# California State Assembly

## HEALTH

**MIA BONTA**
CHAIR



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# AGENDA

Tuesday, June 11, 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 959 | Menjivar | Trans-inclusive care: resources and support services. |
| 2. | SB 999 | Cortese | Health coverage: mental health and substance use disorders. |
| 3. | SB 1016 | Gonzalez | Latino and Indigenous Disparities Reduction Act. |
| 4. | SB 1042 | Roth | Health facilities and clinics: clinical placements: nursing. |
| 5. | SB 1078 | Min | Language access. |
| 6. | SB 1112 | Menjivar | Medi-Cal: families with subsidized childcare. |
| 7. | SB 1119 | Newman | Hospitals: seismic compliance.(Urgency) |
| 8. | SB 1184 | Eggman | Mental health: involuntary treatment: antipsychotic medication. |
| 9. | SB 1230 | Rubio | Strengthen Tobacco Oversight Programs (STOP) and Seize Illegal Tobacco Products Act. |
| 10. | SB 1320 | Wahab | Mental health and substance use disorder treatment. |
| 11. | SB 1369 | Limón | Dental providers: fee-based payments. |
| 12. | SB 1385 | Roth | Medi-Cal: community health workers: supervising providers. |
| 13. | SB 1442 | Ochoa Bogh | Point-of-care tests for fentanyl. |

Date of Hearing: June 11, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 959 (Menjivar) – As Amended May 16, 2024

**SENATE VOTE**: 31-8

**SUBJECT**: Trans-inclusive care: resources and support services.

**SUMMARY:** Requires the California Health and Human Services Agency (CalHHS) to establish a website where the public can access specified information about trans-inclusive health care and other support services in the state. Specifically, **this bill**:

1) Requires, on or before July 1, 2025, the CalHHS, or an entity designated by the agency, to establish an internet website where the public can access information and resources to support transgender, gender diverse, and intersex (TGI) individuals and their families in accessing trans-inclusive health care and other support services in the state.

2) Requires the website to include all of the following information and resources:
   a) Federal and state protections for TGI individuals accessing trans-inclusive health care and for health care providers providing such care;
   b) Information on how to access health care plans, Medi-Cal managed care plans, and health insurer directories that identify in-network providers;
   c) Various support services, such as transportation, family support, and translation;
   d) A general description of trans-inclusive health care, including gender-affirming health care and gender-affirming mental health care;
   e) Information to combat misinformation and disinformation about trans-inclusive health care, including gender-affirming health care and gender-affirming mental health care;
   f) References and links to additional related information and resources for TGI individuals and their families, to the extent such information is available to the agency:
      i) Rights and legal protections for TGI individuals to access health care, housing, employment, public accommodations, and other programs free from discrimination;
      ii) Filing a complaint with the appropriate government agency following a violation of an individual's rights;
      iii) Accessing legal services;
      iv) Resources for victims of hate incidents and hate crimes;
      v) Updating an individual's name and gender marker on state and federal identification records, including, but not limited to, driver's licenses, birth certificates, death certificates, passports, and social security cards;
      vi) Programs and services for those experiencing, or at risk of experiencing, homelessness; and,
      vii) Programs and services to promote economic security, including food and cash assistance programs; and,
   g) Any other information or resources that will assist an individual seeking comprehensive and accurate information about accessing trans-inclusive health care and other support services in the state.

3) Requires the applicable agency or entity to consult with subject matter experts, as defined, and the Department of Justice when determining the information and resources to be posted.

4) Requires the website to have mobile functionality; to be updated regularly, no less than annually; and to comply with existing accessibility requirements. Requires the website to be translated into five enumerated languages and to comply with the Dymally-Alatorre Bilingual Services Act.

5) Allows the state to accept donations to support and maintain the website, and makes donations accepted for this purpose available upon appropriation by the Legislature to support and maintain the website.

6) Prohibits the inclusion of the name or location of any individual who is a provider of gender-affirming services on the website.

**EXISTING LAW**:

1) Establishes CalHHS, which consists of the following departments: Aging, Community Services and Development, Developmental Services, Health Care Services (DHCS), Managed Health Care (DMHC), Public Health (DPH), Rehabilitation, Social Services, and State Hospitals. [Government Code (GOV) §12803, §12806]

2) Requires CHHS to convene a working group of representatives of the transgender, gender diverse, or intersex (TGI) community and state agencies to develop a quality standard for patient experience related to the TGI community and to recommend training curriculum to provide trans-inclusive health care. [Health and Safety Code (HSC) §150950]

3) Requires DPH's Office of Health Equity to administer the TGI Wellness and Equity Fund for purposes of funding grants to create programs, or funding existing programs, focused on coordinating trans-inclusive health care for individuals who identify as TGI. [HSC §150900]

4) Defines "trans-inclusive health care" as comprehensive health care that is consistent with the standards of care for individuals who identify as TGI, honors an individual's personal bodily autonomy, does not make assumptions about an individual's gender, accepts gender fluidity and nontraditional gender presentation, and treats everyone with compassion, understanding, and respect. [Welfare and Institutions Code (WIC) §14197.09]

5) Defines "gender-affirming health care" as medically necessary health care that respects the gender identity of the patient, as experienced and defined by the patient, and may include, but is not limited to, interventions to suppress the development of endogenous secondary sex characteristics; interventions to align the patient's appearance or physical body with the patient's gender identity; and, interventions to alleviate symptoms of clinically significant distress resulting from gender dysphoria. [WIC §16010.2]

6) Defines "gender-affirming mental health care" as mental health care or behavioral health care that respects the gender identity of the patient, as experienced and defined by the patient, and may include, but is not limited to, developmentally appropriate exploration and integration of identity, reduction of distress, adaptive coping, and strategies to increase family acceptance. [WIC §16010.2]

7) Establishes the Dymally-Alatorre Bilingual Services Act, which requires, among other things, that state agencies translate any materials explaining services available to the public into any non-English language spoken by a substantial number of the public served by the agency. [GOV §7290, *et seq*.]

**FISCAL EFFECT**: According to the Senate Appropriations Committee, CalHHS would likely designate DMHC as responsible for developing and maintaining the website. Unknown ongoing costs for DMHC, likely low hundreds of thousands (Managed Care Fund).

**COMMENTS**:

1) **PURPOSE OF THIS BILL**. According to the author, TGI people, especially TGI youth, are confronting an alarming rise in discrimination and violence fueled by misinformation and political attacks. According to the American Civil Liberties Union, over 500 anti-LGBTQ+ bills were introduced in 2023, and 84 were signed into law. These bills disproportionately targeted TGI youth and adults, particularly access to essential health care. The author indicates California must continue leading the nation to ensure that TGI people in California and across the country can access the health care and support services they need. The author asserts this bill will ensure that California provides comprehensive information and resources about access to trans-inclusive health care in the state, as TGI people and their families seek access to affirming health care and support.

2) **BACKGROUND**.

   a) **Gender-Affirming Care and Recent Action in Other States**. Gender-affirming care is considered safe, effective, and medically necessary by major professional health associations, such as the American Medical Association and American College of Obstetricians and Gynecologists (ACOG). Despite this, according to a 2023 report by the University of California, Los Angeles School of Law, Williams Institute, a growing number of states have taken action to restrict access to this care through proposed or enacted legislation or executive action. The report notes that since 2020, 36 states have attempted to restrict access to gender-affirming care, primarily through legislative action, and nine states have enacted legislative bans on gender-affirming care for youth and young adults.

   b) **Particular Informational Challenges Related to Gender-Affirming Care.** Human Rights Campaign, an LGBTQ+ civil rights organization that monitors state restrictions on gender-affirming care, has asserted that the debate on bills related to such care includes misconceptions and lies. In addition, according to ACOG, lack of awareness, knowledge, and sensitivity as well as bias from health care professionals contributes to inadequate access to, underuse of, and inequities within the health care system for transgender patients. Given these factors, it may be particularly challenging for individuals to identify reliable and trusted information on trans-inclusive health care and related protections.

   c) **California Protections on Gender-Affirming Care**. In recent years, California has enacted numerous laws protecting access to gender-affirming health care and protecting the providers offering such care. California agency interpretation by DMHC, California Department of Insurance, and DHCS has also generally been protective of individual's access to gender-affirming health care as a medically necessary service for individuals

covered by commercial insurance and Medi-Cal. This bill would create a web resource for this type of information. Although some similar resources exist online that address components of this bill's requirements, the author and sponsor emphasize the importance of a state government website in combatting disinformation and providing people information they can trust. This bill is modeled on the website "abortion.ca.gov," where individuals can seek reliable information about abortion services, a health care service that has also been the subject of debate and restricted in some states.

3) **SUPPORT**. Cosponsors Equality California, Planned Parenthood Affiliates of California, TransFamily Support Services, and TransYouth Liberation, along with other supporters, write that despite California's strong laws protecting TGI people's access to essential health care, TGI people frequently have trouble finding affirming providers for routine care and identifying health care providers who offer gender-affirming care within their health plan can be even harder. Additionally, TGI individuals often feel unsure about the steps to obtaining care as well as feeling unsure about requirements that may need to be met for care. Supporters explain these access issues exacerbate existing health disparities among TGI Californians, who are more likely to experience chronic health conditions and experience higher rates of health concerns related to HIV, substance use, mental illness, and sexual and physical violence. As attacks on the TGI community continue to escalate, supporters indicate California must take additional steps to be a nationwide leader in supporting TGI people and their families seeking essential health care.

4) **RELATED LEGISLATION**. SB 957 (Wiener) requires DPH to collect demographic data, including sexual orientation, gender identity (SOGI), and intersexuality data, from third parties on any forms or electronic data systems, unless prohibited by federal or state law. Adds SOGI to the information reported for the purpose of statewide or local immunization information systems. Requires DPH to prepare an annual report concerning SOGI data. SB 957 is pending in the Assembly Health Committee.

5) **PREVIOUS LEGISLATION**.

   **a)** SB 345 (Skinner), Chapter 260, Statutes of 2023, enacts various safeguards against the enforcement of other states' laws that prohibit, criminalize, sanction, authorize civil liability against, or otherwise interfere with a person, provider, or other entity in California that offers reproductive health care services or gender-affirming health care services.

   **b)** AB 352 (Bauer-Kahan), Chapter 255, Statutes of 2023, requires businesses that store or maintain medical information to maintain security features to protect the privacy of patients' medical records related to gender-affirming health care, abortion, and contraception.

   **c)** AB 571 (Petrie-Norris), Chapter 256, Statutes of 2023, prohibits insurers from refusing to provide professional liability coverage to health care providers or from imposing a surcharge on health care providers, because they offer abortion, contraception, or gender-affirming services.

   **d)** AB 1707 (Pacheco), Chapter 258, Statutes of 2023, protects licensed health care professionals, clinics, and health facilities from being denied a license or subjected to

discipline on the basis of a civil judgment, criminal conviction, or disciplinary action imposed by another state based solely on the application of a law that interferes with a person's right to receive services, including gender-affirming care, that would be lawful in California.

**e)** SB 923 (Wiener), Chapter 822, Statutes of 2022, requires health plans and insurers to require all of their support staff in direct contact with enrollees or insureds, to complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care for individuals who identify as TGI. Adds processes to continuing medical education requirements related to cultural and linguistic competency for physicians and surgeons specific to gender-affirming care services, as specified.

**f)** SB 107 (Wiener), Chapter 810, Statutes of 2022, enacts various safeguards against the enforcement of other states' laws that purport to penalize individuals from obtaining gender-affirming care that is legal in California.

**g)** SB 1142 (Caballero), Chapter 566, Statutes of 2022, created abortion.ca.gov for resources for abortion services.

**h)** AB 2218 (Santiago), Chapter 181, Statutes of 2020, establishes the Transgender Wellness Equity Fund (now the TGI Equity Fund), for the purpose of funding grants to organizations serving people that identify as TGI, to create or fund TGI-specific housing programs and partnerships with hospitals, health care clinics, and other medical providers to provide TGI-focused health care, as defined, and related education programs for health care providers.

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

7) **POLICY COMMENT**. While this bill would provide a valuable informational resource, some of the required elements of this website are well beyond the scope of trans-inclusive health care. Some of the other issues, including, for example, programs and services for those experiencing or at risk of homelessness, are addressed by other agencies and entities. Although a truly comprehensive state resource may be helpful to some individuals, the author may also wish to consider narrowing the focus to what appears to be the core priority of the bill: providing a resource with information specific to trans-inclusive health care and related services. This would reduce the one-time and ongoing administrative resources required to produce and update a wide variety of information that is outside of the health-related agencies' expertise.

**REGISTERED SUPPORT / OPPOSITION**:

**Support**

Equality California (cosponsor)
Planned Parenthood Affiliates of California (cosponsor)
Transfamily Support Services (cosponsor)
Transyouth Liberation (cosponsor)
Office of Lieutenant Governor Eleni Kounalakis

Access Support Network
American College of Obstetricians and Gynecologists, District IX
APLA Health
Asian Americans Advancing Justice Southern California
Bienestar Human Services
California Faculty Association
California Federation of Teachers AFL-CIO
California Legislative LGBTQ Caucus
California Transcends
Central California LGBTQ + Collaborative
Children Now
Courage California
El/la Para Translatinas
Essential Access Health
Faculty Association of California Community Colleges
Glide
Justice in Aging
Los Angeles LGBT Center
Mental Health America of California
Our Family Coalition
Parivar Bay Area
San Francisco Marin Medical Society
San Joaquin Pride Center
Sharp Healthcare
Somos Familia Valle
The Center for Sexuality & Gender Diversity
The Trevor Project
Transgender Health and Wellness Center
Transgender Resource, Advocacy & Network Service

**Opposition**

None on file.

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

Date of Hearing: June 11, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 999 (Cortese) – As Amended April 8, 2024

**SENATE VOTE**: 31-7

**SUBJECT**: Health coverage: mental health and substance use disorders.

**SUMMARY:** Establishes the California Mental Health (MH) and Substance Use Disorder (SUD) Treatment Patient Safety and Fairness Act. Requires a health plan or disability insurer to comply with utilization review (UR) determination requirements related to MH and SUD treatment. Specifically, **this bill**:

1) Requires a health plan or disability insurer, and an entity acting on a plan or insurer's behalf, to ensure compliance with all of the following:
   a) UR determinations, including initial determinations and appeals, to be made by a health care provider that has appropriate training and relevant experience in the clinical specialty and diagnosis. Requires, to the extent available, a health care provider conducting UR determinations to complete training provided by formal education programs of nonprofit clinical specialty associations, as specified;
   b) Requires the health plan or insurer, or an entity acting on the plan or insurer's behalf, to maintain telephone access and any other direct communication access used for UR during California business hours for a health care provider to request authorization for MH and SUD care and conduct peer-to-peer discussions regarding patient issues, including the appropriateness of a requested treatment, modification of a treatment request, or obtaining additional information needed to make a medical necessity determination; and,
   c) Requires an individual or health care provider performing UR to disclose to the treating health care provider and the enrollee or insured, the name and credentials of the individual or health care provider performing UR, the health plan or insurer's basis for a denial, including a citation to the clinical guidelines reviewed, and an analysis of why the enrollee or insured did not meet the clinical criteria.

2) Specifies that this bill does not preclude existing law as it relates to UR or utilization management (UM).

3) Makes findings and declarations including that coverage of intermediate levels of care such as residential treatment, which are essential components of the level of care continuum called for by nonprofit organizations, and clinical specialty associations such as the American Society of Addiction Medicine (ASAM), are often denied through overly restrictive medical necessity determinations.

**EXISTING LAW**:

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

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

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

4) Requires a health plan or insurer to base any medical necessity determination or the UR 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 UR 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 UR or UM functions, to determine whether to authorize, modify, or deny health care services to:
   a) Be developed with involvement from actively practicing health care providers;
   b) Be consistent with sound clinical principles and processes;
   c) Be evaluated, and updated if necessary, at least annually;
   d) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the enrollee or insured in that specified case; and,
   e) Be available to the public upon request. [HSC §1363.5 and INS §10123.135]

6) Requires a health plan to employ or designate a medical director who holds an unrestricted license to practice medicine in this state, as specified, or, if the plan is a specialized health plan, a clinical director with California licensure in a clinical area appropriate to the type of care provided by the specialized health plan, for purposes of UR or UM functions. Requires the medical director or clinical director to ensure that the process by which the plan reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees. Specifies that no individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. [HSC §1367.01]

7) Establishes the Independent Medical Review (IMR) process as part of the DMHC appeal process when a 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. Requires medical professionals selected by the IMR organizations to review medical treatment decisions to be physicians or other appropriate providers that meet specified minimum requirements, including, that the medical

professional must hold an nonrestricted license in any state and for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the condition or treatment under review. Requires the IMR organization to give preference to the use of a California licensed physician as the reviewer, except when training and experience with the issue under review reasonably requires the use of an out-of-state reviewer. [HSC §1374.30]

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 a health plan or insurer to maintain telephone access for providers to request authorization for health care services. Specifies that any written communication to a physician or other health care provider of a denial, delay, or modification of a request include the name and phone number of the health care professional responsible for the denial, delay, or modification and that the phone number provided by a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. [HSC §1367.01 and INS §10123.135]

**FISCAL EFFECT**: According to the Senate Appropriations Committee, DMHC estimates costs to be approximately $1,621,000 in 2024-25, $4,374,000 in 2025-26, $4,149,000 in 2026-27, $3,951,000 in 2027-28, and $3,955,000 in 2028-29 and annually thereafter for state administration (Managed Care Fund). CDI estimates costs of $13,000 in 2025-26 for state administration (Insurance Fund).

**COMMENTS**:

1) **PURPOSE OF THIS BILL**. According to the author, this bill will ensure that Californians suffering from MH and SUDs are able to receive timely treatment that is consistent with nonprofit professional clinical associations, including criteria developed by ASAM for addiction care. While existing law does require health plans and disability insurers to comply with critical treatment and placement standards, inappropriate UR practices are still commonly used to avoid paying for care. This leaves insured patients unable to access treatment that they need to make full and lasting recoveries. The author states that this bill will remedy this by requiring that UR determinations be performed by a reviewer with appropriate training and relevant experience in the clinical specialty. By implementing the correct clinical and UR criteria for SUD treatment, there is the opportunity to save lives by addressing the escalating rates of overdose deaths and suicides. The author concludes that denials of medically necessary MH and SUD treatment during escalating youth MH, overdose, and suicide rates constitute a life-threatening failure of our health systems.

2) **BACKGROUND**.

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

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

**b)** **UR**. Prior authorization is a decision by a health plan that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. The health plan may require preauthorization for certain services before an individual receives them, except in an emergency. Health plans are subject to various requirements in California, as stated in existing law above, including an obligation to file policies and procedures that describe UR or UM functions, used to authorize, modify, or deny health care services under the benefits provided by the health plan. Additionally, existing law requires these policies and procedures to ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes.

**i)** **SB 855 UR**. Notably, SB 855 requires plans to base medical necessity determinations or UR criteria on current generally accepted standards of MH and SUD. Additionally, plans must apply the most recent criteria and guidelines developed by the nonprofit professional association for the relevant clinical specialty when conducting UR of treatment of MH and SUDs. Further, plans must sponsor a formal education program by nonprofit clinical specialty associations to educate all plan staff and any third parties contracted to review claims, conduct UR, or make medical necessity determinations. SB 855 also requires plans to conduct interrater reliability testing and run reports to achieve an interrater reliability pass rate of at least 90%. Interrater reliability testing measures the consistency in decision making by individuals authorized to determine whether services are medically necessary.

**ii)** **SB 855 regulations**. Both DMHC and CDI issued regulations related to SB 855. DMHC's regulations specify that health plans must issue a written communication to enrollees outlining the basis for the delay, denial, or modification of a requested treatment. According to the author, CDI's recently released proposed regulations for SB 855 include components for UR that are outlined in this bill. CDI regulations require that denials are made only by a licensed physician or other licensed health care provider with appropriate training and relevant experience in the clinical specialty that is involved in the coverage determination. CDI also defines appropriate training and relevant experience in addiction care to include active clinical practice in

the treatment of patients with SUDs at the level of care or service intensity that is under review.

The author states that this bill requires UR reviewers to disclose their name, credentials, and basis for denial, including a citation to the clinical guidelines reviewed. According to the author, this provision will allow advocates, plans, and regulators to better track UR trends.

3) **SUPPORT**. Santa Clara County Office of Education, cosponsor, writes that although federal and state law require health plans and disability insurers to cover medically necessary MH and SUD treatment, plans regularly deny coverage of treatments prescribed by patients' physician or psychologist. These health plans employ staff without appropriate medical expertise to conduct URs and deny physician-prescribed care. Data from the DMHC's annual IMR report show that 67.5% of denials are overturned when independent medical experts review the UR. The Kennedy Forum and Steinberg Institute, cosponsors, state that this bill brings important transparency components to the practice of UR. Utilization reviewers should be able to demonstrate the necessary experience and training to apply the generally accepted standards of care correctly, hold certifications and licenses for the states in which they are reviewing claims, and maintain access hours during California business hours. It is imperative that well-qualified reviewers handle these time-sensitive and often lifesaving claims.

4) **OPPOSITION**. The California Association of Health Plans, the Association of California Life and Health Insurance Companies, and America's Health Insurance Plans are concerned that this bill will allow enrollees to access the personal information and credentials of the health care provider who is making the UR determination. This could unnecessarily expose the provider performing the UR to inappropriate and potentially abusive communication from the enrollee should they disagree with the decision. Current law provides that, when an enrollee disagrees with a UR decision, the enrollee can file a grievance with the health plan regarding the decision. The opposition states that the existing grievance process provides enrollees with a robust and timely process for resolving disputed decisions in a way that also protects the clinical decision-making of the determining provider. Additionally, the opposition has concerns around the proposed communication expectations from health plans/insurers in the bill. Currently, health plans/insurers typically provide the basis for a denial. The opposition is unclear if the intent of this bill is to also require health plans/insurers to share this information verbally or electronically in addition to the issuance of a denial letter and requests that more clarity be added to this bill to ensure health plan/insurer compliance.

5) **RELATED LEGISLATION**.

   **a)** SB 294 (Wiener) requires a health plan or a disability insurer that upholds its decision to modify, delay, or deny a health care service in response to a grievance or has a grievance that is otherwise pending or unresolved upon expiration of the relevant timeframe to automatically submit within 24 hours a decision regarding a disputed health care service to the IMR System, relating to MH or SUD conditions for an enrollee or insured up to 26 years of age. SB 294 is pending in the Assembly Appropriations Committee.

   **b)** AB 2556 (Jackson) requires a health plan or insurer to provide to each subscriber or policyholder of an patient, 10 to 18 years or age, a written or electronic notice regarding

the benefits of a behavioral health and wellness screening. AB 2556 is pending in Senate Health Committee.

**6) PREVIOUS LEGISLATION**.

**a)** SB 999 (Cortese) of 2022 was similar to this bill. SB 999 was vetoed by Governor Newsom who stated in part:

"I share the author's goal of ensuring that patients are able to receive the behavioral health care they need, when they need it. Two years ago, I signed SB 855, a landmark update to California's MH parity statutes. SB 855 and forthcoming regulations implementing the law seek to address the issues targeted by this bill by requiring the use of unbiased MH and SUD clinical standards in coverage reviews and mandating the appropriate training and oversight of staff performing those reviews. Implementation of SB 855 is underway, and the industry is in the process of adapting to California's stringent new requirements. As such, this bill is premature and unnecessary at this time."

**b)** AB 1880 (Arambula) of 2022 would have required a health plan or insurer's UM process to ensure that an appeal of a denial, is reviewed by a clinical peer, as specified. Would have defined clinical peer as a physician or other health professional who holds an unrestricted license or certification from any state and whose practice is in the same or a similar specialty as the medical condition, procedures, or treatment under review. AB 1880 was vetoed by Governor Newsom who stated in part:

"Health plans and health insurers should make every effort to streamline UM processes and reduce barriers to all medically necessary care. However, the bill's requirements, which are limited to denied authorizations for prescription drugs, are duplicative of California's existing IMR requirements, which provide enrollees, insureds, and their designated representatives with the opportunity to request an external review from an independent provider. I encourage the Legislature to pursue options that leverage existing requirements and resources, rather than creating duplicative new processes."

**c)** SB 855 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.

**REGISTERED SUPPORT / OPPOSITION**:

**Support**

California Consortium of Addiction Programs and Professionals (cosponsor)
Santa Clara County Office of Education (cosponsor)
Summit Estate Recovery Center (cosponsor)
The Kennedy Forum (cosponsor)
The Steinberg Institute (cosponsor)
Addiction Therapeutic Services
Alum Rock Counseling Center

Anaheim Family Chiropractic
Anaheim Lighthouse
Asian Americans for Community Involvement
AToN Center
AUBICO INC
Autism Speaks
Bill Wilson Center
Buckeye Recovery Network
California Alliance for State Advocacy
California Association of Social Rehabilitation Agencies
California Commission on Aging
California Council of Community Behavioral Health Agencies
California County Superintendents
California Dental Association
California Hospital Association
California Life Sciences
California Medical Association
California Psychological Association
California School-based Health Alliance
California Teachers Association
Cambridge Healthcare Management Services, LLC
Capo by The Sea
CFT- a Union of Educators & Classified Professionals, AFT, AFL-CIO
Cleanquest, LLC
Clearly Clinical
CNV Detox
Community Social Model Advocates, INC.
Council of Autism Service Providers (CASP)
Covenant Hills Treatment Center
CPCA Advocates, Subsidiary of The California Primary Care Association
Davis Healthcare Management Group
Design for Change
DIR/floortime Coalition of California
Dolorosa Operations INC.
Embodied Recovery
First Responder Wellness
First Responders Recovery Malibu
Greenhouse Therapy Center
Health Access California
New Found Life Treatment Center
Healthcare Consulting and Advocacy Group INC
Inseparable
Intervention 911
JMG Investments Harmony Place
Mental Health America of California
National Alliance on Mental Illness (NAMI-CA)
National Union of Healthcare Workers (NUHW)
New Found Life Treatment Center
Opus Health

Orange County Recovery Collaboration
Recovery Advocacy Project California
Rume Medical Group
San Diego County Dental Association
Santa Clara County School Boards Association
Shatterproof
Steinberg Institute
Sun Street Centers
Synthesis Recovery
The American Foundation for Suicide Prevention
The Council of Autism Service Providers
The Law Foundation of Silicon Valley
The Purpose of Recovery
The Recovery Advocacy Project
The Villa Center, INC.
Valley Restoration Center
West Los Angeles Recovery
Young People in Recovery

**Opposition**

America's Health Insurance Plans (AHIP)
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 11, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1016 (Gonzalez) – As Amended May 16, 2024

**SENATE VOTE**: 34-0

**SUBJECT**: Latino and Indigenous Disparities Reduction Act.

**SUMMARY:** Requires the California Department of Public Health (DPH), whenever collecting demographic data as to the ancestry or ethnic origin of California residents for specified reports, to use separate collection and tabulation categories for each major Latino group, Mesoamerican Indigenous nation, and Mesoamerican Indigenous language group, as specified. Specifically, **this bill**:

1) Requires DPH, on or after January 1, 2027, in the course of collecting demographic data as to the ancestry or ethnic origin of California residents for any report that includes rates for major diseases and leading causes of death in California overall, pregnancy, housing, and mental health rates to do the following:

    a) Utilize separate collection categories in the provided forms that offer respondents the option of selecting one or more ethnic or racial designations and tabulations for Hispanic or Latino groups using standardized federal race and ethnicity categories from the federal Office of Management and Budget (OMB)'s most recent revision to "Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity."

    b) To the extent the standardized federal race and ethnicity categories from the federal OMB most recent revision to "Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity" does not include the group or nation, utilize separate collection categories in the provided forms that offer respondents the option of selecting one or more ethnic or racial designations and tabulations for both of the following:

        i) Each major Latino group, including, but not limited to, Mexican, Guatemalan, Salvadoran, Honduran, Nicaraguan, Puerto Rican, Dominican, Cuban, Colombian, and Peruvian, followed by a blank space to fill in additional groups; and,
        ii) Each major Mesoamerican Indigenous nation, including, but not limited to, Maya, Aztec, Mixteco, Zapoteco, and Triqui, followed by a blank space to fill in additional nations.

2) Requires DPH, when collecting the preferred language of program participants, to include Mixteco, Triqui, Zapoteco, K'iche, Mam, and Kanjobal, followed by a blank space to fill in additional languages.

3) Requires DPH to include data collected pursuant to 1) a) and 1) b) and when available 2) above in every demographic report on ancestry, ethnic origins, or language of Californians by DPH published or released on or after July 1, 2027, including the other groups, nations, or languages that are filled in by the respondents.

4) Requires DPH to make the data collected pursuant 1) a) and 1) b) and 2) above available to the public in accordance with state and federal law, including by posting the data on DPH's internet website, except for personal identifying information, which is to be deemed confidential and not be disclosed.
5) Prohibits DPH from making public demographic data that would permit identification of individuals.

6) Authorizes DPH to prevent identification of individuals, aggregate data categories at a state, county, city, census tract, or ZIP Code level to facilitate comparisons and identify disparities.

7) Prohibits DPH from making available public demographic data that would result in statistical unreliability.

8) Requires DPH, on or before July 1, 2028, and annually thereafter, to report to the Legislature, both of the following:

   a) The data collected pursusant to the above 1) a), 1) b), and 2 above; and,
   b) The methods utilized to collect that data.

9) Requires DPH, within 18 months after a decennial United States Census is released to the public, to update its data collection to reflect the additional Latino groups, major Mesoamerican Indigenous nations, and major Mesoamerican Indigenous language groups as they are reported by the United States Census Bureau.

10) Finds and declares that this bill imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within California Constitution.

11) Finds, to demonstrate the interest protection by the limitation in 10) above and the need for the protecting that interest, that in order to protect the privacy of California residents, while also gathering and publicizing useful demographic data, it is necessary that personal identifying information remain confidential.

**EXISTING LAW**:

1) Establishes DPH, directed by a state Public Health Officer, to be vested with all the duties, powers, purposes, functions, responsibilities, and jurisdiction as they relate to public health and licensing of health facilities, as specified. [Health and Safety Code §131050]

2) Requires a state agency, board, or commission that directly or by contract collects demographic data as to the ancestry or ethnic origin of Californians to use separate collection categories and tabulations for the following: each major Asian group, including, but not limited to, Chinese, Japanese, Filipino, Korean, Vietnamese, Asian Indian, Laotian, and Cambodian; and, each major Pacific Islander group, including, but not limited to, Hawaiian, Guamanian, and Samoan. [Government Code (GOV) §8310.5]

3) Requires DPH, to the extent funding is appropriated, when collecting demographic data as to the ancestry or ethnic origin of persons for a report that includes rates for major diseases, leading causes of death per demographic, subcategories for leading causes of death in

California overall, pregnancy rates, or housing numbers to collect and tabulate data for additional major Asian groups, including Bangladeshi, Hmong, Indonesian, Malaysian, Pakistani, Sri Lankan, Taiwanese, and Thai and additional Native Hawaiian and other Pacific Islander groups, including Fijian and Tongan. [GOV §8310.7]

4) Exempts DPH's data collection from 3) above if the data was collected pursuant to federal programs or surveys whereby the guidelines for data collection categories are defined by the federal program or survey, or the data is collected by another entity not solely funded by DPH. [GOV §8310.7]

**FISCAL EFFECT**: According to the Senate Committee on Appropriations, unknown, ongoing General Fund costs to DPH for data collection.

**COMMENTS**:

1) **PURPOSE OF THIS BILL**. The author notes that Latinos make up more than 40% of California's population, and within the Latino community, there are several ethnic subgroups that experience diverse health outcomes. The author contends that California's state health programs currently view Latinos as a monolith, instead of looking at these subgroups individually and understanding the unique challenges they each face. Using data without the nuances of subgroups can lead to policymakers and researchers relying on less detailed information when making health and policy decisions. Current research has shown that the prevalence of diabetes within Latino subgroups varied from 5% to 18% based on country of origin. This highlights how health data collected by the state isn't necessarily reflective of the diversity of various subgroups within Latino populations and ignores the health trends within those subgroups. Data disaggregation is imperative for discovering disparities among the Latino community and addressing them effectively. During the height of the COVID-19 pandemic, Indigenous communities could not access timely and reliable information to access vaccines in California and suffered a higher death rate as a result. The author concludes that this bill takes the critical and necessary first step to uncover trends and potential disparities that are often hidden in aggregated numbers for Latinos and Indigenous Mesoamericans in California by requiring the state's public health agency to collect and disaggregate data for specified subgroups.

2) **BACKGROUND**.

   a) **Latinos in California.** According to the most recent data from the U.S. Census Bureau, Latinos make up 40.3% of the population of California, making Latino the largest ethnicity in California. The 2022 Census Bureau American Community Survey reports that 81% of the Latinos in California are Mexican, 5% are Salvadoran, 3% are Guatemalen, and the next largest subcategory is "other" at 2%. The American Community Survey only breaks down the Latino category by country of origin using the most common countries of origin in the United States. Other groups that make up a significant portion of Latinos in the United States, such as Puerto Ricans and Cubans, make up 1% or less of California's Latino population. The survey also does not include data on Mesoamerican Indigenous nation or Mesoamerican Indigenous language group. According to the Mixteco Indígena Community Organizing Project, California is home to an estimated 170,000 indigenous migrants from the Mexican state of Oaxaca, Guerrero, and Michoacán, including Mixtecs, Zapotecs, and Purépechas, which would be 1% of the

Latino population. These indigenous populations often only speak their native pre-Hispanic indigenous languages and their unique cultural practices and beliefs often isolate them from other Latino populations.

**b) OMB Interagency Technical Working Group on Race and Ethnicity Standards.** The OMB maintains government-wide standards for federal race and ethnicity data to ensure the ability to compare information and data across federal agencies. In June 2022, the U.S. Chief Statistician identified updating the standards as a top priority to ensure that the standards better reflect the diversity of the American people. The Interagency Technical Working Group on Race and Ethnicity Standards (Working Group) was created to lead this effort and was charged with proposing recommendations for improving the quality and usefulness of federal race and ethnicity data. On March 29, 2024, the OMB published the updated revisions "Revisions to OMB's Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity."

Under the previous 1997 directive, respondents are first asked whether they are Hispanic or Latino as a yes/no question, with another question following to ask what race they are. Respondents can choose one or more of the following categories: American Indian or Alaskan Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, or white. Under new rule, the questions about race and ethnicity are combined. The Hispanic or Latino category asks for further information allowing respondents to check one or more options of the following categories: Mexican, Puerto Rican, Salvadoran, Cuban, Dominican, or Guatemalan. It also includes a blank where additional categories can be included, with the instructions "Enter, for example, Colombian, Honduran, Spaniard, etc." Respondents are also able to include information in the other racial/ethnic categories such as Black or African American if applicable. The directive also gives a short version of the form that may be used only if an agency requests a variance and demonstrates that the potential benefit of the detailed data would not justify the additional burden of collection.

**c) Race/ethnicity data collection in California.** California currently largely follows the 1997 OMB guidance, except where state law requires further disaggregation for Asian and Native Hawaiian or Pacific Islander groups. Starting in 1990, California began collecting additional categories for each major Asian and Pacific Islander (API) group, including Chinese, Japanese, Filipino, Korean, Vietnamese, Asian Indian, Hawaiian, Guamanian, Samoan, Laotian, and Cambodian. Additional subcategories have since been added in specific circumstances or by certain state entities. More recently, starting January 1, 2024, the State Controller's office and the Department of Human Resources (CalHR) are required to collect the following additional collection categories solely about state employees for Black Californians: i) African Americans who are descendants of persons who were enslaved in the U.S.; or, ii) Blacks who are not descendants of persons who were enslaved in the U.S, including, but not limited to, African Blacks, Caribbean Blacks, and other Blacks. Language groups are not included in demographic data requirements. However, numerous federal and state language access laws implicitly require the collection of the preferred language of program participants or require state agencies to calculate the percentage of non-English speaking people served by the agency or its programs. California agencies must conform to the new OMB guidance within five years, though the guidance states most programs should be able to implement sooner than the five-year deadline.

**d) Importance of data disaggregation.** The pandemic highlighted the ways in which systemic racism exacerbates health disparities that exists for vulnerable populations. Data disaggregation would allow for a more accurate and nuanced understanding of the unique challenges and disparities of different subgroups within the larger Latino population. The information would also allow for researchers and policymakers to identify disparities that may not be apparent when examining data for the Latino community as a whole.

**3) SUPPORT**. According to Latino Coalition for a Healthy California, the sponsor of this bill, Latinos are the largest racial and ethnic group in California, making up more than 40 % of the state's population. However, Latinos are also diverse and vary widely in terms of ethnicity, culture, and language. Additionally, Latino subgroups and Indigenous Mesoamericans experience disparate health and life outcomes based on these differences. This is especially true for Indigenous Mesoamericans who speak over 560 Indigenous languages. According to the U.S. Census Bureau, almost 20,000 Indigenous language speakers from Latin America reside in the United States and California has one of the largest Indigenous Latin American populations in the country. The sponsor continues that state systems and programs currently do not collect data on these subgroups. Latino subgroups and Mesoamerican Indigenous Nations have specific needs, such as Indigenous language access, to obtain quality and reliable information and services from our state agencies and programs. The sponsor concludes that without disaggregated data, policymakers and researchers must rely on less detailed data released by state agencies or local data that may be collected inconsistently in different jurisdictions, leading to health and related inequities.

**4) RELATED LEGISLATION**. SB 1078 (Min) establishes the Office of Language Access within the California Health and Human Services Agency to ensure individuals with limited English proficiency have meaningful access to government programs and services. SB 1078 is pending in the Assembly Health Committee.

**5) PREVIOUS LEGISLATION**.

**a)** SB 435 (Gonzalez) of 2023 was similar to this bill. SB 435 was vetoed by Governor Newsom who stated in his veto message, "Providing more detailed health and demographic information for Latino groups and Mesoamerican Indigenous nations is important to inform our services and supports and to help identify disparities. To this end, my Administration is actively monitoring and reviewing the OMB update to federal standards for collection and reporting of race and ethnicity information, and looks forward to engaging stakeholders in this effort. California is required to submit data to the federal government using these federal standards, and programs that receive federal funding must also use these standards. As such, implementing a different framework for data collection in California prior to the release of updated federal standards is premature."

**b)** SB 189 (Committee on Budget and Fiscal Review), Chapter 48, Statutes of 2022 requires, among other things, that the State Controller's Office and CalHR, when collecting demographic data as to the ancestry or ethnic origin of Californians hired into state employment, to use additional collection categories and tabulations for specified Black or African American groups.

**c)** AB 1358 (Muratsuchi) of 2021 would have expanded the groups that state agencies are required to collect disaggregated demographic data on and would have required DPH to establish standards for the collection of demographic information by local health officers and health care providers. AB 1358 was held on the Senate Appropriations Committee suspense file.

**d)** AB 1726 (Rob Bonta) Chapter 607, Statutes of 2016, requires DPH, when collecting demographic data on ancestry or ethnic origin of persons for a report that includes rates for major diseases, including causes of death per demographic, sub categories for leading causes of death in California overall, pregnancy rate, or housing number, to disaggregate those data for specified Native Hawaiian and other API groups.

**e)** AB 295 (Lieu) of 2007 would have required certain state entities, including DPH and the Department of Social Services, to report collected demographic data according to each major API group and make the data available to the public to the extent that disclosure did not violate confidentiality. AB 295 was vetoed by Governor Schwarzenegger who stated in his veto message that "existing law gives state agencies the flexibility to expand upon current demographic categories if necessary."

**f)** AB 814 (Floyd), Chapter 965, Statutes of 1989, requires state agencies, when collecting demographic data as to the ancestry or ethnic origin of Californians to separate collection categories for each major API group, including Chinese, Japanese, Filipino, Korean, Vietnamese, Asian Indian, Hawaiian, Guamanian, Samoan, Laotian, and Cambodian.

**REGISTERED SUPPORT / OPPOSITION**:

**Support**

Latino Coalition for a Healthy California (sponsor)
AARP
Access Reproductive Justice
Action Council of Monterey County
Altamed Health Services Corporation
APLA Health
Asian Health Services
Asian Pacific Partners for Empowerment, Advocacy and Leadership
Asian Resources, INC.
Asociacion De Migrantes Guatemaltecos
Buen Vecino
California Black Health Network
California Certified Organic Farmers (CCOF)
California Food and Farming Network
California Immigrant Policy Center
California Latinas for Reproductive Justice
California Life Sciences
California Pan - Ethnic Health Network
California State Council of Service Employees International Union (seiu California)
California WIC Association
Canal Alliance

Casa Del Diabetico Gualan
Center for Asian Americans in Action
Centro Binacional Para El Desarrollo Indígena Oaxaqueno
Ceres Community Project
Children Now
Community Clinic Association of Los Angeles County (CCALAC)
Community Health Councils
Courage California
CPCA Advocates, Subsidiary of The California Primary Care Association
Empowering Pacific Islander Communities (EPIC) Fiscally Sponsored by Community Partners
End the Epidemics: Californians Mobilizing to End HIV, Viral Hepatitis, STIs, and Overdose
Equality California
First 5 Monterey County
Gender Justice LA
Having Our Say Coalition
Healthy House Within a Match Coalition
Healthy Kids Happy Faces
Justice in Aging
Latino Coalition for A Healthy California
Maternal and Child Health Access
Mixteco/indígena Community Organizing Project (MICOP)
Nicos Chinese Health Coalition
Nourish California
Oasis Legal Services
ORALE: Organizing Rooted in Abolition, Liberation, and Empowerment
Pesticide Action Network
Pesticide Action Network North America
Public Health Advocates
Radio Bilingüe, INC.
Regional Asthma Management & Prevention
San Ysidro Health
Southeast Asia Resource Action Center
The Unity Council
UCLA Latino Policy and Politics Institute
Union De Guatemaltecos Emigrantes
Veggielution
Vision Y Compromiso (UNREG)
Western Center on Law & Poverty

**Opposition**

None on file.

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

Date of Hearing: June 11, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1042 (Roth) – As Amended May 16, 2024

**SENATE VOTE**: 35-2

**SUBJECT**: Health facilities and clinics: clinical placements: nursing.

**SUMMARY:** Requires health facilities and clinics to report data regarding the availability of clinical placements for nursing students to the Department of Health Care Access and Information (HCAI), and requires nursing schools to report data regarding their clinical placement needs to the Board of Registered Nursing (BRN). Requires HCAI to use both sources of data in a manner that allows for the information received by health facilities and clinics to be cross-referenced against the information received by the BRN. Requires health facilities and clinics to meet with nursing schools upon request to discuss clinical placement needs and to work in good faith to meet the demands of the school. Permits the BRN to assist in finding clinical placement slots to meet the needs of schools, and to prioritize requests for assistance from community colleges and California State University campuses when doing so. Specifically, **this bill**:

1) Requires health facilities and clinics, whether or not it currently offers prelicensure clinical placement slots, upon request by an approved nursing program, to meet with representatives of the school to discuss the clinical placement needs of the school. Requires the health facility or clinic and the school to work together in good faith to meet the demands of the school to educate and train nursing students.

2) Requires health facilities and clinics to prepare a report on clinical placements for nursing students. Requires the health facility or clinic to submit the report to HCAI on a form specified by HCAI, with updated reporting at times as HCAI requires, and requires this report to include all of the following information:

    a) Estimated number of days and shifts that will be made available within the subsequent calendar year for student use for each type of licensed bed or unit in the health facility or clinic, including days and shifts available in the following areas of study: geriatrics, medical-surgical, mental health/psychiatric nursing, obstetrics, and pediatrics;

    b) Number of days and shifts being utilized within the preceding calendar year for student use for each type of licensed bed or unit in the health facility or clinic, including days and shifts available in the areas of study listed in a) above; and,

    c) Name of academic institution with an approved school of nursing utilizing each type of licensed bed or unit reported in b) above;

3) Requires an approved school of nursing, by December 31 of each year, to report to the BRN the following information, and requires the BRN to submit the information it receives from the schools to HCAI:

a) The beginning and end dates of all academic terms within the subsequent calendar year for each clinical slot needed by a clinical group with content area and education level; and,

b) The number of clinical slots that the school has been unable to fill within the preceding calendar year.

4) Permits the BRN, upon request by an approved school of nursing and following the receipt of the information in 3) above, and utilizing data reported to HCAI pursuant to 2) above, to assist in finding clinical placement slots to meet the clinical placement needs of that school, by conferring with health facilities and clinics within the appropriate geographic region of each school in an attempt to match available clinical placement slots with needed slots and to encourage the creation of new clinical placement slots at additional clinical training sites to meet school demands.

5) Requires the BRN, if it attempts to meet clinical placement needs of an approved school of nursing, to prioritize requests for assistance from community colleges and California State University campuses.

6) Requires the BRN to report, through its Education/Licensing Committee, a summary of any assistance provided and the outcome of that assistance.

7) Prohibits any attempt by the BRN, a health facility, or a clinic to create or secure additional clinical placement slots from supplanting or disrupting the clinical placement of any nursing student for whom a clinical placement is already in progress or has already been scheduled.

8) Prohibits this bill from being construed to limit, prevent, or justify the approval or denial of new schools of nursing or the expansion of approved nursing programs.

9) Requires HCAI to post the reports received from health facilities and clinics, along with the information received from the BRN, on its website in a manner that allows for the information received by health facilities and clinics to be cross-referenced against the information received by the BRN.

10) Makes the implementation of this bill subject to an appropriation by the Legislature.

11) Makes legislative findings and declarations, including that collecting data on clinical placement needs of nursing programs and comparing the data with the availability of clinical placement slots at health facilities or clinics would provide the information necessary for the BRN to properly match scarce clinical placements with the nursing students who need them.

**EXISTING LAW**:

1) Licenses and regulates health care facilities, including general acute care hospitals, and licenses and regulates primary care clinics and specialty clinics, through the California Department of Public Health. [Health and Safety Code (HSC) §1200 et seq., §1250 et seq.]

2) Designates HCAI as the state agency designated to collect health facility data for use by all state agencies, including various financial data reports. Places numerous healthcare

workforce training and development programs under HCAI, including nursing education scholarships, and loan repayment programs for a variety of health care professionals. [HSC §128730, et seq., §127825 et seq.]

3) Requires HCAI to establish a health care workforce research and data center to serve as the central source of health care workforce and educational data in the state, and requires the research and data center to be responsible for the collection, analysis, and distribution of information on the educational and employment trends for health care occupations and distribution in the state. [HSC §128050]

4) Defines an approved school or an approved nursing program as one that has been approved by the BRN, gives courses of instruction approved by the BRN, covering not less than two academic years, is affiliated or conducted in connection with one or more hospitals and is an institution of higher education, as defined. [Business and Professions Code (BPC) §2786(a)]

5) Requires the BRN to determine, through regulations, the required subjects of instruction, which must be completed for licensure as a registered nurse (RN), and must include the minimum units of theory and clinical experience necessary to achieve essential clinical competency at the entry level of RNs. [BPC §2786(c)]

6) Requires the BRN's regulations to be designed to require all school to provide clinical instruction in all phases of the educational process, except as necessary to accommodate military experience. [BPC §2786(c)]

**FISCAL EFFECT**: According to the Senate Appropriations Committee, unknown one-time costs for HCAI, likely hundreds of thousands, for information technology contract services; and unknown ongoing costs, likely hundreds of thousands, for state administration related to implementing a new data collection and database program (Health Data and Planning Fund). Unknown costs to the BRN related to data collection and providing a summary report (Board of Registered Nursing Fund).

**COMMENTS**:

**1) PURPOSE OF THIS BILL**. According to the author, one major reason that we've been unable to grow capacity in our nursing programs is the challenge of locating and securing the clinical placement slots necessary to provide the clinical training required to obtain a nursing degree and a license. This was confirmed by the State Auditor in a 2020 audit report of the BRN, where the Auditor found that the BRN lacked critical information about the location and availability of clinical placement slots to make enrollment decisions. Thus, we need an inventory of clinical placement slots located in a wide range of healthcare settings if we are to provide the clinical training necessary to expand our nursing school capacity and produce more nurses in the state. The author states that by collecting data on nursing programs' clinical placement needs and collecting data from health facilities and clinics on their clinical placement slots, the BRN and HCAI would have the data necessary to better understand where clinical placement slots currently exist, and where they can potentially be created.

**2) BACKGROUND**.

**a) BRN and nursing education.** The BRN is responsible for the licensure and regulation of the practice of nursing in California through the administration of the Nursing Practice

Act, which contains the laws related to nursing education, licensure, practice, and discipline.

Currently, all schools that offer nursing education in California must be approved by the BRN. In addition to approving schools, the BRN determines the required curriculum to be included in a pre-licensure nursing education program. Existing law specifies the licensure requirements to obtain an RN license, in which an applicant is required to complete preliminary education and complete the courses of instruction in nursing education as approved by the BRN, among others. To graduate from a nursing program, students must complete units in both theoretical coursework and hands-on, clinical experience. California Code of Regulations title 16 §1426 specifies the requirements that a nursing program must comply with as part of the pre-licensure nursing education program. Those regulations specify that theory and clinical practice must be concurrent in the following nursing areas: geriatrics, medical-surgical, mental health/psychiatric nursing, obstetrics, and pediatrics. Instructional outcomes focus on delivering safe, therapeutic, effective, patient-centered care; practicing evidence-based practice; working as part of interdisciplinary teams; focusing on quality improvement; and using information technology. Instructional content includes, but is not limited to, the following: critical thinking, personal hygiene, patient protection and safety, pain management, human sexuality, client abuse, cultural diversity, nutrition (including therapeutic aspects), pharmacology, patient advocacy, legal, social and ethical aspects of nursing, and nursing leadership and management.

Nursing students are required to have a specified amount of clinical experience, which is the opportunity to apply theory to practice. BRN regulations also require that 75% of a nursing student's clinical hours be in a direct patient care model. Direct patient care means providing services to a live patient, which can include both in-person and telehealth. As a result, most clinical placements occur within a healthcare facility and require agreements between nursing programs and the health facility partners for placement of students.

**b) 2020 State Auditor Report on the BRN.** In addition to its other duties as the state agency that regulates the practice of RNs, the BRN oversees California's pre-licensure nursing programs (nursing programs), which prepare students to practice as entry-level RNs. The BRN's governing board (governing board) both approves new nursing programs in the State and makes decisions about the number of students that new and existing nursing programs are allowed to enroll (enrollment decisions). Two of the key factors that should influence BRN's enrollment decisions are the forecasted supply of nurses that the State will need to fulfill demand and the available number of clinical placement slots—placements at a health care facility, such as a hospital, that nursing programs must secure for students to gain required clinical experience. In this audit, it was found that the BRN has failed to gather and use sufficient data related to both of these factors to appropriately inform its enrollment decisions.

Specifically, the BRN's 2017 forecast of the State's future nursing workforce needs indicated that the statewide nursing supply would meet demand; however, it failed to identify the regional nursing shortages that California is currently experiencing and is expected to encounter in the years ahead. The audit notes that although the BRN's methodology for determining the State's overall nursing supply and demand was

reasonable, it did not measure regional variations that would have identified regional nursing shortages. Given the size and diversity of California, regional forecasts would provide critical information to inform enrollment decisions and other actions by BRN's governing board. The audit also found that the BRN's governing board lacks critical information about clinical placement slots when it considers enrollment decisions. When making these decisions, the governing board should consider the available number of clinical placement slots. If the governing board's enrollment decisions allow for more enrolled students than the number of clinical placements available in the region, nursing programs end up having to compete for clinical space for their students.

During the 2017–18 academic year, nursing programs reported that more than 2,300 students were affected by this clinical displacement—an insufficient supply of clinical placement slots. Nearly half of those programs reported that students from another program displaced their students, while many programs also reported losing clinical placements slots because facility staff workloads were too great to allow time for supervising nursing students.

**c) Nursing Programs in California.** As of the 2021-22 school year, there were 152 board approved nursing programs in California. Of those programs, 101 are public schools (community colleges and public universities) and 51 are private schools. Admission to a nursing program is competitive: in academic year 2021–22, the programs received more than 64,000 qualified applications, but only 16,612 new students were able to enroll. All nursing programs must offer at least the minimum curriculum required by regulation, including specific numbers of coursework units in select areas, such as the science of nursing, related natural sciences, and behavioral and social sciences. Nursing programs can meet these curriculum requirements by offering a variety of degree programs: Associate Degree of Nursing (ADN), Bachelor of Science in Nursing (BSN), and entry level master's (ELM) degrees in nursing. According to the BRN, community college nursing students make up about 30% of all nursing students in California, according to nursing enrollment numbers as reported on the October School Survey 2022:

**i)** Total ADN students: 10,994;

**ii)** Community Colleges ADN: 9,409 students (85.5%);

**iii)** Private colleges: 1,585 students (14.5%);

**iv)** Total BSN students: 18,798;

**v)** Public schools: 5,354 (28.5%);

**vi)** Private schools: 13,444 (71.5%);

**vii)** Total ELM students: 1,422;

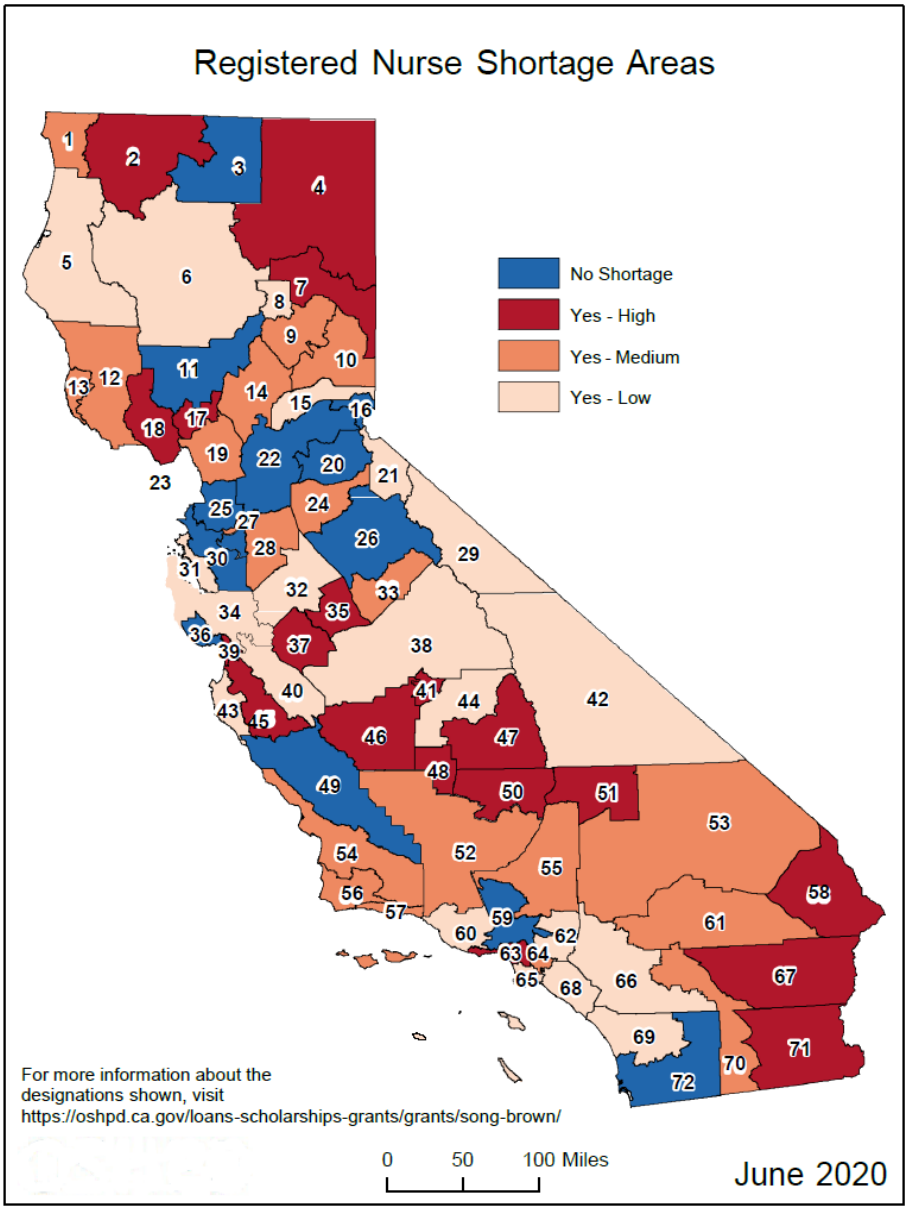
**viii)** Public schools: 313 students (28.5%); and,

**ix)** Private schools: 1,109 (78%).

**d) Budget funding for community colleges.** The state budget for 2023-24 includes $300 million to expand nursing programs at community colleges over a five-year period beginning January 1, 2024. This funding is intended to increase the capacity at the 77 community colleges with nursing schools in order to graduate thousands of additional nurses over the course of the next five years.

**e) Centralized Clinical Placement System and HCAI grant to expand the program.** The Foundation for California Community Colleges (FoundationCCC) launched the Centralized Clinical Placement System (CCPS) as a pilot program that began in the San Francisco Bay Area in 2005, intended to build on existing regional consortia to aggregate school and clinical provider information. The CCPS is an online tool that centralized communication to enable schools and clinical providers to rapidly match clinical placement needs to provider availability. Today, there are three regional consortia in California that are actively collaborating between clinical agencies and nursing schools: in the Bay Area, with 24 schools and 7 hospitals; in Fresno, with 31 schools and 15 hospitals; and in Los Angeles, with 69 schools and 30 hospitals. These consortia work together to coordinate the timing of clinical placement requests and assignments by clinical agencies, and also regularly convene to discuss nursing education and workforce development. HCAI is negotiating a contract with the FoundationCCC. According to FoundationCCC, the HCAI project focuses on three main areas: providing access to CCPS, engaging with existing consortia across California, and supporting regions without a consortium. For existing consortia, FoundationCCC's efforts will concentrate on implementing CCPS. FoundationCCC will also reach out to regions lacking a consortium to organize meetings between nursing schools and clinical agencies, aiming to establish new consortia statewide. The statewide implementation of the CCPS will achieve several goals: streamlining the request and assignment process for clinical placements, expanding the availability of clinical experiences, engaging with non-traditional clinical agencies (such as private clinics and Public Health Offices), and aggregating data to identify gaps in availability and inform policy decisions. Currently, 43 California Community Colleges, ten California State University campuses, and four University of California campuses already use CCPS for clinical placement.

**f) Nursing shortage.** In 2007, the California Healthcare Workforce Policy Commission (Commission) adopted formal criteria for establishing RN Shortage Areas (RNSA). During the June 2020 policy meeting, the Commission voted to revise the methodology using per-capita based calculations and a custom geographic unit of analysis. The Commission also voted to incorporate the degree of shortage into the RNSA designation, categorizing them as high, medium, or low severity areas. HCAI updated the RNSA designations with the new methodology and the most recently available data. This update designates 58 of 72 custom areas in California as RNSAs, of which the Commission considers 19 to be high-severity, 19 to be medium-severity, and 20 to be low-severity.




**3) SUPPORT**. The United Nurses Associations of California/Union of Health Care Professionals (UNAC/UHCP) is the sponsor of this bill and notes that there is a dire nursing shortage in California, and part of that shortage is due to the educational pipeline. UNAC/UHCP states that many approved schools of nursing cannot obtain the necessary clinical placement slots for their students at nearby health facilities. This delays completion of the program, and thereby delays the entry of qualified nurses into the workforce. This bill will begin to address that barrier. The sponsor states that this bill requires approved nursing programs to report to the BRN a variety of information regarding the clinical slots they need for each academic term, as well as the number they were unable to fill. It also requires health facilities to report to HCAI the number of days and shifts available for student use at the facility. The sponsor contends that this information addresses the finding of the State Auditor in 2020, which pointed out the BRN currently lacks sufficient data regarding the location and availability of clinical placement slots, which is critical in making enrollment decisions. The sponsor concludes that this bill also establishes a mechanism for approved nursing programs

to meet with health facilities and work in good faith to accommodate the clinical placement slots needed by the school.

4) **OPPOSE UNLESS AMENDED.** The Association of Independent California Colleges and Universities (AICCU), The Association of California Healthcare Districts (ACHD), and the California Children's Hospital Association (CCHA) are opposed to this bill unless it is amended. AICCU states that while it agrees that the collection of better data on clinical placement needs is foundational to crafting public policies that address nursing workforce issues, they are concerned that the current language functionally mandates the BRN to prioritize meeting the clinical placement needs of community colleges and California State Universities (CSUs). AICCU states that they do not support the notion that state policy should dictate winners and losers in the securing of clinical placements based on the segment of higher education they are in. ACHD states that they are also concerned with the prioritization language centered around community colleges and CSUs, which may have unintended consequences for districts that partner with other types of educational institutions. CCHA has similar concerns, and states that some of the provisions of this bill go beyond the problem identified by the State Auditor, and would inappropriately urge the BRN to interfere with decisions by health facilities about how many clinical placement slots they can accommodate and when, as well as what degree-category of nursing students they should prioritize for those placements.

5) **RELATED LEGISLATION**.

   **a)** SB 895 (Roth) requires the Chancellor of the California Community Colleges to develop a Baccalaureate Degree in Nursing Pilot Program that authorizes up to 15 community college districts to offer a BSN. SB 895 is pending a hearing in the Assembly Higher Education Committee.

   **b)** SB 1015 (Cortese) requires the BRN's Nursing Education and Workforce Advisory Committee to study and recommend standards about how approved nursing programs manage and coordinate clinical placements and requires the BRN to annually collect, analyze, and report information related to a program's management of clinical placements and publish the report annually on the BRN's website. SB 1015 pending a hearing in the Assembly Business and Professions Committee.

   **c)** AB 1577 (Low) requires hospitals to report clinical placement data for nursing students, and requires community college nursing programs to report clinical placement needs. Requires hospitals that offer pre-licensure clinical training slots to work in good faith with community college nursing programs to meet their clinical training needs. Requires a hospital, if it cannot provide additional slots to meet the needs of community college nursing programs, to provide HCAI with a written justification of its lack of capability or capacity within 30 days, requires HCAI to accept or reject the justification, and subjects a hospital to fines if its justification is rejected and the hospital does not take corrective action. AB 1577 is pending in the Senate Health Committee.

6) **PREVIOUS LEGISLATION**.

   **a)** AB 2684 (Berman), Chapter 413, Statutes of 2022 requires the BRN to establish a Nursing Education and Workforce Advisory Committee, requires the BRN's executive

officer to establish a uniform method to evaluate, request, and grant approvals for schools of nursing, prohibits payments for clinical placement, and extends the operations of the BRN by four years, until January 1, 2027. Additionally, AB 2684 extended the provisions of AB 2288 (Low), described below, until the end of the 2023-2024 academic year.

**b)** AB 1015 (Blanca Rubio), Chapter 591, Statutes of 2021 requires the BRN to incorporate regional forecasts into its biennial analyses of the nursing workforce, develop a plan to address regional areas of shortage identified by its nursing workforce forecast, as specified, and annually collect, analyze, and report information related to the number of clinical placement slots that are available and the location of those clinical placement slots within the state.

**c)** AB 2288 (Low), Chapter 282, Statutes of 2020 authorized the director of an approved nursing program to obtain approval from the BRN to utilize substitutions in order to meet requirements for students to earn direct patient care clinical experience and authorizes the use of preceptorships without having to maintain specified written policies during a declared state of emergency, if the approved nursing program meets specified requirements until the end of the declared emergency or the end of the 2020-2021 academic year, whichever occurred sooner.

**d)** SB 1348 (Pan), Chapter 901, Statutes of 2018 requires the California Community College Chancellor's Office to report to the Legislature in an existing annual report, and a private postsecondary institution to report in its annual compliance report, specified information related to programs that offer certificates or degrees relating to allied health professionals that require clinical training.

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

**REGISTERED SUPPORT / OPPOSITION**:

**Support**

United Nurses Associations of California/Union of Health Care Professionals (sponsor)
Board of Registered Nursing
California State Council of Service Employees International Union (SEIU California)
California Teachers Association
Disability Rights California
Faculty Association of California Community Colleges
Public Health Advocates
Rancho Santiago Community College District
Rural County Representatives of California (RCRC)

**Opposition**

None on file.

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

Date of Hearing: June 11, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1078 (Min) – As Amended May 20, 2024

**SENATE VOTE**: 36-0

**SUBJECT**: Language access.

**SUMMARY:** Establishes the Office of Language Access (OLA) within the California Health and Human Services Agency (CalHHS) to lead the development, monitoring, and updating of department Language Access Plans (LAPs), maintain a website with language access information and resources, and submit a report to the Legislature on language access issues within CalHHS departments. Requires CalHHS to develop a LAP Guidance for its departments, review each department's LAP, issue corrective action plans for departments that fail to achieve the goals in their LAP, and establish a Language Access Advisory Workgroup. Specifically, **this bill**:

1) Requires the OLA to do all of the following:
   a) Provide critical oversight, accountability, and coordination across various state departments and agencies to ensure individuals with limited English proficiency (LEP) have meaningful access to government programs and services;
   b) Lead the development, monitoring, and periodic updating of LAP within the CalHHS, which must include:
      i) A LAP for each department and office within CalHHS; and,
      ii) CalHHS' LAP Guidance Document.
   c) Coordinate with the language access coordinators from the various CalHHS departments to implement each department's LAP.
   d) Increase the provision of language assistance services, including translation and interpreter services, through various options, which may include hiring bilingual staff and contracting with community-based organizations and third-party vendors;
   e) Collect data from the various departments and offices within CalHHS to create the report required in i) below;
   f) Ensure a document is translated if an individual with LEP submits a written request to CalHHS, or any of its departments, that a document be translated into the individual's preferred language;
   g) Investigate the number of language access complaints received by each CalHHS department, as well as by other relevant agencies that may receive a language access complaint regarding CalHHS or any of its departments;
   h) Maintain a language access website that contains all of the following:
      i) A publicly available list of translated CalHHS materials and forms;
      ii) A directory of qualified interpreters, translators, and other similar resources within CalHHS;
      iii) Every current CalHHS LAP, every update to those plans, and all corrective action plans; and,
      iv) Notices, instructions, and information for the public regarding an individual's language access rights and how to submit a complaint if a CalHHS department has failed to provide language services.

i) Submit a report for the prior fiscal year to the Legislature containing all of the following, on or before November 1, 2026 and every other year thereafter:
   i) Challenges encountered while implementing the various LAPs;
   ii) The OLA's efforts to address the problems it encountered, if any;
   iii) Lessons learned and best practices;
   iv) The number and percentage of individuals with LEP who use each service, listed by language, in comparison to the estimated population with LEP who are eligible for the department's services, including a description of the methodology or data collection system used to make this determination;
   v) The number of multilingual employees in public contact positions that includes job title, qualifications for bilingual or multilingual capacity, office location, languages spoken in addition to English;
   vi) The name and contact information for each language access coordinator;
   vii) A list of ongoing employee development and training strategies to maintain well-trained multilingual employees and general staff, including quality control protocols for multilingual employees and language service protocols for individuals with LEP who are in crisis situations;
   viii) A list of goals for the upcoming year and an assessment of each department's success at meeting the prior year's goals;
   ix) The number of translation requests received and provided, the languages used to translate materials, and which materials were translated and completed during the prior fiscal year;
   x) The number of interpretation requests received and the number of interpretation services provided, by language, for services provided by department staff, as well as by contracted vendors;
   xi) The number of language access complaints received, investigated, and resolved by each department within CalHHS, or other relevant agency that may receive a language access complaint, including, but not limited to, the Civil Rights Department, and the U.S. Department of Health and Human Services' Office for Civil Rights. Summaries of the investigation results and resolution agreements are also required; and, the number of staff, total dollar amount, and breakdown of annual expenditures, including services provided by vendors, that each department spent on language access services.
j) Develop a LAP containing the following:
   i) Methods to identify individuals with LEP who require language assistance, including a demographic assessment of the department's service population and an effective system of recording and utilizing spoken, sign, or written language preferences;
   ii) Language assistance measures and information about the ways that language assistance will be provided, including all of the following:
      (1) The types of services available, including how a department will provide free sign language interpretation and oral interpretation services in a language, upon request, for all public contacts, including sign language translation of vital documents pursuant to the CalHHS's LAP Guidance 2) below, and how the department will use the federal Department of Justice's safe harbor provisions to determine the languages that a vital document shall be translated into;
      (2) How staff can obtain those services;
      (3) How to respond to an individual with LEP, including via telephone, written communications, and in person contact; and,
      (4) Ensuring the competency of interpreters and translation services.

iii) Training for staff on LEP policies and procedures, including how to work effectively with in person, video, and telephone interpreters;
iv) Notice for individuals with LEP containing the services that are available for an individual with LEP and who is eligible for services; Requires LAPs to contain a mechanism to monitor the implementation of the plan and to be updated every two years, taking into consideration whether new documents, programs, services, and activities shall be made accessible for individuals with LEP; and,
v) Authorizes OLA, when reviewing an LAP for updates, to consider changed demographics, an analysis of internal and external data, and responses to new and unexpected language needs, complaints received and how they were resolved, assessments and measures of client satisfaction, and capacity building efforts regarding funding, staffing and training.

2) Requires CalHHS to:
   a) Delegate a coordinator to work with the OLA.
   b) Develop a LAP Guidance, under the leadership of OLA to support its various departments in their development of a LAP.
   c) Develop a corrective action plan for a department that fails to implement and achieve the goals set forth in its LAP. Requires a corrective action plan to include a plan to address any deficiencies and resolutions to improve language access and to be available on its website.
   d) Submit annual compliance reports to the OLA regarding the progress its departments have made with their LAPs and any corrective action plans.
   e) Convene a Language Access Advisory Workgroup consisting of five to ten individuals with LEP or who have direct experience working with individuals with LEP, commencing January 1, 2025, that meets at least quarterly until January 1, 2028, annually until January 1, 2035, and as needed thereafter, to share the progress of the various LAPs, address relevant issues, and obtain community input.

**EXISTING LAW**:

1) Establishes CalHHS, which consists of the following departments and offices (hereinafter "departments"): Aging, Child Support Services, Community Services and Development, Developmental Services, Health Care Access and Information, Health Care Services, Managed Health Care (DMHC), Public Health (DPH), Rehabilitation, Social Services (DSS), State Hospitals, the Center for Data Insights and Innovation, the Emergency Medical Services Authority, the Office of Technology and Solutions Integration, the Office of Law Enforcement Support, the Office of the Surgeon General, the Office of Youth and Community Restoration, and the State Council on Developmental Disabilities. [Government Code (GOV) §12803, §12806]

2) Requires, under the Dymally-Alatorre Bilingual Services Act, that each state agency, defined as every state office, department, division, bureau, board, or commission directly involved in the furnishing of information or the rendering of services to the public that includes a substantial number of people with LEP, to employ a sufficient number of qualified bilingual persons in public contact positions. Defines "public contact position" as a position determined by the agency to be one, which emphasizes the ability to meet, contact, and deal with the public in the performance of the agency's functions. Allows state agencies to contract for telephone-based interpretation services in addition to employing qualified

bilingual persons in public contact positions. [GOV §7292, §7297, §7299.1]

3) Requires any materials explaining services available to the public to be translated into any non-English language spoken by a substantial number of people with LEP served by the agency. Defines substantial number people with LEP as members of a group who compromise 5% or more of the people served by the statewide or any local office or facility of a state agency. [GOV §7295, §7295.2]

4) Requires state agencies to translate or furnish translation assistance for written materials whenever the following factors are met:
   a) The written materials require the furnishing of information from an individual or provide that individual with information;
   b) The information required or furnished affects or may affect the individual's rights, duties, or privileges with regard to that agency's services or benefits; and,
   c) The statewide or local office or facility or the agency with which the individual is dealing serves a substantial number of persons with LEP. [GOV §7295.4]

5) Requires state agencies to conduct a language survey and develop an implementation plan every other year that includes, among other things: the number of public contact positions and qualified bilingual employees in these positions; the number and percentage of people with LEP served by each statewide and local office; a list of all written materials required to be translated, a list of the materials that have been translated, what languages they are translated into, and procedures for identifying which materials should be translated; a description of how the agency recruits and trains bilingual staff; and, a description of agency complaints regarding language access and procedures for accepting and resolving complaints. [GOV §7299.4]

6) Requires the Department of Human Resources to review state agency surveys and implementations plans, order agencies to supplement or make changes to plans that are deficient, compile data, and provide a report to the Legislature every two years. [GOV §7299.4, §7299.6]

7) Requires state agencies to translate and make accessible on its website forms and processes for submitting complaints of alleged violations of 2) through 5) above. Requires the forms and processes to be translated into all languages spoken by a substantial number of LEP people served by the state agency. Requires translated copies of the forms to be printed and made available in the agency's statewide office and any of its local offices or facilities. [GOV §7299.3]

8) Establishes DMHC to regulate health plans under the Knox-Keene Health Care Service Plan Act. Authorizes the DMHC Director, after appropriate notice and opportunity for a hearing, to suspend or revoke any health plan license or to assess administrative penalties if the director determines that the licensee has committed any of the acts or omissions constituting grounds for disciplinary action. [Health and Safety Code (HSC) §1340, §1386]

9) Requires fines and administrative penalties to be deposited into the Managed Care Administrative Fines and Penalties Fund and to be transferred by DMHC annually, as follows:

a) One million dollars to the Medically Underserved Account for Physicians within the Health Professions Education Fund and, upon appropriation by the Legislature, to be used for the purposes of the Steven M. Thompson Physician Corps Loan Repayment Program, as specified; and,
b) Any amount over the $1,000,000, including accrued interest, in the fund to be transferred to the Health Care Services Plan Fines and Penalties Fund created to be continuously appropriated for the Major Risk Medical Insurance Program and health care services for people eligible for the Medi-Cal program. [HSC §1341.45]

**FISCAL EFFECT**: According to the Senate Appropriations Committee, CalHHS estimates ongoing General Fund costs, likely low millions, for administration. This includes costs for staffing resources and vendor contracts. The Civil Rights Department (CRD) indicates unknown potential costs, likely hundreds of thousands, to investigate, mediate, and prosecute additional complaints related to language access, as well as for state administration to provide data on language access complaints to CalHHS.

**COMMENTS**:

1) **PURPOSE OF THIS BILL**. According to the author, California is home to the one the most diverse populations in the country with residents who speak over 200 languages, variants, and dialects, and the largest LEP population in the United States. The author states that for the nearly 6.4 million Californians with LEP, language barriers pose a significant challenge to their ability to have meaningful access to quality health care coverage and services. Inadequate language services have resulted in longer hospital stays and higher likelihood of hospital readmissions for patients with LEP, and difficulties understanding instructions for post-discharge care, medication and follow-up. The author contends that these avoidable clinical costs can be significantly reduced with improved interpreting and translation services. The author states the OLA would serve as a central hub for building multilingual capacity within the state's healthcare delivery system and ensure LEP individuals have access to government services. The author concludes that this bill will not only close an important gap for those seeking a broad spectrum of health services, but also bolster California's ability to meet statutory language requirements that apply to Medi-Cal health plans.

2) **BACKGROUND**.

   a) **LEP in California.** According to the U.S. Census Bureau, of people older than five years old living in California from 2018 to 2022, 43.9% spoke a language other than English at home, and 17.1% reported they did not speak English "very well". Despite anti-discrimination and language access requirements in federal and state law, not all requirements have been implemented, monitored, or enforced. For example, according to an administrative complaint filed with the U.S. Department of Health and Human Services Office for Civil Rights, local agencies in the counties of Alameda, Los Angeles, Orange, Riverside, and San Bernardino failed to provide individuals with LEP meaningful access to COVID services during the pandemic. This complaint cited poor translations through Google Translate and dependence on volunteer interpreters rather than hiring qualified interpretation staff.

**b) Association between LEP and Health Care Access**. A 2022 study published in the *Journal of Immigrant and Minority Health* investigates healthcare access and utilization among patients with LEP. The researchers analyzed aggregated data from the 2018 California Health Interview Survey, a large population-based survey. A total of 21,177 participants were included with 8.2% having LEP. Compared to participants with proficient English, LEP participants were less likely to have a usual place to go to when sick other than the emergency room or have a preventive care visit in the past year after adjusting for sociodemographic characteristics. However, LEP participants were also less likely to need to see a medical specialist and less likely to delay necessary medical care compared to English proficient participants. While patients with LEP were less likely to have access to preventative care, they were also less likely to delay necessary care.

Another 2020 study published in the *Oman Medical Journal* found that language barriers are a key cause of miscommunication between medical providers and patients, and negatively affect the quality of healthcare services and patient satisfaction. Hospital medical professionals perceive language barriers to be a source of workplace stress and an impediment to the delivery of high-quality healthcare. Much evidence shows a significant association between workplace stress and lower satisfaction among medical providers. In addition, studies indicate that language barriers contribute to medical professionals' incomplete understanding of patients' situations, delayed treatment or misdiagnoses, poor patient assessment and incomplete prescribed treatment.

**c) Federal and State Anti-Discrimination Law.** In federal law, Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, or national origin in any program or activity that receives federal financial assistance. A U.S. Supreme Court case, Lau v. Nichols (1974) later specified that national origin discrimination includes discrimination based on a person's inability to speak, read, write, or understand English. Executive Order 13166, issued by President Clinton in 2000, expanded upon these protections by requiring any organization that receives federal financial assistance to provide meaningful access to programs and activities for persons who are LEP.

In state law, the Dymally-Alatorre Bilingual Services Act requires all state departments involved in providing information or services to the public, when 5% of contact with the public is made with non- or limited-English speaking people, to employ a sufficient number of qualified bilingual staff in public contact positions to ensure information and services are provided in the language of the non- or limited-English speaking person.

**d) Language Access Policy in California.** In 2021, Governor Newsom proposed a new Equity-Centered Programs initiative, which was included in the 2021–22 budget. The initiative included a Language Access Policy Framework with an accompanying request of budget resources to support two limited-term positions to develop and implement an agency-wide language access policy and a protocol framework that considers legal compliance, operational aspects of translation and interpretation; bilingual staff testing, classification, and related human resources requirements; and engagement with community stakeholders and partners. The agency-wide policy framework was intended to ensure consistent language access standards across all programs and services and build off an internal Language Access Work Group that had been convened in 2020 to develop a language access policy and operations framework to improve language assistance services by CalHHS departments. The Governor also issued Executive Order No. N-16-

22 in September 2022, citing the state's investment to improve language access across health and human services programs and ordering CalHHS to develop recommendations to improve language and communications access to state government services and programs.

In May 2023, CalHHS released a memo to department directors outlining a policy based on the work of the initiative and the work group. The policy outlines department-level language assistance plans with the following requirements, regardless of the funding source of the department:

**i)** Be consistent with the U.S. Department of Justice's 2002 guidance to agencies receiving federal financial assistance regarding Title VI's prohibition against national origin discrimination affecting limited English proficient persons and any applicable federal funding agency;

**ii)** Address Title VI's analysis for determining reasonable steps to ensure meaningful access for persons with LEP. The analysis includes a weighing of the number of people with limited English eligible to be served by the program and the frequency of contact they would have with the program, the nature and importance of the program or service, and the resources available to the program and the costs of translation services;

**iii)** Identify and address language access legal requirements specific to that department and its programs and analyze whether the Title VI analysis requires additional language assistance beyond what is otherwise required by state law or the department's programs; and,

**iv)** The departments were required to submit plans to CalHHS by December 1, 2023, and review and update the plans as necessary every two years.

CalHHS also issued minimum language access standards and required each department's LAP to address how it would meet or exceed the standards:

**i)** Provide free sign language interpretation and oral interpretation in any spoken language, upon request for all public contact, including sight translation of vital documents by January 29, 2024;
**ii)** Translate all vital documents intended for use statewide, including essential public website content, into at least the top five threshold languages spoken by persons with LEP in California, per the most recent available Census data (currently Spanish, Chinese, Tagalog, Vietnamese, and Korean). Vital documents and essential public website content are to be identified by each department within its Language Assistance Plan. Essential public website content includes one or more introductory web pages with basic information about the department and its programs and non-English taglines advising of the availability of free oral interpretation services and written translations. Essential public website content is also to be provided in American Sign Language video clips;
**iii)** Identification and translation of vital documents into the top five languages is to be completed by June 1, 2024; and,

**iv)** CalHHS and the Language Access Work Group are to reevaluate the list of statewide threshold languages and the feasibility of adding more than five within one year and then every two years thereafter.

The policy memo additionally stated that CalHHS Language Access Work Group would issue guidance to CalHHS departments to support the development of their Language Assistance Plans and that DSS would administer additional funds for interpretation and translation activities to supplement CalHHS departments' existing language services capacity.

According to a CalHHS policy memo to department directors, departments and offices are required to post their final, public-facing LAPs to their websites by June 1, 2024. Departments under CalHHS have posted LAPs to their websites.

This bill is intended to add accountability and oversight of the state's language access work by establishing an advisory workgroup including members of the public, and requiring the Office of Language Access to submit regular reports to the Legislature.

**3) SUPPORT**. According to Asian Health Services, Asian Resources, Inc., Center for Asian Americans in Action, Orange County Asian and Pacific Islander Community Alliance, and Regional Pacific Islander Taskforce, the cosponsors of this bill, although California has enacted numerous laws and policies recognizing the importance of providing culturally and linguistically competent resources and services for individuals with LEP, there remains a need to improve language access in many state agencies. Most recently, in recognition of this need, the Governor's Executive Order No. N-16-22 directed CalHHS to develop recommendations to improve language and communications access to state government services and programs. Since then, CalHHS has created a Language Access Policy and LAP Guidance and designated Language Access Coordinators to assist all of CalHHS' 12 departments and five offices to develop their own LAPs. The cosponsors contend that there is no mechanism for requiring or monitoring the implementation of the LAPs, coordinating language services across the agency, or enforcing the provisions of the LAPs. This bill would codify CalHHS' current Language Access Policy and LAP Guidance, including its efforts to create LAPs within each department and office. The cosponsors conclude that this bill will help address the systemic language barriers faced by our communities and improve language access to enhance health outcomes, reduce health care disparities, and promote the health and well-being of AANHPI and other marginalized communities across California.

**4) RELATED LEGISLATION**.

**a)** SB 1016 (Gonzalez) requires DPH and DSS, whenever collecting demographic data as to the ancestry or ethnic origin of California residents for specified reports, to use separate collection and tabulation categories for each major Latino group, Mesoamerican Indigenous nation, and Mesoamerican Indigenous language group, as specified. SB 1016 is pending in Assembly Health Committee.

**b)** AB 2155 (Ting) would have required DSS to establish and administer a Bilingual-Oriented Social Equity Services Grant Program to distribute funding to community-based organizations that provide social services to pay a differential to services professionals

who can communicate in a language other than English as part of their job duties. AB 2155 was held on the Assembly Appropriations suspense file.

**5) PREVIOUS LEGISLATION**.

**a)** AB 1084 (Nguyen) of 2023 was substantially similar to AB 2155. AB 1084 was held on the Assembly Appropriations Committee suspense file.

**b)** AB 135 (Committee on Budget), Chapter 85, Statutes of 2021. Requires, among other things, that DSS administer an enhanced language access and cultural competency initiative for individuals with developmental disabilities and their caregivers that includes identification of vital documents and internet content for translation, regular and periodic language needs assessments to determine threshold languages for translation, and coordinating and streamlining of interpretation and translation services.

**c)** AB 1531 (Salas) of 2019 would have lowered the calculation, from 5% to 3%, for determining the threshold languages for a state agency. AB 1531 died on the Assembly Appropriations Committee suspense file.

**d)** AB 2253 (Ting), Chapter 469, Statutes of 2014, requires the Department of Human Resources to issue orders to compel and agency to comply with the Dymally-Alatorre Bilingual Services Act, requires agencies to translate and make accessible information about submitting language access complaints on their websites and as available forms in offices, requires each agency to conduct a bilingual services survey, and revises how threshold languages are determined by state agencies.

**6) DOUBLE REFERRAL.** This bill is double-referred, upon passage of this committee, it will be referred to the Assembly Committee on Human Services.

**7) POLICY COMMENTS.** According to the Senate Appropriations analysis, while the CalHHS received a one-time $20 million investment for related purposes, the CalHHS indicates the funds are supporting the current development and implementation of a CalHHS Language Access Policy and therefore the funds are not available to support the implementation of this bill. Additionally, some of the activities in this bill duplicate the activities of the Dymally-Alatorre Bilingual Services Act. The author may wish to consider working with CalHHS and the Department of Human Resources to prevent duplication of existing efforts and streamline efforts to promote language access in line with the goals of this bill.

**REGISTERED SUPPORT / OPPOSITION**:

**Support**

Asian Health Services (cosponsor)
Asian Resources, Inc. (cosponsor)
Center for Asian Americans in Action (cosponsor)
Orange County Asian and Pacific Islander Community Alliance (OCAPICA) (cosponsor)
Regional Pacific Islander Taskforce (cosponsor)

Access Reproductive Justice
All of Us or None Bakersfield
API Forward Movement
Artogether
Asian American Drug Abuse Program, INC.
Asian Americans Advancing Justice - Asian Law Caucus
Asian Americans Advancing Justice-Southern California
Asian Law Alliance
Asian Pacific Islander American Public Affairs Association (APAPA)
Asian Pacific Islander Forward Movement
Asian Prisoner Support Committee
Association of Asian Pacific Community Health Organizations (AAPCHO)
Buen Vecino
Burma Refugee Families and Newcomers
California Association for Bilingual Education (CABE)
California Pan - Ethnic Health Network
Children Now
Chinese American Citizens Alliance, Oakland Lodge
Chinese for Affirmative Action/aacre
Cleanearth4kids.org
Coalition for Humane Immigrant Rights (CHIRLA)
Community Clinic Association of Los Angeles County (CCALAC)
Council on American-Islamic Relations, California
Courage California
CPCA Advocates, Subsidiary of The California Primary Care Association
East Bay Asian Local Development Corporation
Empowering Pacific Islander Communities (EPIC) Fiscally Sponsored by Community Partners
Families in Good Health
Health Access California
Hmong Innovating Politics
Justice in Aging
Korean American Coalition - Los Angeles
Korean Community Center of The East Bay
Korean Community Services
Latino Coalition for A Healthy California
Little Tokyo Service Center
Marshallese Youth of Orange County Myoc
Merced Lao Family Community INC.
Mixteco/Indígena Community Organizing Project (MICOP)
National Health Law Program
Nicos Chinese Health Coalition
North East Medical Services
Oakland Vietnamese Chamber of Commerce
Pacific Asian Counseling Services
Pacific Islander Health Partnership
Racial and Ethnic Mental Health Disparities Coalition
Richmond Area Multi-services, INC.
San Francisco Community Health Center
South Asian Network

The Black Alliance for Just Immigration
The Fresno Center
The Fund for Santa Barbara
Western Center on Law & Poverty, INC.
Young Invincibles

**Opposition**

None on file.

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

Date of Hearing: June 11, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1112 (Menjivar) – As Amended May 16, 2024

**SENATE VOTE**: 38-0

**SUBJECT**: Medi-Cal: families with subsidized childcare.

**SUMMARY:** Requires the Department of Health Care Services (DHCS) to authorize Medi-Cal managed care plans to enter into a memorandum of understanding (MOU) with an alternative payment agency (Alternative Payment Program or APP agency) to facilitate enrollment of children in Medi-Cal and referral of children to developmental screenings administered by Medi-Cal managed care plans. Requires DHCS to develop a model template for this purpose. Specifically, **this bill**:

1) Requires DHCS to authorize Medi-Cal managed care plans to enter into a MOU with APP agencies.

2) In accordance with the MOU, requires the Medi-Cal managed care plan and APP agency to collaborate on both of the following, upon the consent of the corresponding parent or guardian:
   a) If the child is eligible for coverage under Medi-Cal but is not a Medi-Cal beneficiary, informing and directing the family on how to enroll the child into the Medi-Cal program; and,
   b) If the child is already a Medi-Cal beneficiary, or is newly enrolled in Medi-Cal through the assistance described in a) above, referring the child to developmental screenings available under Medi-Cal and that are administered through the Medi-Cal managed care plan.

3) In accordance with the MOU, authorizes an APP agency to address care coordination and provide expanded navigation and training functions, for the purpose of implementing 2) above.

4) Requires DHCS, in consultation with California Department of Social Services (DSS), to develop a model template MOU to be used by Medi-Cal managed care plans and APP agencies. Requires MOUs to include information in the model developed by DHCS.

5) Defines “alternative payment agency” as an agency that operates alternative payment programs under the Child Care and Development Services Act.

6) Defines “Medi-Cal managed care plan” as an individual, organization, or entity that enters into a contract with the department to provide services to enrolled Medi-Cal beneficiaries, as specified.

7) Authorizes DHCS to seek any necessary federal approvals to implement this bill. Specifies this bill will only be implemented to the extent that any necessary federal approvals have been obtained and federal financial participation is available.

**EXISTING FEDERAL LAW**: Requires state Medicaid programs to cover, for individuals under the age of 21, all necessary health care, diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the Medicaid State Plan, known as the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit. [42 United States Code §1396d]

**EXISTING STATE 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 a schedule of benefits under the Medi-Cal program, which includes benefits required under federal law and benefits provided at state option but for which federal financial participation through Medicaid is available. The schedule of benefits includes EPSDT for individuals under 21 years of age. [WIC §14132]

3) Requires Medi-Cal managed care plans to include developmental screening services for individuals zero to three years of age that comply with the periodicity schedule and standardized and validated developmental screening tools established by the American Academy of Pediatrics (AAP) Bright Future® Guidelines and Recommendations for Preventive Pediatric Care. [WIC §14132.195]

4) Defines APP as a local government agency or nonprofit organization that has contracted with DSS, as specified, to provide payments and to provide support services to parents and providers. [WIC §10213.5]

5) Authorizes the use of child care and development funds for alternative payment programs in order to maximize parental choice in selecting an appropriate child care setting, and establishes requirements regarding alternative payment programs, as specified. [WIC § 10225]

**FISCAL EFFECT**: According to the Senate Committee on Appropriations:

1) Unknown costs to DHCS for state administration (General Fund and federal funds).

2) Unknown General Fund costs to DSS for state administration.

**COMMENTS**:

**1) PURPOSE OF THIS BILL**. According to the author, the early years of a child's life are pivotal points for future success. Developmental screening and early intervention programs offered during these early stages promote the growth and prosperity of youth, families, and communities. The author notes it is estimated that one in six children in the United States has a developmental disability, but that only 3% of infants and toddlers receive early intervention services. Research shows that low-income families and communities of color face additional difficulties in accessing screening, leading to delayed diagnosis and support.

The author laments that while California has made historic investments to expand our health, mental health, and developmental services, data show that California lags in providing these screenings. The author indicates that with this bill, we can leverage a clear pathway for eligible families to access these screenings and services through existing programs and relationships formed at the local level. The author concludes that the state cannot continue to lag behind, letting youth fall between the cracks of receiving timely support and intervention.

**2) BACKGROUND**.

**a) Medi-Cal Managed Care**. The expansion of Medi-Cal managed care was authorized beginning in the mid-1990s. Based on recent changes that transitioned additional populations from Medi-Cal fee-for-service to managed care, managed care plans now provide care to the vast majority of Medi-Cal beneficiaries, although most children were enrolled in managed care plans even prior to the recent transitions. DHCS contracts with both private and public, locally governed managed care plans to deliver Medi-Cal services. The model of managed care varies by county, with one to four plans delivering care in each county.

**b) APP Agencies**. DSS contracts with APP agencies to administer child care subsidy payments for families in all 58 counties. Under federal and state law, families are income eligible for subsidized child care if their household income is below 85% of the State Median Income, depending on family size, pursuant to a priority system. Of the 73 APP agencies, 49 are nonprofit community-based organizations, 13 are county offices of education, nine are county welfare departments, one is a school district, and one is a city government. These programs receive state and federal funds to provide a variety of supports and payment services that enable eligible low-income families to access subsidized child care.

**c) EPSDT and Developmental Screening.** Federal law establishes an entitlement to the EPSDT benefit, forming the foundation for children's coverage under Medicaid. The EPSDT benefit provides a comprehensive array of prevention, diagnostic, and treatment services for individuals under the age of 21 who are enrolled in Medi-Cal. Under EPSDT, Medi-Cal covers periodic screening assessments for infants, children, and adolescents under 21 years of age, as specified in the AAP Bright Futures® preventive healthcare periodicity schedule. The AAP Bright Futures® periodicity schedule provides clear, comprehensive guidance on recommended services at each well-child visit, corresponding to each age milestone up to age 21.

Developmental screening uses a standardized screening tool to identify risk of developmental, behavioral, and social delays. The periodicity schedule referenced above recommends developmental screening at well-child visits occurring at nine months, 18 months, and 24 or 30 months of age. Therefore, according to the schedule, infants and toddlers should be screened in the first, second, and third year of their lives.

DHCS measures how many children enrolled in managed care plans receive recommended developmental screening, using a metric called "Developmental Screening in the First Three Years of Life." DHCS has set a 2025 goal of 35% for this metric, which equals the 2022 national median percentage. According to recent data, California is beating this goal with a statewide average of 42%, with regional averages ranging from 37% to 46%.

The sponsor and supporters of this bill point to the low rates of developmental screening as an impetus for this bill. According to the Centers for Disease Control, in the United States, about one in six children aged three to 17 have one or more developmental or behavioral disabilities, such as autism, a learning disorder, or attention-deficit/hyperactivity disorder. However, many children with developmental disabilities are not identified until they are in school, by which time significant delays might have occurred, and opportunities for treatment may have been missed. The sponsor and supporters of this bill indicate APP agencies have established relationships with the children and families they serve and are well-positioned to support early identification and intervention. The author points out developmental screening and referral to appropriate services and supports is also recommended to promote success in a childcare setting, reducing behavior problems and related expulsions from childcare programs.

**d) Other Required Medi-Cal Managed Care Plan MOUs**. The current Medi-Cal managed care plan contract with DHCS requires plans to build partnerships with a large number of third-party entities to ensure member care is coordinated and members have access to community-based resources in order to support whole-person care:

- **i)** Local health departments;
- **ii)** Local educational and governmental agencies, such as county behavioral health departments for Specialty Mental Health Care and Substance Use Disorder Treatment Services;
- **iii)** Social services;
- **iv)** Child Welfare Departments;
- **v)** Continuums of Care programs;
- **vi)** First 5 programs and providers;
- **vii)** Regional Centers;
- **viii)** Area Agencies on Aging;
- **ix)** Caregiver Resource Centers;
- **x)** Women, Infants, and Children Supplemental Nutrition Programs;
- **xi)** Home and Community-Based Services waiver agencies and providers; and,
- **xii)** Justice departments.

The MOUs are intended to clarify roles and responsibilities between plans and third parties, support local engagement, and facilitate care coordination and the exchange of information necessary to enable care coordination and improve the referral processes between plans and third-party entities. The MOUs are also intended to improve transparency and accountability by setting forth certain existing requirements for each party as they relate to service or care delivery and coordination so that the parties to the MOU are aware of each other's obligations.

DHCS has developed MOU templates for plans and third-party entities to use in this process, to ensure that all plan contract provisions for MOUs are captured and provide standardization in reporting.

This bill would authorize a Medi-Cal managed care plan to enter into an MOU with an APP agency to enroll eligible families into Medi-Cal and provide developmental screening to enrolled children.

3) **SUPPORT**. The sponsor, Child Care Resource Center, writes that in California, approximately 50% of young children receive their care through Medi-Cal. The sponsor asserts the Medi-Cal system has a historically poor performance on developmental screenings. Supporters say this bill will ensure more children have access to a timely screening.

4) **PREVIOUS LEGISLATION**.

   **a)** SB 635 (Menjivar) of 2023 would have directed all subsidized child care programs and home visiting programs to screen all children, following family consent, with a developmental screening tool (for children 0-5). SB 635 was heard in Senate policy committees then amended to a different subject matter.

   **b)** AB 1004 (McCarty), Chapter 387, Statutes of 2019, requires that screenings provided as an EPSDT benefit include developmental screenings for individuals zero to three years of age and requires Medi-Cal managed care plans to ensure that providers who contract with these plans provide the screenings according to the AAP Bright Futures® Guidelines.

5) **DOUBLE REFERRAL**. This bill is double referred. Should it pass out of this Committee, it will be referred to the Committee on Human Services.

**REGISTERED SUPPORT / OPPOSITION**:

**Support**

Association of Regional Center Agencies
BANANAS, Inc.
California Alternative Payment Program Association
California Strategies & Advocacy, LLC
Child Action, INC.
Child Care Alliance of Los Angeles
Child Care Resource Center
Child Development Resources of Ventura County, INC.
Disability Rights California
Early Care and Education Consortium
Everychild California
Latino Coalition for A Healthy California
Pathways LA
Thriving Families California

**Opposition**

None on file.

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

Date of Hearing: June 11, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1119 (Newman) – As Introduced February 13, 2024

**SENATE VOTE**: 39-0

**SUBJECT**: Hospitals: seismic compliance.

**SUMMARY:** Extends the dates by which four hospitals owned by Providence are required to comply with specified seismic safety standards: two hospitals on a consolidated license in Eureka, one hospital in Fullerton, and one hospital in Tarzana. Contains an urgency clause to ensure that the provisions of this bill go into immediate effect upon enactment. Specifically, **this bill**:

1) Extends the dates by which specified buildings at four hospitals owned by Providence are required to comply with seismic safety standards, which under current law are required to meet the 2030 standard by January 1, 2025, as follows:

    a) For Providence St. Joseph Hospital in the City of Eureka, Original Hospital and Central Plant, removal of acute care services or demolition, to January 1, 2027;

    b) For Providence Eureka General Hospital in the City of Eureka, Original Hospital, 1950 Addition Building, 1955 Addition Building, 1957 Addition Center Building, and 1957 Addition West Side Building, removal of acute care services or demolition, to January 1, 2027;

    c) For Providence St. Joseph Hospital in the City of Fullerton, Main Building, Canopies and Boiler Room, removal of acute care services or demolition, to January 1, 2027; and,

    d) For Providence Cedars-Sinai Tarzana Medical Center Patient Tower, removal of acute care services or demolition, to January 1, 2026;

2) Adds additional quarterly reporting dates to the list of required quarterly reports that certain hospitals with a seismic extension are required to submit to the Department of Health Care Access and Information (HCAI) to update their progress toward compliance to accommodate the length of extensions in this bill.

3) Permits HCAI to revoke the seismic compliance waiver for these hospitals if a hospital fails to timely report progress that HCAI deems sufficient to complete their plans, unless due to unforeseen circumstances outside of the control of the hospital, and the hospital has been given at least 90 days written notice with an opportunity to cure the noncompliance.

**EXISTING LAW**:

1) Licenses and regulates health facilities, including general acute care hospitals, by the California Department of Public Health (DPH). [Health and Safety Code (HSC) §1250, et seq.]

2) Establishes the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983 (Alquist Act), to ensure that hospital buildings are designed and constructed to resist the forces generated by earthquakes and requires HCAI to propose building standards for earthquake resistance and to provide independent review of the design and construction of hospital buildings. [HSC §129675, et seq.]

3) Establishes timelines for hospital compliance with seismic safety standards, including a requirement that buildings posing a significant risk of collapse and a danger to the public (referred to as Structural Performance Category (SPC)-1 buildings) be rebuilt or retrofitted to be capable of withstanding an earthquake, or removed from acute care service, by January 1, 2008 (this has since been extended for various hospitals to various dates). Requires hospitals to be capable of continued operation by January 1, 2030. [HSC §130060, §130065]

4) Permits HCAI to grant an extension of up to five years to the 2008 deadline, which would be January 1, 2013, for hospitals for which compliance will result in a loss of health care capacity, as defined. Allows HCAI to grant various further extensions beyond this, including up to seven years, to January 1, 2020, in part based on the loss of essential hospital services to the community if the hospital closed, and financial hardship. [HSC §130060, §130061.5]

5) Permits HCAI (under legislation enacted in 2018) to provide for an extension of the January 1, 2020 deadline described in 4) above, for up to 30 months (until July 1, 2022) for hospitals that plan to replace or retrofit a building to meet the 2020 standard, and up to five years (until January 1, 2025) for hospitals that plan to rebuild to a standard that meets the 2030 continued operation requirement. [HSC §130062]

6) Provides for penalties of $5,000 per calendar day for failure to comply, or failure to meet any agreed upon milestone toward complying, with the provisions in 5) above. [HSC §130062(d)(3) and (e)(3)]

7) Requires the owner of an acute care inpatient hospital whose building does not substantially comply with the January 1, 2030 seismic safety requirement described in 3) above, to submit to HCAI, by January 1, 2020, an attestation that the board of directors of that hospital is aware that the hospital building is required to meet this requirement. [HSC §130066]

**FISCAL EFFECT**: According to the Senate Appropriations Committee, HCAI estimates costs of $198,667 in 2025-26, $198,667 in 2026-27, and $198,667 in 2027-28 (Hospital Building Fund) for state administration due to the continued need to oversee the hospitals' compliance with seismic safety requirements for another extension period.

**COMMENTS**:

**1) PURPOSE OF THIS BILL**. According to the author, the COVID-19 pandemic created a cascade of challenges requiring hospitals to focus on ensuring adequate capacity and critical patient care. The Providence hospital organization currently has three hospitals in California-- St. Jude Medical Center in Fullerton; St. Joseph Hospital in Eureka; and Providence Cedars-Sinai Tarzana Medical Center in Los Angeles—which are in the midst of rebuild plans. While Providence has endeavored to meet the seismic deadlines for California hospitals established in statute for each campus, due to a variety of circumstances beyond its control, particularly the impacts of the pandemic, these three hospitals will not be able to

fully achieve seismic compliance in time to avoid significant financial penalties. The author concludes that without the deadline extension proposed in this bill, the hospitals will be faced with the reality of being unable to renew their licensure under DPH, leading to a loss of vital patient care in their communities

2) **BACKGROUND**. Following the 1971 San Fernando Valley earthquake, California enacted the Alquist Act, which mandated that all new hospital construction meet stringent seismic safety standards. In 1994, after the Northridge earthquake, SB 1953 (Alquist), Chapter 740, Statutes of 1994, required HCAI to establish earthquake performance categories for hospitals, and established a January 1, 2008, deadline by which general acute care hospitals must be retrofitted or replaced so that they do not pose a risk of collapse in the event of an earthquake, and a January 1, 2030, deadline by which they must be capable of remaining operational following an earthquake. Subsequent legislation allowed most hospitals to qualify for an extension of the January 1, 2008 deadline to January 1, 2013.

   HCAI categorizes hospitals into five SPCs. SPC-1 is the category of buildings at most risk of collapse in an earthquake, and it is these hospitals that were originally required to be taken out of service or retrofitted by January 1, 2008, which has since been extended multiple times. Buildings in SPC-2, 3, 4, and 5 are generally categorized based on when they were built and the building code regulations in effect at that time. Hospital buildings in any of these categories may be used up until January 1, 2030, at which time hospitals must either meet SPC-5 requirements, or under more recently adopted regulations, the new category of SPC-4D. SPC-5 generally requires new construction for any building constructed before 1989, while SPC-4D allows for some more recently constructed buildings to be retrofitted and still be compliant with January 1, 2030 standards.

   In addition to the original five-year extension to January 1, 2013, the Legislature has passed additional bills allowing hospitals to extend the deadlines for retrofitting SPC-1 buildings beyond the 2013 deadline. SB 306 (Ducheny), Chapter 642, Statutes of 2007, permitted a hospital owner to comply with seismic safety deadlines and requirements in current law by replacing all of its buildings subject to seismic retrofit by January 1, 2020, rather than retrofitting by 2013 and replacing them by 2030, if the hospital meets several conditions and HCAI certifies that the hospital owner lacks the financial capacity to meet seismic standards, as defined. SB 90 (Steinberg), Chapter 19, Statutes of 2011, allowed a hospital to seek an extension for seismic compliance for its SPC-1 buildings of up to seven years (no later than January 1, 2020) based on the following elements: the structural integrity of the building, the loss of essential hospital services to the community if the hospital closed, and financial hardship.

   a) **2018 seismic deadline extension.** The Providence hospitals affected by this bill are operating under a seismic deadline extension passed in 2018. At that time, the Legislature passed AB 2190 (Reyes), Chapter 673, Statutes of 2018, which was intended to allow the last remaining hospitals that had not yet met the SPC- 2 standard, to meet the mandate without fear of closure should they have a construction or financing delay. AB 2190 provided two paths: a 30 month extension (to July 1, 2022) for hospitals that submitted a retrofit plan or a "replacement plan" (relocating acute care services or beds from nonconforming buildings into a conforming building); or alternatively, a five year extension (to January 1, 2025) for hospitals that submitted a rebuild plan to construct a new building that would meet the 2030 standard. The Providence hospitals affected by

this bill were all granted extensions to January 1, 2025, by which time they should be 2030 compliant in terms of SPC status.

In order to receive the extension to July 1, 2022 for a retrofit or replacement plan, the hospital and HCAI were required to identify at least two major milestones relating to the compliance plan to be used as a basis for determining whether the hospital is making adequate progress toward meeting the new seismic compliance deadline. The hospital needed to start construction by April 1, 2020, and meet any agreed upon milestone, or be subject to a $5,000 fine per calendar day until the requirements or milestones are met. Similarly, hospitals seeking an extension to January 1, 2025 for a rebuild plan had to work with HCAI to identify major milestones, begin construction by January 1, 2022, and are also subject to the daily $5,000 fine for failure to meet requirements or agreed upon milestones. AB 2190 permitted HCAI to grant adjustments to the deadlines to meet milestones or other requirements as necessary to deal with specified delays, but HCAI was prohibited from extending the final seismic compliance dates of July 1, 2022 for replacement or retrofit plans, and January 1, 2025 for rebuild plans. Hospitals granted extensions under AB 2190 are required to provide a quarterly status report to HCAI until seismic compliance is achieved. However, since that time, there has been legislation granting additional extensions for specific hospitals.

**b) Status of hospital seismic safety compliance.** According to HCAI, as of February 22, 2024, there are a total of 3,248 buildings at 410 licensed hospital facilities that are subject to the seismic safety standards. All have achieved at least the SPC-2 standard that allows them to remain in service until 2030 except for 41 buildings spread across 20 hospital facilities. In some cases, there are no plans to retrofit or rebuild, and the hospital has either already taken them out of service but it is not reflected in the data yet, or there are plans to take them out of service prior to the January 1, 2025 deadline. It is unclear how many of the remaining out-of-compliance buildings are expected to remain in service, but are in jeopardy of missing the January 1, 2025 deadline for retrofit or replacement projects.

Regarding the 2030 deadline for buildings to achieve SPC-3, 4, 4D or 5, there are still 658 buildings, spread across 251 licensed hospitals, that have an SPC-2 rating and will need to either be retrofitted to SPC-4D, replaced with an SPC-5 building, or removed from acute care service.

**c) Providence hospitals affected by this bill and their seismic compliance status**.

**i) Providence Cedars-Sinai Tarzana Medical Center.** Providence Cedars-Sinai in Tarzana is licensed for 204 beds. According to HCAI, one building is under an AB 2190 rebuild extension, and the facility has been under three ownerships during the full extension period: Tenet, Providence, and Providence/Cedars-Sinai Joint Venture. The compliance plan anticipated new construction to replace this building. The building decanted of known acute care functions following occupancy of the new patient wing in October of 2023 and relocation of the Neonatal Intensive Care Unit in December 2023. The work remaining to convert the SPC-1 building to a non-acute care building is disconnection of utilities and life safety systems from the conforming buildings, and HCAI deems this remaining work achievable by the end of the current extension.

According to Providence, constructing the new patient wing took longer than anticipated, and they need additional time to complete the utility and building separation work associated with removing the old building from acute care services. The design team is engaged and they are working toward the first HCAI-issued milestone. Providence met the first HCAI issued milestone in April 2024.

ii) **Providence St. Joseph Hospital in the City of Eureka.** Providence St. Joseph in Eureka is licensed for 138 beds. According to HCAI, the hospital currently has one SPC-1 building under an AB 2190 rebuild extension and has missed mutually agreed upon milestones. The compliance plan began with one new building approved and built. When nearing completion, HCAI discovered that general acute care services remained in the nonconforming building. Providence then commenced working with HCAI on a series of amendments to their AB 2190 milestones, none of which have been met. Providence has not submitted plans to resolve the remaining non-conforming conditions. Compliance work has not progressed since January 2020.

According to Providence, planning has been underway for years and make ready projects have been completed to move several impacted departments out of the non-compliant space, and noted that utility separation work had started and was paused due to COVID. Providence states that a design team and general contractor have been engaged. Pre-construction work began in late May 2024.

iii) **Providence Eureka The General Hospital.** The General Hospital is a 15-bed rehabilitation center, and is operating under a consolidated license with its parent facility, Providence St. Joseph in Eureka. According to HCAI, there are five SPC-1 buildings at The General Hospital under an AB 2190 rebuild extension. The buildings house acute rehabilitation nursing. The extension was originally approved to relocate services to the St. Joseph campus. Current plans reflect relocation of services to a new construction at Providence Redwood Memorial Hospital in Fortuna, approximately 20 miles away. Construction of the new facility has not progressed since July 2019, with environmental damage requiring mitigation due to lack of building protection.

According to Providence, the new location for the acute rehabilitation unit project at Redwood Memorial in Fortuna was started in approximately 2017-2019, and HCAI temporarily paused the project to validate construction plans and schedules. COVID further paused the relocation work. Providence states that a design team and general contractor have been engaged. Providence states that due to escalating construction costs (in excess of 30%), for the proposed new acute rehabilitation project, Providence paused the re-location (May), and is actively working to maintain access to this critical service line. HCAI is aware of the project status. Once a pathway is identified, which Providence anticipates to occur within the next month, Providence will work with HCAI to determine new milestones in accordance with the required removal of acute care services for the non-compliant buildings in Eureka. In the interim, Providence continues to make required project progress at the Fortuna site.

iv) **Providence St. Jude Medical Center in the City of Fullerton.** Providence St. Jude is licensed for 320 beds. According to HCAI, there are three SPC-1 buildings left unresolved following completion of a replacement tower in 2014. All three SPC-1 buildings are adjacent to SPC-conforming buildings, whose operations could be

impacted by the nonconforming buildings in the case of a major seismic event.

According to Providence, pre-COVID, the healthcare industry projected increased outpatient utilization and decreased inpatient utilization, which led to the determination to remove acute care services from these buildings. However, those outpatient projections were not realized across the industry, and a strategy shift was needed to address the increasing inpatient needs at St. Jude, which resulted in the seismic requirements now becoming applicable. A design team has been engaged, and a general contractor was contracted in March for preconstruction scoping. Providence states that this work is still underway as it is typically a six to eight month process, and that adding this campus to the AB 2190 program increases transparency by requiring milestones to be established.

**d) Other hospitals under AB 2190 extensions to January 1, 2025 at risk of not meeting the deadline.** According to HCAI, these Providence hospitals are among 43 hospitals, involving 93 buildings, that applied for extensions under AB 2190 of 2018. Of these, 12 facilities with 28 buildings remain in the program. Aside from the Providence hospitals affected by this bill, HCAI has identified the following facilities as at risk of noncompliance with the deadlines associated with AB 2190, with each affected building being at risk for fines of $5,000 per day for missing milestones or completion:

**i)** El Centro Regional Medical Center (Imperial Valley), with five buildings affected. City-owned, considered a distressed hospital, with a work stoppage due to financial constraints;

**ii)** Hollywood Presbyterian Medical Center (Los Angeles), with two buildings affected. This is an investor-owned facility, and a contractor dispute caused work to halt in May of 2023;

**iii)** Pacifica Hospital of the Valley (Los Angeles), with three buildings affected. It is investor-owned, and the contractor stopped work in August of 2023 for nonpayment;

**iv)** Southern California Hospital at Culver City, with one building affected. Investor-owned facility. Work halted in December of 2023 due to financial constraints;

**v)** UC Davis Medical Center (Sacramento), with one building affected. Pace of work not on track to meet deadline; and,

**vi)** Central Valley Specialty Hospital (Modesto) has missed its completion deadline due to failure to start work and make progress through the approved extension period, and is being subject to fines for failure to make progress.

**3) CONCERNS.** The Service Employees International Union California (SEIU) submitted a letter of concern, stating that this bill grants an extension to certain hospitals that have already received an extension under AB 2190. SEIU states that it is time that these hospitals meet these standards and not continue to delay these important safety updates. SEIU states they look forward to continued dialogue and discussion on compliance with California's 2030 seismic standards.

4) **SUPPORT**. Providence is the sponsor of this bill and states that it is critical to ensuring access to care, especially as Providence serves significant Medicare and Medi-Cal populations. Providence notes that the COVID-19 pandemic led to shifting financial priorities and conditions, requiring many hospitals to focus on ensuring adequate capacity and patient care, at the expense of progress toward the unfunded seismic compliance mandates. Providence states that failure to meet current seismic deadlines would result in the revocation of a hospital license, negatively impacting access to care. This legislation is needed so that Providence St. Jude Medical Center in Fullerton, Providence St. Joseph Hospital – Eureka, and Providence Cedars-Sinai Tarzana Medical Center in Tarzana can maintain critical access to care while making progress toward the respective deadlines outlined in the legislation.

5) **OPPOSITION**. The California Nurses Association (CNA) is opposed to this bill and states that delaying seismic compliance plan requirements for four Providence hospitals is arbitrary and unduly endangers patients, as well as health care providers and workers in the event of an earthquake. CNA notes that this bill would allow four Providence hospitals – Providence St. Joseph Hospital Eureka, Providence Eureka General Hospital, Providence St. Jude Medical Center, and Providence Cedars-Sinai Tarzana Medical Center – to further delay compliance in seismic safety by waiving existing requirements for hospitals to submit compliance plans for seismic rebuilds by 2025. CNA contends that Providence's delay is part of the hospital industry's decades-long fight against seismic safety compliance ever since the passage of law that required hospitals to be operational after an earthquake. In response to the 1994 Northridge earthquake that severely damaged 11 hospitals, the law requires hospitals to submit seismic compliance plans for both retrofits and rebuilds. These reporting requirements on seismic compliances plans help ensure that hospitals are adequately taking steps to meet seismic retrofit requirements by the 2030 statutory deadline. CNA states that Providence seeks to delay seismic safety in its buildings after 30 years of opportunity to submit compliance plans. Providence, like much of the hospital industry, seeks to avoid meeting its long overdue obligation to ensure its buildings are structurally safe during earthquakes. Providence has had plenty of opportunities over the past 30 years to develop compliance plans. CNA notes that Providence has plenty of resources to meet the requirement of timely submitting seismic compliance plans—all facilities subject to this bill have enjoyed net inpatient and outpatient revenues. CNA concludes that Providence's delay would disproportionately impact Medi-Cal patients, as well as rural and marginalized communities, given that Providence seeks extensions for hospitals in rural areas, such as two of its hospitals in Eureka.

6) **RELATED LEGISLATION**.

   **a)** AB 869 (Wood) creates a grant program for small and rural hospitals to fund assessments for complying with 2030 seismic safety requirements, including estimating the costs of compliance. Additionally permits qualifying small and rural, as well as financially distressed district hospitals, as defined, to apply for grants for complying with the 2030 seismic safety deadline. AB 869 extends the January 1, 2030 deadline for seismic compliance to January 1, 2035, for hospitals that apply, and qualify for, seismic compliance grants under this bill. AB 869 exempts eligible small and rural and financially distressed district hospitals from the January 1, 2030 seismic safety requirements if the estimated cost of compliance is more than $1 million or 2% of the hospital's revenue, whichever is greater, if HCAI determines that the cost of compliance

results in a financial hardship for the hospital, and state or grant funding is not available to assist with the cost of compliance. AB 869 is pending a hearing in the Senate Health Committee.

**b)** SB 1432 (Caballero) extends the January 1, 2030 deadline which requires hospitals to be capable of continued operations following a major earthquake, until January 1, 2033 if hospitals submit a seismic compliance plan by January 1, 2026. Permits HCAI to grant hospitals an additional extension up to January 1, 2038 based on an application and demonstration by the hospital that it meets specified criteria. SB 1432 is pending hearing in the Assembly Health Committee.

**c)** SB 1447 (Durazo) extends the seismic compliance deadline for hospitals to be capable of continued operations, for Children Hospital Los Angeles, from January 1, 2030 to January 1, 2040. SB 1447 is pending hearing in the Assembly Health Committee.

**d)** SB 759 (Grove) of 2023 would have extended the seismic safety deadline for hospitals to be capable of continued operations following an earthquake, from January 1, 2030 to January 1, 2040. SB 759 was never heard in Senate Health Committee.

**7) PREVIOUS LEGISLATION**.

**a)** AB 1471 (Pellerin), Chapter 304, Statutes of 2023, extended the dates for compliance with seismic safety requirements for three buildings on the campus of Santa Clara Valley Medical Center, with the latest deadline being July 1, 2026.

**b)** AB 1882 (Robert Rivas), Chapter 584, Statutes of 2022, requires owners of general acute care hospital buildings that are not compliant with the January 1, 2030 seismic safety requirement to remain operational following a major earthquake, to submit annual status updates to various entities, including the county board of supervisors, any labor union that represents workers in a building that is not January 1, 2030 compliant, the local office of emergency services, and the medical health operational area coordinator; and, requires hospitals to post in any lobby or waiting area of a hospital building that is not compliant with the January 1, 2030 seismic requirement a notice that the hospital is not in compliance.

**c)** AB 2404 (Luz Rivas), Chapter 592, Statutes of 2022, permits HCAI to waive the requirements of the Seismic Safety Act for Pacifica Hospital of the Valley in Los Angeles County if the hospital submits a plan that proposes compliance by January 1, 2025, HCAI accepts the plan based on it being feasible, and the hospital reports to HCAI on a quarterly basis on its progress to timely complete the plan.

**d)** AB 2904 (Bonta) of 2022 would have extended the January 1, 2030 seismic safety requirement for Alameda Hospital until January 1, 2032. AB 2904 was vetoed by the Governor, who stated that any consideration of an extension must be contemplated across all communities and across all types of facilities in a holistic manner.

**e)** SB 564 (Cortese), Chapter 388, Statutes of 2021, permits HCAI to grant an extension of the seismic safety requirement that hospitals be capable of remaining standing following

a major earthquake, until a maximum of December 31, 2024, for two hospitals owned by the County of Santa Clara.

**f)** AB 1527 (Ting), Chapter 1527, Statutes of 2021, permits HCAI to extend the seismic requirements for Seton Medical Center in Daly City until July 1, 2023.

**g)** SB 758 (Portantino) of 2020, among other provisions, would have extended the 2030 hospital seismic compliance deadline to January 1, 2037. SB 758 was amended in the Assembly Appropriations Committee when it came off the Suspense File, to reduce the extension to January 1, 2032. SB 758 was not taken up on the Assembly Floor.

**h)** AB 2190 (Reyes), Chapter 673, Statutes of 2018, provided for an extension of the January 1, 2020, hospital seismic safety deadline of up to 30 months (until July 1, 2022) for hospitals that plan to replace or retrofit a building to at least the 2020 standard of SPC-2, and up to five years (January 1, 2025) for hospitals that plan to rebuild to SPC-4D or SPC-5 standards that meet 2030 standards.

**i)** AB 908 (Dababneh), Chapter 350, Statutes of 2017, permitted Providence Tarzana Medical Center in Los Angeles to request an additional extension, until October 1, 2022, of the seismic safety requirement that hospital buildings be rebuilt or retrofitted in order to be capable of withstanding an earthquake.

**j)** AB 81 (Wood), Chapter 63, Statutes of 2015 permitted a hospital in the City of Willits to request an eight-month deadline extension of a seismic safety requirement that hospitals be rebuilt or retrofitted to be capable of withstanding an earthquake, which it was required to meet by January 1, 2015, so that this hospital could have until September 1, 2015.

**k)** AB 2557 (Pan), Chapter 821, Statutes of 2014, permitted a hospital located in the Counties of Sacramento, San Mateo, or Santa Barbara or the City of San Jose, that had received an additional extension of the January 1, 2008, seismic safety requirements under specified provisions of existing law to January 1, 2015, to request an additional extension until September 1, 2015, in order to obtain either a certificate of occupancy or a construction final from the HCAI.

**l)** SB 90 (Steinberg), Chapter 19, Statutes of 2011, allowed a hospital to seek an extension for seismic compliance for its SPC-1 buildings of up to seven years based on the following elements: the structural integrity of the building, the loss of essential hospital services to the community if the hospital closed, and financial hardship.

**m)** SB 499 (Ducheny), Chapter 601, Statutes of 2009, required all general acute care hospitals that have SPC-1 buildings to report to HCAI by November 1, 2010, and annually thereafter, on the status of their compliance with the seismic safety deadlines.

**n)** SB 306 (Ducheny), Chapter 642, Statutes of 2007, amended the Alquist Act to permit hospitals to delay compliance with the July 1, 2008 seismic retrofit deadline, and the 2013 extension, to the year 2020, by filing a declaration with HCAI that the owner lacks financial capacity to comply with the law.

**o)** SB 1661 (Cox), Chapter 679, Statutes of 2006, authorized an extension of up to an additional two years for hospitals that had already received extensions of the January 1, 2008 seismic safety compliance deadline if specified criteria were met, and required specified hospital reports to be posted on the HCAI website.

**REGISTERED SUPPORT / OPPOSITION**:

**Support**

Los Angeles County Supervisor Lindsey P. Horvath
Orange County Supervisor Doug Chaffee
Alliance of Catholic Health Care, INC.
California Hospital Association
Cedars Sinai
Cedars-Sinai Medical Center
City of Calabasas
City of Eureka
County of Humboldt
Fullerton Fire Department
Fullerton; City of
Humboldt County Sheriff's Office
North Orange County Chamber of Commerce
Orange County Business Council
Orange County United Way
Providence
South Orange County Economic Coalition
Valley Industry and Commerce Association (VICA)
West Valley Warner Center Chamber of Commerce

**Opposition**

California Nurses Association

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

Date of Hearing: June 11, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1184 (Eggman) – As Amended May 2, 2024

**SENATE VOTE**: 39-0

**SUBJECT**: Mental health: involuntary treatment: antipsychotic medication.

**SUMMARY:** Requires an order for treatment with antipsychotic medication to remain in effect at the beginning of a detention period for various involuntary holds provided that a petition for a new determination on the question of capacity has been filed, as specified. Requires this determination to remain in effect until the court hears a petition for that detention period and issues a decision. Specifically, **this bill**:

1) Authorizes the administration of antipsychotic medication to a person who is involuntarily detained for an additional up-to 30 day period (subsequent to an initial up-to 30 day detention).

2) Clarifies that a person who is involuntarily detained for a subsequent up-to 30 day hold has the right to refuse treatment with antipsychotic medication subject to the existing procedures in the Lanterman-Petris-Short Act (LPS Act).

3) Requires an order for treatment with antipsychotic medication to remain in effect at the beginning of a detention period for the up-to 14 day detention period for suicidal persons; for an initial up-to 30 day detention period (following an up-to 14 day detention); and, for an additional up-to 30 day detention period (subsequent to an initial up-to 30 day detention), provided that a petition for a new determination on the question of the person's capacity has been filed.

4) Requires this determination to remain in effect until the court hears a petition for that detention period and issues a decision.

**EXISTING LAW**:

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

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

3) Defines "antipsychotic medication" as any medication customarily prescribed for the treatment of symptoms of psychoses and other severe mental and emotional disorders. [WIC §5008(l)]

4) Permits antipsychotic medication to be administered to any person subject to various involuntary detention lengths, as specified, if that person does not refuse that medication following disclosure of the right to refuse medication, as well as information required to be given to persons, as specified. [WIC §5332]

5) Requires medication, if any person subject to various specified involuntary detention lengths and for whom antipsychotic medication has been prescribed orally refuses or gives other indication of refusal of treatment with that medication, to be administered only when treatment staff have considered and determined that treatment alternatives to involuntary medication are unlikely to meet the needs of the patient, and upon a determination of that person's incapacity to refuse the treatment in a capacity hearing (known as a "Riese hearing") held for that purpose. [WIC §5332]

6) Requires persons subject to capacity hearings, as specified, to have a right to representation by an advocate or legal counsel. Requires capacity hearings to be heard within 24 hours of the filing of the petition whenever possible. [WIC §5333 and §5334]

7) Requires any determination of a person's incapacity to refuse treatment with antipsychotic medication to remain in effect only for the duration of the up-to 72 hours of detention for evaluation and treatment and the initial up-to 14 days of involuntary detention for intensive treatment, or both, or until capacity has been restored according to standards developed, as specified, or by court determination, whichever is sooner. [WIC §5336]

**COMMENTS**:

**1) PURPOSE OF THIS BILL**. According to the author it should always be our goal to get people with serious mental illnesses into voluntary treatment, however it is a sad reality that some severely mentally ill individuals lack the capacity to recognize their illness or to seek help for it. The author continues that in some of these cases, a person is so ill that they become a danger to themselves or others, or fall into the category of being gravely disabled. In these scenarios, it is sometimes necessary to involuntarily confine and treat a patient in order to stabilize them with the goal of restoring their capacity and helping them live a fuller life; something we all want for our fellow human beings. The author states that it is appropriately a high bar under existing law to place someone into an involuntary hold and in these situations we have a tremendous obligation to the person being held to ensure they receive the appropriate care. The author argues that unfortunately, under existing law, involuntary treatment during a hold can be discontinued when it is not clinically indicated to do so, simply because a person is in the process of transitioning from one hold stage to another. The author concludes that this bill allows the continuation of treatment and ensures a patient's due process rights are protected.

**2) BACKGROUND**.

**a) LPS Act involuntary detentions.** The LPS Act provides for involuntary detentions for varying lengths of time for the purpose of evaluation and treatment, provided certain

requirements are met, such as that an individual is taken to a county-designated facility. Typically, one first interacts with the LPS Act through a "5150" hold initiated by a peace officer or other person authorized by a county, who must determine and document that the individual meets the standard for a 5150 hold. A county-designated facility is authorized to then involuntarily detain an individual for up to 72 hours for evaluation and treatment if they are determined to be, as a result of a mental health disorder, a danger to self or others, or gravely disabled. The professional person in charge of the county-designated facility is required to assess an individual to determine the appropriateness of the involuntary detention prior to admitting the individual. Subject to various conditions, a person who is found to be a danger to self or others, or gravely disabled, can be subsequently involuntarily detained for an initial up-to 14 days for intensive treatment, an additional 14 days (or up to an additional 30 days in counties that have opted to provide this additional up-to 30 day intensive treatment episode), and ultimately a conservatorship, which is typically for up to a year and may be extended as appropriate.

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

**b) Riese hearings**. The Department of Health Care Services (DHCS's) website includes the handbook "Rights for Individuals in Mental Health Facilities," which states that a capacity hearing, also called a Riese hearing, may be held to determine whether an individual can refuse treatment with medications. The capacity hearing is conducted by a hearing officer at the facility where the individual is receiving treatment or by a judge in court. The hearing officer will determine whether the individual has the capacity to consent to or refuse medication as a form of treatment. An individual's representative helps them prepare for the hearing and will answer questions or discuss concerns that they may have about the hearing process. If an individual disagrees with the capacity hearing decision, they may appeal the decision to a superior court or to a court of appeal. Their patients' rights advocate or attorney can assist them with filing an appeal.

The first of these hearings typically occur during the initial 72 hour hold. When a patient's condition necessitates an additional hold beyond the initial 72 hour and 14 day periods, a certification review hearing is held to determine that the patient still meets the criteria to be held at the beginning of each proposed hold. In addition to a certification review hearing, a new Riese hearing may be held to determine the patient's incapacity to refuse treatment prior to each new hold. The hearings impacted by this bill are those for an additional 14 day hold, initial up-to 30 day hold, and additional up-to 30 day hold.

Under current law, Riese hearings are required to be heard within 24 hours of the filing of the petition whenever possible. Twenty-four hour delays are permitted if parties need additional time to prepare or to accommodate county policies regarding the scheduling of hearings. However, current law states that hearings cannot be held beyond 72 hours of the filing of the petition.

3) **SUPPORT**. The California State Association of Psychiatrists (CSAP) are sponsoring this bill, stating that it will modify Reise hearings such that the timeframe covered by judicial determination of incapacity to refuse treatment with antipsychotic medication applies to all periods of involuntary detention, not just the specific phase of involuntary detention under which the Riese was filed, thereby minimizing redundant additional Riese hearings and the dangers of clinically contraindicated interruption of medication treatment. CSAP argues that medications must be carefully titrated and monitored; stopping or interrupting such medication at arbitrary points during involuntary detention, based on local court rules, exposes patients to unjustified clinical risks and prolong the length of stay in inpatient settings. CSAP concludes that nothing in this bill would alter the current ability of individuals to petition for the discontinuation of treatment.

4) **OPPOSITION**. Various patients and civil rights groups oppose this bill, including the ACLU, Cal Voices, and Disability Rights California (DRC). These organizations argue that this bill rolls back the fundamental patients' rights endorsed by the state Supreme Court in *Riese v. St. Mary's Medical Center and Hospital*, which requires a judicial determination of incapacity before involuntary medication can occur, in an effort to address an alleged systemic health care gap that has not been substantiated by data or research. Cal Voices argues that the provisions of this bill are not needed as existing law does not allow for gaps in involuntary hold orders, and any gap is caused by participants in the court system and not the existing law. DRC argues that this bill erodes the fundamental rights to bodily integrity and privacy, which is especially important given the extreme side effects from psychiatric medications. According to DRC one study found 15 to 30% of patients over the age of 45 developed Tardive Dyskinesia, a severe and permanent movement disorder, after one year of treatment from psychiatric medication. Newer antipsychotics are associated with metabolic syndrome, which is important as patients with serious mental illness have higher rates of obesity, diabetes, and cardiovascular disease, dying up to 10 years earlier than non-mentally ill patients from medical problems. The ACLU states that over 30 years ago the Legislature negotiated and researched for two years how to interpret the Riese holding into current law in a way that was workable for hospitals while also protecting civil rights to the greatest extent possible. The ACLU concludes that the harm this bill may create by loosening regulations around the practice of forcing medication on nonconsenting adults, without any research, data, or evaluation of impact, far outweighs any potential benefit.

5) **RELATED LEGISLATION**.

   **a)** SB 1238 (Eggman) expands the definition of a "designated facility" and "facility designated by the county" under the LPS Act and authorizes DHCS to license and ensure reimbursement is provided for facilities that admit patients who are diagnosed only with a severe SUD. SB 1238 is currently pending in the Assembly Health Committee.

   **b)** SB 1317 (Wahab) extends the sunset date until January 1, 2030 on the provision of law authorizing involuntary medication of county jail inmates who are awaiting arraignment, trial or sentencing. SB 1317 is currently pending in the Assembly Public Safety Committee.

6) **PREVIOUS LEGISLATION**.

   **a)** SB 43 (Eggman), Chapter 637, Statutes of 2023, among other things, expanded the definition of "gravely disabled," for purposes of involuntarily detaining an individual under the LPS Act, to include an individual with a severe SUD, or a co-occurring mental health disorder and a severe SUD, or chronic alcoholism, who is unable to provide for food, clothing, shelter, personal safety or necessary medical care.

   **b)** SB 1227 (Eggman) Chapter 619, Statutes of 2022, modified the LPS Act to allow a second 30-day intensive treatment hold for a person who has been certified as "gravely disabled" on top of the existing 72 hour, 14 day, and 30 day treatment holds; the second 30-day treatment hold must be approved by a court pursuant to a petition filed by the professional in charge of the intensive treatment, as specified.

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

8) **POLICY CONCERNS**. According to information submitted by the author's office, idiosyncrasies of local court calendars and procedures can cause gaps between review certification hearings and Riese hearings. The author's office and sponsors argue that when Riese hearings fall within one of these procedural gaps it leads to the interruption of treatment for patients who are often being treated with antipsychotic medications that must be carefully administered. The proponents further argue that stopping or interrupting such medication, based on a timing quirk created by local court rules, exposes patients to unjustified clinical risks.

   No data has been provided to the Committee to demonstrate that these gaps in hearings are a systemic problem. Additionally, existing law requires capacity petitions be heard within 24 hours of the filing of the petition "whenever possible" and "in a manner compatible with, and the least disruptive of, the treatment being provided to the person." This begs the question that if there are gaps between hearings, is this not a result of administrative failure on the part of the courts or providers who are filing petitions for the hearings? Is the most appropriate solution to this problem to extend the involuntary administration of antipsychotic medication until a hearing is held?

   Opposition groups, most of who are lawyers and/or patients' rights advocates that represent patients in Riese hearings, argue that the administrative burden of Riese hearings is low as counties are permitted to hold them informally in the hospital with a patient advocate and a hearing officer from the court presiding. DRC also shared the following anecdote: if a facility plans to place a patient on a new hold and continue involuntary medication, they will time the filing of the new hold with the capacity petition on a day when the capacity petition can be heard by the court. This practice eliminates any gap in involuntary medication treatment that might otherwise occur and is widely utilized throughout the state. To the extent local jurisdictions or individual facilities are struggling with treatment gaps, this is an issue of these entities not utilizing best practices and failing to comply with existing state law requirements.

   Are there alternate policy solutions to ensure that petitions and hearings are filed and heard in timelines that comply with existing law? Judicial procedures are outside the scope of this

Committee, but fall within that of the Assembly Judiciary Committee where this bill will be heard if it passes. Moving forward the author may wish to work with stakeholders and the Assembly Judiciary Committee to explore pathways that ensure timely hearings without relying on extending orders for involuntary treatment with antipsychotic medications. At a minimum, protections should be considered to limit extension periods and ensure a patient's right to a timely Riese hearing is maintained.

**REGISTERED SUPPORT / OPPOSITION**:

**Support**

California State Association of Psychiatrists (sponsor)

**Opposition**

ACLU California Action
Cal Voices
California Association of Social Rehabilitation Agencies
Disability Rights California
Mental Health America of California
The Law Foundation of Silicon Valley

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

Date of Hearing: June 11, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1230 (Rubio) – As Introduced February 15, 2024

**SENATE VOTE**: 31-5

**SUBJECT**: Strengthen Tobacco Oversight Programs (STOP) and Seize Illegal Tobacco Products Act.

**SUMMARY:** Authorizes the Department of Tax and Fee Administration (CDTFA) to seize flavored tobacco products or product flavor enhancers being sold in violation of existing law. Increases civil penalties for violations of the Stop Tobacco Access to Kids Enforcement (STAKE) Act, and requires flavored tobacco products and flavor enhancers forfeited to the state to be destroyed. Specifically, **this bill**:

1) Increases the civil penalties in 2) of existing law below as follows:

    a) $1,000 to $1,500 for the first violation;

    b) $2,000 to $3,000 for the second violation at the same location within a five-year period;

    c) $5,000 to $10,000 for the third violation at the same location within a five-year period;

    d) $10,000 to $20,000 for a fourth violation within a five-year period; and,

    e) At least $20,000 for five or more violations within a five-year period.

2) Permits the CDTFA, if it discovers that a retailer, or any of the tobacco retailer's agents or employees, sell, offer for sale, or possess with the intent to sell or offer for sale, a flavored tobacco product or tobacco product flavor enhancer, to seize those flavored tobacco products or tobacco product flavor enhancers at the retail location or any other person's location. Requires any flavored tobacco products or tobacco product flavor enhancers seized by CDTFA to be deemed forfeited, as specified.

3) Adds flavored tobacco products and tobacco product flavor enhancers to existing law regarding forfeited products to be destroyed.

**EXISTING LAW**:

1) Requires the California Department of Public Health to establish and develop a program to reduce the availability of tobacco products to persons under 21 years of age through authorized enforcement activities pursuant to the STAKE Act. [Business and Professions (BPC) §22950, *et seq*.]

2) Permits an enforcing agency to assess civil penalties against any person, firm, or corporation that sells, gives, or in any way furnishes to another person who is under 21 (except for military personnel 18 years of age or older) any tobacco product, instrument, or paraphernalia that is designed for the smoking or ingestion of tobacco products ranging from $400 to $6,000 for a first, second, third, fourth, or fifth violation within a five-year period.

[BPC §22958]

3) Prohibits a tobacco retailer, or any of the tobacco retailer's agents or employees, from selling, offering for sale, or possessing with the intent to sell or offer for sale, a "flavored tobacco product," as defined, or a "tobacco product flavor enhancer," as defined. [Health and Safety Code §104559.5]

4) Defines "flavored tobacco product" as any tobacco product that contains a constituent that imparts a characterizing flavor. Defines "tobacco product flavor enhancer" as a product designed, manufactured, produced, marketed, or sold to produce a characterizing flavor when added to a tobacco product. [*Ibid.*]

5) Requires any cigarettes or tobacco products forfeited to the state pursuant the Cigarette and Tobacco Products Licensing Act to be destroyed. [Revenue and Taxation Code §30449]

**FISCAL EFFECT**: According to the Senate Appropriations Committee, CDTFA indicates that it initially would incur administrative costs of up to $1 million per year for the destruction of the seized flavored tobacco products or tobacco product flavor enhancers; however, over time, CDTFA anticipates that this amount would decrease as retailers become aware of its enforcement actions (Cigarettes and Tobacco Products Compliance Fund). CDTFA estimates that the bill would likely result in a minor decrease in cigarette and tobacco products tax revenues of an unknown amount.

**COMMENTS**:

1) **PURPOSE OF THIS BILL**. According to the author, as a schoolteacher, she knows all too well that California students continue to have easy access to addictive tobacco products and vapes with flavors designed to appeal to youth. Even after the passage of California's flavored tobacco ban, unauthorized tobacco products continue to flow into California and end up in the hands of consumers of all ages. We must increase enforcement of California's flavored tobacco ban to stop the spread of illegal tobacco products. The author states that this bill – also known as The STOP and Seize Illegal Tobacco Products Act – will strengthen enforcement of the law and remove illegal flavored tobacco products from the market. The bill does this by explicitly authorizing employees of the California Department of Tax and Fee Administration to seize and destroy flavored tobacco products discovered during inspections of tobacco retailers and warehouses, and reasonably increasing the civil penalties for retailers who continue to violate the law and sell flavored tobacco products and tobacco products to people under 21 years old. The author concludes that passing this legislation will send a signal that California cares deeply about the health of our community and we will not allow the industry to break the law to hook the next generation of nicotine addicts.

2) **BACKGROUND**. Cigarette smoking causes more than 480,000 deaths each year in the United States (U.S.), or nearly one in five deaths. Smoking causes more deaths each year than the following causes combined: Human immunodeficiency virus, illegal drug use, alcohol use, motor vehicle injuries, and firearm-related incidents. More than 10 times as many U.S. citizens have died prematurely from cigarette smoking than have died in all the wars fought by the U.S. Smoking causes about 90% (or nine out of 10) of all lung cancer deaths. More women die from lung cancer each year than from breast cancer. Smoking causes about 80% (or eight out of 10) of all deaths from chronic obstructive pulmonary

disease. Cigarette smoking increases the risk for death from all causes in men and women. In California, smoking-related health care costs $13.29 billion per year and smoking-related losses in productivity totals $10.35 billion per year.

a) **Centers for Disease Control and Prevention data on tobacco use**. African American youth and young adults have significantly lower prevalence of cigarette smoking than Hispanics and whites, and although the prevalence of cigarette smoking among African American and white adults is the same, African Americans smoke fewer cigarettes per day. On average, African Americans initiate smoking at a later age compared to whites; however, they are more likely to die from smoking-related diseases than whites.

   American Indian/Alaska Native youth and adults have the highest prevalence of cigarette smoking among all racial/ethnic groups in the U.S, however, it is important to note that some American Indians use tobacco for ceremonial, religious, or medicinal purposes. Regional variations in cigarette smoking exist among American Indians/Alaska Natives, with lower prevalence in the Southwest and higher prevalence in the Northern Plains and Alaska. Hispanic/Latin adults generally have lower prevalence of cigarette smoking and other tobacco use than other racial/ethnic groups, with the exception of Asian Americans. However, prevalence varies among sub-groups within the Hispanic population, for example, 50% of Cuban men and more than 35% of Cuban women report smoking 20 or more cigarettes per day, and Mexican men and women are less likely than other Hispanic/Latinx groups to report that they smoke 20 or more cigarettes per day.

   Although Asian Americans, Native Hawaiians, and Pacific Islanders are often combined together as one group in survey data due to smaller numbers of the individual groups surveyed, they are actually three distinct groups. Cigarette smoking among Asian American/Pacific Islander adults is lower than other racial ethnic groups, however, prevalence among Asian sub-groups varies and can be higher than that of the general population. Like many other minority groups, the LGBTQ+ community has been the target of tobacco industry marketing for several decades. As a result, smoking rates are disproportionately higher among LGBTQ+ individuals than the general population. About one in four LGBTQ+ adults smoke cigarettes compared with about one in six heterosexual/straight adults. More than twice as many LGBTQ+ students report having smoked a cigarette before the age of 13 compared to heterosexual students.

b) **California's flavored tobacco ban.** In 2020 the Legislature passed, and Governor Newsom signed, SB 793 (Hill), Chapter 34, Statutes of 2020. The law prohibits a tobacco retailer, or any of its agents or employees from selling, offering for sale, or possessing with the intent to sell or offer for sale, a flavored tobacco product or a tobacco product flavor enhancer. It exempts the sale of Hookah water pipes and flavored shisha tobacco products, pipe tobacco, and premium cigars from the prohibition. Fueled by kid friendly flavors like cotton candy and bubblegum, 3.6 million more middle and high school students started using e-cigarettes in 2018. The disturbing rates of teen e-cigarette use continued to rise in 2019 with the overwhelming majority of youth citing use of popular fruit and menthol or mint flavors and there are now 5.3 million young Americans who use e-cigarettes regularly. SB 793 also included menthol flavor, which was excluded from the original federal Food and Drug Administration (FDA) ban, because, as the author of SB 793 noted during his bill presentation, unless action is taken, an estimated 1.6 million African Americans alive today, who are now under the age of 18, will become

regular smokers; and about 500,000 of those will die prematurely from a tobacco-related disease.

Immediately after the passage of SB 793, the tobacco industry qualified a referendum for the ballot asking the voters to decide whether or not SB 793 should take effect, and enforcement of the ban was halted pending the November 8, 2022 election. The ballot measure, Proposition 31, was approved, thus upholding SB 793. The next day, R.J. Reynolds, the maker of Newport menthol cigarettes and top-selling vaping products filed a federal lawsuit challenging California's ban on flavored tobacco. However, in December of 2022 the Supreme Court refused to block the law, clearing the way for the ban to take effect the next week. The law states that a tobacco retailer, or agent or employee of a tobacco retailer, in violation of this section is guilty of an infraction and will be punished by a fine of two hundred fifty dollars ($250) for each violation. This law does not specify where the enforcement authority of this statute resides, which implies local jurisdictions have authority to enforce this law.

3) **SUPPORT**. The American Cancer Society Cancer Action Network, the American Heart Association (AHA), the American Lung Association, and Campaign for Tobacco-Free Kids write as co-sponsors to support this bill, also the STOP and Seize Illegal Tobacco Products Act, which will protect the public health of all Californians, including California youth, by strengthening enforcement of California's flavored tobacco law and removing illegal tobacco products from the market.

   According to the 2023 National Youth Tobacco Survey, approximately 2.8 million high school students and middle school students used a tobacco product in the past year, and nearly 90% of youth electronic cigarette users used flavored products. The California State Legislature passed Senate Bill 793 in 2020 to protect public health by prohibiting the sale of flavored tobacco products in California. But despite this law, illegal tobacco products continue to make their way into the hands of our youth. The co-sponsors note that this bill will authorize employees of the CDTFA to seize and destroy flavored tobacco products discovered during existing inspections of locations where tobacco products are sold or stored and increase the civil penalties for retailers who illegally sell tobacco products to people under 21 years old. The co-sponsors conclude that by expanding enforcement of California's flavored tobacco law and removing these illegal products from the market, this bill will curb the spread of these addictive, illegal products in California schools and homes.

4) **RELATED LEGISLATION**. AB 3218 (Wood) requires the Attorney General (AG) to establish and maintain on the AG's website, a list of tobacco product brand styles that lack a characterizing flavor, to be known as the Unflavored Tobacco List.

5) **PREVIOUS LEGISLATION**.

   **a)** AB 935 (Connolly), Chapter 351, Statutes of 2023, makes provisions of current law prohibiting a tobacco retailer, or any of the tobacco retailer's agents or employees, from selling, offering for sale, or possessing with the intent to sell or offer for sale, a flavored tobacco product or a tobacco product flavor enhancer, punishable by civil penalties in the same manner as the STAKE Act.

**b)** SB 793 (Hill) prohibits a tobacco retailer, or any of the tobacco retailer's agents or employees, from selling, offering for sale, or possessing with the intent to sell or offer for sale a flavored tobacco product or a tobacco product flavor enhancer, as specified.

**c)** AB 598 (Rivas) of 2021 would have required the AG to establish and maintain a list of tobacco product brand styles that lack a characterizing flavor. AB 598 was not heard in the Assembly Health Committee.

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

**REGISTERED SUPPORT / OPPOSITION**:

**Support**

American Cancer Society Cancer Action Network INC. (cosponsor)
American Heart Association (cosponsor)
American Lung Association of California (cosponsor)
Campaign for Tobacco Free Kids (cosponsor)
California Dental Association
California Medical Association
Children Now
City of Alameda
CleanEarth4Kids.org
County Health Executives Association of California (CHEAC)
Day One
International Youth Tobacco Control
The Greater Sacramento Smoke and Tobacco Free Coalition
Tobacco - Free Kids Action Fund
Tobacco Education and Research Oversight Committee
Western University of Health Sciences

**Opposition**

None on file.

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

Date of Hearing: June 11, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1320 (Wahab) – As Amended March 18, 2024

**SENATE VOTE**: 36-0

**SUBJECT**: Mental health and substance use disorder treatment.

**SUMMARY:** Requires a health plan or insurer to, for services provided to an enrollee or insured under a health plan contract or insurance policy issued, amended, or renewed on or after July 1, 2025, establish a process to reimburse providers for mental health (MH) and substance use disorder (SUD) treatment services that are integrated with primary care services. Authorizes the reimbursement process required under this bill to be based upon federal rules or guidance issued for the Medicare program.

**EXISTING LAW**:

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

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

**FISCAL EFFECT**: 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 ensures health plans establish a process to reimburse providers for MH and SUD treatments that are integrated with primary care, and requires insurers to reimburse providers for these services. This bill is part of the Senate's innovative bipartisan legislative package that will make our communities both healthier and safer. The author concludes that this bill builds on the DMHC's recommendations and allows Californians to get the help they deserve in an affordable, timely manner.

2) **BACKGROUND**. According to the California Health Care Foundation, people with behavioral health conditions often experience poor health across all domains. While they have higher rates of major chronic illnesses, they are less likely to receive preventive care and often experience a lower quality of care for their physical health needs. Individuals with a diagnosis of serious mental illness (SMI) or SUD die on average over 20 years earlier than individuals without such a diagnosis, often from preventable physical illnesses. People with behavioral health diagnoses incur costs that are four times greater than those without, with the difference largely attributable to increased physical health care spending. Among the over

13 million California residents (in 2019) who receive care from the Medi-Cal program, 5% of enrollees account for over half of all spending, and 45% of this high-cost population has a diagnosis of SMI. In California as in other states, mental illnesses and SUDs are more prevalent in people with lower incomes.

**a) Federal policies**. In late 2022, the U.S. Department of Health and Human Services (DHHS) released its Roadmap for Behavioral Health Integration and identified opportunities to expand access to behavioral health by integrating behavioral health into primary care settings. This will increase access to care by encouraging and reimbursing primary care providers (PCPs) for providing behavioral health care to both adult and pediatric populations. This can also help overcome the stigma associated with receiving behavioral health services in certain communities. Additionally, DHHS identified opportunities to test models of care integration facilitated through value-based payment arrangements and emerging technologies as well as an opportunity to reduce the technology gap between behavioral health care providers and physical health care providers. To properly integrate care, providers and systems must be able to communicate with one another. Finally, DHHS identified opportunities to drive resources into integrated care through pay-for-reporting and pay-for performance mechanisms based on integration-related quality measures. According to DHHS, validated performance measures can not only drive meaningful improvements in the quality of behavioral health care but can also incentivize greater investment in behavioral health services and generate a sustainable revenue stream to support the delivery of behavioral health care and recruitment of providers.

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

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

The DMHC is conducting BHIs of all full-service commercial health plans regulated by the DMHC, with the intent to investigate an average of five health plans per year. The investigations are separate from the DMHC’s routine medical surveys, or audits, which are conducted every three years. The Phase One Summary BHI Report issued last year includes a list of the KKA violations that were identified for each of the

investigated health plans, and provides a summary of barriers to care. Barriers to care may include health plan practices, policies, operations, or other activities that may not rise to a violation of the law, but may contribute to challenges, delays or obstacles faced by enrollees as they navigate the health plan's system to access behavioral health services. Barriers can negatively impact enrollees' ability to obtain behavioral health care.

Some of the barriers in the BHI Report identified plans for not having a process for providing integrated behavioral health care services and for conducting utilization management for behavioral health care services that are not subject to prior authorization. The BHI report specifically stated that behavioral health integration is an approach to delivering behavioral health care that involves PCPs and behavioral health providers working together using a teambased approach. Behavioral health conditions such as depression or anxiety can co-occur as a result of, or in response to, medical conditions including pain or other serious medical conditions. The BHI report cited research conducted for DHHS that indicates that when enrollees have psychological or behavioral problems, they primarily turn to PCPs for care, rather than traditional behavioral health providers. Frequently, enrollees develop positive, ongoing relationships with their PCPs and integrating behavioral health care within those primary care settings enables easy access and "one-stop shopping" for coordinating medical and behavioral health care services. The traditional approach to treating behavioral health conditions is to refer an enrollee outside the primary care setting to a psychologist, psychiatrist or other behavioral health care professional.

ii) **BHI Recommendations.** When PCPs refer enrollees to behavioral health professionals, enrollees do not always end up making, obtaining or keeping appointments. The DMHC recommends that all health plans regulated by the DMHC have policies and procedures for integrated behavioral health care services. The health plans should also have a process for providers to be reimbursed for providing behavioral health integration services, use Current Procedural Terminology (CPT) codes for billing, and collect these CPT codes through fee-for-service billing processes or encounter data when reimbursement occurs through capitation. The health plans should use this data to measure and analyze potential improvement of physical and behavioral health outcomes, care delivery efficiency, and enrollee experience. The recommendation is partially based on the fact that behavioral health integration is already beginning to become part of the California delivery system. For example, on January 1, 2021, the Department of Health Care Services launched the Behavioral Health Integration Incentive Program, which was funded by the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56). The program incentivizes improvement of physical and behavioral health outcomes, care delivery efficiency, and patient experience by establishing or expanding fully integrated care in a Medi-Cal managed health care plan's network, using culturally and linguistically appropriate teams with expertise in primary care. PCPs serve as an important entry point for enrollees to receive or be connected to behavioral health care services and enrollees could greatly benefit from integrated services. In particular, enrollees who are attempting to access behavioral health care services for the first time or those with undiagnosed conditions, would receive the greatest benefit from integrated behavioral health care services due to the coordinated care, where communication is facilitated across disciplines.

This bill requires health plans to establish a process to reimburse providers for MH and SUD treatment services that are integrated with primary care services.

3) **SUPPORT**. The California Association of Alcohol and Drug Program Executives, sponsor, writes that integrating behavioral health care services with primary care is essential for meeting the complex needs of individuals with MH and SUD conditions. These integrated models aim to seamlessly combine primary care and behavioral health services, ensuring comprehensive and holistic care for patients. By promoting collaboration between specialty behavioral health providers and primary care settings, integrated models enhance overall health outcomes, improve patient experiences, and will greatly expand access to SUD treatment. This bill aligns with DMHC's recommendations and will help advance efforts to integrate behavioral health and primary care services. By requiring health plans and insurers to establish reimbursement processes for integrated treatments, this bill will incentivize providers to adopt integrated care models, ultimately benefiting patients across California. The sponsor writes that this bill represents a crucial step forward in improving access to quality MH and SUD treatment services.

4) **RELATED LEGISLATION**.

   **a)** SB 999 (Cortese) requires a health plan and a disability insurer, and an entity acting on a plan's or insurer's behalf, to ensure compliance with specific requirements for utilization review, including maintaining telephone access and other direct communication access during California business hours for a health care provider to request authorization for MH and SUD care and conducting peer-to-peer discussions regarding specific patient issues related to treatment. SB 999 is pending in the Assembly Health Committee.

   **b)** AB 3221 (Pellerin) states that existing law does not prohibit the DMHC Director from taking any action permitted or required under the KKA in response to the survey results before the follow-up review is initiated or completed, including, but not limited to, taking enforcement actions and opening further investigations. AB 3221 is pending in Senate Health Committee.

5) **PREVIOUS LEGISLATION**. SB 855 requires commercial health plans and insurers to provide full coverage for the treatment of all MH and SUDs. Establishes specific standards for what constitutes medically necessary treatment and criteria for the use of clinical guidelines.

**REGISTERED SUPPORT / OPPOSITION**:

**Support**

California Association of Alcohol and Drug Program Executives, Inc. (CAADPE) (sponsor)
Mayor Todd Gloria, City of San Diego
California Hospital Association
California Life Sciences
California Retailers Association
California State Association of Psychiatrists
Californians United for A Responsible Budget
Communities United for Restorative Youth Justice (CURYJ)
Ella Baker Center for Human Rights

Felony Murder Elimination Project
Friends Committee on Legislation of California
Health Access California
Initiate Justice
Prosecutors Alliance
Rady Children's Hospital
Santa Cruz Barrios Unidos
Smart Justice California
Vera Institute of Justice
Youth Leadership Institute

**Opposition**

None on file.

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

Date of Hearing: June 11, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1369 (Limón) – As Amended April 29, 2024

**SENATE VOTE**: 37-0

**SUBJECT**: Dental providers: fee-based payments.

**SUMMARY:** Requires a health plan contract or insurance policy that provides payment directly, or through a contracted vendor, to a dental provider, to have a non-fee-based default method of payment. Requires a health plan or insurer or its contracted vendor to obtain a signed authorization or an electronic signature from a dental provider opting in to a fee-based payment method before the plan or vendor provides a fee-based payment method to the provider. Specifically, **this bill**:

**Non-fee-based Reimbursement**

1) Requires a health plan contract or insurance policy issued, amended, or renewed on and after January 1, 2025, that provides payment directly, or through a contracted vendor, to a dental provider, to have a non-fee-based default method of payment. Requires the health plan or insurer to remit or associate with each payment the claims and claim details associated with payment.

**Opt-in Fee-based Reimbursement**

2) Requires a health plan or insurer or its contracted vendor to obtain a signed authorization or an electronic signature from a dental provider opting in to a fee-based payment method before the plan or vendor provides a fee-based payment method to the provider.

3) Requires the health plan or insurer or its contracted vendor to, at the time a dental provider opts in to a fee-based payment method, provide information on the payment method, including a notice of the fees charged by the plan or contracted vendor, alternative methods of payment, instructions on how to opt out of the fee-based payment method, and a notice of the dental provider's ability to opt out of the fee-based payment method at any time.

4) Allows the health plan or insurer or its contracted vendor to issue payments to the dental provider using a fee-based payment method upon receipt of the dental provider's signed authorization or electronic signature.

5) Requires the health plan or insurer to notify the dental provider if its contracted vendor is sharing any part of the profit, fee arrangement, or board composition with the plan or insurer.

**Opt-Out Fee-based Reimbursement**

6) Authorizes the dental provider to opt out of a fee-based payment method and opt in to a non-fee-based payment method at any time by providing written or electronic notice to the health plan or insurer or its contracted vendor.

7) Requires the provider's payment method decision to remain in effect until the provider informs the plan or contracted vendor of another preferred method of payment, including fee-based or non-fee-based methods if a dental provider opts out of a fee-based method of payment pursuant to 6) above.

8) Provides that this bill does not change, alter, or extend the scope of existing law relating to health plan accessibility standards.

9) Applies the following definitions to this bill:
   a) Contracted vendor as a third party facilitating payment processing on behalf of the health plan or insurer;
   b) Dental provider as an individual or group of individuals licensed under the Business and Professions Code; and,
   c) Fee-based payment refers to any payment type that requires the dental provider to incur a fee to access payment from a plan or its contracted vendor.

**EXISTING LAW**:

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

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

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

**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, dental plans will often contract with third-party companies to issue provider payments to dental practices with virtual credit cards

(VCCs). However, accepting this form of payment charges the dental office processing fees of two to five percent of the total payment amount, in addition to, the standard merchant transaction fee for processing the payment through their credit card terminal. These unjustly high fees simply to access contracted payments owed by the dental plans are compounded by coercive plan behavior that often forces dentists to accept payment via VCC even when they have requested another method of payment. This bill requires that any provider payment that includes a processing fee must be disclosed to dentists and cannot be the default payment method. This bill also mandates that dental plans and VCC companies clearly outline opt-in and opt-out procedures for VCC payments. The author concludes that the process must also outline alternative payment methods, ensuring dentists receive full payment for their services.

2) **BACKGROUND**. The American Medical Association (AMA) writes that an "electronic claim" is a paperless patient claim form generated by computer software that is transmitted electronically over telephone or computer connection to a health insurer or other third-party payer for processing and payment. A "manual claim" is a paper claim form that is typically sent to the payer through the mail and require postage. Electronic claims submission helps physician practices reduce the administrative burden and expense generally associated with manual claims processing and submission. The use of electronic claims can result in significant financial savings for both physician practices and payers. Health information technology solutions are on the rise as more physician practices are submitting electronic claims to payers. By doing so, physician practices may potentially realize increased practice efficiencies and savings in their practice's claims revenue cycle.

   According to a recent *NPR* article, "Why doctors pay millions in fees that could be spent on care," when lawmakers passed the federal Patient Protection and Affordable Care Act (ACA) in 2010, they encouraged the use of electronic payments in health care. Direct deposits are faster and easier to process than checks, requiring less labor for doctors and insurers alike. The ACA expanded efforts to standardize health care business practices, electronic funds transfer (EFT), and electronic remittance advice (ERA). The Centers for Medicare & Medicaid Services (CMS) ERA and EFT rule, published in 2012 and effective in 2014, applied to all insurers, not just Medicare and Medicaid. At that time, CMS predicted that shifting from paper to electronic billing would save $3 billion to $4.5 billion over 10 years.

   Since enactment of these rules, the AMA has advocated that CMS issue guidance spelling out physician rights regarding insurance company electronic payments. According to the AMA, some plans made payments with VCCs, a 16-digit number emailed, faxed or mailed to a provider in order to make a one-time payment. AMA argued that increased administrative burdens and fees as high as five percent were assessed with each VCC transaction. As a result, the AMA alerted physicians of their rights to refuse payments via VCCs and advocated against the coercive tactics used by payers and their vendors to force physicians' acceptance of VCC payments. In response, CMS through guidance, asserted that physicians cannot be forced to take VCCs as payment and had the right to request that a health plan use the EFT transaction. A 2023 ProPublica article wrote that CMS revised its position and concluded that it had no legal authority to flat out prohibit fees. According to the author, states such as Arizona, Connecticut, and Florida have banned dental plans from only offering this payment option.

3) **SUPPORT**. California Dental Association (CDA), sponsor, writes that dental plans contract with third-party vendors to issue provider payment via VCCs, a 16-digit credit card number, commonly faxed or emailed to the provider. To withdraw or access the funds, dental offices must run VCCs through their credit card terminals. Vendor processing fees for VCCs can range from two to five percent of the total amount, on top of which, the dentist pays the usual merchant transaction fee when processing the payment through their credit card terminal. Therefore, dental offices can sometimes pay up to 10% in fees before accessing payment they are owed by the plan. CDA states that these unjustly high fees simply to access contracted payments owed by the dental plans are compounded by coercive behavior that often forces dental offices to accept payment via VCCs. Both dental plans and VCC companies claim dentists can "easily opt-out" of receiving this payment method but will disregard this opt-out shortly after, in some cases as soon as the very next payment. CDA notes that these predatory practices put dentists in a position where they must choose between accepting VCCs with high fees or repeatedly requesting an alternative and delayed payment. This bill would restrict these predatory practices by mandating that any fee-based payment cannot be the default method, requiring the dentist to prospectively opt-in via signature. Dentists deserve to be able to fully understand and choose whether to accept payment processing fees, rather than being essentially trapped into accepting payment methods that charge predatory fees. CDA concludes that these fees nickel and dime dental offices, reducing income that could be used to invest in staff, improve office efficiency and patient experience or increase access.

4) **OPPOSITION**. The California Association of Dental Plans (CADP) write that this bill would delay reimbursement and increase the cost and administrative burden on providers and plans. Issuance of payment may be delayed if a provider opts to receive a paper check or set up EFT as an alternative form of payment over virtual credit cards. Information related to reimbursement methods is currently made accessible to providers on plan websites and portals, including alternative payment methods, instructions, and associated fees making the requirements in this bill unnecessary. CADP notes that the National Conference on Insurance Legislators model act on VCCs includes an opt-out provision. This bill takes California in the opposite direction of the national standard and creates additional administrative costs as plans would have to create a separate process for California providers.

5) **RELATED LEGISLATION**. AB 3275 (Soria) shortens the timeframe of a health plan, including a specialized health plan, or health insurer, as specified, to reimburse a claim, no later than 15 working days after receipt of the claim, or, if the health plan or health insurer contests or denies the claim, to notify the claimant within 15 working days that the claim is contested or denied. AB 3275 is pending in the Senate Health Committee.

6) **PREVIOUS LEGISLATION**.

   **a)** AB 1048 (Wicks), Chapter 557, Statutes of 2023, prohibits, on and after January 1, 2025, a health plan or health insurer that covers dental services, including a specialized health plan or health insurer that covers dental services, from issuing, amending, renewing, or offering a plan contract or policy that imposes a dental waiting period provision or preexisting condition provision, as specified. Requires the plan or health insurer to file with the respective departments the required information at least 120 days before any change in the methodology, factors, or assumptions that would affect rates.

**b)** AB 952 (Wood), Chapter 125, Statutes of 2023, requires a health plan or health insurer that issues, sells, renews, or offers a contract covering dental services, to disclose whether an enrollee's or insured's dental coverage is "State Regulated" through a provider portal, if available, or otherwise upon request, on or after January 1, 2025.

**7) AUTHOR'S AMENDMENTS.** To address concerns from the opposition, the author is proposing the following amendments:

**a)** To delay implementation of this bill to April 1, 2025;

**b)** Require a health plan, insurer, or contracted vendor that obtains written authorization to opt in or opt out of fee-based payment to include both the dental provider's entire practice and all products or services covered pursuant to a dental provider contract; and,

**c)** Define written authorization to mean a dental provider's express consent to opt in or opt out of receiving fee-based payment indicated by a provider's written, signed, or similar authentication, including electronic signature or checking a box to indicate authorization.

**REGISTERED SUPPORT / OPPOSITION**:

**Support**

California Dental Association (sponsor)
California Association of Orthodontists
Children's Choice Dental Care

**Opposition**

America's Health Insurance Plans
California Association of Dental Plans

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

Date of Hearing: June 11, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1385 (Roth) – As Amended June 5, 2024

**SENATE VOTE**: 39-0

**SUBJECT**: Medi-Cal: community health workers: supervising providers.

**SUMMARY:** Clarifies that hospitals can bill Medi-Cal for community health worker (CHW) services delivered in emergency departments (EDs) and in the course of related outpatient follow-up care, and requires the development of related policies and procedures. Specifically, **this bill**:

1) Defines a supervising provider as an enrolled Medi-Cal provider authorized to supervise a CHW pursuant to the Medi-Cal State Plan, who ensures a CHW meets the qualifications established by the Department of Health Care Services (DHCS).

2) Requires DHCS to develop guidance on policies and procedures to effectuate a billing pathway for supervising providers, including contracted hospitals, to bill for the provision of CHW services to fee-for-service (FFS) members during an ED visit and during an outpatient follow up to an ED visit. Requires this guidance to be developed by July 1, 2025, and in consultation with stakeholders, as specified.

3) Requires a Medi-Cal managed care plan to adopt similar billing policies and procedures consistent with those developed by DHCS pursuant to 2) above.

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

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

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

5) Establishes, as California's essential health benefits (EHB) benchmark plan under federal law, the Kaiser Small Group Health Maintenance Organization contract, existing California health insurance mandates, and federally mandated benefits. Specifies EHBs in 10 categories,

including mental health and substance use disorder (SUD) services. [Health & Safety Code §1367.005 and Insurance Code §10112.27]

6) Specifies SUD services included in the state-adopted EHB package as covered Medi-Cal benefits. [WIC §14132.03]

7) Contingent on federal approval and the availability of federal financial participation, defines medication-assisted treatment services, including medications approved for the treatment of opioid use disorder, counseling services, and behavioral therapy as benefits under the Drug Medi-Cal program administered by California counties. [WIC §14124.24]

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

**COMMENTS**:

1) **PURPOSE OF THIS BILL.** This bill is intended to provide a clear billing pathway for SUD navigator services provided in EDs. A program called California Bridge (CA Bridge) that places navigators in EDs has demonstrated that these services effectively connect people who have an opioid use disorder to medication for addiction treatment (MAT) and encourage them to stay in care. The CA Bridge program combines immediate access to MAT with support from a substance use counselor or navigator in the ED. In order to continue this highly effective program, the author indicates this bill creates a billing pathway for those navigator services through the CHW Medi-Cal benefit. The author indicates this bill is part of a bipartisan legislative package titled, "Working Together for a Safer California."

2) **BACKGROUND**.

   a) **Opioid Use Disorder and MAT.** Overdose deaths from both opioids and psychostimulants (such as amphetamines) are soaring. The increased availability of fentanyl, an extremely potent synthetic opioid, has resulted in a 10-fold increase in fentanyl-related deaths between 2015 and 2019.

      According to the federal Substance Abuse and Mental Health Services Administration, research shows that a combination of medication and therapy can successfully treat SUD, and some medications can help sustain recovery. Medications used in MAT for opioid use disorder include buprenorphine, methadone, and naltrexone. These medications can support a person's recovery by helping to normalize brain chemistry, relieving cravings, and in some cases can prevent withdrawal symptoms. Unfortunately, there is no similar evidence-based pharmacological treatment approved for amphetamine addiction.

      Although most SUD treatment services covered by Medi-Cal are financed and delivered by county mental health plans, Medi-Cal managed care and Medi-Cal FFS reimburse for MAT delivered in EDs, as well as outpatient treatment services for opioid use disorder, which include management, care coordination, psychotherapy and counseling.

   b) **CA Bridge**. The CA Bridge program has placed navigators in EDs to provide low-barrier, immediate access to MAT; navigation to ongoing care and community resources;

and a culture of harm reduction. According to DHCS, studies have shown it is feasible to implement low-barrier MAT in all types of EDs, that it successfully reaches low-income patients, and that low-barrier MAT is effective even with the increasing presence of fentanyl in the drug supply. CA Bridge navigators work with hospital staff to change organizational culture to reduce stigma and center patients' goals. A study at Highland Hospital in Oakland demonstrated that patients seen by a navigator were three times more likely to be in follow-up treatment 30 days after their ED visit.

The CA Bridge Program was initially funded through a time-limited allocation of federal funds. The enacted 2023-24 Budget Act also included $4 million one-time to provide statewide capacity to support the CA Bridge program. According to the author and sponsor, California Chapter of the American College of Emergency Physicians, providers implementing the CA Bridge navigator program in EDs are seeking an ongoing fund source to retain the navigators after the expiration of the original funding allocation. Although it is unknown whether billing for the CHW benefit would fully sustain the cost of maintaining navigators in EDs, it would provide an ongoing source of financing.

**c) CHW Services and SUD Navigators**. DHCS added CHW services as a Medi-Cal benefit starting July 1, 2022. The benefit was later codified through AB 2697 (Aguiar-Curry), Chapter 488, Statutes of 2022. CHW services are defined to also include those delivered by promotores, community health representatives who work in tribal communities, navigators, and other non-licensed public health workers.

CHW services include health education; navigation to health care and other community resources that address health-related social needs; screening and assessment that does not require a license and that assists a beneficiary to connect to appropriate services to improve their health; and individual support and advocacy that assists a beneficiary in preventing a health condition, injury, or violence. CHW services are defined as medically necessary for individuals meeting a wide range of criteria and who have different types of health conditions. CHWs can address mental health conditions and SUDs, as well as preventive care and other diseases and conditions.

Medi-Cal billing policy specifies that a supervising provider who bills for CHW services is an enrolled Medi-Cal provider who oversees the services provided and ensures a CHW meets the defined qualifications. The supervising provider can be a licensed provider, a hospital, an outpatient clinic, a local health jurisdiction, or a community-based organization. CHWs cannot bill independently; CHW services are always billed by the supervising provider.

**d) Current Barriers to Billing**. Given the flexibility in how CHWs and CHW services are defined, SUD navigators working under the CA Bridge program appear to fit under the current federally approved definition of a CHW in Medi-Cal. Current CHW billing policies also specify hospitals as supervising providers. However, there is currently no explicit billing policy that applies to CHW or SUD navigator services in an ED and for outpatient follow-up care. Anecdotally, this has led to some confusion over how such CHW services, including SUD navigator services, can be billed when delivered in these settings. This bill would clarify hospitals' ability to bill for the services by requiring DHCS and managed care plans to specify appropriate billing pathways.

3) **SUPPORT**. A range of stakeholders write in support, including criminal justice reform organizations, the California Retailers Association, Health Net, and the Steinberg Institute, a behavioral health advocacy nonprofit. Supporters write that ongoing funding for the CA Bridge navigator program will ensure that this successful model combining immediate access to MAT with support from an SUD counselor or navigator in the ED, will continue.

4) **RELATED LEGISLATION**. AB 2250 (Weber) requires a health plan, health insurer, and Medi-Cal to provide coverage for, and provider reimbursement of, social determinants of health screenings. Requires a health plan or insurer to provide to physicians who provide primary care services with adequate access to peer support specialists, lay health workers, social workers, or CHWs, as defined. AB 2250 is pending in the Senate Health Committee.

5) **PREVIOUS LEGISLATION**.

   **a)** AB 85 (Weber) of 2023 was similar to AB 2250 and was vetoed by Governor Newsom, who cited concerns that the bill was premature and duplicative of existing efforts.

   **b)** AB 2697 codifies CHW services as a covered Medi-Cal benefit. Requires DHCS, through existing and regular stakeholder processes, to inform stakeholders about, and accept input from stakeholders on, implementation of the CHW services benefit.

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

**REGISTERED SUPPORT / OPPOSITION**:

**Support**

California Chapter of the American College of Emergency Physicians (sponsor)
Mayor Todd Gloria, City of San Diego
California for Safety and Justice
California Retailers Association
Californians United for a Responsible Budget
Elderly Care Everywhere
Ella Baker Center for Human Rights
Health Net and Its Affiliated Companies
Prosecutors Alliance of California, a Project of Tides Advocacy
Smart Justice California, a Project of Tides Advocacy
Steinberg Institute
Vera Institute of Justice

**Opposition**

None on file.

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

Date of Hearing: June 11, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1442 (Ochoa Bogh) – As Amended May 16, 2024

**SENATE VOTE**: 38-0

**SUBJECT**: Point-of-care tests for fentanyl.

**SUMMARY:** Permits the California Health and Human Services Agency (CalHHS) to enter into partnerships for the manufacture or purchase of any federally approved point-of-care fentanyl tests, as specified. Specifically, **this bill**:

1) Permits CalHHS to enter into partnership for the manufacture or purchase of any United States Food and Drug Administration (FDA)-approved point-of-care fentanyl tests.

2) Permits partnerships to allow the development, manufacturing, or distribution of approved point-of-care fentanyl tests by any entity that is authorized to do so under federal or state law.

3) Defines "point-of-care test for fentanyl" as a point-of-care test for use by a provider to detect if a person has consumed fentanyl, including but not limited to, a fentanyl test strip (FTS) used to detect fentanyl in urine.

**EXISTING LAW**:

1) Establishes the California Affordable Drug Manufacturing Act of 2020, known as CalRx, and requires CalHHS or its departments to enter into partnerships to increase competition, lower prices, and address shortages in the market for generic prescription drugs, to reduce the cost of prescription drugs for public and private purchasers, taxpayers, and consumers, and to increase patient access to affordable drugs. [Health and Safety Code (HSC) §127690 and §127692]

2) Requires CalHHS to enter into partnerships resulting in the production, procurement, or distribution of generic prescription drugs, with the intent that these drugs be made widely available to public and private purchasers, providers, suppliers, and pharmacies, as specified and as appropriate. [HSC §127693]

3) Permits CalHHS to enter into partnerships regarding over-the-counter (OTC) naloxone products, allowing for the development, manufacturing, or distribution by any entity that is authorized to do so under federal or state law. [HSC §127697]

**FISCAL EFFECT**: According to the Senate Appropriations Committee, unknown General Fund costs for CalHHS for state administration to implement the provisions of the bill.

**COMMENTS**:

1) **PURPOSE OF THIS BILL**. According to the author, fentanyl overdoses have increased over 1,400% in California since 2017. In 2022, 6,473 Californians overdosed on fentanyl, which accounted for nearly 88% of all opioid-related overdose deaths. The author continues that this bill will expand access to point-of-care fentanyl tests by authorizing CalHHS,

through the CalRx initiative, to enter into partnerships to develop, produce, purchase, and distribute such tests. The author concludes that by ensuring that more providers can test for fentanyl use as soon as possible, California will expand its efforts to reduce fentanyl overdoses.

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 FDA for use as an analgesic and anesthetic. It is approximately 50 times stronger than heroin and 100 times stronger than morphine. First developed in 1959, it was introduced in the 1960's as an intravenous anesthetic. Fentanyl is legally manufactured and distributed in the US; however, there are two types of fentanyl: pharmaceutical fentanyl and illicitly manufactured fentanyl. Both are considered synthetic opioids. Pharmaceutical fentanyl is prescribed by doctors to treat severe pain, especially after surgery and for advanced-stage cancer. Most recently, cases of fentanyl-related overdoses are linked to illicitly manufactured fentanyl that is distributed through illegal drug markets for its heroin-like effect. It is often added to other drugs because of its extreme potency, which makes drugs cheaper, more powerful, more addictive, and more dangerous.

   b) **Fentanyl testing.** According to the Department of Public Health's (DPH's) "Facts about Fentanyl" webpage, it is nearly impossible to tell if drugs have been laced with fentanyl without the use of FTS. FTS are small strips of paper that can detect the presence of fentanyl in all different kinds of drugs (cocaine, methamphetamine, heroin, etc.) and drug forms (pills, powder, and injectables). This form of drug testing technology was originally developed for urinalysis, but have been shown to be effective at detecting the presence of fentanyl and fentanyl-analogs in drug samples prior to ingestion. According to DPH, FTS cost approximately $1.00 each and can be purchased from several vendors.

      FTS are a reliable, common-sense means of providing people at risk of fentanyl exposure with more information that may increase their safety. An evaluation of FTS use in San Francisco found that they promote increased fentanyl awareness and lead people to take safety precautions to prevent overdose if fentanyl is detected. A study involving a community-based FTS distribution program in North Carolina found that 81% of those with access to FTS routinely tested their drugs before use. Those with a positive test result were five times more likely to change their drug use behavior to reduce the risk of overdose.

      In April 2021, the Centers for Disease Control (CDC) and the Substance Abuse and Mental Health Services Administration announced federal funding could be used to purchase FTS. This purchase approval applies to all federal grant programs, like CDC's multiyear Overdose Data to Action cooperative agreement, if the purchase of FTS is consistent with the purpose of the program. The CDC states that allowing federal grant

programs to purchase FTS helps create opportunities for people who use drugs to interact with community-based organizations who may also offer behavioral health services a person needs.

c) **OTC fentanyl testing.** On October 27, 2023, the FDA cleared the Alltest Fentanyl Urine Test Cassette, the first OTC test for the preliminary detection of fentanyl in urine. According to the FDA's website, the test works by placing three drops of fresh urine onto a cassette containing a fentanyl test strip. After five minutes, the test result will appear as colored lines. The test provides only preliminary results, and additional testing must be used in order to obtain a confirmed test result. A more specific alternative chemical method (confirmation testing) must be used in order to obtain a confirmed test result. The OTC test includes a pre-addressed mailing box for shipping samples to the manufacturer's laboratory for confirmation testing. The OTC test may provide incorrect results if the urine sample is contaminated, for example by adding bleach. The test does not distinguish between drugs of abuse and certain prescribed medications, and certain foods or food supplements may give a false positive test result.

d) **Naloxone Distribution Project.** The Naloxone Distribution Project (NDP) administered through the Department of Health Care Services (DHCS) allows various entities including schools, first responders, community organizations, public health agencies, and tribal entities to apply for and obtain naloxone hydrochloride (NH) at no cost to the institution. In March of this year DHCS expanded the NDP to include all-in-one FTS kits, also at no cost to applicants. According to DHCS' website the all-in-one kits streamline the process of testing a drug for the presence of fentanyl, by packaging together a measuring scoop, the fentanyl test strip, a water pouch, and test instructions. DHCS states that by providing these free all-in-one kits they aim to help California communities who are at risk of fentanyl exposure to increase their safety and prevent overdoses.

e) **CalRx.** Originally announced in January 2019 through Executive Order and later signed into law in the California Affordable Drug Manufacturing Act of 2020, CalRx enables the state to develop, produce, and distribute generic drugs and sell them at low cost. According to a CalRx fact sheet, the state is targeting prescription drugs where the pharmaceutical market has failed to lower drug costs, even when a generic or biosimilar medication is available. In March of 2023 CalRx announced their first contract with a manufacturer, CIVICA, to manufacture and distribute $30 insulin. In April of this year, CalRx announced a partnership with Amneal Pharmaceuticals that allows the state to purchase CalRx-branded OTC NH for $24 – almost half of the current market price.

3) **SUPPORT**. Smart Justice California supports this bill, stating that in as little as five minutes, the OTC test can indicate to a provider whether their patient has used fentanyl. This indication – though preliminary – could save precious time in directing treatment, leading to improved outcomes.

4) **RELATED LEGISLATION**. SB 997 (Portantino) would permit local educational agencies to develop and adopt a policy that allows pupils at certain schools to carry OTC, nonprescription naloxone, as specified. SB 997 would also require schools to stock and distribute FTS. SB 997 is currently pending in the Assembly Education Committee.

**5) PREVIOUS LEGISLATION**.

**a)** SB 19 (Seyarto), Chapter 857, Statues of 2023, establishes, upon appropriation by the Legislature, the Fentanyl Misuse and Overdose Prevention Task Force to undertake various duties relating to fentanyl misuse including, among others, collecting and organizing data on the nature and extent of fentanyl misuse in California and evaluating approaches to increase public awareness of fentanyl misuse.

**b)** AB 33 (Bains), Chapter 887, Statutes of 2023, mirrors SB 19 (Seyarto).

**c)** SB 838 (Pan), Chapter 603, Statutes of 2022, requires CalHHS when entering into partnership contracts to produce or distribute at least one form of insulin, to establish initial and ongoing metrics to measure progress and efficiency, and remedies in the case those metrics are not met, and to include those metrics and remedies in any partnership contract. Specifies Legislative intent that any partnership contract entered into by CalHHS is a partnership intended to create a California-branded label for generic drugs; and that any manufacturing that is done is intended to benefit the residents of this state, as specified. Requires CalHHS, upon appropriation by the Legislature, to develop a California-based manufacturing facility for generic drugs, as specified.

**d)** SB 852 (Pan), Chapter 207, Statutes of 2020, requires CalHHS to enter into partnerships, in consultation with other state departments as necessary, to increase competition, lower prices, and address shortages in the market for generic prescription drugs, to reduce the cost of prescription drugs for public and private purchasers, taxpayers, and consumers, and, to increase patient access to affordable drugs.

**6) POLICY COMMENT.** This bill defines a "point-of-care test for fentanyl" as a test for use by **a provider** to detect if a person has consumed fentanyl. Given that FTS are available for use and purchase by consumers, the committee may wish to amend this bill to ensure that CalRx manufactured or distributed FTS aren't inadvertently more limited in access or usage than OTC options.

**REGISTERED SUPPORT / OPPOSITION**:

**Support**

Mayor Todd Gloria, City of San Diego
Smart Justice California

**Opposition**

None on file.

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