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California State Assembly

HEALTH

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AGENDA

Tuesday, April 2, 2024
1:30 p.m. -- 1021 O Street, Room 1100

Bills heard in file order
Testimony may be limited:
2 witnesses per side, 3 minutes each

1.	AB 1926	Connolly	Health care coverage: regional enteritis.
2.	AB 1943	Weber	Health information.
3.	AB 1965	Blanca Rubio	Public health: Office of Tribal Affairs.
4.	AB 2052	Jones-Sawyer	School-Based Health and Education Partnership Program.
5.	AB 2081	Davies	Substance abuse: recovery and treatment programs.
6.	AB 2154	Berman	Mental health: involuntary treatment.
7.	AB 2156	Pacheco	Vital records: diacritical marks.
8.	AB 2175	Lowenthal	Hospital specialties database.
9.	AB 2250	Weber	Social determinants of health: screening and outreach.
10.	AB 2300	Wilson	Medical devices: Di-(2-ethylhexyl) phthalate (DEHP).
11.	AB 2319	Wilson	California Dignity in Pregnancy and Childbirth Act.
12.	AB 2339	Aguiar-Curry	Medi-Cal: telehealth.
13.	AB 2402	Lowenthal	Drink spiking.
14.	AB 2435	Maienschein	California Health Benefit Exchange.
15.	AB 2446	Ortega	Medi-Cal: diapers.
16.	AB 2556	Jackson	Behavioral health and wellness screenings: notice.
17.	AB 2703	Aguiar-Curry	Federally qualified health centers and rural health clinics: psychological associates.
18.	AB 2753	Ortega	Rehabilitative and habilitative services: durable medical equipment and services.
19.	AB 2841	Waldron	State hospitals for the mentally disordered: patient funds.

Date of Hearing: April 2, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 1926 (Connolly) – As Amended March 19, 2024

SUBJECT: Health care coverage: regional enteritis.

SUMMARY: Requires health plan contracts or disability insurance policies to provide coverage for dietary enteral formulas, as defined, for the treatment of regional enteritis. Specifically, **this bill**:

1) Requires every health plan contract or disability insurance policy, on and after July 1, 2025, except a specialized health plan contract or disability insurance, to provide coverage for dietary enteral formulas, as defined in 4) below, for the treatment of regional enteritis.

2) Requires coverage for the treatment of the chronic digestive diseases described in 1) above to include dietary enteral formulas that are part of a diet prescribed by a licensed physician and managed by a health care professional in consultation with a physician who specializes in the treatment of chronic digestive diseases and inherited metabolic disorders and who participates in or is authorized by the health plan, provided that the dietary enteral formula is deemed medically necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of regional enteritis.

3) Exempts provisions of this bill from applying to Medi-Cal managed care plans contracting with the Department of Health Care Services, as specified.

4) Defines dietary enteral formula as an enteral formula or enteral formulas that may be taken orally at home that are prescribed by a physician or nurse practitioner, or ordered by a registered dietician upon referral by a health care provider authorized to prescribe dietary treatments, as medically necessary for the treatment of regional enteritis.

EXISTING LAW:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 and the California Department of Insurance (CDI) to regulate health insurers. [Health and Safety Code (HSC) § 1340, *et seq*., and (Insurance Code (INS) § 106, *et seq*.]

2) Establishes as California's essential health benefits (EHBs) benchmark under the Patient Protection and Affordable Care Act (ACA), the Kaiser Small Group Health Maintenance Organization, existing California health insurance mandates, and the 10 ACA mandated benefits. [HSC § 1367.005 and INS § 10112.27]

3) Defines "basic health care services" as all of the following:
   a) Physician services, including consultation and referral;
   b) Hospital inpatient services and ambulatory care services;
   c) Diagnostic laboratory and therapeutic radiologic services;
   d) Home health services;

e) Preventive health services;
f) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage. Basic health care services includes ambulance and ambulance transport services provided through the 911 emergency response system; and,
g) Hospice care. [HSC § 1345]

4) Requires every health plan contract or disability insurance, on or after January 1, 2000, to provide coverage and treatment of Phenylketonuria (PKU). Requires coverage for PKU treatment to include those formulas and special food products that are part of a diet prescribed by a licensed physician and managed by a health care professional in consultation with a physician who specializes in the treatment of metabolic disease who participates in or is authorized by the plan or insurer, provided that the diet is deemed medically necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU. Specifies that coverage is not required except to the extent that the cost of the necessary formulas and special food products exceeds the cost of a normal diet. Defines the following:

   a) Formula to mean an enteral product or enteral products for use at home that are prescribed by a physician or nurse practitioner, or ordered by a registered dietician upon referral by a health care provider authorized to prescribe dietary treatments, as medically necessary for the treatment of PKU; and,

   b) Special food product to mean a food product that is both of the following:
      i) Prescribed by a physician or nurse practitioner for the treatment of PKU consistent with the recommendations and best practices of qualified health professionals with expertise germane to, and experience in the treatment and care of, PKU, and does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving; and,
      ii) Used in place of normal food products, such as grocery store foods, used by the general population. [HSC § 1374.56 and INS § 10123.89]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, early treatment options for metabolic and digestive diseases, like Crohn's, have proven to reduce harm and increase quality of life. There is no reason why Californians suffering from chronic illnesses cannot lead full and productive lives. The author concludes that this bill provides patients with a proven successful alternative to certain medications, which healthcare providers may recommend when complications such as weight loss, surgery, obstruction, or severe inflammation, prevent patients from getting the right nutrients.

2) **BACKGROUND.** California law currently requires coverage for the testing and treatment of PKU only and this bill includes coverage for dietary enteral formulas for the treatment of regional enteritis. It should be noted that this bill, as introduced, included treatment for chronic digestive diseases and inherited metabolic disorders. Digestive disorders are acute or chronic conditions affecting the digestive system which encompasses the gastrointestinal (GI) tract, liver, pancreas, and gallbladder. These conditions affect the body's ability to absorb nutrients, which can result in mild to severe symptoms, disability, or death. Digestive

disorders such as inflammatory bowel disease (IBD) typically develop, or are identified, in adolescence and early adulthood, though it is possible for infants and children to be diagnosed with digestive disorders. Current therapies for digestive disorders typically include use of medication, such as steroids, anti-inflammatories, immunosupressives, or biologics, along with dietary management. The primary concern with digestive disorders is that they may lead to malnutrition, which can occur by a variety of mechanisms: symptoms may result in reduced food intake, the body may not sufficiently absorb nutrients taken in orally, loss of nutrients after absorption (enteric nutrient loss), or increased nutritional requirements due to inflammation. This bill was recently amended to specify coverage of dietary enteral formulas for the treatment of enteritis chronic digestive diseases. These types of diseases are also known as Crohn's disease which is a chronic inflammation of the digestive tract that leads to abdominal pain, severe diarrhea, fatigue, weight loss and malnutrition. Crohn's disease is an IBD and is an example of regional enteritis.

Enteral nutrition (EN) refers to oral nutritional formulas or tube feeding that may supplement or replace dietary modifications in order to restore nutritional requirements. EN involves delivery methods in which absorption occurs through the intestines; parenteral nutrition is delivered via the bloodstream using an intravenous tube. According to the Crohn's & Colitis Foundation, sponsors of this bill, EN is an important part of managing Crohn's disease in particular, as it reduces the inflammatory process of the gut, leading to bowel rest and improving postoperative prognosis for those who require surgery. Enteral nutrition is a liquid dietary regimen, which is administered orally, as a drink, powder, dessert-like snack, or via a feeding tube, with similar efficacy. EN may be recommended as a maintenance diet during the remission phases of Crohn's disease combined with the usual diet. A maintenance enteral diet has been shown to increase the positive effects of biological therapies, thus preventing the relapse of the disease after surgical-induced remission. EN can also be administered as the only nutrition treatment, i.e., exclusive enteral nutrition (EEN). EEN excludes solid food, providing the full amount of necessary calories. The use of this type of diet is particularly recommended during relapse of the disease, when it is applied for six to eight weeks to induce remission. EEN can be the main therapy for mild-to-moderate Crohn's Disease in children and adolescents, as this regimen promotes, beside the remission of the illness in 80 to 85% of the cases, a reduced use of steroids, which are known to impair growth. The sponsor writes that EEN provides other beneficial effects, such as improving the nutritional status and bone metabolism/turnover in children. For pediatric patients, over the counter formulas, recommended and prescribed by their provider, could delay a child's need to begin a more aggressive and more expensive biologic drug and allow them to stay in remission.

a) **California Health Benefits Review Program (CHBRP) analysis.** AB 1996 (Thomson), Chapter 795, Statutes of 2002, requests the University of California to assess legislation proposing a mandated benefit or service and prepare a written analysis with relevant data on the medical, economic, and public health impacts of proposed health plan and health insurance benefit mandate legislation. CHBRP was created in response to AB 1996. SB 125 (Hernandez), Chapter 9, Statutes of 2015, added an impact assessment on EHBs, and legislation that impacts health insurance benefit designs, cost sharing, premiums, and other health insurance topics. CHBRP's analysis of AB 620 (Connolly) of 2023, which is similar to this bill, includes the following:

    i) **Assumptions.** CHBRP states that it appears that formula and special food products administered via tube feeding are already covered in existing law. It should be

noted that AB 620 included coverage of special food, which is not specified in this bill. CHBRP also notes that it appears as if treatments specified in this bill is already covered under Medi-Cal. For this analysis, CHBRP considers the following to be the most common digestive diseases that may benefit from formula and special food products: IBD including Crohn's disease and ulcerative colitis, cystic fibrosis, eosinophilic enteritis, enteropathy, chronic pancreatitis, and intestinal malabsorption. While CHBRP's analysis of AB 620 included inherited metabolic disorders, CHBRP notes that these disorders are individually rare and estimated to be about 1/3,000 individuals overall. Many of these are diagnosed through newborn screening, which is performed in order to initiate life- and brain-saving treatment early, before irreversible damage or death has occurred. These are often grouped into categories including: disorders of amino acid and protein metabolism (e.g., PKU, for which coverage of formula and special food products is already mandated), disorders of carbohydrate metabolism, and disorders of fatty acid oxidation metabolism. CHBRP assumes that this bill is focused on chronic conditions that may benefit from formula and special food products and would exclude various acute digestive disorders. CHBRP notes that if any of the assumptions listed above are incorrect, in particular, if this bill were to require coverage of formulas for acute conditions such as reflux, the cost impacts presented in this analysis may be significantly understated.

ii) **Impact on expenditures.** This bill would increase total net annual expenditures by $24,187,000, or 0.02%, for enrollees with DMHC-regulated plans and CDI-regulated policies. This is primarily due to a $26,928,000 increase in total health insurance premiums paid by employers and enrollees for newly covered benefits, adjusted by a $2,741,000 decrease in enrollee expenses for covered and/or noncovered benefits. Changes in premiums as a result of this bill would vary by market segment, with increases ranging from 0.0227% to 0.0268%. At baseline, for enrollees with inherited metabolic disorders, the annual cost is $6,369 for covered formulas and special food products and $5,846 for noncovered formulas and special food products; for enrollees with digestive disorders, the annual cost is $5,758 for covered formulas and special food products and $2,619 for noncovered formulas and special food products. Postmandate, the 579 enrollees with coverage for formulas and special food products at baseline would experience no change in cost sharing. For the 1,507 enrollees using services at baseline for whom postmandate benefit coverage would be new, enrollees would experience an average decrease in out-of-pocket expenses for noncovered benefits of $2,628. Within the individual DMHC-regulated market, health plans offered by Covered California would experience a 0.0263% premium increase, or $0.1729 per member per month (PMPM). Covered California individual market plans regulated by CDI would experience a 0.0280% increase in premiums, or $0.1500 PMPM.

(1) **Medi-Cal**. Based on the Medi-Cal Rx provider manual, Medi-Cal beneficiaries who have other inherited metabolic disorders or digestive disorders and are enrolled in DMHC-regulated plans already have coverage for formulas and special foods through Medi-Cal Rx.

(2) **CalPERS**. For enrollees associated with CalPERS in DMHC regulated plans, there would be a 0.0227% premium increase, or $0.1579 PMPM.

(3) **Number of Uninsured in California.** Since the change in average premiums does not exceed 1% for any market segment, CHBRP estimates this bill would have no measurable impact on the number of uninsured persons.

iii) **EHBs.** According to CHBRP, this bill does not exceed the definition of EHBs in California because formula and special food products are considered durable medical equipment and would be encompassed with the "rehabilitative and habilitative services and devices."

iv) **Medical effectiveness.** CHBRP found limited evidence from two reviews that nutritional treatment is effective on induction and maintenance of remission in Crohn's disease and comparatively effective to standard treatment (i.e., drug therapy). CHBRP found insufficient evidence from one systematic review on the efficacy of nutritional treatment for ulcerative colitis. Though the studies in the systematic review provide some evidence regarding the efficacy of nutritional treatment for ulcerative colitis, they were not specific to nutritional treatment alone, but to patients on an enteral nutrition diet and steroid therapy. CHBRP found insufficient evidence on the efficacy of nutritional treatment for inherited metabolic disorders. No studies were found that examined the effectiveness of nutritional treatment for inherited metabolic disorders, and available evidence on treatment for these disorders are treatment guidelines based on expert opinion. Limiting factors that contribute to this evidence grade are the small number of individuals with these conditions, need for timely treatment, and ethical barriers to conducting other types of studies with this population.

v) **Utilization.** CHBRP estimates 148 commercial and CalPERS enrollees will use formula or special foods for other inherited metabolic disorders that are covered by insurance and an additional four enrollees use them as a noncovered benefit at baseline. Postmandate, 163 enrollees will use formulas or special food products covered by insurance, including the four who used them at baseline and 11 additional enrollees who begin using them due to the coverage expansion. CHBRP estimates 431 commercial and CalPERS enrollees will use formula or special foods for other digestive disorders that are covered by insurance and an additional 1,503 enrollees use them as a noncovered benefit at baseline. Postmandate, 5,185 enrollees will use formulas or special food products covered by insurance, including the 1,503 who used them at baseline and 3,251 additional enrollees who begin using them due to the coverage expansion. At baseline, a total of 579 enrollees with these conditions who use formula and special food products have coverage. Postmandate, a total of 4,769 enrollees would have new benefit coverage for these products, including 1,507 enrollees using these products at baseline and an additional 3,262 enrollees who begin using these products due to the coverage expansion.

vi) **Public health.** Due to the limited number of enrollees impacted, CHBRP concludes that this bill would have no measurable short-term or long-term public health impact. Although nutritional treatment for inherited metabolic disorders is supported by clinical guidelines, the change in utilization is small, and such disorders are rare. Although utilization of nutritional treatment for digestive disorders would increase, there is limited evidence that this treatment is effective for inducing or maintaining remission compared to standard drug treatment for Crohn's disease and insufficient evidence on the effect of nutritional treatment for ulcerative colitis. Due to no measurable public health impact, CHBRP concludes that this bill would also have no impact on disparities in health outcomes. This bill would also have no measurable long term impact on public health, premature death, or societal economic losses.

vii) **Long-term impacts**. CHBRP estimates utilization after the initial 12 months from the enactment of this bill would likely stay similar to utilization estimates during the

first 12 months postmandate. Utilization changes may occur if new prescription medications or other advancements change the treatment options available for enrollees with digestive or other inherited metabolic disorders. Similarly, utilization may be greater than estimated if detection capabilities improve or overall prevalence increases such that more enrollees are diagnosed with digestive or other inherited metabolic disorders; however, CHBRP is unable to predict these types of changes. In addition, health care utilization may change if effective management of a condition through increased use of newly covered formulas and special food products allows enrollees with digestive or other inherited metabolic disorders to delay use of other treatments such as prescription medications and surgery.

b) **OTHER STATES**. The National Organization for Rare Disorders (NORD) publishes a state report card on coverage for medical nutrition, and for people with private insurance, the 2022 NORD report card shows that nine states mandate coverage for formula only, 27 states mandate coverage for medical nutrition more broadly, and 15 states do not mandate coverage. For people with state-funded insurance, 37 states mandate some degree of coverage for medical nutrition and 14 states do not mandate this coverage. New York law requires health insurers that cover prescription drugs to cover the cost of enteral formulas for home use, whether administered orally or via tube feeding, for which a physician or other licensed health care provider has issued a written order stating that the enteral formula is clearly medically necessary and has been proven effective as a disease-specific treatment regimen. The law lists specific diseases and disorders for which enteral formulas have been proven effective, including inherited diseases of amino acid or organic acid metabolism and Crohn's Disease.

3) **SUPPORT.** The Crohn's & Colitis Foundation, sponsors of this bill, writes IBD, which includes Crohn's disease and Ulcerative Colitis, causes chronic inflammation in the GI tract, the area of the body where digestion and absorption of nutrients take place. Normally, the immune system helps to protect the body from harmful infections and irritants. In IBD, however, the immune system reacts inappropriately, causing inflammation, which leads to symptoms such as abdominal pain and cramping, diarrhea, bleeding, weight loss, and/or fatigue. If left untreated, or when a patient is nonresponsive to treatment, complications can occur, which include malabsorption of nutrients, growth delays, and low bone mass. Some complications could lead to infection and then surgery, including removal of parts of the colon. Despite significant advances in medical care, complications are common, and ultimately occur in about 70% of Crohn's disease patients. Avoiding more expensive biologics and using medical nutrition instead, as provided in this bill, will reduce overall cost to the health care system. Additionally, in its analysis of previous legislation, CHBRP, stated enteral formulas "do not exceed the definition of EHBs in California because formula and special food products are considered durable medical equipment and would be encompassed within the "rehabilitative and habilitative services and devices." Finally, the sponsor concludes that enteral formulas and currently covered by Medi-Cal RX, and as currently drafted, this bill has zero impact on cost of Medi-Cal. While some commercial health plans also cover medical nutrition, such as enteral formulas, a gap remains. This bill simply aligns commercial health care coverage with what is already covered by Medi-Cal

4) **OPPOSITION.** The California Association of Health Plans (CAHP), the Association of California Life and Health Insurance Companies (ACLHIC), and America's Health Insurance Plans (AHIP) oppose mandates for health plans and insurers to cover specific

services, as well as bills that eliminate cost sharing and limit utilization management, which have similar cost impacts as coverage mandates. Moreover, they will increase costs, reduce choice and competition, and further incent some employers and individuals to avoid state regulation by seeking alternative coverage options. These bills will lead to higher premiums, harming affordability and access for small businesses and individual market consumers. CAHP, ACLHIC, and ACLHIC write that state mandates increase costs of coverage, especially for families who buy coverage without subsidies, small business owners who cannot or do not wish to self-insure, and California taxpayers who foot the bill for the state's share of those mandates.

5) **RELATED LEGISLATION.**

   a) AB 3059 (Weber) requires health plan or insure coverage human milk and human milk derivatives covered under the Medi-Cal program as of 1988. AB 3059 is pending in Assembly Health Committee.

   b) SB 1290 (Roth) expresses the intent of the Legislature to review California's EHBs benchmark plan and establish a new benchmark plan for the 2027 plan year. Limits the applicability of the current benchmark plan benefits to plan years on or before the 2027 plan year. SB 1290 is pending in Senate Health Committee.

6) **PREVIOUS LEGISLATION.** AB 620 was substantially similar to this bill and vetoed by Governor Newsom:

> "I am returning Assembly Bill 620 without my signature.
>
> This bill would require health plans to cover formulas that are part of a medically necessary diet for the treatment of chronic digestive diseases and inherited metabolic disorders.
>
> While I support individuals with these conditions having access to the nutritional support they may need, I am concerned this bill would exceed the state's set of essential health benefits, which are established by the state's benchmark plan under the provisions of the federal Affordable Care Act (ACA). As such, this bill's mandate would require the state to defray the costs of coverage in Covered California. This would not only increase ongoing state General Fund costs, but it would set a new precedent by adding requirements that exceed the benchmark plan. A pattern of new coverage mandate bills like this could open the state to millions to billions of dollars in new costs to cover services relating to other health conditions. This creates uncertainty for our healthcare system's affordability.
>
> For these reasons, I cannot sign this bill."

7) **COMMENTS.**

   a) **New mandate and impact to EHBs**. CHBRP's analysis notes that this bill does not exceed the definition of EHBs in California because formula is considered durable medical equipment and would be encompassed with the "rehabilitative and habilitative services and devices." It is unclear whether the appropriate state regulators have conducted this analysis.

b) **Regional enteritis.** The author may wish to define regional enteritis to clarify which conditions apply to this bill.

REGISTERED SUPPORT / OPPOSITION:

Support

Crohn's & Colitis Foundation (sponsor)
California Association of Medical Product Suppliers
California Children's Hospital Assn.
Children's Specialty Care Coalition

Opposition

America's Health Insurance Plans
Association of California Life and Health Insurance Companies
California Association of Health Plans

Analysis Prepared by: Kristene Mapile / HEALTH / (916) 319-2097

Date of Hearing: April 2, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 1943 (Weber) – As Introduced January 29, 2024

SUBJECT: Health information.

SUMMARY: Requires the Department of Health Care Services (DHCS), in collaboration with the California Health and Human Services Agency (CHHSA), to collect specified data on telehealth access and individual and population health outcomes, and use the data to measure the health outcomes of populations using a specified list of determinants. Specifically, **this bill**:

1) Requires DHCS, in collaboration with the CHHSA, to collect appropriate data and identify indicators for tracking telehealth outcomes associated with impacting individual patient outcomes and overall population health, including the following data:
   a) Medi-Cal program data that tracks individual and overall population health outcomes;
   b) Medi-Cal program data on who has access to telehealth, the effectiveness of telehealth, and access to special care; and,
   c) Medi-Cal program morbidity and mortality data, including environmental factors.

2) Requires DHCS to use the data collected to measure the health outcomes of populations by using all of the following determinants:
   a) Medical care;
   b) Public health interventions;
   c) Social determinants, including income, employment, social support, and culture;
   d) Physical environment, including urban design, air quality, and access to clean water;
   e) Genetics; and,
   f) Individual behavior.

EXISTING LAW:

1) Establishes the Medi-Cal Program, administered by DHCS, to provide comprehensive health benefits to low-income individuals who meet specified eligibility criteria. [Welfare and Institutions Code (WIC) §14000 *et seq*.]

2) Establishes a schedule of benefits under the Medi-Cal program. [WIC §14132]

3) Establishes Medi-Cal coverage for health care services provided through telehealth, including specifying that in-person, face-to-face contact between a health care provider and a patient is not required under the Medi-Cal program for covered health care services and provider types designated by DHCS, when those services and settings meet the applicable standard of care and meet the requirements of the service code being billed. [WIC §14132.725 and §14132.100]

4) Defines "telehealth" to:

   a) Mean the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care; and, [Business and Professions Code (BPC)§ 2290.5]

b) Include synchronous interactions as well as asynchronous store and forward transfers, which are defined as the transmission of a patient's medical information from an originating site to the health care provider at a distant site. [BPC § 2290.5 (a)]

5) Requires DHCS to develop a telehealth research and evaluation plan by January 1, 2023. [WIC §14132.725]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, California faces a significant challenge in understanding the usage and effectiveness of telehealth, especially among those enrolled in Medi-Cal, which serves low-income individuals. The author indicates this shortfall in data hampers the ability of policymakers to refine and expand telehealth services to ensure equitable access for all. This bill introduces a statewide policy to collect and analyze multiple Medi-Cal datasets to inform telehealth policy with a comprehensive view of how various social, economic, biological, and environmental factors impact health across populations. This bill is sponsored by the California Emerging Technology Fund (CETF), a non-profit corporation focused on closing the digital divide that was established pursuant to orders from the California Public Utilities Commission as a condition of approving a telecommunications merger.

2) **BACKGROUND.**

   a) **Asynchronous Store and Forward**. Current law defines "asynchronous store and forward" as the transmission of a patient's medical information from an originating site to the health care provider at a distant site without the presence of the patient. This may include, for example, electronic transmission of medical information, such as digital images, documents, and pre-recorded videos to a practitioner, often a specialist, who uses the information to evaluate the case or render a service outside of a real-time or live interaction. According to the Center for Connected Health Policy, store-and-forward technologies are most commonly used in radiology, pathology, dermatology, and ophthalmology. For example:
      i) In radiology, a physician at a small rural hospital can forward an X-ray or magnetic resonance imaging to a specialist at a major medical center for review.
      ii) In dermatology, a primary care provider can take digital photos of their patients' skin conditions and forward the images to a dermatologist for review and determination of treatment if needed.

   b) **Telehealth in Medi-Cal.** Telehealth is a mode of delivering health care services remotely using information technology. The three primary modalities are video, audio (including telephone), and asynchronous store and forward, which can be used when a real-time interaction is not needed.

      Telehealth utilization increased rapidly in response to the COVID-19 pandemic. According to data published by DHCS, prior to the onset of the COVID-19 pandemic, telehealth represented around 300 claims per 100,000 Medi-Cal member months. By April 2020, telehealth claims increased dramatically to over 12,000 claims per 100,000 member months and remained relatively stable through March 2021. Following March

2021, telehealth claims per 100,000 member months remained significantly higher than pre-COVID-19 pandemic levels but declined from the peak to around 7,700 claims per 100,000 member months.

c) **Recent History of Medi-Cal Telehealth Policy**. Prior to the COVID-19 pandemic, DHCS had expanded the availability of telehealth in Medi-Cal by allowing most clinically appropriate services to be provided through telehealth. During the COVID-19 pandemic, DHCS implemented additional telehealth flexibilities to allow Medi-Cal providers to meet the health care needs of enrollees. After significant stakeholder engagement and legislative agreement on final trailer bill language, post-pandemic Medi-Cal telehealth policies were codified through the 2022-23 health trailer bill, SB 184 (Committee on Budget and Fiscal Review), Chapter 47, Statutes of 2022, with minor and clarifying changes made through subsequent legislation.

d) **Medi-Cal Telehealth Policy**. According to DHCS, California has been a leading state in the expansiveness of its coverage and reimbursement for services delivered via telehealth. DHCS has committed to continuing to enable broad telehealth coverage for all Medi-Cal covered benefits and services, as long as the provider is able to meet the standard of care, subject to billing, reimbursement and utilization management policies developed by DHCS. In addition, DHCS notes Medi-Cal is unique among other state Medicaid programs in regard to payment parity, in that the state reimburses a broad array of services at parity when delivered via audio-only visits. Medi-Cal telehealth policies are described below:

i) **Provider Requirements**: A health care provider rendering Medi-Cal covered benefits and services via telehealth must be:

(1) Licensed in California or otherwise authorized by law; and,
(2) Enrolled as a Medi-Cal rendering provider or be a non-physician medical practitioner affiliated with an enrolled Medi-Cal provider group.

Unlicensed providers designated by DHCS, such as doulas, may provide services within their scope through telehealth, as specified in the Medi-Cal Provider Manual.

ii) **Telehealth Covered Services**: Telehealth services are reimbursable if the health care provider believes that the service being provided is clinically appropriate. The telehealth service must meet the procedural definition of the Current Procedural Terminology or Healthcare Common Procedure Coding System code associated with the service, as well as follow any additional guidance provided by DHCS (e.g., through the Medi-Cal Provider Manual).

iii) **Telehealth Covered Modalities**: Medi-Cal reimburses for telehealth visits conducted via audio-only telehealth (i.e., telephone), video telehealth, or through asynchronous telehealth (i.e., store and forward and e-consults).

iv) **Telehealth Payment Parity**: The amount paid by Medi-Cal, through both fee-for-service (FFS) and Medi-Cal managed care plans, for a service rendered via any telehealth modality is the same as the amount paid for the applicable service when rendered in-person.

v) **Telehealth Modifiers**: Providers must designate telehealth modality with an appropriate modifier when billing for telehealth services.

vi) **Establishment of New Patients via Telehealth**: According to DHCS policy, a health care provider may bill Medi-Cal for a visit with a new patient that is conducted via video. AB 32 (Aguilar-Curry), Chapter 515, Statutes of 2022, Medi-Cal also allows a provider to bill for a visit with a new patient that is conducted via audio-only telehealth (e.g., phone or other audio device), but only under certain circumstances. These circumstances include when the visit is related to "sensitive services," including behavioral health and reproductive health services, or when the patient requests an audio-only modality or attests they do not have access to video. Additional exceptions may be made by DHCS in consultation with stakeholders.

vii) **Patient Consent**: A health care provider must inform the patient once prior to the initial delivery of telehealth services about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services. Statute specifies information that must be shared with a patient.

Statute also establishes two policies that are not currently implemented, which will be implemented no sooner than January 1, 2024.

i) **Patient Choice of Telehealth Modality**: No sooner than January 1, 2024, DHCS will phase in an approach that requires a provider offer both video and audio-only telehealth to ensure patients have their choice of telehealth modality. DHCS is developing guidance on exceptions to this requirement, to include exceptions based on a Medi-Cal provider's lack of access to adequate broadband speeds to effectively stream video.

ii) **Patient Right to In-Person Services**: No sooner than January 1, 2024, DHCS will phase in an approach where providers who offer services via telehealth will be required to either offer those same services in-person or arrange for a referral to, and a facilitation of, in-person care that does not require a patient to independently contact a different provider to arrange for that care.

e) **Disparities in Utilization.** In addition to Medi-Cal utilization data, the California Health Interview Survey (CHIS) has been a key data source for statewide telehealth data. According to an October 2023 analysis of CHIS data by the UCLA Center for Health Policy Research, "Telehealth and the Future of Health Care Access in California," in 2021, about half (49%) of California adults reported using telehealth to seek care and telehealth use decreased to 46.7% in 2022. The report notes telehealth remained a popular way to access care even after declining from record-high utilization levels seen during the pandemic. However, the use of telehealth varied widely. The report concluded:

i) Twice as large a proportion of adults who had health insurance used telehealth compared to adults without health insurance.

ii) Compared to adults with employer-sponsored insurance, smaller proportions of adults with Medicaid or private insurance, and larger proportions of adults with either Medicare and Medicaid or Medicaid and other public insurance, used telehealth.

iii) Adults above the age of 26 were more likely to use telehealth than young adults between the ages of 18 and 26, with adults over 65 being the most likely to use telehealth.

iv) Smaller proportions of adults with incomes below 300% of the federal poverty level (FPL) used telehealth compared to adults with incomes at or above 300% FPL.

v) Latinx and Asian adults were less likely to use telehealth compared with white adults. White, Black, and American Indians and Alaska Native adults were more likely to use telehealth compared with the general California adult population.

According to a 2023 Issue Brief released by the California Health Care Foundation, "Telehealth Use and Experiences Among California Adults," in general, the patterns of telehealth use track with broader patterns of having seen a doctor in any setting. People on Medicare (both those dually covered by Medicaid and those only on Medicare) and people in poor health report more doctor visits in general and are more likely to use telehealth. Similarly, the uninsured, younger people, people with lower incomes, and those in better health report fewer doctor visits overall and less telehealth use. Black Californians were slightly more likely to use telehealth than other racial groups and reported a higher level of satisfaction with video visits than the population overall. The brief found no evidence that telehealth exacerbated overall health care access disparities, but neither did it eliminate access to care disparities at the population level during the pandemic. According to the brief, this is likely due to the persistence of structural barriers, such as limited provider availability, even as telehealth use has grown.

f) Currently Available Medi-Cal Data.

i) Administrative Data. DHCS has access to claims data that DHCS pays directly through the FFS Medi-Cal program, as well as encounter data provided to DHCS by managed care plans that pay providers for Medi-Cal services. Claims and encounter data include a large number of data elements about each medical service provided, for instance, type of service (often called a service or billing code), procedures, diagnoses, rendering provider, and dates of service. FFS claims data also includes provider charges and payment data. Although there are some concerns about the accuracy of claims data for certain types of analyses, they provide a detailed picture of health status and service utilization at an individual level. DHCS also has other administrative data, such as on age and race/ethnicity, which it links with claims data to provide a fuller picture of the health status and service utilization of different Medi-Cal populations.

ii) Telehealth Data. DHCS has produced telehealth data reports by analyzing a subset of claims and encounters that include a telehealth "modifier," which is a two-letter code appended to a service code to designate the service was delivered via telehealth. DHCS' telehealth data have been housed within an internal dashboard that includes FFS and managed care data from the DHCS Medi-Cal Data Warehouse. These include outpatient medical and non-specialty mental health services and do not currently include dental, specialty mental health or substance use disorder services; however, DHCS plans to incorporate these data in the future. DHCS has used the internal dashboard to conduct analyses of outpatient claims over time, starting before the pandemic, and also to produce point-in-time measures. DHCS has committed to

creating a public telehealth dashboard to display these data.

DHCS has produced public reports on telehealth visits per 100,000 beneficiaries by age group, sex, race/ethnicity, aid code (which designates a beneficiary's category of Medi-Cal eligibility), delivery system (FFS or managed care), and managed care plan. Additionally, DHCS analyses examined the claims volume and percent of telehealth office visits for new and established patients, including, for example, for behavioral health and treatment of speech, language, and hearing disorders. DHCS analyses have also examined utilization of services by modality of care, e.g., use of telehealth along with in-person office visits.

iii) **Quality Data**. DHCS requires reporting of a large number of quality measures to measure the overall success of managed care plans in delivering recommended care. DHCS has published a Comprehensive Quality Strategy which outlines priority areas, including behavioral health integration, improved maternal outcomes, and children's preventive care. Many of these priority areas are tracked through a set of metrics called Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS a measurement system used nationwide to measure and improve performance in health care. These data can be analyzed with telehealth data to examine the impact of telehealth on HEDIS measures and other quality metrics.

g) **2022 Medi-Cal Telehealth Research and Evaluation Plan** (R&E Plan). Pursuant to a statutory requirement included in SB 184, DHCS issued the R&E plan in December 2022. The R&E Plan described DHCS' state of telehealth data collection processes and capabilities, as well as opportunities to support more comprehensive data collection and analyses in the future. DHCS describes the R&E Plan as a path to assess the impact of telehealth on utilization, access, quality, outcomes, equity, and provider and enrollee experience, which could then inform future telehealth policy development. The plan presented telehealth R&E Plan questions that have been proposed by DHCS and stakeholders across key domains, and proposed both near-term and longer-term R&E Plan questions.

According to the R&E Plan, the most pressing need in the near term is to better understand the impact of all telehealth modalities on access and utilization of care among Medi-Cal enrollees. This is done by collecting data, analyzing and reporting findings on baseline telehealth utilization and access to care among Medi-Cal enrollees. Longer-term, DHCS indicates a desire to use data to understand the impact of Medi-Cal telehealth policy on experience, quality, outcomes, and cost, including the impact of telehealth on HEDIS measures, as mentioned above. This longer-term research has a three to five year time frame. DHCS notes longer-term questions are different from the set of near-term research questions in that the research relies on different data sources, metrics, and data collection, and that the analysis may require the support of external research partners or other entities. Given some of the longer-term questions require careful research designs and significant data analysis, the ability of DHCS to address these longer-term research questions is dependent on the availability of resources.

With respect to the goals of this bill, a "deep dive" to examine the nuanced reasons for disparities in telehealth use and quality of care delivered through telehealth could potentially improve health equity by illuminating barriers to more and better telehealth

use to in the delivery of timely, quality specialty care. As DHCS notes in the R&E Plan, this level of analysis may require the support of external research partners.

3) **SUPPORT.** According to CETF, the bill's sponsor, this is the next step to drive access to health and medical care through the collection of essential data to ensure "Telehealth for All" to achieve health equity. CETF notes that despite the work of the state on telehealth policy and research, the challenge remains to measure to what extent access to telehealth—including specialty care through remote patient visits and expert consultations—can reduce adverse health outcomes for residents who are both economically and medically disadvantaged. Asynchealth, a start-up asynchronous telepsychiatry company that uses Artificial Intelligence to improve care, similarly lauds this bill's impact on health equity.

4) **DOUBLE REFERRAL.** This bill is double referred, upon passage of this Committee, this bill will be re-referred to the Assembly Privacy and Consumer Protection Committee.

5) **RELATED LEGISLATION.** AB 2339 (Aguiar-Curry) allows providers to be reimbursed for a telehealth visit that establishes a new patient relationship through asynchronous store-and-forward when the visit is related to sensitive services, or when the new patient requests such a modality, as specified. AB 2339 is pending in this Committee.

6) **PREVIOUS LEGISLATION.**

   a) AB 1241 (Weber), Chapter 172, Statutes of 2023, clarifies two provisions of current law requiring a provider furnishing services through video or audio telehealth to offer services in-person or facilitate in-person care.

   b) AB 32 establishes Medi-Cal coverage for establishment of new patients through audio telehealth under specified circumstances, including for reproductive health and behavioral health services, and clarified DHCS shall consider a Medi-Cal provider's access to broadband at specified speeds, in establishing exceptions to the requirement that providers offering audio-only telehealth also offer video telehealth.

   c) SB 184 establishes Medi-Cal telehealth policy, including coverage, reimbursement patient consent standards, informational notices, DHCS authority to designate providers who may provide services through telehealth, treatment of telehealth for network adequacy purposes and a research and evaluation plan.

   d) AB 133 (Committee on Budget), Chapter 143, Statutes of 2021, extended until December 31, 2022, flexibilities in reimbursement for care provided to Medi-Cal beneficiaries via telehealth, implemented during the COVID-19 public health emergency and required DHCS to convene a telehealth advisory workgroup, as specified.

   e) AB 457 (Santiago), Chapter 439, Statutes of 2021, established requirements on health plans and health insurers intended to ensure care offered through third-party telehealth providers remain coordinated with a patient's primary care providers.

   f) AB 1022 (Mathis) of 2022 would have expanded the ability of an approved Program of All-Inclusive Care for the Elderly organization, which provides Medi-Cal and Medicare services, authority to use video telehealth to conduct all assessments, as specified. AB 1022 was referred to the Assembly Health Committee and not heard.

6) **AMENDMENTS.** To more clearly define the bill's focus on how telehealth impacts access to specialty care, reduce the administrative potential burden of producing novel data sources, and better align with DHCS's planned telehealth research agenda, the author and Committee have agreed to strike Section 2 of the bill and insert the following language:

(a) Using Medi-Cal data and other data sources available to the department, the department shall produce a public report on telehealth in the Medi-Cal program that includes analyses of the following:

- ***(i) Telehealth access and utilization.***
- ***(ii) Effect of telehealth on timeliness of, access to, and quality of care, including specialty care, for Medi-Cal enrollees, including among target populations of Medi-Cal enrollees identified within the Comprehensive Quality Strategy.***
- ***(iii) Effect of telehealth on clinical outcomes at an individual and population level.***
- ***(iv) Effect of telehealth on preventive care HEDIS quality measures reported by Medi-Cal managed care plans.***

(b) (i) Wherever possible based on the availability of such data, these analyses shall be stratified by geographic, demographic and social determinants of health categories to identify disparities.

(ii) Social determinants of health categories may be approximated using existing data sources such as Healthy Places Index or similar indices.

(c) The department, in collaboration with the California Health and Human Services Agency, may issue policy recommendations based on the report's findings, as determined by the department.

REGISTERED SUPPORT / OPPOSITION:

Support

California Emerging Technology Fund (sponsor)
AARP
American GI Forum Education Foundation of Santa Maria, CA
AsyncHealth
Beehive Technology Solutions
Calexico Wellness Center
California Human Development
California Pan - Ethnic Health Network
California Telehealth Policy Coalition
Central Valley Opportunity Center
Community Tech Network
Contra Costa Health Services
Corporation for Education Network Initiatives in California
First Day Foundation
Inland Coalition for Immigrant Justice

LA Cooperativa Campesina de California
LeadingAge California
Los Angeles Jewish Health
Partners in Care Foundation
Proteus, Inc.

Opposition

None on file.

Analysis Prepared by: Lisa Murawski / HEALTH / (916) 319-2097

Date of Hearing: April 2, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 1965 (Blanca Rubio) – As Introduced January 29, 2024

SUBJECT: Public health: Office of Tribal Affairs.

SUMMARY: Establishes the Office of Tribal Affairs (OTA) within the Department of Public Health (DPH). Specifically, **this bill**:

1) Requires the OTA to be led by a Tribal Health Liaison to assist in addressing the public health disparities impacting Tribal communities.

2) Provides that the Tribal Health Liaison will be appointed by and serve at the pleasure of the State Public Health Officer (PHO).

3) Requires the PHO to regularly consult with and consider input and information provided by the Tribal Health Liaison.

4) Makes related findings and declarations to that effect that tribal communities face significant health disparities.

EXISTING LAW

1) Establishes the Office of Health Equity (OHE) within DPH to do all of the following:

   a) Perform strategic planning to develop departmentwide plans for implementation of goals and objectives to close the gaps in health status and access to care among the state's diverse racial and ethnic communities, women, persons with disabilities, and the lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQQ) communities;

   b) Conduct departmental policy analysis on specific issues related to multicultural health;

   c) Coordinate projects funded by the state that are related to improving the effectiveness of services to ethnic and racial communities, women, and the LGBTQQ communities;

   d) Identify the unnecessary duplication of services and future service needs;

   e) Communicate and disseminate information and perform a liaison function within DPH and to providers of health, social, educational, and support services to racial and ethnic communities, women, persons with disabilities, and the LGBTQQ communities.

   f) Consult regularly with representatives from diverse racial and ethnic communities, women, persons with disabilities, and the LGBTQQ communities, including health providers, advocates, and consumers;

   g) Perform internal staff training, an internal assessment of cultural competency, and training of health care professionals to ensure more linguistically and culturally competent care;

h) Serve as a resource for ensuring that programs collect and keep data and information regarding ethnic and racial health statistics, including those statistics described in reports released by Healthy People 2020, and information based on sexual orientation, gender identity, and gender expression, strategies and programs that address multicultural health issues, including, but not limited to, infant and maternal mortality, cancer, cardiovascular disease, diabetes, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), child and adult immunization, osteoporosis, menopause, and full reproductive health, asthma, unintentional and intentional injury, and obesity, as well as issues that impact the health of racial and ethnic communities, women, and the LGBTQQ communities, including substance abuse, mental health, housing, teenage pregnancy, environmental disparities, immigrant and migrant health, and health insurance and delivery systems;

i) Encourage innovative responses by public and private entities that are attempting to address multicultural health issues;

j) Provide technical assistance to counties, other public entities, and private entities seeking to obtain funds for initiatives in multicultural health, including identification of funding sources and assistance with writing grants; and,

k) Requires DPH to biennially prepare and submit a report to the Legislature on the status of the activities required by this chapter. [HSC § 152]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, Tribal and urban Indian communities have worse health outcomes than any other minority population across nearly every measurable disease prevalence. Many of these health outcomes are related to colonialism, poverty, and historic and intergenerational trauma. The author continues that no one action will address the many health disparities that exist in Tribal communities. The author concludes that establishing an OTA and appointing a Tribal Liaison with regular access to DPH's leadership will provide a dedicated state resource that is responsible for taking these challenges head-on, and providing policy solutions and recommendations to state leaders.

2) **BACKGROUND.**

   a) **Health Disparities for American Indian and Alaska Native (AIAN) subpopulations.**

      i) **Life expectancy.** According to a 2021 National Vital Statistics report, life expectancy at birth was 71.8 years for the total non-Hispanic AIAN population as of 2019. By comparison, life expectancy at birth was 81.9 years for the Hispanic population, 78.8 years for the non-Hispanic white population, and 74.8 years for the non-Hispanic Black population.

      ii) **Obesity.** According to Kaiser Family Foundation (KFF) survey data, 40% of the non-elderly adult (ages 18-64) AIAN population surveyed are obese, compared to

30% the non-elderly white population.

iii) Asthma. According to KFF survey data, 15% of the non-elderly adult (ages 18-64) AIAN population surveyed are obese, compared to 10% the non-elderly white population.

iv) Diabetes. According to DPH data, diabetes prevalence was two times higher among the AIAN population compared to the non-Hispanic white population in 2019. In 2020, diabetes death was two times higher among the AIAN population compared to the non-Hispanic white population.

v) Substance Use Disorder. According to KFF survey data, 15% of the non-elderly adult (ages 18-64) AIAN population surveyed report substance use disorder, compared to 10% the non-elderly white population.

vi) End Stage Renal Disease. According to the Office of Minority Health within the United States Department of Health and Human Services, in 2017, AIAN individuals were twice as likely to be diagnosed with end stage renal disease as non-Hispanic white individuals.

vii) Mental Health. According to DPH's 2023 demographic report, multiracial and AIAN adults in California have higher rates of serious psychological distress during the past year (20.3 and 18.7 percent, respectively) compared to Black or African American and Asian adults (10.2 and 9.8%, respectively). Additionally, AIAN individuals and white individuals had the highest rates of suicide in 2021, with white individuals maintaining their higher rates into 2022. Suicide rates among AIAN more than doubled from 2020 to 2021.

viii) Syphilis. According to the Centers for Disease Control and Prevention (CDC), babies born to AIAN parents were up to eight times more likely to have newborn syphilis in 2021 than babies born to non-Hispanic white individuals.

ix) Cancer. According to the CDC, American Indian and Alaska Native (Native American) people have much higher rates of getting several cancers, including lung, colorectal, liver, stomach, and kidney cancers, compared to non-Hispanic white people in the United States.

b) Executive Orders. Recent Governors have taken steps to encourage communication and consultation between state agencies and departments with California Indian Tribes. Governor Jerry Brown signed Executive Order B-10-11 which states: "that it is the policy of this Administration that every state agency and department subject to my executive control shall encourage communication and consultation with California Indian Tribes. Agencies and departments shall permit elected officials and other representatives of tribal governments to provide meaningful input into the development of legislation, regulations, rules, and policies on matters that may affect tribal communities." Governor Gavin Newsom reaffirmed his predecessors actions through Executive Order N-15-19, which does the following: "recognizes that the State historically sanctioned over a century of depredations and prejudicial policies against California Native Americans; commends and honors California Native Americans for persisting, carrying on cultural and linguistic

traditions, and stewarding and protecting this land that we now share; and apologizes on behalf of the citizens of the State of California to all California Native Americans for the many instances of violence, maltreatment and neglect California inflicted on tribes." Additionally, Executive Order N-15-19 reaffirms and incorporates by reference the principles outlined in Executive Order B-10-11, which requires the Governor's Tribal Advisor and the Administration to engage in government-to-government consultation with California Native American tribes regarding policies that may affect tribal communities.

c) **OTA.** Some state departments and agencies have already established an Office of Tribal Affairs (OTA), including the Department of Social Services (DSS), the Department of Health Care Services (DHCS), and the Governor's Office of Emergency Services. DPH recently established the OHE. The OHE provides a key leadership role to reduce health and mental health disparities experienced by vulnerable communities in California. The OHE works with community-based organizations and local governmental agencies to ensure that community perspectives and input help to shape a health equity lens in policies and strategic plans, recommendations, and implementation activities. According to DPH, the current Tribal Liaison is the Deputy Director of the OHE, who oversees a Tribal Health Equity consultant. Duties for this position include, among other things: engagement with Tribes and other relevant partners to understand needs and serve as the liaison to communicate needs and issue specific (COVID, data sharing) solutions from Tribal communities to DPH, the California Health & Human Services Agency (CHHSA), state COVID-19 Task Forces, and other State agencies, as specified. The Tribal Liaison also ensures that the support and technical assistance provided by DPH is culturally competent, and timely. The Tribal Liaison briefs the Director as needed (several times per year) and annually before the Tribal Nations Summit attended by the Governor, Secretaries, Directors, Tribal Liaisons, and Tribal Chairpersons. In 2020, in response to the COVID-19 State of Emergency, a DPH Tribal Information sharing meeting (bi-weekly, now monthly) was established in partnership with CHHSA Tribal Liaison. In 2022 a Tribal Health Equity Lead was hired. In 2022 a Tribal Long COVID Work Group was established and in 2023 a Tribal Data Work Group was established. To help coordinate work on non-COVID AIAN disparities, a Tribal Coordinator position is expected to be posted later this spring 2024. This position will launch and coordinate an advisory board of Tribal representatives to ensure ongoing feedback and input on emerging issues, ensuring culturally and community responsive program improvements. The position will oversee the DPH Tribal Health Equity meetings, advisory groups, workgroups, among other duties.

   This bill establishes a standalone OTA, separate from the OHE.

3) **SUPPORT.** The California Consortium for Urban Indian Health (CCUIH) states that Office of Tribal Affairs established by this bill would play a crucial role in addressing the persistent health disparities faced by Tribal communities across California. The key provisions of this bill, such as the designation of a Tribal Health Liaison to lead the Office of Tribal Affairs and the requirement for regular consultation with Tribal representatives, underscore a commitment to addressing the unique healthcare needs of Native communities. CCUIH believes that these provisions have the potential to significantly impact Urban Indian Health Organizations by fostering increased collaboration, support, and resource allocation towards improving health outcomes for urban Native American populations. CCUIH recommends

amendments to include language ensuring the active engagement of Indian Health Programs statewide utilized by DHCS and DSS to enhance the effectiveness in addressing the needs of AIAN individuals.

4) **PREVIOUS LEGISLATION.**

   a) AB 2655 (Blanca Rubio) of 2022 would have required DPH to enter into a data sharing agreement with the California Tribal Epidemiology Center for access to and use of the California Reportable Disease Information Exchange and the California Immunization Registry systems no later than January 1, 2023, and prohibits the California Tribal Epidemiology Center from disclosing any information received to any person or entity, except in response to a court order, search warrant, or subpoena, or as otherwise required or permitted by specified federal medical privacy regulation. AB 2655 died on the Senate inactive file.

   b) AB 1467 (Committee on Budget), Chapter 23, Statues of 2012 established the OHE within DPH.

5) **AMENDMENTS.** The author may wish to amend this bill to specify the duties of the OTA.

REGISTERED SUPPORT / OPPOSITION:

Support

The California Consortium for Urban Indian Health (CCUIH)

Opposition

None on file.

Analysis Prepared by: Eliza Brooks / HEALTH / (916) 319-2097

Date of Hearing: April 2, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2052 (Jones-Sawyer) – As Introduced February 1, 2024

SUBJECT: School-Based Health and Education Partnership Program.

SUMMARY: Makes various changes to the grant program within the Public School Health Center Support Program (PSHCSP). Specifically, **this bill**:

1) Requires the State Department of Public Health (DPH) to collaborate with the Office of School-Based Health Programs (OSBHP) within the State Department of Education (CDE) in order to award PSHCSP grant funds.

2) Revises and reorganizes the preferred recipients and gives preference to school-based health centers (SBHCs) serving, among others, schools in which more than 55% of pupils serviced are unduplicated pupils, as defined, or areas experiencing health disparities in child and adolescent access to primary care, behavioral health, preventative health, or oral health services.

EXISTING LAW:

1) Establishes the PSHCSP within DPH, in collaboration with the CDE to perform specified functions, including providing technical assistance to school health centers on effective outreach and enrollment strategies to identify children who are eligible but not enrolled in specified health care programs; serve as a liaison between organizations on prevention services, primary care, and family health; and, to provide technical assistance to facilitate and encourage the establishment, retention or expansion of health centers. [Health and Safety Code (HSC) § 124174.2]

2) Requires DPH to establish standardized data collection procedures and collect specified data from health centers on an ongoing basis. [HSC § 124174.3]

3) Requires CDE, in collaboration with the DPH, to coordinate programs within CDE that support school health centers and programs within the Department of Health Care Services (DHCS), where appropriate and provide technical assistance to facilitate and encourage the establishment, retention, and expansion of school health centers in public schools. [HSC § 124174.4]

4) Requires PSHCSP, in collaboration with the CDE to act as a liaison for SBHCs. [HSC § 124174.5]

5) Requires DPH to establish a grant program within the PSHCSP to provide technical assistance, and funding for the expansion, renovation, and retrofitting of existing school health centers and the development of new health centers, as specified. [HSC § 124174.6]

6) Makes available the following grants:

a) Planning grants in amounts between $25,000 and $50,000 for a six to 12 month period to be used for the costs associated with assessing the need for a school health center in a particular community or area, and developing the necessary partnerships. Applicants for planning grants are required to have a letter of interest from a school or district if the applicant is not a local education agency (LEA).

   i) Requires grantees provided funding to do all of the following:

      (1) Seek input from students, parents, school nurses, school staff and administration, local health providers, and if applicable, special population groups, on community health needs, barriers to health care, and the need for a school health center;
      (2) Collect data on the school and community to estimate the percentage of students that lack health insurance and the percentage that are eligible for Medi-Cal benefits, or other public programs providing free or low-cost health services;
      (3) Assess capacity and interest among health care providers in the community to provide services in a school health center; and,
      (4) Assess the need for specific cultural or linguistic services, or both.

b) Facilities and startup grants to be available in amounts between $20,000 and $250,000 per year for a three-year period for the purpose of establishing a school health center, with the potential addition of $100,000 in the first year for facilities construction, purchase, or renovation. Allows grant funds to be used to cover a portion or all of the costs associated with designing, retrofitting, renovating, constructing, or buying a facility, for medical equipment and supplies for a school health center, or for personnel costs at a school health center. Gives preference to proposals that include a plan for cost sharing among schools, health providers, and community organizations for facilities construction and renovation costs.

c) Requires applicants for facilities and startup grants to meet the following criteria:

   i) Have completed a community assessment determining the need for a school health center;

   ii) Have a contract or memorandum of understanding between the school district and the health care provider, if other than the district, and any other provider agencies describing the relationship between the district and the school health center;

   iii) Have a mechanism, described in writing, to coordinate services to individual students among school and school health center staff while maintaining confidentiality and privacy of health information consistent with applicable state and federal laws;

   iv) Have a written description of how the school health center will participate in the following:
      (1) School and districtwide health promotion, coordinated school health, health education in the classroom or on campus, program/activities that address nutrition, fitness, or other important public health issues, or promotion of policies that create a healthy school environment;
      (2) Outreach and enrollment of students in health insurance programs; and,

(3) Public health prevention, surveillance, and emergency response for the school population.

v) Have the ability to provide the linguistic or cultural services needed by the community. If the school health center is not yet able to provide these services due to resource limitations, requires the school health center to engage in an ongoing assessment of its capacity to provide these services; and,

vi) Have a plan for maximizing available third-party reimbursement revenue stream.

d) Sustainability grants to be available in amounts between $25,000 and $125,000 per year for a three-year period for the purpose of operating a school health center, or enhancing programming at a fully operational school health center, including oral health or mental health services. Specifies criteria for sustainability grants. [HSC § 124174.6]

7) Requires DPH to give preference for grant funding to the following schools:

a) Schools in areas designated as federally medically underserved areas (MUAs) or in areas with medically underserved populations (MUPs);

b) Schools with a high percentage of low-income and uninsured children and youth;

c) Schools with large numbers of limited English proficient (LEP) students;

d) Schools in areas with a shortage of health professionals; and,

e) Low-performing schools with Academic Performance Index (API) rankings in the deciles of three and below of the state. [HSC § 124174.6]

8) Establishes the OSBHP within CDE, no later than January 1, 2022, to among other functions, improve the operation of, and participation in, school based health programs, including the Medi-Cal Administrative Activities claiming process and LEA Medi-Cal Billing Option Program. [Education Code (EDC) § 49418]

9) Requires the OSBHP to collaborate with the DHCS and other departments and offices involved in the provision of school-based health services. [EDC § 49418]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, the PSHCSP was established in 2009 and since then the number of SBHCs in California has grown to 377 centers spread across 37 counties. The author states that SBHCs provide accessible and integrated physical and behavioral health care services to students and their families, regardless of their ability to pay for health services, and have been proven to improve attendance, academic achievement, and aid in school climate. The author contends that in order to make sure these health centers are able to expand and continue serving students and communities, existing law needs to be cleaned-up and improved. The author states that this bill does so by requiring the DPH to

coordinate with the OSBHP in the grant awarding and administration process. The author also states this bill will update the preference for grant funding to align with existing language in the EDC and ensure that schools serving students with the greatest need are prioritized.

2) **BACKGROUND.**

a) **SBHCs.** According to the California School-Based Health Alliance, there are 293 SBHCs in California but over 10,000 schools, and their distribution is not a coordinated, state-wide project, although individual districts have strategically worked to increase access to care. Many SBHCs are located in schools serving some of the state's most vulnerable children: 70% of students attending schools with a SBHC receive free and reduced-priced lunches and primarily serve low-income students and reduce health disparities for young people by increasing access to comprehensive health care. SBHCs also improve educational equity by reducing barriers to learning (e.g. missed school days due to illness), often disproportionately experienced by low-income students and students of color. The most common organizations serving as the health care providers and sponsors of SBHCs in California are community health centers and school districts. Other sponsoring organizations include county health departments, hospitals and medical centers, mental health agencies, nonprofit community-based organizations, and private physician groups. SBHCs are also funded through third-party reimbursement from state-sponsored programs, such as Medi-Cal. SBHCs offer a range of services with the most common being primary medical services. Services are provided at no or low cost to clients. No one is refused service for inability to pay. Some of the common services provided by SBHCs in California (and the percentage of SBHCs offering them) include: medical services (85%); mental health services (70%); reproductive health screening and prevention (57%); reproductive health clinical care (60%); dental prevention services (65%); dental treatment services (35%); and, youth engagement programs (51%).

b) **Impacts of SBHCs.** SBHCs are crucial for providing accessible and integrated physical and behavioral health care services to students and their families, regardless of their ability to pay for health services. According to a national study published in the National Library of Medicine in 2023, students who had access to SBHCs were significantly more likely to have regular dental visits, a regular source of medical care, and health insurance. Regular access to care has been shown to improve long-term health outcomes as well as improve academic outcomes.

   Moreover, rates of depression and suicidal feelings among high school students have steadily increased in the last decade. According to the Centers for Disease Control and Prevention, 32% of high school students nationwide "experienced persistent feelings of sadness or hopelessness" in 2020 and 48.6% of LGBTQ high school students in California seriously considered suicide in 2022. Mental illness is now the number one reason for hospitalization of school aged children in California, with 29,457 children being hospitalized in 2020 alone.

   Lastly, SBHCs have been proven to increase attendance, academic achievement, and aid in school climate, which allows students to focus on their goals and thrive. A Los Angeles study from 2021 found that attendance improved by an average of five days following "any type of visit to a school based health center."

c) **Student Health Index (SHI).** The California School-Based Health Alliance published in Fall 2021 the SHI Report. The SHI Report points out that the twin pandemics of COVID-19 and racial reckoning revealed the increasing need for health and mental health supports and the low access to these services. California is one of 15 states that does not provide state-level funding and support for SBHCs. Highest need schools are concentrated, especially in the Central Valley and Inland Empire. Existing SBHCs are located at higher need schools but not consistently at the highest need schools. Fewer than 3% of California's six million students have access to SBHCs on their school campus. Children in communities of color, where access to healthcare is more challenging, are even less likely to have access to an SBHC. The SHI Report is the first comprehensive analysis to show the counties, districts and schools where new SBHCs will have the greatest return on investment for improving health and education. The key findings of the SHI Report are as follows:

   i) Existing SBHCs are located at higher need schools but not consistently at the highest need schools;
   ii) Highest need schools serve significantly more low-income students of color than lower need schools;
   iii) There are counties and districts with significant levels of unmet need and very few SBHCs, particularly in the Central Valley and Inland Empire; and,
   iv) There are key data limitations that cannot be addressed without the state improving data collection and reporting, particularly around student mental health.

d) **The Public School Health Center Support Program.** AB 2560 (Ridley-Thomas), Chapter 334, Statutes of 2006, established the PSHCSP, in collaboration with CDE, to provide technical assistance to SBHCs on effective outreach and enrollment strategies to identify children who are eligible for, but not enrolled in, the Medi-Cal program, the Healthy Families Program, or any other applicable program; to serve as a liaison between organizations within CDE and between other state entities, as appropriate, and provide technical assistance to facilitate and encourage the establishment, retention, or expansion of SBHCs. SB 564 (Ridley-Thomas), Chapter 381, Statutes of 2008, created, to the extent funds are appropriated for implementation of the PSHCSP, a grant program to provide technical assistance and funding for the expansion, renovation, and retrofitting of existing SBHCs and the development of new SBHCs. According to DPH, the PSHCSP was not established within DPH due to lack of funding appropriated for this purpose. During fiscal year (FY) 2016-17, the Legislature appropriated limited one-time funding of $600,000 for DPH to provide technical assistance in the development and expansion of SBHCs. The FY 2017-18 Budget included an additional $600,000 in one-time funding. CDPH utilized this funding to establish relationships and serve as a liaison to SBHCs.

3) **SUPPORT.** According to the California School-Based Health Alliance, cosponsor of this bill, this bill would reinforce the PSHCSP through greater coordination between DPH and CDE. Beyond the obvious health benefits, SBHCs or wellness centers have led to improved academic outcomes for students including better attendance rates and school climate. In order to ensure the effective administration of the PSHCSP, a few refining changes should be made to existing law. First, this bill would require the OSBHP within CDE to coordinate with the grant administrator, DPH, thus improving communication and collaboration. This bill would also make changes to the criteria for grant award preference in order to align the PSHCSP

with California's commitment to increasing access to health care for the most under-resourced students and communities. These changes would ensure the PSHCSP is run effectively and grants are awarded to the schools with the greatest health needs.

4) **RELATED LEGISLATION.** AB 1955 (Ward) of 2024 requires CDE to include county offices of education and charter schools in the above-described provisions. AB 1955 requires CDE to encourage school districts, county offices of education, and charter schools to participate in programs that offer reimbursement for school-based health services and school-based mental health services. AB 1955 is pending in the Assembly Committee on Education.

5) **PREVIOUS LEGISLATION.**

   a) AB 912 (Jones-Sawyer) of 2023 would have included the PSHCSP among a group of programs which would receive funding available as a result of the cost savings associated with prison closures. AB 912 was vetoed by the Governor.

   b) AB 130 (Committee on Budget), Chapter 44, Statutes of 2021, among various provisions, requires the CDE to, no later than January 1, 2022, establish the OSBHP for the purpose of assisting LEAs regarding the current health-related programs under the purview of CDE. AB 130 would have required OSBHP to, among other things, provide technical assistance, outreach, and informational materials to LEAs on allowable services and on the submission of claims.

   c) AB 563 (Berman) of 2021 would have created OSBHP within CDE to improve the operation of school-based health programs. AB 563 was referred to but not heard in the Senate Committee on Education.

   d) AB 1940 (Salas) of 2022 would have renamed the existing PSHCSP, established within the DPH, as the School-Based Health Center Support Program (SBHCS Program). Would have also updated the functions of the SBHCS Program to include serving as a liaison between organizations on health equity, oral health and behavioral health. AB 1940 would have also revised existing grant programs for purposes of the SBHCS Program. AB 1940 was vetoed by the Governor.

   e) AB 552 (Quirk-Silva) of 2021 would have authorized LEAs and county behavioral health agencies to enter into an Integrated School-Based Behavioral Health Partnership Program to provide school-based behavioral health and substance abuse disorder services on school sites, and would have authorized the billing of private insurance providers for these services under specified conditions. AB 552 was vetoed by the Governor.

   f) AB 1322 (Berman) of 2019 was substantially similar to AB 563 and was vetoed by the Governor.

   g) AB 1025 (Thurmond) of 2015 would have required the CDE to establish a three-year pilot program in school districts to encourage inclusive practices that integrate mental health, special education, and school climate interventions following a multi-tiered framework. AB 1025 was held in the Senate Appropriations Committee.

   h) AB 766 (Ridley-Thomas) of 2015 would have required the DPH to give grant funding preference to schools with a high percentage of students enrolled in Medi-Cal, under the

PSHCSP. AB 766 was held in the Senate Appropriations Committee.

i) SB 118 (Liu) of 2015 would have renamed the PSHCSP as the School-Based Health and Education Partnership Program; would have changed funding amounts for the grants; and, specifies that SBHCs can provide alcohol and substance abuse prevention information and services. SB 118 was held on the Senate Appropriations Committee suspense file.

j) SB 1055 (Liu) of 2014 would have renamed the PSHCSP the School-Based Health and Education Partnership Program; would have made changes to the requirements and funding levels; and would have created a new type of grant to fund interventions related to obesity, asthma, alcohol and substance abuse, and mental health. SB 1055 was held on the Senate Floor.

k) SB 596 (Yee) of the 2013-14 Session would have required CDE to establish a three-year pilot program in four schools to provide school-based mental health services that leverage cross-system resources and offer comprehensive multi-tiered interventions; would have allocated a total of $600,000 in start-up funding to each school selected to participate in the program; and would have required CDE to submit a report to the Legislature evaluating the success of the program. SB 596 was held at the Assembly Desk.

l) AB 1955 (Pan) of 2014 would have required the Superintendent of Public Instruction to establish the Healthy Kids, Healthy Minds Demonstration to provide grants to LEAs for the purpose of employing one full-time school nurse and one full-time mental health professional, and would have ensured that the schools' libraries were open one hour before and three hours after the regular school day. AB 1955 was held on the Assembly Appropriations Committee suspense file.

m) SB 564 (Ridley-Thomas), Chapter 381, Statutes of 2008, expands the definition of "SBHCs" and requires DPH, to the extent funds are appropriated for implementation of the PSHCSP, to establish a grant program to provide technical assistance and funding for the expansion, renovation, and retrofitting of existing SBHCs and the development of new SBHCs.

n) AB 2560 (Ridley-Thomas), Chapter 334, Statutes of 2006, establishes the PSHCSP.

6) **DOUBLE REFERRAL**. This bills is double referred, upon passage in this Committee, this bill will be re-referred to the Assembly Committee on Education.

7) **POLICY COMMENTS.** This bill makes minor changes to the grant program within PSHCSP. The statutory framework for this grant program was created in 2008. Due to lack of funding appropriated for this purpose, the PSHCSP has not been established, and its grant program has not been implemented. The framework includes a requirement for DPH to collaborate with CDE in the request for proposal process for collecting information on applicants, and determining which proposals receive grant funding. Since the statutory framework for the grant program was established, the Legislature and Governor directed CDE to establish the OSBHP for the purpose of assisting local educational agencies regarding the current health-related programs under the purview of CDE. The scope of the OSBHP includes but is not limited to, collaborating with departments and offices involved in the provision of school-based health services.

The author contends that this bill improves the efficacy of the PSHCSP by requiring DPH to collaborate not with CDE in general but specifically with the OSBHP within the CDE. This update is appropriate given the purview of the OSBHP. The author also highlights that the grant preference criteria has not been updated since the grant program was established. The current criteria gives preference to SBHCs serving schools with a high percentage of low-income and uninsured children and youth, schools with large numbers of LEP students, and low performing schools with API rankings in the deciles of three and below of the state. This bill strikes these references and instead refers to schools serving unduplicated pupils, which includes pupils classified as English learners, as eligible for free and reduced-price meals, or as foster youth, aligning with Section 42238.02 of the EDC. The current criteria also gives preference to schools in areas designated as MUAs, areas with MUPs, and areas with a shortage of health professionals. This bill increases access by including SBHCs serving areas experiencing health disparities in child and adolescent access to primary care, behavioral health, preventative health, or oral health services.

The Legislature contemplated updating the statutory framework for the PSHCSP as recently as the 2022-23 Session with the passage of AB 912. In addition to the changes captured in this bill, AB 912 also defines SBHC to mean a student-focused health center or clinic that meets specified conditions and increases funding levels to reflect current costs for SBHC planning, implementation and expansion grants. The Governor vetoed AB 912 due to cost pressures.

8) **SUGGESTED AMENDMENTS.** The author may wish to consider making changes to the bill consistent with AB 912 to modernize the statutory framework for the PSHCSP.

REGISTERED SUPPORT / OPPOSITION:

Support

California School-Based Health Alliance (sponsor)
Alameda County Office of Education
Kern County Superintendent of Schools Office
The Los Angeles Trust for Children's Health

Opposition

None on file.

Analysis Prepared by: Eliza Brooks / HEALTH / (916) 319-2097

Date of Hearing: April 2, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2081 (Davies) – As Amended March 13, 2024

SUBJECT: Substance abuse: recovery and treatment programs.

SUMMARY: Requires an operator of a licensed alcoholism or drug abuse recovery or treatment facility (RTF) or certified alcohol or other drug (AOD) program to disclose on its internet website if a legal, disciplinary, or other enforcement action has been brought by the Department of Health Care Services (DHCS), whether the RTF or program was determined to be in violation, and must include the date and nature of the violation. Specifically, **this bill**:

1) Requires an operator of a licensed alcoholism or drug abuse RTF or certified AOD program to disclose on its internet website if a legal, disciplinary, or other enforcement action has been brought by DHCS, whether the RTF or program was determined to be in violation, and must include the date and nature of the violation.

2) Requires the disclosure to be posted within 14 business days following determination of a violation by DHCS.

3) Imposes a $2,500 civil penalty for failure to comply.

EXISTING LAW:

1) Grants DHCS the sole authority in state government to license alcoholism or drug abuse RTFs. [Health and Safety Code (HSC) §11834.01]

2) Defines "alcoholism or drug abuse RTF" as any place or building that provides 24-hour residential nonmedical services to adults who are recovering from problems related to alcohol, drug, or alcohol and drug misuse or abuse, and who need alcohol, drug, or alcohol and drug recovery treatment or detoxification services. [HSC §11834.02]

3) Requires RTF licensees to provide at least one of the following nonmedical services: recovery; treatment; or, detoxification services. Requires DHCS to adopt regulations requiring records and procedures appropriate for the type of service provided. Provides that the records and procedures can include all of the following: admission criteria; intake process; assessments; recovery, treatment, or detoxification planning; referral; documentation of provision of recovery, treatment, or detoxification services; discharge and continuing care planning; or indicators of recovery, treatment, or, detoxification outcomes. [HSC §11834.26]

4) Permits the DHCS Director to suspend or revoke any license issued to a RTF, or deny an application for licensure, extend the licensing period, or modify a license for any reason that includes, but is not limited to, a violation of licensing laws, repeated violations, conduct that puts the health and safety of a resident of the RTF in jeopardy, and an RTF's refusal to allow DHCS representatives to enter an RTF. [HSC §11834.36]

5) Permits the DHCS Director, to temporarily suspend any license, prior to any disciplinary hearing, when DHCS's Director determines the action is necessary to protect residents of the

RTF from physical and mental abuse, abandonment, or any other substantial threat to health and safety, as specified. [HSC §11834.36]

6) Permits DHCS to levy civil penalties against a RTF in addition to penalties of suspension or revocation of a license or certification. [HSC §11834.34]

7) Prohibits a DHCS licensed or certified program, and specified individuals associated with or employed by those programs, from giving or receiving remuneration or anything of value for the referral of a person who is seeking alcoholism or drug abuse recovery and treatment services, as specified. Permits DHCS to investigate allegations of violations and take action, such as revocation of licensure or certification or assessment of penalties. [HSC §11831.6 and 11831.7]

8) Requires a facility licensed by DHCS to disclose its license number and the date that the license is scheduled to expire on its internet website, in any print, audio, or electronic advertising, and to any person who inquires about the licensure or certification of the program. [HSC §11831.12]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, too many people in California are caught in the deadly cycle of addiction and thankfully we have services where we can send our loved ones to if they need help breaking out of this cycle. However, the author questions where are we really sending them? The author contends that it's all too common today that we see stories of substance abuse facilities taking advantage of their patients and using them for personal gain. The author states that fake substance abuse treatment facilities take advantage of patients with little oversight and this bill will bridge that gap by holding those establishments accountable to the patients they intend to serve. The author concludes when a person seeks treatment they should be able to know who is treating them, at all levels.

2) BACKGROUND. RTFs provide 24-hour nonmedical care to eligible adults who are recovering from AOD usage. RTFs are based on what is commonly referred to as the social model, which centers on experiential knowledge, peer-to-peer interaction, and community engagement. These facilities range in size from six-beds in residential neighborhoods to centers that accommodate more than 100 beds. The basic services provided by these facilities include group, individual and educational sessions, detoxification, alcoholism or drug abuse, recovery and treatment planning. These services can be provided by a variety of health care providers such as alcohol and drug counselors, mental health therapists, social workers, psychologists, nurses, and physicians.

a) **Alcohol and Drug Treatment Facility Licensing and Certification.** DHCS has sole authority to license RTFs in the state. Licensure is required when at least one of the following services is provided: detoxification; group sessions; individual sessions; educational sessions; or, alcoholism or other drug abuse recovery or treatment planning. Additionally, facilities may be subject to other types of permits, clearances, business

taxes, or local fees that may be required by the cities or counties in which the facilities are located.

As part of their licensing function, DHCS conducts reviews of RTF operations every two years, or as necessary. DHCS's Substance Use Disorder Compliance Division checks for compliance with statute and regulations to ensure the health and safety of RTF residents and investigates all complaints related to RTFs, including deaths, complaints against staff, and allegations of operating without a license. DHCS has the authority to suspend or revoke a license for conduct in the operation of an RTF that is inimical to the health, morals, welfare, or safety of either an individual in, or receiving services from, the facility or to the people of the State of California.

AB 118 (Committee on Budget), Chapter 42, Statutes of 2023, requires other non-residential, outpatient AOD programs be certified by DHCS. Certification is required when at least one of the following is provided: outpatient treatment services; recovery services; detoxification; or medications for addiction treatment. DHCS does not license alcohol and drug recovery residences with six or less beds that don’t provide licensable services, known as "recovery residences."

b) **Prevalence of Substance Use Disorder (SUD) in California.** A 2022 publication from the California Health Care Foundation, entitled “Substance Use in California: Prevalence and Treatment” reported that substance use in California is widespread with over half of Californians over age 12 reporting using alcohol in the past month and 20% reporting using marijuana in the past year. According to the report, 9% of Californians have met the criteria for a SUD within the last year. While the health care system is moving toward acknowledging SUDs as a chronic illness, only about 10% of people with an SUD within the last year received treatment. Overdose deaths from both opioids and psychostimulants (such as amphetamines), are soaring. This issue, compounded by the increased availability of fentanyl, has resulted in a 10-fold increase in fentanyl related deaths between 2015 and 2019. The California Department of Public Health’s Opioid Overdose Dashboard reported 7,385 deaths related to “any” opioid overdose in 2022, with 6,473 (87.7%) of those deaths fentanyl related.

3) **SUPPORT.** The League of California Cities is sponsoring this bill, stating it would require a higher standard of transparency and greater protections for individuals seeking alcoholism or substance use treatment. The League of California Cities argues that compliance with state licensing laws administered through DHCS is essential to safeguarding residents’ well-being and maintaining quality care. They continue that this bill would ensure that those seeking treatment easily know what violations, if any, have occurred within a RTF and would hold providers accountable by making these violations easily accessible to the public.

4) **OPPOSITION.** The California Association of Alcohol and Drug Program Executives (CAADPE) is opposed to this bill, stating that it singles out RTFs and AOD programs by mandating them to disclose legal, disciplinary, or enforcement actions on their internet websites. CAADPE states that this requirement creates a disparate standard for SUD providers compared to other types of facilities, such as nursing homes or clinics, which are not subject to similar disclosure mandates. CAADPE continues that this bill does not differentiate between the rarer intentional, serious abuses committed by bad actors and harmless, non-intentional documentation violations that are much more commonplace as

providers strive to navigate the complex landscape of medical rules and requirements regarding documentation. CAADPE argues that imposing blanket disclosure requirements without considering the nature and severity of violations risks unjustly tarnishing the reputation of facilities that may have inadvertently fallen afoul of documentation guidelines.

5) **RELATED LEGISLATION.**

a) AB 2121 (Dixon) requires RTFs licensed by DHCS to be located more than 300 feet from another RTF or community care facility. Requires DHCS to notify the city or county in which the facility is located of the issuance of a license. AB 2121 is currently pending in the Assembly Health Committee.

b) AB 2574 (Valencia) requires sober living homes, as defined, that are an integral part of a licensed RTF to be exempt from being considered a residential use of property. AB 2574 is currently pending in the Assembly Health Committee.

c) SB 1334 (Newman) requires local jurisdictions to require a use permit or conditional use permit for RTFs or recovery residences, as defined, that serve seven or more residents. As part of the permit, the local jurisdiction may require that RTFs and recovery residences be at least 1,000 feet from another RTF or recovery residence. SB 1334 is currently pending in the Senate Health Committee.

6) **PREVIOUS LEGISLATION.**

a) SB 349 (Umberg), Chapter 15, Statutes of 2022, creates the California Ethical Treatment for Persons with Addiction Act to provide protection for SUD treatment clients and their families. Imposes requirements and proscribed unlawful acts relating to marketing and advertising with respect to treatment provide. Requires treatment providers to adopt a client bill of rights for persons seeking treatment for SUD, and to make the bill of rights available to all-clients and prospective clients; a treatment provider to maintain records of referrals to or from a recovery residence (RR), as specified and, provides that acts made unlawful by the bill be subject to a civil fine of up to $20,000 per violation.

b) AB 1158 (Petrie Norris), Chapter 443, Statutes of 2021, requires an RFT licensed by DHCS serving more than six residents to maintain specified insurance coverages, including commercial general liability insurance and employer’s liability insurance. Required a licensee serving six or fewer residents to maintain general liability insurance coverage. Requires any government entity that contract with privately owned RR or RTF serving more than six residents to require the contractors to, at all times, maintain specific insurance coverage.

c) SB 589 (Bates) of 2020 would have prohibited an operator of a licensed RTF, an AOD program, a RR, or a third party from engaging in specified marketing activities including make a false or misleading statements or providing false or misleading information about the entity’s products, goods, services, or geographical locations in its marketing, advertising materials, or media, or on its internet website or on a third-party internet AB 589 was vetoed by the Governor with the following message:

> “This bill would establish several prohibitions related to the advertisement of SUD services by the operator of a RTF, an AOD, a RR, or a third party that

provides any advertising or marketing services or directory listings to any of those entities.
While it is important to protect vulnerable patients and their families from unethical marketing practices, I am concerned that as crafted, this measure creates a false promise. DHCS has no jurisdiction or licensing oversight over RRs or third parties. As such, it cannot take enforcement against those entities for violations of advertisement requirements."

7) **DOUBLE REFERRAL.** This bill is double-referred, upon passage of this Committee, it will be referred to the Assembly Judiciary Committee.

8) **SUGGESTED AMENDMENTS.**

a) DHCS has authority to levy penalties, including license suspension or revocation, against facilities that are in violation of the Chapter this bill is amending. Additionally, the penalty proposed in this bill is higher than defined penalties for more egregious violations, such as operating a facility without a license which is $2,000. The Committee may wish to remove the civil penalty provision from this bill given DHCS's existing authority to levy appropriate fines for violations.

b) As drafted, this bill would require a RTF to post a legal, disciplinary, or other enforcement action brought by DHCS within 14 days. This assumes that the facility will post the action and DHCS will be able to enforce noncompliance in a timely manner. DHCS has the responsibility to investigate all compliance complaints against licensed RTFs and outpatient programs that are certified by DHCS. Complaints are triaged based on priority, ranked from high, medium, to low status, and completion of each complaint varies from 30 days to up to two years. The 2023 state budget restructured licensing and certification fees to provide additional resources to support DHCS' efforts to strengthen compliance oversight. Even so, it is unlikely that DHCS will be able to enforce the provisions of this bill in the timelines outlined in the bill and provide consumers with the transparency the author seeks.

   As part of the DHCS' effort to enhance transparency of licensing and certification compliance reviews, DHCS posts all complaint and compliance reports on the DHCS website. A DHCS webpage posts regularly updated reports of licensed and unlicensed facilities that are: on probationary status; temporary suspension orders; have revoked licenses; and, given notices of operation in violation of law. The Committee may wish to amend the bill to require facilities to provide the link to this webpage to ensure consumers are able to access the most up-to-date information on enforcement actions brought to all facilities by DHCS.

REGISTERED SUPPORT / OPPOSITION:

Support

League of California Cities (sponsor)
City of Laguna Niguel

Oppose

California Association of Alcohol and Drug Program Executives, Inc.

Analysis Prepared by: Riana King / HEALTH / (916) 319-2097

Date of Hearing: April 2, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2154 (Berman) – As Introduced February 6, 2024

SUBJECT: Mental health: involuntary treatment.

SUMMARY: Requires a health facility to provide a family member, as defined, of any person involuntarily detained for assessment, evaluation or treatment under the Lanterman-Petris-Short Act (LPS Act) with a copy of the State Department of Health Care Service's (DHCS) patients' rights handbook. Specifically, **this bill**:

1) Requires a health facility to provide a family member of any person involuntarily detained for assessment, evaluation, or treatment under the LPS Act with a copy of the DHCS patients' rights handbook.

2) Defines "family member" as any of the following:

   a) The spouse or domestic partner of the person;
   b) An adult child of the person;
   c) A parent or legal guardian of the person;
   d) A grandparent of the person;
   e) An adult sibling of the person;
   f) An adult grandchild of the person; or,
   g) An adult relative or close personal friend who has demonstrated special care and concern for the person and is familiar with the person's personal values and beliefs to the extent known.

EXISTING LAW:

1) Establishes the LPS Act to end the inappropriate, indefinite, and involuntary commitment of persons with mental health disorders, developmental disabilities, and chronic alcoholism, as well as to safeguard a person's rights, provide prompt evaluation and treatment, and provide services in the least restrictive setting appropriate to the needs of each person. Permits involuntary detention of a person deemed to be a danger to self or others, or "gravely disabled," as defined, for periods of up to 72 hours for evaluation and treatment, or for up-to 14 days and up-to 30 days for additional intensive treatment in county-designated facilities. [Welfare and Institutions Code (WIC) §5000, *et seq*.]

2) Permits a conservator of a person, or the estate, or of both the person and the estate, to be appointed for someone who is gravely disabled as a result of a mental health disorder or impairment by chronic alcoholism, and who remains gravely disabled after periods of intensive treatment. [WIC §5350]

3) Defines "gravely disabled," for purposes of evaluating and treating an individual who has been involuntarily detained or for placing an individual in conservatorship, as a condition in which a person, as a result of a mental health disorder, a severe substance use disorder (SUD), or both, is unable to provide for their basic personal needs for food, clothing, shelter, personal safety, or necessary medical care. [WIC §5008]

4) Requires that each patient involuntarily detained for evaluation or treatment or as a voluntary patient for psychiatric evaluation or treatment to any health facility must have certain rights, as defined. Requires upon admission to a health facility, each patient to immediately be given a copy of DHCS' prepared patients' rights handbook. Requires patients to be immediately given a copy of a Department of State Hospitals prepared patients' rights handbook upon admission to a state hospital. [WIC §5325]

5) Requires public and private treatment facilities to give requesting family members or designees of a patient information on their diagnosis and treatment, as specified, upon notification and authorization of the patient. Requires if a patient is unable to authorize the release of information, the facility to make a notation in the patient's record and make daily attempts to secure authorization. Requires if the patient is unable to authorize, the requester to be given notification of the patients' presence in the facility. [WIC §5238.1(a)]

6) Requires upon admission of any mental health patient to a 24-hour health facility, the facility to make reasonable attempts to notify next of kin or any other designee of the patient of the patient's admission, release, transfer, serious illness, injury, or death unless the patient requests that this information not be provided. [WIC §5238.1(b)]

7) Defines a "health facility" as a facility, place, or building that is organized, maintained, and operated for the diagnosis, care, prevention and treatment of physical or mental human illness. [Health and Safety Code §1250]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, this bill will ensure that if a person is involuntarily detained under the LPS Act, then a family member of the person detained will be provided a copy of DHCS' patients' rights handbook. The author states this will provide family members with valuable information and resources to enable them to support their loved ones during a mental health crisis and ensure that they receive appropriate treatment, which could expedite recovery. The author concludes that by providing information and resources to family members, this bill will further ensure that the patient's rights are realized.

2) **BACKGROUND.**

   a) **LPS Act involuntary detentions.** The LPS Act provides for involuntary detentions for varying lengths of time for the purpose of evaluation and treatment, provided certain requirements are met, such as that an individual is taken to a county-designated facility. Typically, one first interacts with the LPS Act through a "5150" hold initiated by a peace officer or other person authorized by a county, who must determine and document that the individual meets the standard for a 5150 hold. A county-designated facility is authorized to then involuntarily detain an individual for up to 72 hours for evaluation and treatment if they are determined to be, as a result of a mental health disorder, a danger to self or others, or gravely disabled. The professional person in charge of the county-designated facility is required to assess an individual to determine the appropriateness of the involuntary detention prior to admitting the individual. Subject to various conditions, a person who is found to be a danger to self or others, or gravely disabled, can be

subsequently involuntarily detained for an initial up-to 14 days for intensive treatment, an additional 14 days (or up to an additional 30 days in counties that have opted to provide this additional up-to 30-day intensive treatment episode), and ultimately a conservatorship, which is typically for up to a year and may be extended as appropriate.

Throughout this process, existing law requires specified entities to notify family members or others identified by the detained individual of various hearings, where it is determined whether a person will be further detained or released, unless the detained person requests that this information is not provided. Additionally, a person cannot be found to be gravely disabled if they can survive safely without involuntary detention with the help of responsible family, friends, or others who indicate they are both willing and able to help. A person can also be released prior to the end of intensive treatment if they are found to no longer meet the criteria or are prepared to accept treatment voluntarily.

b) **Patient rights under an involuntary hold.** The LPS Act provides rights to each person who is involuntarily detained or voluntarily admitted for evaluation or treatment at a health facility, including the right to receive a copy of DHCS' patients' rights handbook. The handbook includes the following information:

a) Your Rights as a Patient;
b) Access to the Patients' Rights Advocate;
c) What to Do If You Have a Complaint;
d) Rights While You Are Involuntarily Detained;
e) Confidentiality;
f) Medical Treatment;
g) Right to Refuse Treatment;
h) Medications and the Informed Consent Process;
i) Capacity Hearing for Medications;
j) Rights that Cannot be Denied;
k) Rights That May be Denied with Good Cause;
l) Good Cause; and,
m) Definitions.

The author's office reported experiences of family members left unaware of the rights of their children who were on a 5150 hold. For example, one parent reported that their child was held on a 5150 and had an adverse reaction to a medication that left them catatonic. This led the patient to have an extended six-week stay in the behavioral health hospital, worsening the trauma to the patient and their parents. The author's office argues that if the parent had been aware of their child's rights, they would have been equipped to provide the medical team with their child's clinical history and advocate to ensure they were receiving appropriate medication and treatment.

Another family member reported their teenage daughter was placed on a 5150 hold and struggled to navigate the process while dealing with the trauma of the involuntary hold process. While the parents were authorized to speak with her care team, they had no knowledge of basic and medical definitions, nor their daughter's rights to access things such as regular visitation, telephone access, and a patient's rights advocate. The author argues that receiving this critical information included in the patients' rights handbook as soon as possible is critical to ensure family members can adequately support successful

recovery.

3) **SUPPORT.** The California Association of Psychiatric Technicians (CAPT) is in support of this bill and states that during this involuntary detention period, individuals are entitled to certain rights, however there is currently a gap in ensuring that family members of the detained individual are also provided with this crucial information. CAPT contends that this bill seeks to rectify this oversight by requiring facilities where individuals are involuntarily detained to provide a copy of the patient's rights handbook to a family member of the detained person. CAPT states that this bill not only promotes transparency and accountability within our mental health care system but also empowers families to advocate effectively for their loved ones' well-being. CAPT concludes that ensuring the involvement and support of family members is integral to achieving positive outcomes in treatment and recovery.

4) **OPPOSED UNLESS AMENDED.** Disability Rights California (DRC) is opposed to this bill unless amended, stating they agree it is important to provide information about patient’s rights. DRC continues that they appreciate the proposed committee amendments to address patient medical confidentiality protections, but do not think the language goes far enough. DRC argues that under existing law, facilities are required to provide patients with the DHCS patients’ rights handbook upon admission to a health facility, but patients held on involuntary holds in the emergency department are not considered admitted. DRC argues that this bill creates a disparity by requiring facilities to provide family members a copy of the handbook upon the patient’s detainment.

5) **PREVIOUS LEGISLATION.**

   a) SB 43 (Eggman), Chapter 637, Statutes of 2023, expands the definition under the LPS Act of "gravely disabled," for purposes of involuntarily detaining an individual, to also include a condition in which a person, as a result of a mental health disorder or a SUD, or both, is at substantial risk of serious harm, as defined, or is currently experiencing serious harm to their physical or mental health. Permits county, by adoption of a resolution of its governing body, to defer implementation of the changes in definition until January 1, 2026. Prohibits the existence of a mental health/SUD alone from establishing a substantial risk of serious harm, as specified. Clarifies that the phrase gravely disabled includes a condition in which a person, as a result of impairment by chronic alcoholism, is unable to provide for their basic personal needs for food, clothing, shelter, personal safety, or necessary medical care. Deems statements of specified health practitioners, for purposes of an expert witness in a proceeding relating to the appointment or reappointment of a conservator, as not hearsay, as specified.

   b) AB 2338 (Gipson), Chapter 782, Statutes of 2022, creates a list of relatives who can make medical decisions for an incapacitated adult who does not otherwise have a legally recognized health care decision maker.

6) **SUGGESTED AMENDMENTS.**

   a) Ensuring that family is equipped to advocate for their loved one is important, but there are instances where a patient may not wish for their family to be informed of their medical condition or situation. While DHCS’ patient handbook does not include health information specific to the patient, it would reveal that a patient has been involuntarily held under the LPS Act. Therefore this bill, as drafted, could result in the unauthorized

disclosure of protected patient information. The Committee may wish to amend this bill to include parameters that ensure privacy is protected in instances where a patient does not wish for family to be aware of their involuntary detainment.

b) Health facilities are able to order copies of the 33-page DHCS patient handbook through DHCS or can opt to print copies from versions maintained on the DHCS website. The handbook is available in 10 languages, but some facilities report that keeping a sufficient stock available for patients and family in all languages could prove difficult. Additionally, the handbook is orientated to serve the patient while there are numerous organizations who provide resources specifically for those supporting someone on an involuntary hold. The Committee may wish to consider amending this bill to permit facilities to provide printed and digital copies of the handbook to ensure family can access the handbook in their preferred language, and to permit facilities to provide resources that are targeted to support families.

REGISTERED SUPPORT / OPPOSITION:

Support

California Association of Psychiatric Technicians
California Clubhouse
National Alliance for Mental Illness San Mateo County
19 Individuals

Opposition

None on file.

Analysis Prepared by: Riana King / HEALTH / (916) 319-2097

Date of Hearing: April 2, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2156 (Pacheco) – As Introduced February 6, 2024

SUBJECT: Vital records: diacritical marks.

SUMMARY: Requires the State Registrar of Vital Statistics (State Registrar) to require a diacritical mark on an English letter to be properly recorded on a certificate of live birth, fetal death, or death, and a marriage license. Specifically, **this bill**:

1) Requires the State Registrar to require the use of a diacritical mark on an English letter to be properly recorded, when applicable, on a certificate of live birth, fetal death, or death, and a marriage license.

2) Requires the use of a diacritical mark on an English letter to be deemed an acceptable entry on a certificate of live birth, fetal death, or death, and a marriage license by the State Registrar.

3) Prohibits the absence of a diacritical mark on a document listed in 2) above from rendering the document invalid, or affecting any constructive notice imparted by proper recordation of the document.

4) Defines, for purposes of this bill, a diacritical mark to include, but not be limited to, accents, tildes, graves, umlauts, and cedillas.

5) Authorizes a person, person's conservator, parent, or guardian to submit a written request to the State Registrar for a new document if a name is not accurately recorded because of the absence of a diacritical mark.

6) Requires the State registrar to review a request pursuant to 5) above, and if the request is accompanied with the payment of the fee described in 5) in existing law below, to issue a new document with the accurate name identified in the request.

EXISTING LAW:

1) Establishes the California Department of Public Health (DPH) and sets forth its powers and duties, including, but not limited to, the duties as State Registrar relating to vital records and health statistics. [Health and Safety Code (HSC) §102100, *et seq*.]

2) Requires the State Registrar to prescribe and furnish all record forms for use in carrying out the provisions governing vital records and prohibits the use of any record form or format other than those prescribed by the State Registrar. [HSC §102200]

3) Requires every live birth, fetal death, death, and marriage that occurs in the state to be registered with the local registrar. Requires certificates of live birth, fetal death, or death, and marriage licenses to include specified information, such as the full name of the child on a birth certificate and the full names of the parties to be married on a marriage license. [HSC § 102230]

4) Requires the State Registrar, local registrar, or county recorder to, upon request and payment of the required fee, supply an applicant with a certified copy of the record of a birth, fetal death, death, marriage, or marriage dissolution registered with the official. Prohibits, when the original forms of certificates of live birth furnished by the State Registrar contain a printed section at the bottom containing medical and social data or labeled "Confidential Information for Public Health Use Only," that section from being reproduced in a certified copy of the record except as specifically authorized. [HSC §103525]

5) Sets the base fee for a certified birth, death, or fetal death record at $12, and allows jurisdictions to create local vital and health statistics trust funds to be collected by the applicable jurisdiction to defray administrative costs, modernization of vital records operations, and improved data collection and analysis. [HSC §103625 et seq.]

6) Provides that English is the common language of the people of the United States and the State of California, and that English is the official language of the State of California. [Article III, Section 6, California Constitution].

7) Requires the Legislature to enforce the provisions of 6) above by appropriate legislation, to take all steps necessary to insure that the role of English as the common language of the state is preserved and enhanced, and to make no law which diminishes or ignores the role of English as the states common language. [*Ibid.*]

FISCAL EFFECT: Unknown. This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) PURPOSE OF THIS BILL. The author states that as the most populous and diverse state in the nation, California should allow parents the freedom to name their children as they see fit, without limitations, including the use of diacritical marks such as accents, umlauts, tildes and cedillas. California permitted the use of diacritical marks on all vital records, such as birth certificates, death certificates, and marriage licenses, until this inclusive practice was halted in 1986 following the passage of Prop 63, which declared English the official language of California. The author concludes that government should record the actual names of California residents, reflecting parental and individual rights, preserving cultural and artistic identity as expressed in names and restoring the historic guarantee of free speech that was eliminated in 1986 without any legitimate reason for its discontinuation.

2) BACKGROUND.

a) Vital Records. The Office of Vital Records within DPH is charged with maintaining a uniform system for registration and a permanent central registry with a comprehensive and continuous index for all birth, death, fetal death, marriage, and dissolution certificates registered for vital events which occur in California, which are over one million events each year. Certified copies of vital records are available from DPH, 58 county recorders, and 61 local health jurisdictions. DPH maintains, and can provide, birth and death records from 1905 to the present. For marriage records, DPH maintains and can provide those from 1946 to the present, with some years excluded. At the local level, birth and death records for current-year events and one year prior are available from the county health department; records for all years are maintained by the county recorder. Public marriage

records may be obtained from the county recorder; confidential marriage records are available only through the county clerk of the county where the license was issued.

b) **Diacritical marks**. Diacritical marks include, but are not limited to: grave or acute accents (è or á) and tildes (ñ or ã), commonly found in Spanish language names or umlauts (ö or ü) used in German and cedillas (ç or ş) found in French, Turkish, and other languages. Federal law requires all federal databases to follow standards determined by the National Institute of Standards and Technology and to use the 26 letters of the alphabet without diacritical marks (Public Law 100-235). California law is silent on diacritical marks, however HSC Section 102200 states that the State Registrar "…shall prescribe and furnish all record forms for use in carrying out the purposes of this part, or shall prescribe the format, quality, and content of forms electronically produced in each county, and no record forms or formats other than those prescribed shall be used."

c) **California, the Constitution, and Changing demographics.** The California Constitution was drafted in both English and Spanish by American pioneers, European settlers, and Californios (Hispanics of California), and adopted at the 1849 Constitutional Convention of Monterey, following the American Conquest of California and the Mexican-American War, and in advance of California's Admission to the Union in 1850.

In 1986 California voters approved Proposition 63 which declared that English is the official language of the State of California. Proposition 63 directed the Legislature to enact legislation to "preserve the role of English as the state's common language," and prohibited it from "passing laws which diminish or ignore the role of English as the state's common language." The proposition also stated that its intent was to "preserve, protect and strengthen the English language, and not to supersede any of the rights guaranteed to the people by this Constitution." According to DPH, prior to 1986, registration of vital records was a manual paper process. Birth clerks at the hospitals completed the registration forms and it was their choice whether to include diacritical marks or not.

Currently no race or ethnic group constitutes a majority of California's population: 39% of Californians are Latino, 35% are white, 15% are Asian American or Pacific Islander, 5% are Black, 4% are multiracial, and fewer than 1% are Native American or Alaska Natives, according to the 2020 Census. Only five other states (Hawaii, New Mexico, Texas, Nevada, and Maryland) have similarly diverse populations. However, more than half of young Californians (ages 24 and under) are Latino. Conversely, more than half of those 65 and older are white.

d) **The California Electronic Birth Registration System (EBRS)**. In 2015, the California State Registrar, convened a workgroup to review the contents of California's Birth, Death, and Fetal Death certificates and considered proposed changes to data elements collected on those certificates. The implementation of EBRS in 2018 did not accommodate the use of diacritical marks during the registration process.

The Office of Vital Records: Birth and Death Registration Handbook, referencing the provisions of Proposition 63, states that forms are "to be completed using the 26 alphabetical characters of the English language." The 2023 handbook also explicitly states (on pages five and six) that unacceptable marks include "diacritical marks—any of

various marks added to a letter to indicate its pronunciation or to distinguish it in some way, e.g., è, ñ, ç." Appropriate punctuation is a standardized mark or sign used in sentences or phrases. Acceptable punctuation includes hyphen (-), period (.), comma (,), or apostrophe ('). Examples of appropriate punctuation for vital records: Hyphen such as "Smith-Jones," apostrophe as in "O'Hare," period as used with "Jr.," or a comma such as "Smith, Jr." Therefore, the name O'Brian can be spelled correctly on a vital record, but Hernandéz cannot.

According to DPH, when a vital record is amended the amendment becomes part of the original record, making it a multi-page document. However, since birth and marriage certificates establish a person's identity, there are specific circumstances in existing law where DPH is authorized to instead replace the original birth or marriage certificate with a corrected record that does not indicate it was amended (e.g., after a gender change). Giving DPH authority to seal and replace the original birth or marriage certificate will not significantly increase implementation costs. However, since death and fetal death certificates are not identity documents, there is currently no statutory authority in the registration system to seal and replace death or fetal death certificates. Further, names that are not the registrant or the registrant's parent(s) names are retrieved from external sources (such as the Medical Board for the physician's name), which DPH has no authority to update to include diacritical marks.

e) **Other States**. Although most other states prohibit diacritical marks and other symbols on birth certificates, at least seven states allow diacritical marks: Alaska, Hawaii, Illinois, Kansas, North Carolina, Oregon, and Texas. Oregon's vital records system limits them to a specific set of diacritical marks. Their system simply requires the ALT key to be held down and a 4-digit code to be entered. Oregon also uses a program that removes the diacritical marks prior to sending to the Social Security Administration (SSA). Texas passed House Bill 1823 in 2017, which allows for properly recorded diacritical marks in vital statistics records, driver's licenses, commercial driver's license, and personal identification certificates. According to staff at the Texas Public Health Committee, they began using diacritical marks on vital records in 2019 when they implemented their electronic vital records management system. The vendor that Texas uses allowed for keyboard shortcuts for four diacritical marks: accents, graves, umlautes, and tildes. Texas prints birth certificates with diacritical marks, and then strips the marks from the data that is sent to SSA.

f) **Federal requirements**. All U.S. Passports lettering is in block capitals and does not include diacritical marks. Names on Social Security cards may include only letters, spaces, hyphens, or apostrophes.

3) **RELATED LEGISLATION.** AB 77 (Pacheco) of 2023 was identical to this bill. AB 77 was held on the Assembly Appropriations suspense file.

4) **PREVIOUS LEGISLATION.**

a) AB 82 (Medina) of 2017 would have required the State Registrar to require the use of a diacritical mark on an English letter to be properly recorded, when applicable, on a certificate of live birth, fetal death, or death, and a marriage license, and deemed the use of diacritical marks as an acceptable entry on these certificates and licenses. AB 82 was

vetoed by Governor Edmund G. Brown, Jr., who stated in part: "Mandating the use of diacritical marks on certain state and local vital records without a corresponding requirement for all state and federal government records is a difficult and expensive proposition. This bill would create inconsistencies in vital records and require significant state funds to replace or modify existing registration systems."

b) AB 2528 (Skinner) of 2014 would have required the State Registrar to ensure that diacritical marks on English letters were properly recorded on birth certificates, including, but not limited to, accents, tildes, graves, umlauts, and cedillas. AB 2528 also would have required the State Registrar to develop procedures to include other reasonable requests relating to names on birth certificates and created substantially similar requirements for the Secretary of State relating to certificates of registered domestic partnerships, and the Department of Motor Vehicles relating to identification cards. AB 2528 was held in the Assembly Appropriations Committee**.**

5) **SUGGESTED AMENDMENTS:** Based on technical assistance from DPH, the author may wish to amend this bill to do the following:

a) To allow sufficient time for State and County system updates, delay implementation to January 1, 2027.

b) To save costs associated with implementation, given that DPH currently lacks statutory authority to replace non-identity documents (such as death and fetal death documents), limit the seal and replace process to birth and marriage certificates.

c) Clarify that amendments to add diacritical marks to death and fetal death certificates will be filed with and become part of the record.

d) To mirror the process proposed for the State Registrar, provide county clerks the authority to replace original confidential marriage certificates with ones that do not indicate they were amended.

REGISTERED SUPPORT / OPPOSITION:

Support

None on file.

Opposition

None on file.

Analysis Prepared by: Eliza Brooks / HEALTH / (916) 319-2097

Date of Hearing: April 2, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2175 (Lowenthal) – As Introduced February 7, 2024

SUBJECT: Hospital specialties database.

SUMMARY: Requires a general acute care hospital (GACH) to report all specialties listed on the GACH's call panel to the Department of Health Care Access and Information (HCAI). Specifically, **this bill**:

1) Requires a GACH to report all of the following information to HCAI:

   a) All specialties listed on the hospital's call panel;

   b) For each specialty, whether it is available seven days per week and 24 hours per day, or less than seven days per week and 24 hours per day; and,

   c) The telephone number to contact for inter-facility transfers.

2) Requires HCAI to develop and maintain a searchable database of GACHs by location and available specialties. Requires the database to be searchable by specialty and distance and to be accessible to hospital staff.

EXISTING LAW:

1) Establishes HCAI in the California Health and Human Services Agency to expand equitable access to quality, affordable health care for all Californians through resilient facilities, actionable information, and the health workforce each community needs. [Health and Safety Code (HSC) §127000, *et seq*.]

2) Licenses and regulates hospitals, including GACHs, by the Department of Public Health (DPH). Permits GACHs, in addition to the basic services all hospitals are required to offer (medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services), to be approved by DPH to offer special services, including, among other services, an emergency department (ED). [Health and Safety Code [HSC] §1250 and §1255, *et seq*.]

3) Requires EDs, under the federal Emergency Medical Treatment and Active Labor Act (EMTALA) and also under similar provisions of state law (state EMTALA), to provide emergency screening and stabilization services without regard to the patient's insurance status or ability to pay. Federal EMTALA imposes this requirement on any hospital that participates in Medicare. State EMTALA imposes this requirement on any hospital that operates an ED. [42 United States Code (USC) §1395dd; HSC §1317]

4) Requires GACHs with an ED, through federal and state regulations, to provide an on-call list of physicians available to provide stabilizing treatment after the initial medical screening described in 3) above. Requires hospitals providing basic 24-hour emergency services to provide on-call coverage for the basic services required for licensure, as described in 2) above. [42 USC § 489.20(r)(2); California Code of Regulations 70225(b), 70235(c),

70245(b), 70255(c), 70455(a)(3), 70413(l)(3) and (4), 70415(a)(3), 70577(d)(3), 70653(a)(4) and 71203(a)(1)(B)]

5) Requires hospitals to report various data sets to HCAI including, hospital patient discharge data, payment types and other financial data. [HSC § 128740]

6) Requires hospitals to prepare an annual equity report that includes an analysis of health status and access to care disparities for patients, measures from the Agency for Healthcare Research and Quality's Quality Indicators, and pay data to the Department of Fair Employment and Housing. Requires HCAI to make all equity reports available on their website and annually prepare a report that includes a list of all hospitals that failed to submit equity reports. Authorizes HCAI to fine a hospital up to $5,000 for failure to submit and equity report. [HSC §127372 and 127374 (a)]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, it has become increasingly difficult to transfer patients needing a higher level of care, to other hospitals. There is currently no database or source of information that lists what on-call specialists are available at any given hospital. Physicians and staff in the ED are spending valuable time, calling surrounding hospitals, trying to find a hospital that may have an on-call specialists to treat a patient. Delays in transfers put patients at higher risk of complications and contribute to poorer health outcomes. The author states that this bill will provide emergency physicians and staff with a valuable tool to help reduce the amount of time it takes to find a hospital that has on-call specialists to treat a patient needing a higher level of care. This bill requires the state to create a hospital capability database that is accessible to hospital staff and includes a contact number for inter-facility transfers, a list of specialties on the hospital's physician call panel, and whether or not their services are available seven days a week. The author concludes that the database would be searchable by specialty and distance, making it faster for providers to identify the closest facility with the capability to care for their patient.

2) **BACKGROUND.**

   a) **EMTALA.** EMTALA was passed to address the problem of hospitals refusing to treat indigent, uninsured, or Medicaid patients, or "dumping" these patients by transferring them to county hospitals or other charity hospitals. Federal EMTALA obligates Medicare-participating hospitals that offer emergency services to provide a medical screening and treatment for an emergency medical condition, including active labor, regardless of an individual's ability to pay. State EMTALA imposes its obligation on any hospital that operates an ED, and has similar requirements to federal EMTALA. Hospitals are required to provide stabilizing treatment for patients with an emergency medical condition. A patient is "stabilized" when the patient's medical condition is such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from the release or transfer of the patient. If a hospital is unable to stabilize a patient within its capability, then a patient is required to be transferred to an appropriate facility with the necessary specialized treatment services. Once a patient is stabilized, if the patient needs post-stabilization care, the hospital will

typically seek more information about the medical history of the patient, including whether the patient has insurance.

b) Transfers. EMTALA requires patients to be treated and stabilized: a hospital cannot refuse emergency care to patients based on their inability to pay, age, color, disability, ethnicity, immigration status, lack of insurance coverage, lack of pre-authorization, or national origin. EMTALA also requires hospitals with specialized services, such as a burn unit, to accept patients needing those services. This prevents specialized hospitals from refusing transfers based on the patient's ability to pay or insurance status. When an ED contacts a hospital with specialized services, they can ask no questions regarding insurance. If a specialized facility has the capacity (i.e, available beds and the ability to care for the patient), they cannot refuse an otherwise appropriate transfer. According to 2021 HCAI data, the most frequent transfers occur in patients with transplants and tracheostomies (13.4%), newborns and other neonates with conditions originating in the perinatal period (4.2%), patients with multiple significant trauma (4%), diseases of the circulatory system (2.9%), and, infectious and parasitic diseases (2.5%).

c) ED crowding and patient boarding. ED crowding is a problem in the delivery of emergency care. In 2007, the Institute of Medicine (now the National Academy of Medicine) reported that between 1993 and 2003, the number of hospitals and hospital beds decreased, while the number of ED visits increased dramatically. More recently, the National Hospital Ambulatory Medical Care Survey evaluated ED characteristics for 2017, and reported 139 million visits with 10.4% requiring hospital admission. When hospital occupancy is at or near capacity, ED patient boarding occurs. Boarding is defined by the American College of Emergency Physicians as “a patient who remains in the ED after the patient has been admitted or placed into observation status at the facility, but has not been transferred to an inpatient or observation unit.”

According to a 2007 study in the *Academic Emergency Medicine Journal*, “The opportunity loss of boarding admitted patients in the ED,” boarding leads to increased patient morbidity and mortality for both intensive care and non-intensive care units, longer lengths of stay, and higher costs for the hospital. Insufficient availability of inpatient beds can also lead to loss of ED revenue estimated at millions of dollars.

d) “Call panels.” According to the 2018 edition of the California Hospital Association’s EMTALA Manual, under EMTALA, a hospital with a dedicated ED must maintain a list of physicians who are on call to come to the hospital and provide treatment necessary to stabilize an individual with an emergency medical condition (EMC). Some states, including California, also have licensing regulations requiring EDs to have on-call rosters. The on-call roster must meet the needs of emergency patients in accordance with the resources available to the hospital, including the availability of on-call physicians. The on-call physicians are considered resources available to a dedicated ED that must be used to provide emergency services for an individual who has or may have an EMC.

e) Specialty services. As noted in Existing Law, above, hospitals may provide additional specialty services as approved by DPH. Periodically the Centers for Medicare and Medicaid Services (CMS) releases “interpretive guidelines,” written by CMS headquarters and sent to all state agency surveyors (such as DPH) to help them understand how to evaluate a hospital’s compliance with the Medicare/Medicaid

Conditions of Participation, including the on-call requirements for specialty services.

The Interpretive Guidelines state that hospitals "should strive to provide adequate on-call coverage consistent with the services provided at the hospital and the resources the hospital has available, including the availability of specialists. There is no requirement under the EMTALA regulations that all of the hospital's clinical specialties be listed on the on-call roster at all times. CMS has explained that it has not set requirements on how frequently physicians are expected to provide on-call coverage. Therefore, except for the requirements under state law requiring on-call coverage in an ED for the eight basic services required for licensure, coverage for other specialties that are represented on the hospital medical staff may be full-time or part-time.

Under EMTALA, there are no fixed standards for part-time coverage, including the frequency of coverage by an individual physician (such as three to five days per month) or the periodicity of coverage (consecutive days, weekdays or weekends). These decisions are delegated to each hospital and its medical staff. However, the EMTALA regulations require a hospital to have written policies and procedures for handling emergency patients when a particular specialty is not available.

This bill will require hospitals to provide HCAI with information regarding the specialties listed on the hospital's call panel, the hours of availability of each specialty, and a telephone number for hospitals to contact for inter-facility transfers.

f) **Current Hospital Data Collected by HCAI.** HCAI collects and discloses a variety of data, including financial and utilization information as well as hospital disclosures. These data are collected for a specific time period in arears and published on HCAIs' website. The HCAI hospital utilization data includes:

i) Hospital License Category and Type of Control (DPH source);
ii) Services Provided at the Hospital;
iii) Inpatient bed utilization rates (# of beds DPH source);
iv) Chemical Dependency Recovery Services (# of approved beds DPH source);
v) Newborn Nursery Information;
vi) Number of GACH beds approved for Skilled Nursing care (DPH source);
vii) Acute Psychiatric Patients information including # of patients, ages, and primary payer;
viii) Whether the hospitals has:
(1) Short Doyle Contract Services;
(2) Inpatient hospice program;
(3) Palliative care program;
(4) EMSD Trauma Center Designation (EMSA source); and,
(5) Licensed ED Level (completed by HCAI from DPH source data).
ix) Types of services available on premises;
x) ED Services;
xi) Number of Ambulance diversion hours that occurred at the ED each month;
xii) Types of Surgical Services (Inpatient or Outpatient);
xiii) Types of Operating Rooms (Inpatient or Outpatient);
xiv) Presence of ambulatory surgical program;
xv) Information about live births at the hospital;

xvi) Information about cardiology and cardiovascular surgery services (DPH source);
xvii) Distribution of surgeries performed in catheterization laboratory; and,
xviii) Capital Expenditures.

This bill requires HCAI to develop and maintain a database with information provided by hospitals, much of which is currently being reported to HCAI.

3) **SUPPORT**. The California Chapter of the American College of Emergency Physicians (California ACEP), is the sponsor of this bill and states that when California ACEP surveyed their members in 2022 they found that "97% cited boarding times of more than 24 hours, 33% over one week, and 28% over 2 weeks," as a major problem. The increased difficulty in transferring patients to other hospitals has been documented and is exacerbating boarding. Delays in transfers put people at higher risk of complications. California ACEP notes that the need to transfer patients occurs because not every hospital has every medical specialty available at all times. Thus, when a patient arrives in an ED, is assessed and treated by an emergency physician, some of them will need further care not available at that hospital. It might be a child requiring a pediatric Intensive Care Unit, or a patient requiring ophthalmology services, for example. Federal and state law prevent the transferring hospital from delaying care to get preauthorization of payment, and receiving hospitals are forbidden to consider ability to pay when accepting a patient. But, in order to accept the transfer, they must have the capability to treat the patient (e.g. have the necessary specialist) and have the capacity to treat the patient (an available bed). California ACEP concludes that our emergency care delivery system relies on this sharing of resources to save patient's lives, however, unfortunately, while we all depend on this arrangement, there is in fact no governmental or non-governmental system to coordinate it or to ensure its robustness.

4) **OPPOSE UNLESS AMENDED.** The California Hospital Association (CHA) is opposed to this bill unless it is amended and states that currently DPH issues each hospital a license that delineates every specialty and supplemental service it offers. In addition, hospitals annually provide to HCAI an inventory of all the services they provide on HCAI's Form 7401. CHA notes that they and the sponsors have been exploring whether the currently reported information could be used by HCAI to create the database, rather than having hospitals submit additional, duplicative information each year. CHA notes that it shares the goal of the author and sponsors to ensure that patients are transferred to an appropriate care setting as quickly as possible. However, hospitals should not be required to provide duplicative information to state agencies.

5) **RELATED LEGISLATION.**

a) AB 1991 (Bonta) requires requires healing arts boards that regulate health care providers to require, rather than request, specified workforce data. AB 1991 is pending in the Assembly Business and Professions Committee.

b) AB 3161 (Bonta) Requires DPH to collect self-reported patient demographics when receiving complaints regarding hospitals and long-term care facilities. Requires DPH to review, analyze, and publish trends among patient safety events in a manner consistent with patient privacy. Requires hospital patient safety plans to include specified methods to address racism and discrimination in health care, including procedures for staff to anonymously report instances of racial bias. Requires DPH to publicly publish hospital

patient safety plans. Establishes a partnership between DPH, the California Department of Civil Rights (DCR), and Department of Justice (DOJ) to share data on racial bias in health care specific to patient adverse events. AB 3161 is pending in Assembly Health Committee.

6) PREVIOUS LEGISLATION.

a) SB 363 (Eggman) of 2023 would have required the Department of Health Care Services, in consultation with DPH and the California Department of Social Services, to develop a real-time, internet-based database, to be operational by January 1, 2026, to collect, aggregate, and display information about beds in specified facilities to identify the availability of inpatient and residential mental health or substance use disorder treatment. SB 363 was held in the Assembly Appropriations Committee.

b) AB 1204 (Wicks), Chapter 751, Statutes of 2021, requires hospitals to prepare an annual equity report that includes an analysis of health status and access to care disparities for patients, measures from the Agency for Healthcare Research and Quality's Quality Indicators, and pay data to the Department of Fair Employment and Housing. Requires HCAI to make all equity reports available on their website and annually prepare a report that includes a list of all hospitals that failed to submit equity reports.

7) SUGGESTED AMENDMENTS.

a) In order to ensure that hospitals provide a telephone number to contact for inter-facility transfers, the author is proposing the following clarifying amendment:

(b) The department shall develop and maintain a searchable database of ~~hospitals by location and available specialties~~ ***information required in (a).*** *The database shall be searchable by specialty and distance and shall be accessible to hospital staff.*

b) As currently drafted the bill requires hospitals to report what specialty providers are available on call. This requirement may raise privacy implications for providers, especially those performing sensitive procedures, about potentially having their name or contact information available to the public. The Committee may wish to amend this bill to clarify that hospitals only need to provide the information by specialist type, not by the individuals' name.

c) As currently drafted this bill does not include a required timeframe for hospitals to report the requested data to HCAI. The Committee may wish to amend this bill to require hospitals to report the data on an annual basis, at the time and manner requested by HCAI. This amendment will clarify that the data base does not have to operate in "real time."

8) POLICY COMMENT. As noted by CHA, this bill may require hospitals to provide HCAI with duplicative data sets. Moving forward, the author may wish to work with HCAI and CHA to identify the data currently housed within HCAI that could be used to develop the requested database.

REGISTERED SUPPORT / OPPOSITION:

Support

California Chapter of the American College of Emergency Physicians (sponsor)

Opposition

None on file.

Analysis Prepared by: Lara Flynn / HEALTH / (916) 319-2097

Date of Hearing: April 2, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2250 (Weber) – As Introduced February 8, 2024

SUBJECT: Social determinants of health: screening and outreach.

SUMMARY: Requires a health plan, health insurer, and Medi-Cal to provide coverage for, and provider reimbursement of, social determinants of health (SDOH) screenings. Requires a health plan or insurer to provide to physicians who provide primary care services with adequate access to peer support specialists, lay health workers, social workers, or community health workers (CHWs), as defined. Provides for reimbursement of SDOH screenings at the Medi-Cal fee-for-service (FFS) rate for federally qualified health centers (FQHCs) and rural health clinics (RHCs). Specifically, **this bill**:

1) Requires a health plan contract, insurance policy, issued, amended, or renewed on or after January 1, 2027 to include coverage and provide reimbursement to health care providers for SDOH screenings.

2) Authorizes a provider to, during these screenings, focus or expand their questions to issues relevant to the patient and ask these questions in the manner the provider believes is most appropriate or more likely to elicit the best response from the patient. Requires providers to, when documenting patient responses to these screenings, use existing tools or protocols that have been validated by the federal Centers for Medicare and Medicaid Services (CMS), the National Association of Community Health Centers, the American Academy of Family Physicians, or other nationally recognized organizations and that include the domains of food insecurity, housing insecurity, transportation needs, and utility difficulties.

3) Requires health plans and insurers to provide physicians who provide primary care services with adequate access to peer support specialists, lay health workers, social workers, or CHWs as defined, including Promotores and community health representatives, in counties where the health plan or insurer has enrollees or insureds. Requires health plans and insurers to inform physicians who provide primary care services of how to access these CHWs, Promotores, community health representatives, peer support specialists, lay health workers, or social workers.

4) Authorizes the Department of Managed Health Care (DMHC) and California Department of Insurance (CDI) to adopt guidance for health plans and insurers to implement this bill.

5) Requires FQHCs and rural RHCs to be reimbursed for these SDOH screenings at the Medi-Cal FFS rate. Specifies the reimbursements to FQHCs and RHCs to be in addition to any other amounts payable with respect to those services, including payments received pursuant to existing law, and to not affect any other payments. Prohibits the payments described in this paragraph from being subject to, or factored into, reconciliation and requires payments to be excluded from 15) below under existing law.

6) Defines SDOH as the conditions under which people are born, grow, live, work, and age, including housing, food, transportation, utilities, and personal safety.

EXISTING LAW:

1) Establishes DMHC to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 and CDI to regulate health insurers. [Health and Safety Code (HSC) § 1340, *et seq*. and Insurance Code (INS) § 106, *et seq*.]

2) Establishes as California's essential health benefits (EHBs) benchmark under the Patient Protection and Affordable Care Act (ACA), the Kaiser Small Group Health Maintenance Organization, existing California health insurance mandates, and the 10 ACA mandated benefits, including prescription drug coverage. [HSC § 1367.005 and INS § 10112.27]

3) Defines “basic health care services” as all of the following:
   a) Physician services, including consultation and referral;
   b) Hospital inpatient services and ambulatory care services;
   c) Diagnostic laboratory and therapeutic radiologic services;
   d) Home health services;
   e) Preventive health services;
   f) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage. Basic health care services includes ambulance and ambulance transport services provided through the 911 emergency response system; and,
   g) Hospice care. [HSC § 1345]

4) Requires DMHC, on or before March 1, 2022, to convene a Health Equity and Quality Committee to make recommendations, by September 30, 2022, to DMHC for consideration in establishing standard health equity and quality measures, including annual benchmark standards for assessing equity and quality in health care delivery, by taking into consideration the interaction of multiple characteristics in determining where disparate outcomes exist, including, but not limited to, race, ethnicity, gender, sexual orientation, language, age, income, and disability. [HSC § 1399.870]

5) Requires a health plan, upon DMHC’s establishment or updating of standard measures and annual benchmarks in 4) above, to annually submit to DMHC a report containing health equity and quality data and information. Requires a health plan to implement the policies, procedures, and systems necessary for compliance, as specified. Requires the DMHC to coordinate with DHCS to support the review of, and any compliance action taken with respect to, Medi-Cal managed care plans to maintain consistency with the applicable federal and state Medicaid requirements governing those plans. [HSC § 1399.872]

6) Provides that the standards developed by DMHC pursuant to 4) above apply to health plans that cover hospital, medical, or surgical expenses, including a health plan that contracts with DHCS to provide health care services to Medi-Cal beneficiaries, and specialized health plans that provide behavioral health care. [HSC § 1399.873]

7) Establishes the Medi-Cal program, administered by the Department of Health Care Services (DHCS), under which low-income individuals are eligible for medical coverage. [Welfare and Institutions Code (WIC) § 14000, *et seq*.]

8) Establishes a schedule of benefits under the Medi-Cal program, which includes benefits required under federal law and benefits provided at state option but for which federal financial participation is available. [WIC § 14132]

9) Specifies CHW services as a covered benefit under Medi-Cal. [WIC § 14132.36]

10) Defines CHW to mean a liaison, link, or intermediary between health and social services and the community to facilitate access to services and to improve the access and cultural competence of service delivery. States that CHWs include Promotores, Promotores de Salud, community health representatives, navigators, and other nonlicensed health workers, including violence prevention professionals. Requires a CHW's lived experience to align with and provide a connection to the community being served. [WIC § 18998]

11) Requires FQHC and RHC services to be covered benefits under the Medi-Cal program and requires these services to be reimbursed on a per-visit basis, as defined. [WIC § 14132.100(c)]

12) Defines a "visit" as a face-to-face encounter between a patient of an FQHC or RHC and a health care professional, including a physician, physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, or a visiting nurse, podiatrist, dentist, optometrist, chiropractor, comprehensive perinatal services practitioner providing comprehensive perinatal services, a dental hygienist, a dental hygienist in alternative practice, or a licensed marriage and family therapist, a four-hour day of attendance at an Adult Day Health Care Center; and, any other provider identified in the state plan's definition of an FQHC or RHC visit. [WIC § 14132.100(g)(1)]

13) Authorizes an FQHC or RHC to apply for an adjustment to its per-visit rate based on a change in the scope of services provided by the FQHC or RHC. Requires rate changes based on a change in the scope of services provided by an FQHC or RHC to be evaluated in accordance with Medicare reasonable cost principles. [WIC § 14132.100(e)(1)]

14) Specifies that if FQHC or RHC services are partially reimbursed by a third-party payer, such as a managed care entity, as defined, the Medicare Program, or the Child Health and Disability Prevention Program, DHCS to reimburse an FQHC or RHC for the difference between its per-visit prospective payment system rate and receipts from other plans or programs on a contract-by-contract basis and not in the aggregate, and may not include managed care financial incentive payments that are required by federal law to be excluded from the calculation. [WIC § 14132.100(h)]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, research shows us that an individual's economic and social conditions influences their health status. Identifying these SDOH for individuals and families is a critical step in ensuring health equity and optimal health outcomes for all people in California. Additionally, a recent study discovered that physicians feel discomfort not being able to address their patient's SDOH needs. The author concludes

that this bill will help physicians begin to address patients' needs by referring patients to supportive resources closest to them.

2) **BACKGROUND.** The California Health Care Foundation (CHCF) writes in a Health Equity blog, "Advancing Black Health Equity," that a healthy California for all requires a health care system designed to redress, and not perpetuate, the inequities that too many Californians, especially Black Californians, face. Health is a key value for Black Americans, who are among the most likely groups to say they always make their health a priority. But, CHCF writes, structural barriers in the health care system prevent them from achieving the health they actively seek. Black Californians experience disparities in care and outcomes despite having higher health insurance coverage rates (93%) than the state average. The life expectancy at birth for Black Californians is 75.1 years, five years shorter than the state average and the lowest life expectancy of all racial and ethnic groups. Additionally, Black Californians have the highest rates of new colorectal, lung, and prostate cancer cases, and the highest death rates for breast, colorectal, lung, and prostate cancer. These outcomes cannot be explained away by factors like age, income, or education level. The health care system treats people differently, implicit biases and racism are known to exist at the levels of both the health care system and the individual provider.

   In April 2021, CMS published a report, entitled "On the Front Lines of Health Equity: Community Health Workers," and writes that addressing SDOH is key to achieving health equity. The report notes that CHWs can play an integral role in helping health care organizations achieve health equity and are frontline health workers who are members of, or have a deep understanding of the communities they serve. Well-developed CHW programs address both the clinical and nonclinical needs of patients and clients, especially within organizations that aim to support vulnerable populations. CHWs can help health care organizations improve health care quality, reduce provider burden, and strengthen relationships and trust within the communities for which they provide care.

   a) **California Advancing and Innovating Medi-Cal (CalAIM).** DHCS began implementing provisions of CalAIM in 2022, which is a multi-year program to improve health outcomes and quality of life for Medi-Cal beneficiaries through broad delivery system, program, and payment reform. One of the components of CalAIM is Population Health Management, in which plans identify and manage social risks and needs of Medi-Cal beneficiaries using whole person care approaches to mitigate negative SDOH. Additionally in early 2022, DHCS released an All Plan Letter (APL) to provide guidance for the collection of SDOH data. The letter states that DHCS expects Medi-Cal managed care plans to develop processes to work closely with providers to promote screening and regularly report SDOH data. The APL also emphasizes that clinicians other than a beneficiary's primary care clinician can document and code SDOH. New Medi-Cal managed care contracts require plans to identify and track SDOH and develop partnerships with local agencies to support community needs, including supports like housing and other non-health–related programs.

      Also as part of CalAIM, Medi-Cal managed care plans began providing community supports, a set of supportive services that address SDOH, including housing supports, medically supportive nutrition services, and home modifications to prevent asthma and falls. In July 2022, Medi-Cal released an updated provider manual that included CHW as a covered benefit. CHWs may include people known by a variety of job titles, including

Promotores, community health representatives, navigators, and other nonlicensed public health workers. CHWs must obtain a certificate (or can work without a certificate for up to 18 months) and must work under a supervising provider (this includes licensed clinicians, hospitals, outpatient clinics, local health jurisdictions, or community-based organizations). Covered services include health education, health navigation, screenings and assessments that do not require a license, and support or advocacy. Medi-Cal covers CHW services as preventive services and on the written recommendation of a physician or other licensed practitioner for a subset of beneficiaries (those with one or more chronic conditions, exposure to violence and trauma, at risk for a chronic health condition or environmental health exposure, who face barriers to meeting their health or health-related social needs, and/or who would benefit from preventive services). The Department of Health Care Access and Information (HCAI) is working with stakeholders to develop standards for certifying CHWs and training programs. HCAI is also developing plans for the certification process and training new CHWs.

b) SDOH. This bill requires coverage for SDOH screenings. According to the California Health Benefits Review Program (CHBRP), SDOH are nonmedical underlying structural factors that influence health status and health outcomes. There are multiple definitions of SDOH, but it is commonly defined as "the conditions in which people are born, grow, work, live, and age" in which a "wider set of forces and systems shape the conditions of daily life" and "affect health, functioning, and quality-of-life outcomes and risks." The Centers for Disease Control and Prevention defines these forces and systems as economic policies and systems, development agendas, social norms, social policies, racism, climate change, and political systems. The determinants themselves are neutral concepts (housing, education, food access) that can positively or negatively influence every person's health status, longevity, and quality of life depending on their access to and the quality of these determinants (e.g., good or bad education; un/reliable transportation; un/safe, un/affordable housing).

c) SDOH screening. According to CHBRP, the multidomain SDOH screening tools vary in length (seven to 130 items), format (verbal, electronic, or paper), content (three to six categories), setting in which they are administered (primary care, pediatrics, specialty care, inpatient), and who conducts the screening (provider or self-administered). Many tools are designed for adults or all-ages populations, while some are designed specifically to assess pediatric populations. The screening tools are generally free of charge to use, although there appears to be a growing commercial field including tools embedded in large electronic health record systems. Scoring or interpreting the screener results also varies by tool. Some tools do not instruct clinicians about the number of answers warranting a referral offer to social needs care. A handful of tools have more complicated scoring methods that take longer to calculate. In these cases, a lower total score (but greater than zero) may not trigger an offer of referral. One study cited by CHBRP found that despite tools being easy to administer, clinician ability to interpret the screening results is limited, which may suggest poor directions in how to score a test, unclear score ranges or cut-off scores, or lack of instructions for handling missing data. According to CHBRP, few SDOH screening tools have been tested for their validity (accurately captures the true social risk), reliability (consistently captures the right information), or pragmatic properties (cost, length, readability, etc.). The limited testing among these social screening tools leaves major gaps in evidence to guide screening tool selection.

One of the primary goals of screening for SDOH is to identify unmet social needs to link patients to appropriate nonmedical resources to ultimately improve or maintain their health. Other goals include data collection to calculate prevalence of social needs to inform risk adjustment or plan social service programs. Such information can also inform clinician treatment choices such as using the information about financial security to choose less expensive medications, avoid refrigerated medications, provide point of care ultrasound, or change target blood sugar goals.

d) **CHW workforce.** This bill also requires health insurers to provide primary care clinicians with adequate access to CHWs in counties where the plan/policy has enrollees and provide information about how to access those CHWs. Starting July 2022, DHCS added CHW services as a covered Medi-Cal benefit in California. According to CHBRP, CHW is a general term that can be used to define several types of frontline public health workers. CHWs are trusted members of communities and/or have deep understandings of the communities they serve, which allows them to serve as intermediaries for patients between health care and social service providers and the community. There is evidence of CHW effectiveness in improving chronic disease management and addressing unmet social needs among primary care patients. The 2019 California Future Health Workforce Commission (Commission) noted that CHWs provide an effective and efficient bridge for patients between health care, home, and community, especially when integrated with a care team. The Commission recommended that California modify reimbursement mechanisms to grow the CHW workforce to meet increasing demand for these frontline workers. As of May 2022, the federal Bureau of Labor Statistics estimated about 67,200 CHWs working in the US, with 8,940 working in California. A 2021 survey of CHWs and promotores in California found nearly 60% reported employment with a community-based organization, while close to 20% were employed by a FQHC. The remaining 20% were employed by faith-based organizations, managed care organizations, and agencies offering mental health or social services. As for work settings, more than half of the respondents reported working in a community-based organization and many worked in a community clinic or a community health center. Other work settings included managed care plans, housing agencies, and long-term care/rehabilitation facilities. California does not currently require certification or licensure of CHWs although employers or payers may require CHW training and certification as a condition of employment. Notably, DHCS does require CHW certification to qualify for Medi-Cal reimbursement. CHW training programs vary in length, scope, content, and cost. As noted previously, HCAI is working of CHW certification and eligibility requirements.

e) **CHBRP analysis.** AB 1996 (Thomson), Chapter 795, Statutes of 2002, requests the University of California to assess legislation proposing a mandated benefit or service and prepare a written analysis with relevant data on the medical, economic, and public health impacts of proposed health plan and health insurance benefit mandate legislation. CHBRP was created in response to AB 1996. SB 125 (Hernandez), Chapter 9, Statutes of 2015, added an impact assessment on EHBs, and legislation that impacts health insurance benefit designs, cost sharing, premiums, and other health insurance topics. CHBRP analysis of AB 85 (Weber) of 2023, which is similar to this bill, includes the following:

   i) **Enrollees covered.** This bill requires coverage of SDOH screening and allows clinicians to be reimbursed for SDOH screening. CHBRP assumes the voluntary nature of screening for both patients and clinicians would not result in universal

screening. Instead, the use of screening by clinicians would vary across patient populations. CHBRP estimates that 3.2% of employer-sponsored and CalPERS commercial enrollees would obtain an annual SDOH screening, while 6.4% of individual insurance market enrollees, and 20% of Medi-Cal enrollees would use the service. Despite other state policy efforts to link SDOH screening with care management and coordination activities to address high-cost, high-need populations, this bill does not require enrollment or reimbursement for those activities by a plan or clinician. Therefore, the impact of this bill is limited to the new utilization of SDOH screening itself and the resulting reimbursement for screenings due to new benefit coverage and use of SDOH screening. At baseline, 75% (or 17,202,000) of the 22,842,000 enrollees with health insurance regulated by DMHC or CDI already have coverage for SDOH screening. As a result of this bill, 5,640,000 enrollees (25% of the enrollees with state-regulated health insurance) would gain coverage for SDOH screening, representing a 32.79% increase in benefit coverage postmandate. All of the enrollees who would gain SDOH screening coverage have commercial insurance or insurance through CalPERS; this group represents 40% of the commercial and CalPERS population.

ii) **Impact on expenditures.** This bill would increase total net annual expenditures by $9,926,000 or 0.01% for enrollees in state-regulated insurance. For most commercial market segments, this would translate to increasing premiums by 0.01%. However, enrollees with insurance purchased outside of Covered California would experience the largest proportional increase in enrollee premiums (0.03%) due to lower levels of benefit coverage at baseline. Premiums for enrollees in individual plans purchased through Covered California would increase by $0.05 per member per month (0.01%).

(1) **Medi-Cal**. Since all Medi-Cal plans reported providing and paying for SDOH screening at baseline, no increase is estimated due to this bill. Due to the combination of Medi-Cal contracting requirements, the National Committee for Quality Assurance (NCQA) accreditation requirement changes, and the upcoming CalAIM Medicaid Waiver, CHBRP estimates that this bill would not result in new benefit coverage or increased use of SDOH screening in Medi-Cal managed care plans.

(2) **CalPERS**. For enrollees associated with CalPERS in DMHC-regulated plans, premiums would increase by 0.01% ($0.04 per member per month, $415,000 total increase in expenditures).

(3) **Number of Uninsured in California.** Since the change in average premiums does not exceed 1% for any market segment, CHBRP estimates this bill would have no measurable impact on the number of uninsured persons.

iii) **EHBs.** This bill does not exceed the definition of EHBs in California because screenings are a preventive service and covered under the ACA.

iv) **Medical effectiveness.** According to CHBRP, the medical effectiveness review summarizes findings from 2019 to present on the evidence that multi-domain clinical screening for SDOH leads to referrals to CHWs or other social service navigators, to use of social services, and to changes in social outcomes, health care utilization, or health outcomes. CHBRP also reviewed evidence of harms of SDOH screening in a clinical setting. Studies on screening for SDOH in a clinical setting were limited in number and quality. It is hard to generalize the findings of this research across studies because of the variety of populations included in studies, the various social needs, the variety of SDOH screening tools, and the variety of referral interventions used in the studies. Therefore, taken together, the evidence on

the effectiveness of screening for SDOH in a clinical setting, referral to navigators/social services, and downstream outcomes after screening is a mixture of limited, inconclusive, and insufficient. The lack of evidence due to limited research literature is not evidence of lack of effect.

v) **Public health.** The public health impact of this bill on improved health (or socioeconomic) status and outcomes is unknown. CHBRP notes the following as unknown:

(1) If the supply of CHWs in California is sufficient;

(2) Insufficient evidence indicates that there is not enough evidence available to know whether or not a treatment is effective, either because there are too few studies of the treatment or because the available studies are not of high quality. It does not indicate that a treatment is not effective;

(3) If CHWs can successfully connect patients to ≥1 needed social resources;

(4) If social services/community-based organizations have adequate resources to meet increased needs;

(5) If these commercially insured enrollees would qualify for social services or community-based resources, most of which are income tested;

(6) If these commercially insured enrollees, if eligible for social services, would be able to use them (e.g., geographic, time, transportation or other barriers to their use);

(7) Whether health outcomes would improve within 12 months and to what extent; and,

(8) If and to what extent new social needs would develop and be addressed.

vi) **Long-term impacts**. CHBRP predicts that this bill would not contribute to long-term changes in health care utilization partly due to the unknown mechanism for establishing a reliable clinician CHW network system for patient referral. Additionally, multiple policy changes mitigate the potential effect of this bill including recent changes in Medi-Cal (new Medi-Cal managed care contracts and CalAIM activities), state-mandated NCQA accreditation of health insurance plans, and other clinician-led initiatives to address social needs through SDOH screening. These factors are likely to increase SDOH screening without passage of this bill. In addition, HCAI is convening a workgroup on licensure and reimbursement for CHWs that could change the use of and payment for CHW services in the long-term. However, that workgroup is focused on Medi-Cal coverage to create a mechanism for billing for CHW services and will not directly affect the commercial insurance market unless separate legislation or decisions to require coverage for CHW-related services are adopted in the commercial market. For reasons similar to CHBRP's unknown short-term public health impact finding, there is also an unknown long-term public health impact finding. Although SDOH screening is projected to increase among a concentrated group of commercially insured enrollees (Medi-Cal beneficiaries have baseline benefit coverage), outstanding questions remain about clinician decisions to screen and refer patients, the type and quality of CHW referrals and networks established (including the definition of "adequate" and "access" to CHWs by clinician), and whether there are adequate social resources available for the new influx of commercially insured enrollees with unmet social needs. CHBRP acknowledges that SDOH screening could improve patient health status by increasing the information available to clinical teams about patients' social risk, which might then be used to influence treatment plans for patients experiencing social needs. For example, a clinician learns about housing insecurity, which leads to a different

medication. Over time, broadening the clinical care approach to routinely incorporate social data could become standard. However, CHBRP states the magnitude of this type of change is unknown.

vii) Assembly Actions. On March 12, 2024, the Assembly Committee on Health and Budget Sub 1 Committee, held an informational hearing entitled, "Bright Spots and Remaining Barriers to Realizing the Potential of Community Health Workers, Promotoras, and Representatives to Improve Health in California," to provide background on CHWs, recent state efforts, and to help the state realize the transformative potential of CHWs to improve health and health equity in California. The hearing also provided the Legislature with an update of HCAI's work on CHWs.

Additionally, the Assembly Select Committee on the Social Determinants of Health held an informational hearing entitled, "Environmental Health in Urban Communities," with panelists representing clean water, clean air, green and open spaces, and data-driven policy tools.

The author also notes a $22 million budget request to be allocated to make SDOH screenings a covered benefit and is necessary to ensure that there are resources for health care providers to conduct the screenings, allow more efficient and faster identification of unmet social needs.

3) SUPPORT. The California Academy of Family Physicians (CAFP), the sponsor of this bill, writes that family physicians understand the importance of identifying and addressing SDOH for individuals and families. Screening for SDOH can help physicians better contextualize the care they are providing patients. The challenge is the lack of resources to operationalize this significant, complex task into a busy practice environment in a manner that is actionable and practical. Moreover, physicians do not know how to address the needs of patients outside the clinic walls. This bill seeks to address this by requiring health plans and insurers to pay for the screening for SDOH. This bill will also increase efforts to bridge patients to community resources or government social services to address their SDOH needs by requiring health plans and insurers to provide access to community health workers, promotores, peer support specialist, lay health workers, and social workers. CAFP concludes that access to these community support navigators will provide the necessary linkage between the healthcare team and community resources, which will close the gap in follow-ups after screening. The California Primary Care Association write that this bill will help to improve health outcomes for vulnerable communities and aid in California's efforts to achieve a whole person care health care system.

4) PREVIOUS LEGISLATION.

a) AB 85 (Weber) of 2023 was similar to this bill and was vetoed by Governor Newsom:

"I am returning Assembly Bill 85 without my signature.

This bill would require health plans to provide coverage and reimbursement to health care providers for social determinants of health screenings, beginning January 1, 2027. The bill would also require the Department of Health Care Access and Information to convene a working group to inform policies on social determinants of

health and to submit a report to the Legislature with findings and recommendations by January 1, 2026.

My Administration has made significant investments in policies that contemplate and improve social determinants of health, such as housing, social services, community engagement, economic development, and public education. While I support the overall goal of this proposal, it is duplicative of existing efforts, such as Adverse Childhood Experiences (ACEs) screenings and the work DHCS is doing through CalAIM. Further this bill may be premature; a standardized social determinants of health screening tool does not yet exist, though there are federal efforts ongoing. Our state policy should align with these national efforts to avoid conflicting policies.

For these reasons, I cannot sign this bill."

b) AB 2697 (Aguiar-Curry), Chapter 488, Statutes of 2022, codifies the requirement that CHW services be a covered Medi-Cal benefit. Requires a Medi-Cal managed care plan to engage in outreach and education efforts to enrollees, as determined by DHCS, but that includes, at a minimum, specified information to enrollees, including, among other things, a description of the CHW services benefit and a list of providers that are authorized to refer an enrollee to CHW services. Requires DHCS, through existing and regular stakeholder processes, to inform stakeholders about, and accept input from stakeholders on, implementation of the CHW services benefit. Specifies implementation only to the extent that federal financial participation is available and not otherwise jeopardized. Authorizes DHCS to implement, interpret, or make specific AB 2697 by means of policy letters, provider bulletins, or other similar instructions, without taking any further regulatory action.

c) SB 184 (Committee on Budget and Fiscal Review), Chapter 47, Statutes of 2022, the 2022 Health Trailer Bill, requires HCAI to develop statewide requirements for CHW certificate programs in consultation with stakeholders.

d) SB 428 (Hurtado), Chapter 641, Statutes of 2021, requires a health plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2022, that provides coverage for pediatric services and preventive care to additionally include coverage for adverse childhood experiences.

5) COMMENTS.

a) Eligibility. CHWs work to improve overall health in under-resourced communities by providing social support, care coordination, navigation, coaching, and advocacy. CHBRP notes that since eligibility for social services is often limited to lower-income people, many commercially insured people might not qualify. This may pose challenges to linking them with services that can sustainably address their social needs. This bill does not mandate reimbursement for or coverage of social services that patients with social needs would be linked to through CHWs.

b) Health information exchange. To avoid duplication and ensure that screening services link patients to appropriate social services, it is important that health care providers and health plans share medical information through California's Health and Human Services Agency Data Exchange Framework which requires the exchange of health information

among health information among health care entities and government agencies in California.

REGISTERED SUPPORT / OPPOSITION:

Support

California Academy of Family Physicians (sponsor)
AIDS Healthcare Foundation
Alameda Health Consortium - San Leandro, CA
American Academy of Pediatrics, California
American College of Obstetricians and Gynecologists District IX
APLA Health
Asian Health Services
California Academy of Family Physicians
California Black Health Network
California Kidney Care Alliance
California Medical Association
California Pan - Ethnic Health Network
Child Abuse Prevention Center
Children's Choice Dental Care
Children's Specialty Care Coalition
Communicare+OLE
Community Clinic Association of Los Angeles County
Comprehensive Community Health Centers
CPCA Advocates, Subsidiary of The California Primary Care Association
DAP Health
DaVita Healthcare Partners Inc.
Family Health Centers of San Diego
Golden Valley Health Centers
Health Alliance of Northern California
Health Center Partners of Southern California
Inland Family Community Health Center
La Clinica de La Raza, Inc.
La Maestra Community Health Centers
Lifelong Medical Care
National Association of Social Workers California
National Multiple Sclerosis Society
North Coast Clinics Network
Northeast Valley Health Corporation
Ochin, Inc.
Petaluma Health Center
Planned Parenthood Affiliates of California
San Ysidro Health
Share Our Selves
South Central Family Health Center
The Children's Clinic DBA TCC Family Health
The Los Angeles Trust for Children's Health

Unicare Community Health Center
Western Center on Law & Poverty, Inc.

Opposition

None on file.

Analysis Prepared by: Kristene Mapile / HEALTH / (916) 319-2097

Date of Hearing: April 2, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2300 (Wilson) – As Amended March 6, 2024
AS PROPOSED TO BE AMENDED

SUBJECT: Medical devices: Di-(2-ethylhexyl) phthalate (DEHP).

SUMMARY: Prohibits a person or entity from manufacturing, selling, or distributing into commerce intravenous solution containers or intravenous tubing made with intentionally added di-(2-ethylhexyl) phthalate (DEHP). Specifically, this bill:

1) Prohibits commencing January 1, 2026, a person or entity from manufacturing, selling, or distributing into commerce in the State of California intravenous solution containers made with intentionally added DEHP.

2) Prohibits, commencing January 1, 2031, a person or entity from manufacturing, selling, or distributing into commerce in the State of California intravenous tubing made with intentionally added DEHP for use in neonatal intensive care units, nutrition infusions, or oncology treatment infusions.

3) Prohibits a person or entity from replacing DEHP for revised or new products with other specified ortho-phthalates.

4) Exempts the following items, as described in Title 21 of the Federal Code of Regulations, from the provisions of this bill: human blood collection and storage bags; apheresis and cell therapy blood kits and bags, including integral tubing.

EXISTING LAW:

1) Prohibits a person or entity from manufacturing, selling, or distributing in commerce any toy or child care article that contains DEHP, dibutyl phthalate, or benzyl butyl phthalate, in concentrations exceeding 0.1%. [Health & Safety Code (HSC) § 108937]

2) Requires manufacturers to use the least toxic alternative when replacing phthalates in products for young children. [HSC § 108939]

3) Prohibits manufacturers from replacing phthalates in products for young children with carcinogens rated by the United States Environmental Protection Agency (EPA) as A, B, or C carcinogens, or substances listed as known or likely carcinogens, known to be human carcinogens, likely to be human carcinogens, or suggestive of being human carcinogens, as described in the "List of Chemicals Evaluated for Carcinogenic Potential," or known to the state to cause cancer as listed in the California Safe Drinking Water Act. [HSC § 108939]

4) Prohibits manufacturers from replacing phthalates in products for young children with reproductive toxicants that cause birth defects, reproductive harm, or developmental harm as identified by the EPA or listed in the California Safe Drinking Water Act. [HSC § 108939]

5) Prohibits, commencing January 1, 2025, a person or entity from manufacturing any cosmetic that contains intentionally added DEHP. [HSC § 108980]

FISCAL EFFECT: None.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, "As a recent patient of the medical care system, I have first-hand knowledge related to the need for multiple infusions, with long durations, through medicines administered from IV bags. Each time you are potentially being exposed to a toxic material simply because we haven't passed a law to ban this toxic material. There are alternatives, they are currently being used, and they aren't more expensive. The State decided to ban the use of DEHP in kids' toys, I think it is time to ban this from medical containers that allow leaching directly into our bodies- when we are most vulnerable. People should be focused on their healthcare, not whether the very life-saving procedure is exposing them to cancer and other terrible health impacts."

2) **BACKGROUND.**

   a) **What are phthalates?** According to the Centers for Disease Control and Prevention (CDC), phthalates are chemicals used in the manufacture of plastics, often called plasticizers. Phthalates can prolong the lifespan or durability of plastics and increase the flexibility of some plastics, and have been used as solvents for other materials. They are used in hundreds of products, including vinyl flooring, adhesives, detergents, lubricating oils, some pharmaceutical and pesticide formulations, and personal-care products, such as soap, shampoo, hair spray, and nail polish. Phthalates are also used in flexible polyvinyl chloride plastics, such as plastic bags, food packaging, garden hoses, inflatable recreational toys, intravenous tubing, automotive plastics, and plastic clothing, such as raincoats.

   b) **Phthalates in medical products.** DEHP is the phthalate most commonly used in medical products. Some medical products such as intravenous (IV) bags can contain up to 40% DEHP by weight. Every month, more than 40 million IV infusions are administered in the U.S. to treat dehydration, deliver medicines and nutrition, and for blood transfusions. More than 60% of the IV bags used in those infusions are made from DEHP. The phthalate leaches to varying degrees from medical devices during certain medical procedures and exposes the patient.

      i) **Potential Impacts of Exposure to DEHP.** According to the CDC, exposure to DEHP has been linked to decreased testosterone and sperm motility, preterm birth, altered timing of puberty, delayed mental development. The U.S. Department of Health and Human Services classified DEHP as reasonably anticipated to be a human carcinogen (a substance that can cause cancer in people). The EPA has determined that DEHP is a probable human carcinogen. The International Agency for Research on Cancer has classified DEHP as possibly carcinogenic to humans. Assessments conducted for the governments of the United States, Canada, and the European Union have all concluded that exposures to DEHP are of concern to some patient populations and subsets of the general public. In 2003, the state of California's Office of Health Hazard Assessment listed DEHP as a reproductive toxicant under the Safe

Drinking Water and Toxic Enforcement Act of 1986. In California, manufacturers and others who make or use products containing DEHP are now required to provide warnings to consumers that their products contain a chemical known by the state of California to cause reproductive toxicity. Research suggests that infants and toddlers, pregnant and lactating people, and patients undergoing certain medical procedures are especially vulnerable to DEHP exposure.

c) Calls to label, reduce and phase out the use of DEHP.

i) United States.

(1) In 2002, the federal Food and Drug Administration (FDA) issued draft guidance suggesting that manufactures label certain devices with their DEHP content and consider eliminating the use of DEHP in certain devices that can result in high aggregate exposures in sensitive patient populations.

(2) In 2006, the American Medical Association, among other professional organizations, encouraged hospitals and physicians to reduce and phase out the use of polyvinyl chloride (PVC) medical device products, especially those containing DEHP.

(3) The National Academy of Sciences in their 2008 report, "Phthalates and Cumulative Risk Assessment: The Task Ahead," recommends that risks associated with phthalate exposure should be considered in the context of cumulative exposures to all phthalates and other anti-androgens. When infants, toddlers, fetuses, and pregnant people are exposed to DEHP from medical devices it adds to the already existing burden of chemicals that may also interfere with normal development of the reproductive tract. This highlights the concern for risk of harm from exposures to DEHP.

ii) European Union.

(1) In 2001, the European Parliament adopted a resolution in response to the Commission Green Paper on environmental issues of PVC and called for the Commission and the PVC industry to examine how targets might be set to reduce the use of phthalates, including DEHP, particularly in medical equipment. The resolution also asked the Commission to examine alternatives to the uses of phthalates as plasticizers.

(2) The Swedish Chemicals Inspectorate in its 2004 report for the European Union (EU) assessed the toxicity of DEHP for all human populations. It concluded that DEHP poses risks to many sub-populations, and that there is need for limiting the risks from DEHP exposure for human health for: newborns receiving transfusions, children receiving long-term blood transfusion or extracorporeal oxygenation, and adults receiving long term hemodialysis.

(3) In 2004, the German Federal Institute for Drugs and Medical Devices issued a warning to health care professionals in order to minimize exposure to DEHP primarily for high-risk patient groups. These include fetuses, premature infants and newborns, as well as children in pre-puberty age. It was recommended that: medical devices manufacturers actively engage and strive for further development of safer DEHP-free alternative products; manufacturers consequently provide users with a comprehensive explanation on the risks of DEHP in medical devices as well as label correspondingly their products; neonatal intensive care units use alternative products if available and suitable for the relevant procedure in order to

act with precaution and therefore avoid DEHP exposure for premature infants and newborns.

(4) The EU's 2005 draft Risk Reduction Strategy prepared by the Swedish Chemicals Inspectorate proposed a set of legislative actions to limit the risks of DEHP exposure to all vulnerable populations. The recommended actions include: the use of DEHP should be restricted in medical devices giving rise to exposure of newborns and groups identified to be of concern in the risk assessment report assuming availability of safe alternative.

(5) In February 2005, the European Parliament brought this issue again to the forefront by adopting a resolution on the European Environment & Health Action Plan 2004-2010. The resolution called for restricting the market and/or use of dangerous substances, including DEHP, in domestic products for indoor use and in medical devices, specifically for vulnerable groups, particularly newborn babies, children, pregnant people, elderly persons, workers, and other high-risk sections of the population that are heavily exposed.

(6) Under the new regulation (EU) 2023/2482, issued in November 2023, users of DEHP in medical devices will note that they will no longer be able to use DEHP from July 1, 2030, unless they apply for authorization before January 1, 2029.

d) **Availability of non-DEHP alternatives in medical devices**. Many manufacturers, including B. Braun, Fresenius Kabi USA, Baxter, and ICU Medical, advertise that they already provide products without DEHP.

i) Per B.Braun Medical's website: "More than 40 years ago, B. Braun recognized the environmental and patient risks posed by medical products containing PVC and DEHP. We were the first medical device manufacturer to remove these harmful substances from many of our products, and remain the only supplier offering a full line of IV drug and solution containers not made from PVC or DEHP."

ii) Per Fresenius Kabi USA's website: "Our freeflex and freeflex+ IV bags are designed with safety in mind. Studies have shown that PVC relies on and creates chemicals like DEHP that are highly hazardous to humans and the environment. For that reason, all freeflex IV bags are non-PVC and non-DEHP and can be used across the facility for the broadest clinical application."

iii) Per Baxter's website: "To meet the preferences of some customers and address drug compatibility issues in specific clinical applications, Baxter offers a portfolio of intravenous medications, parenteral nutrition solutions, injectable drugs, biopharmaceuticals, IV sets and access devices, and other products that use or are contained in non-PVC materials or non-DEHP [di-(2-ethylhexyl)phthalate], a common component of PVC materials."

iv) Per ICU Medical's website: "With our broad portfolio of non-PVC, non-DEHP IV containers, you can get the container you need to meet the challenges of hazardous drug compatibility while helping with environmental and patient initiatives focused on phthalate reduction."

e) **The use of DEHP in blood bags**. Commercial blood bags are predominantly made of PVC plasticized with DEHP. DEHP is favorable for storage of red blood cells (RBC). Historically, removal of DEHP from blood bags has been linked to unacceptable haemolysis levels. Oncoming regulatory restrictions for DEHP due to toxicity concerns increase the urgency to replace DEHP without compromising RBC quality. Research

suggests that Di(2-ethylhexyl) terephthalate may be a suitable candidate for replacement of DEHP in blood bags in the future.

3) **SUPPORT.** Breast Cancer Prevention Partners and California Black Health Network, cosponsors of the bill, state that research indicates that DEHP promotes drug resistance and inhibits the effectiveness of breast cancer drugs; interferes with the ability of chemotherapies to fight breast cancer, and that patients with higher levels of DEHP in their system had higher rates of relapse and mortality. California's standards for medical devices need to be higher. DEHP is harmful throughout its entire life cycle, from manufacturing to disposal, and it has serious impacts that extend beyond human health. Non-DEHP containers and tubing have been available for decades. The cosponsors conclude that just as DEHP is no longer legally allowed in make-up and personal care products, toys and other children's products sold in California, it is time for DEHP to be eliminated from these medical devices.

4) **SUPPORT IF AMENDED.** Fresenius Kabi (FK), a health care company that provides products and services for blood infusion and transfusion, states that, at present, replacing DEHP in blood bags remains a scientific challenge worldwide as these products are highly effective at safeguarding the unique properties of blood and blood components, for periods of up to 49 days, against a wider temperature range and a higher degree of force and stress than IV solutions. Until non-DEHP blood products are developed and made widely and affordably available, FK recommends excluding them from this proposed bill. FK concludes that excluding them would have the unintended public health consequences of causing blood shortages in California and perhaps elsewhere as well.

5) **OPPOSE UNLESS AMENDED.** The Advanced Medical Technology Association (AMTA) opposes unless amended. AMTA states that given the robust pre-market medical device and new drug application review process at the United States Food and Drug Administration (FDA), AMTA is concerned with the precedent this bill would set. Medical devices and drugs are distributed nationally, and the FDA regulatory process provides manufacturers, healthcare providers, and patients with a consistent set of rules governing product safety. AMTA argues that it would be extremely difficult for the industry to navigate a patchwork of inconsistent state regulations governing medical devices and drugs. AMTA notes that hanging or substituting product materials is a highly complex process and subject to strict regulatory requirements and lengthy approval times. AMTA requests an effective date for 2035 on the requirements for IV tubing and solution containers and amending the definition of "intentionally added DEHP" to include a 0.1% threshold to allow manufacturers to test products to ensure compliance.

6) **DOUBLE REFERRAL.** This bill is double-referred, upon passage of this Committee, it will be referred to the Assembly Committee on Environmental Safety and Toxic Materials.

7) **RELATED LEGISLATION.**

   a) AB 2066 (Reyes) would, commencing January 1, 2027, prohibit a person or entity from using methylene chloride in the process of decaffeinating coffee. AB 2066makes a violation of these provisions punishable by a civil penalty not to exceed $5,000 for a first violation and not to exceed $10,000 for each subsequent violation, upon an action brought by the Attorney General, a city attorney, a county counsel, or a district attorney. AB 2066 is pending a hearing in the Assembly Committee on Health.

b) AB 2217 (Weber) would, commencing January 1, 2027, prohibit a person or entity from manufacturing, selling, delivering, distributing, holding, or offering for sale, in commerce a food product for human consumption that contains tianeptine. AB 2217 would make a violation of these provisions punishable by a civil penalty not to exceed $5,000 for a first violation and not to exceed $10,000 for each subsequent violation, upon an action brought by the Attorney General, a city attorney, a county counsel, or a district attorney. AB 2217 is pending a hearing in the Assembly Committee on Health.

c) AB 2365 (Haney) would add kratom products, as defined, to the Sherman Food, Drug, and Cosmetic Law and require processors of kratom products to register with the Department of Public Health. AB 2365 would prescribe specified quantities of alkaloids present in kratom products and would establish labeling and packaging requirements. AB 2365 would require that kratom products be registered with the department annually, which would include certification by a laboratory specifying that the product meets certain qualifications. The bill would prohibit the sale of kratom leaf and kratom products to those under 18 years of age. By expanding the scope of a crime, the bill would create a state-mandated local program. AB 2217 is pending a hearing in the Assembly Committee on Health.

8) PREVIOUS LEGISLATION.

a) AB 2762 (Muratsuchi), Chapter 314, Statutes of 2020, prohibits, beginning January 1, 2025, the manufacture, sale, delivery, holding, or offering for sale in commerce of any cosmetic product containing specified intentionally added ingredients.

b) AB 1108 (Ma), Chapter 672, Statutes of 2008, prohibits the use of phthalates in toys and childcare products designed for babies and children under three years of age.

9) AMENDMENTS. To address stakeholder concerns related to the current availability non-DEHP blood bags, the author has proposed amendments to exempt blood bags and human blood cell apheresis kits from the provisions of the bill.

10) POLICY COMMENTS. To address concerns related to the manufacturing and FDA approval process, the author may also wish to consider delaying the implementation of requirements for the IV tubing and solution containers and amending the definition of intentionally added DEHP to include a threshold allowing manufacturers to test products to ensure compliance.

REGISTERED SUPPORT / OPPOSITION:

Support

Breast Cancer Prevention Partners (cosponsor)
California Black Health Network (cosponsor)
A Voice for Choice Advocacy
Access Reproductive Justice
Alliance of Nurses for Healthy Environments
Asian Americans Advancing Justice Southern California
Association of Regional Center Agencies
B. Braun Medical INC.

B. Braun Medical, INC.
Buen Vecino
California Health Coalition Advocacy
California Nurses for Environmental Health and Justice
California Pan-Ethnic Health Network
CALPIRG, California Public Interest Research Group
Center for Community Action and Environmental Justice
Center for Environmental Health
Clean Production Action
Clean Water Action
CleanEarth4Kids.org
Courage California
Defend Our Health
Educate. Advocate.
Health Care Without Harm
Health Equity for African American's League (HEAAL)
Healthy Contra Costa
Keep a Breast
Latino Coalition for a Healthy California
Made Safe
Mixteco Indigena Community Organizing Project
National Association of Environmental Medicine (NAEM)
National Stewardship Action Council
National Union of Healthcare Workers
Northern California Center for Well-Being
Plastic Pollution Coalition
PRC & /Black Leadership Council
Public Health Advocates
San Francisco Bay Physicians for Social Responsibility
Science and Environmental Health Network
Sharp HealthCare
The Last Beach Cleanup
Urban Strategies Council
Western Center on Law & Poverty, INC.
Women's Voices for The Earth
Young Invincibles

Analysis Prepared by: Eliza Brooks / HEALTH / (916) 319-2097

Date of Hearing: April 2, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2319 (Wilson and Weber) – As Amended March 21, 2024

SUBJECT: California Dignity in Pregnancy and Childbirth Act.

SUMMARY: Expands the types of health care providers who must participate in implicit bias training pursuant to the California Dignity in Pregnancy and Childbirth Act (the Act.) Requires initial basic training on implicit bias to be completed by June 1, 2025, and requires facilities subject to the provisions of the Act to provide the Department of Public Health (DPH) with proof of compliance by February 1 of each year. Specifically, **this bill**:

1) Requires hospitals that provide perinatal care, alternative birth centers, and primary care clinics to implement evidence-based implicit bias programs for all health care providers involved in the perinatal care of patients within those facilities.

2) Defines health care providers for the purposes of this bill to include:

   a) Licensed health care providers, including, but not limited to, physicians and surgeons, physicians' assistants, registered nurses, respiratory therapists, and licensed vocational nurses, who are regularly assigned to provide perinatal care, including, but not limited to, those in primary care clinics, alternative birthing centers, outpatient clinics, or emergency departments; and,

   b) All persons who are regularly assigned to positions where they interact with perinatal patients, including, but not limited to, physician assistants, medical assistants, licensed vocational nurses, or doctors.

3) Requires health care providers described in 2) above to complete initial basic training through the implicit bias training by June 1, 2025, for all current health care providers, and for the initial basic training to be provided to new health care providers at all facilities within six months of their start at the new facility.

4) Requires a facility described in 1) above to document each employee's implicit bias training in accordance with regulations adopted by DPH for documenting staff development programs. Requires DPH to assess each hospital's compliance with this provision during periodic inspections conducted pursuant to 2) in existing law, below.

5) Authorizes DPH, if DPH determines that a facility has violated these provisions, to assess an administrative penalty consistent with 11) in existing law, below.

6) Specifies that DPH's ability to issue a penalty is not the exclusive means of enforcing the Act, and that civil remedies available to the Attorney General (AG) under any other statute remain available to enforce the provisions of this Act. Grants DPH full administrative power, authority, and jurisdiction to implement and enforce the Act.

7) Requires DPH to annually post on its internet website by April of each year a list of all facilities that have been issued administrative penalties for violations of the Act. Requires,

when listing facilities that have been issued administrative penalties, DPH to include all of the following:
a) The date the penalty was issued;
b) The amount of the penalty;
c) The reason the penalty was issued;
d) The percentage of untrained providers; and,
e) The date of facility noncompliance.

2) Authorizes, if a facility disputes a determination rendered by DPH pursuant to 5) above, the facility to request a hearing within 10 working days. Requires penalties to be paid when all appeals have been exhausted and DPH's position has been upheld.

3) Requires DPH, on or before ____, to solicit broad public participation and adopt regulations to further the purposes of the Act, including, but not limited to, the following areas:
   a) Guidance on training methodologies sufficient to address the findings and declarations in the Act;
   b) Guidance on each of the categories of training specified in the Act; and,
   c) Authorizing DPH to issue and revise or adopt existing trainings that it certifies as a model sufficient to comply with the requirements of the Act, current research, and best practices. Requires DPH to make any certified training available on its internet website.

4) Requires DPH to review and ensure that the training continues to comply with the requirements of the Act, and to recertify training on an annual basis or to withdraw its certification.

5) Authorizes DPH to adopt additional regulations, as necessary, to further the purposes of the Act.

6) Requires DPH to conduct a review of a facility subject to the requirements of the Act:
   a) Upon the death of a birthing parent or child during or one month after birth, unless DPH had completed a review of the facility within one year prior to the death;
   b) Upon DPH's receipt of at least three complaints of racial bias or quality of care against perinatal or prenatal care providers in a facility subject to the training requirements of the Act by a patient or patients identifying as any race but white, not Hispanic or Latino; or,
   c) At any other time that DPH deems appropriate.

7) Requires a facility review to include a review of the facility's compliance with the training requirements of the Act, and review the substance of the facility's training program to assess compliance with the requirements of the Act, and any relevant regulation.

8) Requires DPH to publish a report outlining compliance data on a biannual basis. Requires the report to be posted on DPH's internet website.

9) Defines "perinatal care" as the provision of care during pregnancy, labor, delivery, and postpartum and neonatal periods. Specifies that perinatal care includes, but is not limited to prenatal care.

10) Makes the provisions of the Act severable.

11) Finds and declares that it is the intent of the Legislature to reduce the effects of implicit bias in pregnancy, childbirth, and postnatal care so that all people are treated with dignity and respect by their health care providers, and that the Legislature recognizes all birthing people, including nonbinary persons and persons of transgender experience.

EXISTING LAW:

1) Establishes DPH, which among other functions, licenses and regulates health facilities, including general acute care hospitals and special hospitals (hospitals) and clinics, as specified. [Health and Safety Code (HSC) §1250 (a) and (f) and §1226]

2) Requires DPH to periodically inspect hospitals no less that once every three years, and as often as necessary to ensure the quality of care being provided. [HSC §1279]

3) Requires a hospital to report an adverse event (AE) to DPH no later than five days after the AE has been detected, or, if that event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, not later than 24 hours after the AE has been detected. [HSC §1279.1]

4) Requires in any case in which DPH receives a report from a facility, or a written or oral complaint involving a hospital, that indicates an ongoing threat of imminent danger of death or serious bodily harm, DPH to make an onsite inspection or investigation within 48 hours or two business days, whichever is greater, of the receipt of the report or complaint and to complete that investigation within 45 days. [HSC §1279.2]

5) Requires a hospital, to develop, implement, and comply with a patient safety plan for the purpose of improving the health and safety of patients and reducing preventable patient safety events. Requires the patient safety plan to be developed by the hospital, in consultation with the hospital's various health care professionals. [HSC §1279.6]

6) Establishes the Act, which requires hospitals that provide perinatal care, and alternative birth centers or primary care clinics to implement an evidence-based implicit bias program for all health care providers involved in the perinatal care of patients within those facilities. [HSC §123630.3]

7) Requires an implicit bias program to include all of the following:

    a) Identification of previous or current unconscious biases and misinformation;
    b) Identification of personal, interpersonal, institutional, structural, and cultural barriers to inclusion;
    c) Corrective measures to decrease implicit bias at the interpersonal and institutional levels, including ongoing policies and practices for that purpose;
    d) Information on the effects, including, but not limited to, ongoing personal effects, of historical and contemporary exclusion and oppression of minority communities;
    e) Information about cultural identity across racial or ethnic groups;
    f) Information about communicating more effectively across identities, including racial, ethnic, religious, and gender identities;
    g) Discussion on power dynamics and organizational decision-making;

h) Discussion on health inequities within the perinatal care field, including information on how implicit bias impacts maternal and infant health outcomes;
i) Perspectives of diverse, local constituency groups and experts on particular racial, identity, cultural, and provider-community relations issues in the community; and,
j) Information on reproductive justice. [*Ibid.*]

8) Requires health care providers involved in the perinatal care of patients within the facilities described in 2) above, to complete initial basic training through an implicit bias program, and upon completion of the initial basic training, a health care provider to complete a refresher course under the implicit bias program every two years thereafter, or on a more frequent basis if deemed necessary by the facility, in order to keep current with changing racial, identity, and cultural trends and best practices in decreasing interpersonal and institutional implicit bias. [*Ibid.*]

9) Requires facilities, described in 2) above, to provide a certificate of training completion to another facility or a training attendee upon request. Authorizes a facility to accept a certificate of completion from another facility to satisfy the training requirements from a health care provider who works in more than one facility. [*Ibid.*]

10) Requires, if a physician involved in the perinatal care of patients is not directly employed by a facility, the facility to offer the training to the physician. [*Ibid.*]

11) Authorizes DPH to assess an administrative penalty for a deficiency constituting an immediate jeopardy violation, as defined, up to a maximum of $75,000 for the first administrative penalty, up to $100,000 for the second administrative penalty, and up to $125,000 for the third and every subsequent administrative penalty. Permits DPH to assess an administrative penalty of up to $25,000 per violation for those not deemed to constitute immediate jeopardy. Prohibits DPH from assessing an administrative penalty for minor violations. [HSC §1280.3 (a) (b) and (c)]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, the United States has the highest maternal mortality rate in the developed world. In California Black women continue to die at three to four times the rate of white women. A 2023 study by DPH, “Centering Black Mothers in California: Insights into Racism, Health, and Well-being for Black Women and Infants,” found that women of color, in particular Black women, die of pregnancy-related complications at much higher rates than white women in California. Evidence suggests one key cause of this disparity is the implicit bias of healthcare providers. A provider’s level of bias, whether conscious or unconscious, can influence their interactions with patients and their diagnoses and treatment of the patient’s pain, and can undermine patients’ trust and engagement in care. The author notes that, to address this, the legislature passed the Act in 2019, which requires hospitals, alternative birth centers and primary care clinics to conduct evidence-based implicit bias training for all health professionals who provide care during a patient’s pregnancy, childbirth, and immediate postpartum period. The California AG recently issued a report following an investigation into facility compliance with the Act. The report and its findings highlight the need for additional action to continue the work started by

the Act. Specifically, additional steps are necessary to ensure hospitals and facilities comply and are equipped to meet those requirements. It is time for these institutions to come into compliance with the law. The author concludes that this is a small, necessary step towards making California a safer place for Black and Brown mothers.

2) **BACKGROUND.**

a) **Implicit bias.** According to the University of San Francisco's Office of Outreach and Diversity, bias is a prejudice in favor of or against one thing, person, or group compared with another usually in a way that is considered to be unfair. Biases may be held by an individual, group, or institution and can have negative or positive consequences. There are types of biases: conscious bias (also known as explicit bias) and unconscious bias (also known as implicit bias). Biases, conscious or unconscious, are not limited to ethnicity and race. Though racial bias and discrimination are well documented, biases may exist toward any social group. Age, gender, gender identity, physical abilities, religion, sexual orientation, weight, and many other characteristics are subject to bias. Unconscious, or implicit, biases are social stereotypes about certain groups of people that individuals form outside their own conscious awareness. Unconscious bias is far more prevalent than conscious prejudice and often incompatible with one's conscious values. It is well-documented that implicit bias among health care professionals is prevalent and impacts patient care.

A July 2022 article, "Tackling Implicit Bias in Health Care," published in the *New England Journal of Medicine*, notes that our individual biases operate within larger social, cultural, and economic structures whose biased policies and practices perpetuate systemic racism, sexism, and other forms of discrimination. The article notes that in medicine, bias-driven discriminatory practices and policies not only negatively affect patient care and the medical training environment, but also limit the diversity of the health care workforce, lead to inequitable distribution of research funding, and can hinder career advancement. The article discusses a review of studies involving physicians, nurses, and other medical professionals which found that health care providers' implicit racial bias is associated with diagnostic uncertainty and, for Black patients, negative ratings of their clinical interactions, less patient-centeredness, poor provider communication, under-treatment of pain, and views of Black patients as less medically adherent than white patients.

While studies examining the effectiveness of anti-implicit bias training among medical providers in the field continue to develop, there are a number of completed studies finding that such training, if grounded in a comprehensive, evidence-based approach, can succeed in significantly reducing implicit stereotyping and prejudice in participants. Such evidence supports the conclusion that comprehensive, multifaceted implicit bias training can help individuals become more attuned to their own biases and lead to improved patient outcomes.

b) **Maternal and infant health outcomes in California.** According to the 2023 California Health Care Foundation report, "Maternity Care in California," there were 420,000 births in California in 2021, accounting for about one in 10 of all births nationwide. The number of births in the state declined 26% between 2007 and 2021. In 2021, about one in four hospital births in California were low-risk, first-birth cesareans (c-sections). In 2021,

half of California hospitals' c-section rates were higher than the Healthy People 2030 target of 23.6%. Significant racial/ethnic disparities existed across a variety of maternal quality measures in California, from prenatal visits to preterm births to maternal and infant mortality rates. For many of these measures, Black women / birthing people and infants had lower scores than their peers in other racial/ethnic groups.

In California, the rate of maternal death since 2006 has decreased by 55% even though the rate in the United States as a whole has steadily increased. However, according to data in DPH's 2018 California Pregnancy-Associated Mortality Review, for women of color, and in particular Black women, the rate remains three to four times higher than that for white women in California. The racial disparity is even starker when looking at particular conditions. Black women account for 5% of those pregnant in California but account for 21% of the total pregnancy-related deaths. Further, the disparity in maternal health between Black and non-Hispanic white birthing mothers exists independent of the socio-economic status of the birthing mother. A recent study that looked at the records of millions of births in California illustrates that across all parental income levels, Black mothers, as well as their infants, have much worse health outcomes than their non-Hispanic white counterparts do.

c) **AG report on the Act.** To ascertain compliance with the Act's training requirements, the Department of Justice (DOJ) sent a letter on August 23, 2021, to facilities subject to the requirements of the Act. Through this letter, DOJ requested that each facility provide:

i) Dates of any implicit bias training providers have completed;
ii) Dates of implicit bias trainings planned for the future;
iii) Lists of attendees at each training;
iv) Copies of all written training materials used;
v) A list of the perinatal healthcare workers at each facility who have yet to participate in any training; and,
vi) A description of each facility's efforts to reduce implicit bias among its perinatal healthcare providers.

DOJ further requested that facilities provide responsive documents and information by September 20, 2021. One hundred and fifty facilities requested, and were granted, an extension and did not produce any responsive documents or information until early January 2022. DOJ continued to receive information from a small minority of letter recipients through April 2022.

DOJ's investigation found that 42 hospitals had not fully trained a single employee prior to being contacted by DOJ on August 23, 2021. Responding hospitals on average completed trainings for 81.36% of their relevant providers, though this figure includes both facilities that completed trainings for all of the appropriate providers and facilities that failed to complete any trainings. Average completion rates were 79.41% at private hospitals, 81.08% at non-profit hospitals, 86.26% at government hospitals, and 84.81% at University of California hospitals. All staff had completed their training at 41 hospitals, and no staff had completed their training at two hospitals.

Nearly a third of facilities to which DOJ reached out, began training only after DOJ contacted them, suggesting that DOJ's outreach caused compliance in many cases.

d) **Current AE reporting requirements.** On September 12, 2021 DPH notified hospitals, via All Facility Letter (AFL), that AE reporting regulations had been updated. The AFL notes that, consistent with existing law, hospitals are required to report AEs no later than five days after the AE is detected. If the event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, the hospital must report no later than 24 hours after detection. The detection of or allegation of sexual assault is considered an ongoing or emergent threat and must be reported within 24 hours. In addition, the regulations specify the hospital is subject to an onsite investigation when DPH determines that an AE or complaint is an ongoing threat of imminent danger of death or serious bodily harm. The regulations require hospitals to report AEs via DPH's secure electronic web-based portal. DPH provides alternative means, by email or telephone, for submission if the web-based portal is unavailable. This requirement preserves patient confidentiality and standardizes reporting requirements. Hospitals are also required to develop policies and procedures for the internal reporting of preventable patient safety events, conducting a root cause analysis, and assessing the hospital's culture of safety every 24 months.

3) **SUPPORT.** AG Rob Bonta is the sponsor of this bill and states that this bill aims to reduce the alarming and disproportionate maternal mortality rate of Black women and other pregnant persons of color by ensuring successful implementation of the California Dignity in Pregnancy and Childbirth Act. Under the Act, health facilities are required to train perinatal care providers in recognizing and overcoming their own implicit or unconscious racial biases and prejudices that could negatively impact the quality of care — and even endanger the lives of — pregnant patients of color. The Act went in to effect on January 1, 2020, and in August 2021, the DOJ initiated an investigation to determine compliance with the law. At that time, fewer than 17% of responding providers had begun training their employees and not a single employee had been fully trained. By the time DOJ’s investigation and outreach efforts concluded 10 months later, the training completion rate had improved to more than 81%. The AG notes that while some facilities have gone above and beyond the requirements of the Act, there is still work to be done to further address the continued racial disparity in maternal morbidity rates by changing the way that healthcare providers recognize and overcome their own implicit bias when treating pregnancy. The AG concludes that investigations into the cause of all pregnancy-related deaths by DPH determined that more than half are preventable, and that this bill is a substantial part of the systemic change needed to reduce the disparate impact on Black mothers and pregnant persons of color and to prevent these deaths from happening.

4) **RELATED LEGISLATION.** AB 3161 (Bonta) requires DPH to collect self-reported patient demographics when receiving complaints regarding hospitals and long-term care facilities. Requires DPH to review, analyze, and publish trends among patient safety events in a manner consistent with patient privacy. Requires hospital patient safety plans to include specified methods to address racism and discrimination in health care, including procedures for staff to anonymously report instances of racial bias. Requires DPH to publicly publish hospital patient safety plans. Establishes a partnership between DPH, the California Department of Civil Rights, and Department of Justice to share data on racial bias in health care specific to patient adverse events. AB 3161 is pending in the Assembly Health Committee.

5) **PREVIOUS LEGISLATION.** SB 464 (Mitchell), Chapter 533, Statutes of 2019, requires hospitals and alternative birth centers to implement an implicit bias program for all health care providers involved in the perinatal care of patients within those facilities, including requiring these healthcare providers to complete initial basic training through the implicit bias program and a refresher course every two years thereafter. Requires DPH to track and publish data on maternal death and severe morbidity, and, adds to the list of written information a hospital is required to provide to each patient upon admission, information on how to file a discrimination complaint with DPH or the Medical Board of California if the patient feels they were discriminated against.

6) **SUGGESTED AMENDMENT.** Moving forward, the author will need to specify the date by which DPH must solicit public participation, and adopt regulations to further the purposes of the Act.

REGISTERED SUPPORT / OPPOSITION:

Support

Attorney General Rob Bonta (sponsor)
Access Reproductive Justice
Asian Americans Advancing Justice-southern California
Black Women for Wellness Action Project
Board of Supervisors for The City and County of San Francisco
California Black Health Network
California Commission on The Status of Women and Girls
California Family Resource Association
California Federation of Teachers AFL-CIO
California State Association of Psychiatrists (CSAP)
California Women's Law Center
Child Abuse Prevention Center and Its Affiliates Safe Kids California, Prevent Child Abuse California and The California Family Resource Association; the
Children Now
Community Health Councils
Courage California
Equality California
Essential Access Health
Health Access California
Hispanas Organized for Political Equality (HOPE)
National Council of Jewish Women Los Angeles
National Health Law Program
Perinatal Health Equity Initiative
Reproductive Freedom for All
The Children's Partnership
Western Center on Law & Poverty, INC.
Women's Foundation California
Women's Health Specialists

Opposition

None on file.

Analysis Prepared by: Lara Flynn / HEALTH / (916) 319-2097

Date of Hearing: April 2, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2339 (Aguiar-Curry) – As Introduced February 12, 2024

SUBJECT: Medi-Cal: telehealth.

SUMMARY: Expands the situations in which health care providers can be reimbursed by Medi-Cal for services rendered to patients through asynchronous store and forward telehealth. Specifically, **this bill**:

1) Allows a health care provider to establish a new patient relationship using asynchronous store and forward telehealth when otherwise consistent with Department of Health Care Services (DHCS) guidance, and either one of the following is true:
   a) The visit is related to sensitive services; or,
   b) A patient requests an asynchronous store and forward modality.

2) Redefines "asynchronous store and forward" to include asynchronous electronic transmission initiated directly by patients, including through mobile telephone applications.

3) Removes the option whereby a patient can attest they do not have access to video, in order to establish the need for an audio-only visit for a new patient.

EXISTING LAW:

1) Defines "telehealth" to:

   a) Mean the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care; and,

   b) Include synchronous interactions and asynchronous store and forward transfers. [Business and Professions Code § 2290.5 (a)(6)]

2) Establishes the Medi-Cal Program, administered by DHCS, to provide comprehensive health benefits to low-income individuals who meet specified eligibility criteria. [Welfare and Institutions Code (WIC) §14000 *et seq*.]

3) Establishes a schedule of benefits under the Medi-Cal program. [WIC §14132]

4) Establishes Medi-Cal coverage for health care services provided through telehealth, including specifying that in-person, face-to-face contact between a health care provider and a patient is not required under the Medi-Cal program for covered health care services and provider types designated by DHCS, when those services and settings meet the applicable standard of care and meet the requirements of the service code being billed. [WIC §14132.725 and §14132.100]

5) Prohibits a health care provider from establishing a new patient relationship with a Medi-Cal beneficiary via telehealth modalities other than video, except as follows:

a) When exceptions are developed by DHCS in consultation with affected stakeholders and published in DHCS guidance.

b) When a visit is conducted through an audio-only synchronous interaction and is otherwise consistent with DHCS guidance, and either one of the following is true:

  i) The visit is related to sensitive services; or,
  ii) A patient requests an audio-only modality or attests they do not have access to video. [WIC §14132.725]

6) Defines "sensitive services" to include health care services related to mental or behavioral health, pregnancy, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and also includes health care services minors may independently consent to receive [Civil Code §56.05]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, in 2022, AB 32 (Aguilar-Curry), Chapter 515, Statutes of 2022, expanded access to telehealth services and was intended to facilitate Medi-Cal coverage of telehealth services through mobile apps. The author indicates these apps are particularly important for working Californians because they can get medical care on their own schedule, without having to take time away from work and their families. However, the author states that Medi-Cal coverage is more restrictive than private insurance plans, which already cover these services. The author contends that this bill will ensure state policy supports expanded access to app-based telehealth services for Californians on Medi-Cal, who need accessible, convenient care regardless of their insurance coverage. Planned Parenthood of California is the bill's sponsor.

2) **BACKGROUND.**

  a) **Telehealth.** Telehealth is a mode of delivering health care services remotely using information technology. The three primary modalities are video, audio (including telephone), and asynchronous store and forward, which can be used when a real-time interaction is not needed. A large body of research supports the use of telehealth for a range of health care services, although the available evidence is mostly discipline-specific. Telehealth has been found to be particularly beneficial for individuals with chronic conditions and behavioral health needs. According to DHCS, from the beneficiary perspective, telehealth can improve access to care and enhance satisfaction by making care more convenient and reducing some of the logistical burdens of seeking in-person care.

  b) **Trends in Telehealth Utilization.** Telehealth utilization in Medi-Cal increased dramatically in response to the COVID-19 pandemic. According to data published by DHCS, prior to the onset of the COVID-19 pandemic, telehealth represented around 300 claims per 100,000 Medi-Cal member months. By April 2020, telehealth claims increased to over 12,000 claims per 100,000 member months and remained relatively stable through March 2021. Following March 2021, telehealth claims per 100,000 member months remained significantly higher than pre-COVID-19 pandemic levels but declined

from the peak to around 7,700 claims per 100,000 member months. Similarly, according to an October 2023 analysis by the UCLA Center for Health Policy Research, "Telehealth and the Future of Health Care Access in California," about half (49%) of California adults reported using telehealth to seek care in 2021, and decreased to 46.7% in 2022. Overall, the report notes telehealth remained a popular way to access care, even after declining from utilization levels seen during the pandemic. Long-term utilization trends are unclear, but telehealth appears likely to remain much more prevalent than it was prior to COVID-19.

c) **Recent History of Medi-Cal Telehealth Policy Development**. Prior to the COVID-19 Public Health Emergency (PHE), DHCS had expanded the availability of telehealth in Medi-Cal by allowing most clinically appropriate services to be provided through telehealth. During the PHE, DHCS implemented additional telehealth flexibilities to allow Medi-Cal providers to meet the health care needs of enrollees. After significant stakeholder engagement and legislative agreement on final trailer bill language, post-PHE Medi-Cal telehealth policies were codified through the 2022-23 health trailer bill, SB 184 (Committee on Budget and Fiscal Review), Chapter 47, Statutes of 2022. Subsequently, AB 32 and AB 1241 (Weber), Chapter 172, Statutes of 2023, made minor and clarifying changes to telehealth policy. These post-PHE policies permanently maintained many flexibilities granted during the PHE.

d) **Medi-Cal Telehealth Policy**. According to DHCS, California has been a leading state in the expansiveness of its coverage and reimbursement for services delivered via telehealth. DHCS has committed to continuing to enable broad telehealth coverage for all Medi-Cal covered benefits and services, as long as the provider is able to meet the standard of care, subject to billing, reimbursement and utilization management policies developed by DHCS. In addition, DHCS notes Medi-Cal is unique among other state Medicaid programs in regard to payment parity, in that the state reimburses a broad array of services at parity when delivered via audio-only visits. General Medi-Cal telehealth policies are described below, while the policies related to establishment of new patients is discussed in the next section.

   i) **Provider Requirements**: A health care provider rendering Medi-Cal covered benefits and services via telehealth must be:

      (1) Licensed in California or otherwise authorized by law; and,
      (2) Enrolled as a Medi-Cal rendering provider or be a non-physician medical practitioner affiliated with an enrolled Medi-Cal provider group.

   Unlicensed providers designated by DHCS, such as doulas, may provide services within their scope through telehealth, as specified in the Medi-Cal Provider Manual.

   ii) **Telehealth Covered Services**: Telehealth services are reimbursable if the health care provider believes that the service being provided is clinically appropriate. The telehealth service must meet the procedural definition of the Current Procedural Terminology or Healthcare Common Procedure Coding System code associated with the service, as well as follow any additional guidance provided by DHCS (e.g., through the Medi-Cal Provider Manual).

iii) Telehealth Covered Modalities: Medi-Cal reimburses for telehealth visits conducted via audio-only telehealth (e.g., telephone), video telehealth, or through asynchronous telehealth (i.e., store and forward and e-consults).

iv) Telehealth Payment Parity: The amount paid by Medi-Cal, through both fee-for-service and Medi-Cal managed care plans, for a service rendered via any telehealth modality is the same as the amount paid for the applicable service when rendered in-person.

v) Telehealth Modifiers: Providers must designate telehealth modality with an appropriate modifier when billing for telehealth services.

vi) Patient Consent. A health care provider must inform the patient once prior to the initial delivery of telehealth services about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services. Statute specifies information that must be shared with a patient.

Statute also establishes two policies that are not currently implemented, which will be implemented no sooner than January 1, 2024.

i) Patient Choice of Telehealth Modality: No sooner than January 1, 2024, DHCS will phase in an approach that requires a provider offer both video and audio-only telehealth to ensure patients have their choice of telehealth modality. DHCS is developing guidance on exceptions to this requirement, to include exceptions based on a Medi-Cal provider's lack of access to adequate broadband speeds to effectively stream video.

ii) Patient Right to In-Person Services: No sooner than January 1, 2024, DHCS will phase in an approach where providers who offer services via telehealth will be required to either offer those same services in-person or arrange for a referral to, and a facilitation of, in-person care that does not require a patient to independently contact a different provider to arrange for that care.

e) Establishment of New Patients via Telehealth. According to DHCS policy, a health care provider may bill Medi-Cal for a visit with a new patient that is conducted via **video**. Pursuant to AB 32, Medi-Cal also allows a provider to bill for a visit with a new patient that is conducted via **audio-only** telehealth (e.g., phone or other audio device), but only under certain circumstances. These circumstances include when the visit is related to "sensitive services," including behavioral health and reproductive health services, or when the patient requests an audio-only modality or attests they do not have access to video. Additional exceptions may be made by DHCS in consultation with stakeholders. This bill would apply similar reimbursement rules to the establishment of new patients through **asynchronous store and forward** telehealth.

According to the DHCS Post-COVID-19 PHE Final Telehealth Policy Proposal published in 2022, the rationale for the policy related to new patients is to increase access to care by allowing the establishment of new patients via telehealth while supporting consumer protections. The restrictions address concerns that initial visits may require a higher level of two-way communication to ensure quality of care. However, stakeholders

have raised various scenarios where synchronous communication may not be critical to care for a new patient or where timely access concerns outweigh the potential benefit of synchronous communication—for instance, for a patient seeking emergency contraception. As noted above, statute allows DHCS to make exceptions to these policies in consultation with stakeholders.

f) **Effect of This Bill**: This bill would essentially make such an exception to current policy that restricts the establishment of new patients via telehealth, expanding the circumstances under which a health care provider may bill for an asynchronous encounter with a new patient. Specifically:

i) This bill would allow asynchronous store and forward to be used for new patient visits when a visit is related to "sensitive services" or when a patient requests one. The author and sponsor explain this exception is needed to reduce barriers to care for patients who may not have an existing relationship with a provider and who may struggle to arrange an audio or video visit. For instance, patients commonly reach out to a provider outside of their normal source of care for birth control, emergency contraception, and urinary tract infection treatment.

ii) This bill also includes, in the definition of asynchronous store and forward, electronic transmission initiated directly by patients, including through mobile telephone applications ("apps"). According to the bill's sponsors, this is important to allow for Medi-Cal patients to be able to access asynchronous services from Medi-Cal providers through apps, often the same apps used for synchronous telehealth services.

iii) As it relates to audio-only, this bill also removes the option whereby a patient can attest they do not have access to video, in order to establish the need for an audio-only visit for a new patient. The author and sponsor explain this as expanding access to care, but this change is technically slightly more limiting than current law. However, from a practical standpoint, the ability for a patient to request the new patient visit through audio-only telehealth already exists and arguably is adequate to allow these visits to occur, regardless of the deletion of the option to attest that they do not have video.

3) **SUPPORT.** The Council of Autism Service Providers (CASP) writes in support that research demonstrates the effectiveness of telehealth in Applied Behavior Analysis, and telehealth may be used to establish new patients or conduct portions of an initial assessment. OCHIN, Inc. writes in support that many patients in the clinics to which they offer technological support must overcome social drivers of health, and the varied telehealth modalities (synchronous and asynchronous) have been essential tools for expanding access.

4) **OPPOSITION.** The California Nurses Association (CNA) writes in opposition to this bill's expansion of the use of telehealth to include mobile apps, arguing such tools are an unacceptable substitute for in-person care. CNA writes that nurses understand that mobile apps can never replace the in-person care that nurses and other health care workers provide, especially for the vulnerable populations Medi-Cal serves. CNA also objects to features of telehealth that it contends jeopardize patient care, which would be particularly problematic when delivered through an app. These include barriers to effective communication, inhibiting the formation of strong provider-patient relationship necessary to establish trust, and increased risk of diagnostic error due to inability to perform physical assessments. CNA

asserts California must not steer Medi-Cal patients toward substandard care because such care will exacerbate health inequities, and that this bill is unnecessary because current law already accounts for establishment of new patients through audio-only telehealth.

5) **RELATED LEGISLATION.** AB 1943 (Weber) requires DHCS, in collaboration with the California Health and Human Services Agency, to collect specified data on telehealth access and individual and population health outcomes, and use the data to measure the health outcomes of populations using a specified list of determinants. AB 1943 is pending in this Committee.

6) **PREVIOUS LEGISLATION.**

   a) AB 1241 clarifies two provisions of current law requiring a provider furnishing services through video or audio telehealth to offer services in-person or facilitate in-person care.

   b) AB 32 establishes Medi-Cal coverage for establishment of new patients through audio telehealth under specified circumstances, including for reproductive health and behavioral health services, and clarified DHCS shall consider a Medi-Cal provider's access to broadband at specified speeds, in establishing exceptions to the requirement that providers offering audio-only telehealth also offer video telehealth.

   c) SB 184 establishes Medi-Cal telehealth policy, including coverage, reimbursement patient consent standards, informational notices, DHCS authority to designate providers who may provide services through telehealth, treatment of telehealth for network adequacy purposes and a research and evaluation plan.

   d) AB 133 (Committee on Budget), Chapter 143, Statutes of 2021, extended until December 31, 2022, flexibilities in reimbursement for care provided to Medi-Cal beneficiaries via telehealth, implemented during the COVID-19 PHE and required DHCS to convene a telehealth advisory workgroup, as specified.

   d) AB 457 (Santiago), Chapter 439, Statutes of 2021, established requirements on health plans and health insurers intended to ensure care offered through third-party telehealth providers remain coordinated with a patient's primary care providers.

   e) AB 1022 (Mathis) of 2022 would have expanded the ability of an approved Program of All-Inclusive Care for the Elderly organization, which provides Medi-Cal and Medicare services, authority to use video telehealth to conduct all assessments, as specified. AB 1022 was referred to the Assembly Health Committee and not heard.

6) **POLICY COMMENT.** WIC §14132.100 establishes telehealth policy for federally qualified health centers (FQHCs) and rural health clinics (RHCs), which is largely but not entirely consistent with Medi-Cal telehealth policy for other providers. The author may wish to engage with stakeholders and consider whether to similarly amend telehealth policy that applies to FQHCs/RHCs related to establishment of new patients through asynchronous store and forward, unless there is a specific reason to maintain the current restrictions for these clinics. Those current restrictions that apply to FQHCs/RHCs are different but appear slightly more restrictive than that proposed by this bill.

REGISTERED SUPPORT / OPPOSITION:

Support

Planned Parenthood Affiliates of California (sponsor)
National Health Law Program (cosponsor)
AIDS Healthcare Foundation
American College of Obstetricians and Gynecologists, District IX
ATA Action
California Telehealth Policy Coalition
Equality California
OCHIN, Inc.
Reproductive Freedom for All
The Council of Autism Service Providers

Opposition

California Nurses Association

Analysis Prepared by: Lisa Murawski / HEALTH / (916) 319-2097

Date of Hearing: April 2, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2402 (Lowenthal) – As Introduced February 12, 2024

SUBJECT: Drink spiking.

SUMMARY: Requires the Department of Public Health (DPH), on or before January 1, 2026, to create and implement a public education campaign to raise awareness of the risks of drink spiking and the availability of drug testing devices. Specifically, this bill:

1) Requires, on or before January 1, 2026, DPH to create and implement a campaign that does all of the following:

   a) Raises public awareness of the risks of drink spiking and the availability of drug testing devices;
   b) Educates the public on all of the following best practices:
      i) How to prevent drink spiking; and,
      ii) What to do if a person believes they have, or another person has, been the victim of drink spiking.
   c) Educates the public on appropriate public resources or other best practices to prevent and mitigate the effects of drink spiking, as determined by DPH.

2) Requires DPH to establish a Safe Bar Training Program (the Program) for bars, night clubs, and restaurants on or before July 1, 2026; and authorizes any bar, night club, or restaurant to participate in the Program.

3) Requires the Program to develop a training that equips and prepares employees of bars, night clubs, and restaurants on all of the following.

   a) Identifying strategies to cultivate a safe and inclusive environment;
   b) Demonstrating the ability to intervene in situations where there is a risk of sexual assault;
   c) Identifying the five types of bystander intervention strategies;
   d) Identifying common responses to trauma;
   e) Identifying appropriate responses to a disclosure of sexual assault;
   f) Best practices on how to prevent or protect a person from drink spiking;
   g) Best practices if the person believes they have, or someone they know has, been drugged as a result of drink spiking;
   h) The availability and use of drug testing devices and other preventative measures to help prevent and protect a person from falling victim to drink spiking; and,
   i) Any other best practices or resources deemed appropriate to educate and raise awareness associated with the ways a person can prevent and protect themselves and others from drink spiking.

4) Requires the Program, utilizing available resources developed by the Campaign, to develop information and resources to raise awareness about the risks associated with, and ways to prevent and protect a person from, drink spiking.

5) Requires a bar, night club, or restaurant that participates in the program to pay a fee, as determined by DPH, in order to receive the Safe Bar training and certification.

6) Requires the fee not to exceed reasonable costs to provide the program

7) Requires DPH to send a bar, night club, or restaurant a Safe Bar certification and sticker or placard that indicates that all the employees of the bar, night club, or restaurant have completed the training.

8) Requires a bar, night club, or restaurant that receives a Safe Bar certification and sticker or placard from DPH to train new employees within eight weeks of the employee starting their position.

9) Allows a bar, night club, or restaurant to display the certification and sticker or placard in order to confirm that all employees have completed the Safe Bar Training Program.

10) Allows DPH to consult with relevant experts, stakeholders, and entities to develop the campaign and the Safe Bar Training Program.

11) Defines the following for purposes of this bill:

    a) "Campaign" means the public education campaign required by this bill;
    b) "Drink spiking" means putting alcohol or drugs into another person's drink without their knowing and express consent, also known as roofying; and,
    c) "Drug testing device" means test strips, stickers, straws, and other devices designed to detect the presence of alcohol or drugs in a drink.

EXISTING LAW:

1) Defines an "on-sale" license as authorizing the sale of all types of alcoholic beverages; namely, beer, wine, and distilled spirits, for consumption on the premises (such as restaurants or bar). [Business and Professions Code (BPC) § 25624]

2) Establishes the Responsible Beverage Service (RBS) Training program that requires the Department of Alcoholic Beverage Control (ABC), implement, and administer a curriculum for an RBS training program for servers of alcohol and their managers, as specified. Alcohol servers are required to successfully complete an RBS training course offered or authorized by ABC. [BPC § 25680]

3) Defines "drug testing devices" to mean test strips, stickers, straws, and other devices designed to detect the presence of controlled substances in a drink [BPC § 25624]

4) Defines "controlled substances" to include but not be limited flunitrazepam, ketamine, and gamma hydroxybutyric acid, also known by other names, including GHB, gamma hydroxybutyrate, 4-hydroxybutyrate, 4-hydroxybutanoic acid, sodium oxybate, and sodium oxybutyrate. [BPC § 25624]

5) Requires an applicant for a new permanent on-sale general public premises (Type 48) license or the holder of an existing Type 48 license to offer for sale to their customers drug testing devices at a cost not to exceed a reasonable amount based on the wholesale cost of those devices. [BPC § 25624]

6) Requires a licensee to post the following notice in a prominent and conspicuous location: “Don’t get roofied! Drink spiking drug test kits available here. Ask a staff member for details.” [BPC § 25624]

7) Does not prevent a Type 48 licensee from offering drug testing devices to their customers free of charge. [BPC § 25624]

8) Prohibits a Type 48 licensee from being held liable for a defective test or inaccurate test result, including, but not limited to, a false positive or false negative test result. [BPC § 25624]

9) Requires a Type 48 licensee to ensure that all testing devices offered to customers have not exceeded their expiration date or recommended period of use, according to the product label, product packaging, or otherwise recommended by the manufacturer. [BPC § 25624]

10) Requires ABC to post on its internet website a link to a page that contains information about the requirements of this section, including, but not limited to, the signage that is required to be posted and the types of drug testing devices that are required to be available on a Type 48 licensed premises. [BPC § 25624]

11) Authorizes DPH to disseminate information relating to the protection, preservation, and advancement of public health. [HSC §131085].

FISCAL EFFECT: Unknown. This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, drink spiking, and the horrific crimes that often follow the act, have largely been underreported and unacknowledged due to factors such as the effects that date rape drugs have on the victim’s memory, and how fast these drugs leave the body. Unfortunately, the victims of these crimes are largely women, and members of the LGBTQ community. The author concludes that this bill is part of a broader bill package to tackle this issue and will increase awareness through the creation of a public awareness campaign, and with the Safe Bar Program, better inform restaurants, bars, nightclubs, and the general public on how to prevent drink spiking, and also how to handle the unfortunate event if it does occur.

2) BACKGROUND.

a) Drink spiking. Media coverage has generated widespread concern that “drink spiking,” defined as the “the unsolicited addition of a drug to a drink consumed in a social setting” is relatively common. According to various media outlets, it's difficult to find comprehensive, up-to-date statistics on the prevalence of drink-spiking/drugging but various police departments across the country have stated that it is a problem that needs to be addressed. For example, the Boston Police Department (BPD) issued a statement warning the public to be mindful of alcohol consumption while in the city's bars and clubs. This was after the BPD said it has "become aware of numerous social media posts from various individuals who state that they were victims of drink spiking at local area bars." In California, in the previous three years, the Long Beach Police Department

received, on average, about 25 reports per year from people who felt they had been drugged while out with friends, possibly by something slipped into their drink.

b) **Drug Facilitated Sexual Assault (DFSA)**. Drink spiking has been associated with drug facilitated sexual assault. A 2015 study in San Francisco focused on a two-year ethnically diverse cohort of 390 patients who presented acutely to an urban rape treatment center, and found that DFSA accounted for over half of the total sexual assault cases. Involuntary DFSA (in which an incapacitating substance was administered to victims without their knowledge or against their will) increased from 25% to 33% of cases over the two-year period. DFSA victims presented sooner, and more often attended medical follow-up and psychotherapy than non-DFSA victims. Incidence rates indicated increasing risk for young males. The researchers concluded that that the field would benefit from innovations to address symptomatology arising from this novel type of trauma and underscoring the ongoing need for DFSA-specific prevention efforts for both victims and perpetrators.

According to the US Department of Women's Health, abusers are able to use any type of drug, including marijuana, cocaine, or prescription or over-the-counter drugs like antidepressants, tranquilizers, or sleeping aids to overpower a victim or make them not remember an assault. Other common date rape drugs include flunitrazepam (Rohypnol), GHB, gamma-butyrolactone GBL, and ketamine, which go by the street names roofies, liquid ecstasy, and Special K respectively. Through drink spiking, the victims often consume these drugs without having realized it and suffer from side effects such as dizziness, confusion, and loss of memory. Additionally, once someone has been drugged, the controlled substances usually pass through their system overnight and the presence of these substances is undetectable after the individual first urinates in the morning and would not be detectable without laboratory testing of hair follicles approximately 30 days after ingestion.

c) **Efforts to address drink spiking.** To help people detect drugs that might otherwise fly under the radar, some companies have begun selling products that identify whether a drink has been tainted. At least two products are on the market that detect drugged drinks: drink coasters and a device that works like a pregnancy test for a drink. Several others are in the works, including a napkin that detects at least 26 drugs.

In response to reports from people who felt as though they had been drugged, possibly via drink spiking, the City of Long Beach is launching a pilot program that will provide residents with a free test strip that can identify specific drugs in a beverage. Distribution of drug detection test strips and educational outreach will both be part of the pilot program. The test strip user drops a small amount of drink fluid onto the test strip, which changes color to a specific shade if a drug is present. The distribution of the strips and other details are still being worked out. The city's Health Department will be in charge of managing the program.

Similarly, following reports of people feeling as though they had been drugged (or "roofied") at West Hollywood nightlife establishments, the City of West Hollywood recently launched a similar program that included outreach and distribution of disposable test kits that check for illegal substances in drinks. Numerous locations (restaurants, bars,

clubs, etc.) have received more than 12,000 test kits, according to reports. The test strips are free, and some bars leave containers of them out for patrons to use.

d) **Availability of drug testing at on-sale general public premises.** AB 1013 (Lowenthal), Chapter 353, Statutes of 2023, requires, commencing July 1, 2024, requires on-sale general public premises Type 48 licensees to offer for sale to their customers drug testing devices at a cost not to exceed a reasonable amount based on the wholesale cost of those devices.

e) **RBS Training Program**. AB 1221 (Gonzalez Fletcher), Chapter 847, Statues of 2017, created the RBS Training Program Act with the intention of reducing alcohol-related harm to local communities. The bill required ABC to create the RBS Training Program to ensure on-premises servers of alcoholic beverages and their managers are educated on the dangers of serving alcohol to minors and over-serving patrons. Approximately 56,000 ABC licensees have on-premises alcohol sales privileges, which means alcohol can be consumed on site. On-premises locations include, but are not limited to, bars, restaurants, tasting rooms, clubs, stadiums, movie theaters, hotels, and caterers. Anyone that is employed at an ABC on-premises licensed establishment who is responsible for checking identifications, taking customer orders, and pouring or delivering alcoholic beverages must have a valid RBS certification from ABC. Servers and their managers must register in the RBS Portal, take RBS training from an approved training provider, and pass the ABC RBS exam within 60 days of their first date of employment. On-premises locations include, but are not limited to, bars, restaurants, tasting rooms, clubs, stadiums, movie theaters, hotels, and caterers. Covered licensees are required to maintain records of their various certifications, and violators are subject to unspecified "disciplinary action." The RBS training is currently available in several different languages.

f) **ABC Licensee Education on Alcohol and Drugs (LEAD) Program**. ABC offers free and voluntary four-hour classes, called Licensee Education on Alcohol and Drugs, or LEAD, for retail licensees, their employees, and applicants. In 1991, the program began with a grant from the California Office of Traffic Safety. The LEAD Program provides the licensee and applicant with practical information and instruction on checking various forms of identification, detecting and preventing illegal activity, and reducing liability. At the conclusion of the class, an exam is given on the material that was covered. Each person who fulfills all of the training requirements receives a certificate certifying that they successfully completed a LEAD training course.

g) **ABC inspection and advisement.** ABC carries out business inspections through its Informed Merchants Preventing Alcohol-Related Crime Tendencies (IMPACT) Program. ABC created IMPACT in 1984 as a preventative and education program. It employs a community-oriented policing strategy that involves local businesses in deterring crime. IMPACT teams select and survey licensed outlets at random. During their visits, IMPACT teams remind licensees of the responsibilities and accountability associated with the sale of alcohol. The officers also inspect licensed premises for compliance with State and local laws.

h) **Safe Bar Program.** Safe Bar is an initiative developed by the Sexual Assault Center (SAC) of Middle Tennessee. Through this program, employees of local bars and

restaurants have access to training how to recognize signs of potential assault or unwanted behaviors, how to safely intervene or respond to sexual assault, and how alcohol and drugs can play a role in sexual assault. The program advertises benefits including a window cling to let patrons know that staff is trained to respond to sexual harassment and discrimination, access to drug detection coasters to detect the presence of GHB and ketamine, and access to ambassadors and trainers for guidance. SAC operates this initiative in partnership with the Tennessee Coalition to End Domestic and Sexual Violence and the Tennessee Department of Health.

3) **SUPPORT**. The California District Attorneys Association writes in support of this bill, stating: "Drink spiking is a dangerous practice too often committed to facilitate rape and other violent sexual offenses. Its primary targets are women and LGBTQ+, and it very often occurs in bars or nightclubs. While a perpetrator may intend only to disable their victim, drink spiking can have serious health impacts, including death. Education about the dangers of drink spiking, how to avoid it, and what to do if it is suspected, can help a person avoid victimization for themselves and others around them. Education aimed at bartenders and other food and drink servers, can further help prevent or minimize victimization."

4) **DOUBLE REFFERAL.** This bill is double referred, upon passage of this committee, it will be referred to the Assembly Committee on Governmental Organization.

5) **RELATED LEGISLATION.**

   a) AB 1013 requires on-sale general public premises Type 48 licensees to offer for sale to their customers drug testing devices at a cost not to exceed a reasonable amount based on the wholesale cost of those devices. A Type 48 licensee shall not be held liable for a defective test or inaccurate test result, including, but not limited to, a false positive or false negative test result.

   b) AB 1524 (Lowenthal) of 2023 would have required the California State University and each community college district and encourages the University of California, independent institutions, and private postsecondary education institutions, to stock an adequate supply of drug testing devices, free of cost and at least one designated location on each campus. AB 1524 is on the Senate inactive file.

   c) AB 771 (Lowenthal) of 2023 would have prohibited the administering a controlled substance, anesthetic, or intoxicating agent to a person without their consent. AB 771 would have imposed an additional penalty if this prohibition was violated with the intent to enable the commission of a crime or if the violation results in bodily injury or death. AB 771 was not heard in the Assembly Committee on Public Safety.

6) **PREVIOUS LEGISLATION.**

   a) AB 1221 establishes RBS Training Program Act of 2017, and requires ABC, on or before January 1, 2020, to develop, implement, and administer a curriculum for an RBS training program, as specified. Additionally, AB 1121 requires, beginning July 1, 2021, an alcohol server, as defined, to successfully complete an RBS training course offered or authorized by ABC.

b) SB 1182 (Galgiani), Chapter 893, Statutes of 2016, provides that possession of GHB, Rohypnol, or ketamine with the intent to commit a sex crime, as defined, is a felony, punishable pursuant to Penal Code Section 1170 (h) for 16 months, two years, or three years.

7) POLICY COMMENTS. The author contends that this program, modeled after Nashville's Safe Bar program, will not only better educate restaurant, bar, and night club employees about the dangers of drink spiking, but also better equip them to help to take preventative measures and promote a safer atmosphere. Given that ABC already administers the RBS training program, the author may wish to consider directing ABC to implement this bill's provisions on training for employees of bars, night clubs, and restaurants and direct ABC to implement the public awareness campaign.

REGISTERED SUPPORT / OPPOSITION:

Support

California District Attorneys Association

Opposition

None on file.

Analysis Prepared by: Eliza Brooks / HEALTH / (916) 319-2097

Date of Hearing: April 2, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2435 (Maienschein) – As Introduced February 13, 2024

SUBJECT: California Health Benefit Exchange.

SUMMARY: Extends California's Health Benefit Exchange (the "Exchange" or "Covered California") authority to adopt necessary rules and regulations by emergency regulations in accordance with the Administrative Procedure Act (APA) from January 1, 2025 to 2030 and the authority of the Office of Administrative Law (OAL) to approve more than two re-adoptions of emergency regulations from January 1, 2030 to 2035. Makes conforming changes to apply extensions to a regulation adopted before 2025.

EXISTING LAW:

1) Establishes the federal Patient Protection and Affordable Care Act (ACA), which enacts various health care coverage market reforms. Requires each state, by January 1, 2014, to establish an Exchange that makes qualified health plans (QHPs) available to qualified individuals and qualified employers. Requires, if a state does not establish an Exchange, the federal government to administer the Exchange. Establishes requirements for the Exchange and for QHPs participating in the Exchange, and defines who is eligible to purchase coverage in the Exchange. Allows, under the ACA and effective January 1, 2014, eligible individual taxpayers, an advance premium tax credit (APTC) based on the individual's income for coverage under a QHP offered in the Exchange. Requires a reduction in cost-sharing for individuals with specified incomes. Provides that lawfully present immigrants are also eligible for the APTC and cost sharing reductions. [42 United States Code 300gg, *et seq*.]

2) Establishes, in state government, Covered California or the Exchange, as an independent public entity not affiliated with an agency or department, and requires the Exchange to compare and make available through selective contracting health insurance for individual and small business purchasers as authorized under the ACA. Specifies the powers and duties of the Covered California board governing the Exchange, and requires the board to facilitate the purchase of QHPs though the Exchange by qualified individuals and small employers. [Government Code (GOV) §100500-100522]

3) Authorizes Covered California's board to adopt, until January 1, 2025, any necessary rules and regulations to implement the eligibility, enrollment, and appeals processes for individual and small business, changes to small business, to be adopted as emergency regulations in accordance with the APA, as specified. [GOV §100504(a)(6)(A)]

4) Requires any emergency regulation adopted pursuant to 3) above to be repealed by operation of law unless the adoption, amendment, or repeal of the regulation is promulgated by the Covered California board, as specified, within five years of the initial adoption of the emergency regulation. Authorizes, until January 1, 2030, the OAL to approve more than two readoptions of an emergency regulation adopted pursuant to 3) above. Requires a rule or regulation adopted to be discussed by the board during at least one properly noticed board meeting before the board meeting at which the board adopts the rule or regulation. [*Ibid.*]

5) Authorizes the Covered California board to standardize products offered through the Exchange. Requires any products standardized by the board to be discussed by the board during at least one properly noticed board meeting prior to the board meeting at which the board adopts the standardized products to be offered through the Exchange. [GOV §100504(c)(1))]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, Covered California, as an independent public entity, has a responsibility to adapt swiftly to changes in health care laws and regulations, particularly those stemming from the ACA. The extension of emergency rulemaking authority is essential to ensure Covered California can effectively implement and update policies, such as new state subsidies and revised regulations in response to federal changes, in a timely manner. The author concludes that the proposed extension will empower Covered California to continue serving its mission of providing affordable health care coverage to Californians while navigating the complex and evolving health care landscape.

2) **BACKGROUND.**

   a) **ACA**. Enacted in March 2010, the ACA provides the framework, policies, regulations and guidelines for the implementation of comprehensive health care reform by the states. The ACA expands access to quality, affordable insurance and health care. As of January 1, 2014, insurers are no longer able to deny coverage or charge higher premiums based on preexisting conditions. These aspects of the ACA, along with tax credits for low and middle income people buying insurance on their own in new health benefit exchanges, make it easier for people with preexisting conditions to gain insurance coverage.

      The ACA required exchanges, also known as Marketplaces, to be established in every state by January 1, 2014, otherwise the federal government will establish one in the state. The central purpose of these Marketplaces is to enable low and moderate income individuals, and small employers to obtain affordable health coverage. Individuals and small businesses are able to purchase private health insurance through a variety of insurance Marketplace models throughout the United States. Each state electing to establish a Marketplace must adopt the federal standards in law and rule, and have in effect a state law or regulation that implements these standards. The Marketplaces are required to carry out a number of different functions, including determining eligibility and enrolling individuals in appropriate plans; conducting plan management activities; assisting consumers; ensuring plan accountability; and providing financial management.

   b) **Covered California**. California was the first state in the nation to enact legislation creating an Exchange under the ACA. Current federal policy discussions regarding the ACA indicate the potential for significant changes to rules governing Exchanges. According to Covered California, it will need extended emergency rulemaking authority to account for new federal and state requirements and to continue implementing and updating current policies to respond to market needs and emergency circumstances. For example, Covered California states it recently needed or will soon need to:

i) Adopt regulations to implement California state enhanced cost-sharing subsidies for Californians up to 600% of the federal poverty level and revise as required by its enabling authority;
ii) Adopt regulations to implement a state subsidy program for workers who have lost minimum essential coverage from an employer or joint labor management trust fund as a result of a strike, lockout, or other labor dispute;
iii) Revise regulations to extend financial assistance to family members whose health coverage available through an employer is unaffordable;
iv) Revise regulations to extend eligibility for coverage and financial assistance to Deferred Action for Childhood Arrivals (DACA) recipients;
v) Revise its eligibility, enrollment, and appeals regulations in response to the federal Health and Human Services annual Benefit and Payment Parameters Rule, which often requires time-sensitive changes to special enrollment period eligibility, financial assistance eligibility, and verification requirements, and provides other optional policies for states to take advantage of to enable consumers to enroll more easily in better and more affordable coverage; and,
vi) Potentially adopt regulations to implement a program to provide coverage and financial assistance to Californians otherwise ineligible because of their immigration status.

Most recently, Assembly Bill 133 (Committee on Budget), Chapter 143, Statutes of 2021, extended Covered California's emergency rulemaking authority until January 1, 2025. Recognizing that transparency and public participation in the rulemaking process, AB 133 also maintained the requirement that any emergency regulation must be publicly discussed by the Covered California board during at least one publicly noticed meeting before the regulation is subsequently voted on by the board at a second publicly noticed meeting. This requirement, which has been Covered California's longstanding practice, ensures that the public is provided at least two opportunities to review and comment on proposed regulations, as well as ample time for stakeholders to engage with Covered California staff to further develop or potentially modify proposed regulations before the board takes any action. Additionally, once Covered California has completed the emergency rulemaking process, Covered California must then complete the permanent rulemaking process within five years. This process allows for another round of public engagement through comments at board meetings and established public comment periods applied to permanent rulemaking generally.

c) **Rulemaking Process.** The OAL is responsible for ensuring that California state agencies comply with the rulemaking procedures and standards set forth in California's APA. A "regulation" is any rule, regulation, order or standard of general application or the amendment, supplement, or revision of any rule, regulation, order, or standard adopted by any state agency to implement, interpret, or make specific the law enforced or administered by it. When adopting regulations, every department, division, office, officer, bureau, board or commission in the executive branch of the California state government must follow the rulemaking procedures in the APA and regulations adopted by the OAL, unless expressly exempted by statute from some or all of these requirements. The APA requirements are designed to provide the public with a meaningful opportunity to participate in the adoption of regulations or rules that have the force of law by California state agencies and to ensure the creation of an adequate record for the OAL and judicial review. Regulations subject to the APA are generally adopted through the "Regular" or

"Emergency" rulemaking processes. The rulemaking process used by an agency to adopt regulations will dictate what procedural requirements must be followed, including but not limited to the contents of the rulemaking record, timeframes, opportunities for public participation, OAL's review and effective dates for the regulations. According to the OAL, a state agency may adopt emergency regulations in response to a situation that calls for immediate action to avoid serious harm to the public peace, health, safety, or general welfare, or if a statute deems a situation to be an emergency under the APA. Since emergency regulations are intended to avoid serious harm and require immediate action, the emergency rulemaking process is substantially abbreviated compared to the regular rulemaking process. OAL reviews emergency regulations for compliance with the APA's emergency rulemaking requirements. The emergency rulemaking process generally includes a brief public notice period, a brief public comment period, review by OAL and an OAL decision. In addition, some agencies have requirements related to emergency rulemakings that are unique to that particular agency. It should be noted that Covered California's emergency rulemaking authority has been extended several times since its establishment.

3) **SUPPORT.** Health Access California (HAC) states that Covered California has received emergency rulemaking authority in order to meet and act on immediate federal actions related to ACA implementation. The early days and years of the ACA necessitated such authority, which made Covered California adaptive and proactive in promulgating rules for implementation, which Health Access supported. Given the ever-changing landscape for health care and the ACA, prior extensions of Covered California's emergency rulemaking authority have been enacted to give Covered California the flexibility needed to comply with changes to federal and state laws and regulations. The existing authority still preserves the ability of stakeholders to actively comment and participate in rulemakings, as HAC does often. Covered California staff are careful to consult extensively with consumers advocates and health plans in the development of regulations and to ensure that emergency regulations are discussed at two public board meetings or even more if controversial. The California Agents & Health Insurance Professionals (CAHIP) write that this bill additionally provides Covered California with the continuity and flexibility it needs to fulfill its mission of ensuring access to affordable, quality health care for Californians. CAHIP concludes that this bill is crucial for maintaining the effectiveness and adaptability of Covered California's operations in the face of evolving health care landscapes.

4) **OPPOSITION.** The California Medical Association (CMA) writes that the APA acts as an oversight mechanism for the Legislature by allowing their input and feedback to be considered during the process. However, in the last several years there has been a proliferation of exemptions to the APA and granting Offices, Departments and Agencies the ability to make regulations through emergency rule-making authority which bypasses the traditional process by which these entities must notice and receive input from interested and affected parties. The notification and comment periods are shorter and there are little to no means available for changes to be made to the proposed rules. CMA is worried about the increase of state entities' use of emergency rule-making authority long after the original "emergency" has receded or been resolved. If the APA is too onerous or costly, then it should be updated and modernized. According to CMA, this bill would limit the ability of stakeholders and members of the public to comment on any rules and regulations being proposed by Covered California through this exemption, not only those that would bring California into compliance with new federal requirements and guidelines. CMA concludes

that emergency rule-making authority should only be used when absolutely justified and should be appropriately narrowed to true emergencies.

5) **RELATED LEGISLATION.** AB 4 (Arambula) requires the Exchange to administer a program to allow persons otherwise not able to obtain coverage by reason of immigration status to enroll in health insurance coverage in a manner as substantially similar to other Californians as feasible given existing federal law and rules. Requires the Exchange to undertake outreach, marketing, and other efforts to ensure enrollment. AB 4 is pending in Senate Appropriations Committee.

6) **PREVIOUS LEGISLATION.**

   a) AB 2530 (Wood), Chapter 695, Statutes of 2022, requires the Exchange to administer a program of financial assistance beginning July 1, 2023, to help Californians obtain and maintain health benefits through the Exchange if they lose employer-provided health care coverage as a result of a labor dispute.

   b) AB 133 (Committee on Budget), Chapter 143, Statutes of 2021, extends Covered California's emergency rulemaking authority until January 1, 2025.

   c) SB 1245 (Leyva), Chapter 417, Statutes of 2018, extends Covered California's emergency rulemaking authority until January 1, 2022, with two readoptions until January 1, 2027. Requires the Exchange to discuss the regulations during at least one properly noticed board meeting prior to its adoption by Covered California.

   d) SB 833 (Committee on Budget & Fiscal Review), Chapter 30, Statues of 2016, extends the emergency regulation authority for Covered California until January 1, 2019, to implement the eligibility, enrollment and appeals processes for the individual and small business exchanges, and changes to the small business exchange, or legislation, that is enacted prior to December 31, 2016.

   e) AB X1 2 (Pan), Chapter 1, Statutes of 2013-14 First Extraordinary Session and SB X1 2 (Hernandez), Chapter 2, Statutes of 2013-14 First Extraordinary Session, establish health insurance market reforms contained in the ACA specific to individual purchasers, such as prohibiting insurers from denying coverage based on preexisting conditions; and, make conforming changes to small employer health insurance laws resulting from final federal regulations.

   f) AB 1083 (Monning), Chapter 854, Statutes of 2012, establishes reforms in the small group health insurance market to implement the ACA.

   g) AB 1602 (John A Pérez), Chapter 655, Statutes of 2010, and SB 900 (Alquist), Chapter 659, Statutes of 2010, establishes the Exchange in California and its powers and duties.

REGISTERED SUPPORT / OPPOSITION:

Support

California Agents & Health Insurance Professionals
California Pan - Ethnic Health Network

Health Access California
National Health Law Program

Opposition

California Medical Association

Analysis Prepared by: Kristene Mapile / HEALTH / (916) 319-2097

Date of Hearing: April 2, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2446 (Ortega) – As Amended March 19, 2024

SUBJECT: Medi-Cal: diapers.

SUMMARY: This bill requires Medi-Cal to cover diapers for children under certain conditions. Specifically, **this bill**:

1) Makes diapers a covered Medi-Cal benefit for infants or toddlers with any of the following conditions:
   a) Urinary tract infection (UTI);
   b) Colic; or,
   c) Any disease of the skin that, in the judgment of a clinician, is related to inadequate diaper hygiene and is at risk of reoccurrence that could be substantially mitigated by a prescription for diapers.

2) Makes diapers a covered Medi-Cal benefit for any child greater than three years of age who has been screened for or diagnosed with a physical, mental, neurological, or behavioral health condition that contributes to incontinence.

3) Notwithstanding any other law, makes diapers a Medi-Cal covered benefit for individuals under 21 years of age if necessary to correct or ameliorate a condition pursuant to federal law (specifically, federal requirements for children's Medicaid services under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT).)

4) Requires the Department of Health Care Services (DHCS) to seek any necessary federal approval to implement this section.

EXISTING FEDERAL LAW requires state Medicaid programs to cover, under EPSDT, periodic and as-needed medical, vision, hearing and dental screening and services, as well as any other Medicaid service, if the service is needed to "correct or ameliorate" defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the state plan. [42 United States Code § 1396d(r)]

EXISTING STATE LAW:

1) Establishes the Medi-Cal Program, administered by DHCS, to provide comprehensive health benefits to low-income individuals who meet specified eligibility criteria. [Welfare and Institutions Code (WIC) § 14000 *et seq*.]

2) Establishes a schedule of benefits under the Medi-Cal program, which includes federally required and optional Medicaid benefits, subject to utilization controls. [WIC § 14132]

3) Establishes EPSDT as a Medi-Cal benefit for any individual under 21 years of age is covered, consistent with the requirements of federal law, as specified. [WIC §14132(v)]

4) Establishes Medi-Cal coverage of medical supplies, including those for treating incontinence. [WIC § 14125.1]

5) Establishes medical necessity standards in Medi-Cal for individuals both under and over the age of 21. [WIC § 14059.5]

6) Establishes the California Advancing and Innovating Medi-Cal (CalAIM) Act, and requires the implementation of CalAIM to support the following goals:
   a) Identify and manage the risk and needs of Medi-Cal beneficiaries through whole-person-care approaches and addressing social determinants of health;
   b) Transition and transform the Medi-Cal program to a more consistent and seamless system by reducing complexity and increasing flexibility; and,
   c) Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform. [WIC §14184.100]

7) Authorizes Community Supports, under CalAIM, that a Medi-Cal managed care plan may elect to cover. Specifies Community Supports are provided "in lieu of" typical Medi-Cal covered services, in accordance with the federally approved CalAIM Terms and Conditions. [WIC §14184.206]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, children under 21 who are covered under Medi-Cal with a health condition caused by insufficient access to clean diapers should have access to prescription diapers through this program. The author contends it is unacceptable that in California in 2024, families are having to choose between feeding their families and buying diapers for their infants, especially since federal EPSDT requirements address medically necessary diaper access. Specifically, the author notes that although California is taking advantage of EPSDT for many services provided to children under 21, the Medi-Cal provider manual clearly states Medi-Cal does not reimburse for incontinence supplies for recipients younger than age five. The author argues this is not only restrictive, but also by default means that the current Medi-Cal standards do not align with EPSDT requirements. The author contends this bill utilizes the existing federal EPSDT entitlement to expand access to much-needed diaper assistance for California children and families stuck in an endless loop of poverty. This bill is cosponsored by GRACE/End Child Poverty and the California Association of Food Banks.

2) **BACKGROUND.**

   a) **Diaper Need**. According to the Center for Budget and Policy Priorities (CBPP), diaper need is the struggle to afford a sufficient supply of diapers required to keep a child clean, dry, and healthy. On average, CBPP notes, diapers cost nearly $100 per month. According to the First 5 Center for Children's Policy, diaper access and affordability are essential components of a child's basic needs. Without consistent diaper changes, babies run the risk of infection, diaper rashes, urinary tract infections, and other significant health problems that may require medical attention. The federal Administration for Children and Families (AFDC) notes geographic barriers worsen diaper need for low-income families in California, most commercial laundry facilities do not allow cloth diapers, and cost-saving measures like buying in bulk are infeasible due to the distance needed to travel to big box stores.

According to a study by the National Diaper Bank Network, "Diaper Check 2023: Diaper Insecurity among U.S. Children and Families: Major Findings:"

i) Diaper need forces families to cut back on other essentials. Forty-six percent of families with diaper need reported reducing other expenditures to afford diapers, with most of those households cutting back in multiple areas. The most common cutback was entertainment outside the home (fifty-six percent). Other common areas for cutbacks included food (thirty-five percent) and utilities (nineteen percent);

ii) Diaper need is associated with stress and worry. Seventy percent of the respondents reporting diaper need said that they were stressed or anxious about their responsibilities as a parent or caregiver. Fifty-three percent said they felt judged as a bad parent/caregiver because they could not afford diapers;

iii) Diaper need impacts daily life. Families with diaper need reported more instances of unmet health needs; stress and anxiety; limitations on free time and social contact; and barriers to work;

iv) Diaper need intersects with food insecurity. More than a quarter of respondents (twenty-eight percent) who reported diaper need said that they skipped meals so that they could afford more diapers; and,

v) Diaper need results in parents missing work and losing wages. One in four parents and caregivers with diaper need reported having to miss work or school because they did not have enough diapers to drop their child off at childcare, and reported missing, on average, more than five workdays in the past 30 days.

b) **Solutions for Diaper Need**. A patchwork of programs and initiatives address diaper need. These programs are generally not universally accessible to those experiencing diaper need, and are often not adequately resourced to cover the total cost of diapers.

i) **Diaper Banks**. Similar to food banks and often administered in tandem with or by food banks, diaper banks provide diapers to families who need them, based on the supply, capacity, and policies of the distributing entity. For instance, the Sacramento Food Bank and Family Services is a participant in the National Diaper Bank Network. Its website lists 18 distribution locations in the Sacramento region, which all have various policies, including some that require appointments, registration, or photo ID. County-administered distribution locations in the Sacramento region require participation in assistance programs such as CalFresh, Medi-Cal, or CalWORKS.

ii) **Federal Grants**. California was awarded $1.2 million from the federal AFDC in the second cohort of grantees for the Diaper Distribution Pilot, which was launched in 2022. Under the pilot, the California Community Action Partnership Association is partnering with the National Diaper Bank Network and five local agencies to distribute diapers and connect families with other anti-poverty programs. Federal legislation has been introduced to create an additional demonstration program to distribute diapers.

iii) **Cash Assistance Programs**. The CBPP published a fact sheet in 2021 titled, "End Diaper Need and Period Poverty: Families Need Cash Assistance to Meet Basic

Needs." As it pertains to diapers, the fact sheet recommends policymakers should expand Temporary Assistance for Needy Families, increasing benefits and easing accessibility, to ensure families can afford personal care products, as well continue the expansion of the Child Tax Credit that provided an increased credit as a monthly cash benefit to the lowest-income families. California has added a diaper benefit to the CalWORKS program, as described below.

iv) **Medicaid Managed Care Plan Programs**. Some health insurers have programs to address diaper need. For instance, UnitedHealthcare Community Plan of Tennessee works with providers and local resources to give free diapers to Medicaid families for completing critical health actions such as well-child visits and immunizations. UnitedHealthcare notes babies are healthier, parents and kids receive the care and daily staples they need, UnitedHealthcare lowers costly claims related to diaper rash, and providers see more patients. Similarly, Priority Health, a Medicaid managed care plan in Michigan, offers a perk for mothers who participate in the state's Maternal Infant Health Program and attend their postpartum appointment. Participants receive two free bags of diapers delivered to their home and are eligible for additional diaper discounts.

c) **Diaper Assistance in CalWORKS and 2017 Report**. Pursuant to a Supplemental Reporting Language (SRL) requirement included in the 2016-17 Budget Act, the California Department of Social Services (DSS) released a report, "Summary of Options for the Provision of Diaper Assistance to Low-Income Families." The report summarized seven potential delivery methods that were considered by DSS. Ultimately, AB 480 (Gonzalez Fletcher), Chapter 690, Statutes of 2017, implemented one of the options: a diaper benefit as a welfare-to-work supportive service within the CalWORKS program. The benefit provides $30 per month to assist with diaper cost for children under 36 months of age.

In the report, Medi-Cal coverage was reviewed and the option was dismissed, per the following analysis in the report:

> "California currently allows for diapers to be prescribed and funded under Medi-Cal for children five and older when a doctor has verified a medically necessary reason for the diaper. Many other states allow for children three and older to receive this benefit funded (mostly) by federal Medicaid dollars. While it may be possible for the state to lower the age restriction, **this delivery option would only benefit children with a medically-based need for diapers and not infants**. Given this limitation, this method was not further evaluated."

d) **Medi-Cal Coverage of Benefits and Medical Necessity.** Medi-Cal provides a comprehensive set of health benefits, which may be accessed as medically necessary. Medi-Cal covers a core set of federally required health care benefits as well as a number of optional benefits. The overwhelming majority of benefits are federally approved and covered under California's Medi-Cal State Plan, which means the state can receive federal financial participation (FFP), or federal matching funds, for the services. The state can add or remove benefits by filing an amendment to the state plan, called a State Plan Amendment (SPA). A SPA is reviewed and must be approved by the federal Centers for Medicare and Medicaid Services (CMS) for a change to Medicaid benefits to be

effectuated.

As noted, Medi-Cal benefits are covered when medically necessary. For many benefits, medical necessity is determined by the health care provider. For some benefits, a beneficiary must meet predefined criteria defined by the department to establish medical necessity. Medical necessity may also be established on a case-by-case basis through the Treatment Authorization Review process in the Fee-for-Service Medi-Cal program, or through the utilization review process of a Medi-Cal managed care plan.

For individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

e) **Medical Necessity under EPSDT**. A different, more generous medical necessity standard applies for children under 21 years of age under the EPSDT benefit. For children under 21, state law references the standards set forth under the federal law establishing EPSDT (see Existing Federal Law, above). This law requires coverage of any benefit or service that can be covered under Medicaid that is necessary to "correct or ameliorate" a child's health condition. The EPSDT benefit also requires a comprehensive array of prevention, diagnostic, and treatment services for individuals under the age of 21 who are enrolled in Medicaid.

f) **Current Medi-Cal Policy on Coverage of Diapers.** Medi-Cal covers incontinence products as medical supplies, including diapers, when prescribed by a physician, nurse practitioner, clinical nurse specialist, or a physician assistant within their scope of practice, for use in chronic pathologic conditions that cause the recipient's incontinence.

The Medi-Cal Provider Manual, "Incontinence Medical Supplies," states that Medi-Cal does not reimburse for incontinence supplies for recipients younger than age five. However, it also states, paradoxically, that Medi-Cal **may** reimburse for incontinence supplies through EPSDT, where the incontinence is due to a chronic physical or mental condition, including cerebral palsy and developmental delay, and at an age when the child would normally be expected to achieve continence. Therefore, although circumstances exist where coverage of diapers may be required under EPSDT, and DHCS coverage policy acknowledges this eventuality, it is unclear how this EPSDT entitlement can be effectuated, based on the policy statement that Medi-Cal does not reimburse for incontinence supplies for children under five and the lack of clear billing guidance for this situation. Current DHCS policy also does not acknowledge the possibility of coverage based on conditions related to inadequate diaper hygiene, as this proposed in this bill. Under certain circumstances, such as severe diaper rash, it appears reasonable that diapers could potentially be considered a medical supply necessary to correct or ameliorate a health condition under EPSDT.

g) **Urinary Incontinence (UI) in Children**. According to the National Kidney and Urologic Diseases Information Clearinghouse of the National Institutes of Health, UI is the loss of bladder control, which results in the accidental loss of urine. In children under age three, it's normal to not have full bladder control. As children get older, they become more able to control their bladder. Wetting in younger children is common and not considered UI, so daytime UI is not usually diagnosed until age five or six, and nighttime UI is not

usually diagnosed until age seven. Incontinence in children over the age of three may be caused by a wide range of underlying medical conditions, mental health conditions such as anxiety, and behavioral factors such as infrequent voiding (hold urine for prolonged periods of time).

h) **Health-Related Social Needs (HRSN) and Community Supports under Medi-Cal.** Beyond coverage of diapers as medical necessity to address an individual child's health condition under EPSDT, diaper need could potentially be considered a HRSN. According to CMS, HRSN are an individual's unmet, adverse social conditions that contribute to poor health. However, the extent to which California could receive federal approval to cover diapers as a HRSN is unclear.

In general, coverage of services under Medicaid/Medi-Cal is limited to medically necessary health care services, supplies, drugs, and equipment. However, the federal government allows various flexibilities to cover other types of benefits. Since the time DSS reviewed the option to cover diapers under Medi-Cal, the state has added coverage of 14 supportive services that address HRSN, through implementation of the CalAIM initiative. These so-called Community Supports include, for example, housing support services, medically tailored meals, and physical modifications to the home to reduce the risk of asthma or falls. DHCS has a pre-approved list of Community Supports that can be provided by Medi-Cal managed care plans.

Community Supports, as defined through CalAIM, are alternative services to those covered under the Medi-Cal State Plan, but are delivered by a different provider or in a different setting than is described in the State Plan. This method of covering alternatives to traditional medical services is also called "In Lieu of Services and Settings" (ILOS) by CMS. According to CMS, ILOS is one of the federal authorities states can use to address HRSN in Medicaid programs. Importantly, the Community Supports can only be covered if the state determines they are medically appropriate and cost-effective substitutes or settings for services covered under the state's Medicaid State Plan. Cost-effectiveness is measured on a population basis, based on a managed care plan's overall expenditures on ILOS services; states do not need to prove the provision of an ILOS service is cost-effective for each beneficiary of a service. As the author and sponsors of this bill point out, there is a mechanism by which providing diapers for children suffering from certain conditions could reduce health care expenditures, for instance, for treatment of skin rashes and UTIs.

To support states in addressing HRSN generally, in November 2023, CMS published a document titled "Coverage of HRSN Services in Medicaid and the Children's Health Insurance Program." It discusses a variety of authorities states can use to address HRSN, including ILOS; however, it does not specifically list diapers or similar products as an intervention eligible for federal approval under any of the available authorities. However, a forthcoming analysis by DHCS should illuminate whether the ILOS/ Community Supports approach or a different approach may be viable, as explained below.

i) **DHCS Update Due in May 2024 on Medi-Cal Coverage of Diapers**. SRL included in the 2023-24 Budget Act, requires, on or before May 15, 2024, DHCS to provide an update to staff in the relevant budget and policy committees of the Legislature and the Legislative Analyst's Office, through a meeting to be conducted at mutually agreed upon

times, on potential options for a federal Medicaid 1115 waiver to reimburse the cost of diapers for infants and toddlers under the age of three in Medi-Cal. The SRL specifies the update may include a discussion of the following components:

i) A summary of existing 1115 waivers in other states that cover the cost of diapers for infants and toddlers in Medicaid;

ii) Potential options for California to implement a program to cover the cost of diapers for infant and toddler Medi-Cal beneficiaries;

iii) The potential steps and timeline for the department to submit a waiver for such a program to CMS; and,

iv) A multiyear fiscal estimate of the new program.

The SRL also requires a similar update related to Medi-Cal coverage of period products (e.g., menstrual pads). DHCS has indicated that it will not be ready with its update before the policy committee deadline.

3) **SUPPORT.** GRACE/End Child Poverty in California and the California Association of Food Banks, cosponsors of this bill, note diaper need is a human rights issue and also an issue of equity, as Latino and Black households face poverty at much higher rates than white households. Cosponsors argue this bill will help address this inequity by enacting a policy to support diaper needs for low-income families on Medi-Cal, one-half of whom are Hispanic. Western Center on Law and Poverty (WCLP) writes in support that the inability to afford diapers has painful consequences for an entire family, and that when diapers are kept on longer than suggested, babies can have painful conditions like UTI or severe diaper rash. WCLP also notes diaper need is linked with food insecurity, parental stress, and lost wages or time at school for caregivers.

4) **RELATED LEGISLATION.** SB 953 (Menjivar) adds menstrual products as a covered Medi-Cal benefit, subject to federal approval and FFP, and requires DHCS to seek any necessary federal approvals to implement the benefit. SB 953 is pending in the Senate Appropriations Committee.

5) **PREVIOUS LEGISLATION.**

a) AB 480 created a $30 per month diaper benefit as a welfare-to-work supportive service within the CalWORKS program, for children under 36 months of age.

b) AB 492 (Gonzalez), of 2016, proposed a $50 diaper supportive service per child two years old or younger in a CalWORKs, Welfare-to-Work family. AB 492 was vetoed by Governor Brown, who voiced concern about the bill's cost and a desire to consider spending proposals through the budget process.

c) AB 1516 (Gonzalez), of 2014, proposed adding an $80 cash aid supplement per child under two in a CalWORKs family. AB 1516 was held on the Suspense File of the Senate Appropriations Committee.

6) **POLICY COMMENT**. This bill correctly identifies an inconsistency between current Medi-Cal coverage criteria and EPSDT requirements, and defines minimum guidelines that should help ensure more consistent coverage under EPSDT based on an individual child's medical conditions. The forthcoming DHCS update that is expected to be available by May 15, 2024, as required by SRL and explained above, should also address broader coverage options for diapers through a federal waiver. The author may wish to review DHCS's update, when available, to assess whether it contains information pertinent to this bill.

7) **CLARIFYING AMENDMENT.** To clarify the coverage criteria for diapers for a child greater than three years of age, the author and Committee have agreed to strike the provision allowing coverage for a child "screened for" a condition that contributes to incontinence, given that a child screened for a condition does not necessarily have the condition. The amendment reads as follows:

   (b) Notwithstanding any other law, diapers are a covered benefit for any child greater than three years of age who has been ~~***screened for or***~~ diagnosed with a physical, mental, neurological, or behavioral health condition that contributes to incontinence.

REGISTERED SUPPORT / OPPOSITION:

Support

California Association of Food Banks (cosponsor)
GRACE - End Child Poverty in California (cosponsor)
Association of Regional Center Agencies
Food Share
Glide
Help a Mother Out
National Health Law Program
San Diego Food Bank
Food for People, the Food Bank for Humboldt County
Western Center on Law & Poverty, Inc.

Opposition

None on file.

Analysis Prepared by: Lisa Murawski / HEALTH / (916) 319-2097

Date of Hearing: April 2, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2556 (Jackson) – As Introduced February 14, 2024

SUBJECT: Behavioral health and wellness screenings: notice.

SUMMARY: Requires a health plan or insurer to provide notices to legal guardians, every two years, regarding the benefits of a behavioral health and wellness screening. Specifically, **this bill**:

1) Requires a health plan or insurer to provide to each legal guardian of an enrollee or insured, 10 to 18 years of age, a written or electronic notice regarding the benefits of a behavioral health and wellness screening.

2) Defines behavioral health and wellness screening as a screening, test, or assessment to identify indicators or symptoms of behavioral health issues in an individual, including, but not limited to, depression or anxiety.

3) Requires a health plan or insurer to provide notice in the preferred method of the legal guardian, including, but not limited to, a hard copy sent by mail or given in person at a visit, or by an electronic transmission including, but not limited to, text message or email.

4) Requires the notice to provide information regarding the benefits of behavioral health and wellness screenings for both depression and anxiety, and provided at least once every two years.

EXISTING LAW:

1) Establishes the Department of Managed Health Care to regulate health plans and California Department of Insurance to regulate health insurance. [Health and Safety Code (HSC) § 1340, *et seq.*; Insurance Code (INS) § 106, *et seq.*]

2) Establishes as California's essential health benefits benchmark under the Patient and Protection and Affordable Care Act (ACA), the Kaiser Small Group Health Maintenance Organization, existing California health insurance mandates, and the 10 ACA mandated benefits, including mental health (MH) and substance use disorder (SUD) coverage. [HSC § 1367.005 and INS § 10112.27]

3) Defines "basic health care services" as all of the following:

   a) Physician services, including consultation and referral;
   b) Hospital inpatient services and ambulatory care services;
   c) Diagnostic laboratory and therapeutic radiologic services;
   d) Home health services;
   e) Preventive health services;
   f) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage. Basic health care services includes ambulance and ambulance transport services provided through the 911 emergency response system; and,
   g) Hospice care. [HSC § 1345]

4) Requires health plans to ensure that all services are readily available at reasonable times to each enrollee consistent with good professional practice, and to the extent feasible, a health plan to make all services readily accessible to all enrollees consistent with existing law on timely access to health care services. [HSC § 1367]

5) Requires every health plan contract and insurance policy that provides hospital, medical, or surgical coverage to provide coverage for medically necessary treatment of MH and SUDs under the same terms and conditions applied to other medical conditions, as specified. [HSC § 1374.72 and INS § 10144.5]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, this bill aims to increase rates of mental health screenings in people aged 10 to 18. In 2022, the United States Preventative Service Task Force recommended screening for anxiety in children and adolescents aged 8 to 18 years old. According to the Centers for Disease Control and Prevention (CDC), early identification and expanded evidence-based prevention and intervention strategies are critical to improving pediatric mental health. The author concludes that this bill will increase early identification and intervention strategies.

2) BACKGROUND. According to the American Academy of Pediatrics (AAP), 3-20% of children in the U.S. experience a MH disorder each year. The use of standardized screening tools by pediatric providers is more effective in the identification of developmental, behavioral and psychosocial issues in children than clinical assessments alone. Although poverty increases the risk for MH conditions, studies show that the greatest increase in prevalence occurred among children living in households earning greater than 400% above the federal poverty line. Universal screening reduces missed opportunities to identify children who may have MH conditions and promotes intervention aimed at preventing some of the long-term effects of a childhood mental disorder. Additionally, Mental Health America writes that 16.39% of youth aged 12-17 reported suffering from at least one depressive episode in 2022-23. Further, nearly 12% of youth are experiencing severe major depression and nearly 60% of youths suffering from major depression did not receive MH treatment. In California, 114,000 youths were not treated for their major depression. Only 28% of youth with severe depression received some consistent treatment.

   a) Developmental screening. This bill ensures that legal guardians are aware of the benefits of behavioral health and wellness screenings for kids. According to the CDC, developmental screening takes a closer look at how a child is developing. The child will get a brief test, or the parent will complete a questionnaire about the child. The tools used for developmental and behavioral screening are formal questionnaires or checklists based on research that ask questions about a child's development, including language, movement, thinking, behavior, and emotions. Developmental screening can be done by a doctor or nurse, but also by other professionals in healthcare, early childhood education, community, or school settings. Developmental screening is more formal than developmental monitoring and normally done less often than developmental monitoring. A child should be screened if a parent or a doctor have a concern. However, developmental screening is a regular part of some of the well-child visits for all children

even if there is not a known concern. The AAP recommends developmental and behavioral screening for all children during regular well-child visits at nine months, 18 months, and 30 months. In addition, AAP recommends that all children be screened specifically for autism spectrum disorder (ASD) during regular well-child visits at 18 months and 24 months. The CDC states that if a child's healthcare provider does not periodically check a child with a developmental screening test, the parent can ask that it be done. If the screening tool identifies an area of concern, a formal developmental evaluation may be needed. This formal evaluation is a more in-depth look at a child's development, usually done by a trained specialist, such as a developmental pediatrician, child psychologist, speech-language pathologist, occupational therapist, physical therapist, or other specialist. The specialist may observe the child, give the child a structured test, ask the parents or caregivers questions, or ask them to fill out questionnaires. The results of this formal evaluation determines whether a child needs special treatments or early intervention services or both.

b) **Health Care Coverage**. The Federal Mental Health Parity law requires, if health plans include services for MH and SUDs as part of their benefits, to provide those services under the same terms and conditions as other medical services. The ACA also specified coverage of the 10 EHBs, including MH and SUD treatment services and preventive and wellness services. According to a 2015 *Health Affairs* Health Policy Brief, the ACA went beyond existing federal law by mandating coverage instead of requiring parity only if coverage is provided.

   SB 855 (Wiener), Chapter 151, Statutes of 2020, requires commercial health plans and insurers to provide full coverage for the treatment of all MH conditions and SUDs. SB 855 also establishes specific standards for what constitutes medically necessary treatment and criteria for the use of clinical guidelines. SB 855 applies to all state-regulated health care service plans and insurers that provide hospital, medical, or surgical coverage, and to any entity acting on the plan or insurer's behalf. A health plan cannot limit benefits or coverage for MH or SUD treatments or services when medically necessary. California law requires health care coverage of behavioral health and wellness screenings.

c) **Recent California Initiatives**. According to the California Health and Human Services Agency, the Children and Youth Behavioral Health Initiative (CYBHI) is a five-year initiative to transform the way California meets the behavioral health needs of children, youth and families. The initiative serves as the core of the Master Plan for Kids' Mental Health, California's historic investment to redefine the way child- and family-serving systems take on these challenges so that young people can thrive. In January 2023, the Department of Health Care Services (DHCS) launched language screening and transition of care tools for Medi-Cal MH services to ensure that Medi-Cal members receive timely and coordinated specialty and non-specialty MH services.

   In January 2024, DHCS launched two behavioral health virtual services platforms for children, youth, and families. Launching as a part of the state's CalHOPE program, with funding from CYBHI, a $4.6 billion investment in youth behavioral health, the web- and app-based platforms will offer all California residents, regardless of insurance coverage, free one-on-one support with a live coach, a library of multimedia resources, wellness exercises, and peer communities moderated by trained behavioral health professionals to ensure the appropriateness of content and the safety of all users. These new CalHOPE

platforms will complement existing services offered by health plans, counties and schools by providing additional care options and resources for parents and caregivers, children, youth and young adults in California.

3) **OPPOSITION.** The California Association of Health Plans (CAHP), the Association of California Life and Health Insurance Companies (ACLHIC), and America's Health Insurance Plans (AHIP) oppose mandates for health plans and insurers to cover specific services, as well as bills that eliminate cost sharing and limit utilization management, which have similar cost impacts as coverage mandates. Moreover, they will increase costs, reduce choice and competition, and further incent some employers and individuals to avoid state regulation by seeking alternative coverage options. These bills will lead to higher premiums, harming affordability and access for small businesses and individual market consumers. CAHP, ACLHIC, and ACLHIC write that state mandates increase costs of coverage, especially for families who buy coverage without subsidies, small business owners who cannot or do not wish to self-insure, and California taxpayers who foot the bill for the state's share of those mandates.

4) **PREVIOUS LEGISLATION.**

a) AB 1450 (Jackson) of 2023 would have required a physician and surgeon, a general acute care hospital, a health plan, and a health insurer to provide to each legal guardian of a patient, enrollee, or insured, 10 to 18 years of age, a written or electronic notice regarding the benefits of a behavioral health and wellness screening. AB 1450 was held at the request of the author in Assembly Health Committee.

b) AB 1451 (Jackson) of 2023 would have required a health plan contract or health insurance policy issued, amended, renewed, or delivered on or after January 1, 2024, to provide coverage for treatment of urgent and emergency mental health and substance use disorders. Would have required the treatment to be provided without preauthorization, and to be reimbursed in a timely manner, pursuant to specified provisions. AB 1451 was vetoed by Governor Newsom, stating in part:

"This bill would require health plans to cover treatment for urgent and emergency mental health and substance use disorders without prior authorization, upon appropriation by the Legislature for administrative costs.

I share the author's concern regarding the importance of accessible behavioral health services statewide, as evidenced by the billions of dollars we have invested to enhance access to timely and necessary behavioral health care, as well as the programs and reforms implemented to improve our delivery system. Existing law already prohibits prior authorization for emergency care, and requires mental health and substance use disorder services to meet timely access standards. The requirements in this bill would result in significant costs in the tens of millions of dollars, to the state General Fund and to consumers through health plan premium increases. These impacts should be considered as part of the annual budget process."

c) AB 988 (Bauer-Kahan), Chapter 747, Statutes of 2022, requires the California Health and Human Services Agency (CHHSA) to appoint and convene a state 988 policy advisory

group to advise CHHSA on the implementation and administration of the five-year implementation plan for the 988 Suicide Prevention System.

5) **AUTHOR'S AMENDMENTS.** The author wishes to amend this bill as follows:

   a) Clarify that the health plan provide notice to the legal guardian of the enrollee without reference to a preferred method, including deleting the option that notices being given in person at a visit; and,

   b) Revise the notice requirement from at least once every two years to on an annual basis.

6) **COMMENTS.** This bill requires notices to legal guardians of enrollees or insureds between the ages of 10 to 18. As this bill moves forward, the author should consider the following for administrative ease:

   a) Whether these notices should be provided to all children under age 18; and,

   b) Whether these notices should be forwarded to subscribers of the minor enrollee.

REGISTERED SUPPORT / OPPOSITION:

Support

None on file.

Opposition

America's Health Insurance Plans
Association of California Life and Health Insurance Companies
California Association of Health Plans

Analysis Prepared by: Kristene Mapile / HEALTH / (916) 319-2097

Date of Hearing: April 2, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2703 (Aguiar-Curry) – As Introduced February 14, 2024

SUBJECT: Federally qualified health centers and rural health clinics: psychological associates.

SUMMARY: Permits federally qualified health centers (FQHCs) and rural health clinics (RHCs) (health centers) to bill Medi-Cal for a visit provided by a psychological associate, subject to supervision and billing requirements consistent with current law and practice, and makes minor technical changes to correct code references.

EXISTING LAW:

1) Establishes the Medi-Cal Program, administered by the Department of Health Care Services (DHCS), to provide comprehensive health benefits to low-income individuals who meet specified eligibility criteria. [Welfare and Institutions Code (WIC) § 14000 *et seq*.]

2) Establishes health center services, as described in federal law, as covered Medi-Cal benefits. [WIC § 14132.100]

3) Requires health centers to be reimbursed on a per-visit basis. [*Ibid.*]

4) Defines a "visit" as a face-to-face encounter between a health center patient and the following health care providers:
   a) Physician;
   b) Physician Assistant;
   c) Nurse Practitioner;
   d) Certified Nurse Midwife;
   e) Clinical Psychologist;
   f) Licensed Clinical Social Worker;
   g) Visiting Nurse;
   h) Dental Hygienist;
   i) Dental Hygienist in Alternative Practice;
   j) Marriage And Family Therapist;
   k) Podiatrist;
   l) Dentist;
   m) Optometrist;
   n) Chiropractor;
   o) Comprehensive Perinatal Services Practitioner providing comprehensive perinatal services;
   p) Four-hour day of attendance at an Adult Day Health Care Center;
   q) Any other provider identified in the state plan's definition of a health center visit; or,
   r) Under certain conditions described in 5), below, an associate clinical social worker or associate marriage and family therapist. [*Ibid.*]

5) Allows health centers to define an encounter with an associate clinical social worker (ACSW) or associate marriage and family therapist (AMFT) as a billable visit under the following conditions:

a) The ACSW/AMFT is supervised by a licensed behavioral health practitioner, as required by the Board of Behavioral Sciences;
b) The visit is billed under the supervising licensed behavioral health practitioner of the health center; and,
c) The health center is otherwise authorized to bill for services provided by the supervising licensed behavioral health practitioner as a separate visit.

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, California's mental health crisis is compounded by a shortage of mental health professionals. Health centers, in particular, need more behavioral health professionals. The author indicates this bill will expand access to such services for safety net patients at health centers by allowing Medi-Cal to reimburse health centers for services provided by psychological associates. The author notes that this bill will also help bring more culturally competent psychologists into the workforce in two ways; namely, it will create more training opportunities and it will expose psychological associates to community-based healthcare, making them more likely to continue working in that setting once they are licensed. This bill is sponsored by California Primary Care Association Advocates, the advocacy organization representing health centers, and the California Psychological Association.

2) **BACKGROUND.**

   a) **FQHCs and RHCs.** FQHCs and RHCs are federally designated health centers that receive federal grant funding under Section 330 of the federal Public Health Service Act. These health centers are core providers in the Medi-Cal program as well as serving as a health care safety net within communities. Health centers are required to provide primary care services regardless of ability to pay; for those without health care coverage, services are provided on a sliding scale fee based on ability to pay. In 2006, there were 476 FQHC service sites, but there are now over 1,000 FQHCs and nearly 300 RHCs in California. The number of health centers in California has grown significantly in recent years, which is largely attributable to the sizable investment in health centers and the expansion of Medicaid eligibility included in the federal Patient Protection and Affordable Care Act.

   b) **Prospective Payment System (PPS)**. Because of their unique role in providing health care to underserved communities and the uninsured, policymakers have historically attempted to ensure health centers remain financially viable. Federal grants provide grants to health centers to fund uncompensated care, and federal law established the PPS rate methodology to ensure state Medicaid agencies compensate health centers for the full cost of care for Medicaid patients. States also may implement an alternative payment method that pays the same or more than the federal PPS.

   A PPS rate is a per-visit rate calculated separately for each health center. Although calculation of a PPS rate is highly technical, it can be generally thought of as an average per-visit cost, derived by dividing costs for Medi-Cal-reimbursable services by Medi-Cal billable visits. A PPS rate is also adjusted annually by an economic inflator, the Medicare Economic Index (MEI). DHCS' Medi-Cal Estimate indicates the MEI rate increase

percent is 4.84% for calendar year (CY) 2022 and 4.77% for CY 2023 and 2024. In addition to the annual inflator, a health center can request a recalculation of its PPS rate based on a change in its scope of services. All health centers must provide at least a defined scope of primary care services, but may provide additional services as well.

Each health center has a specific Medi-Cal PPS rate for each patient encounter, irrespective of the reason for the visit. Importantly, clinics can only bill the PPS rate when the encounter with a patient is with one of a specified list of providers. (See 4) above in Existing Law).

c) **Behavioral Health Services at FQHCs and RHCs.** In recent years, health centers have greatly expanded the provision of mental health services at their sites. Federal law allows, but does not require, health centers to offer behavioral health services, including mental health and substance use disorder services. In 2014, the Medi-Cal program began requiring Medi-Cal managed care plans to provide a basic set of mental health services, broadening the set of services for which health centers can seek Medi-Cal reimbursement. In addition, health centers are now permitted to contract directly with counties as behavioral health providers, pursuant to SB 323 (Mitchell), Chapter 540, Statutes of 2017. SB 323 authorized health centers to receive reimbursement directly for county-funded behavioral health services, outside of the PPS reimbursement structure. Medi-Cal eligibility has also significantly expanded, meaning clinics can bill Medi-Cal for behavioral health services provided to a larger percentage of a clinic's patients who are now Medi-Cal eligible. Given these changes, behavioral health care is now a greater part of clinic settings.

d) **Behavioral Health Trainees in FQHCs and RHCs.** During the COVID-19 Public Health Emergency (PHE), the state pursued a large number of flexibilities to enhance the accessibility of health care. One such temporary flexibility added the services of ACSWs and AMFTs at health centers as billable visits. SB 966 (Limón), Chapter 607, Statutes of 2022, continues this flexibility after the expiration of the PHE. Pursuant to that legislation and as implemented by State Plan Amendment 22-014, FQHCs and RHCs can now permanently bill and receive the PPS rate for an encounter with an ACSW or AMFT.

ACSWs and AMFTs have completed a master's degree and are registered with the Board of Behavioral Sciences but have yet to complete their years of clinical training. According to data from Department of Consumer Affairs, as of fiscal year 2020-21, there are approximately 15,000 AMFTs and 17,000 ACSWs, in addition to 52,000 marriage and family therapists and 35,000 licensed clinical social workers.

Similar to ACSWs and AMFTs, psychological associates are behavioral health professional trainees. Psychological associates and licensed psychologists are regulated by the Board of Psychology (Board). There are 1,645 Psychological Associates registered with the Board, and the Board licenses about 24,000 psychologists. Psychological associates have a master's or doctorate degree or are admitted into a specified doctoral program.

Licensed behavioral health practitioners must supervise and assume professional liability for services furnished by the unlicensed practitioners; for psychological associates, the supervising practitioner is a licensed psychologist.

3) **SUPPORT.** The California Primary Care Association Advocates and the California Psychological Association jointly write as cosponsors in support of this bill, indicating this effort follows up on the success of SB 966, which enjoyed bipartisan support and has expanded the behavioral health workforce at health centers. Cosponsors note this bill will similarly expand training opportunities and opportunities to hire psychologists, as psychological associates who gain experience in clinics may be motivated to work in this setting after they become licensed.

4) **RELATED LEGISLATION.** AB 2303 (J. Carrillo) would require DHCS to submit a waiver for federal approval that allows a health center to request a change in its PPS rates based on a statutory minimum wage increase. AB 2303 is pending in this Committee.

5) **PREVIOUS LEGISLATION.**

   a) SB 966 (Limón) allows health centers to bill for patient visits with an ACSW or AMFT under prescribed circumstances.

   b) SB 323 authorizes health centers to receive reimbursement directly for county-funded behavioral health services, outside of the PPS reimbursement structure.

   c) AB 1863 (Wood), Chapter 610, Statutes of 2016, added licensed MFTs as providers who are permitted to bill for visits at a FQHCs or RHC so long as the health center files for a change in scope of services with DHCS and the change is approved.

   d) AB 858 (Wood) of 2015 would have included a provision that added MFTs to the list of health care professionals that could bill Medi-Cal for purposes of a health center visit. SB 858 was vetoed by Governor Brown, who said it would require new spending at a time when there was considerable uncertainty in the funding of the program.

   e) AB 690 (Wood) of 2015 also would have added MFTs to the list of health care professionals that could bill Medi-Cal for purposes of a health center visit. AB 690 was held on the Assembly Appropriations suspense file.

   f) AB 1785 (Lowenthal) of 2012 also would have added MFTs to the list of health care professionals that could bill Medi-Cal for purposes of a health center visit. AB 1785 was held on the Assembly Appropriations suspense file.

REGISTERED SUPPORT / OPPOSITION:

Support

CPCA Advocates, Subsidiary of the California Primary Care Association (cosponsor)
California Psychological Association (cosponsor)
California Medical Association
Community Clinic Association of Los Angeles County
Health Center Partners of Southern California
Steinberg Institute

Opposition

None on file.

Analysis Prepared by: Lisa Murawski / HEALTH / (916) 319-2097

Date of Hearing: April 2, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2753 (Ortega) – As Introduced February 15, 2024

SUBJECT: Rehabilitative and habilitative services: durable medical equipment and services.

SUMMARY: Includes durable medical equipment (DME), as specified, under essential health benefits (EHBs) coverage of rehabilitative and habilitative services and devices. Specifically, **this bill**:

1) Includes DME, services, and repairs, if the equipment, services, or repairs are prescribed or ordered by a physician, surgeon, or other health professional acting within the scope of their license, under EHB coverage of rehabilitative and habilitative services and devices.

2) Prohibits coverage of DME and services from being subject to financial or treatment limitations, including annual caps or requirements limiting coverage of the devices to those for home use.

3) Defines DME as devices, including replacement devices, that are designed for repeated use and that are used for the treatment or monitoring of a medical condition or injury in order to help a person to partially or fully acquire, improve, keep, or learn, or minimize the loss of, skills and functioning of daily living. Includes, under the prescription or order for DME, fittings, design, adjustment, programming, and other necessary services for the provision or maintenance of the devices.

4) Makes various findings and declarations, including the following:

   a) Lack of access to DME disproportionately affects individuals with disabilities or chronically ill individuals;

   b) In order to comply with federal and state requirements regarding nondiscrimination in benefit design, coverage of EHBs offered by all nongrandfathered individual and small-group market plans must include DME and services;

   c) Coverage of DME is necessary to comply with federal requirements, and is therefore not subject to defrayal, as specified; and,

   d) Because California's EHB base-benchmark plan has been codified in state law, the Legislature has the responsibility to address the lack of DME coverage in the current benchmark that has led to violations of federal nondiscrimination law regarding benefit design. Amending California's DME statute ensures that Californians with disabilities receive the benefits of these federal nondiscrimination protections without delay.

EXISTING LAW:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 and the California Department of Insurance (CDI) to regulate health insurers. [Health and Safety Code (HSC) §1340, *et seq*., and Insurance Code (INS) §106, *et seq*.]

2) Establishes as California's EHB benchmark under the Patient Protection and Affordable Care Act (ACA), the Kaiser Small Group Health Maintenance Organization, existing California health insurance mandates, and the 10 ACA mandated benefits. Specifies EHBs in the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and, pediatric services, including oral and vision care. [HSC §1367.005 and INS §10112.27]

3) Includes, in regulations, DME for home use as other health benefits that EHBs must cover. [Title 28 Code of Regulations §1300.67.005]

4) Defines "basic health care services" as all of the following:
   a) Physician services, including consultation and referral;
   b) Hospital inpatient services and ambulatory care services;
   c) Diagnostic laboratory and therapeutic radiologic services;
   d) Home health services;
   e) Preventive health services;
   f) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage. Basic health care services includes ambulance and ambulance transport services provided through the 911 emergency response system; and,
   g) Hospice care. [HSC §1345]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, private health plans regularly exclude or severely limit coverage for DME such as wheelchairs, hearing aids, or ventilators, causing people to go without medically necessary devices or obtaining inferior ones that put their health and safety at risk. This gap in private coverage occurs despite the ACA's clear mandate to cover all EHBs, including rehabilitative and habilitative devices, in a nondiscriminatory way. Without adequate coverage, the lives of adults and children with disabilities are severely impacted, many are unable to attend school, work, or participate in community life. Others face institutionalization because they cannot function in their own homes without needed equipment. The author states that this bill would clarify that DME is a covered EHB in California-regulated health plans, when prescribed by a provider for rehabilitative or rehabilitative purposes. This bill would also prohibit targeted limitations, such as annual dollar caps and "home use only" restrictions on DME coverage, consistent with all EHBs. The author concludes that this bill would be cost neutral because, when a benefit is required through state action for the purpose of complying with federal requirements (in this case federal nondiscrimination law), then the State is not responsible for defraying the cost of the benefit.

2) **BACKGROUND.** According to the California Health Benefits Review Program (CHBRP), DME is not currently defined under California law. However, the ACA requires that all state-regulated nongrandfathered health plans and policies in the individual and small-group markets — plans regulated by the DMHC and policies regulated by the CDI — cover all tests, treatments, and services included within the California EHB benchmark plan, which

includes coverage for a limited number of DME. It should be noted that state-regulated health plans and policies may cover more than what is required within the EHB benchmark plan. There are five major categories of DME, including personal mobility devices, bathroom safety devices, medical furniture, monitoring and therapeutic devices, and patient lifts. DME can be used for either chronic or temporary conditions. Although some DME equipment comes in a standard size, others require special modifications or customization to meet the medical needs of the user. The process of obtaining authorization for coverage of DME varies by health plan or policy. Health plans and policies may impose terms and conditions on authorization of coverage for DME, such as limiting coverage to only a single item that meets the minimum specifications for the enrollee's needs, limiting coverage based on the proposed location of use of the device, or authorizing only one type of DME device to be covered within a certain timeframe. Health plans and policies also typically require a prescription, medical chart notes, and a letter of medical necessity written by a physician, occupational therapist, or physical therapist as part of the prior authorization process. CHBRP states the process for authorization of coverage may take several months, depending on the request. Barriers to access to DME include challenges such as differences in commercial insurers' coverage and a lack of transparency in guidelines; lack of understanding by health care professionals on device coverage; varying health plan and policy guidelines on patient testing, clinical policies and standards, and documentation requirements; and, communication difficulties with commercial insurers. Studies have demonstrated disparities in populations with disabilities, use of DME, and authorization of DME requests.

a) **DME Coverage.** Health plans are required to cover DME for use in the enrollee's home (or another location used as the enrollee's home). DME for home use is an item that is intended for repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, and appropriate for use in the home. Under regulations, a health plan may limit coverage to the standard equipment or supplies that adequately meet the enrollee's medical needs. Coverage includes repair or replacement of covered equipment. The health plan may decide whether to rent or purchase the equipment, and may select the vendor. The enrollee may be required to return the equipment to the plan or pay the fair market price of the equipment or any unused supplies when they are no longer medically necessary.

b) **CHBRP analysis.** AB 1996 (Thomson), Chapter 795, Statutes of 2002, requests the University of California to assess legislation proposing a mandated benefit or service and prepare a written analysis with relevant data on the medical, economic, and public health impacts of proposed health plan and health insurance benefit mandate legislation. CHBRP was created in response to AB 1996. SB 125 (Hernandez), Chapter 9, Statutes of 2015, added an impact assessment on EHBs, and legislation that impacts health insurance benefit designs, cost sharing, premiums, and other health insurance topics. CHBRP reviewed AB 1157 (Ortega) of 2023, which is substantially similar to this bill, and states the following in its analysis:

   i) **Enrollees covered.** This bill impacts small-group and individual plans regulated by DMHC and policies regulated by CDI, which includes the health insurance of approximately 4.7 million enrollees (12% of all Californians). This represents approximately 21% of the 22.8 million Californians who will have state-regulated health insurance that may be subject to any state mandate law. Since this bill

specifies "group and individual" plans and policies, the health insurance of Medi-Cal beneficiaries enrolled in DMHC-regulated plans would not be subject to this bill's requirements. This bill does not define or delineate specific devices or equipment that would be covered under the mandate, thus CHBRP assumes these definitions are subject to interpretation by regulators, plans, and insurers. CHBRP assumed that at baseline, some DMHC-regulated health plans and CDI-regulated policies cover only the minimum requirements for DME, per the state's EHB benchmark plan, and that postmandate, coverage would shift to be similar to those health plans and policies that include coverage for a more expansive list of DME (i.e., plans and policies with the fewest coverage restrictions).
CHBRP calculated those cost estimates based on those shifts in coverage. Thus, the estimates in this report are based on a modeling scenario where, while DME coverage would be expanded by the mandate, it would be principally bounded by the DME covered by health plans and policies with the fewest restrictions on coverage.

ii) **Impact on expenditures.** Estimates of utilization and cost are likely to be higher if DMHC and CDI interpret this bill to require coverage for more DME than the plans and policies with the fewest restrictions cover and without caps on coverage, prior authorization, or other techniques that plans and policies with the most restrictions use to manage utilization and cost of DME. This bill would increase total net annual expenditures by $26,410,000 or 0.02% for enrollees with DMHC-regulated plans and CDI-regulated policies. This is due to a $57,162,000 increase in total health insurance premiums paid by employers and enrollees for newly covered benefits, adjusted by an increase in enrollee expenses for covered benefits ($11,432,000) and decrease in enrollee expenses for noncovered benefits (−$42,184,000). Postmandate percent changes in premiums are in the range of $0.001 to $0.002 per member per month (PMPM), with the greatest value in the DMHC-regulated small-group and individual plans ($0.002 PMPM for both). This bill's changes in cost sharing for covered benefits (deductibles, copays, etc.) and out-of-pocket expenses for noncovered benefits would vary by market segment. CHBRP projects no change to copayments or coinsurance rates but does project an increase in utilization of DME and related services and repairs and therefore an increase in enrollee cost sharing for covered DME. It is possible that some enrollees incurred expenses related to DME and related services and repairs for which coverage was denied, but CHBRP cannot estimate the frequency with which such situations occur and so cannot offer a calculation of impact. For enrollees with coverage for DME at baseline, 6.0% of enrollees in small-group and 5.8% of enrollees in individual plans and policies have out-of-pocket expenses due to DME. For enrollees for whom postmandate DME coverage would be new, 1.6% of enrollees in small-group and 1.6% in individual plans and policies would experience an average decrease in out-of-pocket expenses for noncovered DME benefits of −$395.21.

iii) **EHBs.** According to CHBRP, this bill requires coverage for a new state benefit mandate that may exceed the definition of EHBs in California by requiring benefit coverage for DME beyond what is present in the California EHB benchmark plan.

iv) **Long-term impacts**. Qualitatively, CHBRP expects the key long-term impact of this bill would be increased utilization of DME should a greater number of items be classified as DME by DMHC and CDI or interpreted by plans/policies over time; however, CHBRP is unable to assess the likelihood of this occurring.

3) **SUPPORT.** The National Multiple Sclerosis Society writes that the medical costs associated with living with Multiple Sclerosis (MS) are $65,612 more each year than medical costs for individuals who do not have MS. The lack of adequate coverage for needed DME adds to that high cost and the difficulty of living with this expensive disease. By clarifying that DME is a covered EHB in California-regulated health plans and policies when prescribed by a doctor for rehabilitative or habilitative purposes and removing limitations such as annual caps, this bill will help people living with MS maintain their quality of life. Children Now states that many Californians do not have access to the wheelchairs, hearing aids, oxygen equipment, and other DME that they need. Children Now writes that the importance of this bill also extends to the fact that individuals with disabilities would be able to receive the benefits of comprehensive DME coverage without delay.

4) **OPPOSITION.** The California Chamber of Commerce (CCC) writes that employer-based health care coverage is usually one of the largest expenses a business experiences and, while this bill is well-intentioned, it will unintentionally exacerbate health care affordability issuesWhen health plans and insurers are required to cover new services or to waive/limit cost-sharing requirements for certain services, premiums for all enrollees and purchasers go up. This is true even though only some enrollees will utilize the mandated product or services, or benefit from the reduction in cost-sharing. CCC states that premiums for employers and enrollees consistently increase year after year due to a number of issues including benefit mandates. The 2022 Kaiser Family Foundation Employer Health Benefits Survey indicated that the average premium for family coverage has increased 20% over the last five years and 43% over the last 10 years. CCC concludes that annual premiums for employer-sponsored family health coverage reached $22,463 in 2022, with workers on average paying $6,106 toward the cost of their coverage.

5) **RELATED LEGISLATION.** SB 1290 (Roth) expresses the intent of the Legislature to review California's EHB benchmark plan and establish a new benchmark plan for the 2027 plan year. Limits the applicability of the current benchmark plan benefits to plan years on or before the 2027 plan year. SB 1290 is pending in Senate Health Committee.

6) **PREVIOUS LEGISLATION.**

   a) AB 1157 (Ortega) of 2023 is substantially similar to this bill and was held in Senate Appropriations Committee.

   b) SB 842 (Dodd) of 2021 would have required the Department of Rehabilitation (DOR), upon appropriation by the Legislature, to establish a device reutilization pilot program in Contra Costa, Napa, Solano, and Yolo Counties to facilitate the reuse and redistribution of assistive technology, including DME. The Governor Newsom's veto stated, in part:

   "This bill would require DOR to contract with one or more nonprofit entities to establish a three-year device reutilization pilot program in the Counties of Contra Costa, Napa, Solano, and Yolo to facilitate the reuse and redistribution of assistive technology, including durable medical equipment. The bill would also require the contracting nonprofit agency to use a computerized system to track the available inventory of equipment and supplies and organize pickup and delivery of those items.

   I agree with the author's goal of increasing access to assistive technology for people with disabilities and older adults, while also reducing waste in landfills. Although the bill is

subject to appropriation, the proposed pilot is duplicative of existing assistive technology reuse programs and would cost an estimated $5.1 million General Fund over a three-year period that was not included in the state budget.

The Legislature sent measures with potential costs of well over $20 billion in one-time spending commitments and more than $10 billion in ongoing commitments not accounted for in the state budget. Bills with significant fiscal impact, such as this measure, should be considered and accounted for as part of the annual budget process."

7) **COMMENTS. EHBs**. The ACA requires states to defray the costs of state-mandated benefits in qualified health plans that are in excess of the EHB. If a state were to choose a benchmark plan that does not include all State-mandated benefits, the ACA requires the state to defray the cost of those mandated benefits in excess of EHB as defined by the selected benchmark. CHBRP's analysis notes that DME for use outside of the home are not included in California's EHB package. It is unclear whether the appropriate state regulators have conducted this analysis. As this bill moves forward, the author may wish to request DMHC to conduct this analysis.

REGISTERED SUPPORT / OPPOSITION:

Support

Western Center on Law and Poverty (sponsor)
Access Reproductive Justice
Asian Americans Advancing Justice-Southern California
Association of Regional Center Agencies
Bay Area Legal Aid
California Domestic Workers Coalition
California Federation of Teachers AFL-CIO
Children Now
Children's Specialty Care Coalition
Community Legal Aid Socal
County Health Executives Association of California
Courage California
Hand in Hand: the Domestic Employers Network
Health Access California
Let California Kids Hear Coalition
National Health Law Program
National Multiple Sclerosis Society
The Leukemia & Lymphoma Society

Opposition

America's Health Insurance Plans
Association of California Life & Health Insurance Companies
CalChamber
California Association of Health Plans

Analysis Prepared by: Kristene Mapile / HEALTH / (916) 319-2097

Date of Hearing: April 2, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2841 (Waldron) – As Introduced February 15, 2024

SUBJECT: State hospitals for the mentally disordered: patient funds.

SUMMARY: Authorizes state hospital "Benefit Funds" to be used for the welfare of the patients of the institution.

EXISTING LAW:

1) Establishes the Department of State Hospitals (DSH) consisting of the following:

   a) Atascadero, Coalinga, Metropolitan, Napa, and Patton State Hospitals;
   b) The Admission, Evaluation, and Stabilization (AES) Center in the County of Kern, and other AES Centers, as specified;
   c) A county jail treatment facility under contract with DSH to provide competency restoration services; and,
   d) Any other DSH facility subject to available funding by the Legislature. [Welfare & Institutions Code (WIC) §4000 & §4100, *et seq.*]

2) Grants DSH general control and direction of the property and concerns of each state hospital, and requires DSH to establish such bylaws, rules, and regulations as it deems necessary and expedient for regulating the duties of officers and employees of the hospital, and for its internal government, discipline, and management. [WIC §4109]

3) Authorizes the DSH Director to deposit patient funds in the possession of a hospital administrator in a trust or interest-bearing bank account. Authorizes the hospital administrator, with the consent of the patient, to deposit the interest or increment on the patient's funds in a special fund for each state hospital, called the "Benefit Fund." Authorizes the hospital administrator, with the approval of the DSH Director, to expend the moneys in this fund for the education or entertainment of the patients of the institution. Requires the hospital administrator to take recommendations of representatives from patient government and patient groups before expending any funds. [WIC §4125]

4) Requires each patient who has resided in a state hospital for at least 30 days be provided monthly aid, when added to their income equals $12.50 per month, for personal and incidental needs. [WIC §4136]

FISCAL EFFECT: None.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, for over 50 years residents within the DSH system have benefited from the use of a hospital's Benefit Fund for their education and entertainment. However, the author states that existing law was drafted in a way that prohibits funds from being utilized for other quality-of-life items, such as clothing or comfort

items. The author contends that this bill simply ensures that state hospital patients are afforded the opportunity for a better quality of life.

2) **BACKGROUND.** Each state hospital maintains a Benefit Fund to be expended for the education or entertainment of the patients of the institution. The funds vary in amount due to differing patient contributions, hospital fundraising activities, and private donations from families and members of the community. DSH produces an annual report on each hospital's fund. In fiscal year 2021-2022, state hospital Benefit Fund expenditures were as follows:

   a) Atascadero, $37,475;
   b) Metropolitan (in Los Angeles County), $25, 639;
   c) Napa, $20,095;
   d) Patton, $72,058; and,
   e) Coalinga, $0.

   DSH reported five categories for patient expenditures: Patient Activities, Arts and Crafts, Entertainment, Holiday Activities and Patient Library and Newspapers. The services fulfilled range from educational and vocational programs, social events and parties, leather and ceramic supplies, live entertainment, and newspaper and magazine subscriptions. The report did not include expenditures on any personal items for patients.

3) **SUGGESTED AMENDMENT.** Existing law requires hospital administrators to consider recommendations from patient governments and groups before making expenditures from the Benefit Fund. The committee may wish to ensure that patients are notified of the new option to use the Benefit Fund on items for their welfare to make certain these groups are aware of this change as they form recommendations for their hospital administrator.

REGISTERED SUPPORT / OPPOSITION:

Support

None on file.

Opposition

None on file.

Analysis Prepared by: Riana King / HEALTH / (916) 319-2097