California State Assembly

HEALTH

MIA BONTA
CHAIR

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AGENDA

Tuesday, June 4, 2024
1:30 p.m. -- 1021 O Street, Room 1100

Bills heard in file order

Testimony may be limited:

2 witnesses per side, 2 minutes each

1.	SB 294	Wiener	Health care coverage: independent medical review.
2.	SB 908	Cortese	Fentanyl: child deaths.
3.	SB 1131	Gonzalez	Medi-Cal providers: family planning.
4.	SB 1132	Durazo	County health officers.
5.	SB 1213	Atkins	Health care programs: cancer.
6.	SB 1257	Blakespear	Geographic Managed Care Pilot Project: County of San Diego: advisory board.
7.	SB 1289	Roth	Medi-Cal: call centers: standards and data.
8.	SB 1428	Atkins	Health care coverage: triggering events.
9.	SB 1464	Ashby	Health facilities: cardiac catheterization laboratory services.

Date of Hearing: June 4, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 294 (Wiener) – As Amended May 24, 2024

SENATE VOTE: 31-7

SUBJECT: Health care coverage: independent medical review.

SUMMARY: Requires a health plan or disability insurer that provides coverage for mental health (MH) or substance use disorders (SUDs) to treat a modification, delay, or denial issued in response to an authorization request for coverage of treatment for a MH or SUD for an enrollee or insured up to 26 years of age as if the modification, delay, or denial is also a grievance submitted by the enrollee or insured. Requires a health plan or insurer that upholds its decision to modify, delay, or deny a health care service in response to a grievance to automatically submit within 24 hours a decision regarding a disputed health care service to the independent medical review (IMR) System, if the decision is to deny, modify, or delay specified services relating to MH or SUD conditions for an enrollee or insured up to 26 years of age. Specifically, **this bill**:

1) Requires a health plan or insurer, commencing January 1, 2026, that provides coverage for MH or SUDs to treat a modification, delay, or denial issued in response to an authorization request for coverage of treatment for a MH or SUD for an enrollee or insured up to 26 years of age as if the modification, delay, or denial is also a grievance submitted by the enrollee or insured, as specified.

2) Requires a grievance automatically generated pursuant to 1) above to be treated by the plan or insurer and the Department of Managed Health Care (DMHC) or California Department of Insurance (CDI) in the same manner as a grievance, and to be considered to have been submitted by the enrollee or insured or their representative to the plan or insurer on the same date as the decision to modify, delay, or deny the requested treatment is issued by the plan or insurer. Prohibits the plan or insurer from requiring the enrollee or insured or their representative to take any additional action to initiate or continue the grievance processing procedure.

3) Requires the plan or insurer to provide a written acknowledgment of the grievance generated concurrent with the notification to the enrollee or insured of 1) above and requires the acknowledgment to include an explanation of the grievance process and relevant timeframes for completion, specified criteria for treatment of a grievance as an expedited case, including whether the present grievance is to be processed on an expedited basis and automatically submitted to the IMR system, contact information for the plan or insurer, including a telephone number through which the enrollee or insured may receive a status update on the grievance or withdraw the automatically generated grievance, and contact information for the DMHC or CDI.

4) Requires the acknowledgment described in 3) above to include a statement that the enrollee or insured may choose to withdraw the automatically generated grievance. Prohibits a withdrawal by the enrollee or insured from, by itself, disqualifying the enrollee or insured or their representative from later submitting a grievance related to the same underlying modification, delay, or denial of the requested MH or SUD treatment.

5) Provides that grievances automatically generated pursuant to 1) above are subject to automatic submission to IMR, commencing January 1, 2026, within 24 hours of a decision regarding a disputed health care service to the IMR System and justification if the health plan or insurer's decision is to deny, modify, or delay either of the following with respect to an enrollee or insured up to 26 years of age:

   a) A MH or SUD service based on the lack of medical necessity of the requested covered health care service, in whole or in part; or,

   b) The use of experimental or investigational therapies, drugs, devices, procedures, or other therapies, if the enrollee or insured has a seriously debilitating or life-threatening MH or SUD condition, as defined. Specifies that the IMR for experimental or investigational therapies, drugs, devices, procedures, or other therapies be consistent with existing law.

6) Provides that an IMR required under this bill is subject to any relevant provisions of existing law that do not otherwise conflict, including notice requirements, the assessment fee system, and provisions regarding the DMHC or CDI's authority to determine the nature of a grievance as a matter of coverage or medical necessity, in whole or in part.

7) Prohibits the requirement that an enrollee or insured complete the health plan or insurer grievance process before automatic submission of a decision to the IMR System to cases involving an imminent and serious threat to the health of the enrollee or insured, as described in existing law. Requires the health plan or insurer to immediately submit the case to the IMR System and coordinate with the enrollee or insured or representative on the submission of all information and documentation required by the DMHC or CDI to process the expedited IMR.

8) Requires the health plan or insurer to provide notice to the DMHC or CDI, the enrollee or insured, their representative, if any, and their provider within 24 hours after submitting its decision to the IMR System pursuant to 7) above. Requires the notice to include the following:

   a) Notification to the enrollee or insured that they may cancel the IMR at any time before the rendering of a determination and may provide additional information or documentation as described;

   b) Instructions for canceling the IMR and submitting additional information or documentation;

   c) The DMHC or CDI's application for IMR; and,

   d) Any other content that is required by the DMHC or CDI.

9) Requires the health plan or insurer to, concurrent with the notice specified in 8) above, provide the enrollee or insured and the provider with copies of all documents, as described. Requires the health plan or insurer to coordinate with the enrollee or insured and provider for the completion of a signed IMR application that includes consent to release medical records and, if necessary, an authorized representative form.

10) Authorizes the DMHC or CDI to close IMR cases submitted automatically pursuant to this bill if the enrollee or insured or authorized representative fails to complete an IMR application within 30 days of the DMHC or CDI notifying the enrollee or insured or authorized representative and provider of the incomplete application.

11) Authorizes the DMHC Director or CDI Commissioner to issue instructions to health plans or insurers regarding compliance with this bill. Provides that such instructions be not subject to the Administrative Procedure Act (APA) until regulations are adopted pursuant to the APA.

12) Requires the DMHC or CDI to provide a quarterly public report on the number of automatic IMR cases that are received, the number of automatic IMR cases that are resolved, the outcome of resolved cases, and the number of automatic IMR cases that are canceled and closed.

13) Exempts Medi-Cal managed care plan contracts, as specified.

14) Makes various findings and declarations, including the following:

    a) In 2021, MH disorder diagnosis cases made up 48% of all total youth IMRs, up from 36% in 2017;

    b) Since 2017, the percentage of health plan and insurer decisions about youth MH disorders that were overturned by the IMR System has more than doubled to 79%; and,

    c) Like older adults, children and youth represent a vulnerable population. However, children and youth covered by commercial health care coverage do not have the protections afforded by Medicare procedures. If a Medicare Advantage (Part C) health plan upholds its initial adverse organization determination to deny a drug or service, the plan must automatically submit the case file and its decision for review by the Part C Independent Review Entity.

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 under the Insurance Code. [Health and Safety Code (HSC) §1340, *et seq*., and Insurance Code (INS) §106, *et seq*.]

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

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

4) Requires a health plan or insurer that provides hospital, medical, or surgical coverage to base any medical necessity determination or the utilization review criteria that the plan, and any entity acting on the plan’s behalf, applies to determine the medical necessity of health care

services and benefits for the diagnosis, prevention, and treatment of MH and SUDs on current generally accepted standards of MH and SUD care, as specified. Requires a health plan or insurer to apply the criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty in conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of MH and SUDs in children, adolescents, and adults. [HSC §1374.721 and INS §10144.52]

5) 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, to 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]

6) Requires every health plan to establish and maintain a grievance system approved by the 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]

7) Allows a subscriber or enrollee to submit a grievance to DMHC for review after completing the plan's grievance process for at least 30 days, unless determined by the DMHC to be a case involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, cancellations, rescissions, or the nonrenewal of a health plan contract, or in any other case where the DMHC determines that an earlier review is warranted. [*ibid.*]

8) 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]

9) 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.

10) Requires, if there is an imminent and serious threat to the health of the insured or enrollee, all necessary information and documents to be delivered to an IMR organization within 24 hours of approval of the request for review. Defines "seriously debilitating" as diseases or conditions that cause major irreversible morbidity. 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; or,
    b) Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival. [HSC §1370.4 and INS §10145.3]

11) Requires DMHC or CDI to expeditiously review IMR requests and immediately notify the insured or enrollee if the request has been approved, in whole or in part, and, if not, the reasons for the denial. Requires the plan or insurer to promptly issue a notification to the enrollee or insured, after submitting all of the required material to the IMR organization, including an annotated list of documents submitted and offer the enrollee or insured the opportunity to request copies of those documents. Requires any request for IMR not approved by DMHC or CDI to be treated as an immediate request to review the grievance. [HSC §1374.31 and INS §10169.1]

FISCAL EFFECT: According to the Senate Appropriations Committee,

1) Unknown ongoing costs to DMHC for staffing and resources due to an increase in the number of IMRs to be processed under this bill, likely in the low tens of millions annually (Managed Care Fund).

2) Unknown ongoing costs to CDI, likely hundreds of thousands, for state administration (Insurance Fund).

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, this bill will ensure that young people receive faster access to treatment by requiring MH treatment denials made by commercial insurance plans for children and young people under the age of 26 in California to automatically be referred to the state's existing IMR process in life threatening cases and to an auto-grievance process followed by an IMR review if treatment is still denied in non-life threatening cases. Unfortunately, many young people are denied MH coverage by their insurance companies, but a very high percentage of those who seek review get their denial overturned. Nearly all families that do seek review are English speakers, signifying that almost no multilingual speakers are seeking review. By requiring automatic review of denials, this bill will remove burdensome barriers that prevent families from accessing care and will ensure no child is denied care because of an insurance company's decision to maximize its profits at their expense.

2) BACKGROUND.

a) MH and Children. In a July 2022 California Health Care Foundation (CHCF) publication entitled, "Mental Health in California: Waiting for Care," CHCF reported that nearly one in seven adults (an estimated 4.4 million individuals) statewide experiences a mental illness of some kind. One in 26 (an estimated 1.2 million individuals) has a

Serious Mental Illness that makes it difficult to carry out daily activities. Additionally one in 14 (an estimated 621,000) children has a Serious Emotional Disturbance (SED) that limits functioning in family, school, or community. The CHCF report found that SED in California children varied slightly by race/ethnicity. SED is more common among children in families with lower incomes. One in 10 children in families below the federal poverty level experienced a SED. In 2018 and 2019, approximately 6% of California children experienced anxiety and about 3% experienced depression. Between 2015–16 and 2018–19, the percentage of adolescents reporting a major depressive episode (MDE) increased in California and the United States. One in seven adolescents reported experiencing an MDE in the past year in 2018–19. Approximately 70% of teens who have an MDE experience functional limitations that meet criteria for severe impairment. According to Mental Health America, in 2022-23, 16.39% of youth aged 12-17 reported suffering from at least one depressive episode. Further, nearly 12% of youth experienced severe major depression and nearly 60% of youths suffering from MDE did not receive MH treatment. In California, 114,000 youths were not treated for their MDE. Only 28% of youth with severe depression received some consistent treatment.

b) Grievance and appeals under California law. Under state law, 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 application with the DMHC. This bill removes the requirement that an enrollee has to apply for an IMR and instead requires a health plan that upholds a medical necessity denial on appeal for a MH or SUD condition for a child to automatically submit the request to IMR.

i) Non-urgent. According to the DMHC, 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.

ii) Urgent. 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 called an expedited IMR. A health problem is urgent if it is a serious and immediate threat to an individual's health. The enrollee must send DMHC written documentation that the enrollee's health problem is urgent. This bill specifies that enrollees are not required to appeal a denial prior a plan's automatic submission of a decision to IMR in cases involving an imminent and serious threat to the enrollee's health.

c) DMHC IMRs. The author and sponsors of this bill provided information detailing that through the IMR process, the MH diagnosis category has increased for youth under the age of 21, especially from 2017-2022. In 2021, more than 50% of all youth IMR cases were for a MH diagnosis. According to the DMHC Annual Report, approximately 67.5%

of enrollees that submitted IMR requests in 2021 received the service(s) or treatment(s) they requested. Of those decisions, 19% were reversed by the health plan before being reviewed, 49% of cases denied by health plans were overturned by IMR providers, and 32% were upheld. In 2023, the author notes that 76% of health plan denials were overturned by IMR for children and youth to age 20. Since 2017, the percentage of IMRs overturning health plans' decisions has more than doubled.

3) **SUPPORT**. Children Now, a cosponsor, writes that while the IMR process allows for greater oversight of health plans, it places the burden on the consumer and delays or prevents children and youth in California from accessing critical, timely MH treatment. Language barriers, health literacy, and demanding jobs may prevent some parents from filing IMRs, furthering MH access inequities. The cosponsor states that because MH resources are disproportionately hard to access for low-income and minority children, MH treatment denials for urgent services for children and youth in California should automatically be sent to the IMR process, while non-life threatening denials should be filed as a grievance. This policy change would ensure that plan denials do not go unnoticed or unchallenged due to health equity and literacy barriers. The County of Santa Clara (County), also a cosponsor, write that counties serve as backstop for those who are underserved or inappropriately served by commercial plans, providing for individuals through crisis care, school-based services, and other specialty services. Insufficient care by commercial plans too frequently causes behavioral health conditions to deteriorate, with severe consequences to enrollees and impacts that are felt across the broader safety nets provided by counties. The County's Behavioral Health Services Department provides treatment for residents experiencing serious MH disorder or SED. Last year, roughly half the County's MH clients were 26 years old or younger, reflecting a broader trend showing a rise in the rates of behavioral health disorders for children and youths. The County values this bill as an important step forward to ensure more timely review and minimize barriers faced by children and young adults and their families trying to access the care they need. Given that approximately 50% of all MH disorders begin by age 14, and 75% by age 24, eliminating barriers and delays to care is vital. Shifting the responsibility and burden of escalating grievances away from parents, empowers families and prevents unnecessary delays and barriers to accessing care.

4) **OPPOSITION**. The California Association of Health Plans, the Association of California Life and Health Insurance Companies, and America's Health Insurance Plans (opposition) write that this bill proposes to create a new, bifurcated review process which requires health plans and insurers to automatically review all youth related MH services when the plan has issued an initial denial, delay or modification. While many initial denials, delays or modifications can be resolved through a plans/insurers' internal review process, the opposition believes that is excessive to require that every modification or denial should automatically be submitted for review regardless of merit. The opposition contends that it is critical to acknowledge that should a grievance move forward, the success of these reviews are dependent on the engagement of the individual patient and/or physician. This bill expressly prohibits health plans and insurers from requiring that the patient or provider take any action to initiate or continue the grievance processing procedure. Without their involvement, the grievance process will likely result in an increase in unnecessary adverse benefit determinations due to lack of involvement or input. The opposition is also concerned that this bill may unintentionally create patient privacy concerns. Currently, the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 Privacy Rule expressly prohibits covered entities from sharing psychotherapy notes without direct consent

from the enrollee. Psychotherapy notes may be required for health plans and insurers to adequately assess medical necessity. The opposition writes that automatically referring cases to IMR and requiring plans/insurers to provide clinical notes, without the explicit authorization of the patient, puts health plans and insurers in the untenable position of violating federal HIPAA laws while attempting to comply with the requirements of this bill.

5) **RELATED LEGISLATION**. AB 3260 (Pellerin) 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 health plan, for grievances. Requires the health plan or insurer to provide specified correspondence and documents to an enrollee or insured if the enrollee or insured has submitted a grievance concerning a disputed health care service or coverage decision to DMHC or CDI. AB 3260 is pending in Senate Rules Committee.

6) **PREVIOUS LEGISLATION**.

   a) SB 238 (Wiener) of 2023 was similar to this bill. SB 238 was held in Assembly Appropriations Committee.

   b) SB 855 (Wiener), Chapter 151, Statutes of 2020, revises and recasts California's MH 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 MH and SUD, 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 MH and SUD to short-term or acute treatment. Specifies that if services for the medically necessary treatment of a MH and SUD 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) **COMMENT.** This bill establishes a new appeal process for enrollees up to 26 years old who have received a denial of MH or SUD services. This bill also excludes Medi-Cal managed care plans. However, denials are also occurring in other health care services that are subject to IMR. Given the consumer impact of these denials, it may be prudent for the Legislature to consider a broader review of the timeframe associated with all IMRs to ensure continuity and timely access to health care services.

REGISTERED SUPPORT / OPPOSITION:

Support

Children Now (sponsor)
County of Santa Clara (sponsor)
Alliance of Californians for Community Empowerment (ACCE) Action
American Academy of Pediatrics, California
Asian Americans Advancing Justice-southern California

Autism Behavior Services INC.
Autism Speaks
Autism Speaks
Bay Area Council
Board of Behavioral Sciences
California Academy of Child and Adolescent Psychiatry
California Alliance of Child and Family Services
California Association of Social Rehabilitation Agencies
California Children's Hospital Assn
California Coalition for Pans/pandas Advocacy
California Hospital Association
California Medical Association
California Pan - Ethnic Health Network
California Psychological Association
California School-based Health Alliance
California Yimby
Children's Specialty Care Coalition
Council of Autism Service Providers (CASP)
County Behavioral Health Directors Association of California
County of San Diego
Courage California
Culver City Democratic Club
Democrats for Israel - CA
Democrats for Israel Los Angeles
Didi Hirsch Mental Health Services
Dir/floortime Coalition of California
Etta
Foster Care Counts
Friends Committee on Legislation of California
Greenhouse Therapy Center
Hadassah
Health Access California
Holocaust Museum LA
Jcrc Bay Area
Jewish Center for Justice
Jewish Community Federation and Endowment Fund
Jewish Democratic Club of Marin
Jewish Democratic Club of Solano County
Jewish Democratic Club of the Bay Area
Jewish Family and Children's Service of Long Beach and Orange County
Jewish Family and Children's Services of San Francisco, the Peninsula, Marin and Sonoma Counties
Jewish Family Service of Los Angeles
Jewish Family Service of San Diego
Jewish Family Service of The Desert
Jewish Family Services of Silicon Valley
Jewish Federation of Greater Los Angeles, the
Jewish Federation of The Greater San Gabriel and Pomona Valleys
Jewish Long Beach

Jewish Public Affairs Committee
Jewish Silicon Valley
Jvs Socal
Latino Coalition for A Healthy California
Mental Health America of California
National Health Law Program
Progressive Zionists of California
San Diego; County of
Santa Clara County Office of Education
Seneca Family of Agencies
South Pasadena Residents for Responsible Growth
Steinberg Institute
Sunrise Silicon Valley
The Children's Partnership
The Council of Autism Service Providers
The Kennedy Forum
Western Center on Law & Poverty, INC.

Opposition

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

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

Date of Hearing: June 4, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 908 (Cortese) – As Amended May 16, 2024

SENATE VOTE: 38-0

SUBJECT: Fentanyl: child deaths.

SUMMARY: Requires the Department of Public Health (DPH) to use best efforts to utilize all of its relevant data to monitor and identify current trends of fentanyl-related deaths of children up to five years of age. Specifically, **this bill**:

1) Requires DPH to use best efforts to utilize all of its relevant data to monitor and identify current trends of fentanyl-related deaths of children up to five years of age.

2) Requires DPH to develop guidance and spread awareness of the trends to protect and prevent children from fentanyl exposure.

3) Requires DPH, commencing June 1, 2025, to annually distribute findings and guidance to local health departments, county boards of supervisors, and the Legislature.

4) Permits, but does not require, a local health department or county board of supervisors to adhere to guidance distributed by DPH.

5) Repeals the provisions of this bill on January 1, 2031.

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 disease prevention, as specified. 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) Requires a county coroner to inquire into and determine the circumstances, manner, and cause of certain deaths, including all violent, sudden, or unusual deaths, and deaths due to drug addiction, among other types of deaths. [Government Code (GOV) §27491]

3) Permits a county Board of Supervisors to abolish the office of coroner and provide instead for the office of medical examiner, as specified, and requires the medical examiner to be a licensed physician qualified as a specialist in pathology. [GOV §24010]

4) States the intent of the Legislature that fatal drug overdose information be used for the purpose of making decisions regarding the allocation of public health and educational resources to communities adversely impacted by the use of drugs that lead to overdoses. [HSC §11758.02]

5) Requires a coroner or medical examiner who evaluates an individual who died, in the coroner or medical examiner's expert opinion, as the result of an overdose as a contributing factor, to

report the incident to the Overdose Detection Mapping Application Program (ODMAP) managed by the Washington/Baltimore High Intensity Drug Trafficking Area program. [HSC §11758.04]

FISCAL EFFECT: According to the Senate Appropriations Committee, DPH estimates General Fund costs of $259,000 per year until January 1, 2031, for staffing resources.

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, 25 children younger than five died between 2019 and 2022 from fentanyl poisoning in California. The author argues that with the distressing increase in fentanyl-related fatalities among the state's youngest residents, this bill takes steps to mitigate exposure risks for infants and toddlers. The author concludes that this bill addresses the critical need for a standardized public health response to the fentanyl crisis by mandating DPH to track and analyze trends in fentanyl poisonings of children aged zero to five, develop preventative guidelines, and annually disseminate the findings to counties, local officials, and the Legislature.

2) **BACKGROUND**. California is facing an overdose epidemic. According to a 2022 California Health Care Foundation report "Substance Use in California: Prevalence and Treatment," 9% of Californians have met the criteria for a substance use disorder (SUD). While the health care system is moving toward acknowledging SUDs as a chronic illness, only about 10% of people with a 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.

   a) **Fentanyl.** Fentanyl is a potent synthetic opioid drug approved by the United States Food and Drug Administration 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.

   b) **DPH Overdose Dashboard.** As part of DPH's Opioid Prevention Initiative, DPH maintains the California Overdose Surveillance Dashboard (Dashboard). The Dashboard tracks deaths related to any opioid overdose, deaths related specifically to fentanyl, emergency department (ED) visits related to any opioid overdose, and the number of prescriptions issued for opioids in California. The data can be broken down by County, sex, age, race/ethnicity, or a specified time frame. The Dashboard reported there were 10 fentanyl-related overdose deaths and 15 fentanyl-related overdose ED visits, and 35 fentanyl-related overdose hospitalizations among children under five years of age in 2022.

c) **ODMAP.** In 1988, Congress created the High Intensity Drug Trafficking Areas (HIDTA) program to provide assistance to federal, state, local, and tribal law enforcement agencies operating in areas determined to be critical drug-trafficking regions of the United States. There are currently 33 HIDTAs, including four in California: Central Valley, Northern California, Los Angeles, and San Diego/Imperial Valley.
In January of 2017, the Washington/Baltimore HIDTA launched ODMAP as a response to the lack of a consistent methodology to track overdoses, which limited the ability to understand and mobilize against the crisis. ODMAP is a free, web-based tool that provides near real-time suspected overdose surveillance data across jurisdictions to support public safety and public health efforts to mobilize an immediate response to a sudden increase, or spike in overdose events. For over five years, ODMAP has been available to government (state, local, federal, or tribal) agencies serving the interests of public safety and health. Each agency wishing to participate signs a data-sharing agreement that is designed to protect the data within the system. Once signed, they can begin uploading data and have access to the National Map feature which allows users to view nationwide data and built-in analytical tools (i.e., filters, pre-built charts, and adding additional data layers). Additionally, once an agency is approved, they can set up county-level spike alerts.

   Currently, there are almost 4,000 agencies in all 50 states, the District of Columbia, and Puerto Rico who are utilizing the tool. To date more than 850,000 overdose events have been entered.

d) **Media coverage of infant overdose deaths.** Since 2020, the *San Jose Mercury News* has covered the fentanyl-related deaths of five children under the age of two in the Bay Area. In a subsequent story published on March 23, 2024, the author is cited as saying this bill was inspired by this ongoing reporting. The author is also cited as suggesting delaying the reunification of children younger than age five with parents who have a SUD. The article notes that from 1999 to 2021, just over 340 children under age five nationally were killed by fentanyl, including 105 who were younger than one year old. However, some experts noted in the article that the state already does a decent job providing policy guidance to counties on how to handle tricky child abuse cases and that the recent deaths were due to dysfunctional county policies and practices, not faulty state guidance. Other experts were cautious about any state policy that automatically delayed the reunification of children with parents suffering from SUD. Experts also said a problem with releasing this data on child fatalities is that there are few recorded, about a dozen or fewer statewide each year, and publishing these statistics could present privacy concerns.

3) **SUPPORT**. First 5 Santa Clara County supports this bill, stating that over the last two decades more than 100 infants younger than age one died from fentanyl poisoning. In California alone, 25 children younger than five died between 2019 and 2022. First 5 Santa Clara County continues that with the distressing increase in fentanyl-related fatalities among the state's youngest residents, this bill takes steps to mitigate exposure risks by codifying the analysis of data already being collected by DPH. First 5 Santa Clara County argues that this information will inform and educate elected officials, health departments, and families about a standardized public health response to ensure this trend does not continue to rise.

4) RELATED LEGISLATION.

a) AB 1859 (Alanis) requires a coroner to test the bodily fluid of a deceased person for the presence of xylazine if the coroner reasonably suspects the person died from an accidental or intentional opioid overdose or if the person was administered an overdose intervention drug prior to death and was unresponsive to the drug. AB 1859 is currently pending in the Senate Rules Committee.

b) AB 2871 (Maienschein) authorizes a county to establish an interagency overdose fatality review team to assist local agencies in identifying and reviewing overdose fatalities, facilitate communication among persons and agencies involved in overdose fatalities, and integrate local overdose prevention efforts through strategic planning, data dissemination, and community collaboration. AB 2871 is currently pending in the Senate Rules Committee.

5) PREVIOUS LEGISLATION. SB 67 (Seyarto), Chapter 859, Statutes of 2023, requires coroners and medical examiners to report actual or suspected overdoses to the Emergency Medical Services Agency, which is then required to submit this data to the ODMAP.

REGISTERED SUPPORT / OPPOSITION:

Support

Mayor Todd Gloria, City of San Diego
American Academy of Pediatrics, California
Ella Baker Center for Human Rights
First 5 California
First 5 Santa Clara County
Steinberg Institute

Opposition

None on file.

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

Date of Hearing: June 4, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1131 (Gonzalez) – As Amended May 16, 2024

SENATE VOTE: 31-8

SUBJECT: Medi-Cal providers: family planning.

SUMMARY: Allows additional flexibility for Family Planning, Access, Care and Treatment (Family PACT) clinics to identify a "site certifier" at the clinic level, requires Department of Health Care Services (DHCS) to comply with specified requirements related to orientation and training of site certifiers, and excludes a Family PACT clinic from disenrollment in the program for conduct that is not deemed to be unprofessional conduct under California law. Specifically, this bill:

1) Allows a clinic corporation that operates a primary care clinic that serves as a parent clinic and one or more of its affiliate primary care clinics to enroll all or multiple service addresses in the Family PACT program under one site certifier.

2) Allows a site certifier to be any employee of a primary care or affiliate care clinic, including non-clinicians.

3) Defines "site certifier" as an individual identified by the enrolled or enrolling provider to be responsible for ensuring that all practitioners and personnel providing services on behalf of the Family PACT program complete and track required trainings approved by DHCS's Office of Family Planning on an annual basis.

4) Requires any orientation or training required by DHCS to be offered at least once per month, in person and through a virtual platform, and to be updated at least annually to be consistent with current laws, policies, and medical standards.

5) Requires DHCS to allow providers a minimum of six months from the date of enrollment to complete the required orientation.

6) Creates an exception from requirements that DHCS disenroll from Family PACT a provider whose license, certificate, or other approval is revoked, lost, or surrendered pending a disciplinary hearing, if the revocation, loss, or disciplinary hearing is a result of conduct that is not deemed to be unprofessional conduct under California law. Creates a similar exception for a provider listed on lists of suspended or ineligible providers published by the federal Office of the Inspector General, to the extent an individual's inclusion on the list is based on conduct not deemed to be unprofessional conduct under California law.

EXISTING LAW:

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

2) Establishes the Family PACT program, administered by DHCS, to provide family planning services for men and women, including emergency and complication services directly related to the contraceptive method and follow-up, consultation, and referral services. [WIC §24007]

3) Requires providers offering the full range of family planning medical services covered by Family PACT to be licensed medical personnel with family planning skills, knowledge, and competency, and enrolled Medi-Cal providers. [*Ibid.*]

4) Requires DHCS to require providers to enter into clinical agreements with DHCS to ensure compliance with program standards and maintain the fiscal integrity of the program. Requires DHCS to screen applicants and to deny enrollment to any applicant who has been convicted of or is under investigation for fraud or abuse. [WIC §24005]

5) Requires enrolled providers to attend specific orientation approved by DHCS in comprehensive family planning services. [*Ibid.*]

FISCAL EFFECT: According to the Senate Committee on Appropriations, unknown ongoing costs, likely hundreds of thousands (General Fund and federal funds), to DHCS for state administration.

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, since 1997, California has been providing family planning services to low-income individuals at no cost through the Family PACT program under Medi-Cal. Family PACT clinics must be certified by a designated health care professional. Despite being in a health care workforce shortage, the author indicates the state continues to limit who can certify a clinic for Family PACT services. By limiting which professionals can certify a site, clinics have a difficult time providing these essential services to their community. This bill is intended to increase access to essential family planning services by streamlining Family PACT enrollment requirements, including who can certify a clinic, and addressing additional barriers.

2) BACKGROUND.

a) Family PACT. Family PACT provides comprehensive clinical family planning and family planning-related services to qualified individuals with incomes below 200% of the federal poverty level. According to DHCS, Family PACT is designed to narrow the gap between insured and uninsured individuals in California. The program is designed to make contraception easily accessible to individuals who qualify. Unlike other programs with more complex and lengthy eligibility processes, enrolled Family PACT providers can determine an individual's eligibility for Family PACT at the site of clinical service delivery, on the same day the individual seeks services.

b) Current Site Certification Requirements. A provider's enrollment is location-specific and only the service location is enrolled in Family PACT. Individual practitioners are not enrolled in Family PACT and are instead added under a location's enrollment. Each service location must designate one eligible representative, who works at the service location, to be the location's site certifier. A medical director, physician, physicians assistance (PA), certified nurse practitioner, or certified nurse midwife who is enrolled as

a Medi-Cal provider is eligible to certify the site. The designated site certifier must be identified on the application for enrollment and is responsible for overseeing the family planning services rendered at the identified service location to be enrolled.

Site certifiers can only certify one location and are responsible for ensuring all practitioners and personnel providing services on behalf of the Family PACT Program complete and track trainings required by Office of Family Planning. The Office has three separate learning tracks: one for site certifiers, one for clinicians, and one for administrators. While most of the trainings are self-directed online trainings, site certifiers also attend a virtual orientation that is currently offered every other month. This bill would require the orientation to be offered every month.

3) **SUPPORT**. Cosponsor, the California Academy of PAs (CAPA) write in support of including PAs as site certifiers. CAPA points to a California Health Care Foundation report that states that PAs are more likely to work in rural areas and with underserved populations than physicians are. Cosponsor Planned Parenthood Affiliates of California writes that while they support the intended purpose of the Family PACT site certifier program, many of the current site certifier requirements are difficult to implement with Planned Parenthood's affiliated structure wherein a centralized administrative office oversees the operations across multiple health centers.

4) **RELATED LEGISLATION.** AB 90 (Petrie-Norris) of 2023 specifies inpatient services related to the placement or insertion of a contraceptive device are a covered benefit in the Family PACT Program. AB 90 is pending in the Senate Health Committee.

5) **PREVIOUS LEGISLATION**.

   a) SB 487 (Atkins), Chapter 261, Statutes of 2023, authorizes DHCS to elect not to suspend a Medi-Cal provider who has a license, certificate, or other approval to provide health care suspended or revoked in another state if the revocation or suspension is based solely on conduct that is not that is not deemed to be unprofessional conduct under California law.

   b) AB 1524 (Chiu) of 2019 would have required expedited enrollment of specified clinics and student health centers in the Family PACT program. AB 1524 was held on the Assembly Appropriations Committee Suspense file.

   c) AB 2051 (Gonzalez-Fletcher and Bocanegra), Chapter 356, Statutes of 2014, streamlined the process for affiliate primary care clinics into the Medi-Cal and Family PACT programs.

REGISTERED SUPPORT / OPPOSITION:

Support

California Academy of PAs (cosponsor)
Planned Parenthood Affiliates of California (cosponsor)
California Association for Nurse Practitioners
Equality California
LeadingAge California

Reproductive Freedom for All

Opposition

None on file.

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

Date of Hearing: June 4, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1132 (Durazo) – As Amended April 9, 2024

SENATE VOTE: 36-0

SUBJECT: County health officers.

SUMMARY: Clarifies that "private detention facilities," as defined under existing law, are subject to inspection by local health officers (LHOs).

EXISTING LAW:

1) Requires each county board of supervisors (board) to appoint a LHO. Requires LHOs to enforce and observe orders of the board pertaining to public health and sanitary matters, including regulations prescribed by the California Department of Public Health (DPH), and statutes relating to public health. [Health and Safety Code (HSC) §101000 and §101030]

2) Requires LHOs to investigate health and sanitary conditions in every publicly operated detention facility in the county or city (including county and city jails), and all private work furlough facilities and programs, at least annually. Requires private work furlough facilities and programs to pay an annual fee commensurate with the annual cost of investigations. Permits LHOs to make additional investigations of any detention facility as determined necessary. Requires LHOs to submit a report to the Board of State and Community Corrections (BSCC), the person in charge of the jail or detention facility, and to the board or city governing board (in the case of a city that has an LHO). [HSC §101045]

3) Requires LHOs, whenever requested by the sheriff, the chief of police, local legislative body, or the BSCC, but not more often than twice annually, to investigate health and sanitary conditions in any jail or detention facility, and submit a report to the officer and agency requesting the investigation and to the BSCC. [HSC §101045]

4) Requires the investigating LHO to determine if the food, clothing, and bedding is of sufficient quantity and quality that at least equal minimum standards and requirements of the BSCC for the feeding, clothing, and care of prisoners in all local jails and detention facilities, and if the sanitation requirements under the California Retail Food Code, have been maintained. [HSC §101045]

5) Defines a "detention facility" as a facility in which persons are incarcerated or otherwise involuntarily confined for purposes of execution of a punitive sentence imposed by a court or detention pending a trial hearing or other judicial or administrative proceeding. Defines a "private detention facility" as a detention facility that is operated by a private, nongovernmental, for-profit entity pursuant to a contract or agreement with a governmental entity. Specifies that a "detention facility" does not include:

    a) A facility providing rehabilitative, counseling, treatment, mental health, educational, or medical services to a juvenile that is under the jurisdiction of the juvenile court;

b) A facility providing evaluation or treatment services to a person who has been detained, or is subject to an order of commitment by a court;

c) A facility providing educational, vocational, medical, or other ancillary services to an inmate in the custody of, and under the direct supervision of, the Department of Corrections and Rehabilitation or a county sheriff or other law enforcement agency;

d) A residential care facility;

e) A school facility used for the disciplinary detention of a pupil;

f) A facility used for the quarantine or isolation of persons for public health reasons; or,

g) A facility used for the temporary detention of a person detained or arrested by a merchant, private security guard, or other private person. [Government Code §7320]

FISCAL EFFECT: None.

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, the ability of LHOs to enter and inspect private detention facilities is not clearly addressed under current California law. As it stands, the relevant statutes empower LHOs to enter public detention facilities and private work furlough facilities. The author continues that the lack of clarity on oversight of private detention facilities poses a unique and critical public health challenge. Conditions in these facilities not only affect the lives of those detained, but also impacts the surrounding communities. The author states that during the COVID-19 pandemic, an outbreak at Otay Mesa Detention Facility resulted in more than 300 staff and detained individuals becoming infected. The author concludes that in order to ensure public health regulations and standards are upheld in private detention facilities for the health and safety of people detained and working in these facilities, this bill clarifies that LHOs have authority to inspect private detention facilities as deemed necessary.

2) **BACKGROUND**.

   a) Private Detention Facilities. The federal government contracts with private detention facilities across the country to house immigration detainees. There are currently six private detention facilities operating in California in four counties—San Bernardino County, Kern County, San Diego County, and Imperial County.

   Federal, state, and local laws, including county public health orders, govern all immigration detention facilities operating in California. According to the California Department of Justice, facilities that contract to hold detained noncitizens are also required to comply with national detention standards, which establish requirements for emergency planning, security protocols, detainee classification, discipline, medical care, food service, activities and programming, detainee grievances, and access to legal services. The standards set the expectation that the Centers for Disease Control and Prevention guidelines for the prevention and control of infectious and communicable diseases are to be followed and directs each facility have written plans that address the management of infectious and communicable diseases.

b) Inspection of Detention Facilities. LHOs serve a number of public health functions at the local level, including managing infectious disease control, implementing emergency preparedness and response, and overseeing public health services. There are 61 appointed physician LHOs in California—one for each of the 58 counties and the cities of Berkeley, Long Beach, and Pasadena. Regulations establish minimum standards for local detention facilities, including standards for the administration and operation of the facilities, medical and mental health care, nutritional quality of food, and environmental standards. Regulations define "local detention facility" to mean "any city, county, city and county, or regional jail, camp, court holding facility, or other correctional facility, whether publicly or privately operated, used for confinement of adults or of both adults and minors, but does not include that portion of a facility for confinement of both adults and minors which is devoted only to the confinement of minors."

County jails, city jails, and other publicly operated detention facilities are subject to biennial inspections by the BSCC. Those biennial inspections include the annual health and safety inspections that LHOs are required to conduct annually, and which LHOs are authorized to conduct more frequently if necessary. The BSCC is required to publicly post the inspection reports as well as submit a report every two years to the Legislature which includes information pertaining to the inspection of those local detention facilities that have not complied with the minimum standards, specifying the areas in which the facility has failed to comply and the estimated cost to the facility in order to comply with the minimum standards.

c) Jurisdiction Over Private Detention Facilities. According to the National Center for Immunization and Respiratory Diseases, communicable disease can easily spread in congregate living facilities or other housing where people who are not related reside in close proximity and share at least one common room. According to a 2021 *CalMatters* article, during the COVID-19 pandemic, there were reports that there was confusion about the role of state and local health authorities with regard to federal detention facilities, which may have led to delays for vaccine distribution. For example, immigrant rights organizations sent a letter to public health officials in Kern County asking about LHO oversight, including how it planned to ensure detainees were being tested for COVID-19. In response, the county's director of public health services said they did not have jurisdiction over the center. *CalMatters* indicated that there were similar instances of confusion over jurisdiction in other counties. This bill clarifies that LHOs have authority to inspect private detention facilities as deemed necessary. This bill would not impose an annual inspection requirement.

d) Health Concerns in Private Detention Facilities. According to a January 2023 article published in the *Los Angeles (LA) Times*, an investigation by the California Division of Occupational Safety and Health found six violations of state code by a private detention facility operator, which appealed. The *LA Times* reported that the complaint was filed by Immigrant Defense Advocates and the California Collaborative for Immigrant Justice on behalf of several detainees, alleging safety violations including failures by the facility administrators to provide personal protective equipment, maintain sanitary work spaces, prevent the spread of COVID-19 and safeguard against workplace-related illnesses and injuries.

3) **SUPPORT**. According to Immigrant Defense Advocates, California Collaborative of Immigrant Justice, California Immigrant Policy Center, and Next Gen California, cosponsors of this bill, private detention facilities continue to pose challenges with respect to health, safety, and sanitary conditions. Detained individuals in these facilities continue to file numerous grievances. The cosponsors state that these grievances primarily revolve around detainees facing challenges in accessing timely medical attention, enduring prolonged waits for treatment of persistent conditions, often stretching to months, and encountering difficulties in obtaining essential medications. The cosponsors continue that one specific detainee recounted losing multiple teeth due to a two-year delay in receiving dental cavity fillings. During inspections, a prison dentist reportedly proposed that detainees could improve their dental hygiene by using strings from their shoes for flossing their teeth. The cosponsors conclude that bill does not impose an annual inspection requirement to county health officials, but empowers them to ensure that these private facilities adhere to public health orders and guidelines that are necessary to keep our state safe.

4) **PREVIOUS LEGISLATION**. AB 263 (Arambula), Chapter 294, Statutes of 2021, requires a private detention facility operator to comply with, and adhere to, all local and state public health orders and occupational safety and health regulations.

5) **DOUBLE REFERRAL**. This bill is double referred; upon passage in this Committee, this bill will be referred to the Assembly Committee on Public Safety.

REGISTERED SUPPORT / OPPOSITION:

Support

California Collaborative of Immigrant Justice (cosponsor)
California Immigrant Policy Center (cosponsor)
Immigrant Defense Advocates (cosponsor)
Nextgen California (cosponsor)
Aaaj- Asian Law Caucus
ACLU California Action
All Rise Alameda
Alliance for Boys and Men of Color
Amnesty International USA
Apla Health
Asian Americans Advancing Justice-Southern California
Bravo & Bravo
Buen Vecino
California Coalition for Women Prisoners
California Pan-ethnic Health Network
California Public Defenders Association
California Rural Legal Assistance Foundation (CRLA Foundation)
California Voices for Progress
Center for Gender and Refugee Studies-California
Center for Immigration Law and Policy At UCLA Law
Central Valley Immigrant Integration Collaborative
Communities United for Restorative Youth Justice (CURYJ)
Courage California

Disability Rights California
Dolores Huerta Foundation
Ella Baker Center for Human Rights
Friends Committee on Legislation of California
Health Officers Association of California
Human Impact Partners
Immigrant Health Equity and Legal Partnership
Immigrant Legal Defense
Indivisible CA Statestrong
Initiate Justice
Inland Coalition for Immigrant Justice
Interfaith Movement for Human Integrity
Keck Human Rights Clinic
Kern Welcoming and Extending Solidarity to Immigrant
LA Cosecha
Latin Advocacy Network
Lawyers' Committee for Civil Rights of The San Francisco Bay Area
National Lawyers Guild San Francisco Bay Area Chapter
Norcal Resist
Oakland Privacy
Orale: Organizing Rooted in Abolition Liberation and Empowerment
Public Counsel
San Francisco Marin Medical Society
Secure Justice
Social Justice Collaborative
Southeast Asia Resource Action Center
The Justice & Diversity Center of The Bar Association of San Francisco
Voices for Progress
Worksafe

Opposition

None on file.

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

Date of Hearing: June 4, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1213 (Atkins) – As Amended April 8, 2024

SENATE VOTE: 39-0

SUBJECT: Health care programs: cancer.

SUMMARY: Increases the income threshold for the state's breast and cervical cancer early detection and treatment programs from 200% to 300% of the federal poverty level FPL).

EXISTING LAW:

1) Requires the Department of Health Care Services (DHCS) to develop and maintain the Breast and Cervical Cancer Treatment Program (BCCTP) to provide coverage for breast and cervical cancer treatment and services related to a cancer diagnosis, for individuals whose family income is at or below 200% FPL. [Health and Safety Code (HSC) §104160, 104162]

2) Requires a provider or entity that participates in the federal National Breast and Cervical Cancer Early Detection Program (NBCCEDP), administered in the state by DHCS as the Every Woman Counts (EWC) Program, to provide screening services to an individual only if the individual's family income has been determined not to exceed 200% of the federal poverty level (FPL). [HSC §104150]

3) Requires treatment services—if an individual is made eligible for treatment due to a diagnosis of breast cancer, cervical cancer, or a reoccurrence of breast cancer or cervical cancer, whether at the original cancer site or a different cancer site—to be provided for the duration of the period of treatment, as long as the individual continues to meet all other eligibility requirements. [HSC §104161.1]

FISCAL EFFECT: According to the Senate Appropriations Committee, unknown, ongoing costs (General Fund) to provide breast and cervical cancer screening and treatment services to individuals between 200% and 300% of FPL.

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, breast cancer is the most common cancer in women in the United States, except for skin cancers, and the second leading cause of cancer death in women behind lung cancer. The author states that about one out of every 100 breast cancers diagnosed in the United States is found in a man. The author continues that the American Cancer Society estimates there will be about 13,820 new cases of invasive cervical cancer diagnosed and about 4,360 women will die from cervical cancer in the United States in 2024. The author states that although California's incidence of breast cancer and cervical cancer are lower than the national rates, there is more we could do to expand access to life-saving services to detect and treat breast and cervical cancer early. The author notes that currently 33 states cover individuals with incomes up to 250% FPL and five states cover individuals with incomes up to 300% FPL or more, while California is currently in the bottom 20% of coverage levels. The author concludes that by expanding eligibility to the

EWC Program, which provides breast and cervical cancer screening, and the BCCTP, we will have the opportunity to close the gap on cancer care to the Californians who don't have access to affordable health care options and further our work to reduce cancer deaths.

2) **BACKGROUND**. In 2000, Congress passed the Breast and Cervical Cancer Prevention and Treatment Act, which allowed states to offer those who are diagnosed with cancer in the NBCCEDP with screening and diagnostic services, and referrals to treatment, through Medicaid. NBCCEDP is administered by DHCS as the EWC Program. According to DHCS's website, the mission of the EWC Program is to mitigate the devastating medical, emotional, and financial effects of breast and cervical cancer by eliminating health disparities for medically underserved, low-income individuals.

   The EWC report published in February 2024, which included information for Fiscal Year (FY) 2022-23, states that caseload was 65,401 individuals from July 1 through December 31, 2022. The EWC Program experienced a caseload decrease of 23.7% compared to the caseload (85,728 individuals) for the same period of the previous FY (July 1 through December 31, 2021). The EWC income threshold is currently 200% FPL for an individual ($30,120), compared to 250% FPL ($36,450) for an individual for the NBCCEDP.

   The EWC report further states that regional health educators (RHEs) and community health workers (CHWs) held 319 classes and 233 one-on-one sessions, reaching 3,169 individuals. RHEs and CHWs continued to collaborate with various organizations in counties with advanced breast and cervical cancer rates to schedule virtual and in-person health education classes and conduct one-on-one sessions. During this period, EWC also completed screening navigation for 148 women and helped them resolve barriers to obtaining breast and/or cervical cancer screening and treatment services. As of December 31, 2022, there were 1,100 primary care providers enrolled in the EWC Program.

   The federal BCCTP provides full-scope, no-cost Medi-Cal to individuals diagnosed with and found to be in need of breast and/or cervical cancer treatment and meet all Federal BCCTP requirements.

   AB 430 (Cardenas), Chapter 171, Statutes of 2001, established a state funded BCCTP program that provides limited-scope Medi-Cal for individuals diagnosed with and found to be in need of breast and/or cervical cancer treatment and meet all State BCCTP requirements. The state BCCTP expands access for individuals who do not meet all of the federal BCCTP requirements.

   DHCS has statutory authority to manage both Federal and State Medicaid options to cover eligible low-income individuals screened and found to be in need of breast and/or cervical cancer treatment by EWC's Cancer Detection Program and Family Planning, Access, Care and Treatment program. BCCTP requires beneficiaries to be California residents and that their gross family income not exceed 200% FPL for their family size (based on Non-Modified Adjusted Gross Income rules).

3) **SUPPORT**. According to the American Cancer Society Cancer Action Network (ACSCAN), the EWC Program is funded by both federal dollars through grants from the Centers for Disease Control and Prevention and from two state tobacco taxes and breast cancer awareness specialty license plates general funds. ACSCAN notes that due to recent

expansion of full-scope Medi-Cal to low-income individuals previously deemed ineligible for the program because of their immigration status, many of those previously eligible for EWC and BCCTP will now be eligible for full-scope Medi-Cal and will no longer need these programs. ACSCAN contends that for people who are uninsured or underinsured with income above 200% FPL and not eligible for Medi-Cal, purchasing insurance may still be prohibitively expensive. Individuals without satisfactory immigration status are not eligible for subsidies to reduce premiums. Even for those who are eligible for subsidies, premiums and out-of-pocket expenses could be at least $10,000 per year. ACSCAN further argues that expanding eligibility for EWC and BCCTP from 200% FPL to 300% FPL will ensure that these individuals will have access to critical cancer screening and treatment.

According to Susan G. Komen (SGK), raising the income eligibility level from 200 to 300% FPL would extend these critical services to Californians making up to $45,180. SGK notes 33 states across the U.S. already provide coverage up to 250% FPL and five states currently provide coverage up to 300%. SGK concludes that with costs of living continuing to rise in California and across the country, now is a crucial time to expand access to these life saving programs, especially for geographically isolated populations.

4) **RELATED LEGISLATION**. SB 1172 (Grove) extends, to January 1, 2032, the ability for individuals to donate through their personal income tax return to the California Breast Cancer Research Voluntary Tax Contribution Fund and the California Cancer Research Voluntary Tax Contribution Fund, as specified. SB 1172 is pending in the Assembly Revenue and Taxation Committee.

5) **PREVIOUS LEGISLATION**.

   a) SB 945 (Atkins) of 2018 would have deleted time limits for breast and cervical cancer treatment under the BCCTP, and instead require services to continue for the duration of the period of treatment, as long as the individual continued to meet all other eligibility requirements. SB 945 was not heard in the Assembly Health Committee.

   b) AB 1795 (Atkins), Chapter 608, Statutes of 2016, requires individuals of any age who are symptomatic, as specified, to be eligible for breast cancer screening and diagnostic services through the EWC Program if they meet specified eligibility requirements. AB 1795 also clarifies that an individual who is diagnosed with a reoccurrence of cancer, as specified, is required to be eligible for an additional period of treatment, as long as the individual meets all other applicable eligibility requirements, and the respective treatment duration limits apply.

   c) AB 430 (Cardenas), Chapter 171, Statues of 2001, as the health budget trailer bill, implemented the EWC Program, among other things.

REGISTERED SUPPORT / OPPOSITION:

Support

American Cancer Society Cancer Action Network, Inc. (cosponsor)
Susan G. Komen (cosponsor)

Albie Aware Breast Cancer Foundation
American College of Obstetricians and Gynecologists District Ix
California Chronic Care Coalition
California Hospital Association
California Life Sciences
California Pan - Ethnic Health Network
California Retired Teachers Association
California School Employees Association
California State Council of Service Employees International Union (seiu California)
City of Hope National Medical Center
County Health Executives Association of California (CHEAC)
CPCA Advocates, Subsidiary of The California Primary Care Association
Health Access California
Truecare
Valley Breast Care
Western Center on Law & Poverty, Inc.

Opposition

None on file.

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

Date of Hearing: June 4, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1257 (Blakespear) – As Amended April 15, 2024

SENATE VOTE: 36-0.

SUBJECT: Geographic Managed Care Pilot Project: County of San Diego: advisory board.

SUMMARY: Updates the structure of boards that advise the County of San Diego on the implementation of Medi-Cal managed care in the county, including allowing advisory board members who are Medi-Cal recipients to be reimbursed by the county for their service and, consistent with current practice, combining two advisory boards into a single board.

EXISTING LAW:

1) Establishes the Medi-Cal program, administered by the Department of Health Care Services (DHCS), under which health care services are provided to qualified, low-income persons. [Welfare and Institutions Code (WIC) § 14000, et seq.]

2) Permits DHCS to implement a Geographic Managed Care (GMC) project in the County of San Diego offering multiple Medi-Cal managed care plans, upon the approval of the county board of supervisors, for the provision of Medi-Cal benefits to eligible Medi-Cal recipients. [WIC § 14089.05 (a)]

3) Permits the County of San Diego to establish two advisory boards, one composed of consumer representatives and one composed of health care professional representatives, to advise the county's Department of Health Services and review and comment on all aspects of the implementation of the GMC project described in 2) above. [WIC § 14089.05 (b)]

4) Requires the county board of supervisors to establish the number of members to serve on each advisory board and requires each supervisor to appoint an equal number of members from their district. [*Ibid.*]

5) Prohibits advisory board members from being compensated for activities related to their duties as members, except for members who are Medi-Cal recipients, who are required to be reimbursed for their travel and child care expenses incurred while performing their duties as advisory board members. [WIC § 14089.05]

FISCAL EFFECT: According to the Senate Appropriations Committee, pursuant to Senate Rule 28.8, negligible state costs.

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, in 2022, California embarked on the statewide initiative to modernize the Medi-Cal program, an initiative known as the California Advancing and Innovating Medi-Cal (CalAIM). The author explains that CalAIM involves far-reaching transformations of Medi-Cal's managed care program, which is administered at the county level, and that implementation in San Diego County is particularly challenging

because the County is one of two counties that contract with multiple commercial Medi-Cal managed care plans under the GMC model. By clarifying the County advisory board's authority to advise on Medi-Cal managed care implementation more broadly, this bill aims to enhance coordination among stakeholders and success of CalAIM initiatives, as well as to ensure a sound statutory basis for the advisory board activities.

2) **BACKGROUND**. The vast majority of Medi-Cal beneficiaries receive their care through a Medi-Cal managed care plan. Some counties have only one or two plans available, which can restrict choice but enhance efficiency. In most counties, a county-administered or county-authorized plan is available. Sacramento County and San Diego County are unique in that multiple commercial plans deliver Medi-Cal managed care in these two counties.

   The GMC program in San Diego is operated under an umbrella within the county Health and Human Services Agency called Healthy San Diego. According to the County of San Diego, the sponsor of this bill, the two statutorily mandated advisory boards have operated as a joint consumer and health professional advisory board to advise the county.

   As referenced above, CalAIM is a multipronged and complicated set of initiatives. The need to coordinate with multiple plans to implement these initiatives locally can pose challenges, and the county has found the current advisory board is a successful forum to convene these conversations locally. Current statute authorizes the advisory boards to advise the county on implementation on the GMC model; this bill would provide authority to advise on the local implementation of Medi-Cal policy more broadly. In addition, according to the Center for Health Care Strategies, a nonprofit focused on Medicaid policy, compensating consumer members of an advisory board for their time and expertise is a best practice to support consumer meaningful participation.

3) **SUPPORT**. The County of San Diego writes that this bill would modernize the Healthy San Diego Advisory Board to ensure health care quality for Medi-Cal recipients. This bill establishes a single Healthy San Diego Advisory Board composed of consumers and health care professionals to advise the board on the implementation of state Medi-Cal policy in San Diego County and allows the County to reimburse Medi-Cal recipients for their time performing duties on the advisory board.

REGISTERED SUPPORT / OPPOSITION:

Support

County of San Diego

Opposition

None on file.

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

Date of Hearing: June 4, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1289 (Roth) – As Amended April 29, 2024

SENATE VOTE: 39-0

SUBJECT: Medi-Cal: call centers: standards and data.

SUMMARY: Requires Department of Health Care Services (DHCS) to collect specified data and establish customer service standards for county call centers that process Medi-Cal eligibility and enrollment. Specifically, **this bill**:

1) Requires DHCS to establish statewide minimum standards for assistance provided by a county's call center to applicants or beneficiaries applying for, renewing, or requesting help in obtaining or maintaining Medi-Cal coverage. Requires standards to take into account challenges that Medi-Cal applicants or beneficiaries face in communicating with county agencies during regular business hours.

2) Requires DHCS to seek input from stakeholders, including, but not limited to, counties, representatives of employee organizations representing county eligibility workers, and consumer advocates, prior to establishing standards.

3) Requires the standards be promulgated in regulation by July 1, 2026, and be consistent with standards for other call centers operated by, or under contract with, DHCS and any applicable federal reporting requirements.

4) Requires, by April 1, 2025, and each quarter thereafter, a county with a call center to collect and submit to DHCS specified call-center data metrics.

5) Requires DHCS to prepare quarterly reports on call center data that also identify challenges and targets or standards for improvement; and requires the initial report by May 15, 2025.

EXISTING LAW:

1) Establishes the Medi-Cal program, administered by DHCS, under which low-income individuals are eligible for medical coverage. [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) Gives individuals the option to apply for Medi-Cal in person, by mail, online, by telephone, or by other commonly available electronic means. Requires renewal procedures to include all available methods for reporting renewal information, including, but not limited to, face-to-face, telephone, mail, and online renewal or renewal through other commonly available electronic means. [WIC §15926]

4) Requires a county to perform redeterminations of eligibility for Medi-Cal recipients every 12 months and to promptly redetermine eligibility whenever the county receives information about changes in a recipient's circumstances that may affect eligibility for Medi-Cal benefits. Allows a recipient to provide information regarding a change in circumstances or requested by the county over the telephone. Allows recipients to provide signatures over the telephone for forms that are required to be signed. [WIC §14005.37]

5) Requires a county to notify a Medi-Cal recipient when their Medi-Cal eligibility worker changes and to include in the notice the worker's telephone number and hours during which the eligibility workers may be contacted. [WIC §14005.33]

6) Requires DHCS to provide assistance over the telephone to any applicant or recipient that requests help with the application or redetermination process, subject to certain conditions. [WIC §14000.7]

7) Establishes the CalFresh program to provide food benefits under the federal Supplemental Nutrition Assistance Program. [WIC §18900 et seq.]

8) Requires counties to ensure that Medi-Cal applicants who also may be eligible for CalFresh, are screened and given the opportunity to apply at the same time they are applying for Medi-Cal or submitting information for the renewal process, and ensure the same staff that receive Medi-Cal and CalFresh applications conduct the eligibility determination functions needed to determine eligibility or ineligibility for CalFresh. [WIC §18918.1]

FISCAL EFFECT: According to the Senate Committee on Appropriations:

1) Unknown, ongoing costs, likely hundreds of thousands, for DHCS for state administration (General Fund (GF) and federal funds).

2) Unknown, ongoing costs to counties for the collection of data. Cost to counties for administration would be potentially reimbursable by the state, subject to a determination by the Commission on State Mandates.

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, for years, people on Medi-Cal have struggled to reach county eligibility workers by phone due to long wait times and disconnected calls. When they cannot get through by phone, they often cannot complete a Medi-Cal application or renewal, reinstate their Medi-Cal, or make other corrections, despite state and federal law requirements allowing people to do these things over the phone. This situation predates the COVID-19 pandemic, but has gotten worse due to county workforce shortages and the federal requirement to renew everyone's Medi-Cal for the first time since the pandemic began. When Medi-Cal recipients who lost their coverage during this recent renewal effort were surveyed, one third who tried to complete their renewal responded that they called their county but got no answer, were on hold too long, or got disconnected. This bill would require DHCS to develop minimum standards for assistance provided by county call centers to Medi-Cal applicants and recipients, and to collect and report county call center data.

2) BACKGROUND.

a) Basic Medi-Cal Eligibility Redetermination Requirements and Processes. Medicaid is a state-federal program, and states have a variety of options in program design as long as they meet federal requirements. In California's Medi-Cal program, counties are responsible for eligibility and enrollment functions. This includes things like determining individuals' initial eligibility to enroll in the program, maintaining accurate records on individuals' ongoing eligibility, and administering regular eligibility redeterminations. Counties also are responsible for similar functions in major human services programs, including California Work Opportunity and Responsibility to Kids (CalWORKs), CalFresh, and In-Home Supportive Services.

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, a beneficiary or enrollee will automatically have their eligibility redetermined based on the new information.

Counties 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. However, eligibility for many applicants and beneficiaries cannot be processed in an automated way. In addition, if an applicant has a unique situation or encounters any glitches during the process, they may need to reach out to a county eligibility worker.

b) Current Data Collection and Reporting. DHCS tracks certain county eligibility and enrollment processes, such as eligibility redeterminations processed by month, but does not report or collect county-level or state-level data related to county call centers. For instance, the state doesn't know how many calls counties receive, nor how long applicants or beneficiaries wait, on average, when they contact a county for assistance.

According to DHCS, the state only reports call center volume, average wait time, and average abandonment rate to the Centers for Medicare & Medicaid Services from the following call centers:

i) Covered California regional call centers;
ii) Health Care Options, a contracted Medi-Cal managed care plan enrollment call center; and,
iii) DHCS provider and member billing customer service line.

c) Public Health Emergency (PHE) Eligibility Processes and "Unwinding." The federal government required states to pause redeterminations of Medi-Cal eligibility through the COVID-19 PHE, keeping most people on the program rolls. Beginning in 2023, California began resuming redeterminations. This resumption of redetermination processes is colloquially called the "PHE Unwinding." 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 were not familiar with required paperwork and processes.

According to DHCS, there have been anecdotal reports of long wait times during the PHE Unwinding. DHCS and counties have been working together to address these challenges. For instance, some counties have implemented interactive voice response to local navigators at their local site. DHCS has emphasized there is autonomy in decision-making at the county level to best allocate available resources to meet the needs.

d) May Revision Proposals. To balance the 2024-25 budget, a number of budget solutions have been proposed in the Governor's May Revision to the 2024-25 Budget. Two proposals are particularly relevant to this bill:

i) County Administration Funding Freeze. Counties receive a Cost of Living Adjustment annually to the administrative funding they receive from the state to process Medi-Cal eligibility and enrollment functions. The May Revision proposes to freeze county administration funding at current levels to save $20.4 million GF in fiscal year 2024-25 and $42.0 million in 2025-26, as well as additional GF resources in future fiscal years. The impact of this freeze is unknown, but it would likely reduce resources available to improve customer service levels.

ii) Health Enrollment Navigators Funding Elimination. The May Revision proposes to eliminate the last year of funding for a limited-term Health Enrollment Navigators program, including $16 million in fiscal year 2024-25 for grants and $8 million for grants specific to navigators in clinics. According to DHCS, these efforts fund county, clinic, and community-based organization entities to engage in eight specified activities for hard-to-reach target populations to enroll, retain, and assist Medi-Cal applicants and current Medi-Cal members. Although county eligibility staff are primarily responsible for Medi-Cal eligibility and enrollment functions, navigators have in recent years reduced some pressure on county administrative staff by helping assist applicants and beneficiaries, including in culturally and linguistically concordant ways.

e) Survey Data Indicates Challenges Reaching County Staff. An individual can be disenrolled from Medi-Cal because they are verified as ineligible, for example, their income is too high. In contrast, a procedural disenrollment from Medi-Cal occurs when someone cannot be verified eligible for the program based on missing documentation or inability to contact the person to gather information. DHCS has partnered with the California Health Care Foundation to survey individuals who have been procedurally disenrolled from Medi-Cal during the PHE unwinding period in order to identify barriers leading to disenrollments. A recent survey of individuals who were procedurally disenrolled found that, of those who received a renewal form and completed or tried to complete it, 35% said that they called the county but got no answer, were on hold too long, or got disconnected. The survey also found that Hispanic respondents were significantly more likely to experience challenges as compared to white respondents.

3) SUPPORT. Cosponsors Western Center on Law & Poverty and Coalition of California Welfare Rights Organizations write that people are struggling to reach county workers by phone and wait times can exceed five hours. Even in counties with shorter wait times, actual processing times are much longer. For instance, Los Angeles County averages a 30-minute wait time with a ticket system that workers process later. At any time, approximately 40,000 of those tickets are languishing in queue, waiting to be processed. Meanwhile, Californians

are losing their health coverage. Legal Services of Northern California gives an example of one person in Santa Cruz who spent four months trying to disenroll from Medi-Cal when her income went up so that she could enroll in Covered California. In another example, a couple submitted their renewal packet but were still disenrolled. While trying to contact an eligibility worker, one of them had to delay an eye surgery and the other incurred over $1,000 in medical debt after an emergency room visit. The Community Clinic Association of Los Angeles County writes in support that enrollment counselors and health navigators that work in their member clinics have also struggled with wait times, disconnects and other challenges reaching county eligibility workers quickly by phone.

4) **OPPOSITION UNLESS AMENDED**. The California Welfare Directors Association (CWDA) opposes this bill unless amended to address their concerns about the imposition of standards in light of cost, staffing constraints, other priorities, and technical ability to collect data specified by the bill and comply with this bill**'s** requirements. CWDA indicates they appreciate the April 29, 2024, amendments to this bill, but they express a number of remaining concerns and requests. First, CWDA requests that compliance with this bill be contingent on funding and that necessary staffing levels be calculated using a specified methodology. CWDA points out counties have different needs and capabilities, such as lines in different languages and the availability of different functionality, which would make apples-to-apples comparisons as well as compliance difficult, and therefore asks that the metrics be provided only "where available." CWDA also requests the bill exempt call centers operated under the provisions of the "Quick Sort Transfer" warm handoff process between counties and Covered California, which already have standards and reporting metrics. Finally, CWDA requests that the implementation date reflect the necessary lead time for hiring, training, labor consultation, and other needed adjustments. Additionally, CWDA notes the costs are unknown until standards are established, and points out applying standards for Medi-Cal would also have an unintended consequence of imposing these standards for CalFresh and potentially CalWORKS.

5) **RELATED LEGISLATION**. AB 2956 (Boerner) makes various changes to Medi-Cal redetermination procedures including the requirement that counties collect and submit to DHCS call center data metrics. AB 2956 was held on the Suspense File of the Assembly Appropriations Committee.

6) **PREVIOUS LEGISLATION**.

   a) AB 1X 1 (John A. Pérez), Chapter 3, Statutes of 2013, codified the Patient Protection and Affordable Care Act's (ACA's) Medi-Cal redetermination requirements, among other things.

   b) AB 1296 (Bonilla), Chapter 641, Statutes of 2011, codified the ACA's rules for Medi-Cal and Covered California applications.

7) **POLICY COMMENTS**. This bill addresses an important gap in the state's ability to collect and report on data on a critical customer service function—the ability to reach a Medi-Cal county eligibility worker by phone. Although counties administer these functions, DHCS is the single state agency responsible for Medi-Cal administration. The state's choice to make eligibility a local function does not lessen the state's responsibility to monitor and ensure a reasonable level of customer service. In addition, other call centers, such as those administered by Covered California, do report such data.

On the other hand, counties raise legitimate questions about resources needed to meet standards and the difficulty in imposing one-size-fits-all standards on a system that varies significantly among counties. The author may wish to engage further with DHCS and counties and consider whether it is appropriate to approach improvements in a stepwise fashion. This could look like, for instance, first initiating data collection and, later, imposing standards based on a consideration of whether meeting industry standards would require more resources.

In addition, this bill is prescriptive in the data that must be reported by counties, including call volume, average call wait times by language, call answer rate, call abandonment rate, maximum wait times, total handle time, disconnects, calls resolved by interactive voice response, callbacks, and calls disconnected during high-call-volume periods. The author may wish to consider whether there is benefit to providing DHCS more flexibility to define specific metrics that must be reported, in consultation with stakeholders and based on analysis of feasibility and review of consistency with other call centers, as long as important aspects of the customer service experience are captured.

8) **AMENDMENTS.** The author and Committee have agreed to amend the bill streamline the quarterly reporting. Per this change, quarterly reporting will only include the data metrics, while the standards, targets, and challenges will be discussed through the stakeholder process identified in the bill's other provisions.

Specifically, Section 1, Welfare and Institutions Code Section 14000.8 (b)(2) will be amended as follows:

(2) The department shall prepare a report, excluding any personally identifiable information, on call-center data as described in paragraph (1)~~***, identifying challenges and targets or standards for improvement***~~. The department shall post the report on the department's internet website on a quarterly basis no later than 45 calendar days after the conclusion of each quarter. The initial report on call-center data described in paragraph (1) shall be due on May 15, 2025.

REGISTERED SUPPORT / OPPOSITION:

Support

Western Center on Law & Poverty (cosponsor)
Coalition of California Welfare Rights Organizations (cosponsor)
Asian Americans Advancing Justice-southern California
Asian Resources, Inc.
Bet Tzedek Legal Services
California Association of Food Banks
CANHR
Children Now
Children's Partnership
Community Clinic Association of Los Angeles County (CCALAC)
Community Legal Aid SoCal
CPCA Advocates
Grace Institute - End Child Poverty in CA

Justice in Aging
Latino Coalition for a Healthy California
Legal Services of Northern California
Maternal and Child Health Access
National Health Law Program
Northeast Valley Health Corporation
Parent Engagement Academy
Second Harvest Food Bank of Orange County
South Asian Network
Venice Family Clinic

Opposition

None on file.

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

Date of Hearing: June 4, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1428 (Atkins) – As Amended March 18, 2024

SENATE VOTE: 39-0

SUBJECT: Health care coverage: triggering events.

SUMMARY: Clarifies existing law to allow an individual 60 days before and after the date of a triggering event to apply for health plan coverage outside of California's Health Benefit Exchange (Covered California or the Exchange), and on the Exchange, to the extent there are no conflicts with the availability and length of special enrollment periods pursuant to federal law.

EXISTING LAW:

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

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

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

4) Establishes annual enrollment periods for individual health benefit plans offered on and off the Exchange, beginning November 1 of the preceding calendar year, to January 31 of the benefit year. [HSC §1399.848 and INS §10965.4]

5) Requires plans and insurers to allow an individual to enroll in or change individual plans through a special enrollment period as a result of specified triggering events, such as:
   a) The individual or the individual's dependent loses minimum essential coverage (MEC);
   b) The individual gains a dependent or becomes a dependent;
   c) The individual is mandated to be covered as a dependent pursuant to a valid state or federal court order;
   d) The individual has been released from incarceration;

e) The individual's health coverage issuer substantially violated material provisions of the health coverage contract;
f) The individual gains access to new health benefit plans, as a result of a permanent move;
g) The individual was receiving services from a contracting provider under another plan for a specified condition and that provider is no longer participating in the plan;
h) The individual demonstrates to Covered California, with respect to a participating plan, or DMHC or CDI with respect to a plan offered outside of Covered California, that the individual did not enroll during the enrollment periods because the individual was misinformed that the individual was covered under MEC;
i) The individual is a member of the US military reserve or California National Guard returning from active duty; and,
j) For plans offered through Covered California, any other events listed in federal regulations, as specified. [HSC §1399.849 and INS §10965.4]

6) Requires, for plans offered outside of Covered California, an individual to have 60 days from the date of a triggering event to apply for coverage; and, for plans offered through Covered California, an individual to have 60 days from the date of a triggering event to apply for coverage, unless a longer period is provided in federal regulations. [HSC §1399.849 and INS §10965.4]

7) Requires the effective dates of coverage for plans purchased through and outside of Covered California, during a special enrollment period to be as follows:
   a) When premium is delivered or postmarked within the first 15 days of the month, coverage is effective no later than the first day of the following month;
   b) When premium is delivered or postmarked after the 15th day of the month coverage is effective no later than the first day of the second month following delivery or postmark of the payment;
   c) In the case of a birth, adoption, or placement for adoption, the coverage is effective on the date of birth, adoption, or placement for adoption; or,
   d) In the case of marriage or domestic partnership or in the case where a qualified individual loses MEC, the coverage effective date is the first day of the month following the date the plan receives the request for special enrollment. [HSC §1399.849 and INS §10965.4]

FISCAL EFFECT: According to the Senate Appropriations Committee, pursuant to Senate Rule 28.8, negligible state costs.

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, in California, and under the ACA, when an individual is required to purchase health insurance, they may purchase that insurance through the state based Exchange, known as Covered California, or off the Exchange. Generally, this is only allowed during a set period of time known as open enrollment. However, certain life events, known as qualifying or triggering events, may cause a person to lose their existing health insurance outside of the open enrollment period and qualify them for a special enrollment period. Covered California allows individuals to sign up for health insurance 60 days before and after certain qualifying events. Individuals seeking to purchase insurance outside of the Covered California Health Exchange currently only have 60 days after the qualifying life event to sign up for coverage. This bill ensures that Californians have the same special enrollment periods outside of the Exchange as they do on

the Exchange. This bill also codifies the policies adopted by Covered California for special enrollment periods.

2) BACKGROUND.

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

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

b) Covered California. California was the first state in the nation to enact legislation creating an Exchange under the ACA. Open enrollment is from November 1 through January 31. As of January 31, there are 1,784,653 Californians who have chosen a health plan through Covered California for 2024, with 306,382 new enrollees and 1,478,271 renewing their coverage. This total surpasses the previous high set in 2022, plus the number of new sign-ups is the highest during an open-enrollment period since 2020. With increased federal subsidies through the Inflation Reduction Act paired with California's new cost-sharing reduction program, more financial help than ever before is available to consumers who need health insurance coverage.

According to Covered California, individuals and families who experience a qualifying life event can enroll in a Covered California health insurance plan outside of the annual open enrollment period. This is called special enrollment. In most cases, individuals have 60 days after the date of a qualifying life event to enroll or change their existing plan. If individuals know ahead of time when they will lose health insurance, they have an additional 60 days to enroll before that date to prevent any gaps in coverage. Existing law allows an individual to have 60 days from the date of a triggering event to apply for coverage from a health plan during special enrollment. This bill clarifies that an individual has 60 days before and after the triggering event to apply for coverage.

3) SUPPORT. Health Access California writes that this bill would give more flexibility to Californians to sign up for coverage when going through a triggering event, like a family change or change in employment, where sometimes the situation is known and they want to

have everything planned, and sometimes the situation is sudden, and coverage needs to be secured afterwards.

4) **RELATED LEGISLATION**. AB 4 (Arambula) of 2023 requires Covered California to administer a program to allow persons otherwise not able to obtain coverage by reason of immigration status to enroll in health insurance coverage in a manner as substantially similar to other Californians as feasible given existing federal law and rules. Requires Covered California to undertake outreach, marketing, and other efforts to ensure enrollment. Requires Covered California to adopt an annual program design for each coverage year to implement the program, and requires the Exchange to provide appropriate opportunities for stakeholders, including the Legislature, and the public to consult on the design of the program. AB 4 is pending in Senate Appropriations Committee.

5) **PREVIOUS LEGISLATION**.

   a) SB 1473 (Pan), Chapter 545, Statutes of 2022, establishes an annual enrollment period from November 1 of the preceding calendar year to January 31 of the benefit year. Specifies that the effective date of coverage for individual health benefit plans offered outside and through the Exchange would be no later than January 1 of the benefit year for plan selection made from November 1 to December 31 of the preceding calendar year, inclusive, and would be no later than February 1 of the benefit year for plan selection made from January 1 to January 31 of the benefit year. Makes the effective dates of coverage for plans purchased through and outside of Covered California to be as follows: no later than January 1 of the benefit year for plan selection made from November 1 to December 31 of the preceding calendar year; and, no later than February 1 of the benefit year for plan selection made from January 1 to January 31 of the benefit year.

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

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

REGISTERED SUPPORT / OPPOSITION:

Support
American College of Obstetricians and Gynecologists District IX
California Pan - Ethnic Health Network
County of Santa Clara
Health Access California

Opposition
None on file.

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

Date of Hearing: June 4, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1464 (Ashby) – As Amended March 18, 2024

SENATE VOTE: 38-0

SUBJECT: Health facilities: cardiac catheterization laboratory services.

SUMMARY: Makes clarifying and conforming changes regarding the Elective Percutaneous Coronary Intervention (PCI) Program by deleting an outdated reference to hospitals that are licensed to provide "urgent and emergent" cardiac catheterization services, and by deleting language limiting cardiac catheterization laboratory services to only diagnostic services when the hospital is not approved to provide cardiac surgery services. Specifically, **this bill**:

1) Revises the requirement that the Department of Public Health (DPH) adopt standards and regulations for cardiac catheterization laboratory services, which specify that only diagnostic services may be offered at a hospital that is not approved to provide cardiac surgery service, by deleting the limitation to diagnostic services and instead requiring the standards and regulations to specify the type of services that may be offered.

2) Revises the Elective PCI Program to delete the reference to certifying hospitals that are licensed to provide "urgent and emergent" cardiac catheterization services, and instead refer to certifying hospitals that do not offer cardiac surgery services but are licensed to provide cardiac catheterization services.

EXISTING LAW:

1) Establishes DPH, which among other functions, licenses and regulates general acute care hospitals (GACHs), and in addition to the basic services offered under that license, permits GACHs to seek approval from DPH to offer special services, including cardiac surgery and cardiac catheterization laboratory services. [Health and Safety Code (HSC) §1250, §1255]

2) Requires DPH, for cardiac catheterization laboratory services, to adopt standards and regulations that specify that only diagnostic services, and which diagnostic services, may be offered by a GACH that is approved to provide cardiac catheterization laboratory service but is not also approved to provide cardiac surgery service. [HSC §1255(d)]

3) Establishes the Elective PCI Program in DPH to certify GACHs that are licensed to provide urgent and emergency cardiac catheterization laboratory service in California to perform scheduled, elective percutaneous transluminal coronary angioplasty and stent placement for eligible patients. [HSC §1256.01]

4) Requires GACHs, in order to obtain certification from DPH to participate in the Elective PCI program, to meet certain requirements, including the following:
   a) Demonstrating that it complies with the recommendations of the Society for Cardiovascular Angiography and Interventions (SCAI), the American College of Cardiology Foundation, and the American Heart Association, for performance of PCI without onsite cardiac surgery, as those recommendations may evolve over time;

b) Providing evidence showing the full support from hospital administration in fulfilling the necessary institutional requirements, including appropriate support services such as respiratory care and blood banking; and,
c) Participating in, and timely submission of, data to the American College of Cardiology-National Cardiovascular Data Registry, and conferring the rights to transfer this data to the California Department of Health Care Access and Information (HCAI). [HSC 1256.01(c)]

FISCAL EFFECT: According to the Senate Appropriations Committee, pursuant to Senate Rule 28.8, negligible state costs.

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, this bill makes technical changes to the Elective PCI program and services provided in cardiac catheterization labs. This code section was written when PCI was a new procedure. However, the Society for Cardiovascular Angiography & Interventions recommendations no longer align with current law. This bill resolves the conflict in current law and specifies that an Elective PCI Program can operate in a hospital that does not have on-site cardiac surgery services, but is licensed to provide cardiac catheterization lab services. This bill will remove obstacles currently faced by GACHs in receiving approval to provide essential care.

2) **BACKGROUND**. According to UCSF Health, PCI refers to a family of minimally invasive procedures used to open clogged coronary arteries. By restoring blood flow, the treatment can improve symptoms of blocked arteries. In a PCI, the doctor reaches a blocked vessel by making a small incision in the wrist or upper leg and then threading a catheter (a thin, flexible tube) through an artery that leads to the heart. The doctor uses X-ray images of the heart as a guide to locate the blockage or narrowed area, and then uses the most appropriate PCI techniques to open the vessel. Techniques include balloon angioplasty, where the catheter has a balloon on its tip and is inflated at the site where plaque buildup is causing a blockage, widening the passageway and restoring blood flow to the heart. The balloon is then deflated and removed. Another technique is angioplasty with stent, where a tiny mesh tub is place in the area of the blockage after the balloon is removed to keep the artery open.

   PCI can either be elective, where it is a scheduled procedure, or "primary PCI," which is when the procedure is used as an emergency medical intervention as a result of a myocardial infarction (heart attack). PCI is a much less invasive treatment option compared to a coronary artery bypass graft procedure, sometimes referred to as open-heart surgery.

   a) **History of the Elective PCI Program**. Until the passage of SB 891 (Correa), Chapter 295, Statutes of 2008, only California hospitals that were licensed to provide cardiac surgery, such as bypass surgery, were permitted to perform scheduled, elective PCI treatment. SB 891 was prompted by studies showing that elective PCI for low- to medium-risk patients can be safely and effectively performed at hospitals without cardiac surgery services if they meet certain requirements. SB 891 created the Elective PCI Pilot Program, which allowed six California GACHs that were licensed to provide cardiac catheterization services, that had off-site cardiac surgery backup, and that met the specified rigorous selection criteria, to perform scheduled, elective PCI for low to medium risk patients. SB 891 required DPH to prepare and submit a report to the

Legislature on the results of the Elective PCI Pilot Program, including a recommendation on whether elective PCI without onsite cardiac surgery should be continued in California, and if so, under what conditions. The final report from the PCI Pilot Program Advisory Oversight Committee, dated November 19, 2013, found no significant outcome differences between the six hospitals in the pilot program, and the control group of 116 hospitals performing these procedures with onsite cardiac surgery services. No strong relationship was noted between hospital volumes and overall safety and efficacy. Potential worse outliers were identified only in the non-pilot control group of hospitals with onsite surgery.

SB 906 (Correa), Chapter 368, Statutes of 2014, created a permanent Elective PCI Program based on the successful pilot program, where DPH certifies hospitals that are not authorized to perform cardiac surgery but are permitted to perform scheduled, elective PCI procedures using their authorized catheterization laboratory.

b) Updated SCAI guidelines. A 2023 SCAI expert consensus statement on PCI intervention without on-site surgical backup, published in the *Journal of the Society for Cardiovascular Angiography & Interventions,* notes that Elective PCI in settings without surgery on site (no-SOS) has increased in volume and complexity. In addition, PCI is now being performed outside of the hospital setting, in office-based laboratories and ambulatory surgery centers. The statement also notes that several new studies in the United States and abroad have demonstrated that PCIs performed at no-SOS centers have very low rates of complications and similar outcomes to PCIs performed at surgical centers, finding that, "…despite increase in age, comorbidities, and lesion complexity, the rate of post-procedural complications has remained constant, or declined, with rates of emergency surgery as low as 0.1% in many series."

c) HCAI report on Elective PCI Program. As part of the Elective PCI Program, HCAI is required to use data collected by the American College of Cardiology's National Cardiovascular Data Registry to create annual reports of performance for hospitals certified by DPH to participate in this program. According the most recent report (from 2022), there are 21 hospitals certified to participate in the Elective PCI Program. HCAI looked at two outcome measures: mortality and post-PCI stroke. Risk-adjusted rates for the certified hospitals are compared to overall observed statewide rates derived from all 122 hospitals that performed PCIs in 2022 (21 certified hospitals, and 112 non-program hospitals). According to this report, the elective PCI mortality rate for certified hospitals was 0.28% compared to a statewide elective PCI mortality rate of 0.26%. The all-PCI mortality rate (which includes primary PCIs for patients experiencing a heart attack) for certified hospitals was 2.55% compared to a statewide rate of 2.60%. For post-PCI strokes, the elective PCI stroke rate for certified hospitals was 0.21% compared to a statewide rate of 0.12% (though in 2021, the elective PCI stroke rate in certified hospitals was only 0.07%). According to HCAI, based on these findings, the procedures in certified hospitals continues to be safe when compared with facilities that do have onsite cardiac surgery.

3) PREVIOUS LEGISLATION.

a) SB 906 established the PCI Program at DPH to certify GACHs that are licensed to provide cardiac catheterization laboratory service in California, and that meet prescribed, additional criteria, to perform scheduled, elective PCI.

b) SB 357 (Correa), Chapter 202, Statutes of 2013, extended the January 1, 2014 sunset date for the PCI Pilot Program to January 1, 2015, and required the final report by the PCI Pilot Program oversight committee to be completed by November 30, 2013, rather than at the conclusion of the pilot program.

c) SB 891 enacted the PCI Pilot Program to allow DPH to authorize up to six general acute care hospitals that are licensed to provide cardiac catheterization laboratory service in California, and that meet specified requirements, to perform scheduled, elective percutaneous transluminal coronary angioplasty and stent placement for eligible patients without onsite cardiac surgery.

REGISTERED SUPPORT / OPPOSITION:

Support

None on file.

Opposition

None on file.

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