if applicable.

30 (5) The area of specialty, including board certification, or other  
31 accreditation, if any.

32 (6) The provider's office email address, if available.

33 (7) The name of each affiliated provider group or specialty plan  
34 practice group currently under contract with the plan through which  
35 the provider sees enrollees.

36 (8) The names of each allied health care professional to the  
37 extent there is a direct contract for those services covered through  
38 a contract with the plan.

39 (9) The non-English language, if any, spoken by a health care  
40 provider or other medical professional as well as non-English

1 language spoken by a qualified medical interpreter, in accordance  
2 with Section 1367.04, if any, on the provider's staff.

3 (10) Identification of providers who no longer accept new  
4 patients for some or all of the plan's products.

5 (11) All other applicable information necessary to conduct a  
6 provider search pursuant to paragraph (2) of subdivision (c).

7 (j) (1) The contract between the plan and a provider shall  
8 include a requirement that the provider inform the plan within five  
9 business days when either of the following occurs:

10 (A) The provider is not accepting new patients.

11 (B) If the provider had previously not accepted new patients,  
12 the provider is currently accepting new patients.

13 (2) If a provider who is not accepting new patients is contacted  
14 by an enrollee or potential enrollee seeking to become a new  
15 patient, the provider shall direct the enrollee or potential enrollee  
16 to both the plan for additional assistance in finding a provider and  
17 to the department to report any inaccuracy with the plan's directory  
18 or directories.

19 (3) If an enrollee or potential enrollee informs a plan of a  
20 possible inaccuracy in the provider directory or directories, the  
21 plan shall promptly ~~investigate~~, *investigate* and, if necessary,  
22 undertake corrective action within 30 business days to ensure the  
23 accuracy of the directory or directories.

24 (k) (1) On or before December 31, 2016, the department shall  
25 develop uniform provider directory standards to permit consistency  
26 in accordance with subdivision (b) and paragraph (2) of subdivision  
27 (c) and development of a multiplan directory by another entity.  
28 Those standards shall not be subject to the Administrative  
29 Procedure Act (Chapter 3.5 (commencing with Section 11340) of  
30 Part 1 of Division 3 of Title 2 of the Government Code), until  
31 January 1, 2021. No more than two revisions of those standards  
32 shall be exempt from the Administrative Procedure Act (Chapter  
33 3.5 (commencing with Section 11340) of Part 1 of Division 3 of  
34 Title 2 of the Government Code) pursuant to this subdivision.

35 (2) In developing the standards under this subdivision, the  
36 department shall seek input from interested parties throughout the  
37 process of developing the standards and shall hold at least one  
38 public meeting. The department shall take into consideration any  
39 requirements for provider directories established by the federal

Centers for Medicare and Medicaid Services and the State Department of Health Care Services.

(3) By July 31, 2017, or 12 months after the date provider directory standards are developed under this subdivision, whichever occurs later, a plan shall use the standards developed by the department for each product offered by the plan.

(l) (1) A plan shall take appropriate steps to ensure the accuracy of the information concerning each provider listed in the plan's provider directory or directories in accordance with this section, and shall, at least annually, review and update the entire provider directory or directories for each product offered. Each calendar year the plan shall notify all contracted providers described in subdivisions (h) and (i) as follows:

(A) For individual providers who are not affiliated with a provider group described in subparagraph (A) or (B) of paragraph (8) of subdivision (h) and providers described in subdivision (i), the plan shall notify each provider at least once every six months.

(B) For all other providers described in subdivision (h) who are not subject to the requirements of subparagraph (A), the plan shall notify its contracted providers to ensure that all of the providers are contacted by the plan at least once annually.

(2) The notification shall include all of the following:

(A) The information the plan has in its directory or directories regarding the provider or provider group, including a list of networks and plan products that include the contracted provider or provider group.

(B) A statement that the failure to respond to the notification may result in a delay of payment or reimbursement of a claim pursuant to subdivision (p).

(C) Instructions on how the provider or provider group can update the information in the provider directory or directories using the online interface developed pursuant to subdivision (m).

(3) The plan shall require an affirmative response from the provider or provider group acknowledging that the notification was received. The provider or provider group shall confirm that the information in the provider directory or directories is current and accurate or update the information required to be in the directory or directories pursuant to this section, including whether or not the provider or provider group is accepting new patients for each plan product.



1 (4) If the plan does not receive an affirmative response and  
2 confirmation from the provider that the information is current and  
3 accurate or, as an alternative, updates any information required to  
4 be in the directory or directories pursuant to this section, within  
5 30 business days, the plan shall take no more than 15 business  
6 days to verify whether the provider's information is correct or  
7 requires updates. The plan shall document the receipt and outcome  
8 of each attempt to verify the information. If the plan is unable to  
9 verify whether the provider's information is correct or requires  
10 updates, the plan shall notify the provider 10 business days in  
11 advance of removal that the provider will be removed from the  
12 provider directory or directories. The provider shall be removed  
13 from the provider directory or directories at the next required  
14 update of the provider directory or directories after the  
15 10-business-day notice period. A provider shall not be removed  
16 from the provider directory or directories if ~~he or she~~ *the provider*  
17 responds before the end of the 10-business-day notice period.

18 (5) General acute care hospitals shall be exempt from the  
19 requirements in paragraphs (3) and (4).

20 (m) A plan shall establish policies and procedures with regard  
21 to the regular updating of its provider directory or directories,  
22 including the weekly, quarterly, and annual updates required  
23 pursuant to this section, or more frequently, if required by federal  
24 law or guidance.

25 (1) The policies and procedures described under this subdivision  
26 shall be submitted by a plan annually to the department for  
27 approval and in a format described by the department pursuant to  
28 Section 1367.035.

29 (2) Every health care service plan shall ensure processes are in  
30 place to allow providers to promptly verify or submit changes to  
31 the information required to be in the directory or directories  
32 pursuant to this section. Those processes shall, at a minimum,  
33 include an online interface for providers to submit verification or  
34 changes electronically and shall generate an acknowledgment of  
35 receipt from the health care service plan. Providers shall verify or  
36 submit changes to information required to be in the directory or  
37 directories pursuant to this section using the process required by  
38 the health care service plan.

39 (3) The plan shall establish and maintain a process for enrollees,  
40 potential enrollees, other providers, and the public to identify and

1 report possible inaccurate, incomplete, or misleading information  
2 currently listed in the plan's provider directory or directories. This  
3 process shall, at a minimum, include a telephone number and a  
4 dedicated email address at which the plan will accept these reports,  
5 as well as a hyperlink on the plan's provider directory ~~Internet~~  
6 ~~Web site~~ *internet website* linking to a form where the information  
7 can be reported directly to the plan through its ~~Internet Web site~~.  
8 *internet website*.

9 (n) (1) This section does not prohibit a plan from requiring its  
10 provider groups or contracting specialized health care service plans  
11 to provide information to the plan that is required by the plan to  
12 satisfy the requirements of this section for each of the providers  
13 that contract with the provider group or contracting specialized  
14 health care service plan. This responsibility shall be specifically  
15 documented in a written contract between the plan and the provider  
16 group or contracting specialized health care service plan.

17 (2) If a plan requires its contracting provider groups or  
18 contracting specialized health care service plans to provide the  
19 plan with information described in paragraph (1), the plan shall  
20 continue to retain responsibility for ensuring that the requirements  
21 of this section are satisfied.

22 (3) A provider group may terminate a contract with a provider  
23 for a pattern or repeated failure of the provider to update the  
24 information required to be in the directory or directories pursuant  
25 to this section.

26 (4) A provider group is not subject to the payment delay  
27 described in subdivision (p) if all of the following occurs:

28 (A) A provider does not respond to the provider group's attempt  
29 to verify the provider's information. As used in this paragraph,  
30 "verify" means to contact the provider in writing, electronically,  
31 and by telephone to confirm whether the provider's information  
32 is correct or requires updates.

33 (B) The provider group documents its efforts to verify the  
34 provider's information.

35 (C) The provider group reports to the plan that the provider  
36 should be deleted from the provider group in the plan directory or  
37 directories.

38 (5) Section 1375.7, known as the Health Care Providers' Bill  
39 of Rights, applies to any material change to a provider contract  
40 pursuant to this section.

1 (o) (1) Whenever a health care service plan receives a report  
2 indicating that information listed in its provider directory or  
3 directories is inaccurate, the plan shall promptly investigate the  
4 reported inaccuracy and, no later than 30 business days following  
5 receipt of the report, either verify the accuracy of the information  
6 or update the information in its provider directory or directories,  
7 as applicable.

8 (2) When investigating a report regarding its provider directory  
9 or directories, the plan shall, at a minimum, do the following:

10 (A) Contact the affected provider no later than five business  
11 days following receipt of the report.

12 (B) Document the receipt and outcome of each report. The  
13 documentation shall include the provider's name, location, and a  
14 description of the plan's investigation, the outcome of the  
15 investigation, and any changes or updates made to its provider  
16 directory or directories.

17 (C) If changes to a plan's provider directory or directories are  
18 required as a result of the plan's investigation, the changes to the  
19 online provider directory or directories shall be made no later than  
20 the next scheduled weekly update, or the update immediately  
21 following that update, or sooner if required by federal law or  
22 regulations. For printed provider directories, the change shall be  
23 made no later than the next required update, or sooner if required  
24 by federal law or regulations.

25 (p) (1) Notwithstanding Sections 1371 and 1371.35, a plan may  
26 delay payment or reimbursement owed to a provider or provider  
27 group as specified in subparagraph (A) or (B), if the provider or  
28 provider group fails to respond to the plan's attempts to verify the  
29 provider's or provider group's information as required under  
30 subdivision (l). The plan shall not delay payment unless it has  
31 attempted to verify the provider's or provider group's information.  
32 As used in this subdivision, "verify" means to contact the provider  
33 or provider group in writing, electronically, and by telephone to  
34 confirm whether the provider's or provider group's information  
35 is correct or requires updates. A plan may seek to delay payment  
36 or reimbursement owed to a provider or provider group only after  
37 the ~~10-business-day~~ 10-business-day notice period described in  
38 paragraph (4) of subdivision (l) has lapsed.

39 (A) For a provider or provider group that receives compensation  
40 on a capitated or prepaid basis, the plan may delay no more than

1 50 percent of the next scheduled capitation payment for up to one  
2 calendar month.

3 (B) For any claims payment made to a provider or provider  
4 group, the plan may delay the claims payment for up to one  
5 calendar month beginning on the first day of the following month.

6 (2) A plan shall notify the provider or provider group 10  
7 business days before it seeks to delay payment or reimbursement  
8 to a provider or provider group pursuant to this subdivision. If the  
9 plan delays a payment or reimbursement pursuant to this  
10 subdivision, the plan shall reimburse the full amount of any  
11 payment or reimbursement subject to delay to the provider or  
12 provider group according to either of the following timelines, as  
13 applicable:

14 (A) No later than three business days following the date on  
15 which the plan receives the information required to be submitted  
16 by the provider or provider group pursuant to subdivision (l).

17 (B) At the end of the ~~one-calendar month~~ *one-calendar-month*  
18 delay described in subparagraph (A) or (B) of paragraph (1), as  
19 applicable, if the provider or provider group fails to provide the  
20 information required to be submitted to the plan pursuant to  
21 subdivision (l).

22 (3) A plan may terminate a contract for a pattern or repeated  
23 failure of the provider or provider group to alert the plan to a  
24 change in the information required to be in the directory or  
25 directories pursuant to this section.

26 (4) A plan that delays payment or reimbursement under this  
27 subdivision shall document each instance a payment or  
28 reimbursement was delayed and report this information to the  
29 department in a format described by the department pursuant to  
30 Section 1367.035. This information shall be submitted along with  
31 the policies and procedures required to be submitted annually to  
32 the department pursuant to paragraph (1) of subdivision (m).

33 (5) With respect to plans with Medi-Cal managed care contracts  
34 with the State Department of Health Care Services pursuant to  
35 Chapter 7 (commencing with Section 14000), Chapter 8  
36 (commencing with Section 14200), or Chapter 8.75 (commencing  
37 with Section 14591) of the Welfare and Institutions Code, this  
38 subdivision shall be implemented only to the extent consistent  
39 with federal law and guidance.

1 (q) In circumstances where the department finds that an enrollee  
2 reasonably relied upon materially inaccurate, incomplete, or  
3 misleading information contained in a health plan's provider  
4 directory or directories, the department may require the health plan  
5 to provide coverage for all covered health care services provided  
6 to the enrollee and to reimburse the enrollee for any amount beyond  
7 what the enrollee would have paid, had the services been delivered  
8 by an in-network provider under the enrollee's plan contract. Prior  
9 to requiring reimbursement in these circumstances, the department  
10 shall conclude that the services received by the enrollee were  
11 covered services under the enrollee's plan contract. In those  
12 circumstances, the fact that the services were rendered or delivered  
13 by a noncontracting or out-of-plan provider shall not be used as a  
14 basis to deny reimbursement to the enrollee.

15 (r) Whenever a plan determines as a result of this section that  
16 there has been a ~~10 percent~~ 10-percent change in the network for  
17 a product in a region, the plan shall file an amendment to the plan  
18 application with the department consistent with subdivision (f) of  
19 Section 1300.52 of Title 28 of the California Code of Regulations.

20 (s) *If an enrollee contacts a health care service plan for*  
21 *assistance in finding an in-network provider, the plan shall respond*  
22 *within 24 hours and shall provide search results within two*  
23 *business days. For purposes of this subdivision, "search results"*  
24 *means a list of providers covered by the enrollee's contract that*  
25 *are accepting patients, which shall be confirmed by the health*  
26 *care service plan at the time of the enrollee's request.*

27 ~~(s)~~

28 (t) This section applies to plans with Medi-Cal managed care  
29 contracts with the State Department of Health Care Services  
30 pursuant to Chapter 7 (commencing with Section 14000), Chapter  
31 8 (commencing with Section 14200), or Chapter 8.75 (commencing  
32 with Section 14591) of the Welfare and Institutions Code to the  
33 extent consistent with federal law and guidance and state law  
34 guidance issued after January 1, 2016. Notwithstanding any other  
35 provision to the contrary in a plan contract with the State  
36 Department of Health Care Services, and to the extent consistent  
37 with federal law and guidance and state guidance issued after  
38 January 1, 2016, a Medi-Cal managed care plan that complies with  
39 the requirements of this section shall not be required to distribute

1 a printed provider directory or directories, except as required by  
2 paragraph (1) of subdivision (d).

3 ~~(t)~~

4 (u) A health plan that contracts with multiple employer welfare  
5 agreements regulated pursuant to Article 4.7 (commencing with  
6 Section 742.20) of Chapter 1 of Part 2 of Division 1 of the  
7 Insurance Code shall meet the requirements of this section.

8 ~~(u)~~

9 (v) This section shall not be construed to alter a provider's  
10 obligation to provide health care services to an enrollee pursuant  
11 to the provider's contract with the plan.

12 ~~(v)~~

13 (w) As part of the department's routine examination of the fiscal  
14 and administrative affairs of a health care service plan pursuant to  
15 Section 1382, the department shall include a review of the health  
16 care service plan's compliance with subdivision (p).

17 ~~(w)~~

18 (x) For purposes of this section, "provider group" means a  
19 medical group, independent practice association, or other similar  
20 group of providers.

21 *SEC. 2. Section 10133.15 of the Insurance Code is amended*  
22 *to read:*

23 10133.15. (a) Commencing July 1, 2016, a health insurer that  
24 contracts with providers for alternative rates of payment pursuant  
25 to Section 10133 shall publish and maintain provider directory or  
26 directories with information on contracting providers that deliver  
27 health care services to the insurer's insureds, including those that  
28 accept new patients. A provider directory shall not list or include  
29 information on a provider that is not currently under contract with  
30 the insurer.

31 (b) An insurer shall provide the online directory or directories  
32 for the specific network offered for each product using a consistent  
33 method of network and product naming, numbering, or other  
34 classification method that ensures the public, insureds, potential  
35 insureds, the department, and other state or federal agencies can  
36 easily identify the networks and insurer products in which a  
37 provider participates. By July 31, 2017, or 12 months after the date  
38 provider directory standards are developed under subdivision (k),  
39 whichever occurs later, an insurer shall use the naming, numbering,

1 or classification method developed by the department pursuant to  
2 subdivision (k).

3 (c) (1) An online provider directory or directories shall be  
4 available on the insurer's ~~Internet Web site~~ *internet website* to the  
5 public, potential insureds, insureds, and providers without any  
6 restrictions or limitations. The directory or directories shall be  
7 accessible without any requirement that an individual seeking the  
8 directory information demonstrate coverage with the insurer,  
9 indicate interest in obtaining coverage with the insurer, provide a  
10 member identification or policy number, provide any other  
11 identifying information, or create or access an account.

12 (2) The online provider directory or directories shall be  
13 accessible on the insurer's ~~public Internet Web site~~ *internet website*  
14 through an identifiable link or tab and in a manner that is accessible  
15 and searchable by insureds, potential insureds, the public, and  
16 providers. By July 1, 2017, or 12 months after the date provider  
17 directory standards are developed under subdivision (k), whichever  
18 occurs later, the insurer's ~~public Internet Web site~~ *internet website*  
19 shall allow provider searches by, at a minimum, name, practice  
20 address, city, ZIP Code, California license number, National  
21 Provider Identifier number, admitting privileges to an identified  
22 hospital, product, tier, provider language or languages, provider  
23 group, hospital name, facility name, or clinic name, as appropriate.

24 (d) (1) An insurer shall allow insureds, potential insureds,  
25 providers, and members of the public to request a printed copy of  
26 the provider directory or directories by contacting the insurer  
27 through the insurer's toll-free telephone number, electronically,  
28 or in writing. A printed copy of the provider directory or directories  
29 shall include the information required in subdivisions (h) and (i).  
30 The printed copy of the provider directory or directories shall be  
31 provided to the requester by mail postmarked no later than five  
32 business days following the date of the request and may be limited  
33 to the geographic region in which the requester resides or works  
34 or intends to reside or work.

35 (2) An insurer shall update its printed provider directory or  
36 directories at least quarterly, or more frequently, if required by  
37 federal law.

38 (e) (1) The insurer shall update the online provider directory  
39 or directories, at least weekly, or more frequently, if required by

1 federal law, when informed of and upon confirmation by the insurer  
2 of any of the following:

3 (A) A contracting provider is no longer accepting new patients  
4 for that product, or an individual provider within a provider group  
5 is no longer accepting new patients.

6 (B) A contracted provider is no longer under contract for a  
7 particular product.

8 (C) A provider's practice location or other information required  
9 under subdivision (h) or (i) has changed.

10 (D) Upon the completion of the investigation described in  
11 subdivision (o), a change is necessary based on an insured  
12 complaint that a provider was not accepting new patients, was  
13 otherwise not available, or whose contact information was listed  
14 incorrectly.

15 (E) Any other information that affects the content or accuracy  
16 of the provider directory or directories.

17 (2) Upon confirmation of any of the following, the insurer shall  
18 delete a provider from the directory or directories when:

19 (A) A provider has retired or otherwise has ceased to practice.

20 (B) A provider or provider group is no longer under contract  
21 with the insurer for any reason.

22 (C) The contracting provider group has informed the insurer  
23 that the provider is no longer associated with the provider group  
24 and is no longer under contract with the insurer.

25 (f) The provider directory or directories shall include both an  
26 email address and a telephone number for members of the public  
27 and providers to notify the insurer if the provider directory  
28 information appears to be inaccurate. This information shall be  
29 disclosed prominently in the directory or directories and on the  
30 insurer's ~~Internet Web site~~. *internet website*.

31 (g) The provider directory or directories shall include the  
32 following disclosures informing insureds that they are entitled to  
33 both of the following:

34 (1) Language interpreter services, at no cost to the insured,  
35 including how to obtain interpretation services in accordance with  
36 Section 10133.8.

37 (2) Full and equal access to covered services, including insureds  
38 with disabilities as required under the federal Americans with  
39 Disabilities Act of 1990 and Section 504 of the Rehabilitation Act  
40 of 1973.



1 (h) The insurer and a specialized mental health insurer shall  
2 include all of the following information in the provider directory  
3 or directories:

4 (1) The provider's name, practice location or locations, and  
5 contact information.

6 (2) Type of practitioner.

7 (3) National Provider Identifier number.

8 (4) California license number and type of license.

9 (5) The area of specialty, including board certification, if any.

10 (6) The provider's office email address, if available.

11 (7) The name of each affiliated provider group currently under  
12 contract with the insurer through which the provider sees ~~enrollees~~  
13 *insureds*.

14 (8) A listing for each of the following providers that are under  
15 contract with the insurer:

16 (A) For physicians and surgeons, the provider group, and  
17 admitting privileges, if any, at hospitals contracted with the insurer.

18 (B) Nurse practitioners, physician assistants, psychologists,  
19 acupuncturists, optometrists, podiatrists, chiropractors, licensed  
20 clinical social workers, marriage and family therapists, professional  
21 clinical counselors, qualified autism service providers, as defined  
22 in Section 10144.51, ~~nurse midwives~~, *nurse-midwives*, and dentists.

23 (C) For federally qualified health centers or primary care clinics,  
24 the name of the federally qualified health center or clinic.

25 (D) For any provider described in subparagraph (A) or (B) who  
26 is employed by a federally qualified health center or primary care  
27 clinic, and to the extent their services may be accessed and are  
28 covered through the contract with the insurer, the name of the  
29 provider, and the name of the federally qualified health center or  
30 clinic.

31 (E) Facilities, including, but not limited to, general acute care  
32 hospitals, skilled nursing facilities, urgent care clinics, ambulatory  
33 surgery centers, inpatient hospice, residential care facilities, and  
34 inpatient rehabilitation facilities.

35 (F) Pharmacies, clinical laboratories, imaging centers, and other  
36 facilities providing contracted health care services.

37 (9) The provider directory or directories may note that  
38 authorization or referral may be required to access some providers.

39 (10) Non-English language, if any, spoken by a health care  
40 provider or other medical professional as well as non-English

1 language spoken by a qualified medical interpreter, in accordance  
2 with Section 10133.8, if any, on the provider's staff.

3 (11) Identification of providers who no longer accept new  
4 patients for some or all of the insurer's products.

5 (12) The network tier to which the provider is assigned, if the  
6 provider is not in the lowest tier, as applicable. ~~Nothing in this~~  
7 ~~section shall be construed to~~ *This section does not* require the use  
8 of network tiers other than contract and noncontracting tiers.

9 (13) *A statement at the top of the directory advising an insured*  
10 *to contact the insurer for assistance in finding an in-network*  
11 *provider.*

12 ~~(13)~~  
13 (14) All other information necessary to conduct a search  
14 pursuant to paragraph (2) of subdivision (c).

15 (i) A vision, dental, or other specialized insurer, except for a  
16 specialized mental health insurer, shall include all of the following  
17 information for each provider directory or directories used by the  
18 insurer for its networks:

19 (1) The provider's name, practice location or locations, and  
20 contact information.

21 (2) Type of practitioner.

22 (3) National Provider Identifier number.

23 (4) California license number and type of license, if applicable.

24 (5) The area of specialty, including board certification, or other  
25 accreditation, if any.

26 (6) The provider's office email address, if available.

27 (7) The name of each affiliated provider group or specialty  
28 insurer practice group currently under contract with the insurer  
29 through which the provider sees insureds.

30 (8) The names of each allied health care professional to the  
31 extent there is a direct contract for those services covered through  
32 a contract with the insurer.

33 (9) The non-English language, if any, spoken by a health care  
34 provider or other medical professional as well as non-English  
35 language spoken by a qualified medical interpreter, in accordance  
36 with Section 10133.8, if any, on the provider's staff.

37 (10) Identification of providers who no longer accept new  
38 patients for some or all of the insurer's products.

39 (11) All other applicable information necessary to conduct a  
40 provider search pursuant to paragraph (2) of subdivision (c).

1 (j) (1) The contract between the insurer and a provider shall  
2 include a requirement that the provider inform the insurer within  
3 five business days when either of the following occurs:

4 (A) The provider is not accepting new patients.

5 (B) If the provider had previously not accepted new patients,  
6 the provider is currently accepting new patients.

7 (2) If a provider who is not accepting new patients is contacted  
8 by an insured or potential insured seeking to become a new patient,  
9 the provider shall direct the insurer or potential insured to both the  
10 insurer for additional assistance in finding a provider and to the  
11 department to report any inaccuracy with the insurer's directory  
12 or directories.

13 (3) If an insured or potential insured informs an insurer of a  
14 possible inaccuracy in the provider directory or directories, the  
15 insurer shall promptly investigate and, if necessary, undertake  
16 corrective action within 30 business days to ensure the accuracy  
17 of the directory or directories.

18 (k) (1) On or before December 31, 2016, the department shall  
19 develop uniform provider directory standards to permit consistency  
20 in accordance with subdivision (b) and paragraph (2) of subdivision  
21 (c) and development of a multiplan directory by another entity.  
22 Those standards shall not be subject to the Administrative  
23 Procedure Act (Chapter 3.5 (commencing with Section 11340) of  
24 Part 1 of Division 3 of Title 2 of the Government Code), until  
25 January 1, 2021. No more than two revisions of those standards  
26 shall be exempt from the Administrative Procedure Act (Chapter  
27 3.5 (commencing with Section 11340) of Part 1 of Division 3 of  
28 Title 2 of the Government Code) pursuant to this subdivision.

29 (2) In developing the standards under this subdivision, the  
30 department shall seek input from interested parties throughout the  
31 process of developing the standards and shall hold at least one  
32 public meeting. The department shall take into consideration any  
33 requirements for provider directories established by the federal  
34 Centers for Medicare and Medicaid Services and the State  
35 Department of Health Care Services.

36 (3) By July 31, 2017, or 12 months after the date provider  
37 directory standards are developed under this subdivision, whichever  
38 occurs later, an insurer shall use the standards developed by the  
39 department for each product offered by the insurer.

1 (l) (1) An insurer shall take appropriate steps to ensure the  
2 accuracy of the information concerning each provider listed in the  
3 insurer's provider directory or directories in accordance with this  
4 section, and shall, at least annually, review and update the entire  
5 provider directory or directories for each product offered. Each  
6 calendar year the insurer shall notify all contracted providers  
7 described in subdivisions (h) and (i) as follows:

8 (A) For individual providers who are not affiliated with a  
9 provider group described in subparagraph (A) or (B) of paragraph  
10 (8) of subdivision (h) and providers described in subdivision (i),  
11 the insurer shall notify each provider at least once every six months.

12 (B) For all other providers described in subdivision (h) who are  
13 not subject to the requirements of subparagraph (A), the insurer  
14 shall notify its contracted providers to ensure that all of the  
15 providers are contacted by the insurer at least once annually.

16 (2) The notification shall include all of the following:

17 (A) The information the insurer has in its directory or directories  
18 regarding the provider or provider group, including a list of  
19 networks and products that include the contracted provider or  
20 provider group.

21 (B) A statement that the failure to respond to the notification  
22 may result in a delay of payment or reimbursement of a claim  
23 pursuant to subdivision (p).

24 (C) Instructions on how the provider or provider group can  
25 update the information in the provider directory or directories using  
26 the online interface developed pursuant to subdivision (m).

27 (3) The insurer shall require an affirmative response from the  
28 provider or provider group acknowledging that the notification  
29 was received. The provider or provider group shall confirm that  
30 the information in the provider directory or directories is current  
31 and accurate or update the information required to be in the  
32 directory or directories pursuant to this section, including whether  
33 or not the provider group is accepting new patients for each  
34 product.

35 (4) If the insurer does not receive an affirmative response and  
36 confirmation from the provider that the information is current and  
37 accurate or, as an alternative, updates any information required to  
38 be in the directory or directories pursuant to this section, within  
39 30 business days, the insurer shall take no more than 15 business  
40 days to verify whether the provider's information is correct or

1 requires updates. The insurer shall document the receipt and  
2 outcome of each attempt to verify the information. If the insurer  
3 is unable to verify whether the provider's information is correct  
4 or requires updates, the insurer shall notify the provider 10 business  
5 days in advance of removal that the provider will be removed from  
6 the directory or directories. The provider shall be removed from  
7 the directory or directories at the next required update of the  
8 provider directory or directories after the ~~10-business-day~~  
9 *10-business-day* notice period. A provider shall not be removed  
10 from the provider directory or directories if ~~he or she~~ *the provider*  
11 responds before the end of the ~~10-business-day~~ *10-business-day*  
12 notice period.

13 (5) General acute care hospitals shall be exempt from the  
14 requirements in paragraphs (3) and (4).

15 (m) An insurer shall establish policies and procedures with  
16 regard to the regular updating of its provider directory or  
17 directories, including the weekly, quarterly, and annual updates  
18 required pursuant to this section, or more frequently, if required  
19 by federal law or guidance.

20 (1) The policies and procedures described under this subdivision  
21 shall be submitted by an insurer annually to the department for  
22 approval and in a format described by the department.

23 (2) Every insurer shall ensure processes are in place to allow  
24 providers to promptly verify or submit changes to the information  
25 required to be in the directory or directories pursuant to this section.  
26 Those processes shall, at a minimum, include an online interface  
27 for providers to submit verification or changes electronically and  
28 shall generate an acknowledgment of receipt from the insurer.  
29 Providers shall verify or submit changes to information required  
30 to be in the directory or directories pursuant to this section using  
31 the process required by the insurer.

32 (3) The insurer shall establish and maintain a process for  
33 insureds, potential insureds, other providers, and the public to  
34 identify and report possible inaccurate, incomplete, or misleading  
35 information currently listed in the insurer's provider directory or  
36 directories. This process shall, at a minimum, include a telephone  
37 number and a dedicated email address at which the insurer will  
38 accept these reports, as well as a hyperlink on the insurer's provider  
39 directory ~~Internet Web site~~ *internet website* linking to a form where

1 the information can be reported directly to the insurer through its  
2 ~~Internet Web site.~~ *internet website.*

3 (n) (1) This section does not prohibit an insurer from requiring  
4 its provider groups or contracting specialized health insurers to  
5 provide information to the insurer that is required by the insurer  
6 to satisfy the requirements of this section for each of the providers  
7 that contract with the provider group or contracting specialized  
8 health insurer. This responsibility shall be specifically documented  
9 in a written contract between the insurer and the provider group  
10 or contracting specialized health insurer.

11 (2) If an insurer requires its contracting provider groups or  
12 contracting specialized health insurers to provide the insurer with  
13 information described in paragraph (1), the insurer shall continue  
14 to retain responsibility for ensuring that the requirements of this  
15 section are satisfied.

16 (3) A provider group may terminate a contract with a provider  
17 for a pattern or repeated failure of the provider to update the  
18 information required to be in the directory or directories pursuant  
19 to this section.

20 (4) A provider group is not subject to the payment delay  
21 described in subdivision (p) if all of the following occurs:

22 (A) A provider does not respond to the provider group's attempt  
23 to verify the provider's information. As used in this paragraph,  
24 "verify" means to contact the provider in writing, electronically,  
25 and by telephone to confirm whether the provider's information  
26 is correct or requires updates.

27 (B) The provider group documents its efforts to verify the  
28 provider's information.

29 (C) The provider group reports to the insurer that the provider  
30 should be deleted from the provider group in the insurer's provider  
31 directory or directories.

32 (5) Section 10133.65, known as the Health Care Providers' Bill  
33 of Rights, applies to any material change to a provider contract  
34 pursuant to this section.

35 (o) (1) Whenever an insurer receives a report indicating that  
36 information listed in its provider directory or directories is  
37 inaccurate, the insurer shall promptly investigate the reported  
38 inaccuracy and, no later than 30 business days following receipt  
39 of the report, either verify the accuracy of the information or update

1 the information in its provider directory or directories, as  
2 applicable.

3 (2) When investigating a report regarding its provider directory  
4 or directories, the insurer shall, at a minimum, do the following:

5 (A) Contact the affected provider no later than five business  
6 days following receipt of the report.

7 (B) Document the receipt and outcome of each report. The  
8 documentation shall include the provider's name, location, and a  
9 description of the insurer's investigation, the outcome of the  
10 investigation, and any changes or updates made to its provider  
11 directory or directories.

12 (C) If changes to an insurer's provider directory or directories  
13 are required as a result of the insurer's investigation, the changes  
14 to the online provider directory or directories shall be made no  
15 later than the next scheduled weekly update, or the update  
16 immediately following that update, or sooner if required by federal  
17 law or regulations. For printed provider directories, the change  
18 shall be made no later than the next required update, or sooner if  
19 required by federal law or regulations.

20 (p) (1) Notwithstanding Sections 10123.13 and 10123.147, an  
21 insurer may delay payment or reimbursement owed to a provider  
22 or provider group for any claims payment made to a provider or  
23 provider group for up to one calendar month beginning on the first  
24 day of the following month, if the provider or provider group fails  
25 to respond to the insurer's attempts to verify the provider's  
26 information as required under subdivision (I). The insurer shall  
27 not delay payment unless it has attempted to verify the provider's  
28 or provider group's information. As used in this subdivision,  
29 "verify" means to contact the provider or provider group in writing,  
30 electronically, and by telephone to confirm whether the provider's  
31 or provider group's information is correct or requires updates. An  
32 insurer may seek to delay payment or reimbursement owed to a  
33 provider or provider group only after the ~~10-business-day~~  
34 *10-business-day* notice period described in paragraph (4) of  
35 subdivision (I) has lapsed.

36 (2) An insurer shall notify the provider or provider group 10  
37 days before it seeks to delay payment or reimbursement to a  
38 provider or provider group pursuant to this subdivision. If the  
39 insurer delays a payment or reimbursement pursuant to this  
40 subdivision, the insurer shall reimburse the full amount of any

1 payment or reimbursement subject to delay to the provider or  
2 provider group according to either of the following timelines, as  
3 applicable:

4 (A) No later than three business days following the date on  
5 which the insurer receives the information required to be submitted  
6 by the provider or provider group pursuant to subdivision (l).

7 (B) At the end of the one-calendar-month delay described in  
8 paragraph (1), if the provider or provider group fails to provide  
9 the information required to be submitted to the insurer pursuant  
10 to subdivision (l).

11 (3) An insurer may terminate a contract for a pattern or repeated  
12 failure of the provider or provider group to alert the insurer to a  
13 change in the information required to be in the directory or  
14 directories pursuant to this section.

15 (4) An insurer that delays payment or reimbursement under this  
16 subdivision shall document each instance a payment or  
17 reimbursement was delayed and report this information to the  
18 department in a format described by the department. This  
19 information shall be submitted along with the policies and  
20 procedures required to be submitted annually to the department  
21 pursuant to paragraph (1) of subdivision (m).

22 (q) In circumstances where the department finds that an insured  
23 reasonably relied upon materially inaccurate, incomplete, or  
24 misleading information contained in an insurer's provider directory  
25 or directories, the department may require the insurer to provide  
26 coverage for all covered health care services provided to the insured  
27 and to reimburse the insured for any amount beyond what the  
28 insured would have paid, had the services been delivered by an  
29 in-network provider under the insured's health insurance policy.  
30 Prior to requiring reimbursement in these circumstances, the  
31 department shall conclude that the services received by the insured  
32 were covered services under the insured's health insurance policy.  
33 In those circumstances, the fact that the services were rendered or  
34 delivered by a noncontracting or out-of-network provider shall not  
35 be used as a basis to deny reimbursement to the insured.

36 (r) Whenever an insurer determines as a result of this section  
37 that there has been a 10-percent change in the network for a product  
38 in a region, the insurer shall file a statement with the commissioner.

39 (s) *If an insured contacts an insurer for assistance in finding*  
40 *an in-network provider, the insurer shall respond within 24 hours*



1 *and shall provide search results within two business days. For*  
2 *purposes of this subdivision, “search results” means a list of*  
3 *providers covered by the insured’s policy that are accepting*  
4 *patients, which shall be confirmed by the insurer at the time of the*  
5 *insured’s request.*

6 ~~(s)~~

7 (t) An insurer that contracts with multiple employer welfare  
8 agreements regulated pursuant to Article 4.7 (commencing with  
9 Section 742.20) of Chapter 1 of Part 2 of Division 1 shall meet the  
10 requirements of this section.

11 ~~(t)~~

12 (u) This section shall not be construed to alter a provider’s  
13 obligation to provide health care services to an insured pursuant  
14 to the provider’s contract with the insurer.

15 ~~(u)~~

16 (v) As part of the department’s routine examination of a health  
17 insurer pursuant to Section 730, the department shall include a  
18 review of the health insurer’s compliance with subdivision (p).

19 ~~(v)~~

20 (w) For purposes of this section, “provider group” means a  
21 medical group, independent practice association, or other similar  
22 group of providers.

23 *SEC. 3. No reimbursement is required by this act pursuant to*  
24 *Section 6 of Article XIII B of the California Constitution because*  
25 *the only costs that may be incurred by a local agency or school*  
26 *district will be incurred because this act creates a new crime or*  
27 *infraction, eliminates a crime or infraction, or changes the penalty*  
28 *for a crime or infraction, within the meaning of Section 17556 of*  
29 *the Government Code, or changes the definition of a crime within*  
30 *the meaning of Section 6 of Article XIII B of the California*  
31 *Constitution.*

32 ~~SECTION 1. Section 127345 of the Health and Safety Code~~  
33 ~~is amended to read:~~

34 ~~127345. As used in this article, the following terms have the~~  
35 ~~following meanings:~~

36 ~~(a) “Charity care” means free health services provided without~~  
37 ~~expectation of payment to persons who meet the organization’s~~  
38 ~~criteria for financial assistance and are unable to pay for all or a~~  
39 ~~portion of the services. Charity care shall be reported at cost, as~~  
40 ~~reported to the Department of Health Care Access and Information.~~

1 ~~Charity care does not include bad debt, defined as uncollectible~~  
2 ~~charges that the organization recorded as revenue but wrote off~~  
3 ~~due to a patient's failure to pay.~~

4 ~~(b) "Community benefits plan" means the written document~~  
5 ~~prepared for annual submission to the Department of Health Care~~  
6 ~~Access and Information that shall include, but shall not be limited~~  
7 ~~to, a description of the activities that the hospital has undertaken~~  
8 ~~in order to address identified community needs within its mission~~  
9 ~~and financial capacity, and the process by which the hospital~~  
10 ~~developed the plan in consultation with the community.~~

11 ~~(c) "Community" means the service areas or patient populations~~  
12 ~~for which the hospital provides health care services.~~

13 ~~(d) (1) Solely for the planning and reporting purposes of this~~  
14 ~~article, "community benefit" means a hospital's activities that are~~  
15 ~~intended to address community needs and priorities primarily~~  
16 ~~through disease prevention and improvement of health status,~~  
17 ~~including, but not limited to, any of the following:~~

18 ~~(A) Health care services, rendered to vulnerable populations,~~  
19 ~~including, but not limited to, charity care and the unreimbursed~~  
20 ~~cost of providing services to the uninsured, underinsured, and those~~  
21 ~~eligible for Medi-Cal, Medicare, California Children's Services~~  
22 ~~Program, or county indigent programs.~~

23 ~~(B) The unreimbursed cost of services included in subdivision~~  
24 ~~(d) of Section 127340.~~

25 ~~(C) Financial or in-kind support of public health programs.~~

26 ~~(D) Donation of funds, property, or other resources that~~  
27 ~~contribute to a community priority.~~

28 ~~(E) Health care cost containment.~~

29 ~~(F) Enhancement of access to health care or related services~~  
30 ~~that contribute to a healthier community.~~

31 ~~(G) Services offered without regard to financial return because~~  
32 ~~they meet a community need in the service area of the hospital,~~  
33 ~~and other services including health promotion, health education,~~  
34 ~~prevention, and social services.~~

35 ~~(H) Food, shelter, clothing, education, transportation, and other~~  
36 ~~goods or services that help to maintain a person's health.~~

37 ~~(2) "Community benefit" does not mean activities or programs~~  
38 ~~that are provided primarily for marketing purposes or are more~~  
39 ~~beneficial to the organization than to the community.~~

1 (e) “Community needs assessment” means the process by which  
2 the hospital identifies, for its primary service area as determined  
3 by the hospital, unmet community needs.

4 (f) “Community needs” means those requisites for improvement  
5 or maintenance of health status in the community.

6 (g) “Hospital” means a ~~private not-for-profit acute hospital~~  
7 ~~licensed under subdivision (a), (b), or (f) of Section 1250 and is~~  
8 ~~owned by a corporation that has been determined to be exempt~~  
9 ~~from taxation under the United States Internal Revenue Code.~~  
10 “Hospital” does not mean any of the following:

11 (1) Hospitals that are dedicated to serving children and that do  
12 not receive direct payment for services to any patient.

13 (2) ~~Small and rural hospitals, as defined in Section 124840,~~  
14 ~~unless the hospital is part of a hospital system.~~

15 (3) ~~A district hospital organized and governed pursuant to the~~  
16 ~~Local Health Care District Law (Division 23 (commencing with~~  
17 ~~Section 32000)) or a nonprofit corporation that is affiliated with~~  
18 ~~the health care district hospital owner by means of the district’s~~  
19 ~~status as the nonprofit corporation’s sole corporate member~~  
20 ~~pursuant to subparagraph (B) of paragraph (1) of subdivision (h)~~  
21 ~~of Section 14169.31 of the Welfare and Institutions Code.~~

22 (h) “Mission statement” means a hospital’s primary objectives  
23 for operation as adopted by its governing body.

24 (i) “Vulnerable populations” means ~~any population that is~~  
25 ~~exposed to medical or financial risk by virtue of being uninsured,~~  
26 ~~underinsured, or eligible for Medi-Cal, Medicare, California~~  
27 ~~Children’s Services Program, or county indigent programs.~~  
28 “Vulnerable populations” also includes both of the following:

29 (1) ~~Racial and ethnic groups experiencing disparate health~~  
30 ~~outcomes, including Black/African American, American Indian,~~  
31 ~~Alaska Native, Asian Indian, Cambodian, Chinese, Filipino,~~  
32 ~~Hmong, Japanese, Korean, Laotian, Vietnamese, Native Hawaiian,~~  
33 ~~Guamanian or Chamorro, Samoan, or other nonwhite racial groups,~~  
34 ~~as well as individuals of Hispanic/Latino origin, including~~  
35 ~~Mexicans, Mexican Americans, Chicanos, Salvadorans,~~  
36 ~~Guatemalans, Cubans, and Puerto Ricans.~~

37 (2) ~~Socially disadvantaged groups, including all of the following:~~

38 (A) ~~The unhoused.~~

- 1     ~~(B) Communities with inadequate access to clean air and safe~~
- 2     ~~drinking water, as defined by an environmental California Healthy~~
- 3     ~~Places Index score of 50 percent or lower.~~
- 4     ~~(C) People with disabilities.~~
- 5     ~~(D) People identifying as lesbian, gay, bisexual, transgender,~~
- 6     ~~or queer.~~
- 7     ~~(E) Individuals with limited English proficiency.~~