Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2650 (Zbur) – As Amended March 18, 2024

SUBJECT: Licensed adult residential facilities and residential care facilities for the elderly: data collection.

SUMMARY: Requires the California Department of Social Services (DSS) to collect demographic information, as specified, from licensed residential care facilities for the elderly (RCFEs) and licensed adult residential care facilities (ARFs). Specifically, **this bill**:

1) Requires DSS, beginning May 1, 2026 and annually thereafter, to collect information and report to each county's department of mental health or behavioral health the:

    a) Total number of licensed RCFEs and licensed ARFs that exclusively accept public benefits recipients or residents diagnosed with a serious mental illness (SMI);

    b) Total number of licensed RCFEs and licensed ARFs that serve public benefits recipients or residents diagnosed with a SMI and that have exclusive use contracts with other public agencies; and,

    c) The total number of residents occupying beds in licensed RCFEs and ARFs who are any of the following:

        i) A public benefits recipient or a person diagnosed with a serious mental illness;

        ii) A person described in i) above who is receiving regional center funding; or,

        iii) A person described in i) above has a previous history of homelessness, incarceration, or institutionalization.

2) Requires DSS to post the report required by this section on its internet website.

3) Sunsets the provisions of this bill on January 1, 2029.

EXISTING LAW:

1) Establishes the "California Community Care Facilities Act" to provide for the licensure and regulation of community care facilities. [Health and Safety Code (HSC) §1500, *et seq*.]

2) Defines "community care facility" to mean any facility, place, or building that is maintained and operated to provide nonmedical residential care, day treatment, adult day care, or foster family agency services for children, adults, or children and adults, including, but not limited to, individuals with physical disabilities or mental impairments and abused or neglected children. Includes within this definition, among a number of other facilities: adult day programs, foster family homes, small family homes, full-service adoption agencies, short-term residential therapeutic programs, and crisis nurseries. [HSC §1502]

3) Defines "residential facility" to mean any family home, group care facility, or similar facility determined by DSS, for 24-hour nonmedical care of persons in need of personal services, supervision, or assistance essential for sustaining the activities of daily living for the protection of the individual. [HSC §1502]

4) Establishes the "California Residential Care Facilities for the Elderly Act" to provide for the licensure and regulation of RCFEs as a separate category within the existing licensing structure of DSS. Defines RCFE to mean a housing arrangement chosen voluntarily by individuals ages 60 and older, or their authorized representative, where varying levels and intensities of care and supervision, protective supervision, personal care, or health-related services are provided, based upon their varying needs, as determined in order to be admitted and to remain in the facility. [HSC §1569, *et seq.*]

5) Defines ARF to mean any facility of any capacity that provides 24-hour-a-day nonmedical care and supervision to persons 18-59 years of age. [22 California Code of Regulations §80001(a)(5)]

6) Requires DSS to annually collect information and send a report to each county's department of mental health or behavioral health of all licensed ARFs and RCFEs in the county that accept the federal supplemental security rate and accept residents with a serious mental disorder, and the number of licensed beds at each facility. [HSC §1507 and §1569.4]

7) Requires DSS to quarterly send to each county's department of mental health or behavioral health the report of licensed ARFs and RCFEs that closed permanently in the prior quarter, by county, and must include the number of licensed beds of each facility and the reason for closing. [HSC §1507.4 and 1569.4]

8) Establishes the State Supplementary Payment (SSP) for people who are aged, blind, or disabled, which is intended to supplement federal Supplemental Security Income (SSI) and provide persons whose needs result from age, blindness, or disability with assistance and services that help them meet basic needs and maintain or increase independence. Further provides that eligibility requirements for SSP match federal SSI criteria, and requires a minimum level of SSP benefits to be provided in order to maintain federal Medicaid funding, as specified. [Welfare and Institutions Code (WIC) §12000, *et seq.*]

9) Defines "serious mental disorder" as a mental disorder that is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. [WIC §5600.3]

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

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, licensed ARFs and RCFEs are integral to California's housing response, offering essential services like housing, meals, medication management, and support to vulnerable populations, including those on public benefits and individuals with SMIs. The author continues that despite their significant contribution to our communities, many of these facilities are closing due to funding

constraints, placing the residents at risk of becoming unhoused, incarcerated, or institutionalized. The author argues that to equip us to respond to this challenge, this bill requires DSS to collect and publicly report data, including details regarding bed counts, information regarding the number of residents who rely on public benefits, and more. The author concludes that this information will help policymakers and local health officials understand the populations that these facilities serve and will inform future decisions and prevent further closures of these essential facilities.

2) **BACKGROUND.** RCFEs are nonmedical facilities that house and care for the aging population that do not need 24 hour nursing care, but need basic daily help for services such as housekeeping, medication assistance, personal and hygiene care, and eating. There are three levels of care permitted in an RCFE which range from basic care when a resident still can retain some independence, to nonmedical care when a resident needs help with personal daily living activities, and the highest level of care is reserved for someone who needs extensive care with daily living activities and may have chronic health problems.

   ARFs are residential facilities that offer 24-hour nonmedical care and supervision for persons in need of personal services, supervision, or assistance essential for sustaining the activities of daily living or for the protection of the individual. ARFs may serve persons who are 18-59 years of age or those who are 60 years of age or older under specified requirements. These clients may have a mental, physical or developmental disabilities. Like RCFEs, ARFs are for people who are unable to live by themselves but who do not need 24 hour nursing care.

   a) **Statewide Facility Shortages.** The California Behavioral Health Planning Council (CBHPC) published a report in 2018 titled "Highlighting the critical need for adult residential facilities for adults with serious mental illness in California." The report details that a combination of facility closures and a lack of new facilities or other adequate supportive housing options are leaving individuals with SMI without sustainable housing options that meet their care needs after discharge from a treatment program, hospital or correctional institution. The CBHPC report notes that this results in a "revolving door scenario" where people are discharged or released from one of the above and then are unable to find appropriate residential care or housing. Thus, another mental health crisis ensues, resulting in a return to high-level crisis programs, facilities, hospitals, jails/prisons or homelessness.

      In 2020 the Legislature passed AB 1766 (Bloom), Chapter 139, Statutes of 2020, which requires DSS to collect and report quarterly data on RCFEs and ARFs that close permanently, and requires DSS to notify the county mental or behavioral health department within three days upon receiving notice that a facility intends to close permanently. AB 1766 also required DSS to collect data on the number of facilities that accept residents with a SMI or are on public benefits. *The Los Angeles Times* reported on the 2023 data, citing that 142 facilities closed and a total of 3,057 beds were lost statewide. This bill aims to build upon existing reporting required by DSS to provide more detailed insights on the implications of this facility closure crisis for populations with a SMI or receiving public benefits.

3) **SUPPORT.** The Licensed Adult Residential Care Association (LARCA) is the sponsor of this bill, stating that the behavioral health and housing systems for our most vulnerable populations are severely overwhelmed and struggle to provide adequate care and the problem

is especially pronounced for those living with serious mental illness and receiving public benefits. LARCA continues that this bill is a crucial step in better understanding the scope of ARFs and RCFEs and the challenges they face by fixing a data shortfall in the collection of information related to how many residents diagnosed with serious mental illness or receiving public benefits actually occupy beds in facilities. LARCA concludes that this is crucial to better understand and stabilize this housing and behavioral health solution that keeps low-income individuals and those experiencing serious mental illness in housing and off the streets.

4) **RELATED LEGISLATION.** SB 1017 (Eggman) requires the State Department of Health Care Services (DHCS), in consultation with the State Department of Public Health (DPH) and DSS, to develop a solution to collect, aggregate, and display information about beds to identify the availability of inpatient and residential mental health or substance use disorder (SUD) treatment for specified types of facilities.

5) **PREVIOUS LEGISLATION.**

   a) SB 363 (Eggman) of 2023 would have required DHCS, in consultation with DPH, DSS, and specified stakeholders, to develop a real-time, internet-based database to collect, aggregate, and display information about beds in specified facilities to identify the availability of inpatient and residential mental health or SUD treatment. SB 363 was held on the Assembly Appropriations Committee suspense file.

   b) SB 648 (Hurtado) of 2021 would have established the Enriched Care Adult Residential Facility pilot program for the purpose of promoting the sustainability of essential residential care facilities that serve recipients who receive SSI/SSP benefits. Specifically, SB 648 would have established a monthly stipend of $1,000 per SSI/SSP recipient residing in qualifying licensed adult residential facilities and RCFEs. The stipend would have been capped at $4,000 per month. SB 648 was placed on the Senate inactive file.

   c) AB 1766 requires DSS to collect information and send a report to each county's department of mental health or behavioral health of all licensed ARFs and RCFEs in the county that accept the federal supplemental security rate and accept residents with a serious mental disorder, as defined, and the number of licensed beds at each facility. Requires DSS to send to each county's department of mental health or behavioral health the report of licensed ARFs and RCFEs that closed permanently in the prior quarter, by county, the number of licensed beds of each facility, and the reason for closing, as specified.

   d) SB 1259 (Hurtado) of 2020 would have required DSS to establish a task force for the purpose of issuing a report that would have included recommendations on how to meet the housing and care needs of low-income individuals who are blind, disabled, or over 65 years of age and receiving SSI/SSP. SB 1259 would also have required DSS to provide updates on its progress in developing the report to specified committees. SB 1259 was held on the Assembly Appropriations Committee suspense file.

6) **DOUBLE REFERRAL.** This bill is double referred, it passed the Assembly Committee on Human Services with a 6-0 vote on April 9, 2024.

REGISTERED SUPPORT / OPPOSITION:

Support

Licensed Adult Residential Care Association (sponsor)

Opposition

None on file.

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

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2680 (Aguiar-Curry) – As Introduced February 14, 2024

SUBJECT: Alzheimer's disease.

SUMMARY: Makes several changes to the Alzheimer's Disease and Related Disorders (ADRD) Advisory Committee in the California Health and Human Services Agency (CHHSA).

1) Renames the ADRD Advisory Committee to the Alzheimer's Disease and Related Conditions (ADRC) Advisory Committee.

2) Expands the number of members serving on the ADRC Advisory Committee from 14 to at least 21, but not more than 25, members. Adds the following members to the ADRC Advisory Committee:
   a) One member representing local health jurisdictions;
   b) One member representing first responders;
   c) One member who is a Commissioner on the California Commission on Aging (CCA) who has expertise regarding Alzheimer's disease (AD) and related conditions;
   d) One member representing primary care physicians;
   e) Two ex officio, nonvoting members, consisting of one Senator appointed by the Senate Committee on Rules and one Member of the Assembly appointed by the Speaker of the Assembly. Requires these members to participate in the activities of the ADRC Advisory Committee to the extent that their participation is not incompatible with their respective positions as Members of the Legislature; and,
   f) Up to four additional members selected by the CHHSA Secretary.

3) Specifies that members described in 2) a) through d) and 2) f) above serve at the pleasure of the CHHSA Secretary and members described in 2) e) above serve at the pleasure of their appointing authority.

4) Removes the one-year term limit for the two people who have been diagnosed with AD or a related condition.

5) Revises references to AD to also refer to related conditions.

EXISTING LAW:

1) Requires the CHHSA Secretary to be responsible for the oversight and coordination of programs serving people living with AD and related disorders and their families, including, but not limited to:
   a) State level support and assistance to all programs within CHHSA and member departments developed for this target population;
   b) Establishment of the ADRD Advisory Committee; and,
   c) Review of the recommendations contained in the 1987 California Alzheimer's Disease Task Force Report and subsequent state plans, in consultation with appropriate state departments and the ADRD Advisory Committee. [Health & Safety Code (HSC) § 1568.15**]**

2) Requires CHHSA to establish an ADRD Advisory Committee consisting of 14 members selected as follows:
   a) One representing the field of academic medical research;
   b) One representing the field of social research;
   c) One representing the field of mental health;
   d) One representing the AD day care resource centers;
   e) One representing the AD diagnostic and treatment centers;
   f) Two representing families of persons suffering from AD or related disorders;
   g) Two representing organizations providing services to AD patients;
   h) One representing a consumer organization representing persons with AD;
   i) One representing a member of the State Bar who is familiar with the legal issues confronting AD victims and their families;
   j) Two people who have been diagnosed with AD to serve one-year terms; and
   k) The CHHSA Secretary or their designee. [HSC § 1568.17**]**

3) Provides that members of the ADRD Advisory Committee serve at the pleasure of the CHHSA Secretary. [*Ibid*]

4) Authorizes the CHHSA Secretary to establish fixed terms for ADRD Advisory Committee membership and requires those terms to be staggered. [*Ibid*]

5) Requires members of the ADRD Advisory Committee to serve without compensation, but to receive reimbursement for travel and other necessary expenses actually incurred in the performance of their official duties. [*Ibid*]

6) Requires the ADRD Advisory Committee to do all of the following:
   a) Provide ongoing advice and assistance to the Administration and the Legislature as to the program needs and priorities of the target population;
   b) Provide planning support to the Administration and the Legislature by updating recommendations of the 1987 California Alzheimer's Disease Task Force Report and regularly review and update recommendations as needed;
   c) Appoint a chairperson and vice chairperson; and,
   d) Meet quarterly. [*Ibid*]

7) Requires the ADRD Advisory Committee to do all of the following when making policy and plan recommendations:
   a) Consult with a broad range of stakeholders, including, but not limited to, people diagnosed with AD, family caregivers, community-based and institutional providers, AD researchers and academicians, formal caregivers, the Alzheimer's Association (AA), CCA, and other state entities;
   b) Consider the recommendations of other state plans, including, but not limited to, the Olmstead Plan, the Long-Range Strategic Plan on Aging, and the California Department of Aging's (CDA's) State Plan on Aging;
   c) Consider cultural and linguistic factors that impact persons with AD and their families who are from diverse populations; and,
   d) Review current state policies and practices concerning care and treatment related to AD and other dementia disorders, and develop recommendations concerning all of the following issues:

i) Community-based support for California's diverse people with AD and their family members;
ii) Choices for care and residence for persons with AD and their families;
iii) An integrated public health care management approach to AD in health care settings that makes full use of dementia care practices;
iv) The dementia competence of health care professionals; and,
v) Early identification and intervention through increasing public awareness of AD. [*Ibid*]

8) Requires all meetings of the ADRD Advisory Committee, and any subcommittees thereof, to be open to the public and adequate notice be provided in accordance with the Bagley-Keene Open Meeting Act. [HSC § 1568.17**]**

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

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author**,** nearly 700,000 people aged 65 and older are living with AD in California now. Of people aged 45 and older, nearly 12% have subjective cognitive decline. The ADRD Advisory Committee was established in 1988 to provide ongoing advice and assistance on program needs and priorities of persons impacted by AD and related dementia disorders. Since its creation, the population of people living with AD is increasing, and the needs of the people affected along with our understanding of AD has changed. The expansion of membership and terms of the members of the ADRD Advisory Committee will better reflect the needs of today. This bill also replaces outdated, stigmatizing language and allows committee members who have AD to serve longer terms consistent with improved outcomes thanks to modern medicine. The author concludes that law and representation of this community has to grow with our understanding of this devastating group of diseases and the increasingly specialized needs of their caregivers, who are disproportionately women.

2) BACKGROUND.

a) AD. According to a 2021 report "Related Dementias Facts and Figures in California: Current Status and Future Projections" by the California Department of Public Health (DPH) in conjunction with the AA, AD and the number of Californians 65 and older living with AD is projected to more than double by the year 2040. Additionally, while California's population is expected to grow by just 16% by 2040, the number of people living with AD will grow by 127%. Nearly 700,000 people aged 65 and older are living with AD in California now. Of people aged 45 and older, nearly 12% have subjective cognitive decline. Over the next 20 years, the impact of AD on the State of California will increase dramatically. Longer life expectancies and the aging of the large baby boom cohort will lead to an increase in the number and percentage of Californians who will be 65 years of age and older. Since the primary risk factor for AD is older age, substantial increase is anticipated in the numbers of people who will be living with the disease.

b) ADRD Advisory Committee. The ADRD Advisory Committee was established in 1988 to provide ongoing advice and assistance on program needs and priorities of persons impacted by AD and related dementia disorders. Since its creation, the population of

people living with AD continues to increase and the needs of the people affected along with our understanding of AD has evolved. Currently composed of 14 members, the ADRD Advisory Committee has been instrumental in strategic planning projects like the 2011 California State Plan for AD.

According to DPH, AD is a type of dementia that causes problems with memory, thinking, and behavior. Symptoms usually develop slowly and get worse over time, becoming severe enough to interfere with daily tasks. Dementia is a general term for memory loss and other cognitive problems that are serious enough to interfere with daily life. AD is an irreversible, progressive brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out simple tasks. While the specific causes of AD are not fully known, it is characterized by changes in the brain that result in loss of neurons and their connections. These changes affect a person's ability to remember and think. In June 2021, the U.S. Food and Drug Administration granted conditional approval to Aduhelm (aducanumab) for the treatment of AD even though an advisory panel had recommended against allowing the drug on the market. Aduhelm is the first drug on the market able to remove amyloid, the sticky substance that builds up in the brains of AD patients. According to news reports, Aduhelm is not reaching many patients and the reasons include its high cost, insurers' reluctance to cover it, and lingering questions about whether it actually slows memory loss.

c) Health Equity. According to the AA, AD and other dementias disproportionately affect Black Americans, Hispanic Americans, Asian Americans, American Indian/Alaska Natives, members of the LGBTQ and women. Black Americans are about two times more likely than white Americans to have AD and other dementias. Hispanic Americans are about one and one-half times more likely than white Americans to have AD and other dementias. By 2050, Asian Americans are projected to comprise nearly 8% of those aged 65 and older. Native Americans have high rates of chronic conditions, including conditions that are suspected risk factors for AD, such as obesity, diabetes and hypertension. Almost two-thirds of those living with AD are women. Below are recommendations from the AA on what the public health community can do:

- **i)** In addressing dementia, public health should identify underserved populations and those who experience a disproportionate burden of disease;
- **ii)** Public health officials must learn about the impact of AD and other forms of dementia on these populations;
- **iii)** The public health community must identify the local causes of these disparities and collaborate with community partners and stakeholders to develop initiatives to address them;
- **iv)** Public health practitioners should be sure to identify culturally, linguistically, and age appropriate strategies for people living with AD and their caregivers; and,
- **v)** The public health community should collaborate with or lead initiatives to ensure that government agencies that serve these populations are trained in appropriate and effective strategies.

d) AD and Dementia in California. According to the January 2021 "Related Dementia Facts and Figures in California: Current Status and Future Projections" (2021 Report), in 2019, approximately 660,000 Californians over 65 years of age lived with AD, which accounted for approximately 11% of the nation's AD prevalence (5.8 million people). The 2021 Report points out that between 2019 and 2040:

i) The population of California will expand by 16%, whereas the population of people living with AD will expand by 127%;
ii) The number of Californians over 75 years of age living with AD will more than double, growing to over 1.3 million;
iii) The number of Californians between 55 and 74 years of age living with AD will increase 26%, growing to 194,975 people;
iv) The number of people living with AD in California's 15 most populous counties (those with a population of 700,000 or more) will at least double;
v) The number of Californians living with AD will increase 11% for women, growing to 917,482 people; and increase 8% for men, growing to 609,197 people;
vi) The number of people living with AD will more than triple for Californians who identify as Latino/Latina/Latinx (Latino/a/x) American, growing to 431,982 people; nearly triple for Californians who identify as Black/African American, growing to 91,071 people; and more than double for Californians who identify as Asian American/Pacific Islander, growing to 241,106 people;
vii) The number of people living with AD will more than double for Californians who identify as lesbian, gay, or bisexual, growing to 74,522 people; and,
viii) People with Down syndrome have an increased risk of developing AD. Estimates show that AD affects about 30% of people living with Down syndrome who are between 50 and 59 years of age and closer to 50% of people living with Down syndrome who are 60 years of age and older.

The 2021 Report also included discussions on living arrangements for people living with AD; caregiving for people with AD and the costs of caring for people with AD.

e) AD Program. In 1984, legislation was enacted that established the AD Program. To meet the legislative mandates of relieving the human burden and economic cost of AD and related disorders, and to assist in ultimately discovering the cause and treatment of these diseases, the AD Program:

i) Established and administers a statewide network of 10 California Alzheimer's Disease Centers (CADCs) at university medical centers. The CADCs are dedicated to improving the quality of life of persons affected with AD and their families by providing diagnostic and treatment services; professional training for medical residents, postdoctoral fellows, nurses, interns, and medical students; and community education, such as caregiver training and support; and,

ii) Established and administers the Alzheimer's Disease Research Fund, which awards grants through a competitive process to scientists in California engaged in the study of AD.

Key Partners include: CDA, California Department of Health Care Services, ADRD Advisory Committee, AA, Caregiver Resources Centers, Area Agencies on Aging, and the federal Centers for Disease Control and Prevention.

f) Master Plan for Aging (MPA): In January of 2021, the Governor released his MPA. The MPA prioritizes the health and well-being of older Californians and the need for policies that promote healthy aging. The MPA serves as a blueprint for state government, local government, the private sector, and philanthropy to prepare the state for the coming

demographic changes and continue California's leadership in aging, disability, and equity. The work plan laid out in the MPA two years after its release continues to highlight the urgent needs facing California's older adults, people with disabilities, their families, advocates and the workforce supporting these populations. The MPA outlines five bold goals and 23 strategies to build a California for All Ages by 2030. It also includes a Data Dashboard on Aging to measure progress. The Goals of the MPA are as follows:

i) Goal One: Housing for All Ages and Stages;
ii) Goal Two: Health Reimagined;
iii) Goal Three: Inclusion and Equity, Not Isolation;
iv) Goal Four: Caregiving That Works; and,
v) Goal Five: Affording Aging.

g) Taskforce on Alzheimer's Disease Prevention and Preparedness (Taskforce). In 2019, Governor Gavin Newsom formed the Taskforce. The purpose of the Taskforce was to present recommendations to the Governor on how local communities, private organizations, businesses, government, and families can prevent and prepare for the rise in the number of cases of AD and all its consequences. Recommendations from the Taskforce were incorporated into the MPA.

Specifically, the Taskforce states: "While California is known for its 'youth culture,' the state has the second-longest life span in the nation: 80.8 years. With age comes greater risk for AD and all dementias. It is also true that no other state has the media-savvy or industry our state has, meaning California is uniquely positioned to dispel myths about aging and de-stigmatize AD. Widespread misinformation, lack of understanding and negative perceptions in the population about dementia, AD and other age-related diseases present a major barrier to policy change and health system transformation. Designing an 'Alzheimer's Public Awareness Campaign' that educates the public about the different neurodegenerative diseases, their prevention, symptoms, diagnosis and treatments is essential."

3) SUPPORT. AA, the sponsor this bill, states that this bill updates the ADRD Advisory Committee membership to include critical partners for systems change, including primary care providers, local public health officials and first responders. This bill expands the ADRD Advisory Committee from 14 to at least 21, but not more than 25, members, adding one representing local health jurisdictions, one representing first responders, an additional consumer organization representative, a commissioner from the CCA who has expertise regarding Alzheimer's conditions or related disorders, and a representative of primary care physicians. This bill also adds non-voting members (one Senator appointed by the Senate Committee on Rules and one member of the Assembly appointed by the Speaker of the Assembly), and up to four additional members selected by the CHHSA Secretary. AA continues that this bill also removes stigmatizing language and practices from code that negatively impact persons living with AD and their caregivers. AA concludes that this bill overcomes stigma by removing unfair term limits for committee members living with AD or related dementias, broadens caregiver terminology to reflect the realities of informal caregiving, and removes other harmful terminology.

4) RELATED LEGISLATION. AB 2613 (Zbur) of 2024 establishes within CHHSA, until January 1, 2029, the Jacqueline Marie Zbur Rare Disease Advisory Council (Council),

composed of a minimum of 17 members, appointed as specified. The Council would generally act as the advisory body on rare diseases to the Legislature and state and private entities that provide services to, or that are charged with the care of, persons with rare diseases. AB 2613 is pending a hearing in the Assembly Committee on Health.

5) PREVIOUS LEGISLATION.

a) AB 387 (Aguiar-Curry) of 2023 was substantially similar to this bill but was held on the Assembly Appropriations Committee suspense file.

b) AB 1618 (Aguiar-Curry) of 2022 would have expanded the membership of the Advisory Committee and would have established the Office of the Healthy Brain Initiative at DPH. AB 1618 was held in Senate Appropriations Committee suspense file.

c) AB 1684 (Voepel) of 2022 would have required DPH to implement a public awareness campaign on AD that includes education for unpaid caregivers, including family and friends who provide care to someone with AD or dementia. AB 1684 was held in Senate Appropriations Committee suspense file.

d) SB 861 (Limón) of 2022 would have established, upon appropriation by the Legislature, the Dementia Care Navigator Grant Pilot Program under the CDA for the purpose of incentivizing local organizations to provide dementia care navigation training services. SB 861 was vetoed by the Governor.

e) SB 491 (Alquist), Chapter 339, Statutes of 2008, expands the membership of the ADRD Advisory Committee, and requires the ADRD Advisory Committee to update the 1987 Task Force Report on Alzheimer's and make recommendations to the CHHSA Secretary and the Legislature.

f) SB 139 (Mello), Chapter 303, Statutes of 1988, required the establishment of the ADRD Advisory Committee.

REGISTERED SUPPORT / OPPOSITION:

Support

Alzheimer's Association
Alzheimer's Greater Los Angeles
Alzheimer's Orange County
Alzheimer's San Diego
California Assisted Living Association
California Life Sciences
County Health Executives Association of California (CHEAC)
LeadingAge California

Opposition

None on file.

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

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2775 (Gipson) – As Amended April 1, 2024

SUBJECT: Emergency medical services.

SUMMARY: Authorizes the Emergency Medical Services Authority (EMSA) to develop planning and implementation guidelines for the use of telehealth, within existing authority, in emergency medical services (EMS) systems. Authorizes EMSA to develop guidelines for the collection of data regarding the use of telehealth in EMS systems and requires EMSA to consider existing data collection systems, including the California Emergency Medical Services Information System (CEMSIS).

EXISTING LAW:

1) Establishes EMSA, which is responsible for the coordination and integration of all state activities concerning EMS, including the establishment of minimum standards, policies, and procedures. [Health and Safety Code (HSC) §1797.100, *et seq*.]

2) Authorizes counties to develop an EMS program and designate a local EMS agency (LEMSA) responsible for planning and implementing an EMS system, which includes day-to-day EMS system operations. [HSC §1797.200, *et seq*.]

3) Requires an emergency medical care provider to do both of the following when collecting and submitting data to a LEMSA:
   a) Use an electronic health record system that exports data in a format that is compliant with the current versions of CEMSIS and the National Emergency Medical Services Information System (NEMSIS) standards and includes those data elements that are required by the LEMSA; and,
   b) Ensure that the electronic health record system can be integrated with the LEMSA's data system, so that the LEMSA may collect data from the provider. [HSC § 1797.227]

4) Defines "Emergency Medical Technician-Paramedic," "EMT-P," "paramedic" or "mobile intensive care paramedic" as an individual whose scope of practice includes the ability to provide advanced life support, as specified, including administering specified medications. EMT-Ps are licensed and regulated at the state level through EMSA. [HSC §1797.84]

5) Establishes the Health Workforce Pilot Projects (HWPP) in the Department of Health Care Access and Information (HCAI) which states legislative findings that experimentation with new kinds and combinations of health care delivery systems is desirable and that for purposes of this experimentation, a select number of publicly evaluated HWPPs should be exempt from the healing arts practices acts. [HSC §128125, *et seq*.]

6) Permits HCAI to designate HWPPs as approved projects where the projects are sponsored by community hospitals or clinics, nonprofit educational institutions, or governmental agencies engaged in health or education activities. Permits a trainee (defined as a person being taught health care skills) in an approved project to perform health care services under the

supervision of a supervisor (someone who is already licensed to provide the health care services) where the general scope of the services has been approved by HCAI. [HSC §128135 and §128140]

7) Establishes the Community Paramedicine or Triage to Alternate Destination Act of 2020. Defines "community paramedicine program" as consisting of one of two specialties: providing directly observed therapy to persons with tuberculosis in collaboration with a public health agency; and, providing case management services to frequent EMS users in collaboration with, and by providing referral to, existing appropriate community resources. Defines "triage to alternate destination" as consisting of three specialties: providing care and comfort services to hospice patients in their homes in response to 911 calls; providing patients with advanced life support triage and assessment by a triage paramedic and transportation to an alternate destination facility, which can include an authorized mental health facility or an authorized sobering center; and, providing transport services for patients who identify as veterans and desire transport to a local veterans administration emergency department (ED) for treatment. [HSC §1800 *et seq*.]

8) Requires EMSA to develop regulations that establish minimum standards for the development of a community paramedicine or triage to alternate destination program, and requires the Commission on EMS to review and approve the regulations. Requires the regulations to be based upon, and informed by, the Community Paramedicine Pilot Program under HWPP #173, and the protocols and operation of the pilot projects approved under HWPP #173. [HSC §1830]

9) Defines "telehealth" to 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. Includes synchronous interactions and asynchronous store and forward transfers. [Business and Professions Code § 2290.5 (a)(6)]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, today's existing healthcare model of directing all transports to hospitals has created congestion in EDs. Community Paramedicine can play an important role in improving California's healthcare delivery system and is an innovative model of care. This bill would ensure that the Legislature maintains oversight of the community paramedicine programs created in AB 767 (Gipson) Chapter 270, Statutes of 2023. These programs aim to improve the effectiveness and efficiency of healthcare delivery by using specially trained paramedics in partnership with other healthcare providers to address the needs of local healthcare systems.

2) **BACKGROUND.**

   a) **The Community Paramedicine or Triage to Alternate Destination Act**. In November of 2014, the Office of Statewide Health Planning and Development (which has since been merged into HCAI) approved an application from EMSA to establish HWPP #173, to test different concepts of community paramedicine. Initially, HWPP #173 encompassed 13

sites testing six concepts, with more sites added over the ensuring years, including a seventh concept testing transporting patients to a sobering center. HWPP #173 was extended multiple times, and over the years, some sites were added while other pilot project sites were shut down. The following are the concepts that were tested by this pilot project:

i) Post-Discharge Short-Term Follow-Up, intended to provide home-based follow up care to people recently discharged from a hospital due to a chronic condition;
ii) Frequent EMS Users, intended to provide case management to frequent 911 callers and frequent visitors to EDs by connecting them with primary care, behavioral health, housing, and social services;
iii) Directly Observed Therapy for Tuberculosis, where the paramedic dispensed medication and observed patients taking them to assure effective treatment;
iv) Hospice, where paramedics, in response to 911 calls, collaborated with hospice agency nurses, patients, and family members to treat patients in their homes, according to their wishes, instead of transporting to an ED;
v) Alternate Destination – Behavioral Health, where paramedics, in response to 911 calls, offer to transport people who have behavioral health needs but no emergency medical needs to a mental health crisis center instead of an ED;
vi) Alternate Destination – Urgent Care, where paramedics, responding to 911 calls, offer people with low-acuity medical conditions transport to an urgent care center instead of an ED; and,
vii) Alternate Destination – Sobering Center, where paramedics, in response to 911 calls, offer people who are acutely intoxicated but do not have acute medical or mental health needs transport directly to a sobering center for monitoring instead of an ED.

After several legislative attempts to authorize these concepts in statute to make them permanent, AB 1544 (Gipson), Chapter 138, Statutes of 2020, was signed into law in 2020, creating the Community Paramedicine or Triage to Alternate Destination Act. Of the seven concepts, all were included in AB 1544 except for two: Alternate Destination – Urgent Care, which was not included because all project sites testing this concept had closed down; and Post-Discharge, Short-Term Follow-up, which had mixed results in early test sites. While Post-Discharge, Short-Term Follow-up was not included as part of the Community Paramedicine or Triage to Alternate Destination Act, AB 1544 did include a provision permitting the two remaining pilot project sites in that specialty at the time, Solano County and the City of Alameda (since closed down), to continue operating until January 1, 2024.

AB 1544 required EMSA to adopt regulations implementing the bill, and included a provision that permitted the existing pilot programs to continue operating while the regulations were being developed until up to one year after EMSA adopted the regulations. Once the regulations were adopted, EMSA could approve additional community paramedic or alternative destination programs that were developed by LEMSAs, and the existing pilot programs would have to be approved to continue after the initial year. However, regulations were not finalized until October 31, 2022, and because the entire program was scheduled to sunset in January of 2024, no new programs were added, and some pilot project sites are no longer operating. AB 1544 extended the sunset on these pilot programs to January 1, 2031.

AB 767 added short-term, post discharge follow-up for persons recently discharged from a hospital to the list of eligible community paramedicine services, requires EMSA to amend existing regulations to include that service, and extends the sunset date of the community paramedicine program from January 1, 2024, to January 1, 2031.

During the discussion around AB 767 technical assistance was provided by EMSA that raised the issue of telehealth use in the field by deploying higher medical authorities operating within their scope of practice. After review of the issue, EMSA recommended that they be authorized to develop guidelines to ensure consistency in system design and data collection across EMS systems in California.

b) NEMSIS and CEMSIS. NEMSIS was formed in 2001 by the National Association of State EMS Directors, in conjunction with the National Highway Traffic Safety Administration and the Trauma/EMS Systems program of the Health Resources and Services Administration's Maternal Child Health Bureau, in order to develop a national EMS database. NEMSIS is the national repository that will be used to potentially store EMS data from every state in the nation, and was developed to help states collect more standardized elements to allow submission to the national database.

CEMSIS is a demonstration project for improving EMS data analysis across California. CEMSIS offers a secure, centralized data system for collecting data about individual EMS requests, patients treated at hospitals, and EMS provider organizations. CEMSIS uses the NEMSIS standard for how patient care information resulting from a 9-1-1 call for emergency assistance is collected. Thirty-three of California's 34 LEMSAs currently send a variety of local data collections to CEMSIS on a voluntary basis, and in return, these local agencies gain access to digital tools for running comprehensive reports on their own data at no cost.

3) SUPPORT. The California Professional Firefighters (CPF) are a cosponsor of this bill and state that the healthcare needs of Californians have changed dramatically in recent years, compounded by the COVID-19 pandemic as well as the behavioral health and homelessness crises. Many people now rely on both emergency medical care and the ED of the hospital for their primary medical care, resulting in overcrowding and long delays that lead to impacts across the emergency system. In order to manage these needs, new paradigms of medical care have developed in order to divert cases from the ED that can be effectively treated elsewhere, as well as connecting patients with needed services to reduce hospital readmissions and future 911 calls. Fire departments throughout California have been at the forefront of these efforts, piloting and implementing community paramedicine and triage to alternate destination programs as well as developing mobile integrated health units to meet their community members where they are needed.

CPF notes that providing access to medical professional and advice via telehealth with fully licensed physicians gives another tool to paramedics in the field to reduce unnecessary transports to EDs. Whether it is writing a refill for a necessary prescription or confirming transport to a specialized psychiatric unit that can provide the appropriate treatment for a behavioral health crisis, telemedicine offers flexibility and additional options for emergency medical services providers. CPF concludes that by developing enhanced data collection systems, this bill will strengthen consistency in use of telehealth to ensure the highest quality of patient care.

The California Chapter of the American College of Emergency Physicians (California ACEP) is also a cosponsor and states that this bill continues to build on California's commitment to providing safe, high quality community paramedicine services by clarifying EMSA's authority to develop guidelines surrounding telemedicine, including considering data collection systems used in community paramedicine. With these guidelines in place, the utilization of telemedicine would operate under consistent guidance across systems, improving access to care. Community paramedicine is an innovative model of care that when implemented thoughtfully can improve access and reduce healthcare costs. California ACEP concludes that this bill allows for consistent guidance statewide to maintain standards for patient safety and quality care.

4) **OPPOSE UNLESS AMENDED**. Association of Regional Center Agencies (ARCA) is opposed to this bill unless it is amended and states that this bill would move the sunset back on the expansion of a program allowing paramedics to triage individuals and, when appropriate, transport them to mental health facilities (or sobering centers). But for individuals with developmental disabilities, a physical health crisis may seem solely behavioral. For instance, a person with non-verbal autism may have a ruptured appendix, causing a severe behavioral crisis that, in itself, would warrant use of this program's triage provisions. But with the underlying physical issue remaining undiagnosed, the chance to avert permanent injury or death may be missed.

   County-specific protocols state that if a reliable exam cannot be obtained through clear and coherent communication with the patient, they shall be transported to an emergency department. We continue to believe this mandate should be built into this statewide program, and urge the inclusion of a new subdivision within Health and Safety Code as follows:

   § 1831(f) A requirement that when a reliable exam cannot be obtained, including due to communication barriers, the patient shall only be transported to an emergency department.

   With this change, ARCA believes existing county guidance can be made uniform and statewide, the safety of individuals with developmental disabilities can be better protected, and the worthy core intent of triage to alternate destinations can be retained.

5) **RELATED LEGISLATION.** AB 2700 (Gabriel) requires the state to survey and analyze the facilities in each county that could serve as an alternate destination facility. Requires EMSA to publish a report that provides each LEMSA with the current number, capacity and type of alternate destination facilities. Requires a LEMSAs, in consultation with the county, to develop an alternate destination facility plan with protocols for transporting an individual to an alternate destination facility instead of ED. AB 2700 is pending a hearing in the Assembly Emergency Management Committee.

6) **PREVIOUS LEGISLATION.**

   a) AB 767 adds short-term, post discharge follow-up for persons recently discharged from a hospital to the list of eligible community paramedicine services and requires EMSA to amend existing regulations to include that service. Extends the sunset date of the community paramedicine program from January 1, 2024, to January 1, 2031.

   b) AB 1544 establishes the Community Paramedicine or Triage to Alternate Destination Act of 2020, which permits LEMSAs, with approval by EMSA, to develop programs to

provide community paramedic or triage to alternate destination services in one of the following specialties: i) providing directly observed tuberculosis therapy; ii) providing case management services to frequent emergency medical services users; iii) providing hospice services to treat patients in their homes; and, iv) providing patients with transport to an alternate destination, which can either be an authorized mental health facility, or an authorized sobering center.

REGISTERED SUPPORT / OPPOSITION:

Support

California Chapter of The American College of Emergency Physicians (cosponsor)
California Professional Firefighters (cosponsor)

Opposition

None on file.

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

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2859 (Jim Patterson) – As Amended March 18, 2024

SUBJECT: Emergency medical technicians: peer support.

SUMMARY: Authorizes an emergency medical services (EMS) provider to establish a peer support and crisis referral program to provide a network of peer representatives available to aid fellow employees on emotional or professional issues. Provides that EMS personnel, whether or not a party to an action, have a right to refuse to disclose, and to prevent another from disclosing, a confidential communication between the EMS personnel and a peer support team member, crisis hotline, or crisis referral service, except under limited circumstances, including, if disclosure is reasonably believed to be necessary to prevent death, substantial bodily harm, or commission of a crime, or in a criminal proceeding. Specifically, **this bill**:

1) Authorizes an EMS provider to establish a peer support and crisis referral program. Requires the program to be responsible for providing a network of peer representatives, reflective of the provider's workforce both in job positions and personal experiences, who are available to come to the aid of their fellow employees on a broad range of emotional or professional issues.

2) Authorizes the peer support and crisis referral program to provide employee support and referral services for matters that include any of the following:
   a) Substance use and substance abuse;
   b) Critical incident stress;
   c) Family issues;
   d) Grief support;
   e) Legal issues;
   f) Line-of-duty deaths;
   g) Serious injury or illness;
   h) Suicide;
   i) Victims of crime; and,
   j) Workplace issues.

3) Requires the EMS provider's hiring authority to consult with an employee representative organization to develop and implement a program created pursuant to this bill.

4) Grants, other than in a criminal proceeding, an EMS personnel, whether or not a party to an action, the right to refuse to disclose, and to prevent another from disclosing, a confidential communication between the EMS personnel and a peer support team member made while the peer support team member was providing peer support services, or a confidential communication made to a crisis hotline or crisis referral service.

5) Allows, notwithstanding 4) above, a confidential communication to be disclosed under the following circumstances:
   a) To refer an EMS personnel to receive crisis referral services by a peer support team member;

b) During a consultation between two peer support team members;
c) If the peer support team member reasonably believes that disclosure is necessary to prevent death, substantial bodily harm, or commission of a crime;
d) If the EMS personnel expressly agrees in writing that the confidential communication may be disclosed;
e) In a criminal proceeding; or,
f) If otherwise required by law.

6) Allows, notwithstanding 4) above, a crisis hotline or crisis referral service to disclose confidential information communicated by an EMS personnel to prevent reasonably certain death, substantial bodily harm, or commission of a crime.

7) Provides that this bill does not limit an obligation to report instances of child abuse.

8) Prohibits, except as otherwise provided in 9) below, a peer support team member who provides peer support services and has completed a training course described in 11) below, and the EMS provider that employs them, from being liable for damages, including personal injury, wrongful death, property damage, or other loss related to an act, error, or omission in performing peer support services, unless the act, error, or omission constitutes gross negligence or intentional misconduct.

9) Provides that 8) above does not apply to an action for medical malpractice.

10) Prohibits a peer support team member from providing peer support services in any of the following circumstances:
a) If, when serving in a peer support role, the peer support team member's relationship with an EMS personnel receiving peer support services could be reasonably expected to impair objectivity, competence, or effectiveness in providing peer support, or would otherwise risk exploitation or harm to the EMS personnel;
b) If the peer support team member and the EMS personnel receiving peer support services were involved as participants or witnesses to the same specific incident; or,
c) If the peer support team member and the EMS personnel receiving peer support services are both involved in a shared active or ongoing investigation.

11) Requires, to be eligible for the confidentiality protections afforded by this bill, a peer support team member to complete a training course or courses on peer support approved by the local EMS agency that may include the following topics:
a) Precrisis education;
b) Critical incident stress defusings;
c) Critical incident stress debriefing;
d) On-scene support services;
e) One-on-one support services;
f) Consultation;
g) Referral services;
h) Confidentiality obligations;
i) The impact of toxic stress on health and well-being;
j) Grief support;
k) Substance abuse awareness and approaches;
l) Active listening skills;

m) Stress management; and,
n) Psychological first aid.

12) Grants an EMS provider the ability to deny or rescind an EMS personnel's participation as a peer support team member consistent with EMS provider policy.

13) Defines the following for purposes of this bill:

a) "Confidential communication" to means any information, including written or oral communication, transmitted between an EMS personnel, a peer support team member, or a crisis hotline or crisis referral service staff member while the peer support team member provides peer support services or the crisis hotline or crisis referral service staff member provides crisis services, and in confidence by a means that, as far as the EMS personnel is aware, does not disclose the information to third parties other than those who are present to further the interests of the EMS personnel in the delivery of peer support services or those to whom disclosures are reasonably necessary for the transmission of the information or an accomplishment of the purposes for which the peer support team member is providing services. "Confidential communication" does not include a communication in which the EMS personnel discloses the commission of a crime or a communication in which the EMS personnel's intent to defraud or deceive an investigation into a critical incident is revealed;
b) "Crisis referral services" to include all public or private organizations that provide consultation and treatment resources for personal problems, including mental health issues, chemical dependency, domestic violence, gambling, financial problems, and other personal crises. Specifies that neither crisis referral services nor crisis hotlines include services provided by an employee association, labor relations representative, or labor relations organization, or any entity owned or operated by an employee association, labor relations representative, or labor relations organization;
c) "Critical incident" to mean an event or situation that involves crisis, disaster, trauma, or emergency;
d) "Critical incident stress" to mean the acute or cumulative psychological stress or trauma that EMS personnel may experience in providing emergency services in response to a critical incident. Specifies that the stress or trauma is an unusually strong emotional, cognitive, behavioral, or physical reaction that may interfere with normal functioning and could lead to post-traumatic stress injuries, including one or more of the following:
    i) Physical and emotional illness;
    ii) Failure of usual coping mechanisms;
    iii) Loss of interest in the job or normal life activities;
    iv) Personality changes;
    v) Loss of ability to function; and,
    vi) Psychological disruption of personal life, including the person's relationship with a spouse, child, or friend.
e) "EMS" to mean emergency medical services;
f) "EMS personnel" to mean currently licensed California health care professionals, including physicians, physician assistants, registered nurses, nurse practitioners, nurse-midwives, clinical nurse specialists, nurse anesthetists, mobile intensive care nurses, and currently licensed or certified California paramedics and advanced emergency medical technicians, emergency medical technicians (EMTs), lifeguards, firefighters, peace officers, and emergency medical dispatchers;

g) "EMS provider" to mean a local or regional department or agency, or any political subdivision thereof, that employs EMS personnel, including providers that are private, contracted with a local or regional department or agency, or volunteer;
h) "Peer support program" to mean a program administered by an EMS provider to deliver peer support services to EMS personnel;
i) "Peer support services" to mean authorized peer support services provided by a peer support team member to EMS personnel and their immediate families affected by a critical incident or the cumulative effect of witnessing multiple critical incidents. Peer support services assist those affected by a critical incident in coping with critical incident stress and mitigating reactions to critical incident stress. Peer support services may include one or more of the following:
    i) Precrisis education;
    ii) Critical incident stress defusings;
    iii) Critical incident stress debriefings
    iv) On-scene support services;
    v) One-on-one support services;
    vi) Consultation;
    vii) Referral services;
    viii) Confidentiality obligations;
    ix) The impact of toxic stress on health and well-being;
    x) Grief support;
    xi) Substance abuse awareness and approaches; and,
    xii) Active listening skills.
j) "Peer support team" to mean a response team composed of EMS peer support team members; and,
k) "Peer support team member" to mean any EMS personnel who has completed a peer support training course or courses, as specified. Requires EMS provider selection criteria for peer support team members to be incorporated into EMS provider policies.

14) Makes findings and declarations that EMS personnel, alongside and including firefighters, frequently respond to traumatic incidents and dangerous circumstances, including fires, accidents, natural disasters, and violent incidents. These situations expose them to harmful substances, such as blood and vomit, as well as witnessing severe injuries, death, and grief. EMS personnel are regularly placed in harm's way, facing significant risks of bodily harm or physical assault while performing their duties.

EXISTING LAW:

1) Requires confidential communications between a patient and a psychotherapist to be considered privileged, which means the patient has a right to refuse to disclose, and prevent the psychotherapist from disclosing, those communications. Defines psychotherapist to include all licensed mental health professionals, persons training to be licensed mental health professionals, as well as certain other credentialed persons providing professional psychotherapy services. Specifies that there is no privilege in specified circumstances, including if the psychotherapist has reasonable cause to believe that the patient is in a mental or emotional condition as to be dangerous to himself of to the person or property of another and that disclosure is necessary to prevent the danger. [Evidence Code §1010, *et seq*.]

2) Establishes the Office of Emergency Services (OES) within the office of the Governor, which is responsible, among other duties, for the coordination of disaster preparedness and response. [Government Code (GOV) §8585, *et seq*.]

3) Requires OES to establish a Curriculum Development Advisory Committee to advise OES on the development of course curricula, and requires this Committee to include representatives from public safety, health, first responder, and emergency services agencies. Requires OES to contract with the California Firefighter Joint Apprenticeship Committee to develop a fire service specific course of instruction on the responsibilities of first responders to terrorism incidents, and requires this course to include curriculum content recommended by the Curriculum Development Advisory Committee. [GOV § 8588.10]

4) Enacts the California Firefighter Peer Support and Crisis Referral Services Act authorizing the state or any local or regional public fire agency to establish a Peer Support and Crisis Referral Program. [GOV §8669.05 *et seq.*]

5) Enacts the Law Enforcement Peer Support and Crisis Referral Services Program authorizing a local or regional law enforcement agency to establish a Peer Support and Crisis Referral Program. [GOV §8669.1 *et seq.*]

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 address the mental health and well-being of EMTs and other ambulance employees by introducing a peer-to-peer support program. This bill recognizes the unique challenges faced by these frontline responders and seeks to establish a network of peer representatives to provide assistance on emotional and professional issues.

2) BACKGROUND. More than 80% of first responders experience traumatic events on the job, and because they face challenging and dangerous situations, first responders are at a high risk of developing post-traumatic stress disorder (PTSD) as a work-related injury or condition. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), roughly one in three first responders develop PTSD. In comparison, the incidence of PTSD in the general population is one in five people.

According the United States Department of Labor Occupational Safety and Health Administration (OSHA), workers responding to emergency events or disasters will see and experience events that will strain their ability to function. These events, which include having to witness or experience tragedy, death, serious injuries, and threatening situations, are called "Critical Incidents." The physical and psychological well-being of those experiencing this stress, as well as their future ability to function through a prolonged response will depend upon how they manage this stress. However, OSHA has no standards that apply to the hazards associated with critical incident stress.

a) Peer Support. According to a 2012 study published by the International Society for Traumatic Stress Studies, “Guidelines for Peer Support in High-Risk Organizations,” peer support programs have emerged as standard practice for supporting staff in many high-risk organizations, those that routinely expose their personnel to potentially

traumatic events, such as emergency services and the military. Peer support programs are often provided as a way of meeting the legal duty to care for employees, as well as resolving barriers to care, including stigma, lack of time, poor access to providers, lack of trust, and fear of job repercussions.

b) Critical incident stress debriefing. Following trauma exposure, an individual can experience multiple emotional, mental, and physical symptoms that impact their well-being. According to the American Journal of Managed Care, critical incident stress debriefing (CISD) is a practice that allows survivors to process and reflect on the traumatic events they've experienced and gain personal control over the incident. Stress debriefing often occurs shortly after the traumatic event to increase effectiveness. It's recommended that CISD occurs within the first 24 to 72 hours to provide the most effective support to the trauma survivor. Prompt treatment is also crucial since symptoms and reactions may take time to develop.

The provisions of this bill are based upon two recently enacted bills authorizing Peer Support and crisis Referral Programs for firefighters and law enforcement.

c) Stigma of seeking mental health treatment in First Responders. According to a 2012 study, "Treating posttraumatic stress disorder in first responders: A systematic review," published in *Clinical Psychology Review*, barriers exist that often prevent first responders from seeking mental health treatment. One such barrier is social stigma related to treatment-seeking, which is driven by a high value placed on mental toughness. To reduce social stigma barriers peer-directed interventions exist that target the social environment to encourage treatment-seeking behavior. Evidence suggests that peer-focused interventions may be preferred to other forms of interventions in high-risk occupations for several reasons. First, work peers can better understand the features of the job, which promotes the expression of genuine empathy for the intervening peer. The fact that the supporter "really gets the job" and "has walked in their shoes" can also promote buy-in for the first responder with mental health concerns. Second, first responders tend to prefer informal post-incident intervention methods and peers may achieve a relatable, informal tone over other sources. Finally, first responders tend to trust their peers more than mental health professionals. In the context of mental health, peers are not providing therapy, but rather they provide support, normalize the use of services, and encourage and assist the first responder in accessing a higher level of care, such as an employee assistance program.

3) SUPPORT. American Medical Response (AMR) support this bill and states that it would authorize an EMS provider to establish a peer support and crisis referral program to provide a network of peer representatives available to aid fellow employees on emotional or professional issues. AMR notes that the goal of this measure is to enhance the overall well-being and resilience of emergency medical technicians and ambulance employees by fostering a supportive network within their professional community.

The Tuolumne County Board of Supervisors supports this bill and states that EMS personnel pay a vital role in our communities, often facing challenging and traumatic situations as they provide life-saving care to those in need. The nature of their work exposes them to high levels of stress and emotional strain, which can have serious implications for their mental health and wellbeing. EMS clinicians suffer from suicide rates approximately 50% higher

than those of the average populations. It is essential that we prioritize the mental health support of our EMS workforce and provide them with the resources they need to cope with the demands of their profession

4) **OPPOSE UNLESS AMENDED.** The American Federation of State, County and Municipal Employees (AFSCME) is opposed to this bill unless it is amended. AFSCME notes that a peer support program can certainly bring innumerable benefits to a public safety agency, but it isn't without its challenges. When developing and structuring peer support programs, there are many things to consider to ensure the success of and engagement with the program. If peer support isn't properly developed, established and implemented, personnel won't utilize it, keeping the program from serving its purpose. AFSCME states that they are concerned that the bill fails to include worker input on developing a peer support program within their workplace, and proposes the following amendments to add language specifying that, "A peer support program shall be implemented through a labor-management agreement negotiated separately and apart from any collective bargaining agreement covering affected emergency medical personnel. The labor-management agreement may cover topics, including any of the following:
   a) Program structure and administration;
   b) Selection and training of peer support team members;
   c) Peer support operations;
   d) Program evaluation, monitoring, and continuous improvement;
   e) Funding; and,
   f) Dispute resolution and program amendments."

   AFSCME is also concerned with language in the bill that allows an EMS provider to deny or rescind an EMS personnel's participation as a peer support team member without guardrails to ensure that the employer is not retaliating against an employee for participation.

5) **PREVIOUS LEGISLATION.**

   a) AB 1116 (Grayson), Chapter 388, Statutes of 2019, enacts the California Firefighter Peer Support and Crisis Referral Services Act authorizing the state or any local or regional public fire agency to establish a Peer Support and Crisis Referral Program.

   b) AB 1117 (Grayson), Chapter 621, Statutes of 2019, enacts the Law Enforcement Peer Support and Crisis Referral Services Program authorizing a local or regional law enforcement agency to establish a peer support and crisis referral program.

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

7) **COMMITTEE AMENDMENTS.** In order to ensure that EMS provider employees engage with the peer support programs proposed by this bill, the Committee may wish to amend the bill to require employers to consult with employees, and their employee representatives, if any, when developing a peer support program, and, to develop clear policies on why a person is denied or rescinded from peer to peer participation. Finally, the Committee may wish to amend this bill to ensure that it does not conflict with the requirements of existing peer programs for firefighters.

REGISTERED SUPPORT / OPPOSITION:

Support

Emergency Medical Services Administrators' Association of California (EMSAAC)
EMS Medical Directors' Association of California (EMDAC)
Global Medical Response
Sonora Police Officers' Association
Tuolumne County Board of Supervisors

Opposition

None on file

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

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2866 (Pellerin) – As Introduced February 15, 2024

SUBJECT: Pool safety: State Department of Social Services regulated facilities.

SUMMARY: Requires child daycare facilities regulated by the California Department of Social Services (DSS) be subject to the Swimming Pool Safety Act. Specifically, **this bill**:

1) Requires a child daycare facility licensed by DSS, as either a daycare center or a family daycare home with a swimming pool on the premises, to comply with all of the following requirements:
   a) Requires the swimming pool be equipped with at least two safety features, which includes one feature in both of the following categories:
      i) Either an enclosure or mesh fence, as defined; and,
      ii) Either a cover or an alarm, as defined.
   b) Perform a daily inspection of all of the drowning prevention safety features before opening the facility and maintain a log of the inspections to be provided to DSS during scheduled inspections.

2) Requires DSS to update its regulations relating to the implementation of this bill.

3) Repeals the exemption that any facility regulated by DSS, even if the facility is also used as the private residence of the operator, is not subject to the Swimming Pool Safety Act.

4) Consistent with 1) and 2) above, requires, when a building permit is issued for the construction of a new swimming pool or spa or the remodeling of an existing pool or spa at a private single-family home, the respective swimming pool or spa be equipped with at least two of the seven drowning prevention safety features, as specified.

EXISTING LAW:

1) Establishes the California Child Day Care Facilities Act, creating a separate licensing category for child daycare centers and family daycare homes within DSS' existing licensing structure. [Health and Safety Code (HSC) § 1596.70 *et seq.*]

2) Defines the following terms:
   a) "Child daycare facility" to mean a facility that provides nonmedical care to children under 18 years of age in need of personal services, supervision, or assistance for sustaining the activities of daily living or for the protection of the individual on less than a 24-hour basis. Child daycare facilities include daycare centers, employer-sponsored childcare centers, and family daycare homes. [HSC § 1596.750]
   b) "Daycare center" to include infant centers, preschools, extended daycare facilities, and school-age childcare centers. [HSC § 1596.76]
   c) "Family daycare home" to mean a facility that regularly provides care, protection, and supervision for 14 or fewer children, including children under 10 years of age who reside at the home, in the provider's own home, for periods of less than 24 hours per day, while the parents or guardians are away. [HSC § 1596.78]

3) Requires any person or entity operating, as specified, a child daycare facility in California to have a current valid license from DSS. [22 California Code of Regulations (CCR) § 101156(a)]

4) Directs DSS and any local agency with which it contracts for purposes of licensing activities, to conduct an initial site visit and grant or deny an application for license within 30 days of receiving a complete licensing application for a daycare center. [HSC § 1597.13]

5) Establishes the "Swimming Pool Safety Act," encompassing regulations and requirements aimed at enhancing safety in and around swimming pools. [HSC § 115920 *et seq.*]

6) Defines the following terms:
   a) "Swimming pool" or "pool" to mean any structure intended for swimming or recreational bathing that contains water over 18 inches deep, which includes in-ground and aboveground structures and includes, but is not limited to, hot tubs, spas, portable spas, and nonportable wading pools. [HSC § 115921(a)]
   b) "Enclosure" to mean a fence, wall, or other barrier that isolates a swimming pool from access to the home. [HSC § 115921(c)]
   c) "Approved safety pool cover" to mean a manually or power-operated safety pool cover that meets all of the performance standards of the American Society for Testing and Materials, in compliance with standard F1346-91. [HSC § 115921(d)]
   d) "Exit alarms" to mean devices that make audible, continuous alarm sounds when any door or window, that permits access from the residence to the pool area that is without any intervening enclosure, is opened or is left ajar. Exit alarms may be battery-operated or may be connected to the electrical wiring of the building. [HSC § 115921(e)]

7) Requires an enclosure to have all of the following characteristics:
   a) Any access gates through the enclosure open away from the swimming pool, and are self-closing with a self-latching device placed no lower than 60 inches above the ground;
   b) A minimum height of 60 inches;
   c) A maximum height clearance from the ground to the bottom of the enclosure of two inches;
   d) Gaps or voids, if any, that do not allow passage of a sphere equal to or greater than four inches in diameter; and,
   e) An outside surface free of protrusions, cavities, or other physical characteristics that would serve as handholds or footholds that could enable a child below the age of five to climb over. [HSC § 115923]

8) Requires, whenever a building permit is issued for the construction of a new swimming pool or spa or the remodeling of an existing swimming pool or spa at a private single-family home, the respective pool or spa be equipped with specified safety features. [HSC § 115922(a)]

9) Requires local building code officials to inspect drowning-prevention features installed to comply with requirements and to give final approval for the completion of construction or remodeling if no violations are found. [HSC § 115922(b)]

10) Requires all licensees to ensure the inaccessibility of pools, including swimming pools (in-ground and above-ground), fixed-in-place wading pools, hot tubs, spas, fish ponds, or similar

bodies of water, through a pool cover by surrounding the pool with a fence. Provides further guidance on fencing requirements. [22 CCR §§ 101238(e); 102417(5)]

11) Exempts from fencing requirements inflatable or other portable plastic wading pools with sides low enough for children using the pool(s) to step out unassisted. Requires these pools to be emptied after each use. [22 CCR § 101238.5(a)]

12) Requires DSS to issue a Notice of Operation in Violation of Law if it is found and documented that continued operation of the family childcare home will be dangerous to the health and safety of the children. Specifies situations endangering the health and safety of the children to include, but are not limited to, unfenced or accessible pools or other bodies of water. [22 CCR § 102357(3)(E)]

13) Requires daycare center directors and licensees of a family daycare home to ensure that at least one staff member who has a current course completion card in pediatric first aid and pediatric cardiopulmonary resuscitation (CPR) issued by the American Red Cross, the American Heart Association, or by a training program that has been approved by the Emergency Medical Services Authority be on site at all times when children are present at the facility, and be present with the children when children are offsite from the facility for facility activities. [HSC § 1596.866(b)]

14) Establishes the federal "Virginia Graeme Baker Pool and Spa Safety Act" (VGB Act) to prevent drain entrapment and child drowning in swimming pools and spas by requiring each public pool and spa in the United States to be equipped with specified anti-entrapment devices or systems, and requires each state to meet specified minimum state law requirements regarding pool and spa safety standards. [15 United States Code § 8001 *et seq*]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, on Monday October 2, 2023, one-year-old Payton Cobb and 18-month-old Lillian Hanan lost their lives in a horrific event. These children were at a licensed home daycare located in San Jose when three toddlers accessed the swimming pool located on the premises unsupervised. After being transported to the hospital in critical condition, two of the children were pronounced dead. The author states that this bill will create a multi-faceted safety requirement to update the existing standards to allow for better drowning prevention standards. This bill requires an updated safety requirement for an enclosure or fence that meets current standards as well as either a pool cover or alarm system. This would create a two-step system in the event of a failure a secondary safety precaution that will prevent a drowning. The author concludes that this bill will create a requirement for a daily assessment log to document that pools at facilities are being secured and properly monitored by the two step system in accordance with the law before the center opens each day.

2) **BACKGROUND.**

   a) **Licensed Childcare**. The California Child Day Care Facilities Act governs the licensure, maintenance, and operation of child daycare centers and family daycare homes in the state. This law and the associated regulations found in Title 22 of the CCR establish,

among other things, general health and safety requirements, staff-to-child ratios, and provider training requirements. Daycare centers include infant centers, preschools, extended daycare facilities, and school-age childcare centers. DSS' Community Care Licensing Division (CCLD) has the responsibility of licensing and monitoring the state's 10,481 childcare centers and 25,205 family childcare homes, according to 2021 data. As of January 2024, 158,959 children were served in licensed family childcare homes, 124,708 in childcare centers, and 82,704 in license-exempt settings in fiscal year 2022-23.

b) **Drowning Fatalities and Near-Drowning Injuries.** Swimming pools provide recreational opportunities but also pose significant risks, especially to children. According to the Centers for Disease Control and Prevention (CDC), drowning is identified as the primary cause of death for children between the ages of one and four in the United States (U.S.), surpassing all other causes. Among children aged five to 14, drowning ranks as the second leading cause of unintentional injury-related deaths after motor vehicle crashes in the U.S. Additionally, the CDC highlights that for every child under the age of 18 who succumbs to drowning, another seven require emergency medical attention for nonfatal drowning incidents, often resulting in hospitalization. In California, the Department of Developmental Services (DDS) also identifies drowning as the leading cause of injury-related death among children under the age of five. According to data from the California Department of Public Health's EpiCenter, from 2010 to 2014, over 160 children aged one to four experienced fatal drownings, predominantly occurring in residential pools. Additionally, between 2010 and 2015, more than 740 children aged one to four were hospitalized following near-drowning incidents, with the primary reason for hospitalization being brain injury caused by oxygen deprivation, also referred to as asphyxiation. Drowning injuries can cause serious health outcomes, including brain damage, paralysis, seizures, memory loss, and long-term disability. DDS reported that as of December 2016 the agency was providing care for more than 755 near-drowning victims with severe brain damage resulting from the near-drowning. Several factors contribute to a greater risk of drowning among children, including a lack of swimming ability, inadequate or absent pool fencing, insufficient supervision, and failure to utilize life jackets.

c) **Pool Safety Regulations.** Regulations aim to mitigate these risks by establishing standards for pool safety features and practices. At the federal level, organizations such as the Consumer Product Commission (CPSC) play a central role in establishing and enforcing standards for swimming pools and related equipment. The CPSC's guidelines cover a wide range of safety measures, including pool fencing, drain covers, alarm systems, and safety barriers. At the state level, swimming pool safety is often regulated through legislation and building codes that mandate specific safety features and practices for both public and private swimming pools. For example, whenever a building permit is granted for the construction of a new swimming pool or spa, or for the renovation of an existing one in a private single-family residence, it is mandatory for the pool or spa to be equipped with designated safety features. At the local level, building code officials are required to conduct inspections on the installed drowning prevention features to ensure compliance with the stipulated requirements. Final approval for the completion of construction or renovation is only granted if no violations are detected during these inspections. While the International Building Code and the majority of U.S. states require only one barrier to restrict access to residential pools, the California Swimming Pool

Safety Act, signed into law in 1995, requires the installation of a two-stage safety system in residential pools, which requires the pool to be equipped with either an enclosure or mesh fence, along with either a cover or a safety alarm, as defined in existing law. The second safety feature provides additional assurance for families who may overlook replacing an alarm or a removable fence, or who cannot promptly address a malfunctioning latch or alarm. Apart from physical safety features, regulations specify that daycare center directors and licensees of family daycare homes are required to have at least one staff member be certified in pediatric first aid and CPR, and remain on-site at all times.

d) Pool Safety in Childcare Facilities. Childcare facilities serve as environments where children spend a significant amount of time under the care of providers. Ensuring safety within these facilities is paramount to protecting the well-being of the children in their care. Childcare facilities are responsible for implementing measures to prevent accidents and injuries, including those related to swimming pool safety. Children in daycare settings may be more vulnerable to accidents or drowning incidents due to factors such as limited supervision among caregivers. Historically, regulations governing swimming pool safety in daycare facilities have been less stringent compared to other types of public or private pools. For instance, despite the implementation of the two-stage safety system in the Swimming Pool Safety Act, an exemption was granted for facilities regulated by DSS, including daycare facilities, group homes, and senior facilities. According to DSS regulations, only a fence is required to prevent accidental drowning. While existing regulations have contributed to improvements in swimming pool safety over the years, this bill aims to address gaps in regulations and enhance safety standards for swimming pools not only in childcare facilities but across all DSS-regulated facilities by updating existing standards to align with the Swimming Pool Safety Act. Specifically, this bill establishes a dual-step system whereby, in the event of a failure of one safety measure, a secondary safety measure can prevent drowning. Furthermore, this bill requires a daily assessment log to record the adherence of facilities to the two-step system, ensuring that the pool is adequately secured and monitored.

e) Recent California Drowning Fatality Incidence. As described in the purpose of this bill above, in 2023, two infants fell into the San Jose Happy Happy Daycare's pool and fatally drowned. A third child, who was two years of age, was hospitalized and survived. According to DSS' CCLD, program analysts conducted a pre-licensing inspection of the home in 2020. During this inspection, they instructed the daycare to implement modifications to the pool area and guarantee its security by installing a fence, per regulations. Subsequently, after an inspection in 2021, the facility was granted a license. According to police reports, one day before the drowning, the homeowner's husband watered plants behind the pool gate and failed to close the gate after watering the plants. The gate was not checked on by either of the co-owners of Happy Happy Daycare. After the children arrived at the daycare, one of the co-owners opened a door to the backyard and told the children to go outside. After leaving the children unsupervised for just a few minutes, the co-owner stepped back outside and found an infant floating in the shallow end, prompting her to remove him and attempt CPR. Two more infants were found in the deep end of the pool, and CPR was also attempted.

This bill seeks to prevent incidents such as these preventable accidental drownings among children in daycare facilities by implementing a two-step safety measure in the event that one of the safety measures fails.

3) **SUPPORT.** According to the American Academy of Pediatrics, California (AAP-CA), AB 2866 addresses crucial pool safety measures within facilities regulated by DSS. AAP-CA states that ensuring that child day care facilities implement comprehensive pool safety measures is essential in preventing tragic accidents and safeguarding the lives of our youth. AAP-CA concludes that by requiring the installation of safety barriers and implementing regular inspections, this bill seeks to mitigate the risk of drowning incidents and promote a safe environment for children to thrive.

4) **RELATED LEGISLATION.** AB 2384 (Wilson) requires a public swimming pool constructed on or after January 1, 2025, to comply with the standards and requirements of the federal VGB Act. Requires a person or entity that owns or maintains a public swimming pool, as defined, to ensure that there is an operating telephone on or adjacent to the pool deck, available and conspicuously labeled for emergency use, at all times. AB 2384 is pending a hearing in the Assembly Committee on Health.

5) **PREVIOUS LEGISLATION.**

   a) SB 442 (Newman), Chapter 670, Statutes of 2017, requires newly constructed or remodeled swimming pools at private single-family residences to incorporate at least two of seven specified drowning-prevention safety features. SB 442 also requires home inspections conducted as part of the transfer of a property with a pool to include an assessment of whether the pool is equipped with adequate safety features.

   b) AB 2977 (Mullin), Chapter 478, Statutes of 2006, requires new and remodeled pools and spas to provide at least one safety feature from a list of eligible features, add mesh fences and swimming pool alarms to the list of enumerated drowning prevention safety features, and requires remodeled pools and spas to cover drains with an anti-entrapment grate.

   c) AB 389 (Arambula) of 2006, would have authorized the Department of Health Services (DHS) to produce and place on its website a document explaining the child drowning hazards of home swimming pools and spas, safety measures and drowning hazard prevention measures if such a document has not been donated to DHS, or if DHS has not approved a donated document. AB 389 was held in the Senate Rules Committee.

   d) AB 24 (Negrete McLeod), Chapter 433, Statutes of 2003, allowed for the creation and distribution of a brochure containing information regarding swimming pool and spa safety.

   e) AB 3305 (Setencich), Chapter 925, Statutes of 1996**,** established the Swimming Pool Safety Act.

6) **DOUBLE REFERRAL**. This bill is double referred, it passed the Assembly Committee on Human Services with a 7-0 vote on April 2, 2024.

REGISTERED SUPPORT / OPPOSITION:

Support

American Academy of Pediatrics, California
Association of Regional Center Agencies

Opposition

None on file.

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

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2956 (Boerner) – As Amended March 13, 2024

SUBJECT: Medi-Cal eligibility: redetermination.

SUMMARY: Extends numerous temporary federally allowable processes (federal flexibilities) related to the redetermination of Medi-Cal eligibility and establishes 12-month continuous Medi-Cal eligibility for adults. Federal flexibilities were put into place as part of a resumption of eligibility redeterminations, following a pause in redeterminations during the COVID-19 Public Health Emergency (the resumption of redeterminations and related processes are referred to as the "PHE unwinding"). Specifically, **this bill**:

1) Establishes continuous eligibility to individuals over 19 years old, which means they remain eligible for 12 months from the date of determination of eligibility. For existing beneficiaries, this means for a 12 month period starting at renewal, and for new beneficiaries, for a 12 month period starting with the first month of eligibility.

2) Requires a county to attempt communication through additional available channels prior to completing redetermination or terminating eligibility.

3) Requires a county to complete eligibility determination at renewal without requiring additional information or documentation, if either:

    a) All of the following are true:
        i) An individual's most recent income documentation was based on previously verified attestation of income at or below 100% of the federal poverty level (FPL) during initial application or at their most recent renewal within the last 12 months;
        ii) The county has checked financial data sources and no info was received, but all other eligibility criteria has been verified; and,
        iii) There is no contradictory information on file;
        or,
    b) All of the following are true:
        i) The most recent income determination, at either initial application or most recent renewal within the last 12 months;
        ii) The beneficiary receives Social Security benefits or other sources of stable income at the most recent determination; and,
        iii) There is no contradictory information on file.

4) Deletes from existing law a requirement that a beneficiary must sign a renewal form if delivered in person or via mail.

5) Requires a county to attempt to contact a beneficiary twice if a beneficiary has not responded to a request for additional information or has provided an incomplete response.

6) Requires, if a beneficiary has not responded, a county to again review all information in an attempt to renew eligibility without needing a response from a beneficiary.

7) Prohibits a county from terminating eligibility until it has processed all submitted renewal information.

8) Requires, when income is found not reasonably compatible from electronically available sources, a county to first attempt to obtain a reasonable explanation verbally or in writing, in an attempt to resolve discrepancies in financial information. Requires counties, if that information is unavailable, to obtain any other information needed to complete the financial eligibility determination.

9) Requires a county, if a redetermination is conducted based on a loss of contact with a beneficiary, to attempt communication through all additionally available channels prior to completing a redetermination. Requires, if the beneficiary does not supply the necessary information within a 30-day period, a 10-day notice of termination of Medi-Cal eligibility to be sent.

10) Requires a county to attempt to contact a beneficiary twice by telephone or other means to request necessary information.

11) In the case of a redetermination, for purposes of income verification, when a renewal is received without a reasonable explanation or other income verification, requires a county to accept self-attested information. Allows beneficiaries to provide income verification through a verbal or written explanation.

12) Modifies the process by which a beneficiary is entitled to receive retroactive eligibility based on the provision of information needed to complete an individual's determination of eligibility, within 90 days of a termination date or change in eligibility status. Changes this process from one based on a beneficiary request, to an opt-out process whereby retroactive eligibility is granted unless the beneficiary opts out.

13) Requires a county, in the case of a Medi-Cal beneficiary who is a member of a "vulnerable or difficult to reach population," a county to begin a new, 12-month eligibility period each time the beneficiary makes contact with the county, if specified conditions are met. Defines vulnerable or difficult to reach populations as including but not limited to:

    a) Medi-Cal beneficiaries who are unsheltered or without a fixed address;
    b) Aged, blind, or disabled individuals;
    c) Victims of a natural disaster;
    d) Medi-Cal beneficiaries who live in a remote area;
    e) Incarcerated Medi-Cal beneficiaries;
    f) Migrant workers;
    g) Individuals in foster care;
    h) Unaccompanied immigrant minors; and,
    i) Any other population that the county determines is appropriate for designation as a vulnerable or difficult-to-reach population.

14) Requires the Department of Health Care Services (DHCS) to set a goal, in the form of a target rate of at least 50%, for successful ex parte renewals for populations.

15) Requires DHCS to prepare a public report on causes of missing the target described in 14) above, if applicable, and action steps to increase ex parte renewal rates.

16) Requires counties to collect and submit to DHCS specified data metrics related to their call center operations.

17) Requires, in a county's attempt to contact a beneficiary, a second attempt to be made through a different modality when the beneficiary's file includes a phone number or email address.

18) Requires DHCS to seek any necessary federal approvals to make permanent all temporary eligibility rules not included in this bill that were originally implemented for Medi-Cal renewals that were due between June 2023 and May 2024, inclusive, as part of the COVID-19 unwinding period.

19) Makes various conforming changes and conditions implementation on federal approval and the availability of federal financial participation.

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) Makes Medi-Cal eligibility and enrollment functions a county function and responsibility, subject to the direction, authority, and regulations of DHCS. [WIC § 14001.11]

3) Establishes a processes for the determination and redetermination of an individual's eligibility for Medi-Cal, as specified in 4) through 14), below. [WIC § 14005, *et seq.*]

4) Requires a county to perform redeterminations of eligibility for beneficiaries every 12 months and promptly redetermine eligibility whenever the county receives information about changes in a beneficiary's circumstance that may affect eligibility. [WIC § 14005.37]

5) Requires a loss of contact, as evidenced by the return of mail marked in such a way as to indicate it could not be delivered or that there was no forwarding address, to prompt a redetermination of eligibility. [*Ibid*.]

6) Requires eligibility to continue during the redetermination process and prohibits eligibility from being terminated until the county makes a specific determination based on facts clearly demonstrating the beneficiary is no longer eligible, and due process rights have been met. [*Ibid*.]

7) Requires, for purposes of acquiring information necessary to conduct eligibility redeterminations, a county to gather information available to the county that is relevant to the beneficiary's eligibility, prior to contacting the beneficiary. Specifies state and federal data sources for this information. [*Ibid*.]

8) Requires, if a county is able to make an eligibility determination based on accessible data, the county to notify the beneficiary of the determination and the information on which it is

based, and requires the county to notify the beneficiary that they must inform the county if any of the information is inaccurate, but that the beneficiary is not required to sign and return the notice if all information is accurate. [*Ibid*.]

9) Requires a beneficiary to sign a renewal form if the beneficiary chooses to return the form in person or via mail. [*Ibid*.]

10) Requires, in the case of a redetermination due to a change in circumstances, if a county cannot obtain sufficient information to redetermine eligibility, a county to send the beneficiary a form that states the information needed to redetermine eligibility, and limits the additional data a county can request from the beneficiary. [*Ibid*.]

11) Requires a county to terminate eligibility if the purpose for a redetermination is loss of contact with the beneficiary, and the renewal form is also returned as undeliverable. [*Ibid*.]

12) Requires, during the 30-day period after the date of mailing a form to the beneficiary requesting additional information for redetermination of eligibility, the county to attempt to contact the beneficiary to request necessary information. Requires, if the beneficiary does not supply the necessary information to the county within the 30-day limit, a 10-day notice of termination of eligibility to be sent. [*Ibid*.]

13) Specifies procedures whereby an individual can request to receive retroactive eligibility for the three months preceding an eligibility determination. [*Ibid*.]

14) Requires a beneficiary to report any change in circumstance that may affect their eligibility within 10 calendar days following the date the change occurred. [*Ibid*.]

15) As of January 1, 2025, contingent on funding, systems changes, and federal approval, makes a child continuously eligible for Medi-Cal up to five years of age and prohibits a redetermination of Medi-Cal eligibility before a child reaches five years of age, except in specified circumstances. [WIC § 14005.255]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, over a million individuals lost their Medi-Cal coverage in the first six months of the PHE unwinding period. Without the protections of temporary unwinding flexibilities, the overwhelming majority (92%) of Medi-Cal disenrollments have been for procedural or ‘paperwork’ reasons, meaning they are disenrolled by no fault of their own, even when they are likely still eligible for Medi-Cal. Of these, children and youth account for roughly one-third of all disenrollments in California. Furthermore, the data shows that people who speak Spanish as their primary language, seniors 65 and over and those with disabilities are disproportionately impacted by this issue. The author notes procedural disenrollments in Medi-Cal result in eligible people cycling on and off the program. This gap in healthcare coverage can lead to postponing visits to the doctor or not refilling a prescription. Not only does the disenrollment and re-enrollment process present yet another administrative hurdle for low-income Californians, the author argues, but it also stresses overburdened and understaffed county social services agencies.

The author states DHCS's actions to adopt numerous federal flexibilities have removed unnecessary barriers and burdens in the enrollment and renewal process, allowing millions of Californians to keep access to lifesaving health care. However, the federal flexibilities are scheduled to sunset in December 2024. If we let these policies expire, the author warns, it will be much more difficult to bring them back and result in more procedural terminations.

The author notes children already enjoy continuous eligibility for a full 12 months, regardless of changes in family income, and this bill would extend this continuous eligibility for adults. The author concludes this bill reduces and remedies procedural terminations, simplifies the income verification requirements, increases automatic Medi-Cal renewals, and improves program outreach and customer service. The author notes these changes would reduce barriers to access associated with Medi-Cal renewals and protect the most vulnerable communities in California from losing healthcare coverage.

2) **BACKGROUND.** Federal requirements to "pause" redeterminations of Medi-Cal eligibility through the COVID-19 PHE caused Medi-Cal enrollment to swell to a peak of 16 million people. As states resume redeterminations, the federal government has encouraged states to implement a number of strategies to simplify and reduce procedural disenrollments, or disenrollments due to lack of paperwork verification rather than a proactive determination of ineligibility. This resumption of redetermination processes is colloquially called the "PHE Unwinding." This bill extends a number of the strategies, or "federal flexibilities," the state implemented on a temporary basis during the PHE Unwinding with respect to redetermination of eligibility. It also implements additional requirements that aim to retain more individuals on the program and create user-friendly eligibility processes.

   a) **Basic Medi-Cal Eligibility Redetermination Requirements and Processes.** As with most components of Medicaid, the federal government has rules establishing minimum requirements for eligibility groups that must be covered and eligibility rules that must be followed, and states have a variety of options in how they design their programs, as long as they seek federal approval for program changes.

      Individuals who have been found eligible and are enrolled in Medi-Cal must have their eligibility redetermined every 12 months in order to retain coverage for the next year. If, during the 12-month period, new information that affects eligibility becomes available to the county, either reported by the individual or accessed through other electronic data sources, a beneficiary or enrollee will automatically have their eligibility redetermined based on the new information. Beneficiaries must report to the county any change in their circumstances that may affect their Medi-Cal eligibility within ten calendar days of the change.

      To renew beneficiaries' Medicaid coverage, states must first attempt to confirm ongoing eligibility using data available to the agency without requiring information from the individual. This requirement, also known as ex parte renewals, can reduce the administrative burden for states and simplify the process for beneficiaries. An ex parte renewal is a redetermination of eligibility that states can make based on reliable information available to the agency without requiring information from the individual.

      The federal Patient Protection and Affordable Care Act (ACA) required states to implement data-sharing strategies to simplify eligibility and redetermination processes

for beneficiaries. Medicaid and Children's Health Insurance Program (CHIP) agencies now rely primarily on information available through data sources (e.g., the Social Security Administration, the Departments of Homeland Security and Labor) rather than paper documentation from families for purposes of verifying eligibility.

State law establishes specific process requirements and due process safeguards for redeterminations of eligibility. Generally, a beneficiary has 30 days to respond to a request for information, if additional information is needed to establish eligibility. If the beneficiary does not provide the necessary information to the county within the 30-day period, the county may send the beneficiary a ten-day Notice of Action of terminating their eligibility. If terminated, the beneficiary still has 90 days from termination to "cure" or provide the information requested. Beneficiaries also have the right to appeal an adverse determination.

b) COVID-19 PHE Redetermination Pause and Enrollment Growth. In 2020, federal legislation, the Families First Coronavirus Response Act, amended by the Coronavirus Aid, Relief, and Economic Security Act, authorized a 6.2 percentage point increase in federal Medicaid matching funds to help states respond to the COVID-19 pandemic. As a condition of receiving enhanced funds, states were required to provide continuous eligibility through the end of the month in which the public health emergency ends for those enrolled as of March 18, 2020 or at any time thereafter during the PHE period, unless the person ceased to be a state resident or requested a voluntary coverage termination. The state paused redetermination activities and, as a result, from July 2020 through July 2023, Medi-Cal enrollment increased by approximately 2.6 million people.

Subsequent federal legislation, the Consolidated Appropriations Act (CAA) of 2023, delinked the continuous coverage requirements from the PHE. Pursuant to the CAA, continuous coverage requirements ended on March 31, 2023 and the PHE Unwinding began as of April 1, 2023.

As a result, Medi-Cal redeterminations resumed in June 2023. The first Medi-Cal eligibility terminations occurred on July 1, 2023. Between June 2023 and May 2024, Medi-Cal members will have their eligibility redetermined based on their "renewal month," in order to maintain beneficiaries on coverage and spread redetermination workload throughout the year.

c) PHE Unwinding and Federal Flexibilities. Preparing for and implementing the PHE Unwinding has been a major effort for DHCS and counties. Many enrollment workers hired during the pandemic had never processed a redetermination, and counties have been struggling with staff shortages and burnout. A large number of beneficiaries changed addresses and contact information, and many had never had their Medi-Cal eligibility redetermined and are not familiar with required paperwork and processes. Despite the heavy lift for all involved, DHCS has indicated it prioritized maximizing continuity of coverage for Medi-Cal beneficiaries throughout the PHE Unwinding.

According to the federal Centers for Medicare and Medicaid Services (CMS) that oversees state Medicaid programs, many individuals enrolled in Medicaid and other programs lose coverage at renewal due to procedural or administrative reasons rather than eligibility-related factors, such as not submitting information needed to complete their

renewal in a timely fashion. To prevent inappropriate coverage loss among eligible individuals, CMS advises states to implement actionable strategies to strengthen their renewal processes and avoid such procedural disenrollments.

Through guidance to states, including through State Health Official letter 22-001 and subsequent guidance such as a December 18, 2023, Center for Medicaid & CHIP Services Informational Bulletin, CMS laid out a number of targeted enrollment strategies that can be used to facilitate renewals, leading to fewer discontinuances during the 12-month unwinding period. Specifically, CMS has identified and made available to states temporary waivers allowable under the Social Security Act. According to KFF, a nonprofit health news source that tracks state Medicaid trends, nearly all states adopted one or more of these temporary waivers.

According to "California's Journey with Medi-Cal Redeterminations," an issue brief published by the California Health and Human Services Agency (CHHSA issue brief), California implemented 17 flexibilities approved by CMS through waiver authority or under existing federal Medicaid law to streamline enrollment and keep individuals in coverage as the Medi-Cal redetermination process restarted. These flexibilities are extended by this bill, and include many income-based and administrative waivers and flexibilities that make the redetermination process easier for beneficiaries.

d) Recent State Experience; Improvements in Ex Parte Renewals. According to DHCS, recent nationwide data on Medicaid unwinding of the COVID-19 emergency continuous coverage provision show that a majority of disenrollments occurred due to procedural reasons (e.g., late submission of paperwork, failure to respond to a state's request for information, lost forms), rather than legitimate losses of eligibility (i.e., changes in income or circumstances that would make individuals ineligible for Medicaid).

California recently partnered with the United States Digital Services (USDS) to automate income-based waivers in the state's Medi-Cal eligibility and enrollment systems. According to the CHHSA issue brief, starting in August 2023, USDS provided engineering and system design support to the state policy team and state's system vendor teams to expedite implementation timelines. USDS identified opportunities to improve the steps in the ex parte renewal process that would have the greatest impact on the ex parte renewal rate. With the USDS's assistance, the state's ex parte rate significantly increased from an average of 34% from June to November to 66% in December 2023. With the increase in ex parte, California's overall Medi-Cal disenrollments dropped from around 20% to nine percent in December.

e) Churn and Continuous Eligibility. States conduct annual renewals of Medicaid eligibility, but enrollees are required to report changes in circumstances, such as changes in family income, during the year. This can lead to "churn," where individuals go through short periods of disenrollment and re-enrollment in coverage, leading to disruptions in coverage and lapses in continuity of care. According to DHCS, people who experience churn are more likely to delay or forego care, receive less preventive care, stop filling their prescriptions, and have more emergency department visits. Furthermore, DHCS notes, churn has health equity implications. DHCS notes one study found Black and Hispanic Medicaid members were more likely to be disenrolled and reenrolled within 12 months compared to their white counterparts.

Continuous eligibility guarantees 12 months of continuous coverage even if there are fluctuations in income. The CAA required all states to implement 12-month continuous eligibility for children beginning on January 1, 2024. California has had this in place for children up to age 19 since 2000. SB 184 (Committee on Budget and Fiscal Review), Chapter 47, Statutes of 2022, implemented continuous eligibility for children younger than age five, but made the bill contingent on appropriation and the availability of funds. Although the Governor's January 2024 Budget did not fund this item based on the poor General Fund condition, as of January 2024, DHCS is seeking federal approval to make this change when funding allows.

KFF notes five states have some level of continuous eligibility for adults and other states are pursuing this option to help to provide more stable coverage once the unwinding period ends. California has not pursued 12-month continuous eligibility for adults, which this bill would implement.

f) Effect of This Bill. This bill extends a number of temporary federal waivers as noted below.

i) Income under 100% FPL, zero income, or "stable income." The temporary flexibilities, effective June 1, 2023, through the end of the unwinding period, allow for automatic determination of income for households whose attestation of income under 100 % FPL was verified within the last 12 months (at application or renewal) when no income information is returned through data sources, which will allow more beneficiaries with low income to have the annual renewal completed through ex-parte and without the need to complete an annual renewal packet. This bill will extend such flexibility indefinitely. This bill also extends automatic determination of income to individuals who receive payments under the Social Security disability insurance program or "other stable sources of income" and have no other conflicting income information on file. Furthermore, this bill extends to individuals who were verified at 100% FPL or below at the time of their initial application, i.e., without requiring 100% or lower income to be verified within the last 12 months. According to the CHHSA brief, these changes have had the largest impact on improving the ex parte renewal rate.

ii) Additional contact attempts to households with incomplete renewals or loss of contact. DHCS implemented an additional contact requirement to help mitigate possible procedural terminations during the PHE Unwinding period. DHCS issued Medi-Cal Eligibility Division Information Letter (MEDIL-24-09) to advise counties this change is being made permanent, and this bill codifies this change. This bill also requires a second contact attempt to be made through a different modality, such as phone or email, if such information is available. It also requires counties to make additional attempts to contact beneficiaries if return mail indicates a loss of contact.

iii) Renew at any time for hard-to-reach populations. The temporary flexibility allows counties to renew people at any time, instead of having to wait for assigned renewal month. This helps maintain hard-to-reach populations on the program. This bill will require a county to begin a new 12-month eligibility period for hard-to-reach populations if specified conditions are met.

iv) **Allow counties to continue attempting to renew, after a renewal packet is sent.** The temporary flexibility allows counties, after a renewal packet is sent, to still use other information to process the renewal, without requiring return of the packet or additional information. This bill would make the change permanent.

v) **"Reasonable compatibility threshold" for income.** Counties use a standard to determine whether or not the income in federal data sources is compatible with the information an individual reports. The temporary flexibility allows counties to verify income on an ex parte basis when attested income is below the FPL, and income reported through electronic sources is no greater than 20% higher than the FPL limit. In the state's Modified Adjusted Gross Income (MAGI)-Based Eligibility Verification Plan, DHCS indicates it plans to reduce this threshold reduced to 10% in June 2024, assuming the 12-month resumption to normal operations has concluded at that time. This bill would maintain the 20% threshold permanently and implement it for all populations, including those who have income counted using the MAGI method as well as "non-MAGI" populations.

vi) **Reasonable explanations.** CMS allows states to permit an applicant or beneficiary to provide a reasonable explanation why their self-attested information did not align with electronic verification sources in order to complete the Medi-Cal eligibility determination. In the state's MAGI-Based Eligibility Verification Plan, DHCS notes effective July 1, 2022, California implemented the use of reasonable explanation as part of the verification process, which is conducted on a manual basis until July 2024, when systems will be automated to obtain a reasonable explanation at application, annual renewal or a change in circumstance. If certain reasonable explanations are selected, income will be verified automatically and eligibility will be determined "real time" without additional verification. This bill codifies these processes.

vii) **Self-attestation of income**. Per MEDIL I 23-49E, renewals received without a reasonable explanation or new income verification can use self-attested information under a federally approved waiver. Effective October 1, 2023, DHCS notes, the waiver will allow the acceptance of self-attestation of income for instances where the renewal packet is required, no income waivers are applicable, and utilization of the self-attested income will not lead to a negative action such as discontinuance. Counties must still follow normal business processes to verify all other required non-financial eligibility criteria. This bill continues the provisions of the Self-Attestation of Income Waiver.

viii) **Improvements to 90-day cure period**. The temporary flexibility makes submissions of information during 90-day cure period automatically restore Medi-Cal eligibility back to date of discontinuance, when person is found eligible based on the new information. This bill would extend the flexibility.

ix) **All other flexibilities**. The following federal unwinding waivers and flexibilities are included in a comprehensive list in the CHHSA issue brief. These additional flexibilities do not appear to be specifically addressed by this bill, but would be maintained by the bill's catch-all extension of all temporary flexibilities not specifically added by the bill. They include:

(1) Partnering with the National Change of Address Database and United States Postal Service In-State Forwarding Address to update member contact information;
(2) Partnering with Program of All-Incisive Care for the Elderly organizations to update member contact information;
(3) Extending the timeframe for members to request a State Fair Hearing from 90 to 120 days;
(4) Extending timeframe to take final administrative action on State Fair Hearing requests from 90 to 120 days;
(5) Suspending the requirement to apply for other benefits;
(6) Suspending the requirement to cooperate with child support agencies in establishing the identity of a child's parents and in obtaining medical support; and,
(7) Using Medi-Cal managed care plans and all available outreach modalities (phone call, email, text) to contact members when renewal forms are mailed and when they should have received them by mail. (This bill requires outreach by multiple modalities but does not specifically reference the role of managed care plans.)

This bill also imposes requirements that are not directly related to and go beyond the PHE-era flexibilities, but are also meant to improve customer service for eligibility functions and make it easier to stay on Medi-Cal. These include:

i) **Continuous eligibility**. This bill would implement 12-month continuous eligibility for adults regardless of changes in circumstances. Although this wasn't specifically one of the federal flexibilities under the PHE, the pause of redeterminations essentially created continuous eligibility for adults during that time period.

ii) **Require a manual review before eligibility is terminated**. This bill would prohibit eligibility from being automatically terminated without a manual review. It would require counties to review information on each case before discontinuing eligibility. According to the sponsor, this provision would help ensure individuals are not terminated from the program when they may be eligible under other eligibility pathways, and would ensure all information has been processed prior to eligiblity being terminated.

iii) **Requiring reporting of call center metrics**. Counties are not currently required to report on call center metrics, such as wait times. This bill would require such reporting.

iv) **Set ex parte success rate goals and require mitigations if goals not met**. According to the sponsor, the Center for Budget and Policy Priorities recommends states set goals for the percentage of renewals that are conducted on an ex parte basis. This bill requires DHCS to set a target of at least 50% successful ex parte for the MAGI population, and to submit a report on causes of missing target and action steps to increase ex parte rates in months they fail to meet the target.

v) **Streamlining**. This bill removes a requirement for a beneficiary to sign a renewal form if returned to the county in person or by mail. Individuals can currently respond

to the county with information through other means, including email or telephone.

3) **SUPPORT.** Numerous consumer, legal aid, and children's advocates support this bill because it will maintain low-income children, adults and families on Medi-Cal, reduce procedural barriers, and improve customer service for individuals seeking help.

4) **RELATED LEGISLATION.** SB 1287 (Roth) requires counties to report call center metrics. SB 1287 is pending in the Senate Health Committee.

5) **PREVIOUS LEGISLATION.** SB 184 implemented continuous eligibility for children younger than age five, contingent on funding, federal approval, and systems readiness.

6) **POLICY COMMENT.** The changes imposed by the pause in redetermination and the PHE Unwinding provided an opportunity for the state, county, and system stakeholders to step back and reassess the performance of the Medi-Cal eligibility system, and think critically about the costs and benefits of eligibility requirements. Since the ACA, the state and federal government have moved firmly toward a smarter, more user-friendly system that minimizes burden on individuals to provide information necessary retain coverage, which has many benefits, including easing administrative workload and stabilizing coverage for individuals and families. Further careful analysis and technical assistance from DHCS and engagement with counties is advised to ensure the language in the bill extends flexibilities as intended and, where this bill goes beyond what was approved under temporary flexibilities to create permanent, ongoing business processes, that appropriate safeguards are in place against unintended consequences, such as a situation in which automatic ex parte renewals "auto-verify" each other indefinitely.

   In addition, as this bill moves forward, in consultation with DHCS and to provide all parties clarity over the long term, the author may wish to eliminate the provision extending all other temporary flexibilities not specifically enumerated, and instead specifically enumerate all these rules in statute.

7) **TECHNICAL AMENDMENTS.** The Committee, author, and sponsor have identified the following minor technical amendments:

   a) Section 14005.251. (a) The department shall seek federal approval ~~***under Section 1115 of the federal Social Security Act***~~ to extend continuous eligibility to individuals over 19 years of age.

   b) Section 14005.37 (e)(5)(B)(i) The most recent income determination, at either initial application or most recent renewal, ***was*** within the last 12 months.

REGISTERED SUPPORT / OPPOSITION:

Support

Access Reproductive Justice
American Cancer Society Cancer Action Network INC.
American Diabetes Association

Asian Americans Advancing Justice-southern California
Asian Resources, INC.
Bay Area Legal Aid
California Association of Food Banks
California Dental Association
California Immigrant Policy Center
California Pan - Ethnic Health Network
California School-based Health Alliance
California State Association of Psychiatrists (CSAP)
California State Council of Service Employees International Union (SEIU California)
California WIC Association
CANHR
Children Now
Children's Institute
Children's Specialty Care Coalition
Community Clinic Association of Los Angeles County (CCALAC)
Community Health Councils
County of Santa Clara
Courage California
Friends Committee on Legislation of California
Health Access California
Indivisible CA StateStrong
Justice in Aging
Latino Coalition for A Healthy California
LeadingAge California
Legal Services of Northern California
Oasis Legal Services
Public Law Center
Second Harvest Food Bank of Orange County
Steinberg Institute
The Children's Partnership
The Leukemia & Lymphoma Society
Western Center on Law & Poverty

Opposition

None on file.

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

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2960 (Lee) – As Amended April 2, 2024

SUBJECT: Sexually transmitted diseases: testing.

SUMMARY: Requires a licensed primary care clinic or hospital emergency department (ED) to offer a syphilis test at least once per year to all patients who can become pregnant. Prohibits a violation of these provisions from being a crime. Makes findings and declarations regarding the alarming increase of syphilis cases, rising 287% in the last 10 years of Department of Public Health (DPH) data. Specifically, **this bill:**

1) Requires, at least once per year, a primary care clinic or a hospital ED to offer a syphilis test to patients who can become pregnant. Exempts a primary care clinic if the patient's primary care clinic has tested the patient for syphilis or if the patient has been offered a syphilis test and declined the test within the previous 12 months.

2) Authorizes a primary care clinic or ED to charge a patient to cover the cost of syphilis testing. Deems the primary care clinic or ED to have complied with this bill if a syphilis test is offered.

3) States that it is the intent of the Legislature that if there is a shortage of bicillin, the preferred treatment for pregnant persons with syphilis, bicillin should be provided first to persons who are pregnant.

4) Makes findings and declarations regarding the alarming increase of syphilis cases, rising 287% in the last 10 years of DPH data

EXISTING LAW:

1) Establishes DPH, directed by a state Public Health Officer (PHO), to be vested with all the duties, powers, purposes, functions, responsibilities, and jurisdiction as they relate to public health and licensing of health facilities, as specified. Gives the PHO broad authority to detect, monitor, and prevent the spread of communicable disease in the state. [Health and Safety Code (HSC) §131050 and §120130, et seq.]

2) Exempts various types of clinics from licensure and regulation by DPH, including any place or establishment owned or operated as a clinic or office by one or more licensed health care practitioners and used as an office for the practice of their profession, and any clinic operated as an outpatient department of a hospital. [HSC §1206]

3) Defines "outpatient setting," for purposes of establishing standards for accreditation of surgical settings that are not otherwise licensed, as any facility, clinic, unlicensed clinic, center, office, or other setting that is not part of a general acute care hospital (GACH), and where anesthesia, except local anesthesia or peripheral nerve blocks, is used in compliance with the community standard of practice in doses that have the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes. [HSC §1248]

4) Requires every health care provider, knowing of or in attendance on a case or suspected case of a disease on the list of reportable diseases and conditions, to be reported as required to DPH, including syphilis. [Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5- 2643.20, and §2800-2812]

5) Requires a person who works in a health facility, service or operation, or who has occupational tuberculosis (TB) exposure in public health services in connection with health care to be periodically screened for TB. [Title 22, CCR Div. 5, Chapters 1-12]

6) Requires an adult patient who receives primary care services to be offered a hepatitis B and C screening test according to the latest recommendations from the U.S. Preventive Services Task Force (USPSTF), and to the extent these services are covered under the patient's health insurance, unless the patient lacks capacity to consent to the test, or is being treated in the ED of a GACH. [HSC §1316.7]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, cases of syphilis have been rising significantly in California, including cases of congenital syphilis (CS) that caused nearly 200 stillbirths or neonatal deaths between 2012 and 2021. This bill seeks to increase testing among people who may be pregnant so that proper treatment can be provided.

2) **BACKGROUND.** Syphilis is an infection caused by bacteria. Most often, it spreads through sexual contact. The disease starts as a sore that's often painless and typically appears on the genitals, rectum, or mouth. Syphilis spreads from person to person through direct contact with these sores. It also can be passed to a baby during pregnancy and childbirth and sometimes through breastfeeding. After the infection happens, syphilis bacteria can stay in the body for many years without causing symptoms, however the infection can become active again. Without treatment, syphilis can damage the heart, brain or other organs. Early syphilis can be cured, sometimes with a single shot of penicillin.

   a) **Centers for Disease Control and Prevention (CDC) guidelines.** According to the CDC, syphilis case reports continue to increase since reaching a historic low in 2000 and 2001. During 2021, there were 176,713 new cases of syphilis (all stages). Gay, bisexual, and other men who have sex with men (MSM) are experiencing extreme effects of syphilis. They account for 36% of all primary and secondary (P&S) syphilis cases in the 2021 sexually transmitted disease (STD) Surveillance Report. They also account for 47% of all male P&S cases. However, case rates are increasing among heterosexual men and women in recent years. CS continues to be a concern in the United States. CS occurs when a pregnant person passes syphilis to their baby. Final 2021 data show more than 2,800 cases of CS. The CDC screening recommendations are as follows:
      i) Screen asymptomatic women at increased risk (history of incarceration or transactional sex work, geography, race/ethnicity) for syphilis infection;
      ii) Pregnant Women:
         (1) All pregnant women at the first prenatal visit; and,

(2) Retest at 28 weeks gestation and at delivery if at increased risk due to geography or personal risk (substance use, sexually transmitted infections (STIs) during pregnancy, multiple partners, a new partner, partner with STIs).

iii) Men Who Have Sex With Women: Screen asymptomatic adults at increased risk (history of incarceration or transactional sex work, geography, race/ethnicity, and being a male younger than 29 years) for syphilis infection;

iv) MSM:

(1) At least annually for sexually active MSM; and,

(2) Every three to six months if at increased risk.

v) Screen asymptomatic adults at increased risk (history of incarceration or transactional sex work, geography, race/ethnicity, and being a male younger than 29 years) for syphilis infection;

vi) Transgender and Gender Diverse People: Consider screening at least annually based on reported sexual behaviors and exposure;

vii) Persons with HIV:

(1) For sexually active individuals, screen at first HIV evaluation, and at least annually thereafter; and,

(2) More frequent screening might be appropriate depending on individual risk behaviors and the local epidemiology.

b) CS. CS is an infection transmitted from pregnant person to child during pregnancy and/or delivery caused by the bacterium Treponema pallidum. CS can cause severe illness in infants including premature birth, low birth weight, birth defects, blindness, and hearing loss. It can also lead to stillbirth and infant death. Tests and treatment for pregnant people are readily available.

Over the last several years, California has experienced a steep increase in syphilis among females and in CS. From 2012 to 2021, female early syphilis cases increased over 1,113% and CS cases increased 1,500%, from 33 cases in 2012 to 528 cases in 2021. This is the highest number of reported CS cases since 1992 when 522 cases were reported. According to the CDC, California had the 11th highest CS rate of all states in 2021. Thirty-seven (60.7%) of California's 61 local health jurisdictions reported at least one case of CS in 2021. Most pregnant females who gave birth to infants with CS received prenatal care late in pregnancy or not at all.

c) DPH guidelines. In response to the alarming rise in CS, DPH recognized an urgent need to expand syphilis detection among people who are or could become pregnant in order to ensure detection, timely treatment, and subsequent CS prevention. California STD screening recommendations to date have aligned with national guidelines, which recommend all pregnant patients receive syphilis screening at the first prenatal visit, with additional screening in the third trimester and at delivery for those with identified risk, including in communities and populations with high syphilis prevalence. Because the majority of California CS cases in 2017 and 2018 were born to pregnant patients with delayed or no prenatal care, DPH supports a more thorough, multipronged approach to case detection and CS prevention, which includes expanded syphilis screening for people who could become pregnant. This is especially important for people identified in settings that serve populations at increased risk for syphilis, as well as patients who might have disruptions in prenatal care and communicable disease treatment due to contributing

social factors (e.g., substance use, incarceration, poverty, homelessness, etc.), such as the ED. DPH recommends:

i) All pregnant patients should be screened for syphilis at least twice during pregnancy: once at either confirmation of pregnancy or at the first prenatal encounter (ideally during the first trimester) – and again during the third trimester (ideally between 28–32 weeks' gestation), regardless of whether such testing was performed or offered during the first two trimesters;

ii) Patients should be screened for syphilis at delivery, except those at low risk who have a documented negative screen in the third trimester;

iii) ED providers in local health jurisdictions with high-CS morbidity should consider confirming the syphilis status of all pregnant patients prior to discharge, either via documented test results in pregnancy, or a syphilis test in the ED if documentation is unavailable;

iv) All people who are or could become pregnant entering an adult correctional facility health jurisdiction with high-CS morbidity should be screened for syphilis at intake, or as close to intake as feasible;

v) All sexually active people who could become pregnant should receive at least one lifetime screen for syphilis, with additional screening for those at increased risk; and,

vi) All sexually active people who could become pregnant should be screened for syphilis at the time of each HIV test.

3) **SUPPORT.** AIDS Healthcare Foundation (AHF) is the sponsor of this bill and states that the epidemic of STIs in California has been growing since 2000. The most alarming increase has been in the number of all syphilis cases, rising 287% in the last 10 years as reported by DPH. The impact of syphilis among females has been even greater, increasing 1,113% over the same period. California is outpacing the rest of the country, with a rate that is 41% higher than the national rate. Particularly tragic is that the persistence of syphilis infections among women in their reproductive years has led to a meteoric rise in CS, when the infection is transmitted from the mother to the child during pregnancy. Cases of CS increased by 1500% during the last 10 years, leading to hundreds of stillbirths, neonatal deaths and other symptoms and complications. According to the CDC, California has the 11th highest rate of CS in the nation, which is 63% higher than the national rate. AHF notes that both DPH and the CDC agree that a priority target for syphilis testing and treatment are people who can become pregnant and who face obstacles in obtaining healthcare. Moreover, the USPSTF found convincing evidence that screening for syphilis infection in asymptomatic, nonpregnant persons at increased risk for infection provides substantial benefit. AHF concludes that a mandate to offer syphilis testing screen persons who are infected and allow medical professionals to treat them before the patient becomes pregnant, will provide an opportunity to educate people about syphilis and expand awareness among the public about the adverse impacts of syphilis infection and how to protect themselves.

4) **OPPOSE UNLESS AMENDED.** The California Emergency Nurses Association (CA ENA) is opposed to this bill unless it is amended. CA ENA states that they believe mandating syphilis screening in EDs, even for a small portion of the qualifying patients cared for in EDs, would add to the burden of emergency providers in caring for very sick or injured patients, with an unintended consequence of increased ED crowding. Crowding occurs when the identified need for emergency services exceeds available resources for patient care in the ED, hospital, or both. Crowding is also related to decreased access/availability of services over the entire health care delivery system (e.g. skilled nursing facility beds, behavioral

health services, hospital inpatient beds, home health care services, wound care services and any other service not available). When routine patient care, testing, and evaluation is required in an emergent environment, ED length of stay is often negatively impacted with prolonged results, and in effect, creates a higher patient volume waiting for those results. As the ED becomes increasingly crowded and patients must wait longer for care, frustration intensifies in patients/families and can lead to violence against healthcare providers.

CA ENA states that multiple studies have reported that the quality of care decreases as EDs become more crowded, and this bill will increase ED length of stay. CA ENA points to a DPH report published in 2019 found that, on average, EDs spend 28 minutes per patient offering the HIV test, securing consent, and providing information and counseling. CA ENA contends that one can presume it would take approximately 28 minutes to meet this mandate for syphilis screening – 28 minutes that could be dedicated to life-threatening or life-changing care for ED patients and their families.

5) **OPPOSITION.** The American College of OB/GYN's District IX (ACOG) writes in opposition that this bill requires syphilis testing to be offered to all women of reproductive age at least once per year regardless of clinical guidelines or recommendations. ACOG recommends all pregnant people are screened for syphilis at their first prenatal visit and potentially retested at delivery if at high risk; however, it does not recommend routine screening for all people who are not pregnant. A broad mandate that requires tests to be offered to all reproductive aged women regardless of risk, even when not needed or recommended through clinical guidance, could strain public health resources, diverting them from other critical areas or from higher risk populations, and take time away from why the women sought healthcare to begin with. Efficient and more cost-effective use of limited public health resources often requires prioritizing interventions based on risk assessments and epidemiological data. Rather than a blanket mandate, we should focus on high-risk groups, improve access to voluntary testing, and invest in education and prevention might yield better outcomes in terms of both health and economics.

   The California Medical Association is opposed to this bill and states that like many other bills legislating medicine, this bill offers a "one-size-fits-all approach" that does not take into consideration the many other clinical factors. Efficient and more cost-effective use of limited public health resources often requires prioritizing interventions based on risk assessments and epidemiological data. Rather than a blanket mandate, public health strategies benefit more from being targeted and nuanced, focusing on higher-risk populations and tailored interventions based on clinical guidance.

6) **RELATED LEGISLATION.** AB 2132 (Low) requires an adult patient receiving primary care services in specified health care settings, to be offered a TB risk assessment and TB screening test, if certain conditions apply. AB 2132 is pending in the Assembly Appropriations Committee.

7) **PREVIOUS LEGISLATION.**

   a) AB 789 (Low), Chapter 470, Statutes of 2021, requires an adult patient who receives primary care services to be offered a hepatitis B and C screening test according to the latest recommendations from the USPSTF, and to the extent these services are covered

under the patient's health insurance, unless the patient lacks capacity to consent to the test, or is being treated in the ED of a GACH.

b) SB 306 (Pan), Chapter 486, Statutes of 2021, permits pharmacists to dispense a drug, without the name of an individual for whom the drug is intended, when prescribed for the sexual partner of someone who has been diagnosed with a STD; prohibits health care providers who prescribe, dispense, or furnish such a drug from being subject to, civil, criminal, or administrative penalties, as specified; requires a syphilis blood test, during the third trimester of pregnancy and at delivery, as specified; requires public and commercial health coverage of home STD test kits; and, adds rapid STD tests to existing law which permits HIV counselors to perform rapid HIV and hepatitis C tests.

REGISTERED SUPPORT / OPPOSITION:

Support

AIDS Healthcare Foundation

Opposition

American College of Obstetricians and Gynecologists District IX
California Medical Association

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

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 2995 (Jackson) – As Introduced February 16, 2024

SUBJECT: Public health: alcohol and drug programs: definitions.

SUMMARY: Strikes outdated terminology from existing law in relation to substance use disorder (SUD) and replaces with person-first terminology. Specifically, **this bill**:

1) Replaces the following terms throughout various Health and Safety Code (HSC) sections:

   a) "Alcohol abuser" with "person with an alcohol disorder;"

   b) "Drug abuser" with "person with a substance use disorder;"

   c) "Alcohol and other drug abuse," "narcotic and alcohol and other drug abuse," and "problem of narcotics addiction or drug abuse" with "substance use disorder;" and,

   d) "Alcohol and other drug abuse problem" and "problems of alcohol and other drug abuse" with "misuse or inappropriate use of alcohol and other drugs."

2) Makes related technical and non-substantive changes.

EXISTING LAW:

1) Grants the Department of Health Care Services the administrative authority over all SUD and community mental health functions [HSC § 11750, *et seq.*]

2) Defines "alcohol and other drug problems" as problems of individuals, families, and the community that are related to the abuse of alcohol and other drugs. [HSC §11752.1]

3) Defines "alcohol abuser" as anyone who has a problem related to the consumption of alcoholic beverages whether or not it is of a periodic or continuing nature. [HSC §11752.1]

4) Defines "drug abuser" as anyone who has a problem related to the consumption of illicit, illegal, legal, or prescription drugs or over-the-counter medications in a manner other than prescribed, whether or not it is of a periodic or continuing nature. [HSC §11752.1]

5) Defines "alcohol and other drug service" as a service that is designed to encourage recovery from the abuse of alcohol and other drugs. [HSC §11752.1]

6) Defines "alcohol and other drug abuse program" as a collection of alcohol and other drug services that are coordinated. [HSC §11752.1]

7) Defines "alcoholism or drug abuse residential treatment facility" 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]

8) Defines "narcotic and drug abuse program" as any program that provides services for detoxification and treatment, as specified, to alleviate the problems of narcotic addiction or habituation or drug abuse addiction or habituation. [HSC §11842]

FISCAL EFFECT: None.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author this bill aims to redefine the terminology used for individuals grappling with SUDs. The author continues that these revisions reflect a deeper empathy and understanding, acknowledging that those facing SUD challenges require support and treatment rather than condemnation and stigma. The author concludes that this shift not only promotes a more compassionate approach to public health but also empowers those impacted to seek assistance without the fear of being discriminated against or shamed.

2) **BACKGROUND.**

   a) **Prevalence of 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.

   b) **Stigmatizing Terminology.** Research shows that stigmatizing language is one of many barriers to seeking treatment for a substance use or mental health disorder. Slang, medically inaccurate, and non-person first terms, such as "drug abuser" or "alcoholic," can invite negative judgments about individuals with SUD, including deeming them as blameworthy, untrustworthy, and dangerous. Individuals with SUD may internalize these beliefs, which could bring feelings of shame and anxiety and create barriers to seeking treatment. Stigmatizing language has also been found to lead to negative impacts within interpretation of existing law, leading to judges and juries prioritizing punishment rather than SUD treatment, and reinforcing structural and public stigma around SUD. The National Institute on Drug Abuse within the National Institutes of Health (NIH) has published guidance on preferred language for talking about addiction. This guidance urges providers to use person-first language and avoid terms that increase stigma and negative bias when discussing the disease of addiction. The educational resources published by NIH discourage use of the term "addict" and advocate for its replacement with the term "person with substance use disorder," explaining that shifting to person-first language "shows that a person 'has' a problem, rather than 'is' the problem."

In response to the escalating prevalence of SUD in California, this Legislature has advanced policies to promote harm reduction strategies, bolster treatment programs, and shift towards tackling SUD as a public health issue instead of a criminal one. Yet state statutes currently contain outdated and harmful terms that persist in contrast to the policy progress that's been made.

3) **SUPPORT.** The County Behavioral Health Directors Association California (CBHDA) are the sponsors of this bill stating that antiquated current law contains significant stigma surrounding the treatment of SUD. CBHDA continues that stigma surrounding SUD in language and statute reflects societal attitudes that lead to discrimination in obtaining housing, accessing health services and treatment, education, and employment opportunities. CBHDA concludes that this bill is an important measure that takes one step toward combatting and addressing the societal stigma surrounding substance use disorders and treatment.

4) **RELATED LEGISLATION.** AB 2119 (Weber) strikes outdated terminology from existing law in relation to mental health and replaces them with person-first terminology. AB 2119 is pending in the Assembly Health Committee.

5) **PREVIOUS LEGISLATION.**

   a) AB 248 (Mathis), Chapter 797, Statutes of 2023, strikes the terms "handicapped," "mentally retarded persons," "mentally retarded children," and "retardation" and instead uses the terms "individuals with intellectual, developmental disabilities," "impaired," or "disability" throughout code.

   b) AB 1130 (Berman), Chapter 21, Statutes of 2023, updates various provisions of code to replace use of the term "addict" with the term "person with substance use disorder."

   c) AB 1096 (Luz Rivas), Chapter 296, Statutes of 2021, strikes the offensive and dehumanizing term "alien" used to describe a person who is not a citizen or national of the United States where it appears in multiple California Code sections and, replaces it with other terms that do not include the word "alien."

6) **SUGGESTED AMENDMENTS**. This bill as drafted updates terminology across six code sections. However there are dozens of other code sections that contain stigmatizing language relating to SUD. The committee may wish to amend this bill to ensure all relevant code sections are updated with person-first terminology.

REGISTERED SUPPORT / OPPOSITION:

Support

County Behavioral Health Directors Association of California (sponsor)
California Association of Alcohol and Drug Program Executives, INC.

Opposition

None on file.

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

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 3149 (Garcia) – As Amended March 18, 2024

SUBJECT: Promotores Advisory and Oversight Workgroup.

SUMMARY: Requires the Department of Health Care Services (DHCS) to convene the Promotores Advisory and Oversight Workgroup (workgroup) to examine the implementation of the community health worker (CHW) benefit under the Medi-Cal program. Specifically, **this bill**:

1) Requires the workgroup to be convened by January 1, 2026, and until December 31, 2026.

2) Specifies the makeup of the workgroup, including no less than 51% promotores, including, but not limited to, a representative from a statewide network of promotores and community health workers, a representative from a community-based organization, a representative from a health clinic or community health center, and a representative from a regional organization.

3) Specifies the duties of the workgroup, including advising on access to CHW services, cultural and linguistic appropriateness of training and outreach materials, outreach and awareness efforts, and providing input on other issues based on the workgroup members' lived experience.

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 CHW services as a Medi-Cal benefit and requires DHCS, through existing and regular stakeholder processes, to inform stakeholders about, and accept input from stakeholders on, implementation of the CHW services benefit. [WIC §14132.36]

4) 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]

5) Requires DHCS to convene a workgroup to examine the implementation of the Medi-Cal doula benefit and to, by July 1, 2025, publish a report on utilization of the benefit that identifies any barriers that impede access to doula services and make recommendations to reduce any identified barriers. [WIC §14132.24]

6) Requires the Department of Health Care Access and Information (HCAI) to develop statewide requirements for CHW certificate programs in consultation with stakeholders. [WIC § 18998.1, *et seq.*]

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

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, promotoras, as included under the state's definition of CHWs, are a predominantly women-led Latina workforce, working with low-income and traditionally underserved communities to provide reliable information, connections to resources, public health, social services, education, housing, and legal systems. The author notes they provide effective connections to components recognized as social determinants of health, and promatoras are trusted community ambassadors serving as vital resource links between our most vulnerable populations and traditional health systems to improve health outcomes. The author concludes that as California embarks on the important work to include Community Health Worker, Promotora, and Representatives (CHW/P/R) as a Medi-Cal benefit and augment the workforce, we must integrate the voices and feedback of promotoras, our on the ground community health leaders, in the planning and decision-making.

2) **BACKGROUND.**

   a) **CHW Services.** As of July 1, 2022, over half of states (29 of 48) reported allowing Medicaid payment for services provided by CHWs. DHCS engaged with stakeholders and experts on Medicaid coverage of CHW services in other states to inform policy and implementation of the CHW benefit. DHCS added CHW services, including violence prevention services, as a Medi-Cal benefit starting July 1, 2022. The benefit was codified through AB 2697 (Aguiar-Curry), Chapter 488, Statutes of 2022. CHW services are defined to include those delivered by promotores, community health representatives (CHRs; professionals who work in a tribal setting), navigators, and other non-licensed public health workers.

      i) **General Rules**. CHW services are defined in Medi-Cal under federal regulations on "preventive services," and must therefore be recommended by a physician or other licensed practitioner of the healing arts within their scope of practice under state law. In addition to physicians, a range of non-physician medical practitioners and behavioral health professionals can recommend CHW services. The recommending provider does not need to be enrolled in Medi-Cal or be a network provider for the Medi-Cal member's managed care plan. Medical necessity for services is defined fairly broadly—individuals are eligible for services if they have one or more chronic conditions, have a behavioral health diagnosis or suspected behavioral health condition, have visited a hospital emergency department or had an inpatient stay within the prior six months, express need for support in health system navigation or resource coordination, or meet at least one of a number of other criteria. To provide more than 12 units (six hours) of CHW services for an individual, the services must be provided pursuant to a written plan of care. Services can be provided in an individual or group setting, and can be provided virtually. There are no restrictions as to where services can be delivered. The federally approved State Plan Amendment19 for CHW services describes the services and qualifications, and the Medi-Cal

Provider Manual for CHW services further describes billing procedures, policies, and supervision of CHWs.

The supervising provider, who submits claims for services, is an enrolled Medi-Cal provider who oversees the services provided and ensures a CHW meets the defined qualifications. The supervising provider can be a licensed provider, a hospital, an outpatient clinic, a local health jurisdiction (LHJ), or a community-based organization (CBO). CHWs may be supervised by a CBO or LHJ that does not have a licensed provider on staff.

ii) **Health Topics Addressed**. CHWs can address issues that include but are not limited to control and prevention of chronic conditions or infectious diseases; mental health conditions and substance use disorders; perinatal health conditions; sexual and reproductive health; environmental and climate-sensitive health issues; child health and development; oral health; aging; injury; domestic violence; and, violence prevention.

iii) **Definition of Services**. Medi-Cal defines CHW services as including health education; navigation to health care and other community resources that address health-related social needs; screening and assessment to identify the need for services; and individual support and advocacy that assists a beneficiary in preventing a health condition, injury, or violence.

b) **CHW Benefit Utilization and Expenditure Data**. As of July 1, 2022, CHW services have been a covered benefit in Medi-Cal Fee-for-Service (FFS) and managed care. The 2023 Budget and the 2024-25 Governor's Budget each assume total annual Medi-Cal expenditures of $91.9 million for the CHW benefit ($82.7 million in managed care and $9.2 million in FFS).

Costs associated with CHW services are reflected in managed care rates as of January 1, 2023; however, billing data shows little utilization. Actual data on CHW visits billed to Medi-Cal through FFS and managed care through January 25, 2024, have not exceeded $1 million. These data only include CHW services that were individually billed through the CHW benefit. CHW services are also billed in other ways, so these data also exclude other important avenues through which CHW services may be delivered in Medi-Cal, such as though DHCS initiatives called Enhanced Care Management and Community Supports. Services provided at federally qualified health centers (FQHCs) and rural health centers (RHCs) are also not included; based on nuances of the way these clinics bill Medi-Cal, FQHCs and RHCs cannot directly bill for CHW services.

Budget estimates for new benefits, particularly when provided by non-traditional providers, are often uncertain and a ramp-up period is expected. Although the data show thousands of Medi-Cal members have received CHW services through the CHW benefit, given the size of the Medi-Cal population and the potential to deploy CHWs in many different areas to meet health and health-related social needs, it is apparent that the rollout of the CHW benefit has been slower than anticipated.

DHCS has taken a number of actions to describe expectations for coverage and provision of the CHW benefit, as well as planned monitoring, including guidance to managed care

plans, requiring plans to describe how they will integrate CHWs, creating a new enrollment pathway for community-based organizations and local health jurisdictions, basing incentive payments to plans on utilization of CHW services, adding CHW services to the Medi-Cal dental program to address oral health, and monitoring the provision of CHW services through another initiative called "Population Health Monitoring."

c) HCAI CHW Workforce Effort. The 2022 Budget Act included approximately $281.4 million over three years to support a new program to recruit, train, and certify 25,000 new CHWs by 2025, including those with specialized training to work with specific populations or on specific issues. According to HCAI, the training requirements would align with Medi-Cal requirements for reimbursement. Although most of the funding has been delayed until the 2024-25 and 2025-26 fiscal years, the multi-year amount in the 2024 Governor's Budget is still the same as originally proposed.

SB 184 (Committee on Budget and Fiscal Review), Chapter 47, Statutes of 2022, the 2022 Health Trailer Bill, required HCAI to develop statewide requirements for CHW certificate programs in consultation with stakeholders. . In July 2023, following a series of stakeholder consultation sessions, HCAI issued a guidance letter implementing the requirements. However, the guidance letter has since been "paused," pending additional stakeholder engagement.

HCAI also notes it is working closely with DHCS to align pathways and eventually consolidate into one state certificate process for CHW/P/Rs.

d) HCAI's Stakeholder Engagement.

i) Initial Stakeholder Work: To inform the development of the July 2023 guidance letter, HCAI conducted 43 stakeholder sessions with a total attendance of 1,573 across all sessions. HCAI developed the certificate model through three iterative models in response to stakeholder feedback. HCAI shared each certificate model iteration in draft form during information sessions and solicited suggestions for improvement. HCAI conducted sessions in Spanish and offered Spanish language translation services during English sessions. Written feedback from stakeholders was also encouraged, and HCAI received written comments in both English and Spanish. HCAI offered to provide translation and interpretation services in other languages upon request.

ii) Current Work: The state team comprised of California Health and Human Services Agency (CHHSA), DHCS, and HCAI launched a further stakeholder engagement process in February 2024, with work planned to conclude in June 2024. The agencies first convened an ad hoc advisory group comprised of a number of key organizations and thought leaders in the CHW/P/R space. This group advised on the dialogue guide, process, and site selection for stakeholder input and will continue to advise to ensure the process is comprehensive, relevant, and appropriate. The goal of this stakeholder effort is to get feedback on what is working well and what are the barriers to expanding the CHW/P/R workforce, how HCAI can best use its funds for recruiting, training, and certifying CHW/P/Rs, and the value, risks, scope, and unintended consequences of a statewide certificate.

HCAI indicates the intent is to conduct approximately 20 stakeholder dialogues from February to June 2024, with dialogues appropriately distributed by geography and also covering the wide range of populations that CHW/P/Rs serve. Once the stakeholder process has concluded, HCAI plans to finalize funding priorities with input from the ad hoc advisory group, with the aim of launching grants and contracts reflecting these priorities in early 2025. The first dialogue was held on February 24th, 2024, at La Clinica de la Raza in Oakland. Subsequent sessions are being scheduled with a list of host sites selected to maximize geographic distribution and population representation.

e) Assembly Informational Hearing. On March 12, 2024, the Assembly Committee on Health and Budget Subcommittee No.1 on Health held an informational hearing on implementation of the Medi-Cal CHW benefit and the CHW/P/R workforce efforts within HCAI. It noted both initiatives are still in the early stages of implementation, and although there is significant excitement about these investments and the potential of both initiatives, and a number of promising developments, a diverse array of stakeholders have noted various barriers to implementing these efforts and to expanding CHW/P/R workforce and services generally. The hearing provided background on CHW/P/Rs and recent state efforts, and documented and discussed both bright spots and challenges in implementation of these state initiatives and broader deployment of CHWs.

Bright spots include having the "policy infrastructure" in place for Medi-Cal financing of CHW services, the responsiveness of the state to stakeholder input, the availability of CHW training programs in California, statewide and regional collaboratives to promote CHWs, capacity-building investments at DHCS, and federal funding and attention.

Challenges and barriers include limited administrative infrastructure for community-based organizations and other small, community-based potential providers of CHW services; a constrained workforce; ongoing financial sustainability, including inadequacy of rates, the inability of FQHCs and RHCs to directly bill for services, and little public health funding for CHWs; disagreement among stakeholders about the purpose and value of certification; a lack of ongoing support for promoting best practices; training "deserts" throughout the state, such as the rural north; and the dual roles CHWs occupy, as embedded in and advocates for their community as well as part of the "professional culture" of health care.

Based on the findings of the hearing, the successful expansion and integration of CHW services through the Medi-Cal CHW benefit has the potential to be transformative, but there are many implementation hurdles to address that will require significant dialogue and partnership among many stakeholders.

f) Doula Benefit Implementation Workgroup. Medi-Cal added doula services as a covered benefit effective January 1, 2023. DHCS convened an ad hoc advisory workgroup of doulas and other interested parties to advise DHCS on the development of the doula benefit, similar the CHW-specific workgroup convened to advise on the development of the CHW benefit.

The CHW benefit and doula benefit are similar in that they were both recently added as preventive services to improve health outcomes and health equity in Medi-Cal; the

qualifications of both types of nonclinical personnel are defined through the Medi-Cal benefit for purposes of the program, because no external certification standards exist; and the initial rollout of both efforts have been challenged by inadequate workforce and concerns regarding low reimbursement by providers. However, DHCS has since significantly increased rates for doula services and proposed additional rate increases for these services, and pursuant to SB 65 (Skinner), Chapter 449, Statutes of 2021, DHCS is convening an additional time-limited workgroup to examine and advise on implementation of the doula benefit.

The Doula Implementation Workgroup is comprised of 30 members. Meetings are quarterly, facilitated by an expert organization that helps government agencies center equity in their work and strengthen their cultural responsiveness. Per SB 65, the workgroup addresses access to doula services, outreach efforts, minimizing barriers and delays in payments, and helping to inform DHCS's legislative report due July 1, 2025.

This bill would implement a similar, time-limited committee to oversee and advise on implementation of the CHW benefit.

3) **SUPPORT.** Supporters, including California Pan - Ethnic Health Network, Latino Coalition for a Healthy California, numerous individual promotoras and others, note the importance of including voices of historically marginalized communities in decisions that impact their health and wellness, including the availability of and cultural and linguistic relevance of CHW/P/R services.

4) **RELATED LEGISLATION.** AB 2250 (Weber) requires commercial health plans and insurers, as well as Medi-Cal, to provide cover social determinants of health screenings, and requires commercial health plans and insurers to provide to physicians who provide primary care services with adequate access to peer support specialists, lay health workers, social workers, or CHWs, as defined. AB 2250 passed the Assembly Health Committee on April 2, 2024, on a 15-0 vote and is pending in the Assembly Appropriations Committee.

5) **PREVIOUS LEGISLATION.**

   a) AB 85 (Weber) of 2023 was similar to AB 2250 (Weber) and was vetoed by Governor Newsom, who said it was premature and duplicative of existing efforts.

   b) AB 2697 (Aguiar-Curry), Chapter 488, Statutes of 2022, codifies CHW services as a covered Medi-Cal benefit.

   c) SB 184 (Committee on Budget and Fiscal Review), Chapter 47, Statutes of 2022, the 2022 Health Trailer Bill, codified the HCAI workforce initiative.

   d) SB 65 enacts programs aimed at improving maternal health and required DHCS to convene a workgroup no later than April 1, 2022, and until December 31, 2023 to examine the implementation of the Medi-Cal doula benefit and submit a report. AB 118 (Committee on Budget), Chapter 42, Statutes of 2023, subsequently extended the workgroup until June 30, 2025.

6) **AMENDMENTS**. Based on discussion between the author, sponsor and Committee regarding the ability of promotoras to engage on a broader range of issues under

consideration by state health agencies, the author and Committee have agreed to amend this bill to broaden the scope of the workgroup beyond the CHW benefit to other relevant initiatives under CHHSA and move the workgroup under the auspices of CHHSA. The author and Committee have also agreed to amend the bill to use the term "promotoras," in addition to promotores, to recognize the role and emphasize the voices of promotoras.

REGISTERED SUPPORT / OPPOSITION:

Support

Visión Y Compromiso (sponsor)
California Pan - Ethnic Health Network
Centro La Familia Advocacy Services
Latino Coalition for a Healthy California
Sierra Community House
A large number of individuals who identify as promotoras

Opposition

None on file.

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

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 3221 (Pellerin) – As Amended April 1, 2024

SUBJECT: Department of Managed Health Care: review of records.

SUMMARY: Requires the records, books, and papers of a health plan and other specified entities to be open to inspection by the Department of Managed Health Care (DMHC) Director, including through electronic means. Specifically, **this bill**:

1) Requires the records, books, and papers of a health plan and other specified entities to be open to inspection by the DMHC Director, including through electronic means.

2) Requires the plan, management company, solicitor, or solicitor firm, and a provider or subcontractor providing health care or other services to a plan, management company, solicitor, or solicitor firm to which the request is made, as described in 1) above, to do both of the following:
   a) Furnish in electronic media records, books, and papers that are possessed in electronic media; and,
   b) Conduct a diligent review of the records, books, and papers and make every effort to furnish those responsive to the DMHC Director's request.

3) Requires all records, books, and papers described in 1) above and furnished pursuant to a request under this bill to be furnished in a format that is digitally searchable to the greatest extent feasible. Requires records, books, and papers to be preserved until furnished if requested by the DMHC.

4) Authorizes the DMHC Director to, in addition to the powers granted to the DMHC Director, as specified, do both of the following:

   a) Inspect and copy records, books, and papers described in 1) above; and,

   b) Seek relief from an administrative law proceeding if, in the DMHC Director's determination, a plan, management company, solicitor, or solicitor firm, and a provider or subcontractor providing health care or other services to a plan, management company, solicitor, or solicitor firm fails to fully or timely respond to a duly authorized request for production of records, books, and papers.

5) Includes records, books, and papers that are possessed in any medium, including electronic media for purposes of this bill.

6) Authorizes the DMHC Director to assess administrative penalties if the plan fails to respond fully or timely, or both, to a duly authorized request for production of records.

7) Specifies that nothing in existing law prohibits the DMHC Director from taking any action permitted or required in response to the survey results described in 2) below of existing law before the followup review is initiated or completed, including, but not limited to, taking enforcement actions and opening further investigations.

EXISTING LAW:

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

2) Requires the DMHC to conduct periodically an onsite medical survey of the health delivery system of each plan. Requires the survey to include a review of the procedures for obtaining health services, the procedures for regulating utilization, peer review mechanisms, internal procedures for assuring quality of care, and the overall performance of the plan in providing health care benefits and meeting the health needs of the subscribers and enrollees. [HSC §1380]

3) Requires the DMHC Director to give the plan a reasonable time to correct deficiencies. Specifies that failure on the part of the plan to comply to the DMHC Director's satisfaction constitute cause for disciplinary action against the plan. [HSC §1380(i)]

4) Requires the DMHC to conduct a follow-up review to determine and report on the status of the plan's efforts to correct deficiencies no later than 18 months following release of the final report. Requires the DMHC's report to identify any deficiencies that have not been corrected to the satisfaction of the DMHC Director. [HSC §1380(j)]

5) Requires all records, books, and papers of a plan, management company, solicitor, solicitor firm, and any provider or subcontractor providing health care or other services to a plan, management company, solicitor, or solicitor firm to be open to inspection by the DMHC Director. Specifies that, to the extent feasible, all records, books, and papers to be located in this state. Requires the DMHC Director to consider the cost to the plan, consistent with the effectiveness of the DMHC Director's examination, and may upon reasonable notice require that such records, books and papers, or a specified portion thereof, be made available for examination in this state, or that a true and accurate copy of records, books and papers, or a specified portion thereof, be furnished to the DMHC Director, in examining such records outside this state. [HSC §1381]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, far too often, consumers don't receive access to the physical and behavioral health care they need, and that they have paid for, in a timely and appropriate manner. While California leads the nation in mandating timely access and behavioral health parity, our state's mental health crisis could be more effectively addressed if DMHC were empowered to take faster and more efficient enforcement actions. While the KKA provides for the regulation of the health plans by DMHC, several provisions of the KKA are outdated, ineffective, or both, causing unnecessary and expensive delays in DMHC's taxpayer-funded oversight process. The author states that in order to reflect the technological advancements since the KKA's passage, this bill allows DMHC to request health plan records in a searchable digital format, which allows for faster receipt and review of records. Additionally, this bill allows DMHC's Director to take disciplinary action when health plans fail to respond to records requests fully or in a timely manner. This bill allows DMHC to seek relief on consumers' behalf through administrative hearings rather than

through the slower Superior Court hearing process currently required. The author concludes that this bill is an important step in ensuring that California consumers have access to the health care that they need.

2) **BACKGROUND.** The DMHC protects consumers' health care rights and ensures a stable health care delivery system. The DMHC recently released its 2022 Annual Report and Infographic, highlighting DMHC's achievements and activities during the year. The DMHC regulates the majority of health care coverage in California including 96% of commercial and public enrollment in state-regulated health plans. In 2022, 97 full service health plans licensed by the DMHC provided health care services to 29.7 million Californians. In addition to full-service health plans, the DMHC oversees 46 specialized health plans including chiropractic, dental, vision, behavioral health (psychological), and pharmacy. As of the end of 2022, the DMHC has assisted 2.8 million consumers through the DMHC's Help Center. The Infographic also identifies $126.1 million assessed against health plans that violated the law.

   a) **DMHC medical surveys.** DMHC uses a wide range of reporting and surveillance tools to assist with oversight. Examples include quarterly grievance reports, reviews of block transfer fillings, engagement with its customer complaint center, premium rate review for health plans, medical surveys, and financial examinations. Additionally, the DMHC Director has broad authority over enforcement actions. Enforcement actions may include cease and desist orders, the imposition of administrative penalties, freezing enrollment, nonrenewal of licensure, and the request for corrective actions by health plans.

      The medical survey is a comprehensive evaluation of the plan's compliance with the law in the following health plan program areas:

      i) Quality Assurance;

      ii) Grievances and Appeals (enrollee complaints);

      iii) Access and Availability;

      iv) Utilization Management (referrals and authorizations); and,

      v) Overall plan performance in meeting enrollees' health care needs.

      California law requires the DMHC to conduct a routine medical survey of each licensed full service and specialty health plan at least once every three years. The DMHC may also perform an investigative medical survey as often as deemed necessary by the DMHC's Director. When the survey is complete, the DMHC issues a Final Report that is publicly available. The DMHC may perform a followup Survey within 18 months of the Final Report for any uncorrected deficiencies. This bill clarifies that nothing in existing law prohibits the DMHC Director from taking any action in response to the survey results before the followup review is initiated or completed, including, taking enforcement actions and opening further investigations. This bill also requires the records, books, and papers of a health plan and other specified entities to be open to inspection by the DMHC Director, including through electronic means.

b) Behavioral Health Investigations (BHI). The DMHC received approval in the 2020-21 state budget to conduct focused BHI of all full service commercial health plans regulated by the DMHC to further evaluate health plan compliance with California laws and assess whether enrollees have consistent access to medically necessary behavioral health care services. Any parity issues discovered or suspected during the BHI process will be referred internally for further investigation. A goal of the investigations is to identify and understand the challenges and barriers enrollees may still face in obtaining behavioral health care services, and to identify systemic changes that can be made to improve the delivery of care.

The DMHC is conducting BHIs of all full-service commercial health plans regulated by the DMHC, with the intent to investigate an average of five health plans per year. The investigations are separate from the DMHC's routine medical surveys, or audits, which are conducted every three years. The Phase One Summary BHI Report issued last year includes a list of the KKA violations that were identified for each of the investigated health plans, and provides a summary of other barriers to care. Barriers to care may include health plan practices, policies, operations, or other activities that may not rise to a violation of the law, but may contribute to challenges, delays or obstacles faced by enrollees as they navigate the health plan's system to access behavioral health services. Barriers can negatively impact enrollees' ability to obtain behavioral health care. Some of the barriers in the BHI Report identified plans for not having a process for providing integrated behavioral health care services and for conducting utilization management for behavioral health care services that are not subject to prior authorization.

The health plans were provided an opportunity to submit a separate written response to the barriers identified in each health plan's respective report, describing any steps taken or to be taken to address the barriers. The KKA violations noted in the BHI Reports, along with corrective action plans, will be referred to the DMHC's Office of Enforcement to evaluate and take appropriate enforcement actions, which may include corrective actions and administrative penalties. For the barriers not related to KKA violations, the DMHC provided recommendations to assist health plans in considering ways to address barriers and improve access to timely, appropriate behavioral health care for all enrollees. According to the DMHC, the barriers, recommendations and health plan actions may serve to inform future statutory and/or regulatory changes.

3) SUPPORT. The National Union of Healthcare Workers (NUHW), sponsor, write that by taking faster and more effective enforcement action when merited, DMHC will resolve health plan violations more quickly for all consumers who have been wronged. This will result in fewer improper denials of coverage and fewer improper treatment limitations, and more consumers will receive access to care they need, and for which they, their employers, and taxpayers have paid. In particular, more patients with mental health and substance use disorders will get care that prevents them from decompensating, experiencing episodes of acute illness, and far too often developing debilitating chronic and severe disorders that ultimately can interfere with their ability to maintain employment, sustain personal relationships, and remain in their homes. These patients will also be spared risk for other illnesses that can reduce their quality and years of life, and cost enormous sums of additional healthcare expenditures that could have been avoided. NUWH concludes that just as slow, weak enforcement of patients' rights harms most the communities of color, recent immigrants, low-income Californians, and residents of medically underserved areas who

suffer from the highest disease burdens, so speedy, strong enforcement should help these groups most.

The California Hospital Association (CHA) writes that it has previously expressed concerns about health plan practices that are detrimental to patients and has advocated for increased vigilance and oversight by DMHC and other regulatory agencies. CHA appreciates this opportunity to support reasonable, practicable changes that will support this oversight process, as it is an important step toward protecting the rights of Californians to receive medical care appropriate to their needs.

4) PREVIOUS LEGISLATION.

a) SB 858 (Wiener), Chapter 985, Statutes of 2022, increases fines on deficient health plans, including civil penalties of not more than $25,000 for each day a violation continues, per enrollee harmed; requires a one-time adjustment, and annual adjustments to specified fine amounts based on individual and small group average rate of change of premiums and cost-sharing, weighted based on enrollment; and, establishes factors for the DMHC Director to use to determine the appropriate amount of a penalty.

b) SB 855 (Wiener), Chapter 151, Statutes of 2020, requires commercial health plans and insurers to provide full coverage for the treatment of all mental health conditions and substance use disorders. Establishes specific standards for what constitutes medically necessary treatment and criteria for the use of clinical guidelines.

REGISTERED SUPPORT / OPPOSITION:

Support

National Union of Healthcare Workers (NUHW) (sponsor)
Access Reproductive Justice
Asian Americans and Pacific Islanders for Civic Empowerment
Buen Vecino
California Federation of Teachers AFL-CIO
California Hospital Association
California Labor Federation, AFL-CIO
California Onecare
California State Association of Psychiatrists (CSAP)
California Youth Empowerment Network
Courage California
Equality California
Hand in Hand: the Domestic Employers Network
Health Access California
Health Care for All - California
Healthcare Action Committee
Mental Health America of California
Steinberg Institute
UNITE-HERE, AFL-CIO

Opposition

None on file.

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

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 3260 (Pellerin) – As Amended April 1, 2024

SUBJECT: Health care coverage: reviews and grievances.

SUMMARY: Requires a determination of urgency by a health care provider, with respect to a decision to approve a health care service for prior authorization, to be binding on the health plan. Entitles an enrollee to automatically proceed with a grievance, if the health plan fails to make a decision to approve, modify, or deny the request for authorization within the specified timeframes in existing law. Makes a determination of urgency by an enrollee's health care provider to be binding on a plan or insurer, for grievances. Requires the Department of Managed Health Care (DMHC) or California Department of Insurance (CDI) to provide specified correspondence and documents to an enrollee or insured if the enrollee or insured has submitted a grievance for review under the Independent Medical Review (IMR) System. Specifically, **this bill**:

Health Plan Utilization Review

1) Expands existing law to allow an enrollee to make a prior authorization request to a health plan based on medical necessity. Specifies that urgent requests be communicated to enrollees or providers by telephone, facsimile, or electronically, as well as mail for urgent requests, in a timely fashion appropriate for the nature of the enrollee's condition and not to exceed 72 hours from the plan's receipt of the clinical information reasonably necessary and requested by the plan to make the determination.

2) Requires the plan to notify the enrollee and the provider of the specific information necessary to complete the request, when the plan lacks the information reasonably necessary to make a decision to approve, modify, or deny an urgent request. Requires the notification to be made as soon as possible, but no later than 24 hours after the plan's receipt of the request from the enrollee or provider. Affords the enrollee and the provider a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information.

3) Requires the plan to notify the enrollee and the provider of the plan's decision as soon as possible, but no later than 48 hours after the earlier of the following:
   a) The plan's receipt of specified additional information; or,
   b) The end of the period afforded the enrollee and the provider to submit the specified additional information.

4) Considers the request to be urgent when either of the following conditions are met:
   a) The enrollee faces an imminent and serious threat to the enrollee's physical or behavioral health, including but not limited to, severe pain or the potential loss of life, limb, or other major bodily function; or,
   b) The normal timeframe for the decisionmaking process (not to exceed five business days) could be detrimental to the enrollee's life or physical or behavioral health, cause severe pain, or jeopardize the enrollee's ability either to regain maximum function or to minimize any loss of function.

5) Requires a determination of urgency by an enrollee's health care provider to be binding on the health plan or insurer.

6) Requires a health plan to automatically treat the request for authorization as a grievance and immediately provide notice to the enrollee that a grievance has commenced if a health plan fails to make a decision, or provide notice of a decision to approve, modify, or deny the request for prior authorization within specified timeframes in existing law.

Health Plan Grievance and Appeals

7) Requires the final determination of urgent complaints about access to care, including complaints about the waiting time for, or distance to, covered health care services that are resolved by the next business day to be communicated to the enrollee and provider by telephone, electronically, or both, as well as by hard copy mailed, no later than 72 hours from receipt of the grievance.

8) Entitles an enrollee to automatically proceed with a grievance, if the health plan fails to make a decision to approve, modify, or deny the request for authorization within the specified timeframes in existing law.

9) Requires the health plan to communicate its final determination to the enrollee and the enrollee's provider by telephone, electronically, or both, as well as by hard copy mailed to their designated mailing address, no later than 72 hours from receipt of the urgent grievance.

10) Requires the health plan to communicate its final determination to the enrollee and the enrollee's provider in writing no later than 30 days from receipt of the grievance in the case of a nonurgent grievance.

11) Amends expedited plan requests for urgent grievances when the enrollee faces an imminent and serious threat to the enrollee's physical or behavioral health, including but not limited to, severe pain, or the normal timeframe for the decisionmaking process could be detrimental to the enrollee's life or physical or behavioral health, cause severe pain, or jeopardize the enrollee's ability to regain maximum function or minimize any loss of function. Requires a determination of urgency by the enrollee's health care provider to be binding on the health plan.

12) Requires the health plan to furnish enrollees, insureds, subscribers, health care providers, and the DMHC with a written statement on the disposition no later than 72 hours (rather than three days in existing law).

13) Requires a health plan that fails to comply with the timeframes and with the notice requirements to automatically resolve the grievance in favor of the enrollee or insured.

14) Authorizes the DMHC Director to extend the IMR application deadline beyond 12 months (existing law specifies six months).

Health Insurer Grievance

15) Requires the insurer to communicate its final determination to the insured and the insured's provider by telephone, electronically, or both no later than 72 hours from receipt of the grievance, in the case of an urgent internal grievance that an insured files with the insurer.

16) Requires the insurer to communicate its final determination to the insured and the insured's provider in writing no later than 30 days from receipt of the grievance in the case of a nonurgent internal grievance that an insured files with the insurer.

17) Requires the insurer to, upon notice from CDI to a disability insurer that an insured, including the insured's representative, has submitted a grievance to CDI, respond to the insured, the insured's representative, and CDI within one of the following timeframes, as appropriate:
    a) Within 24 hours, if directed by CDI, regarding an urgent grievance concerning coverage decisions, disputed health care services, or both; or,
    b) Within five calendar days regarding a nonurgent grievance concerning coverage decisions, disputed health care services, or both.

18) Authorizes CDI to determine whether or not a grievance is urgent, as specified, unless the grievance is designated as urgent by the insured's referring or treating provider, in which case the provider's designation of urgency controls.

Enrollee/Insured Communications

19) Requires the DMHC or CDI to promptly provide to the enrollee or insured and, to the extent applicable, the enrollee or insured's representative unredacted copies of all correspondence, including ongoing correspondence, between the DMHC or CDI and the plan or insurer concerning the enrollee or insured's grievance with respect to an enrollee or insured grievance to the DMHC or CDI concerning a disputed health care service or coverage decision, *or access to care, including complaints about the waiting time for, or distance to, health care services (italics only apply to health plans)*.

20) Requires the DMHC or CDI to provide the enrollee or insured and, to the extent applicable, the enrollee or insured's representative with an unredacted copy of the nonbinding expert opinion by the IMR organization if the DMHC or CDI determines that the enrollee or insured's grievance concerns a coverage decision, *access to care, or both*, and the DMHC or CDI seeks a nonbinding expert opinion from an IMR organization.

21) Requires the DMHC or CDI to provide to the enrollee or insured and, to the extent applicable, the enrollee or insured's representative a reasonable opportunity to respond to any communications between the DMHC or CDI and the plan or insurer and, if applicable, between the DMHC or CDI and the IMR organization before the enrollee or insured's grievance is adjudicated (*is resolved*).

22) Prohibits the DMHC or CDI, including its IMR organization, from engaging in ex parte communication with the plan or insurer, the enrollee or insured, or the representatives of either party without concurrently providing the plan or insurer, the enrollee or insured, and, to the extent applicable, their respective representatives unredacted copies of all communications, as specified.

EXISTING LAW:

1) Establishes the 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) Requires the criteria or guidelines used by health plans and insurers, or any entities with which plans or insurers contract for utilization review or utilization management functions, to determine whether to authorize, modify, or deny health care services to:
   a) Be developed with involvement from actively practicing health care providers;
   b) Be consistent with sound clinical principles and processes;
   c) Be evaluated, and updated if necessary, at least annually;
   d) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the enrollee or insured in that specified case; and,
   e) Be available to the public upon request. [HSC §1363.5 and INS §10123.135]

3) Authorizes a health plan to use utilization review, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Requires these decisions to be made within 30 days, or less than 72 hours when the enrollee faces an imminent and serious threat to their health. [HSC §1371]

4) Requires every health plan to establish and maintain a grievance system approved by DMHC under which enrollees may submit grievances to the plan. Requires a plan's response to also comply with federal requirements. Requires, in regulations, that a plan's grievance system be established in writing and provide for procedures that will receive, review and resolve grievances within 30 calendar days of receipt by the plan, or any provider or entity with delegated authority to administer and resolve the plan's grievance system. Defines grievance as a written or oral expression of dissatisfaction regarding the plan and/or provider. [HSC §1368 and 28 California Code of Regulation §1300.62]

5) Requires reviews, for purposes of IMR, to determine whether the disputed health care service was medically necessary based on the specific medical needs of the enrollee or insured and any of the following:
   a) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service;
   b) Nationally recognized professional standards;
   c) Expert opinion;
   d) Generally accepted standards of medical practice; or,
   e) Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious. [HSC §1374.33 and INS §10169.3]

6) Requires health plans and disability insurers to provide an external, IMR to examine the insurer's or plan's coverage decisions regarding experimental or investigational therapies for an individual with a life-threatening or seriously debilitating condition, as specified. Defines "life-threatening" as either or both of the following:
   a) Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted;

b) Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

Defines "seriously debilitating" as diseases or conditions that cause major irreversible morbidity. [HSC §1370.4 and INS §10145.3]

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

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author, health plans do not consistently decide or provide proper notice of their decisions concerning claims, such as prior authorization based on medical necessity and/or access to care and grievances within the time and manner specified by law, leading consumers to bear the financial cost of prescribed care while waiting for their health plans to respond. Sometimes, they are forced to forgo treatment altogether. Additionally, there are no internal claims and grievance procedures for health plans regulated by the CDI. California consumers do not have sufficient transparency and due process in the DMHC and CDI complaint processes, resulting in regulatory reviews that are one-sided and based on information that is often marred by inaccuracies, omissions, and misrepresentations. The author states that this bill sets forth internal claims and grievance procedures to improve transparency and provide due process for consumers filing regulatory complaints concerning denied health care services, coverage disputes, and access to care. This bill also clarifies consumers' rights to file grievances concerning a lack of access to care and allows consumers to file grievances immediately if their health plans or disability insurers fail to respond to their claims within the time period and in the manner required by existing law. Furthermore, this bill requires health plans and disability insurers to automatically resolve grievances in favor of the consumer if they do not respond within the legally required timeframe. The author concludes that this bill will improve transparency and provide due process for consumers filing regulatory complaints concerning denied health care services, coverage disputes, and access to care.

2) **BACKGROUND.** The DMHC Help Center assists consumers with understanding their health care rights and benefits, and helps to resolve complaints and coverage issues between health plan enrollees and health plans. In 2022, the DMHC Help Center assisted 128,405 health care consumers, and handled 12,266 complaints and 3,240 IMRs. Approximately 68% of consumers who submitted an IMR request to the DMHC Help Center received the service or treatment they requested.

   a) **Existing consumer protections.** In California, consumers have many health care rights, including the right to know why a plan denies a service or treatment, and the right to file a grievance if the consumer disagrees. Health plans are required to have grievance and appeals systems to assist consumers in resolving these issues. A health plan's grievance program informs consumers of their full grievance and appeal rights and the protections afforded to them under the law, including the right to pursue an IMR or file a complaint with the DMHC if they are dissatisfied with their health plan's decision. A robust grievance program also allows health plans to track and trend grievances for the purpose of uncovering systemic problems, thereby providing the opportunity for quality improvement.

   b) **Grievance and appeals under California law.** According to the author, this bill addresses two problems: i) the untimely adjudication of consumer claims and grievances

by health plans and disability insurers as required by existing law; and, ii) a lack of transparency and due process, as well as ex parte communication, with regard to regulatory complaints and IMR. In most circumstances, enrollees are required to file a grievance regarding each issue/request with a health plan and participate in the process for 30 days before submitting a complaint to the DMHC. Exceptions to this requirement include when there is an immediate threat to an enrollee's health or the request was denied as experimental/investigational. California law requires an expedited plan review of an imminent and serious threat to the health of the patient, including, but not limited to, severed pain, potential loss of life, limb, or major bodily function. Existing law also requires the health plan to provide enrollees, subscribers, and DMHC with a written statement on the disposition or status of the grievance no later than three days from receipt of the grievance.

If an enrollee's health plan denies, changes, or delays a request for medical services, denies payment for emergency treatment or refuses to cover experimental or investigational treatment for a serious medical condition, an enrollee can apply for an IMR. Before filing an IMR with the regulator, enrollees are first required to file a grievance with the health plan (absent an emergency). Once an enrollee has participated in the 30-day process with the health plan, if the issue has not been resolved or an enrollee is not satisfied with the decision, an enrollee can proceed with filing an IMR with the DMHC. According to the DMHC, if an enrollee's health problem is urgent, an IMR is usually decided within seven days after DMHC receives the supporting documentation from the enrollee, the doctor, and the health plan. This is an expedited IMR. A health problem is urgent if it is a serious and immediate threat to an enrollee's health. The enrollee must send DMHC written documentation that the enrollee's health problem is urgent. California law

If the enrollee's health problem is not urgent, an IMR is usually decided within 45 days after receipt of the supporting documentation from the enrollee, the doctor, and the health plan. An IMR can take longer if DMHC does not receive all of the medical records needed from the enrollee or treating doctor. The health plan is required to get copies of an enrollee's medical records from doctors who are in the network. This bill requires DMHC to provide enrollees unredacted copies of all correspondence between the DMHC and the plan regarding the enrollee's grievance.

3) **SUPPORT.** The National Union of Healthcare Workers (NUHW), sponsor of this bill, writes that this bill is motivated specifically by the shortcomings that NUHW members have encountered in advancing consumers' rights to due process and transparency when pursuing grievances and complaints regarding delays and denials of access to behavioral healthcare. Strengthening consumers' rights to timely resolution of their grievances and complaints made with plans and regulators, and to due process and transparency when pursuing these grievances and complaints, will result not only in resolving health plan violations more quickly and fairly, but in fewer improper denials of coverage and improper treatment limitations in the first place. NUHW states that more consumers will get the care for which they, their employers, and taxpayers have paid, and avoid needless cost for treatment of serious conditions that result from care delayed or denied. Barriers to self-assertion of patients' rights are most harmful to communities of color, recent immigrants, low-income Californians, and other residents of medically underserved areas who suffer from lack of

access to care. NUHW concludes that these communities stand to benefit the most from lifting those barriers.

The Steinberg Institute writes that this bill proposes essential reforms to empower consumers and protect their rights. By prohibiting health plans from overriding healthcare providers' urgency determinations and setting clear timelines for responding to consumers' claims and grievances, this bill will allow patients to access lifesaving care in a timely manner. This bill mandates that grievances be automatically resolved in favor of the consumer if a response is not provided within specified timeframes - 72 hours for urgent cases and 30 days for non-urgent cases. Additionally, it aims to align the state's "urgent care claims" definition with federal standards, enhancing clarity and consistency in the process. This bill's provisions to improve transparency and due process in regulatory complaint processes will ensure consumers have a fair chance when disputes arise.

4) **OPPOSITION.** The California Association of Health Plans, the Association of California Life and Health Insurance Companies, and America's Health Insurance Plans (collectively "opposition"), write that in the HMO model, generally providers are responsible for submitting authorization requests. This is a critical component to ensure that the requested service is clinically appropriate for the enrollee. Requiring the provider to submit the authorization request ensures that a clinical evaluation has been conducted. Additionally, allowing enrollees to submit authorization requests does not consider that they are unlikely to have the records needed to make a medical necessity review. All of this will complicate and delay the authorization process. The opposition also write that this bill limits health plans/insurers ability to conduct exemptions to grievances as unnecessary, would complicate the authorization process, and would add no value to the enrollee. This bill also creates potential conflict of interest by requiring health plans to send written responses of grievances to providers when the treating provider may actually be the subject of the grievance. The opposition concludes that this bill unfairly grants enrollees access to confidential communication while limiting health plan access to the same information.

5) **RELATED LEGISLATION.**

   a) AB 3221 (Pellerin) requires the records, books, and papers of a health plan and other specified entities to be open to inspection by the DMHC Director, including through electronic means. AB 3221 is pending in Assembly Health Committee.

   b) SB 294 (Wiener), beginning July 1, 2025, requires a health plan or a disability insurer that upholds its decision to modify, delay, or deny a health care service in response to a grievance or has a grievance that is otherwise pending or unresolved upon expiration of the relevant timeframe to automatically submit within 24 hours a decision regarding a disputed health care service to the IMR System, as well as the information that informed its decision, if the decision is to deny, modify, or delay specified services relating to mental health or substance use disorder conditions for an enrollee or insured up to 26 years of age. Requires a health plan or disability insurer, within 24 hours after submitting its decision to the IMR System to provide notice to the appropriate department, the enrollee or insured or their representative, if any, and the enrollee's or insured's provider. SB 294 was amended to include the provisions of SB 238 (Wiener) of 2023 after it was held in the Assembly Appropriations Committee. SB 294 is pending in the Assembly.

6) **PREVIOUS LEGISLATION.**

a) SB 238 (Wiener) of 2023 is substantially similar to SB 294 (Wiener). SB 238 was held in Assembly Appropriations Committee.

b) SB 858 (Wiener), Chapter 985, Statutes of 2022, increases the base amount of a civil penalty from $2,500 per violation to not more than $25,000 per violation, and authorizes a lower, proportionate penalty for specialized dental and vision health plans under DMHC's disciplinary authority. Adjusts the civil penalty base amount beginning January 1, 2028, and every 5 years thereafter, as specified. Doubles the minimum and maximum amounts of the civil and administrative penalties, and, beginning January 1, 2028, and every five years thereafter, adjusts these civil and administrative penalties, as specified. Authorizes the DMHC Director to impose a corrective action plan under certain circumstances.

c) SB 221 (Wiener), Chapter 724, Statutes of 2021, codifies existing timely access to care standards for health plans and insurers, applies these requirements to Medi-Cal Managed Care plans, and adds a standard for non-urgent follow-up appointments for nonphysician mental health care or substance use disorder providers that is within 10 business days of the prior appointment.

d) SB 855 (Wiener), Chapter 151, Statutes of 2020, revises and recasts California's Mental Health Parity provisions, and requires a health plan contract or disability insurance policy issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of mental health and substance use disorder, as defined, under the same terms and conditions applied to other medical conditions and prohibits a health plan or disability insurer from limiting benefits or coverage for mental health and substance use disorder to short-term or acute treatment. Specifies that if services for the medically necessary treatment of a mental health and substance use disorder are not available in network within the geographic and timely access standards in existing law, the health plan or insurer is required to arrange coverage to ensure the delivery of medically necessary out of network services and any medically necessary follow up services, as specified.

7) COMMENTS.

a) Inconsistency between the DMHC and CDI. As this bill moves forward, the author should consider making changes to the grievance and appeals process to ensure that both regulators are applying consumer protections consistently for California consumers.

b) Health information exchange. According to California's Health and Human Services Agency (CHHSA), California's sharing of health care data is a voluntary patchwork that limits the health care ecosystem from making material advances in equity and quality, and functionally inhibits patient access to personalized, longitudinal health records. CHHSA's Data Exchange Framework which requires the exchange of health information among health information among health care entities and government agencies in California is the first step to better coordinate health care. Through these efforts, the exchange of an enrollee's health care data, including information submitted as part of a grievance, should be closer to reality.

REGISTERED SUPPORT / OPPOSITION:

Support

National Union of Healthcare Workers (NUHW) (sponsor)
Asian Americans and Pacific Islanders for Civic Empowerment
Buen Vecino
California Association of Marriage and Family Therapists
California Federation of Teachers Afl-cio
California Labor Federation, Afl-cio
California Life Sciences
California Nurses Association
California Onecare
California Orthopedic Association
California State Association of Psychiatrists (CSAP)
California Youth Empowerment Network
County of Santa Clara
Courage California
Equality California
Hand in Hand: the Domestic Employers Network
Health Access California
Health Care for All - California
Healthcare Action Committee
Mental Health America of California
Steinberg Institute
The Kennedy Forum
Unite-here, Afl-cio

Opposition

America's Health Insurance Plans (AHIP)
Association of California Life & Health Insurance Companies
California Association of Health Plans
Local Health Plans of California

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

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 3271 (Joe Patterson) – As Introduced February 16, 2024

SUBJECT: Pupil health: opioid antagonists.

SUMMARY: Requires each public school operated by a school district, county office of education (COE), or charter school that has chosen to permit school nurses or voluntarily trained personnel to use naloxone hydrochloride (NH) or another opioid antagonist to provide emergency medical aid to persons suffering from an opioid overdose, to maintain at least two units of NH or another opioid antagonist on its site.

EXISTING LAW:

1) Establishes State Department of Public Health (DPH), directed by a state Public Health Officer (PHO), to be vested with all the duties, powers, purposes, functions, responsibilities, and jurisdiction as they relate to public health disease prevention. Gives the PHO broad authority to detect, monitor, and prevent the spread of communicable disease in the state. [Health & Safety Code (HSC) §131050 and §120130, *et seq*.]

2) Authorizes DPH, in order to reduce the rate of fatal overdose from opioid drugs including heroin and prescription opioids, to award funding to local health departments, local government agencies, or on a competitive basis to community-based organizations, regional opioid prevention coalitions, or both, to support or establish programs that provide naloxone, or any other opioid antagonist that is approved by the United States Food and Drug Administration (FDA) for the treatment of an opioid overdose, to first responders and to at-risk opioid users through programs that serve at-risk drug users, including, but not limited to, syringe exchange and disposal programs, homeless programs, and substance use disorder (SUD) treatment providers. [HSC §1179.80]

3) Establishes within the California Health and Human Services Agency a grant program to reduce fentanyl overdoses and use throughout the state by providing six one-time grants: two in northern California, two in the central valley, and two in southern California. [Welfare and Institutions Code §3200]

4) Permits a pharmacy to furnish NH or another opioid antagonist to a school district, COE, or charter school pursuant to existing law if certain requirements are met. [Business and Professions Code (BPC) §4119.8]

5) Authorizes a pharmacy, wholesaler, or manufacturer to furnish NH or other opioid antagonists to a law enforcement agency if specified conditions are met. [BPC §4119.9]

6) Classifies controlled substances under the California Uniform Controlled Substances Act, into five schedules and places the greatest restrictions and penalties on the use of those substances placed in Schedule I. Classifies the drug fentanyl in Schedule II. [HSC §11054-11058]

7) Establishes ongoing funding for COEs to purchase and maintain sufficient stock of emergency NH or another opioid antagonist for local educational agencies (LEAs) within its jurisdiction. [Education Code (EDC) §49414.8]

8) Authorizes school districts, COEs, and charter schools to provide emergency NH or another opioid antagonist to school nurses or trained volunteer personnel for the purpose of providing emergency medical aid to persons suffering, or reasonably believed to be suffering, from an opioid overdose. [EDC §49414.3 *et seq.*]

9) Authorizes public and private elementary and secondary schools to voluntarily determine whether or not to make emergency NH or another opioid antagonist and trained personnel available at its school. Requires a school to evaluate the emergency medical response time to the school and determine whether initiating emergency medical services is an acceptable alternative to NH or another opioid antagonist and trained personnel. [EDC §49414.3 (c)]

10) Requires the Superintendent of Public Instruction (SPI) to establish minimum standards of training for the administration of NH or another opioid antagonist and to review the minimum standards of training every five years, or sooner, as deemed necessary. Requires the SPI to consult with organizations and providers with expertise in administering NH or another opioid antagonist and administering medication in a school environment, including, the California Society of Addiction Medicine, the Emergency Medical Services Authority, the California School Nurses Organization, the California Medical Association, and the American Academy of Pediatrics. [EDC §49414.3(e)]

FISCAL EFFECT: None.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the author it is time we take the initiative to have simple and proven preventative care available to schools where our kids spend a majority of their time. The author argues that fentanyl is being disguised as candy and is readily available in every community and questions why we aren't we putting NH on every campus. The author continues that many schools refuse to carry NH, primarily because they are unsure about statutory authority and protection from liability. The author concludes that we can solve that by passing this bill to save lives at a nominal cost.

2) **BACKGROUND.** California is facing an overdose epidemic. According to a California Health Care Foundation 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. According to DPH, fentanyl-related overdose deaths increased 625% among youth ages 10 to 19 from 2018 to 2020. DPH's Opioid Overdose Dashboard reported there were 177 fentanyl-related overdose deaths and 1,165 opioid-related overdose emergency department visits among youth ages 10 to 19 years old in 2022.

   a) **Fentanyl.** Fentanyl is a potent synthetic opioid drug approved by the FDA for use as an analgesic and anesthetic. It is approximately 50 times stronger than heroin and 100 times

stronger than morphine. First developed in 1959, it was introduced in the 1960's as an intravenous anesthetic. Fentanyl is legally manufactured and distributed in the US; however, there are two types of fentanyl: pharmaceutical fentanyl and illicitly manufactured fentanyl. Both are considered synthetic opioids. Pharmaceutical fentanyl is prescribed by doctors to treat severe pain, especially after surgery and for advanced-stage cancer. Most recently, cases of fentanyl-related overdoses are linked to illicitly manufactured fentanyl that is distributed through illegal drug markets for its heroin-like effect. It is often added to other drugs because of its extreme potency, which makes drugs cheaper, more powerful, more addictive, and more dangerous.

The California Department of Education, in conjunction with DPH, provides LEAs with resources and information that they can provide to parents and students. The Fentanyl Awareness and Prevention toolkit page offer information about the risks of fentanyl and how to prevent teen use and overdoses. In addition to the toolkit, DPH's Substance and Addiction Prevention branch also provides resources for parents, guardians, caretakers, educators, schools, and youth-serving providers.

b) Reversing opioid overdoses. NH is the generic name for an opioid antagonist that rapidly reverses an opioid overdose. It attaches to opioid receptors and reverses and blocks the effects of other opioids. NH can quickly restore normal breathing to a person if their breathing has slowed or stopped because of an opioid overdose. NH comes in two FDA-approved forms: injectable and prepackaged nasal spray. Narcan nasal spray was first approved by the FDA in 2015 as a prescription drug.

According to the FDA, in accordance with a process to change the status of a drug from prescription to nonprescription, the manufacturer of Narcan provided data demonstrating that the drug is safe and effective for use as directed in its proposed labeling. The manufacturer also showed that consumers can understand how to use the drug safely and effectively without the supervision of a healthcare professional. The application to approve Narcan nasal spray for over-the-counter (OTC) use was granted priority review status and was the subject of an advisory committee meeting in February 2023, where committee members voted unanimously to recommend it be approved for marketing without a prescription.

As of July 2023 the FDA approved Narcan and RiVive, for OTC, nonprescription use. These are the first NH products approved for use without a prescription. This approval will allow the medications to be sold directly to consumers in drug stores, grocery stores, as well as online. According to an FDA Commissioner, "The approval of OTC NH nasal spray will help improve access to NH, increase the number of locations where it's available and help reduce opioid overdose deaths throughout the country. We encourage the manufacturer to make accessibility to the product a priority by making it available as soon as possible and at an affordable price."

c) NH Availability in California school districts. The 2023-24 state Budget appropriated $3.5 million annually for COEs to purchase and maintain a sufficient stock of emergency opioid antagonists for school districts and charter schools within their jurisdiction, and to maintain a minimum of two units at each middle school, junior high school, high school, and adult school site. As a condition of receiving the funding, each school or charter school must ensure two staff members meet minimum training standards.

d) DPH statewide standing order for NH. NH can help reduce opioid overdose deaths in California, but many organizations find it difficult to obtain the required standing order to obtain NH from health care providers. According to DPH, of the 7,175 opioid-related overdose deaths in 2021, 83% or 5,961 were related to fentanyl. The number of deaths each year involving fentanyl increased dramatically between 2012 and 2021. During this time period fentanyl related overdose deaths increased by more than 7,250% from 82 to 5,961 in 2021. DPH issued a standing order, in 2017, to address this need and support equitable NH access. The standing order:

i) Allows community organizations and other entities in California that are not currently working with a physician, to distribute NH to a person at risk of an opioid-related overdose or to a family member, friend, or other person in a position to assist; and,

ii) Allows for the administration of NH by a family member, friend, or other person to a person experiencing or reasonably suspected of experiencing an opioid overdose.

Among the organizations and entities that can distribute NH under the order are colleges and universities. An individual at risk of experiencing an overdose or someone who can assist an individual at risk is allowed to do so. Under the statewide standing order, staff of community organizations and other entities distributing NH must be trained. They are also required to provide training to individuals who receive NH from them. Colleges and other organizations may apply to use the statewide standing order if they meet certain conditions. As of November 2023, DPH stated that a standing order is no longer needed for Narcan due to its OTC status, all other formulations remain available by prescription only and require a standing order to distribute and administer.

e) Naloxone Distribution Project (NDP). A separate distribution program administered through the Department of Health Care Services (DHCS), the NDP allows various entities, including schools, universities and colleges, to apply for and obtain NH at no cost to the institution. As of February 20, 2024 the NDP has approved more than 10,800 applications for NH (17% of which are from schools and universities), distributed more than 3.8 million kits of NH and reversed more than 245,000 opioid overdoses. DHCS reports that less than one percent of the overdose reversals reported in the NDP occurred in schools and universities.

3) SUPPORT. The California Emergency Nurses Association (CA ENA) supports the bill, stating for the first time in California, drug overdoses are deadlier than car accidents and homicides combined. CA ENA argues that the potential of an opioid overdose is becoming more common as fentanyl is flooding into California and doses have been made to look like prescription drugs and even candy. CA ENA continues that this bill will help to save lives when minutes count by promoting easy access to an opioid blocker throughout our schools.

4) RELATED LEGISLATION.

a) AB 1915 (Arambula) requires DPH to develop by July 1, 2026, a training program and toolkit for public school pupils in grades nine to 12, to gain skills in how to identify and respond to an opioid overdose, including the administering of a federally approved opioid overdose reversal medication. AB 1915 is pending in Assembly Appropriations Committee.

b) AB 2998 (McKinnor) permits minors 12 years of age and above to consent to receiving, carrying, and administering NH or another opioid antagonist if approved by a physician. AB 2998 is pending in Assembly Health Committee.

c) SB 997 (Portantino) requires middle and high schools operated by a LEA to stock and distribute fentanyl test strips, in addition to authorizing LEAs, COEs, and charter schools to develop and adopt a policy that allows pupils in middle schools and high schools to carry federally approved NH. SB 997 is pending in Senate Health Committee.

5) PREVIOUS LEGISLATION.

a) SB 472 (Hurtado) of 2023 would have required each campus of a public school operated by an LEA, COE, or charter school to maintain at least two doses on its campus, and distribute, NH or another opioid antagonist pursuant to the standing order for naloxone and would have required LEAs, COEs, and charter school to report to the DHCS for failure to distribute naloxone. This bill was held on the Senate Appropriations Committee suspense file.

b) AB 915 (Arambula) of 2023 would have required DPH to develop by March 1, 2024, a training program and toolkit for public school pupils in grades nine to 12, to gain skills in how to identify and respond to an opioid overdose, including the administering of a federally approved opioid overdose reversal medication. AB 915 was held in the Senate Appropriations Committee suspense file.

c) AB 1748 (Mayes), Chapter 557, Statutes of 2016, authorizes school nurses and other trained personnel to use NH or another opioid antagonist to provide emergency medical aid to persons suffering, or reasonably believed to be suffering, from an opioid overdose.

d) SB 1438 (Pavley), Chapter 491, Statutes of 2014, required the development of training and other standards for the administration of NH by emergency medical technicians and other pre-hospital emergency care personnel.

e) AB 635 (Ammiano), Chapter 707, Statutes of 2013, revised certain provisions from a pilot program authorizing prescription of opioid antagonists for treatment of drug overdose and limiting civil and criminal liability, expanded these provisions statewide, and removed the 2016 sunset date for the pilot program. Permits a licensed health care provider who is authorized by law to prescribe an opioid antagonist, if acting with reasonable care, to prescribe and subsequently dispense or distribute an opioid antagonist to a person at risk of an opioid-related overdose or a family member, friend, or other person in a position to assist the person at risk, and limited the professional and civil liability of licensed health care providers and persons who possess or distribute opioid antagonists.

6) DOUBLE REFERRAL. This bill is double referred, it passed the Assembly Committee on Education with a 7-0 vote on March 20, 2024.

REGISTERED SUPPORT / OPPOSITION:

Support

Association for Los Angeles Deputy Sheriffs
California Association for Health, Physical Education, Recreation & Dance
California Consortium of Addiction Programs and Professionals
California District Attorneys Association
California Emergency Nurses Association
Orange County Sheriff's Department
San Diego County District Attorney's Office

Opposition

None on file.

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

Date of Hearing: April 16, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
AB 3275 (Soria and Robert Rivas) – As Amended April 1, 2024

SUBJECT: Health care coverage: claim reimbursement.

SUMMARY: Requires a health plan, including a specialized health plan, or health insurer, as specified, to reimburse a claim for a small and rural provider, critical access provider, or distressed provider within ten business days after receipt of the claim, or, if the health plan or health insurer contests or denies the claim, to notify the claimant within five business days that the claim is contested or denied. Specifies that the health plan or insurer has 15 business days after receipt of the additional information to complete reconsideration of the claim, if a claim for reimbursement to a small and rural provider, critical access provider, or distressed provider is contested on the basis that the health plan or health insurer has not received all information necessary to determine payer liability for the claim and notice has been provided. Specifies that interest accrue at a rate of 15% per annum for health plans and insurers if a claim is not reimbursed, contested, or denied pursuant to these timelines, as specified. Requires the Department of Managed Health Care (DMHC) or California Department of Insurance (CDI) to develop respective lists for categories of claims that a health plan or insurer is required to pay a small and rural, critical access, or distressed provider no later than five days after receipt of claim, as specified. Requires a health plan or insurer to maintain a registry of providers subject to this bill. Specifically, **this bill**:

1) Requires a health plan, including a specialized health plan, or insurer issuing group or individual policies of health insurance that covers hospital, medical, or surgical expenses, to reimburse a claim or portion of a claim for a small and rural, critical access, or distressed provider within 10 business days, unless the claim or portion is contested by the plan or insurer, in which case requires the health plan or insurer to notify the claimant that the claim is contested, in writing or via electronic means, within five business days after receipt of the claim by the health plan or insurer.

2) Requires the notice that a claim is being contested to identify the portion of the claim that is contested and the specific reasons for contesting the claim. Requires a health plan or insurer to be responsible for documenting that a provider has received notice of a contested claim.

3) Accrues interest at the rate of 15% per annum beginning with the first calendar day after the 10 business day period if a uncontested claim is not reimbursed by delivery to the claimants' address of record within specified timelines, consistent with existing law.

4) Revises the fee for a plan or insurer failing to comply with specified timelines to pay claims from $10 to a fee of no less than 10% of the accrued interest.

5) Requires the plan or insurer to have 15 business days after receipt of additional information to complete reconsideration of the claim if a claim or portion thereof for reimbursement to a small and rural provider, critical access provider, or distressed provider is contested on the

basis that the plan or insurer has not received all information necessary to determine payer liability for the claim or portion thereof and notice has been provided pursuant to this bill.

6) Accrues interest to be payable at a rate of 15% per annum beginning with the first calendar day after the 10-business-day period if a plan or insurer has received all of the information necessary to determine payer liability for a contested claim and has not reimbursed a claim it has determined to be payable within 10 business days of receipt of that information.

7) Requires DMHC and CDI to develop a list of categories of claims to be paid by a health plan and insurer to a small and rural provider, critical access provider, or distressed provider no later than five days after receipt of the claim, so long as the provider can document that care was provided. Allows categories to include, but are not limited to, emergency care levels one and two, uncomplicated labor and delivery, or skilled nursing facility care provided in a swing bed.

8) Requires a health plan or insurer to maintain a registry of small and rural providers, critical access providers, and distressed providers to facilitate compliance with this bill. Requires the registration to be available to the DMHC or CDI for verification and to providers to determine if they qualify for shorter reimbursement timeframes. Specifies that no action is required on the part of the provider in order to qualify for shorter reimbursement timeframes.

9) Applies provisions of this bill to Medi-Cal managed care plans, as defined.

10) Makes conforming changes to the prompt payment provisions for emergency care.

11) Applies the following definitions to this bill:
    a) Critical access provider as a hospital that is certified as a critical access hospital by the Secretary of the United States Department of Health and Human Services under the federal Medicare Rural Hospital Flexibility Program. Includes a physician with privileges at a critical access hospital;
    b) Distressed provider as a hospital that meets the standards established by Department of Health Care Access and Information (HCAI) for a hospital in financial distress under the Distressed Hospital Loan Program (DHLP) and for one year after HCAI has determined that the hospital no longer meets the standards for a hospital in financial distress. Includes a physician with privileges at a hospital, as described; and,
    c) Small and rural provider as a small and rural hospital, as defined in 6) below under existing law. Includes a physician with privileges at a small and rural hospital.

EXISTING LAW:

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

2) Requires health plans to ensure that all services be 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]

3) Requires contracts between providers and health plans to be in writing and prohibits, except for applicable copayments and deductibles, a contracted provider from invoicing or balance billing a health plan's enrollee for the difference between the provider's billed charges and the reimbursement paid by the health plan or the health plan's capitated provider for any covered benefit. Prohibits a provider, in the event that a contract has not been reduced to writing, or does not contain the prohibition above, from collecting or attempting to collect from the subscriber or enrollee sums owed by the health plan. Prohibits a contracting provider, agent, trustee, or assignee from taking an action against a subscriber or enrollee to collect sums owed by the health plan. [HSC §1367.03]

4) Prohibits a health plan from engaging in an unfair payment pattern, defined as, engaging in a demonstrable and unjust pattern of reviewing or processing complete and accurate claims that results in payment delays; engaging in a demonstrable and unjust pattern of reducing the amount of payment or denying complete and accurate claims; failing on a repeated basis to pay the uncontested portions of a claim within specified timeframes; and, failing on a repeated basis to automatically include the interest due on claims, as specified. [HSC §1371.37]

5) Requires a health plan or a health insurer to reimburse each complete claim, as specified, as soon as practical, but no later than 30 working days, or for a health maintenance organization (HMO), 45 working days, after receipt of the complete claim. Authorizes a health plan or insurer to contest or deny a claim, as specified within 30 working days, or 45 working days for a HMO, after receipt of the claim. Authorizes the health plan or insurer to request reasonable additional information about a contested claim within 30 working days, or for a HMO, 45 working days. Allows the health plan or insurer 30 working days, or a HMO 45 working days, after receipt of the additional information to reconsider the claim. Requires interest to accrue at 15% per annum (or $15 whichever is greater) once the plan or insurer has received all the information necessary to determine payer liability for the claim and has not reimbursed the claim deemed to be payable within 30 working days, or 45 working days for a HMO. Requires a health plan to automatically include in its payment of the claim all interest that has accrued without requiring the claimant to submit a request for the interest amount, and failure to comply with this requirement is subject to a $10 fee. [HSC §1371.35 and INS §10123.13]

6) Defines small and rural hospital as an acute care hospital that meets either of the following criteria:
   a) Meets the criteria for designation within peer group six or eight, as defined in the report entitled Hospital Peer Grouping for Efficiency Comparison, dated December 20, 1982;
   b) Meets the criteria for designation within peer group five or seven and has no more than 76 acute care beds and is located in an incorporated place or census designated place of 15,000 or less population according to the 1980 federal census. [HSC §124840]

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 is in response to findings that health plans are delaying prompt payment to many hospitals. These delays are severely impacting the financial viability of small and rural hospitals, critical access hospitals, and

distressed hospitals and their providers who disproportionately serve vulnerable Medicare and Medi-Cal patients. The current payment timeframes are not sustainable for these hospitals because of their payor mix while serving mostly vulnerable and people of color. Last year, the author led the charge to create the Distressed Hospital Loan Program (DHLP) to assist financially distressed hospitals and allow them to remain open. Many challenges remain for these hospitals but the author believes an accelerated payment timeline from health plans would go a long way to assist in the financial survival of these hospitals. The author points out commercial health plans are paying small and rural hospitals less than the costs of delivering services; these small and rural hospitals do not have the workforce and negotiating resources compared to these big and profitable health plans. Many challenges remain for these hospitals and there are various causes for rural hospital closures but the author believes the precarious finances that a delayed on non-payment of claims by health plans can greatly contribute to their decline. This bill is a critical first step to help sustain small and rural hospitals so they can deliver the needed services in rural areas.

The author concludes that existing timeframes on payment of claims were adopted in 2000 when most billing were paper or fax based/manual system and contributed to a lag in payment. In this 21st century, technology has evolved and advance and electronic billing is now the norm. There is just no excuse for health plans or health insurers to not pay these small and rural hospitals at a faster timeline.

2) **BACKGROUND.** According to a 2023 U.S. Government Accountability Office blog, more than 60 million Americans, about one-fifth of the U.S. population, live in rural areas. On average, rural residents are older and generally have worse health conditions than urban residents. But while they may require more medical attention and care, they also might have more limited access to health care. A 2022 University of Pennsylvania publication entitled, "The Plight of Rural Hospitals: They've Been Closing at a Faster Rate Than Urban Facilities for Years," indicates there is some evidence to suggest that rural hospital closures were more likely to occur in counties with larger shares of non-white residents. This is the context of rapidly changing demographics and migration patterns in rural America, which is becoming increasingly represented by racial and ethnic minority populations. There's also prior work showing that rural counties with higher proportions of non-Hispanic Black populations were more likely to lose access to obstetric care. Taken together, these trends raise concerns that the populations left behind may be overrepresented by communities of color. In a California Health Care Foundation 2023 blog, six rural hospitals in California were identified as at risk of closing, according to the Center for Healthcare Quality and Payment Reform. This bill shortens the timeframe for claims reimbursement to small and rural, critical access, or distressed providers.

   a) **Distressed hospitals**. In 2023, California created the DHLP to offer interest-free, working capital loans to non-profit and publicly-operated financially distressed hospitals, including hospitals that belong to integrated health care systems with no more than two separately licensed hospitals in California that are facing a risk of closure, while they implement turnaround strategies to regain financial viability. One of the criteria used to evaluate eligibility was cash on hand or whether the applicant was experiencing lower levels of cash. The author provided information that Madera Community Hospital, which closed in December of 2022, was a recipient of the loan, and one of the issues that emerged were the delays in prompt payment. The bankruptcy court handling Hazel Hawkins Memorial Hospital (Hazel Hawkins) highlighted reimbursement delays as one

of the events that led to the declaration of fiscal emergency for Hazel Hawkins. According to the March 2024 court order, "Anthem Blue Cross had approximately $4 million in delayed claims between August and December 2022."

b) Health Plan Requirements to Pay Timely Claims. In 2000, California passed SB 1177 (Perata), Chapter 825, Statutes of 2000, and AB 1455 (Scott), Chapter 827, Statutes of 2000, that authorized the DMHC to monitor the payment patterns of health plans, track plans' payment histories, and if a plan displays a pattern of slow payment, unfair denial of payment, downcoding (the practice of coding at a lower level or service supported by medical documentation or medical necessity) or other irregularities. California law requires HMOs to pay claims in 45 days and preferred provider organizations (PPOs) to pay claims in 30 days. Legislation also increased the interest on late payments from 10% to 15%. In addition, if an HMO determines that it paid an erroneous claim, it is up to the plan to prove the billing mistake. The DMHC, on its website, recognizes that it is important for hospitals, doctors and other providers to be paid promptly and accurately, and offers its Provider Complaint process as a means of ensuring prompt payment. Before the DMHC conducts a review, the provider is required to submit the dispute to the payor's Provider Dispute Resolution mechanism for a minimum of 45 working days or until receipt of the payor's written determination, whichever period is shorter. The DMHC will determine whether there is non-compliance with the provisions of the KKA. In many instances, a case review will make a determination of whether claims should have been paid, or whether interest is due. At the time SB 1177 regarding prompt pay was passed, proponents of the bill noted that health plans owed hospitals roughly $1 billion in overdue claims payment and that late payments from HMOs contribute to about 64% of California hospitals' financial losses.

c) DMHC Enforcement Actions. The DMHC released a March 2023 All Plan Letter (APL), noting that it has been contacted by a number of hospitals informing the DMHC that many health plans are not following the claims payment requirements which has resulted in delayed or non-payment of rendered services. DMHC reminded plans of the legal obligation to timely pay claims submitted by providers, including hospitals, that provide covered services to the plans' enrollees. In addition, plans must timely review and respond to provider requests for authorization of health care services. The APL reminded plans of those timely payment and utilization management obligations with respect to hospitals. The DMHC encouraged plans to go beyond the minimum requirements regarding timely payment and to evaluate how plans can support the hospitals in their networks to ensure enrollees continue to have timely and geographic access to hospital services. California law includes the following:

i) A plan must pay all claims within the statutory timeframes. If the plan pays a claim beyond the statutory timeframes, the plan's payment must automatically include specified interest and/or monetary penalties. If the plan contests a portion of a claim, the plan must reimburse any uncontested portions of the claim within the statutory timeframes;

ii) If a plan contests or denies all or a portion of a claim, the plan must specify the reason(s) for the contest or denial within the statutory timeframes. If the plan needs additional information to complete a claim, the plan must request such additional information within the statutory timeframes;

iii) Plans may not request irrelevant or unnecessary information from providers during claims processing, and must specify why the requested information is necessary to complete the claim;

iv) A plan or its delegate, if applicable, must timely reimburse complete claims for authorized services or for services that do not require prior authorization. The plan or its delegate are prohibited from rescinding or modifying an authorization after the authorized service has been rendered; and,

v) A plan must approve, modify, or deny, based on medical necessity, requests by providers prior to or concurrent with the provision of health care services within a timely fashion but no later than five business days from the plan's receipt of the request and no later than 72 hours if the enrollee faces an imminent and serious threat to their health.

Some of the most recent examples of DMHC enforcement actions that generally describe prompt pay violations include the following:

i) Health Net of California. On March 27, 2023, the DMHC initiated an enforcement action against Health Net of California, Inc. including a $225,000 fine for failing to properly reimburse thousands of claims to the plan's providers. Through a routine financial examination, the DMHC found the plan failed to accurately reimburse a portion of its claims including interest and penalties. The plan agreed to pay the fine, take corrective actions and remediated 34,433 claims totaling $1.2 million in payments to providers.

ii) Blue Shield of California. On December 13, 2023, DMHC fined Blue Shield of California $200,000 for mishandling provider claims.

iii) Anthem Blue Cross. In January 2024, DMHC fined Anthem Blue Cross $690,000 for delaying reimbursement to providers and members.

3) **SUPPORT.** The District Hospital Leadership Forum (DHLF) writes that district and municipal hospitals are proud to be local governments responsible for providing the health care needs of their communities. Over two-thirds are rural, and more than half have a critical access hospital designation, which are the smallest and most remote hospitals. In addition to rural and remote areas of California, district hospitals serve provider shortage areas, and urban underserved areas. In most communities, they are the sole provider of health care or specific services. Prior to the COVID-19 pandemic, most district and municipal hospitals were operating near break-even margins with some holding operating reserves. However, since the public health emergency, member hospitals have liquidated their reserves and now are facing significant financial distress, struggling with rising inflation and increased labor costs. Unfortunately, for the DHLP program, more than 30% of district and municipal hospitals qualified for these loans and received more than 50% of the available funds in the program. Given that district and municipal hospitals only represent 8% of hospitals statewide, qualifying for this level of support with short-term loans should illustrate the current financial status for these providers and the inherent risk of access to health care in the communities they serve. DHLF continues these efforts and if passed this bill would provide prompt access to claims reimbursement, bolstering the financial solvency of hospitals who

need it most. It is essential to preserve these services for patients when and where they need it most.

The California Hospital Association (CHA) state that hospitals must devote significant resources to a time-consuming communication and appeals process, just to receive payment for care that has already been provided. The situation is dire for our rural, critical access, and distressed hospitals, who serve our state's most vulnerable citizens. Such hospitals operate on very thin or even negative margins, and do not have reserves to support ongoing operations when plans delay payments for care provided to their members. In recent years, CHA has seen individual hospitals forced to declare bankruptcy or even close. While the financial pressures on these hospitals are multiple and complex, ensuring timely and accurate payment would address one of the major contributing factors.

4) **OPPOSITION.** The California Association of Health Plans, the Association of California Life and Health Insurance Companies, and America's Health Insurance Plans (collectively "opposition") write that hospitals are paid in part based on a Capitated Model, which are voluntary contracts under which health plans make periodic payments to providers. These payments are not tied to patient volume and provide an important funding source for keeping hospitals operating. These capitated payments are an important funding mechanism for our health care system, but they are also governed by consumer protection rules that ensure that both health plans and capitated providers remain financially solvent. The opposition states that the DMHC is entrusted with monitoring the financial solvency of both health plans and hospitals. Health plans are required to report their own claims timelines data to the DMHC on a quarterly basis and will be placed on a corrective action plan should they fail to pay claims on time 95% of the time. If the plan fails to pay the claim within the statutory timeframe, the payment is subject to interest and financial penalties, and the DMHC may take enforcement action against the plan. Member health plans have reported that the vast majority of clean claims are paid well within the current legal 30-day window. However, health plan payment systems are only as good as the information they receive. If the claim is missing information, it needs to be resubmitted, and notices are sent regularly to update all parties involved. This bill ignores all the work California's health plans have instituted to help financially distressed hospitals, including the utilization of $150 million from the Managed Care Organization (MCO) Tax and $300 million overall General Fund spending, which is going to the DHLP. This bill dramatically reduces the amount of time health plans have to adjudicate and pay claims. These are not reasonable amounts of time to adjudicate and pay claims appropriately, especially considering that health plans need to assess which type of provider is requiring the payment statutorily. Additionally, this bill would require health plans to overhaul their existing IT systems to separately track payment types for small and rural providers, critical access providers, and distressed providers, including physicians with privileges at those facilities. Providers generally maintain privileges at multiple facilities and are not necessarily financially stressed as a result of privileges at one particular facility. The opposition concludes that this bill would subsequently privilege certain providers over others, as health plans would be required to expedite claims processing for these providers for a specific service and track them in real-time, regardless of whether the services are rendered at a distressed hospital.

5) **RELATED LEGISLATION.** AB 2098 (Garcia) extends the repayment requirements for nondesignated public hospitals participating in a California Health Facilities Financial Authority loan program. AB 2098 is pending in Assembly Health Committee.

6) PREVIOUS LEGISLATION.

a) AB 112 (Committee on Budget), Chapter 6, Statutes of 2023, establishes the DHLP, until January 1, 2032, providing interest free cashflow loans to not-for-profit hospitals and public hospitals, as defined, in significant financial distress, or to governmental entities representing closed hospitals.

b) AB 1162 (Villapudua) of 2021 would have required a health plan or disability insurer that provides hospital, medical, or surgical coverage to provide access to medically necessary health care services to its enrollees or insureds that are displaced or otherwise affected by a state of emergency. Would have shortened the time requirements for a plan or insurer to pay or contest a claim for emergency or nonemergency services to 20 working days. Would have shortened the time limit for requesting additional information about a claim to 20 working days. AB 1162 was held in Assembly Appropriations Committee.

c) AB 454 (Rodriquez) of 2021 would have authorized the DMHC Director or the CDI Commissioner to require a health plan or health insurer to provide specified payments and support to a provider during and at least 60 days after the end of a declared state of emergency or other circumstance, as specified. AB 454 was held in the Assembly Appropriations Committee.

d) AB 2674 (Aguiar-Curry), Chapter 303, Statutes of 2018, requires the DMHC to review complaints of unfair payment patterns on or before July 1, 2019, and at least annually. Authorizes the DMHC to conduct an audit or an enforcement action, as specified, if the department determines the complaint review indicates a possible unfair payment pattern.

7) SUGGESTED AMENDMENT. Reimbursement in 5 days. This bill requires DMHC and CDI to develop a list for categories of claims that a health plan or insurer is required to pay no later than five days after receipt of a claim. As this bill moves forward, the author should consider requiring DMHC and CDI to develop a joint list. The author has agreed to amend this bill to specify an implementation date for this provision of January 1, 2026.

8) COMMENTS.

a) HMO versus PPO prompt pay timeframes. California law requires a health plan to reimburse PPO claims in 30 working days and HMO claims in 45 working days. As this bill moves forward, the author has agreed to align the two products so that all claims are paid within 30 days.

b) Medi-Cal Managed Care Plans. The proposed prompt pay timeframes in this bill apply to Medi-Cal managed care plans. At this time, the author intends to apply these timeframes to County Organized Health Systems overseen by the Department of Health Care Services in addition to plans regulated by DMHC. Moving forward, the author has agreed to continue working to ensure that the definition currently in this bill is consistent with the author's intent.

c) HIE. Health information exchange (HIE) allows health care providers and health plans to appropriate access and securely share patients medical information, including claims, electronically, improving the speed, quality, safety and cost of patient care. The

prevalence of HIE should assist health plans in paying electronic claims faster than paper claims.

REGISTERED SUPPORT / OPPOSITION:

Support

California Hospital Association
California State Council of Service Employees International Union
District Hospital Leadership Forum
Martin Luther King, Jr. Community Hospital

Oppose

Association of California Life & Health Insurance Companies
California Association of Health Plans
Local Health Plans of California

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