California State Assembly

HEALTH

MIA BONTA
CHAIR

1020 N Street, Room 390
(916) 319-2097
FAX: (916) 319-2197

AGENDA

Tuesday, June 18, 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 26	Umberg	Mental health professions: CARE Scholarship Program.
2.	SB 402	Wahab	Involuntary commitment.
3.	SB 909	Umberg	Steven M. Thompson Physician Corps Loan Repayment Program.
4.	SB 957	Wiener	Data collection: sexual orientation and gender identity.
5.	SB 963	Ashby	Health facilities: self-identifying human trafficking system.
6.	SB 980	Wahab	The Smile Act.
7.	SB 1120	Becker	Health care coverage: utilization review.
8.	SB 1147	Portantino	Drinking water: bottled water: microplastics levels.
9.	SB 1180	Ashby	Health care coverage: emergency medical services.
~~10.~~	~~SB 1238~~	~~Eggman~~	~~Lanterman-Petris-Short Act: designated facilities.~~
11.	SB 1266	Limón	Product safety: bisphenol.
12.	SB 1300	Cortese	Health facility closure: public notice: inpatient psychiatric and maternity services.
13.	SB 1319	Wahab	Skilled nursing facilities: approval to provide therapeutic behavioral health programs.
14.	SB 1333	Eggman	Communicable diseases: HIV reporting.
15.	SB 1382	Glazer	Community and rural health clinics: building standards.
16.	SB 1397	Eggman	Behavioral health services coverage.
17.	SB 1447	Durazo	Hospitals: seismic compliance: Children's Hospital Los Angeles.

Date of Hearing: June 18, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 26 (Umberg) – As Amended January 11, 2024

SENATE VOTE: 34-0

SUBJECT: Mental health professions: CARE Scholarship Program.

SUMMARY: Establishes, upon appropriation, the Community Assistance, Recovery, and Empowerment (CARE) Scholarship Program. Requires the Department of Health Care Access and Information (HCAI) to administer an annual scholarship for purposes of increasing the number of culturally competent licensed marriage and family therapists (MFTs), clinical social workers (CSWs), professional clinical counselors (PCCs), and psychologists, and requires scholarship recipients to agree to work for county behavioral health agencies in meeting its needs and obligations to implement the CARE Act for a minimum of three years upon being licensed to practice in this state. Specifically, **this bill**:

1) Establishes the CARE Scholarship Program requiring HCAI to administer an annual scholarship to increase the number of culturally competent MFTs, CSWs, PCCs, and psychologists needed to work for county behavioral health agencies to implement the CARE Act.

2) Requires HCAI to develop the necessary requirements to implement the CARE Scholarship Program, and requires applicants for the scholarship to meet all of the following requirements:
   a) Is pursuing a degree program that meets the requirements for licensure as an MFT, CSW, PCC, or psychologist; and,
   b) Agrees to work for a county behavioral health agency in support of the county's CARE Act needs and obligations for a minimum of three years upon being licensed to practice in this state.

3) Requires HCAI to post information regarding the CARE Scholarship Program on its internet website.

4) Finds and declares that, California must increase the number of culturally competent, licensed mental health practitioners that are trained and licensed to diagnose mental health disorders among unhoused individuals by incentivizing mental health practitioner graduates to work with county behavioral health agencies.

EXISTING LAW:

1) Enacts the CARE Court Act to help connect an individual with a court-ordered care plan for up to 12 months, with the possibility to extend for an additional 12 months, that provides a clinically appropriate, community-based set of services and supports that are culturally and linguistically competent, which include short-term stabilization medications, wellness and recovery supports, a CARE navigator, connection to social services, and a housing plan. [Welfare and Institutions Code (WIC) §5970, et seq.]

2) Establishes the Lanterman-Petris-Short 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. [WIC §5000, et seq.]

3) Establishes the Board of Behavioral Sciences (BBS) within the Department of Consumer Affairs to administer MFT Act, the Educational Psychologist Practice Act, the CSW Practice Act, and the PCC Act. [Business and Professions Code §4990.12]

4) Establishes HCAI to, among other functions, collect, analyze, and publish data about healthcare workforce and health professional training, identify areas of health workforce shortages, and provide scholarships, loan repayments, and grants to students, graduates, and institutions providing direct patient care in areas of unmet need. Authorizes HCAI to award competitive grants to entities and individuals it deems qualified to expand the supply of behavioral health counselors, coaches, peer supports, and other allied health care providers serving children and youth. [Health and Safety Code (HSC) §127000, §127825, et seq.]

5) Establishes the Health Professions Education Fund within HCAI to provide loans to students. Authorizes HCAI to receive private donations and specifies that all money in the fund is continuously appropriated to HCAI. [HSC §128355]

6) Establishes the Licensed Mental Health Services Provider Education Program (LMH Program) within HCAI with the mission of increasing and diversifying California's health care workforce by providing scholarships and loan repayments to health professional students and graduates who provide direct patient care. Funds the LMH Program through a $20 surcharge for renewal and licensure fees of psychologists, MFTs, CSWs, andLPCCs. [HSC §128454]

FISCAL EFFECT: According to the Senate Appropriations Committee, HCAI anticipates unknown significant General Fund (GF) cost pressures, likely several millions of dollars, for development and establishment of the scholarship program. HCAI estimates 5% of the amount appropriated would be needed for state administration

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, SB 1338 (Umberg) Chapter 319, Statues of 2022, created the CARE Act (also known as CARE Court) as a response to the urgent need for innovative solutions for individuals who are suffering with untreated schizophrenia spectrum and psychotic disorders, often unhoused in our communities, and who face high risks for repeated hospitalization, incarceration, institutionalization, mental health conservatorship, and premature death. However, it is well-documented that there is a significant shortage of behavioral healthcare professionals in California. The shortage of professionals in this space, that was apparent before the passage of CARE Court, has hindered prompt medical treatment for many Californians. Therefore, this bill aims to further support the CARE Act's implementation by creating the CARE Scholarship fund. This

program would provide annual scholarships to individuals pursuing a degree in behavioral health if they agree to work for the CARE Program in county behavior health agencies. The author concludes that this scholarship would help financially support and incentivize a new workforce to effectively implement the CARE Act and mend California's mental health, substance abuse, and homelessness crises.

2) BACKGROUND.

a) CARE Court. CARE Court was developed to help connect a person in crisis with a court-ordered care plan for up to 12 months, with the possibility to extend for an additional 12 months. The framework provides individuals with a clinically appropriate, community-based set of services and supports that are culturally and linguistically competent, which includes short-term stabilization medications, wellness and recovery supports, connection to social services, and a housing plan. According to the California Health and Human Services Agency's (CalHHS) website, housing is an important component—finding stability and staying connected to treatment, even with the proper supports, is next to impossible while living outdoors, in a tent, or in a vehicle. CalHHS states that CARE Court is an upstream diversion to prevent more restrictive conservatorships or incarceration, based on evidence that demonstrates many people can stabilize, begin healing, and exit homelessness in less restrictive, community-based care settings. The first cohort of counties to implement CARE Court included Glenn, Orange, Riverside, San Diego, Stanislaus, and Tuolumne, and the City and County of San Francisco, beginning no later than October 1, 2023. The second cohort of counties, representing the remaining population of the state, is required to begin implementing CARE Court no later than December 1, 2024, unless a county is provided additional time if it experiences a state or local emergency and the delay of the provision of the CARE Court is necessary as a result of the emergency. All counties are ultimately required to implement CARE Court by December 1, 2025.

b) LMH Program. In exchange for a 12-month service obligation to serve medically underserved areas and/or in a qualified facility in California, eligible mental health professionals may receive a loan repayment of up to $15,000. Awardees are expected to meet program requirements for the duration of the LMH Program. Applicants currently licensed and practicing in one of the eligible disciplines below can receive loan repayment assistance through the LMH Program:

i) Associate CSW;
ii) Licensed PCC;
iii) Associate MFT;
iv) Licensed Psychologist;
v) Associate PCC;
vi) Postdoctoral Psychological Assistant;
vii) CSW;
viii) Postdoctoral Psychological Trainee;
ix) MFT; and,
x) Waivered Psychologist.

An applicant must provide direct client care in one of the following eligible geographic areas or approved site designations:

i) Children's Hospital;

ii) Health Professional Shortage Area – Mental Health;
iii) Non-Profit Mental Health Facility that contracts with a county entity to provide mental health services;
iv) Clinics providing Reproductive Health and abortion-related services;
v) Publicly Funded Mental Health Facility;
vi) State-Operated Health Facility;
vii) Correctional Facility;
viii) Public Mental Health Facility;
ix) Substance Use Facility;
x) County-Operated Health Facility;
xi) Public School Facility; and,
xii) Veteran's Facility.

c) HCAI workforce programs. HCAI currently oversees the Health Care Workforce Program through its Health Care Workforce Development Division to improve access to medical, mental, and dental health care providers in underserved areas throughout California. The program conducts research to identify areas of unmet need and administers grants that provide financial incentives to individuals and institutions to increase the number of providers in those areas, as well as to promote diversity and cultural competency within the health care workforce. HCAI administers several scholarship and loan forgiveness programs that provide financial assistance to qualified health care professionals in exchange for working in underserved areas of California and provides funds to institutions that train health professionals to provide health care in California's medically underserved areas. Among these programs are the Workforce, Education, and Training (WET) program that was part of the Mental Health Services Act. The WET program aims to remedy the shortage of mental health practitioners in the public mental health system (PMHS) via programs that fund stipends, mental health loan assumption, education capacity, consumer and family member employment, and regional partnerships. Some of these funds went to create the Mental Health Loan Assumption Program, in order to retain qualified professionals working within the PMHS. Counties determine which professions are eligible for their hard-to-fill or -retain positions. Some of the eligible professions include: registered or licensed psychologists, registered or licensed psychiatrists, postdoctoral psychological assistants, postdoctoral psychological trainees, registered or licensed MFTs, registered or licensed CSWs, PCCs, PCC interns, and registered or licensed psychiatric mental health nurse practitioners in California.

d) Author's Budget request. The author has requested funding in the current year budget for the implementation of this bill, which will go into effect upon appropriation.

e) Recent budget proposals to reduce workforce funding. The 2023 Budget Act, to address a GF shortfall, implemented a package of delays and fund shifts to a number of the healthcare workforce programs adopted in the 2022 Budget Act. These delays and fund shifts included the following:

i) **CHW**. Delay of $115 million GF from 2023-24 until 2024-25 ($57.5 million) and 2025-26 ($57.5 million).
ii) **Addiction Psychiatry and Addiction Medicine Fellowship Programs.** Shift of $48.5 million from GF to Mental Health Services Fund (MHS Fund) in 2023-24.
iii) **University and College Training Grants for Behavioral Health Professionals.** Shift of $52 million from GF to MHS Fund in 2023-24.

iv) **Expand Masters in Social Work Slots at Public Schools of Social Work.** Shift of $30 million from GF to MHS Fund in 2023-24.
v) **Social Work Initiative.** Shift of $51.9 million from GF to MHS Fund in 2023-24.

In addition to these fund shifts and delays, the 2023 Budget Act included ongoing GF expenditure authority of $2.8 million to support the California Medicine Scholars Program, a pilot project to enable a statewide pathway to medicine to prepare community college students for careers as primary care physicians in underserved communities.

f) New GF and MHS Fund Budget Solutions at May Revision. The Governor's May Revision proposes the following GF budget solutions:

i) **Health Care Workforce Reductions – CHWs**. HCAI requests reduction of GF expenditure authority of $188.9 million ($6.6 million state operations and $182.3 million local assistance) in 2024-25, and $57.5 million in 2025-26 that currently supports workforce development programs for CHWs. According to HCAI, if these reductions are approved, $15 million would be available for community health workers programs.
ii) **Health Care Workforce Reductions – Nursing Initiative.** HCAI requests reduction of GF expenditure authority of $70 million ($2.7 million state operations and $67.3 million local assistance) in 2023-24, $70 million ($7 million state operations and $63 million local assistance) in 2024-25, and $70 million in 2025-26 that currently supports workforce development programs for nursing-related professionals. The January budget originally proposed delaying $70 million GF from 2023-24 until 2025-26. According to HCAI, if these reductions are approved, no additional funding would be available for the nursing initiative.
iii) **Health Care Workforce Reductions – Social Work Initiative**. HCAI requests reduction of GF expenditure authority of $70.1 million ($3.5 million state operations and $66.6 million local assistance) and expenditure authority from the MHS Fund of $51.9 million in 2025-26 that currently supports workforce development initiatives to expand the number of social workers in California. The January budget originally proposed delaying these resources from 2023-24 until 2025-26. According to HCAI, if these reductions are approved, no additional funding would be available for the social work initiative.
iv) **Health Care Workforce Reductions – Addiction Psychiatry and Medicine Fellowships**. HCAI requests reduction of expenditure authority from the MHS Fund of $48.5 million in 2025-26 that currently supports addiction psychiatry and addiction medicine fellowships. According to HCAI, if these reductions are approved, approximately $800,000 would be available for addiction psychiatry or addiction medicine fellowships.
v) **Health Care Workforce Reductions – University and College Grants for Behavioral Health Professionals**. HCAI requests reduction of expenditure authority from the MHS Fund of $52 million in 2025-26 that currently supports expansion of grants for behavioral health professionals. The January budget originally proposed delaying these resources from 2023-24 until 2025-26. According to HCAI, if these reductions are approved, no additional funding would be available for university and college grants for behavioral health professionals.
vi) **Health Care Workforce Reductions – Expansion of Masters in Social Work Slots**. HCAI requests reduction of expenditure authority from the MHS Fund of $30 million in 2025-26 that currently supports expansion of slots for Masters in Social

Work (MSW) in California colleges and universities. The January budget originally proposed delaying these resources from 2023-24 until 2025-26. According to HCAI, if these reductions are approved, no additional funding would be available for the expansion of MSW slots in California.

vii) **Health Care Workforce Reductions – Psychiatry Local Behavioral Health Programs**. HCAI requests reduction of expenditure authority from the MHS Fund of $7 million in 2025-26 that currently supports loan repayment programs for psychiatrists who agree to a term of service at a local behavioral health department. The January budget originally proposed delaying these resources from 2023-24 until 2025-26. According to HCAI, if these reductions are approved, no additional funding would be available for psychiatry loan repayment programs for local behavioral health.

viii) **Health Care Workforce Reductions – California Medicine Scholars Program.** HCAI requests reduction of GF expenditure authority of $2.8 million in 2024-25, 2025-26, and 2026-27, that currently supports medical professional pipeline programs through the California Medicine Scholars Program. According to HCAI, if these reductions are approved, $2.8 million would remain available for the California Medicine Scholars Program.

ix) **Health Care Workforce Reductions – Health Professions Careers Opportunity Program**. HCAI requests reduction of annual GF expenditure authority of $16 million ($800,000 state operations and $15.2 million local assistance) that currently supports the Health Professions Careers Opportunity Program. According to HCAI, if these reductions are approved, this would be an ongoing reduction of $16 million to the Health Professions Careers Opportunity Program.

x) **Health Care Workforce Reductions – Song-Brown Nursing.** HCAI requests reduction of GF expenditure authority of $15 million in 2024-25 that currently supports nurse training in the Song-Brown Healthcare Workforce Training Program. According to HCAI, if these reductions are approved, $1 million would be available for nursing training in Song-Brown.

xi) **Health Care Workforce Reductions – Song-Brown Residencies.** HCAI requests reduction of GF expenditure authority of $10 million in 2024-25 that currently supports residency programs in the Song-Brown Healthcare Workforce Training Program. According to HCAI, the ongoing $33 million GF resources allocated to Song-Brown residencies would continue in 2025-26 and beyond.

xii) **Health Care Workforce Reductions – Prior Year Healthcare Workforce**. HCAI requests reduction of GF expenditure authority of $231 million ($3.5 million state operations and $227.5 million local assistance) in 2023-24 to reflect unspent prior year funds and current year savings for health care workforce programs.

xiii) **Children and Youth Behavioral Health Initiative – Workforce Programs.** According to HCAI, $208.3 million would be maintained for behavioral health workforce programs implemented as part of the Children and Youth Behavioral Health Initiative. A significant portion of these resources support development and training of certified wellness coaches, recently added as a benefit in the Medi-Cal program. According to the Medi-Cal Local Assistance Estimate, wellness coaches offer six core services, including: (1) wellness promotion and education; (2) screening; (3) care coordination; (4) individual support; (5) group support; and, (6) crisis referral.

3) **SUPPORT**. The BBS supports this bill and states that this bill would create a scholarship program in order to incentivize those seeking licensure as an MFT, CSW, PCC, or psychologist to work in a county behavioral health agency in support of the CARE Act. The BSS is supportive of this effort to encourage employment in underserved areas where it is most needed. In its discussion, the BBS also wished to relay to the author that there are several counties which have not yet updated their administrative systems so that they are able to employ PCCs. PCCs are the BBS's newest license type, and the BSS began issuing this license type in 2012. Currently, there are approximately 4,300 actively licensed PCCs in California. Ensuring that all counties are able to utilize PCCs is an additional avenue that could help ensure sufficient staffing to implement the CARE Act.

4) **OPPOSE UNLESS AMENDED.** ACLU California Action, California Youth Empowerment Network, Disability Rights California, and Mental Health America of California write in coalition that they share the authors' interest in expanding the workforce available to support individuals living with serious mental illness who are unlikely to survive safely in the community without supports, and whose condition is substantially deteriorating. The coalition notes that many of these individuals are unhoused in our community and face high risks for repeated hospitalization, incarceration, institutionalization, mental health conservatorship, and premature death and the numbers show that California does not have enough mental health professionals, peers, and outreach workers specialized in supporting this population, and they agree that the State must immediately take steps to fill this gap. The coalition urges the author to expand this bill to incentivize mental health professionals to serve in an array of roles and programs evidenced to meet the needs of individuals with serious mental illness and housing instability. The coalition states they will oppose this bill unless it is amended to expand the proposed scholarship program to accept applicants who agree to work for a county behavioral health agency for at least three years in support of any of the county's programs to treat individuals with serious mental illness and housing instability, not just CARE Court.

   The coalition also notes that Counties are working to roll out new mental health programs that will require significant personnel, such as mobile crisis teams. However, this bill proposes to only incentivize licensed mental health professionals to serve in roles related to CARE Court, a new program that has no evidence basis or proven results, while leaving counties still unable to fill roles in their existing and other emerging programs.

5) **PREVIOUS LEGISLATION**.

   a) AB 921 (Bonta) of 2023 would have required HCAI to establish a mentorship program to connect eligible students enrolled in a relevant undergraduate program or in an HCAI-approved behavioral health certification program with concrete resources and mentorship that would convert the educational experience to sustained employment. AB 921 was held on the Assembly Appropriations Committee suspense file.

   b) AB 2666 (Salas) of 2022 would have required HCAI to establish and administer a grant program to allocate stipends to students in behavioral health fields of study and practice who are participating in internships or completing licensure hours at federally qualified health centers (FQHCs). AB 2666 was vetoed by Governor Newsom, who stated in part, that he shares the author's commitment to supporting a strong pipeline of trained behavioral health professionals, but this program is duplicative of California's recent

efforts in this area. HCAI has programs that provide stipends to behavioral health professionals including those that choose to work in FQHCs. Today, many of California's students who are studying to become behavioral health providers and who can provide post-graduate services at certain facilities receive financial support from HCAI's Allied Healthcare Scholarship Program. Additionally, the 2022 Budget includes a $1.4 billion health care workforce initiative, including $248 million over five years to increase the number of licensed behavioral health professionals through grants to existing university or college behavioral health professional training programs, as well as through stipends, scholarships, and loan repayment.

c) SB 539 (Caballero) of 2019 would have created the Mental Health Services Workforce Education and Training Account, as specified, to be continuously appropriated to HCAI for the purpose of funding the WET five-year plan. SB 539 was held on the Senate Appropriations Committee suspense file.

d) AB 1619 (Weber) of 2019 would have appropriated $20 million from the GF to HCAI to increase available grant moneys for students eligible to apply for Mental Health Loan Assumption Program and to, among other things, attract and encourage eligible students from culturally and ethnically diverse communities. AB 1619 was held on the Assembly Appropriations Committee suspense file.

6) **POLICY COMMENT.** Given the breadth of the types of mental health professionals eligible for loan forgiveness when serving medically underserved areas and/or in a qualified facility in California under the existing LMH Program, and the Mental Health Loan Assumption Program (which is specific to public health/county programs), as well as the deep cuts proposed to workforce programs in the Governor's May Revision, the Author may wish to consider whether or not instructing HCAI to develop a duplicative program without funding is the best use of limited state workforce dollars.

REGISTERED SUPPORT / OPPOSITION:

Support

Association of Independent California Colleges & Universities (AICCU)
Board of Behavioral Sciences
California Contract Cities Association
The Chicago School

Opposition

None on file.

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

Date of Hearing: June 18, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 402 (Wahab) – As Amended January 12, 2024

SENATE VOTE: 37-1

SUBJECT: Involuntary commitment.

SUMMARY: Adds licensed mental health professionals (LMHPs) to the list of those authorized to initiate involuntary holds for those who are found to be a danger to self or others, or gravely disabled. Specifically, **this bill**:

1) Adds LMHP, as defined, to the list of those authorized to initiate involuntary holds for those who are found to be a danger to self or others, or gravely disabled.

2) Defines LMHP as a psychiatrist, psychologist, licensed clinical social worker, licensed marriage and family therapist, or a licensed professional clinical counselor who has completed all required supervised clinical experience and who is designated by the county.

EXISTING LAW:

1) Establishes the Lanterman-Petris-Short Act (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) Permits a county behavioral health director to develop procedures for the county's designation and training of professionals who will be designated to perform functions for involuntary holds, as specified. [WIC §5121]

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, this bill will allow for appropriately trained LMHPs to initiate the placement of an individual experiencing a mental health crisis on a 72 hour involuntary hold—or what is called a 5150 hold. The author argues that mental health professionals are significantly limited in providing support to vulnerable populations, even with current law allowing for community based organizations to provide prevention & early intervention services. The author continues that the current framework reveals

limitations that hinder our ability to respond adeptly to mental health crises by first responders and healthcare professionals. The author states that this bill seeks to rectify this by authorizing a broader spectrum of licensed mental health professionals to intervene promptly in mental health emergencies; all of whom work one-on-one with those struggling with mental health. The author concludes that this strategic expansion aligns with contemporary best practices, ensures more inclusive crisis response, reduces the burden on law enforcement, and ultimately enhances public safety.

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) County designation. The LPS Act permits a county behavioral health director to develop procedures for designating and training people to initiate involuntary holds—outside of peace officers. Those procedures may include, but not be limited to, the following:

i) The license types, practice disciplines, and clinical experience of professionals eligible to be designated by the county;

ii) The initial and ongoing training and testing requirements for professionals eligible to be designated by the county;

iii) The application and approval processes for professionals seeking to be designated by the county, including the timeframe for initial designation and procedures for renewal of the designation; and,

iv) The county's process for monitoring and reviewing professionals designated by the county to ensure appropriate compliance with state law, regulations, and county procedures.

3) SUPPORT. The California Police Chiefs Association (CPCA) supports this bill, stating that when an individual experiencing a psychiatric crisis presents a significant risk of harming themselves or others, there will be a need for law enforcement to protect both the individual and the public. CPCA argues that it remains important to expand LMHP's role in these situations in order to not overly rely on a law enforcement response. CPCA continues that many cases, it is more than appropriate to have LMHPs initiate an involuntary hold. North East Medical Services (NEMS) also supports this bill, stating that allowing licensed mental health professionals who have a preexisting relationship with their patients to also initiate a 5150 hold could potentially reduce the intensity, danger, and mistrust that usually occurs when a hold is initiated. NEMS argues that people who are undergoing mental health crises are often further triggered when encountered by law enforcement and this bill would allow for people who are experiencing a mental health crisis to be first approached by a person they trust, which could reduce the need for law enforcement in certain situations. NEMS continues that this bill merely aims to reduce, not eliminate, the need for law enforcement involvement.

4) OPPOSITION. ACLU California Action is opposed to this bill stating that it increases the likelihood that more holds will be placed, not that fewer people will engage with peace officers. The ACLU contends that involuntary commitment should be used in only a narrow set of circumstances because a 5150 hold can lead to weeks or months of detainment, job loss, and trauma, and these holds do not have robust evidence of long-term success in addressing mental health needs. The ACLU cites concerns that this bill expands the universe of people with the discretion to limit a person's autonomy in a way that lacks evidence basis or necessary guardrails. The ACLU continues that not all mental health professionals are trained in crisis response or risk assessment, arguing that under this bill counties would be encouraged to allow a marriage and family therapist who provides couples' counseling, or a licensed social worker who works as a middle manager at a food bank, to place people into involuntary commitment. The ACLU further contends that community safety instead requires creation and expansion of non-law enforcement alternatives, such as AB 118 (Kamlager), Chapter 694, Statutes of 2021, which has proven that emergency interventions can be "addressed more safely, with greater impact, and more cost effectively and efficiently by community-based organizations which often have deeper knowledge and understanding of the issues, trusted relationships with the people and communities involved, and specific knowledge and relationships surrounding the emergency."

5) PREVIOUS LEGISLATION.

a) SB 929 (Eggman), Chapter 539, Statutes of 2022, expands the Department of Health Care Services' responsibility in current law to collect and publish information about involuntary detentions to include additional information, including the number of persons admitted or detained and the amount of times they have been admitted or detained; clinical outcomes for specified individuals, including the services provided or offered to them; waiting periods for individuals prior to receiving an evaluation; and, an analysis

and evaluation of the efficacy of mental health assessments, detentions, treatments, and supportive services.

b) AB 1443 (McCarty), Chapter 399, Statutes of 2021, permits a county to develop training and procedures related to taking, or causing to be taken, a person into custody for an involuntary detention, as specified. Requires the County of Sacramento to develop a written policy for training and procedures for designating persons who are employed by the City of Sacramento and who meet specified criteria to involuntarily detain individuals.

6) DOUBLE REFERRAL. This bill is double referred; upon passage in this Committee, this bill will be referred to the Assembly Committee on Judiciary.

7) POLICY COMMENTS.

a) Stated intent vs. language in this bill. The author of this bill argues that it authorizes LMHPs to initiate involuntary holds. Under the LPS Act an involuntary hold can be 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. Current law permits a county to develop procedures for the county's designation and training of people who will be permitted to perform functions for 5150 holds. This means counties have authority to ultimately decide the appropriateness of designating certain individuals, including LMHPs. This bill does nothing to change a county's authority in creating their own designation standards and processes for individuals that place 5150 holds. This bill does unnecessarily state a narrow definition of LMHPs who can be, and in many counties already are, designated to initiate 5150 holds.

The author also argues that this bill will reduce law enforcement involvement in 5150 holds and crisis response. There is nothing in this bill that in effect reduces law enforcement involvement in either instance. Once an LMHP initiates an involuntary hold, the mechanics of enforcement of that involuntary hold will require police to be called as they are the only agency with the authority to involuntarily transport someone. The author's office and proponents of this bill have argued that an LMHP will be equipped with the tools from their training and clinical experience to de-escalate and get an individual to willingly go to treatment – but if this is the case, the person would be **voluntarily** agreeing to treatment and there is no need for an **involuntary** 5150 hold to be initiated. Some proponents of this bill have also argued that LMHPs can call an ambulance or mobile crisis team if involuntary transportation is needed, but neither emergency medical technicians nor mobile crisis units have the authority to transport people against their will.

The author and proponents of this bill have also stated that some licensed professionals are excluded from designation under current law and that counties are not designating practitioners that are not employees or contracted. Current law permits any "professional person" to be designated by the county – there are no requirements that they work for or be contracted with the county. In speaking with various counties, this committee learned about a range of professionals who are designated across the state ranging from emergency room doctors to community based organizations. What is true is that counties have control over their designation authority, and processes differ county by county.

Counties are charged with delivering all specialty mental health services in their community, and are thus given the agency to build protocols and processes that reflect the diversity of their county mental health system's needs. Rural, urban, large, and small counties will all have differing needs, capacities, and resources. Additionally, 5150 designation is a huge responsibility – it is a rare area in our state's law where people are granted the authority to strip away a person's autonomy with no Miranda Rights. Counties can therefore be selective in their designation processes to ensure they are able to appropriately train, oversee, and ultimately take on liability for those in their jurisdiction with this power.

8) **PROPOSED AMENDMENTS.** While the language in this bill does not achieve the author's stated goals, this bill has highlighted an important gap in recent legislative efforts to collect more data on the LPS Act across the state. The Committee may wish to amend this bill to expand upon SB 929 by adding the collection of data on county designees and their professions, the number of involuntary holds initiated by designees and peace officers, and the number of designations denied or revoked by a county. These data would create transparency around county designation processes and involuntary holds by peace officers and designees across the state. These data would additionally ensure the Legislature and stakeholders can make informed and evidence-based proposals to alter these processes, as needed.

REGISTERED SUPPORT / OPPOSITION:

Support

Behavioral Health Collaborative of Alameda County
California Police Chief's Association
City of Fremont
La Familia Counseling Service
North East Medical Services
Westcoast Children's Clinic

Opposition

ACLU California Action
Cal Voices
Citizens Commission on Human Rights
Disability Rights California
Mental Health America of California

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

Date of Hearing: June 18, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 909 (Umberg) – As Amended June 10, 2024

SENATE VOTE: 39-0

SUBJECT: Steven M. Thompson Physician Corps Loan Repayment Program.

SUMMARY: Makes changes to the parameters of the Steven M. Thompson Physician Corps Loan Repayment Program (STLRP) including: Removing the requirement for the Department of Health Care Access and Information (HCAI) to establish an advisory committee for the STLRP and updating the definition of the practice setting in which a physician can practice. Decreases the service obligation to two years in a medically underserved area (MUA). Authorizes HCAI to award up to 20% of the funds established with the Medically Underserved Account for Physician (Account) for applicants from specialties outside of the primary specialties, and authorizes HCAI to create additional positions, not using funds from the account. Removes the maximum limit for loan repayments per individual physician who has completed three consecutive years of services in an MUA.

EXISTING LAW:

1) Establishes HCAI, and requires HCAI to administer multiple workforce development activities. Establishes the STLRP under HCAI, which provides for the repayment of educational loans for physicians who practice in MUAs of the state, as defined. [Health and Safety Code (HSC) §127000, et seq., §128550, *et seq*.]

2) Requires HCAI to develop guidelines for the selection and placement of STLRP applicants, with priority consideration given to applicants best suited to meet the cultural and linguistic needs of patients by meeting such criteria as speaking a Medi-Cal threshold language, being from an economically disadvantaged background, having significant training in culturally and linguistically appropriate service delivery, having completed a three-year residency in a primary specialty, and, agreeing to practice in an MUA. [HSC §128553]

3) Authorizes HCAI to award up to 20% of available positions to program applicants from specialties outside of the primary care specialties. [*Ibid.*]

4) Establishes the Account within Health Professions Education Foundation (HPEF), with the primary purpose of providing funding for the ongoing operations of STLRP. Prohibits loan repayments under the program from exceeding $105,000 per licensed physician and from exceeding the amount of the educational loans incurred by the recipient. [HSC §128555]

5) Reserves funds generated by the recent passage of Proposition 1 for HCAI to administer a behavioral health workforce initiative in collaboration with the California Health and Human Services Agency (CalHHS). Prohibits funding for this purpose from exceeding thirty-six million dollars. Makes the funds available subject to appropriation in the annual Budget Act. [Welfare and Institutions Code 5892]

6) 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 Insurance Code §10144.5]

FISCAL EFFECT: According to the Senate Appropriations Committee, unknown, ongoing cost pressures (Health Professions Education Fund) due to potential increases in fund expenditures for loan repayments.

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, CalHHS designates 172 regions in the state as MUAs, and roughly 11 million Californians live in areas with shortages of primary health care providers. To combat this, the STLRP provides physicians with up to $105,000 in loan debt forgiveness in exchange for three consecutive years of service in MUAs. Unfortunately, this limit of $105,000, established in 2002, is too low to account for medical student debt trends. According the Association of American Medical Colleges, the average medical student's debt rose over $150,000 in the past 20 years. Accordingly, the financial incentive that may have worked when the program first started has less force today.

2) **BACKGROUND**.

   a) **California physicians**. According to a March 2021 California Health Care Foundation (CHCF) report "California Physicians: A Portrait of Practice," although the number of active physicians increased by 21% between 2006 and 2018, and exceeded the 10% population growth, many areas in California face substantial shortages of primary care providers and specialists. Key findings of the CHCF report include:

      i) The supply of licensed physicians does not adequately reflect their availability to provide care. Less than half of California's physicians provided patient care 40 or more hours per week;
      ii) Physician supply varied by region. Out of nine regions in the state, only four regions (Greater Bay Area, Orange County, Sacramento Area, San Diego Area) had the recommended supply of primary care physicians (PCPs). The Inland Empire and San Joaquin Valley had the lowest supply of PCPs and specialists;
      iii) Over one-third of California's physicians were over 60. Physicians over 50 work fewer hours per week on patient care than their younger counterparts;
      iv) The Latinx population is underrepresented among physicians. Latinx represented 39% of California's population, but only 6% of the state's physicians and 8% of the state's medical school graduates;
      v) Physicians were less likely to accept uninsured patients than patients with any type of insurance, including Medi-Cal; and,
      vi) California ranked first in the nation in the percentages of both medical students and residents who remain in the state to practice.

   b) **STLRP.** STLRP was established in 2003 to increase access to health care and promote the retention of primary care physicians in California MUAs. STLRP is funded through a $25 surcharge on physician licenses. Eligible applicants may receive loan repayments of up to $105,000 in exchange for a 36-month service obligation providing direct outpatient

care in a "qualified facility" (largely clinics, substance use facilities, government-operated facilities, Native American health centers, children's hospitals, and other federally designated Health Professional Shortage Area facilities). To be eligible for an STLRP award, each applicant must be currently licensed and practicing one of the following disciplines: family medicine, general internal medicine, general pediatrics, emergency medicine, gerontology, obstetrics/gynecology, psychiatry, or surgery; and, must:

i) Possess a valid and unrestricted Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO) license to practice in California;
ii) Be in good standing with the Medical Board of California (MBC) or the Osteopathic Medical Board of California (OMBC);
iii) Not have any other existing service obligations with other entities, including other HCAI programs;
iv) Not be in breach of any other health professional service obligation;
v) Have completed a three-year residency;
vi) Have unpaid educational loans;
vii) Commit to providing a three-year full-time (40 hours/week) service obligation in a MUA or qualifying facility in California;
viii) Provide 32 hours or more per week of direct patient care (exception: obstetricians must be providing at least 21 hours of direct patient care); and,
ix) Be practicing outpatient care (patients must not be admitted to the hospital).

c) STLRP awards. According to HCAI, since the program's inception in 2003, STLRP has received 2,940 applications, awarded more than $101 million to 1,195 recipients providing direct patient care, and monitored awardees' compliance with the three-year service obligation in a qualifying practice setting. Approximately 80% of all recipients are PCPs. The following table is based on the most recent information available from HCAI:

Application Cycles – Fiscal Year (FY) 2021-22, FY 2022-23, and FY 2023-24

FY	Applicants	Awarded	Dollars Awarded	Award Start Date
2021-22	80	68	$6,334,794.00	3/31/2022
2022-23	105	88	$8,867,479.61	3/31/2023
2023-24	70	25	$2,292,554.00	10/31/2023
TOTAL	**255**	**181**	**$17,494,827.61**	

Application Cycle Results – FY 2021-22, FY 2022-23, and FY 2023-24

FY	Applicants	# of Counties (Applicants)	Total Applicant Educational Debt	Awarded	Eligible, but Not Awarded	Ineligible
2021-22	80	23	$18,332,266	68	0	12
2022-23	105	28	$23,482,407	88	7	10
2023-24	70	11	$14,594,118	25	31	14
TOTAL	**255**	**62**	**$56,408,791**	**181**	**38**	**36**

Specialty Certifications Awarded – FY 2021-22, FY 2022-23, and FY 2023-24

American Board of Medical Specialties Certifications	FY 2021-22 Recipients	FY 2022-23 Recipients	FY 2023-24 Recipients	TOTAL
Family Physician	24	36	12	**72**
Gerontologist			1	**1**
Internist	9	10	2	**21**
OB/GYN	6	10	3	**19**
Pediatrician	8	11	5	**24**
Psychiatrist	3	10		**13**
Emergency Med & Other Specialties	18	11	2	**31**
TOTAL	**68**	**88**	**25**	**181**

Based on the past three award cycles, 77% of applicants awarded received the maximum award amount of $105k. The remaining 23% had educational debt that was lower than the $105k maximum and received lower award amounts. HCAI awards the maximum to most awardees so long as they demonstrate that they have educational debt at or above that amount. According to HCAI, most awardees demonstrate debt amounts above the maximum award level.

d) Psychiatric Education Capacity Expansion (PECE). HCAI also administers the PECE Grant Programs. These workforce programs promote the expansion of postsecondary education and training to meet behavioral health workforce needs. For 2023-24, up to $37.5 million will be available for the PECE program. HCAI is offering a one-time grant opportunity with no implied or expressed guarantee of subsequent funding after the initial contract award resulting from the application. Awardees must use the funding to create new and expanded Psychiatry Residency Programs, or enhance the capacity of Psychiatric Mental Health Nurse Practitioner (PMHNP) training programs to meet mental health occupation shortage needs.

e) Revisions to STLRP. As recently amended, this bill makes several significant revisions to STLRP, including adding psychiatry to the list of primary specialties. This will allow HCAI to support the increase of newly trained psychiatrists created through HCAIs' psychiatry education expansion programs.

The STLRP Account is currently funded with a $25 surcharge on physician licenses. Recent amendments authorize HCAI to create additional positions for program applicants from specialties outside of primary specialties, using funds separate from the Account. This provides HCAI with the flexibility to make awards and create additional positions with other funding that may be available, such as funds from Proposition 1, which could be used to fund PECE programs, while preserving the original primary care focus of the STLRP awards financed through the $25 surcharge.

f) Proposition 1. In the 2024 statewide primary election, California voters approved Proposition 1, which revises and recasts the Mental Health Services Act as the Behavioral Health Services Act (BHSA). The act among other things, modifies local and state spending priorities under the BHSA, provides funding for HCAI workforce initiatives, and renames the Mental Health Services Oversight and Accountability Commission to the Behavioral Health Services Oversight and Accountability Commission and changes the duties of the Commission to include promoting transformational change in California's behavioral health system. Proposition 1 goes into effect on January 1, 2025.

3) SUPPORT. The Ella Baker Center for Human Rights (EBCHR) supports this bill and states that Medical school debt averages have increased substantially since the program's inception. While the $105,000 limit may have sufficed with respect to contemporary debt averages (e.g., graduates in 1998 owing ~$85,200 on average), it fails to withstand increases to tuition and the cost-of-living. Recent medical school graduates—faced with $239,700 in debt on average—may opt for more fiscally advantageous employment opportunities over participation in STLRP. EBCHR concludes that this bill revitalizes the STLRP by removing the maximum payment limit, so that it may once again provide meaningful support to doctors practicing in underserved communities.

4) RELATED LEGISLATION. SB 26 (Umberg) establishes, upon appropriation, the Community Assistance, Recovery, and Empowerment Scholarship Program. Requires HCAI to administer an annual scholarship for purposes of increasing the number of culturally competent licensed marriage and family therapists, clinical social workers, professional clinical counselors, and psychologists, and requires scholarship recipients to agree to work for county behavioral health agencies in meeting its needs and obligations to implement the

CARE Act for a minimum of three years upon being licensed to practice in this state. SB 26 is pending a hearing in Assembly Health Committee.

5) PREVIOUS LEGISLATION.

a) AB 133 makes a number of revisions to provisions of law governing HCAI programs, including deleting language that tiered and capped loan repayment amounts for STLRP, and instead requires HCAI to establish terms of loan repayment.

b) AB 565 (Maienschein) of 2019 and AB 2018 (Maienschein) of 2018 would have expanded the definition of "practice setting" for purposes of STLRP to include a program or facility operated by, or contracted to, a county mental health plan; and, would have required 20% of the available STLRP scholarships to be awarded to applicants in certain practice specialties. AB 565 and AB 2018 were held on the Senate Appropriations Committee suspense file.

c) AB 2539 (Mathis) of 2018 and AB 148 (Mathis) of 2017 would have changed the definition of "practice setting" for purposes of applying to participate in the STLRP to include practice settings in rural areas with at least 30% of patients who are uninsured, Medi-Cal beneficiaries, or beneficiaries of another publicly funded program. AB 2539 and AB 148 were held on the Senate Appropriations Committee suspense file.

d) SB 1471 (Hernandez) of 2016 would have required any funds over $2 million in the Managed Care Administrative Fines and Penalties Fund (MCAFP) to be used for the purposes of the STLRP. SB 1471 was held on the Assembly Appropriations Committee suspense file.

e) AB 565 (Salas), Chapter 378, Statutes of 2013, revised the definition of a practice setting for purposes of the STLRP to include a physician-owned and-operated medical practice setting that provides primary care located in a MUA.

f) SB 20 (Hernandez), Chapter 24, Statutes of 2014, requires, beginning on the date that the California Major Risk Medical Insurance Program becomes inoperative, all the funds in the MCAFP to be transferred for use by STLRP.

g) AB 860 (Perea and Bocanegra) of 2013 would have appropriated $600,000 from the MCAFP Fund to the STLRP. AB 860 was held on the Assembly Appropriations Committee suspense file.

h) SB 635 (Hernandez) of 2012 was substantially similar to SB 20, but would have instead transferred the MCAFP funds to a newly created Song-Brown Program Account, which would have supported training for health care professionals. SB 635 was held on the Assembly Appropriations Committee suspense file.

i) SB 606 (Ducheny), Chapter 600, Statutes of 2009, requires the OMBC to assess an additional $25 fee for issuance or renewal of a license. Requires the funds to be transferred to the STLRP and permits osteopathic physicians to be eligible to apply for the program.

j) SB 1379 (Ducheny), Chapter 607, Statutes of 2008, requires fines and administrative penalties levied against health plans to be placed in the MCAFP Fund and used, upon appropriation by the Legislature, for a physician loan repayment program and MRMIP.

k) AB 2439 (De La Torre), Chapter 640, Statutes of 2008, mandates the MBC assess a $25 fee to applicants for issuance or renewal of a physician license. Requires up to 15% of the funds collected be dedicated to loan assistance for physicians who agree to practice in geriatric care settings or settings that primarily serve adults over the age of 65 or adults with disabilities.

l) AB 1403 (Nuñez), Chapter 367, Statutes of 2004, renames the California Physician Corps Loan Repayment Program as STLRP.

m) AB 982 (Firebaugh), Chapter 1131, Statutes of 2002, establishes the California Physician Corps Loan Repayment Program.

REGISTERED SUPPORT / OPPOSITION:

Support

Mayor Todd Gloria, City of San Diego
California Chapter American College of Cardiology
California Chapter of the American College of Emergency Physicians
CPCA Advocates, Subsidiary of the California Primary Care Association
California Rheumatology Alliance
California Society of Plastic Surgeons
Children's Bureau of Southern California
Ella Baker Center for Human Rights
Prosecutors Alliance
Prosecutors Alliance of California, a Project of Tides Advocacy
Smart Justice California, a Project of Tides Advocacy
Uncommon Law

Opposition

None on file.

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

Date of Hearing: June 18, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 957 (Wiener) – As Introduced January 22, 2024

SENATE VOTE: 31-8

SUBJECT: Data collection: sexual orientation and gender identity.

SUMMARY: Requires, rather than permits, the California Department of Public Health (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. Specifically, **this bill**:

1) Requires, rather than permits, DPH to collect demographic data, including SOGI and intersexuality data, from third parties, including, but not limited to, local health jurisdictions, on any forms or electronic data systems, unless prohibited by federal or state law. Requires DPH to provide a report to the Legislature on this data by July 1, 2026.

2) Adds SOGI to the information reported for the purpose of statewide or local immunization information systems.

3) Requires DPH to prepare an annual report concerning SOGI data. Requires DPH to annually post the report on its website and to submit it to the Legislature. Requires the annual report to exclude any personally identifiable information. Requires the report to include:

    a) DPH's efforts to collect, analyze, and report SOGI data, including a comprehensive list of forms through which the collection of SOGI data is required under existing law, the level of compliance with SOGI data collection requirements through those forms, the forms exempt from those requirements, and the reasons for those exemptions;

    b) The status of any improvement or replacement of the California Reportable Disease Information Exchange (CalREDIE);

    c) The outcomes of data analyses that DPH has performed, or has allowed other qualified researchers to perform, using SOGI data has been collected;

    d) The steps that DPH has taken, or has caused to be taken, to improve services or program outcomes for underserved lesbian, gay, bisexual, transgender, queer, or questioning (LGBTQ) populations; and,

    e) Until fully implemented, the progress that DPH has made in implementing recommendations set forth in a report (numbered 2022-102 and dated April 27, 2023) by the California State Auditor's (CSA) Office.

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

5) Finds, due to the sensitive general nature of data relating to sexual orientation, gender identity, and intersexuality and the need to protect the safety of those who would provide voluntary self-identification information pertaining to their sexual orientation, gender identity, or intersexuality, that it is necessary to prohibit the public disclosure of personal identifying information that would allow the identification of an individual who provided voluntary self-identification information pertaining to sexual orientation, gender identity, or intersexuality.

EXISTING LAW:

1) Requires DPH, among other specified state agencies, in the course of collecting demographic data as to the ancestry or ethnic origin of Californians, to also collect voluntary self-identification information pertaining to SOGI and intersexuality. Permits these state agencies to collect this demographic data either pursuant to federal programs or surveys, or through any other state offices, departments, and agencies; surveys administered by third-party entities; or, third-party entities, including private employers, that provide aggregated data. [Government Code (GOV) §8310.8]

2) Requires specified state agencies, including DPH, to report to the Legislature the data collected in 1) above and the method used to collect that data, and make the data available to the public in accordance with state and federal law, except for personal identifying information, which is deemed confidential and cannot be disclosed. [GOV §8310.8(c)]

3) Requires any electronic tool used by local health officers (LHOs) for the purpose of reporting cases of communicable disease to DPH to include the capacity to collect and report data relating to the SOGI of individuals who are diagnosed with a reportable disease, and requires health care providers who are in attendance on a case of a reportable disease to report the patient's SOGI, if known. [Health and Safety Code (HSC) §120255]

4) Permits LHOs and DPH to operate immunization information systems, separately or jointly. Requires health care providers and other entities, including schools, child care facilities, health plans, foster care agencies, and county human services agencies, to disclose specified immunization and other personal information about the patient or client (such as the patient's or client's date of birth, race and ethnicity, and gender) to local health departments (LHDs) and DPH. Permits LHDs and DPH to disclose most of that information, as specified, to each other and to other entities. Permits a patient or a patient's parent or guardian to refuse to permit record sharing, as specified. [HSC §120440]

FISCAL EFFECT: According to the Senate Appropriations Committee, unknown, ongoing costs, likely hundreds of thousands (General Fund) for DPH for administration, including activities related to collecting the data and preparing the annual report. Unknown, potential ongoing costs (General Fund), for local health jurisdictions and LHDs to comply with new data reporting and disclosure requirements. Cost to counties for administration would be potentially reimbursable by the state, subject to a determination by the Commission on State Mandates.

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, this bill implements the recommendations from last year's CSA report that found that DPH is failing to adequately assess health disparities faced by the LGBTQ community. The author states that this bill requires the DPH to collect SOGI data from third-party entities, including local health jurisdictions, on any forms or electronic data systems. The author contends that the Mpox [monkeypox] outbreak of 2022 showed once again the danger of leaving LGBTQ health invisible to the public health system. The author concludes that by forcing DPH to finally collect SOGI Data, this bill takes us one step closer to health equity.

2) **BACKGROUND**.

   a) **Health Disparities Among Those in the LGBTQ Population.** In 2016 the National Institutes of Health designated sexual and gender minorities as a health disparity *population,* which means a population that disproportionately experiences differences in health outcomes that are often preventable. According to the Public Policy Institute of California, approximately 9% of adults in California, or 2.7 million people, identified in 2022 as lesbian, gay, bisexual or transgender.

   Although SOGI data is not yet widely available to perform health outcome analyses, some studies have already established that individuals who identify LGBTQ face significantly higher risks of a variety of health problems, including the leading causes of death in California in 2020: cancer, heart disease, and COVID-19. For example, the American Association for Cancer Research highlighted a study that analyzed data from the National Health Interview Survey from 2013 through 2016 and found that gay men had greater than 50% increased odds of a reported cancer diagnosis, and bisexual women had 70% increased odds of a reported cancer diagnosis, when compared to their respective heterosexual counterparts. The American Heart Association reported in 2020 that adults in the LGBTQ population experience worse cardiovascular health relative to their cisgender heterosexual peers. A 2021 study from the Centers for Disease Control and Prevention (CDC) found that adults in the LGBTQ population experience a high prevalence of several health conditions that have been associated with severe COVID-19, such as cancer, kidney or heart disease, breathing issues, obesity, diabetes, hypertension, and stroke. The CDC study also acknowledged that COVID-19 surveillance systems have not captured SOGI data and that doing so would improve knowledge about disparities in infection and adverse outcomes that could have informed a more equitable response to the pandemic.

   b) **Audit findings.** The 2023 CSA report, numbered 2022-102, and titled "California Department of Public Health: It Has Missed Opportunities to Collect and Report Sexual Orientation and Gender Identity Data," states that DPH has been slow to adopt and enforce standardized definitions, guidelines, and training to ensure the consistent collection, analysis, and reporting of demographic data that details SOGI. As a result, DPH has limited ability to identify and address health disparities that exist among those in the LGBTQ population. Specifically, the CSA found:

      i) DPH collects SOGI data on only a small portion of the forms it uses to gather demographic data. Of the 129 forms reviewed, 105 were exempt, but not prohibited,

from collecting SOGI data. Most of these forms were exempt because the data is collected by a third party, such as a local health jurisdiction. This exemption severely limits the amount of SOGI data DPH is required to collect. Lack of clear and consistent policies and procedures have also hindered collection of SOGI data. Of the remaining 24 forms required to collect SOGI data, only 17 do so in a complete manner;

ii) DPH's system for collecting and reporting data on communicable diseases, CalREDIE, is inadequate for collecting and reporting SOGI data. Because of resource and technical limitations, DPH cannot export the SOGI data it collects for over 100 of the 128 reportable disease conditions in CalREDIE. Three of California's largest local health jurisdictions (the counties of Los Angeles, San Francisco, and San Diego) do not use CalREDIE to report certain diseases. Instead of resolving the technical issues, DPH plans to replace its current system with a new surveillance system in 2025;

iii) DPH has only made SOGI data available to the public from 17 of the forms the CSA reviewed, and it has not reported directly to the Legislature any SOGI data from the forms reviewed; and,

iv) Despite their critical role in collecting SOGI information, DPH has not provided guidelines, training, or resources to local health jurisdictions or health care providers regarding definitions for collecting SOGI information or for recommended questions and response fields.

c) CSA recommendations. CSA made four key recommendations as a result of their audit:

i) The Legislature should amend the SOGI data collection law to require DPH to collect SOGI data from third-party entities, including local health jurisdictions, on any forms or electronic data systems unless prohibited by federal or state law;

ii) The Legislature should require DPH to provide an annual report to the public and to the Legislature that highlights its efforts to improve SOGI data collection and address health disparities;

iii) DPH should standardize its definitions and provide guidance for how its forms should ask questions related to sexual orientation and gender identity, and it should implement procedures to review and approve its branches' SOGI data collection processes, including a review of its branches' reasons for not collecting SOGI data; and,

iv) DPH should develop an action plan to ensure that CalREDIE users and Public Health programs can extract SOGI data for all of the reportable disease conditions currently in CalREDIE.

This bill implements the recommendations in i) and ii) above, and requires DPH to include in the report required by ii) above its progress on implementing the recommendations set forth the audit.

d) DPH's response to the audit findings. During a March 15, 2024 Senate Budget and Fiscal Review Subcommittee #3 hearing, DPH provided testimony stating that it is working diligently to address the audit findings. There is a SOGI data workgroup (convened in 2022) that is working with LHDs and community organizations to update its set of data collection standards and recommendations for reporting. DPH reported that they are on track to meet the audit recommendations, with milestones as follows:

i) DPH Director approval of SOGI data workgroup best practices and standards by October 2023 (completed);

ii) Develop a SOGI data collection reference document for LHDs and others outside of DPH with the goal of producing best practice standards for display by August 2024;

iii) Develop processes for county communicable disease offices that are not using CalREDIE (including compliance with SOGI data reporting requirements) by March 2026;

iv) Ensure CalREDIE users and public health programs can extract SOGI data for all reportable diseases by June 2024;

v) Create processes, policies, and procedures for standardized form review and monitoring by September 2024; and,

vi) Ensure that CalREDIE can receive SOGI data by LHDs by July 2026 (DPH does not have funding to meet this milestone).

e) Potential Benefits of Collecting and Analyzing SOGI data. The CSA's report notes that the San Francisco Department of Homelessness and Supportive Housing has gathered substantial SOGI data and has implemented LGBTQ-targeted initiatives. These initiatives have led to a 33% increase, from the previous year, in LGBTQ households accessing permanent housing solutions. DPH's Office of AIDS has also used SOGI data to identify vulnerable populations, and as a result, DPH has implemented the PrEP/PEP Navigator Project to provide direct services to people in these specific priority populations, including transgender women. Navigator Projects allow physicians, health educators, and outreach workers to collaborate in identifying and addressing barriers to successful treatment.

These efforts demonstrate that collecting and analyzing SOGI data can help identify and understand the health and other disparities that people who identify as LGBTQ face and can offer direction to public health officials working to resolve these disparities.

3) SUPPORT. According to Equality California, the San Francisco AIDS Foundation and the California LGBTQ Health and Human Services Network, cosponsors of this bill, collecting accurate SOGI data is essential to understanding the extent to which LGBTQ+ people in California are experiencing disparities in health and well-being and whether government programs are reaching LGBTQ+ people in need of care and assistance. The cosponsors continue that failing to collect accurate SOGI data makes the LGBTQ+ community invisible and undermines opportunities to ensure that all Californians receive the care and services they need. The cosponsors argue that this oversight can have significant consequences for

LGBTQ+ people, including increased stigma, misinformation, ineffective service provision, and a delayed response to public health emergencies like COVID-19 and the recent Mpox outbreak. The cosponsors state to ensure that DPH collects complete SOGI data to effectively deliver services for LGBTQ+ people, this bill will require DPH to collect SOGI data from third-party entities, including local health jurisdictions, on all forms or electronic data systems unless prohibited by federal or state law. This bill will also allow voluntarily provided SOGI data to be included in the statewide immunization registry to better identify immunization-related disparities among LGBTQ+ people. The cosponsors conclude that this bill will require DPH to provide an annual report to the public and to the Legislature on its efforts to collect, analyze, and report SOGI data as well as its progress in implementing the recommendations from the state audit.

4) **RELATED LEGISLATION**. AB 3161 (Bonta) requires hospitals to provide demographic information about patients when reporting adverse events, requires DPH to revise the process for submitting complaints against hospitals and long-term care facilities by permitting complainants to include demographic information, requires the patient safety plan for hospitals and skilled nursing facilities to include a process for addressing racism and discrimination, including monitoring sociodemographic disparities in patients safety events, and permits DPH to impose a fine of up to $5,000 on health facilities for failure to adopt, update, or submit patient safety plans. AB 3161 is pending in the Senate Judiciary Committee.

5) **PREVIOUS LEGISLATION**.

   a) AB 1163 (Luz Rivas), Chapter 832, Statutes of 2023, expands the list of state entities required to collect voluntary self-identification information on SOGI to include the Department of State Hospitals, the Department of Rehabilitation, the Department of Developmental Services, and the Department of Community Services and Development.

   b) SB 932 (Wiener), Chapter 183, Statutes of 2020, requires any electronic tool used by LHOs for the purpose of reporting cases of communicable disease to DPH to include the capacity to collect and report data relating to the SOGI of individuals who are diagnosed with a reportable disease, and requires health care providers who are in attendance on a case of a reportable disease to report the patient's SOGI, if known.

   c) AB 677 (Chiu), Chapter 744, Statutes of 2017, expands the list of state entities required to collect voluntary self-identification information on SOGI to include various education and employment-related agencies.

   d) AB 959 (Chiu), Chapter 565, Statutes of 2015, requires the Department of Health Care Services, DPH, the Department of Social Services, and the Department of Aging to collect voluntary self-identification information on sexual orientation and gender identity, beginning no later than July 1, 2018, when collecting demographic data.

6) **PROPOSED AMENDMENTS.** The author is proposing amendments to do the following:

   a) Clarify that providers should not report information that is not voluntarily provided, or disclose any information relating to any patient or client who is under 18.

b) Amend the existing "intersexuality" language to "variations in sex characteristics/intersex status," amend, "SOGI" to "SOGISC," and;

c) Amend the reporting provision in Sec. 4 to ensure that the department's reports reflect the collected intersex data as well.

d) Renames the Lesbian, Gay, Bisexual and Transgender Disparities Reduction Act to the Lesbian, Gay, Bisexual, Transgender and Intersex Disparities Reduction Act.

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

REGISTERED SUPPORT / OPPOSITION:

Support

A Seat At the Table Books
AARP
ABD/Skywatchers
Amador County Arts Council
API Equality-LA
APLA Health
Asian Americans Advancing Justice Southern California
Bienestar Human Services
California Democratic Party
California LGBTQ Health and Human Services Network
California Pan-ethnic Health Network
California School-based Health Alliance
California State University, Fresno
California Transcends
CASA Neighborhoods
Children Now
City of Long Beach
Connecting for Better Health
Courage California
Democrats for Israel - CA
Democrats for Israel Los Angeles
El/la Para TransLatinas
End the Epidemics: Californians Mobilizing to End HIV, Viral Hepatitis, STIs, and Overdose
Equality California
Etta
Gender Justice LA
Glide
GLSEN
GLSEN San Diego County
Hadassah
Harvey Milk LGBTQ Democratic Club
Health Access California
Healthright 360

Holocaust Museum LA
Institute for Immigrant & LGBTQ Justice
Insure the Uninsured Project
Jcrc Bay Area
Jewish Center for Justice
Jewish Community Federation and Endowment Fund
Jewish Democratic Club of Marin
Jewish Democratic Club of Solano County
Jewish Democratic Coalition of The Bay Area
Jewish Family and Children's Service of Long Beach and Orange County
Jewish Family and Children's Services of San Francisco, the Peninsula, Marin and Sonoma Counties
Jewish Family Service of Los Angeles
Jewish Family Service of San Diego
Jewish Family Services of Silicon Valley
Jewish Federation of Greater Los Angeles, the
Jewish Federation of The Greater San Gabriel and Pomona Valleys
Jewish Long Beach
Jewish Public Affairs Committee
Jewish Silicon Valley
Justice in Aging
Latino Coalition for A Healthy California
Lavender Alliance At Sac State
LGBT Community Network
LGBTQ Center OC
LGBTQ Center Orange County
LGBTQ+ Collaborative
Los Angeles Lgbt Center
Lyon-Martin Community Health Services
Madera Coalition for Community Justice
National Center for Lesbian Rights
National Health Law Program
Oasis Legal Services
Orchid Angel Consulting
Our Family Coalition
Parivar Bay Area
PRC
PRC Baker Places
Progressive Zionists of California
Public Law Center
Queer Hmong Intersectional Pride
Radiant Health Centers
Rainbow Pride Youth Alliance
Sacramento LGBT Community Center
San Diego Pride
San Francisco AIDS Foundation
San Francisco Pretrial Diversion Project
San Joaquin Pride Center
SF LGBT Center

Solano Pride Center
Somos Familia
Somos Familia Valle
Still Bisexual
The Center for Sexuality & Gender Diversity
The Children's Partnership
The Gubbio Project
The Source LGBT+ Center
The Trevor Project
Tom Homann LGBTQ+ Law Association
TransFamily Support Services
Transgender Advocates for Justice and Accountability Coalition
Transgender Health and Wellness Center
Transgender Resource, Advocacy & Network Service
TransYouth Liberation
Viet Rainbow of Orange County
Western Center on Law & Poverty, INC.
Youth Leadership Institute

Opposition

None on file.

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

Date of Hearing: June 18, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 963 (Ashby) – As Amended June 11, 2024

SENATE VOTE: 38-0

SUBJECT: Health facilities: self-identifying human trafficking system.

SUMMARY: Requires all general acute care hospitals (GACHs) with an emergency department (ED) to adopt and implement policies and procedures to facilitate the self-identification of an ED patient as a victim of human trafficking or domestic violence to hospital personnel. Specifically, **this bill**:

1) Requires all GACHs with an ED to adopt and implement policies and procedures to facilitate the self-identification of an ED patient as a victim of human trafficking or domestic violence to hospital personnel.

2) Requires the policies and procedures adopted and implemented pursuant to 1) above to meet all of the following minimum requirements:
   a) Provides for patient confidentiality in accordance with the Confidentiality of Medical Information Act;
   b) Provides an ED patient with a safe and discreet means of informing hospital personnel that they are a victim of human trafficking or domestic violence;
   c) Facilitates a reasonably prompt and private interview of the patient by hospital personnel for the purpose of providing information to the patient pursuant e) below, and clarifies that a patient is not required to participate in a private interview if the patient declines;
   d) Defines "hospital personnel" to includes any health care professional licensed under the Business and Professions Code;
   e) Refers patients to local services and resources for victims of human trafficking or domestic violence, if any, and,
   f) Incorporates principles of trauma-informed care.

3) Authorizes every GACH subject to the provisions of this bill to track the use of the self-identification procedure, including the total number, ages, and racial demographics of patients who self-identify as a victim of human trafficking or domestic violence, to the extent that this information is provided by the patient.

4) Prohibits a GACH subject to the provisions of this bill from being required to report the identities of any patients who self-identify as a victim of human trafficking or domestic violence to the Department of Public Health (DPH) or to any law enforcement agency, except as may be required pursuant to 4) of Existing Law, below.

5) Exempts a GACH, including its directors, officers, employees, medical staff, contracted health care providers, and agents, and all persons licensed under the Business and Professions Code acting in compliance with this bill, from being liable for any injuries or damages arising from or related to a patient who is offered or receives the information in 2) above, or who self-identifies, including any injuries inflicted by a trafficker or abuser based

on acts or omissions taken pursuant to the policies and procedures established pursuant to this section; so long as they have acted in good faith.

6) Specifies that the liability limitations described in 5) above, are not to be construed to limit a person's liability for any act or omission that constitutes gross negligence or willful or wanton misconduct.

EXISTING LAW:

1) Licenses and regulates health facilities, including GACHs, by DPH. [Health and Safety Code §1250, *et seq*.]

2) Requires a health practitioner, as defined, employed by a health facility, clinic, physician's office, local or state public health department, or a local government agency, who provides medical services to a patient whom the health practitioner knows or reasonably suspects is a person described as follows, to immediately make a report to a local law enforcement agency:
   a) A person suffering from a wound or other physical injury inflicted by the person's own act or inflicted by another where the injury is by means of a firearm; or,
   b) A person suffering from a wound or other physical injury as a result of assaultive or abusive conduct. [Penal Code (PEN) §11160 et seq.]

3) Requires, under the Child Abuse and Neglect Reporting Act, a "mandated reporter" (which includes teachers, peace officers, firefighters, and health care practitioners, among others) to make reports of suspected child abuse or neglect to law enforcement agencies, as specified. [PEN §11164 et seq.]

4) Requires, under the Elder Abuse and Dependent Adult Civil Protection Act, health practitioners, among others, to report known or suspected cases of abuse of elders and dependent adults. [Welfare and Institutions Code §15600 et seq.]

5) Defines the following terms:
   a) "Human trafficking" as, in part, a person who deprives or violates the personal liberty of another with the intent to obtain forced labor or services, or who causes, induces, or persuades a minor to engage in a commercial sex act. [PEN §236.1]
   b) "Domestic violence" as, in part, abuse committed against an adult or a minor who is a spouse, former spouse, cohabitant, former cohabitant, or person with whom the suspect has had a child or is having or has had a dating or engagement relationship. [PEN §13700(b)]

6) Requires a list of specified businesses and establishments, including EDs within GACHs, urgent care centers, and facilities that provide pediatric care, to post a notice in a conspicuous place near the public entrance that states the following (in part): "If you or someone you know is being forced to engage in any activity and cannot leave – whether it is commercial sex, housework, farm work, construction, factory, retail, or restaurant work, or any other activity – text 233-733 (Be Free) or call the National Human Trafficking Hotline at 1-888-373-7888 or the California Coalition to Abolish Slavery and Trafficking (CAST) at 1-888-KEY-2-FRE(EDOM) or 1-888-539-2373 to access help and services." [Civil Code (CIV) §52.6]

7) Prohibits, under the state Confidentiality of Medical Information Act, a health care provider, a health care service plan, a contractor, a corporation and its subsidiaries and affiliates, or any business that offers software or hardware to consumers, including a mobile application or other related device, as defined, from intentionally sharing, selling, using for marketing, or otherwise using any medical information, as defined, for any purpose not necessary to provide health care services to a patient, except as expressly authorized by the patient, enrollee, or subscriber, as specified, or as otherwise required or authorized by law. States that a violation of these provisions that results in economic loss or personal injury to a patient is a crime. [CIV §56, *et. seq*.]

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, existing initiatives within hospital EDs have demonstrated their effectiveness in identifying human trafficking victims, particularly impacting the lives of women and children in dangerous situations. These programs serve as a vital foundation for the proactive identification of trafficking victims, addressing a concerning trend where many victims, despite seeking emergency medical attention, often go unnoticed. The author concludes that this bill seeks to build on the successes of existing programs by further strengthening the capacity of all emergency rooms to detect and support victims of human trafficking and violence, further emphasizing the importance of equipping emergency rooms with the necessary resources to empower victims to self-identify safely, without fear of consequences from a suppressor

2) **BACKGROUND**. Human trafficking is a violation of human rights, involving force, coercion, or fraud to exploit a person into slave labor or sexual exploitation. Human trafficking happens to people of all ages and genders and any race or religious background.

   a) **Human Trafficking and the ED.** According to a 2020 report in *Emergency Medicine Resident,* "Concealed but Not Forgotten: Human Trafficking in the ED," Emergency physicians are in a unique position to recognize human trafficking, as the ED may be the first or only contact a victim has with the medical community.

      The report notes that in 2018, the National Human Trafficking Hotline received the most calls from California, followed by Texas and Florida. It is also estimated that 50,000 people are trafficked into the United States each year, most often from Mexico and the Philippines. In 2018, 1,649 human trafficking victims were cited in criminal cases with approximately half being adult and half being children. Child-only sex trafficking encompasses 52% of cases and females make up 94% of all human trafficking victims identified. The internet was used to facilitate trafficking in 88% of the cases. It is estimated that only 0.04% of victims and survivors of human trafficking cases are identified.

      Although there is no true profile of a human trafficking victim, individuals who were at one time homeless and runaway youth have been shown to make up greater than 50% of prostitutes. Foreign nationals and individuals who have experienced trauma and violence in the past are also noted to be at increased risk of exploitation through human trafficking.

Studies have shown that 50% to 90% of human-trafficking victims have sought medical care while being trafficked. This population suffers from increased morbidity and mortality, both while being trafficked and after surviving trafficking. Victims that are forced into prostitution have an increased rate of being murdered and increased overall mortality when compared to the general population. Mortality rates for victims of child- and labor-trafficking are more difficult to ascertain as these victims are often concealed by their perpetrators.

b) Sutter Health protocol. According to the author, Sutter Health has implemented a self-identification protocol for trafficking victims that was at least partly the impetus for this bill. According to Sutter Health, its practice for assisting patients who are potentially victims of human trafficking includes a discrete method that allows patients to self-identify without alerting their abuser. This is a very delicate scenario as abusers often attempt to control every moment and activity of their victim. Patients suspected of being victims of human trafficking are provided a bag containing a urine cup, a blue dot sticker and asked to give a urine sample. Inside both men's and women's restrooms are posted instructions in multiple languages directing individuals in an abusive situation to place the dot on the urine sample cup. The cup is then placed in the lab who notifies the registered nurse (RN) of the presence of a blue dot. The RN will notify a Case Manager, Social Worker, or House Supervisor of possible human trafficking. A bogus order for an X-ray is submitted and the patient is isolated in Diagnostic Imaging to have a private conversation to determine if the patient needs help. If they need services, staff follows the steps to connecting with appropriate support and care and notify the police department. All contacts with suspected abusers occur with Law Enforcement off site and away from any other Sutter Health patients or staff.

3) SUPPORT. This bill is cosponsored by the California Medical Association, CAST and San Francisco SafeHouse. According to the sponsors, EDs and front-line healthcare workers have the opportunity to play a role in identifying victims of domestic violence and human trafficking. Sponsors cite a 2010 study that found ED personnel have the highest likelihood of coming into contact with human trafficking victims, and trafficking victims are more likely to talk to medical staff than police. A 2016 survey from CAST found that although 64% of survivors had accessed healthcare at least once during their trafficking situation, almost all (97%) were never provided information or resources about trafficking from healthcare providers. Sponsors state that California has a chance to become a leader in ensuring that survivors are identified and connected to services in a trauma-informed manner. Sutter Health writes in support that it understands the importance of their role in this system and have implemented programs, like those outlined in this bill, in their EDs to help victims of human trafficking, and believes that their programs have been able to break the cycle of abuse these victims incur.

4) PREVIOUS LEGISLATION.

a) SB 376 (Rubio), Chapter 109, Statutes of 2023, provides that a victim of human trafficking or abuse has the right to have a human trafficking advocate and a support person, of the victim's choosing at an interview by a law enforcement authority.

b) AB 1740 (Sanchez), Chapter 104, Statutes of 2023, added pediatric care facilities to the list of establishments that must post a notice regarding human trafficking.

c) AB 2130 (Cunningham), Chapter 256, Statutes of 2022, requires every emergency medical technician, upon initial licensure, to complete at least 20 minutes of training on issues relating to human trafficking

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

REGISTERED SUPPORT / OPPOSITION:

Support

California Medical Association (cosponsor)
Coalition to Abolish Slavery and Trafficking (cosponsor)
San Francisco SafeHouse (cosponsor)
California Association of Nurse Anesthetists
California Chapter of The American College of Emergency Physicians
California Emergency Nurses Association
California Hospital Association
California Kidney Care Alliance
California Nurses Association
FIndHelp, a Public Benefit Corporation
San Francisco Marin Medical Society
Sutter Health

Opposition

None on file.

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

Date of Hearing: June 18, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 980 (Wahab) – As Amended June 10, 2024

SENATE VOTE: 38-0

SUBJECT: The Smile Act.

SUMMARY: Requires Medi-Cal Dental coverage of dental implants and aligns statute with current policy related to age criteria for coverage of laboratory-processed crowns and coverage of such crowns on anterior teeth. Specifically, **this bill**:

1) Covers dental implants for qualified persons of any age if extraction or removal of the corresponding tooth is medically necessary or if the corresponding tooth is missing, subject to conditions specified in 2) below. Defines "qualified" as a person who has no medical contraindications to dental implant surgery.

2) Specifies that a dental implant is covered subject to prior authorization and on the condition that no other covered functional alternatives for prosthetic replacement would correct the person's dental condition, as determined by the provider in consultation with an oral surgeon or periodontist.

3) Covers laboratory-processed (lab-processed) crowns on all teeth for individuals 13 and over, consistent with current Department of Health Care Services (DHCS) policy.

4) Prohibits coverage of dental implants or lab-processed crowns, as specified above, from being construed to exclude Medi-Cal coverage for the same, if otherwise required under early and periodic screening, diagnostic, and treatment services pursuant to federal or state law.

EXISTING LAW:

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

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

3) Specifies coverage of adult dental benefits. [WIC § 14131.10]

4) Covers, to the extent funds are made available in the annual Budget Act, for persons 21 years of age or older, lab-processed crowns on posterior teeth when medically necessary to restore a posterior tooth back to normal function based on the criteria specified in the Medi-Cal Dental Manual of Criteria. [WIC § 14132.88]

5) Requires covered dental benefits and accompanying criteria for receipt of those dental benefits under the Medi-Cal program to be identified in the Medi-Cal Dental Manual of Criteria. Requires DHCS to evaluate all covered dental benefits for evidence-based practices

consistent with the American Academy of Pediatric Dentistry and the American Dental Association guidelines. [*Ibid.*]

FISCAL EFFECT: According to the Senate Committee on Appropriations:

1) Unknown, ongoing costs to provide Medi-Cal benefit coverage for dental implants, as specified (General Fund and federal funds).

2) DHCS indicates no fiscal impact related to the coverage of lab-processed dental crowns, since the Medi-Cal program currently provides this coverage.

COMMENTS:

1) PURPOSE OF THIS BILL. Today, the author notes, Californians are suffering from dental issues by simply having teeth removed without having a functional option for replacement. According to the author, we have a growing aging population that demands deeper investments in all systems that protect and support our vulnerable communities. The author cites the large number of people covered by Medi-Cal and asserts they lack meaningful dental care. The author indicates Medi-Cal offers tooth extractions as well as dental implant removals as a covered benefit, however, dental implants are not a covered benefit. This leads to other oral health issues, creating quality of life issues and other health concerns. The author concludes that the Smile Act is a step toward ensuring fair and equitable access to dental services and allow a better quality of life.

2) BACKGROUND.

a) Tooth Loss. Tooth loss is a debilitating and irreversible condition that one recent study described as the "final marker of disease burden for oral health." Tooth loss can impact facial physiology and lead to bone loss, as well as affect one's speech, ability to eat and chew, and quality of life. People with lower income and education levels, poorer oral health, and poorer general health are more likely to have tooth loss.

b) Dental Prosthesis Devices. Dental prosthesis devices can replace or repair missing or damaged teeth. These devices include fixed appliances, such as crowns, bridges, and implants; and removable devices, such as full or partial dentures:

i) Dental Crowns. A tooth is trimmed down and a new covering is placed upon the tooth. Dental crowns may be provided as either prefabricated crowns or lab-processed crowns that are custom built.

ii) Dental Bridges. Crowns are placed on either side of a missing tooth or missing teeth, and artificial teeth are connected to the crowns to "bridge" the gap created by the missing tooth or teeth. Bridges are also called fixed partial dentures or bridgework.

iii) Dental Implants. A dental implant replaces the root of a tooth, and is installed into the bone. The process includes several steps: removing the tooth and potentially doing a bone graft, implanting a screw or other device to take the place of a root, healing, potentially placing a temporary tooth, and later installing the artificial tooth.

iv) **Dentures**. A denture is a removable replacement for missing teeth and surrounding tissues. Dentures can be complete, when all the teeth are missing, or partial.

c) **Medicaid Requirements and State Optional Benefits**. Medicaid programs are required to cover dental services for all child enrollees. Adult dental benefits are optional for states, meaning they have flexibility to determine what dental benefits are provided to adult Medicaid enrollees. According to the Centers for Medicare and Medicaid Services, while most states provide at least emergency dental services for adults, less than half of the states currently provide comprehensive dental care. There are no minimum federal requirements for adult dental coverage.

d) **Medi-Cal Adult Dental Coverage and Recent Adult Dental Changes**. Medi-Cal now covers a fairly comprehensive set of adult dental benefits at the state's option. However, along with a list of other optional Medi-Cal benefits, adult dental benefits were eliminated from Medi-Cal in 2009 as a budget cost-cutting solution. In May 2014, Medi-Cal adult dental benefits were partially restored. The 2014 restored benefits included basic preventive, diagnostic, restorative, anterior tooth endodontic treatment, complete dentures and complete denture reline/repair services. Effective January 1, 2018, the remaining adult optional dental benefits that were previously covered were restored, including additional exams, deep cleanings, lab-processed crowns, partial dentures, and root canals in posterior teeth. SB 184 (Committee on Budget and Fiscal Review), Chapter 47, Statutes of 2022, updated Medi-Cal Dental criteria for lab-processed crowns.

   Medi-Cal will pay up to $1,800 in a year for covered dental services for adults, although there are exceptions for pregnancy and medically necessary services that exceed the $1,800 limit on a case by case basis.

e) **Medi-Cal Current Coverage of Dental Implants.** According to the current Medi-Cal Dental Manual of Criteria that specifies Medi-Cal Dental coverage policy, dental implant services are a covered benefit only when exceptional medical conditions are documented and pursuant to a finding of medical necessity by the Medi-Cal Dental program. Implants are only considered medically necessary when other medical prostheses (e.g., full or partial dentures and bridges without an implant) cannot be used due to underlying medical problems such as skeletal deformities, oral cavity cancer, or traumatic injury such that a dental implants are the only prosthesis that will work. The policy also specifies that single implants are not covered, but that implant removals are a covered service, as is tooth extraction generally. This bill significantly expands coverage of dental implants.

f) **Medi-Cal Coverage of Lab-Processed Crowns**. Until 2022, Medi-Cal coverage of lab-processed crowns was very restrictive. As noted in d) above, SB 184 updated Medi-Cal Dental criteria for lab-processed crowns. Specifically, the update changed the criteria to allow a person 21 years of age or older receive lab-processed crowns on posterior teeth when medically necessary to restore a posterior tooth back to normal function. The Medi-Cal Dental Manual of Criteria extends this coverage to children aged 13 or older and does not limit lab-processed crowns to posterior teeth. This bill codifies this current policy.

g) **Dental Provider Shortage and Low Utilization**. It is important to consider the expansion of adult dental benefits in context of current utilization of the Medi-Cal dental

program and overall challenges in access to dental providers. According to the February 2024 Dental Fee-For-Service and Dental Managed Care Performance Fact Sheet published by DHCS, Dental Utilization in Adults Ages 21+, only about a quarter of adults have had an annual dental visit over the last several years. This is among adults enrolled in fee-for-service Medi-Cal Dental (the majority of Medi-Cal enrollees), while utilization among adults enrolled in most dental plans in Sacramento and Los Angeles counties were even lower. To sum up, every year, three-quarters of Medi-Cal enrolled adults are not receiving basic preventive dental care.

According to the Health Services Resource Administration, 2.9 million Californians live in 535 designated health professional shortage areas. Dentists even in areas with an adequate workforce are less likely to accept new patients insured by Medicaid.

3) **SUPPORT**. This bill is supported by a long list of consumer and aging advocates, who point to the positive impact of replacing a lost tooth with a dental implant on a patient's health and quality of life. According to California Alliance for Retired Americans (CARA), this bill's sponsor, families on Medi-Cal are already at the poverty threshold, so they have no financial means to pay thousands of dollars out of pocket for a dental procedure that should be a covered benefit under Medi-Cal. CARA asserts the lack of accessible dental services across the state means everyday Californians who are suffering from dental issues are simply having teeth removed without having that tooth replaced. According to the Western Center on Law and Poverty (WCLP), although lab-processed crowns for back teeth are narrowly covered by Medi-Cal, the very high standards DHCS imposes means that essentially no custom crowns are approved. WCLP indicates this bill would improve access by including front teeth and expanding access to people ages 13 and over.

4) **SUPPORT IF AMENDED**. California Dental Association (CDA) has a support if amended position on this bill, and seeks amendments to expand coverage for basic prevention and treatment services and make strategic investments in improving reimbursement rates for existing services. CDA notes that dental implants are a costly benefit. In the commercial market, CDA states, implants can cost several thousand dollars. Furthermore, CDA indicates that while implants are becoming more commonly utilized, they are often not covered by commercial dental insurance and there are other, less invasive, and lower-cost options for replacing missing teeth, including bridges and partial dentures. While California's Medi-Cal dental benefit covers many adult dental services, CDA argues there are still significant gaps in coverage, including basic prevention and treatment that would better support Medi-Cal beneficiaries in maintaining existing teeth and replacing lost teeth.

   CDA also has significant concerns about the state's ability to fully fund a benefit as costly and extensive as dental implants, given the historically low Medi-Cal reimbursement rates. Accordingly, CDA argues underfunding a benefit like dental implants will further compromise the Medi-Cal Dental program without increasing access for patients. For instance, CDA notes a lab-processed crown can cost a dental office upwards of $1,200, including materials, lab fee and dental team staff time, but that Medi-Cal reimburses far less. CDA requests that this bill be amended to also increase the rate for lab-processed crowns.

5) **RELATED LEGISLATION**. AB 2701 (Villapudua) requires Medi-Cal dental coverage of one additional prophylaxis cleaning and periodic dental exam per year (a total of two per

year) for adults age 21 and over, when medically necessary. AB 2701 is pending in the Senate Health Committee.

6) PREVIOUS LEGISLATION.

a) SB 184 requires DHCS to consider evidence-based practices consistent with the American Academy of Pediatric Dentistry and the American Dental Association guidelines for all covered dental benefits, and provides Medi-Cal dental coverage of lab-processed crowns on posterior teeth for adults older when medically necessary to restore a posterior tooth back to normal function.

b) AB 82 (Committee on Budget), Chapter 23, Statutes of 2013, partially restored Medi-Cal adult dental benefits including basic preventive, diagnostic, and restorative services.

c) SB 97 (Committee on Budget and Fiscal Review), Chapter 52, Statutes of 2017, fully restored adult optional dental benefits that were not restored through AB 82.

7) POLICY COMMENT. This bill requires broad coverage for dental implants, which are often more complicated and involved than other procedures that are covered on a very limited basis by Medi-Cal Dental, such as fixed partial dentures (dental bridges). Dental implants also require placement of the device into the bone and are generally placed by dental specialists like oral surgeons and prosthodontists, making them often more invasive, time-consuming, and costly than alternatives.

Similar to concerns expressed by CDA, staff notes that requiring broad coverage of implants without considering coverage of dental prosthesis more holistically may create incongruity in Medi-Cal Dental coverage that may seem illogical in the field. For instance, an individual may be faced with a situation where a dental bridge is appropriate, less costly, and less invasive, but Medi-Cal Dental coverage is not available, and yet the individual could potentially receive coverage for a dental implant. Staff does not have a specific recommendation on amendments to this bill to address this issue, since this more holistic analysis would represent a fundamentally different approach than that of this bill. However, the author may wish to consider ways to resolve this issue so that the Medi-Cal Dental benefit remains coherent and balanced overall across various prosthetic options, as well as consider, on a practical basis, how reimbursement levels and the shortage of dental providers may impact the effectiveness of this proposed expansion to Medi-Cal Dental.

REGISTERED SUPPORT / OPPOSITION:

Support

AARP
Advisory Council for Sourcewise
Alameda County Democratic Central Committee
California Alliance for Retired Americans
California Alternative Payment Program Association
California Association of Orthodontists
California Commission on Aging
California Conference of Machinists

California IHSS Consumer Alliance
California Long Term Care Ombudsman Association (CLTCOA)
California OneCare
California State Council of Service Employees International Union
Californians for SSI
Caring Across Generations
County Health Executives Association of California (CHEAC)
Courage California
Educate. Advocate.
Health Access California
Healthy California Now
Jewish Family Service of Los Angeles (UNREG)
Justice in Aging
Movement to End Privatization of Medicare
National Union of Healthcare Workers (NUHW)
North East Medical Services
On Lok Senior Health Services
San Francisco Senior and Disability Action
Sourcewise
UDW/AFSCME Local 3930
UNITE HERE, AFL-CIO
Western Center on Law & Poverty, INC.

Opposition

None on file.

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

Date of Hearing: June 18, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1120 (Becker) – As Amended June 10, 2024

SENATE VOTE: 37-0

SUBJECT: Health care coverage: utilization review.

SUMMARY: Requires algorithms, artificial intelligence (AI), and other software tools used for utilization review (UR) or utilization management (UM) decisions to comply with specified requirements, including that it be based on an enrollee or insured's medical history and individual clinical circumstances, and be fairly and equitably applied. Specifically, **this bill**:

1) Requires health plans and insurers, or a specialized health plan or insurer covering dental services, to comply, as part of their UR or UM functions, using algorithms, AI, and other software tools, with all of the following:

    a) Be based upon an enrollee or insured's medical or dental history and individual clinical circumstances as presented by the requesting provider, as well as other relevant clinical information contained in the enrollee or insured's medical or dental record, and to not supplant health care provider decisionmaking;

    b) Not directly or indirectly discriminate on the basis of race, color, religion, national origin, ancestry, age, sex, gender, gender identity, gender expression, sexual orientation, present or predicted disability, expected length of life, degree of medical dependency, quality of life, or other health conditions;

    c) Be fairly and equitably applied;

    d) Be open to inspection and disclosed in the written policies and procedures required by existing law that medical necessity decisions are consistent with criteria or guidelines that are supported by clinical principles and processes;

    e) Be governed by policies that establish accountability for performance, use, and outcomes that are reviewed and revised for accuracy and reliability;

    f) Not allow data to be used beyond its intended and stated purpose; and,

    g) Be protected from risk that may directly or indirectly cause harm to the enrollee or insured.

2) Requires a denial, delay, or modification of health care services based on medical necessity to be made by a licensed physician or other health care provider competent to evaluate the specific clinical issues involved in the health care services requested by the provider and with the same or similar specialty as the requesting provider, as provided in 4) of existing law below, by considering the requesting provider's recommendation and based on the enrollee or insured's medical or dental history, as applicable, and individual clinical circumstances.

3) Defines AI as an engineered or machine-based system that varies in its level of autonomy and that can, for explicit or implicit objectives, infer from the input it receives how to generate outputs that can influence physical or virtual environments.

EXISTING LAW:

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

2) Requires health plans to demonstrate that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management. [HSC §1367]

3) 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, to be disclosed to the provider and the enrollee or insured in that specified case; and,
   e) Be available to the public upon request. [HSC §1363.5 and INS §10123.135]

4) 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, is 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]

5) Establishes the Independent Medical Review (IMR) process as part of the DMHC or CDI appeal process when a health plan or insurer 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 and INS §10169]

6) 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]

FISCAL EFFECT: According to the Senate Appropriations Committee, DMHC estimates costs of approximately $18,000 in 2024-25, $4,671,000 in 2025-26, $4,192,000 in 2026-27, $3,780,000 in 2027-28, $4,781,000 in 2028-29, and $4,779,000 in 2029-30 and annually thereafter for state administration (Managed Care Fund). CDI anticipates minor fiscal impacts (Insurance Fund).

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, recent reports of automated decision tools inaccurately denying provider requests to deliver care is worrisome. While AI has the potential to improve healthcare delivery, trained medical professionals who understand the complexities of each patient's situation need to have the final say. Wrongful denial of insurance claims based on AI algorithms can lead to serious health consequences, and even death. The author concludes that this bill strikes a common sense balance that puts safeguards in place for automated decision tools without discouraging companies from using this new technology.

2) **BACKGROUND**.

   a) AI And GenAI. In a draft regulation, the California Privacy Protection Agency (CPPA), the entity tasked with implementing and enforcing the California Privacy Rights Act of 2020, defines AI as follows:

> AI means a machine-based system that infers, from the input it receives, how to generate outputs that can influence physical or virtual environments. The AI may do this to achieve explicit or implicit objectives. Outputs can include predictions, content, recommendations, or decisions. Different AI varies in its levels of autonomy and adaptiveness after deployment. For example, AI includes generative (GenAI) models, such as large language models, that can learn from inputs and create new outputs, such as text, images, audio, or video; and facial- or speech-recognition or -detection technology.

   b) Recent State and Federal Activity. Below is a high-level overview of some recent activity:

      i) State Executive Order (EO). In September 2023, Governor Gavin Newsom signed an EO to study the development, use, and risks of AI technology throughout the state and to develop a deliberate and responsible process for evaluation and deployment of AI within state government. The Administration is implementing the EO, including

moving forward to evaluate procurement proposals by state agencies, two of which relate to health care: one proposal to improve efficiency in inspections of health facilities by the Department of Public Health, and another within the California Health and Human Services Agency to improve translations.

ii) **Assembly Informational Hearing.** On February 27, 2024, the Assembly Privacy and Consumer Protection Committee held an informational hearing titled, "Understanding AI: Myths, Magic, and Machine Learning." The briefing paper notes AI is already embedded into most online systems, that it is integral to many aspects of modern society, and that the advent of GenAI will undoubtedly lead to an even greater number of applications. It also notes, however, that AI is not an inherently benevolent technology – it is a tool, and it can be used for good or ill. It suggests policymakers will need to design regulatory guardrails to limit harmful uses while allowing for the development and refinement of tools that benefit society. The paper discusses negative aspects of AI that imply a role for regulation, and a variety of troubling applications of AI. Specifically, it discusses bias and discrimination, effect on labor, deepfakes (the creation of realistic text, imagery, video, and audio by GenAI), questionable originality and copyright issues, and the inability to remove data from a trained model.

With respect to health care, it notes that when AI tools are deployed in healthcare, biased historical data can lead to patients being recommended substandard care on the basis of their race or ethnicity. It also notes the capacity for GenAI to "hallucinate," or generate output that has no basis in reality, is a unique risk if GenAI is embedded in health care applications. Disclosure and digital watermarking (the practice of embedding visible or invisible markers into a GenAI product) are presented as stopgap measures to prevent harms in the short term.

iii) **Centers for Medicare & Medicaid Services (CMS) Frequently Asked Questions (FAQs).** In February 2024, CMS released its FAQs related to coverage criteria and UM requirements in its Final Rule. CMS clarified that an algorithm or software tool can be used to assist Medicare Advantage (MA) plans in making coverage determinations, but it is the responsibility of the MA organization to ensure that the algorithm or AI complies with all applicable rules for how coverage determinations by MA organizations are made. For example, compliance is required with all of the rules for making a determination of medical necessity, including that the MA organization base the decision on the individual patient's circumstances, so an algorithm that determines coverage based on a larger data set instead of the individual patient's medical history, the physician's recommendations, or clinical notes would not be compliant. Additionally, CMS is concerned that algorithms and many new AI technologies can exacerbate discrimination and bias and reminds MA organizations of the nondiscrimination requirements of the federal Patient Protection and Affordable Care Act, which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities. MA organizations should, prior to implementing an algorithm or software tool, ensure that the tool is not perpetuating or exacerbating existing bias, or introducing new biases.

c) **Prior Authorization (PA).** PA is a decision by a health plan or insurer that a health care service, treatment plan, prescription drug, or durable medical equipment is medically

necessary. The health plan or insurer may require preauthorization for certain services before an individual receives them, except in an emergency.

Health plans and insurers are subject to various requirements in California, 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, California 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. Finally, current law prohibits an individual, other than a licensed physician or licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, from denying authorization for health care services based on medical necessity.

According to the Kaiser Family Foundation, insurers use PA to reduce payments for care that is not medically necessary or appropriate, which in turn helps to keep premiums down. However, PA has come under scrutiny for creating unnecessary burdens for providers, plans, and patients. Patients can find it challenging to know what services require PA, the process and criteria plans use to make a PA coverage decision, and whether providers are giving the needed information to a plan to determine coverage. Inefficient processes can delay decisions and consequently access to care, increasing health risks to patients. Improper denials may increase patient out-of-pocket costs or cause patients to abandon care. The process itself may have a chilling effect on individuals seeking out care and providers recommending it.

In December 2023, the National Association of Insurance Commissioners issued guidance that the use of AI should be designed to mitigate the risk that the insurer's use of AI will result in adverse outcomes for consumers. Insurers should have robust governance, risk management controls, and internal audit functions, which all play a role in mitigating such risk including, but not limited to, unfair discrimination in outcomes resulting from predictive models and AI systems. The guidance reminds insurance carriers that decisions impacting consumers that are made or supported by advanced analytical and computational technologies, including AI, must comply with all applicable insurance laws and regulations, including unfair trade practices.

3) **SUPPORT**. The California Medical Association, sponsor, writes that AI has been and will continue to be an essential tool in improving health care access and affordability for patients, but physicians must have oversight of critical UR decisions to allow for the best health outcomes for our communities. This bill provides essential guardrails to allow us to continue successfully integrating AI into our health care system.

4) **SUPPORT IF AMENDED.** The California Academy of Preventive Medicine recommends amendments to assure that no AI criteria or computerized algorithms tools be utilized in PA without the approval of the medical director or clinical director and to clarify that final decisions involving denials be made by a licensed physician or licensed health care professional.

5) **OPPOSE UNLESS AMENDED.** The California Association of Health Plans, the Association of California Life and Health Insurance Companies, and America's Health

Insurance Plans (opposition), write that plans and insurers have been using automated decision tools for years, as these tools are critical to increasing efficiencies, informing decision-making, and reducing administrative burdens. Current practice dictates that these tools are not used in isolation to make UM decisions and that these tools are monitored by appropriate health professionals. While the opposition appreciate that much of the bill seems to mirror current federal guidelines regarding the use of AI tools, the opposition is concerned that the bill includes narrow clinical peer review language that goes well beyond existing law. This bill would substantially limit who is allowed to conduct UR by requiring the reviewing provider be within the same or similar specialty as the requesting provider. Current law already requires that all peer review must be done by a competent health professional within a timely manner. If the treating provider disagrees with the reviewing provider, current law already affords a process for the resolution of the dispute through IMR.

6) RELATED LEGISLATION.

a) SB 516 (Skinner) prohibits a health plan or health insurer from requiring a contracted health professional to complete or obtain a PA for any covered health care services if the plan or insurer approved or would have approved not less than 90% of the PA requests they submitted in the most recent completed one-year contracted period. SB 516 is pending in the Assembly Appropriations Committee.

b) AB 3030 (Calderon) requires specified health care providers to disclose the use of a GenAI tool when it is used to generate responses that are communicated to a patient, and requires such a communication to include clear instructions permitting a patient to communicate with a human health care provider. AB 3030 is pending in the Senate Health Committee.

7) PREVIOUS LEGISLATION.

a) SB 598 (Skinner) of 2023 was similar to SB 516. SB 598 was held in the Assembly Appropriations Committee.

b) AB 1880 (Arambula) of 2022 would have required a health plan's or health insurer's UM process to ensure that an appeal of a denial of an exception request is reviewed by a clinical peer of the health care provider or prescribing provider, as specified. Would have defined a 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."

8) DOUBLE REFERRAL. This bill is double referred. Upon passage in this Committee, this bill will be re-referred to the Assembly Committee on Privacy and Consumer Protection.

9) COMMITTEE AMENDMENTS. The Committee is recommending the following:

a) To address concerns that UR determinations utilizing AI is inconsistent with existing UR law (without AI), the requirement that the UR reviewer be of the same or similar specialty of the requesting provider should be deleted from the provisions of this bill; and,
b) To make the following technical amendment: ~~**Be protected from risk that may**~~ **Not** directly or indirectly cause harm to the enrollee or insured.

REGISTERED SUPPORT / OPPOSITION:

Support

California Medical Association (sponsor)
Autism Business Association
Breathe California
Breathe Southern California
California Chapter American College of Cardiology
California Dental Association
California Hospital Association
California Life Sciences
California Orthopedic Association
California Podiatric Medical Association
California Rheumatology Alliance
California State Council of Service Employees International Union (seiu California)
Consumer Attorneys of California
Cpca Advocates, Subsidiary of The California Primary Care Association
Oakland Privacy
Physician Association of California (PAC)
Providence
Providence Medical Group & Physician Enterprise
Psychiatric Physicians Alliance of California (PPAC)
San Francisco Marin Medical Society
Spondylitis Assocation of America

Opposition

None on file.

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

Date of Hearing: June 18, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1147 (Portantino) – As Amended April 10, 2024

SENATE VOTE: 32-3

SUBJECT: Drinking water: bottled water: microplastics levels.

SUMMARY: Requires the State Water Resources Control Board (Board) to adopt a primary drinking water standard for microplastics based on a public health goal developed by the Office of Environmental Health Hazard and Assessment (OEHHA), and requires water bottling plants that produce bottled water sold in this state to provide an annual report to the Food and Drug Branch (FDB) of the Department of Public Health (DPH), on the levels of microplastics found in the source water and the final bottled water product. Specifically, **this bill**:

1) Requires, upon adoption by the Board of a primary drinking water standard for microplastics, any water-bottling plant that produces bottled water that is sold in California to provide the FDB an annual report on the levels of microplastics found in the source water used for bottling and in the final bottled water product that is offered for sale.

2) Requires the report in 1) above and any related testing to be conducted in accordance with existing law, including, but not limited to, the use of methods outlined in the Board's Division of Drinking Water's August 9, 2022, publication entitled "Policy Handbook Establishing a Standard Method of Testing and Reporting of Microplastics in Drinking Water," and any subsequent document published or released by the Board pursuant to the requirements of existing law or that is related to the publication, including, but not limited to, an update to the publication.

3) Requires the report required by this section to be included with the bottled water report pursuant to existing law, and upon request, to be made available to each consumer.

4) Requires OEHHA to prioritize studying the health impacts of microplastics in drinking water, including bottled water, to evaluate and identify a level of microplastics in those types of water that is not anticipated to cause or contribute to adverse health effects, or that does not pose any significant risk to health.

5) Requires OEHHA, after the Board adopts a standard methodology and requirements for the testing and reporting of microplastics in drinking water, and upon the request of the Board, to develop and deliver to the Board a public health goal for microplastics in drinking water, including bottled water, using the criteria set forth in existing law.

6) Requires the Board to review the public health goal developed pursuant to 5) and, pursuant to existing law adopt a primary drinking water standard for microplastics.

EXISTING LAW:

1) Establishes the California Safe Drinking Water Act, under the Board to establish primary drinking water standards that are at least as stringent as those established under the federal Safe Drinking Water Act, and to establish a program that is more protective of public health than the minimum federal requirements. [Health and Safety Code (HSC) §116270 et seq.]

2) Requires a license from the FDB in order to bottle, collect, treat, hold, distribute, haul, vend, or sell bottled water, vended water, or operate a retail water facility, or operate a private water source. [HSC §11120]

3) Requires each bottled water plant, as a condition of licensure, to annually prepare a bottled water report, as specified, and upon request, make that report available to each customer. [HSC §111071]

4) Requires bottled and vended water to meet all maximum contaminant levels set for public drinking water that DPH determines are necessary or appropriate so that bottled water may present no adverse effect on public health. [HSC §111080]

5) Requires the Board when adopting primary drinking water standards for contaminants in drinking water, to consider specified criteria, including the public health goal for the contaminant established by OEHHA. [HSC §116365]

6) Requires OEHHA to prepare and publish an assessment of the risks to public health posed by each contaminant for which the Board proposes a primary drinking water standard. Requires the risk assessment to contain an estimate of the level of contaminant in drinking water that is not anticipated to cause or contribute to adverse health effects, or that does not pose any significant risk to health. This is known as the public health goal for the contaminant. [HSC §116365(c)]

7) Requires the Board to adopt a definition of microplastics in drinking water by July 1, 2020, and by July 1, 2021 to adopt a standard methodology to be used in the testing of drinking water for microplastics, along requirements for four years of testing and reporting of microplastics in drinking water, including public disclosure of those results. [HSC §116376]

FISCAL EFFECT: According to the Senate Appropriations Committee, Board estimates ongoing costs of $450,000 annually (special fund) to handle the increased number of assessments that would potentially result from testing bottles for microplastics. Costs would initially be incurred from the Underground Storage Tank Cleanup Fund, until more labs become accredited, to which costs these costs would then be attributed through fees paid into the Environmental Laboratory Improvement Fund. OEHHA estimates ongoing costs of $253,000 annually and one-time costs of $100,000 in 2025-26 (General Fund) for staff resources and contract costs to prioritize studying the health impacts of microplastics in drinking water and bottled water, and to develop a public health goal for microplastics in drinking water upon request of the Board.

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, with the global urgency of plastic pollution, we begin to discover the extent of environmental damage and the breakdown of these materials into what we call, microplastics. This material can be found in soil, rain, drinking water, air, and the human heart. The author continues that current research shows that microplastics have been detrimental to the behaviors and wellbeing of marine life, fish, mammals, and plants, although more consistent research is needed to dissect the true health impact of microplastics, especially on human health. The author contends that with the existing damage that microplastics have on animals, sea life, and plants, it is plausible that microplastics pose concern for human health as well. With adequate studies on the health impacts of microplastics in water and by identifying a safe level of microplastics in water, we can decrease significant health risks. The author concludes the intent of this bill is to adopt primary drinking water standards for microplastics and for beginning to analyze how plastic materials may leech into plastic water bottles.

2) **BACKGROUND**.

   a) **Microplastics**. According to the National Ocean Service, microplastics are small plastic pieces less than five millimeters long. Microplastics come from a variety of sources, including from larger plastic debris that degrades into smaller and smaller pieces. In addition, microbeads, a type of microplastic, are very tiny pieces of manufactured polyethylene plastic that are added as exfoliants to health and beauty products, such as some cleansers and toothpastes. These tiny particles easily pass through water filtration systems and end up in the ocean.

   b) **Nanoplastics found in drinking water bottles.** On January 8, 2024, the *Los Angeles Times* reported that scientists at Columbia University's Lamont-Doherty laboratory examined water samples from three popular brands and found hundreds of thousands of bits of plastic per liter of water (on average, 240,000 pieces in a liter of bottled water). Ninety percent of those plastics were small enough to qualify as nanoplastics: microscopic flecks so small that they can be absorbed into human cells and tissue, as well as cross the blood-brain barrier. The researchers found that the quantity of such particles was 10 to 100 times greater than previously estimated.

   c) **Microplastics and their potential impacts on health**. In 2019, the World Health Organization (WHO) commissioned a report to evaluate the evidence for risks to human health associated with exposure to nano- and microplastic particles (NMP) in drinking-water. The report was based on literature reviews of studies published up to December 2021 in which original data on the occurrence of NMP in air, water, food and beverages were reported and also experimental studies on their toxicity. WHO experts evaluated the quality of the studies of environmental monitoring and of toxicity, particularly with regard to the reliability and relevance of the data for characterizing risk. The possible role of NMP as vectors of chemicals and pathogens was also assessed, and clinical observations from occupational epidemiology are summarized. A key observation is that MP are ubiquitous in the environment and have been detected in environmental media with direct relevance for human exposure, including air, dust, water, food and beverages. In 2022, WHO noted that although there are substantial limitations of available information on the adverse impacts of NMP are low, there is an awareness and consensus

among stakeholders that measures should be taken to mitigate exposure to NMP.

A 2023 review article published in the South Korean *Yonsei Medical Journal*, highlighted research which showed that nano-sized plastics were associated with mitochondrial damage in human respiratory cells.

In a March 2024 study in the *New England Journal of Medicine*, an international team of physicians and researchers showed that surgical patients who had a build-up of micro and nanoplastics in their arterial plaque had a 2.1 times greater risk of nonfatal heart attack, nonfatal stroke or death from any cause in the three years postsurgery than those who did not.

d) Efforts to monitor microplastics in drinking water. SB 1422 (Portantino), Chapter 902, Statutes of 2018, required the State Water Board to adopt a definition of microplastics in drinking water, and to adopt requirements for the testing and reporting of the amount of microplastics in drinking water for four years. The definition the Board adopted is as follows: "Microplastics in Drinking Water are defined as solid polymeric materials to which chemical additives or other substances may have been added, which are particles which have at least three dimensions that are greater than 1 nanometer and less than 5,000 micrometers. Polymers that are derived in nature that have not been chemically modified (other than hydrolysis) are excluded."

Following the adoption of this definition, the Board in 2022 adopted a policy handbook establishing a standard method of testing and reporting microplastics in drinking water. However, the testing program itself is still in the process of being established. The Board is currently working on a phased approach for monitoring microplastics in order to inform how public water systems will be required to monitor and report microplastics in water going forward. Laboratories will need to be accredited by the Environmental Laboratory Accreditation Program to analyze for microplastics, and there is currently limited laboratory capacity in this field. Once the testing process, including the sampling method, has been completed, a select number of public water systems will test for microplastics, focusing on sources that serve the greatest number of consumers, and looking for microplastics 50 micrometers (.05 millimeter) and larger. After this phase, additional monitoring orders will be issued, and focus on microplastics 5 micrometers (.005 millimeters) and larger in treated water.

This bill is structured so that once testing results from SB 1422 come in, the Board will request OEHHA to develop and deliver a public health goal for microplastics in drinking water, and based on that goal; adopt a standard for drinking water. Once the drinking water standard is adopted, under this bill, water-bottling plants would be required to test and report on the level of microplastics in their source water and in their final products.

e) How is bottled water is regulated in California? Manufacturers of bottled water (whether located in-state, out-of-state, or in a foreign country) must be licensed and regulated by the FDB in order to sell or distribute their products in California. FDB inspects in-state bottlers for sanitation, manufacturing operation control, equipment and quality control procedures, testing requirements, record keeping, labeling, and advertising. For bottlers located out-of-state or in foreign countries, FDB relies on the inspection by the pertinent regulatory agency of the state or the country where the plant is

located. However, the bottlers must provide pertinent documents to FDB for review and must apply for a Bottled Water Plant License.

f) Distinctions between the regulations for bottled water and drinking water. The regulations for drinking water (which the average consumer knows as "tap water") are different from those for bottled water mainly because their sources are different. Source waters for producing public drinking water include lakes, rivers, and wells, while bottled water must be produced only from already approved sources (e.g., public drinking water or a licensed private water source). DPH indicates the key purpose of treatments for drinking water is to make the water safe. Accordingly, the regulations for drinking water are to meet that purpose. On the other hand, a water bottling plant, a water vending machine, or a retail water facility treats approved water to improve its quality (mainly clarity, flavor, and taste) by treatment with filtration processes (such as activated carbon, reverse osmosis, micro-filtration) and disinfection (such as ozone, ultraviolet light). According to DPH's website, since the source water, purpose, and the types of equipment used for tap water are different from those for bottled water, comparing the regulations for the two different groups of products is not appropriate.

As noted in existing law, bottled water is required to meet the same maximum contaminant level as drinking water.

g) Bottled water reports. As a condition of licensure by DPH, each water bottling plant is required to prepare an annual bottled water report. The information required in the report includes the source of the bottled water, such as a spring, artesian well, drilled well, municipal water supply, or any other source that has been inspected and the water sampled, analyzed, and found to be of a safe and sanitary quality. Additionally, the report is required to include a brief description of the treatment process used, such as reverse osmosis, carbon filtration, distillation, ultraviolet treatment, etc. The report is required to include information on the levels of unregulated substances, if any, and which water bottlers are required to monitor pursuant to state or federal law. Finally, it is recommended, though not required, that the report include the current or immediate previous year water quality test results of contaminant levels that is required under both federal and state law.

This bill would require, once a standard is set for microplastics in drinking water, that water bottlers include an annual report on the levels of microplastics found both in the source water, and in the final bottled water product.

3) SUPPORT. The Climate Reality Project, writes in support, this bill will establish the harmful effects of microplastics, regular monitoring of microplastic levels, and government regulation of microplastics within our drinking water. The prevalence of microplastics underscores the need to understand their effects whether benign or injurious, particularly if injurious. Microplastics are ubiquitous. They have been detected in bodies of water, humans, and animals and throughout the world from Mount Everest to the Mariana Trench. The Climate Reality Project continues that there remains concern and confusion over whether microplastics-plastic particles less than 5 millimeters/one-fifth of an inch-fall into those categories. The Climate Reality Project continues that this bill would establish this clarity, noting that the following integral actions will occur: The health impacts of microplastics will finally and officially be investigated and known; The OEHHA will establish safe and unsafe

levels of microplastics; The Board will establish standards and objectives based upon those levels to reduce danger(s); The Board will implement annual testing and reporting obligations specifically for bottled water. In sum, the effect of microplastics will be understood, microplastics will be monitored, and most importantly, regulated. The Climate Reality Project concludes that this bill is pivotal to understanding and eventually combating the negative effects, health implications, and environmental degradation associated with microplastics.

4) **RELATED LEGISLATION**. AB 2648 (Bennett) prohibits state agencies from purchasing single-use plastic bottles. AB 2648 is on the Assembly inactive file.

5) **PREVIOUS LEGISLATION**.

   a) SB 1422 (Portantino), Chapter 902, Statutes of 2018, requires the Board to adopt requirements for the testing and reporting of the amount of microplastics in drinking water for four years.

   b) SB 1263 (Portantino), Chapter 609, Statutes of 2018, requires, on or before December 31, 2024, the Ocean Protection Council, in collaboration with specified entities, to adopt and implement a Statewide Microplastics Strategy and authorizes those entities to enter into contracts with marine research institutes for the provision of research services that would contribute directly to the development of the Statewide Microplastics Strategy.

   c) AB 223 (Stone) of 2019, would have required the Board, to the extent possible, and where feasible and cost effective, to work with DPH in complying with those requirements in existing law to requires the Board, on or before July 1, 2020, to adopt a definition of microplastics in drinking water and, on or before July 1, 2021, to adopt a standard methodology to be used in the testing of drinking water for microplastics and requirements for four years of testing and reporting of microplastics in drinking water, including public disclosure of those results. AB 223 was not heard in the Assembly Committee on Environmental Safety and Toxic Materials.

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

REGISTERED SUPPORT / OPPOSITION:

Support

California Environmental Voters (formerly Clcv)
California Nurses for Environmental Health & Justice
CleanEarth4Kids.org
Climate Reality Project, California Coalition

Opposition

None on file.

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

Date of Hearing: June 18, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1180 (Ashby) – As Amended May 16, 2024

SENATE VOTE: 35-0

SUBJECT: Health care coverage: emergency medical services.

SUMMARY: Requires a health plan contract or health insurance policy to establish a process to reimburse for services provided by a community paramedicine program (CPP), a triage to alternate destination program (TADP), and a mobile integrated health program (MIHP), as defined. Requires coverage of these programs under Medi-Cal, upon appropriation, receipt of any necessary federal approvals, and the availability of federal financial participation (FFP). Specifically, **this bill**:

1) Requires a health plan contract or insurance policy, issued, amended, or renewed on or after January 1, 2025, to establish a process to reimburse for services provided by a CPP, TADP, or MIHP.

2) Prohibits a health plan contract or insurance policy issued, amended, or renewed on or after January 1, 2025, from requiring an enrollee or insured who receives covered services from a noncontracting program pursuant to 1) above, from paying more than the same cost-sharing amount that the enrollee or insured would pay for the same covered services.

3) Specifies that the reimbursement for a noncontracting program pursuant to 1) above to follow the same process as described in 4) below under existing law.

4) Mandates coverage of services provided by a CPP, TADP, or MIHP under the Medi-Cal program. Provides for implementation only to the extent that the Department of Health Care Services (DHCS) obtains any necessary federal waivers or other federal approvals; that FFP is available and not otherwise jeopardized; and, subject to appropriation by the Legislature.

5) Requires DHCS to develop rates of reimbursement for services pursuant to 4) above in consultation with CPPs, TADPs, and MIHPs.

6) Defines the following for purposes of this bill:
   a) CPP as defined under 13) of existing law below;
   b) MIHP as a team of licensed health care practitioners, operating within their scope of practice, who provide mobile health services to support the Emergency Medical Services (EMS) System; and,
   c) TADP as defined under 14) of existing law below.

EXISTING LAW:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans and the 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 EHBs. [HSC § 1367.005 and INS § 10112.27]

3) Requires health plans and health insurers to provide basic health care services, including: physician services; hospital inpatient and ambulatory care services; diagnostic laboratory and diagnostic and therapeutic radiologic services; home health services; preventive health services; emergency health care services; including ambulance and ambulance transport services and out of area coverage; and, hospice care. Defines basic health care services to include ambulance and ambulance transport services provided through the "911" emergency response system. [HSC § 1345 and INS § 10112.281]

4) Requires a health plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2024, to require an enrollee or insured who receives covered services from a noncontracting ground ambulance provider to pay no more than the same cost-sharing amount that the enrollee or insured would pay for the same covered services received from a contracting ground ambulance provider. Prohibits a noncontracting ground ambulance provider from billing or sending to collections a higher amount, and prohibits a ground ambulance provider from billing an uninsured or self-pay patient more than the established payment by Medi-Cal or Medicare fee-for-service amount, whichever is greater. Requires a plan or insurer to reimburse for ground ambulance services at the rate established or approved by the governing board of the local government having jurisdiction for that area or subarea, including an exclusive operating area, as specified. [HSC § 1371.56 and INS § 10126.66]

5) Establishes the EMS System and the Prehospital Emergency Medical Care Personnel Act to provide for a statewide system for EMS, and establishes the Emergency Medical Services Agency (EMSA), which is responsible for the coordination and integration of all state activities concerning EMS, including the establishment of minimum standards, policies, and procedures. [HSC § 1797, *et seq*.]

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

7) Requires every LEMSA to have a licensed physician as medical director, to assure medical accountability throughout the planning, implementation, and evaluation of the EMS system. Requires the medical direction and management of an EMS system to be under the medical control of the medical director. [HSC § 1797.202 and HSC § 1798]

8) Requires every 911 system to include police, firefighting, and emergency medical and ambulance services. Requires every 911 system, in those areas in which a public safety agency provides ambulance emergency services, to include such public safety agencies. Permits 911 systems to incorporate private ambulance services. [Government Code § 53110]

9) Requires a county to enter into a written agreement with the city or fire district regarding the provision of prehospital EMS for that city or fire district. [HSC § 1797.201]

10) Authorizes a LEMSA to create one or more exclusive operating areas in the development of a local plan, if a competitive process is utilized to select the provider or providers of the services pursuant to the plan. [HSC § 1797.224]

11) Establishes the Community Paramedicine or Triage to Alternate Destination Act of 2020, and states the intent of the Legislature that, among other provisions, delivery of community paramedicine or triage to alternate destination services is a public good and is complementary to the existing emergency response system. [HSC §1800]

12) Requires EMSA to develop regulations that establish minimum standards for the development of a community paramedicine or triage to alternate destination program, and requires the Commission on EMS to review and approve the regulations. [HSC §1830]

13) Defines CPP as a program developed by a LEMSA and approved by EMSA to provide community paramedicine services consisting of one or more of the following the program specialties under the direction of medical protocols developed by the LEMSA that are consistent with the minimum protocols established by EMSA. Permits community paramedic services to consist of the following specialties:

    a) Providing directly observed therapy to persons with tuberculosis in collaboration with a public health agency; and,
    b) Providing case management services to frequent EMS users in collaboration with, and by providing referral to, existing appropriate community resources. [HSC §1815]

13) Defines TADP as a program developed by a LEMSA and approved by EMSA to provide triage paramedic assessments consisting of one or more of the following specialties operating under triage and assessment protocols developed by the LEMSA that are consistent with the minimum triage and assessment protocols established by EMSA:

    a) Providing care and comfort services to hospice patients in their homes in response to 911 calls by providing for the patient's and family's immediate care needs, including grief support, in collaboration with the patient's hospice agency until the hospice nurse arrives to treat the patient;
    b) Providing patients with advanced life support triage and assessment by a triage paramedic and transportation to an alternate destination facility; and,
    c) Providing transport services for patients who identify as veterans and desire transport to a local veterans administration emergency department (ED) when appropriate. [HSC §1819]

FISCAL EFFECT: According to the Senate Appropriations Committee, DMHC estimates costs of approximately $294,000 in 2024-25, $368,000 in 2025-26, $432,000 in 2026-27, $434,000 in 2027-28, $436,000 in 2028-29, and $438,000 in 2029-30 and annually thereafter for state administration (Managed Care Fund). Unknown costs for CDI for state administration (Insurance Fund). Unknown, ongoing costs for the Medi-Cal program to cover the new benefit; and unknown ongoing costs for DHCS for state administration (General Fund and federal funds).

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, substance abuse centers and mental health facilities, both mandated in this bill, offer a cost-effective solution to ED overcrowding and help to better address patients with acute needs, particularly for our vulnerable communities. Drug addiction and mental illnesses are consistent risk factors associated with entering into homelessness, a population with little access to healthcare, which is a significant barrier to finding stable employment or securing permanent housing. The author writes that substance abuse centers and mental health facilities offer specialized alternatives to EDs while providing the extensive resources needed to address intensive care. It is vital that we deliver the resources needed to protect our most vulnerable populations by allowing our emergency medical response teams to connect patients with appropriate services. The author concludes that this bill will ensure that California can provide proper medical transportation to the best health resource for each patients individualized needs.

2) **BACKGROUND**.

   a) **EMS in California**. EMSA is responsible for statewide coordination and leadership for planning, developing, and implementing local EMS systems and local trauma care systems in California. It also sets training standards and scope of practice for emergency services workers (e.g., paramedics, emergency medical technicians, mobile intensive care nurses, firefighters) among other duties. There are 34 LEMSAs that serve California's 58 counties. The state oversees the actions and compliance of these local agencies. The LEMSAs coordinate and contract with EMS transport entities.

   b) **CPP and TADP pilots**. According to the California Health Benefits Review Program (CHBRP), an emerging area within the EMS field involves alternative models of care delivery that expand EMS professionals' scope of practice beyond responding to 911 calls and transporting patients to EDs. This may involve providing additional services such as nonemergency care and transporting patients to non-ED destinations. The specific programs may be developed and led by EMSAs, fire departments, hospitals or health systems, insurers, or independent companies, and the services may be targeted to vulnerable populations such as seniors, individuals with chronic conditions, underserved communities, or those who frequently use emergency services. In 2014, California sponsored a six year pilot project that implemented 10 CPP and 10 TADPs across the state. According to CHBRP, many programs have since ended. These are funded by grants, public EMS or city/county government agencies, or private EMS agencies (and health care partner organizations). These pilot projects intended to improve the efficiency and effectiveness of emergency medical and health care services by expanding the role of specially trained paramedics in the field. Of the 20 pilot projects launched in California between 2015 and 2020, five remain operational, one CPP and four TADPs. In addition, CHBRP is aware of two MIHPs in California. EMSA requires that LEMSAs apply for approval of CPP and TADPs. MIHPs are not subject to this process since they include staff who are licensed medical professionals. In California, CPP, TADP, and MIHPs have been and are currently funded by grants, public EMS or city/county government agencies, or private EMSAs (and health care partner organizations), not through payments from health plans or policies, or the Medi-Cal program. CHBRP is not aware of any California health plans or policies that currently pay for services provided by existing CPP, TADP, or MIHPs, as defined in this bill. Some state Medicaid programs cover community paramedicine services, as do some commercial insurers in other states. However, there is

no standardized approach by insurers on how the services are delivered and covered, and coding for the covered services is not standardized between state Medicaid programs or insurers.

c) California laws. AB 1544 (Gipson), Chapter 138, Statutes of 2020, codified the Community Paramedicine or Triage to Alternate Destination Act of 2019, permitting LEMSAs, with approval by EMSA, to develop programs to provide CPP or TADP services in one of the following specialties: i) providing directly observed tuberculosis therapy; ii) providing case management services to frequent EMS users; iii) providing hospice services to treat patients in their homes; and, iv) providing patients with TADP, which can either be an authorized mental health facility, or an authorized sobering center. AB 767 (Gipson), Chapter 767, Statues of 2023, extended the sunset in AB 1544 to 2031.

In 2023, DHCS received its approval of the State Plan Amendment to add community-based mobile crisis intervention services (mobile crisis services) as a Medi-Cal benefit. Mobile crisis services are a community-based intervention designed to provide de-escalation and relief to individuals experiencing a behavioral health or substance use-related crisis wherever they are, including at home, work, school, or in the community. As part of its California Advancing and Innovating Medi-Cal program's Mobile Crisis Services Initiative, mobile crisis services are provided by a multidisciplinary team of trained behavioral health professionals. Mobile crisis services provide rapid response, individual assessment and community-based stabilization to Medi-Cal beneficiaries who are experiencing a behavioral health crisis. Mobile crisis services are designed to provide relief to beneficiaries experiencing a behavioral health crisis, including through de-escalation and stabilization techniques; reduce the immediate risk of danger and subsequent harm; and, avoid unnecessary ED care, psychiatric inpatient hospitalizations, and law enforcement involvement.

3) **SUPPORT**. The California Professional Firefighters, sponsor, writes under current law, fire departments may not seek reimbursement for the cost of CPP services or TADP transports as they are not considered emergency services. As a result, such programs must either operate at a loss or rely on limited-term grant funding that is not guaranteed to continue. This also has the unintended consequence of limited CPP, TADP, and MIHP to larger, more well-funded departments that are able to either absorb the costs of the programs or dedicate personnel to pursuing funding. The sponsor states that this bill will ensure that departments are able to recover the necessary costs for the services that they provide outside of the traditional EMS system. The implementation of these programs has already resulted in decreases in hospital readmissions, follow-up transport, and emergency room overcrowding, and their further expansion throughout California to departments that would otherwise not have been able to operate them will provide continued benefits. The sponsor concludes that California's firefighters are dedicated to serving their communities and seeking innovative solutions to the issues impacting the state, and this bill will ensure that they have the supportive framework that is needed to do so.

4) **OPPOSITION**. The California Association of Health Plans, the Association of California Life and Health Insurance Companies, and America's Health Insurance Plans, write that this bill will lead to higher premiums, harming affordability and access for small businesses and individual market consumers.

5) **PREVIOUS LEGISLATION**.

a) AB 716 (Boerner), Chapter 454, Statutes of 2023, requires a health plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2024, to require an enrollee or insured who receives covered services from a noncontracting ground ambulance provider to pay no more than the same cost-sharing amount that the enrollee or insured would pay for the same covered services received from a contracting ground ambulance provider. Prohibits a noncontracting ground ambulance provider from billing or sending to collections a higher amount, and prohibits a ground ambulance provider from billing an uninsured or self-pay patient more than the established payment by Medi-Cal or Medicare fee-for-service amount, whichever is greater. Requires a plan or insurer to reimburse for ground ambulance services at a rate established or approved by the governing board of the local government having jurisdiction for that area or subarea, including an exclusive operating area, as specified.

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

6) AUTHOR'S AMENDMENTS. The author wishes to amend this bill to allow for a different reimbursement rate of noncontracting providers and to delay implementation to July 1, 2025.

REGISTERED SUPPORT / OPPOSITION:

Support

California Professional Firefighters (sponsor)
Pat Hume, Sacramento County Supervisor, District 5
California Agents & Health Insurance Professionals
California Chiropractic Association
California Life Sciences
California State Association of Psychiatrists
City and County of San Francisco
County of Sacramento
Elderly Care Everywhere
Emergency Medical Services Administrators' Association of California
Sacramento Metropolitan Fire District
San Francisco Fire Department

Opposition

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

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

Date of Hearing: June 18, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1266 (Limón) – As Amended April 24, 2024

SENATE VOTE: 39-0

SUBJECT: Product safety: bisphenol.

SUMMARY: Expands the prohibition in existing law against children's bottles and cups containing bisphenol A (BPA) to instead prohibit any form of bisphenol (BP) in juvenile's feeding, sucking, or teething products. Specifically, **this bill**:

1) Prohibits the manufacture, sale, or distribution into a commerce any juvenile's feeding product or juvenile's sucking or teething products that contain any form of BP at a detectable level above 0.1 parts per billion (ppb).

2) Authorizes the Department of Toxic Substances Control (DTSC) to establish standards for any juvenile's feeding product or juvenile's sucking or teething product that are more protective of public health, sensitive populations, or the environment.

3) Prohibits manufacturers from replacing any form of BP with any chemical identified by DTSC as a Candidate Chemical.

4) Prohibits manufacturers from replacing any form of BP with chemicals classified by the United States Environmental Protection Agency (EPA) as carcinogenic to humans, likely to be carcinogenic to humans, or for which there is suggestive evidence of carcinogenic potential, or identified by the state to cause cancer as listed in the Safe Drinking Water and Toxic Enforcement Act of 1986 (Proposition or Prop 65) list of chemicals known to cause cancer or reproductive toxicity.

5) Prohibits manufacturers from replacing any form of BP with reproductive toxicants that cause birth defects, reproductive harm, or developmental harm as identified by the EPA or listed in Prop 65 list of chemicals known to cause cancer or reproductive toxicity.

6) Establishes the following terms:
   a) "Bisphenol" means a chemical with two phenol rings connected by a single linker atom. The linker atom and phenol rings may have additional substituents.
   b) "Juvenile" means an individual or individuals younger than 12 years of age.
   c) "Juvenile's feeding product" means any consumer product, marketed for use by, marketed to, sold, offered for sale, or distributed to juveniles in the State of California that is designed or intended by the manufacturer to be filled with any liquid, food, or beverage intended primarily for consumption from that bottle or cup by a juvenile.
   d) "Juvenile's sucking or teething product" means any consumer product, marketed for use by, marketed to, sold, offered for sale, or distributed to juveniles in the State of California that is designed or intended by the manufacturer to help a juvenile with sucking or teething in order to facilitate sleep or relaxation.

EXISTING LAW:

1) Prohibits the manufacture, sale, or distribution of any bottle or cup that contains BPA, at a detectable level above 0.1 ppb, if it is designed or intended to be filled with liquid, food, or beverage intended primarily for consumption by children three years of age or younger. [Health and Safety Code (HSC) §108940 (a)]

2) Specifies, if DTSC adopts regulations regarding the use of BPA in one of these products that the prohibition does not apply to that product upon the date that DTSC posts a notice on its website. [HSC §108940 (c)]

3) Requires manufacturers to use the least toxic alternative when replacing BPA in containers. Prohibits manufacturers from replacing BPA with chemicals classified by the EPA as carcinogenic to humans, likely to be carcinogenic to humans, or for which there is suggestive evidence of carcinogenic potential, or identified by the state to cause cancer as listed in Prop 65's list of chemicals known to cause cancer or reproductive toxicity. Prohibits manufacturers from replacing BPA with reproductive toxicants that cause birth defects, reproductive harm, or developmental harm as identified by the EPA or listed in Prop 65's list of chemicals known to cause cancer or reproductive toxicity. [HSC §108941]

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, BPs are chemical compounds that are used in a variety of industrial and consumer products – ranging from automobile parts to food containers. BPA is considered an endocrine disruptor, which means it can interfere with the hormone system in the body and is associated with harmful health outcomes such as asthma, cardiovascular disease, and obesity. Children, in particular infants, are even more susceptible to the harms of BPA and can have adverse health impacts upon exposure. The author notes that recognizing this harm, in 2012, the U.S. Food and Drug Administration (FDA) banned BPA from baby bottles and sippy cups. Although manufacturers have eliminated BPA from these products, they have shifted to using alternative chemicals to replace it – such as bisphenol S (BPS) and bisphenol F (BPF) – which have been found to be even more harmful than BPA. The author contends that this poses a serious health concern amongst children and parents that must be addressed. The author concludes that this bill prohibits the manufacture, sale, or distribution of any feeding, sucking, or teething product that contains BP at a detectable level above 0.1 ppb. Additionally, it requires DTSC to establish health and environmental standards on children's products.

2) **BACKGROUND**.

   a) **Background on BPs**. BPs represent a large class of phenolic organic chemical compounds. BPs are a group of chemical compounds commonly used in the production of plastics to make them strong, durable, and clear.

   b) **BPA**. The most well-known BP, BPA, is widely used in the manufacture of plastic resins that line food and beverage cans. According to the National Institute of Environmental Health Sciences, BPA is a chemical produced in large quantities for use primarily in the

production of polycarbonate plastics. It is found in various products including shatterproof windows, eyewear, water bottles, and epoxy resins that coat some metal food cans, bottle tops, and water supply pipes. BPA leaches into food and beverages, which can have negative impacts on human health. A 2017 list in the Comparative Toxicogenetics Database showed BPA as associated with 202 diseases. BPA has been banned in certain products, including an FDA and California ban for baby bottles and sippy cups. Following these and other regulations on the production and usage of BPA, structurally similar substitutes such as BPS and BPF have been used as a replacement for BPA.

c) Other BPs and their health impacts. According to a February 2019 article in *Diabetes & Metabolism Journal*, BPA substitutes-based products are consumed under the label of "BPA-free." This term gives the impression that the products are safe, but the safety of the substitutes is not fully verified. Research suggests that structurally similar alternatives also show endocrine disruption effects like BPA, and many studies on adverse health effects of these alternatives are being reported.

Another 2019 article in the *Diabetes & Metabolism Journal* showed that exposure to BPF, a commonly used substitute for BPA, was positively associated with higher risk of obesity in children and adolescents. The association of BPA and BPF with general and abdominal obesity was primarily observed in boys.

According to a review published in December 2022 in the *International Journal of Environmental Research and Public Health*, BPS and BPF are structurally and chemically similar to BPA; and they are expected to promote adverse effects by acting as endocrine disrupters. Over the last decade, BPS and BPF have been widely used by manufacturers as a substitute for BPA; they are present in a wide range of products such as food products, cleaning agents, thermal papers, dental sealants, and personal care products. High concentrations of BPF were found in different vegetable and seafood products in China. In thermal paper receipt samples, BPS was detected in 62% of samples from Italy and all samples from the U.S., Japan, Korea, and Vietnam. Furthermore, BPS and BPF were detected in 89.4% and 66.5% of urinary samples from U.S. adults and children, respectively. The review stated that as a large population is exposed to BPA substitutes at a relatively high level, the safety of BP substitutes has been questioned over the last few years.

In recognition of the potential adverse health outcomes associated with BP analogs, this bill prohibits the use of all BPs in juvenile sucking, teething, and feeding products and further prohibits the replacement of these BPs with chemicals identified by DTSC as a candidate chemical, or chemical which exhibits a "hazard trait which may contribute to adverse effects in humans, animals or ecological communities. This bill further prohibits manufacturers from replacing any form of BP with chemicals classified by the EPA as carcinogenic to humans, likely to be carcinogenic to humans, or for which there is suggestive evidence of carcinogenic potential, or identified by the state to cause cancer as listed in Prop 65's list of chemicals known to cause cancer or reproductive toxicity. This bill further prohibits manufacturers from replacing any form of BP with reproductive toxicants that cause birth defects, reproductive harm, or developmental harm as identified by the EPA or listed in Prop 65's list of chemicals known to cause cancer or reproductive toxicity.

3) **SUPPORT**. California Health Coalition Advocacy (CHCA) writes in support of this bill, California has been a leader in banning BPA in bottles and sippy cups but, unfortunately, many manufacturers just replaced BPA with other types of BPs, such as BPS or BPF. CHCA states that BPs have been linked to a myriad of adverse health outcomes, including: developmental disorders; reproductive abnormalities; disruption of hormone function, leading to neurobehavioral problems; learning disabilities and attention deficits in children; and, increased risk of obesity, diabetes, and cardiovascular diseases. CHCA concludes that BPs also have the ability to leach out of plastic products and contaminate the food and beverages children consume making it all the more important for the health and well-being of our youngest generation to expand current statute to remove all BPs, not BPA.

4) **PREVIOUS LEGISLATION**.

   a) AB 1347 (Ting) of 2023 would have required a business to offer a consumer the option to receive or not receive a proof of purchase and would prohibit a paper proof of purchase from containing BP. AB 1347 was held in Senate Appropriations Committee.

   b) AB 1319 (Butler), Chapter 797, Statutes of 2011, enacts the Toxin-Free Infants and Toddlers Act, which prohibits the manufacture, sale, or distribution of any bottle or cup that contains BPA, at a detectable level above 0.1 ppb, if the bottle or cup is designed or intended to be filled with liquid, food, or beverage intended primarily for consumption by infants or children three years of age or younger.

   c) SB 797 (Pavley) of 2010 was substantially similar to AB 1319. SB 797 failed concurrence on the Senate Floor.

   d) SB 1713 (Migden) of 2008 contained provisions similar AB 1319 which would have prohibited the sale, manufacture of food containers for children that contain BPA above a 0.1 ppb. SB 1713 failed passage on the Assembly Floor.

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

REGISTERED SUPPORT / OPPOSITION:

Support

A Voice for Choice Advocacy
American College of Obstetricians and Gynecologists District IX
Arts District Community Council LA
Breast Cancer Prevention Partners
California Health Coalition Advocacy
California Water Association
Californians Against Waste
Clean Water Action
CleanEarth4Kids.org
Educate. Advocate.
Environmental Working Group
National Stewardship Action Council

Opposition

None on file.

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

Date of Hearing: June 18, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1300 (Cortese) – As Amended April 8, 2024

SENATE VOTE: 27-9

SUBJECT: Health facility closure: public notice: inpatient psychiatric and maternity services.

SUMMARY: Extends the public notice requirement when a health facility eliminates a supplemental service, from 90 days prior to elimination of the service, to instead be 120 days, when it involves the closure of either inpatient psychiatric services or maternity services. Requires a health facility that is eliminating an inpatient psychiatric or maternity supplemental service to complete an impact analysis report prior to providing notice of the proposed elimination of the supplemental service. Specifically, **this bill**:

1) Requires, not less than 120 days prior to eliminating a supplemental service of either inpatient psychiatric services or maternity services, a health facility to provide public notice of the proposed elimination of the supplemental service, including a notice posted at the entrance to all affected facilities and a notice to the Department of Public Health (DPH) and the board of supervisors of the county in which the health facility is located.

2) Authorizes a hospital, if DPH determines that the use of resources to keep the inpatient psychiatric services or maternity services open for the full 120 days threatens the stability of the hospital as a whole, or if DPH cites the hospital for unsafe staffing practices related to inpatient psychiatric services or maternity services, a hospital to close the inpatient psychiatric service or maternity service 90 days after providing public notice of the planned closure.

3) Requires a health facility subject to the provisions of 1) above, to complete an impact analysis report prior to providing notice of a proposed elimination of the supplemental service of either inpatient psychiatric services or maternity services. Specifies that this impact analysis report is in addition to the public notice described in 1) above.

4) Requires a health facility, on or after July 1, 2025, when providing notice of elimination of a supplemental service of either inpatient psychiatric services or maternity services, to submit the impact analysis report to DPH and to the board of supervisors of the county in which the health facility is located.

5) Requires the impact analysis report to include, but is not limited to, all of the following information:
   a) An analysis of the impact on the health of the community resulting from the proposed elimination of the services. Requires the analysis to include a good faith estimate of the impact of the closure on the county, including potential increased annual costs to the county for providing additional inpatient psychiatric care or maternity care, and on the continuum of care capacity in the county;
   b) Identification of the three nearest available comparable services. Requires, if the health facility closing these services serves Medi-Cal or Medicare patients, the health facility to specify if the providers of the nearest available comparable services serve these patients;

c) Aggregated data about the patients who had been treated by the health facility within the past five years, including, but not limited to:
   i) The conditions treated;
   ii) The ethnicities of patients served;
   iii) The ages of patients served; and,
   iv) Whether the patients served had private insurance, Medi-Cal, Medicare, or no insurance.

6) States that the cost of preparing the analysis will be borne by the hospital.

7) Requires, on or before July 1, 2025, the Department of Health Care Access and Information (HCAI) to create a report format for the submission of the impact analysis report as described in 5) above.

8) Strongly encourages, within 15 days of the receipt of a notice of elimination of services and receipt of an impact analysis, the county board of supervisors in the county in which the health facility is located to convene a public hearing to provide an overview of the impact analysis report and to hear public testimony. The county board of supervisors is also strongly encouraged to post the impact analysis on its internet website.

9) Strongly encourages the board of supervisors of the county in which the services are proposed to be eliminated to ensure that all health facilities in the geographic area impacted are informed of the proposed elimination of services prior to the public hearing.

10) Requires DPH, if the loss of beds will have an impact on the health of the community, to prioritize and expedite the licensing of additional beds to replace the number of lost beds necessary to mitigate the negative impacts identified in the impact analysis report.

EXISTING LAW:

1) Licenses and regulates health facilities by DPH, including general acute care hospitals, acute psychiatric hospitals, skilled nursing facilities, and intermediate care facilities, among others. [Health and Safety Code (HSC) §1250, et seq.]

2) Requires any hospital that provides emergency medical services (EMS) to provide notice of a planned reduction or elimination of the level of EMS to DPH, the local government entity in charge of the provision of health services, and all health care service plans or other entities under contract with the hospital, as soon as possible but not later than 180 days prior to the planned reduction or elimination of emergency services. Requires the hospital to also provide public notice, within the same time limits, in a manner that is likely to reach a significant number of residents of the community serviced by that facility. [HSC §1255.1]

3) Specifies that a hospital is not subject to the notice requirements in 2) above if DPH determines that the use of resources to keep the emergency center open substantially threatens the stability of the hospital as a whole, or if DPH cites the emergency center for unsafe staffing practices. [HSC §1255.1(c)]

4) Requires a health facility implementing a downgrade or change to make reasonable efforts to ensure that the community served by its facility is informed of the downgrade or closure,

including advertising the change in terms likely to be understood by a layperson, soliciting media coverage regarding the change, informing patients of the facility of the impending change, and notifying contracting health plans. [HSC §1255.2]

5) Requires, not less than 120 days prior to closing a health facility, or 90 days prior to eliminating a supplemental service, the facility to provide public notice of the proposed closure or elimination of the supplemental service, including a notice posted at the entrance to all affected facilities and a notice to DPH and the board of supervisors of the county in which the health facility is located. [HSC §1255.25]

6) Permits a health facility license holder, with the approval of DPH, to surrender its license or special permit for suspension or cancellation by DPH. Requires DPH, before approving a downgrade or closure of emergency services, to receive a copy of an impact evaluation by the county to determine impacts of the closure or downgrade on the community. Permits the county to designate the local EMS agency as the appropriate agency to conduct the impact evaluation. Requires development of the impact evaluation to incorporate at least one public hearing, and requires the impact evaluation and hearing to be completed within 60 days of the county receiving notification of intent to downgrade or close emergency services. [HSC §1300]

7) Requires a general acute care hospital (GACH) or acute psychiatric hospital, not less than 120 days prior to closing the facility, or 90 days prior to eliminating a supplemental service, or relocating a supplemental service to a different campus, to provide public notice, containing specified information, of the proposed closure, elimination, or relocation, including a notice posted at the entrance to all affected facilities and a notice to DPH and the board of supervisors of the county in which the health facility is located. [HSC §1255.25]

8) Excludes county facilities from the public notice requirements of 6) above, as county facilities are subject to separate provisions of law requiring counties to provide public notice and public hearings when proposing to eliminate or reduce the level of medical services provided by a county, or when selling or transferring management of these service. This process is known as the Beilenson Act. [HSC §1442.5]

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, the closure of vital psychiatric and maternity units, such as the one at Good Samaritan Hospital in the author's district, can be catastrophic for families and creates a public health crisis. Some of these sudden hospital closures occur in lower-income areas. The outcome is 21st-century redlining, with underrepresented people cut off from essential services. The author states this bill will ensure that hospitals provide sufficient notice and conduct comprehensive impact analyses when discontinuing such essential services. The author concludes this will help communities better plan for the impact of a closure and provide a lifeline to those needing access to critical health services.

2) BACKGROUND.

a) Supplemental Services. With some exceptions, GACHs are required to provide eight basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary. Beyond these basic services, hospitals can be authorized to offer supplemental services, including outpatient services such as emergency services, or inpatient services such as intensive care, cardiovascular surgery, maternity, and a psychiatric unit, among others.

b) Increasing Maternity Unit Closures. On November 15, 2023, *CalMatters* published an investigative story focusing on the increase in maternity unit closures in California, titled "As Hospitals Close Labor Wards, Large Stretches of California Are Without Maternity Care." According to this report, from 2012 to 2019, at least 19 hospitals stopped offering labor and delivery services (six of those were because the hospitals closed completely). In an acceleration, 16 more closed maternity services from 2020 to 2022. By the time of publication, 11 more had announced maternity closures in 2023, including one hospital that completely closed (Madera Community Hospital). *CalMatters* reported that after El Centro Regional Medical Center closed its maternity service in January of 2023, Imperial County was left with only one hospital doing births for the approximately 2,500 babies born every year in Imperial County. In total, according to the *CalMatters* analysis, at least 46 California hospitals have shut down or suspended labor and delivery since 2012, and 27 of those have taken place in the last three years. Twelve rural counties do not have any hospitals delivering babies, and Latino and low-income communities have been hit hardest by losses. *CalMatters* noted that the closures come as the country and state contend with a maternal mortality crisis, with pregnancy-related deaths reaching a 10 year high in 2020 in California.

The *CalMatters* report stated that hospital administrators cite a number of reasons for the closures, including high costs, labor shortages, and declining birth rates. In the past 30 years, the number of births have dropped by half in California, and the birth rate is at its lowest level on record. *CalMatters* noted that the trend is not unique to California, with labor and delivery units closing across the country. Many closures result from hospital systems consolidating maternity care into one location, which hospitals argue can help maintain staff training and provide a higher level of care. According to *CalMatters*, labor and delivery units are often the second-most expensive department for hospitals to run, second only to emergency rooms, and quoted a health researcher as stating that obstetrics units are often unprofitable for hospitals to operate.

As recently as February 8, 2024, Adventist Health Simi Valley announced it was closing its labor and delivery department and neonatal intensive care unit effective May 8, 2024. Adventist stated that births had declined by 25% at the hospital and it could no longer sustain the service. Adventist noted that Ventura County births dropped from 19 per 1,000 in 1990 to 10.5 per 1,000 in 2021.

c) Effects of Maternity Ward Closures. A 2018 study published by the *Journal of the American Medical Association* showed that rural counties not adjacent to urban areas fare the worst with the loss of hospital-based obstetric services. For these counties, maternity ward closures were associated with increases in out-of-hospital and preterm births and births in hospitals without obstetric units in the following year. The latter "emergency

births" in unprepared facilities also occurred in urban-adjacent counties. The Association of State and Territorial Health Organizations notes that the effect of hospital closures goes well beyond isolated negative health consequences, including the exacerbation of poor socioeconomic conditions, job loss, transportation barriers, and overall higher health care costs for disadvantaged communities. A study set for publication in April 2024 shows that obstetric closures have a nuanced impact on communities, depending on the size and rurality of the community. For example, in far northern counties, birthing people take the understood risk of giving birth while making the long drive to their obstetric facility. Others, in more urban communities may face other negative impacts not otherwise revealed without a specific impact assessment.

d) Closure of inpatient psychiatric unit operated by Good Samaritan Hospital. As the author stated, one impetus for this bill was the decision by HCA Healthcare, which operates Good Samaritan Hospital in San Jose along with its Mission Oaks campus in Los Gatos, to close its 18-bed inpatient psychiatric unit at Mission Oaks, effective in August of 2023. HCA Healthcare cited the difficulty to secure and sustain physicians and therapists to maintain the program when explaining the decision to close the unit. The closure left Santa Clara County with only 211 inpatient psychiatric beds for its population of nearly 1.9 million residents.

e) Insufficient inpatient psychiatric beds. According to the California Hospital Association (CHA), since 1995 the state has lost at least 37 facilities, either through the elimination of psychiatric inpatient care, or complete hospital closure, representing a 20% drop. CHA states that while there has been an increase in psychiatric beds over the past several years, California has lost nearly 30% of the psychiatric beds it had in 1995. On a per capita basis, accounting for the growth in California's population, this translates into a loss of more than 42% of the psychiatric inpatient beds per capita since 1995. California now has only 17 psychiatric beds for every 100,000 residents, compared to nearly 30 beds per 100,000 in 1995, and well short of the recommended minimum number of 50 psychiatric beds per 100,000. A County Behavioral Health Directors Association of California Governing Board Policy Brief from November 2015 cites specific challenges that contribute to the lack of crisis and inpatient care capacity, including:

- **i)** The federal Medicaid Institutions for Mental Disease exclusion, which prohibits states from receiving federal matching funds for inpatient services they provide to adult Medicaid enrollees aged 18 to 65 years in a hospital, nursing home, or other inpatient care setting with more than 16 beds;
- **ii)** Stigma and discrimination, due to negative attitudes and myths about the dangerousness of people with mental illness. Counties and providers often face substantial community opposition when attempting to construct or repurpose a facility intended to be used for individuals in psychiatric crisis or in need of inpatient care; and,
- **iii)** Divestment in acute psychiatric care and competing demands on hospitals, as, according to a report by the California Health Care Foundation, hospitals have focused more in the last decade on general acute care services (both adult and newborn intensive care capacity) over skilled nursing and acute psychiatric services. According to the American Hospital Association, hospitals have been closing psychiatric units because of low payments from public and private payers, uncompensated care for uninsured patients, and a dearth of psychiatrists willing to work in hospitals.

f) Current Process for Closing an emergency department Requires an Impact Evaluation. Under existing law, while most supplemental services only require a 90 day notice, hospitals are required to provide at least a 180 day notice prior to a planned reduction or elimination of the level of EMS to DPH, the local health department, and all health plans or other entities under contract with the hospital to provide services to enrollees. A separate provision of law, which permits a hospital to surrender a license or permit with the approval of DPH, specifies that "before approving a downgrade or closure of emergency services," the county or the local EMS authority is required to conduct an impact evaluation of the downgrade or closure upon the community, and how that downgrade or closure will affect emergency services provided by other entities. This impact evaluation is required to incorporate at least one public hearing, and must be done within 60 days of DPH receiving notice of the intent to downgrade or close emergency services. Despite the language stating, "before approving a downgrade or closure of emergency services," DPH has not interpreted this provision of law as giving them the ability to deny a hospital the ability to close or reduce emergency services, and therefore the impact evaluation is more of a tool to help the community and the local emergency services agency prepare for the reduction or closure.

3) **SUPPORT**. The National Alliance on Mental Illness – California (NAMI-CA), is the sponsor of this bill and states that it responds to the state's mental health and "maternity deserts" crises by increasing accountability, transparency and mitigating the impact to the health of the community. NAMI-CA notes that under current law, a health facility must give a 90-day public notice before closing or discontinuing services like maternity or inpatient psychiatric care. Such short notice for psychiatric facility closures deeply affects our loved ones. Sudden service disruption risks leaving vulnerable individuals without critical support, leading to increased mental health crises, emergency room visits, and potentially escalating to homelessness and incarceration. NAMI-CA states that this bill would require a health facility to provide a 120-day public notice of the elimination of its inpatient psychiatric or maternity ward unit. As part of its public notice, a health facility would be required to conduct, complete, and submit a in impact analysis report indicating the impact to the health of the surrounding community. The report would inform and allow the county board of supervisors and the public to determine the magnitude of the reduction of beds and services within a locality on the public health system and whether to expedite licensing of new bed services to account for the loss.

4) **OPPOSITION**. The California Hospital Association (CHA) is opposed to this bill and contends that hospitals are facing many challenges that are forcing them to eliminate or reduce services just to keep their doors open. CHA notes that they support policy changes and payment reforms that can improve access to care. Unfortunately, this bill does not address the underlying challenges that might force a hospital to make the difficult decision to reduce services. In fact, it will likely make current problems even worse. Specifically, this bill expands existing public noticing requirements from 90 days to 120 days. CHA states that it is unclear how an additional 30 days of public notice would mitigate the effects of service closure, or prevent the closure from occurring. Extending the public notice requirements will exacerbate the situation and speed up closures as health care providers and staff leave their jobs quickly after learning that a service is closing. CHA points out that hospitals already experience this challenge with the 90-day notification requirement; service lines often operate at reduced capacity than initially expected or close sooner than 90 days due to staff shortages caused by departures. Additionally, this bill would require hospitals to pay for and

provide an impact analysis to HCAI before issuing the 120-day notice of the proposed closure or elimination. The bill requires the impact analysis to include demographic data about every patient treated by the hospital over the past five years — data that hospitals already report to HCAI, and which is already publicly available.

This bill does not explain the purpose of providing the impact analysis to HCAI, yet gives HCAI new responsibilities without an identified funding source. Specifically, this bill would require HCAI to create a report format for the impact analysis that hospitals would be required to submit. CHA further notes that this bill requires DPH to determine whether the use of resources to keep the inpatient psychiatric services or maternity services open for the full 120 days would threaten the stability of the hospital as a whole. This bill also requires DPH to prioritize and expedite the licensing of additional beds to replace the number of lost beds "necessary to mitigate the negative impacts identified in the impact analysis report." CHA posits that presumably, DPH would need to obtain the impact analysis from the hospital or HCAI and then assess necessary service levels in a particular community, then require licensing staff to re-prioritize their existing workload, without any new resources. CHA concludes that, ultimately, this bill places new and ineffectual responsibilities and costs on the state and hospitals — without demonstrating any evidence these activities will prevent the closure of inpatient psychiatric care or maternity care services.

5) **RELATED LEGISLATION**. AB 1895 (Weber) requires, if a hospital that offers maternity services determines that those services are at risk of closure in the next 12 months, to report certain information to the Department of Health Care Services, HCAI, DPH, and the chairs of the Assembly and Senate Health Committee, including the number of patients served and prior and projected financial performance metrics, and requires this information to be kept confidential. Requires HCAI, in conjunction with DPH, to conduct a community impact assessment regarding the closure, to be completed within six months of notice from the hospital that the service is at risk. Requires this impact analysis to be provided to the public as part of the 90 day notice required under existing law. AB 1895 is pending in the Senate Health Committee.

6) **PREVIOUS LEGISLATION**.

   a) SB 45 (Roth) of 2023 would have established the California Acute Care Psychiatric Hospital Loan Fund to provide loans to qualifying county applicants for the purpose of constructing or renovating acute care psychiatric hospitals or psychiatric health facilities, or renovating or expanding general acute care hospitals in order to add or expand an inpatient psychiatric unit. SB 45 was held on the Assembly Appropriations Committee Suspense File.

   b) SB 1143 (Roth) of 2022 was substantially similar to SB 45. SB 1143 was vetoed by the Governor. In the veto message, the Governor stated that creating a new loan program without a funding source would create millions of dollars in General Fund pressure, and that bills with significant fiscal impact should be considered and accounted for as part of the annual budget process.

   c) AB 2037 (Wicks), Chapter 95, Statutes of 2020, increased the period of time when a hospital is required to provide public notice of a proposed closure or elimination of a supplemental service, from 90 days for the closure or downgrading of emergency

services and 30 days for all other closures or eliminations of supplemental services, to 180 days prior to the elimination or downgrading of emergency services, 120 days prior to the closure of a hospital, and 90 days prior to the elimination of any other supplemental service.

d) AB 1014 (O'Donnell) of 2019 would have increased the period of time when a hospital is required to provide public notice of a proposed closure or elimination of a supplemental service, from 90 days for the closure or downgrading of emergency services and 30 days for all other closures or eliminations of supplemental services, to 180 days prior to the closure of a hospital or the elimination or downgrading of emergency services, and 90 days prior to the elimination of any other supplemental service. AB 1014 was vetoed by the Governor, who stated the following in his veto message: "I agree that hospital closures have vast impacts on communities. However, this bill would not change the fact that the State is not able to force a hospital to stay open when they are financially unable. I am concerned that this bill may exacerbate the financial and patient safety concerns that often lead to closures."

e) AB 2874 (Thurmond) of 2018 would have required any hospital that provides EMS to notify the Attorney General no later than 180 days prior to a planned reduction or elimination of the level of EMS. AB 2874 failed passage on the Assembly Floor.

f) SB 687 (Skinner) of 2017 would have required a nonprofit corporation that operates a health facility that includes a licensed emergency center to obtain the consent of the Attorney General prior to a planned elimination or reduction in the level of EMS provided. SB 687 was vetoed by Governor Brown.

g) AB 2400 (Price), Chapter 459, Statutes of 2008, requires hospitals, not less than 30 days prior to closing a general acute care or acute psychiatric hospital, eliminating a supplemental service, as defined in existing regulations, or relocating the provision of a supplemental service to a different campus, to provide notice to the public and the applicable administering state department.

7) **AMENDMENTS**. In an attempt to address some of the concerns expressed by CHA, the author is proposing to amend this bill as follows:

a) To remove the option of closing a service line early if DPH cites for unsafe staffing practices, and instead to allow for earlier closure if DPH determines the hospital cannot maintain required staffing levels due to employee attrition;

b) Clarify language regarding the identification of the three nearest facilities with comparable services; and,

c) Specify that the data the health facility must report pertains only to the patients that received either inpatient psychiatric services or maternity services.

8) **POLICY COMMENT**. As currently drafted, this bill requires a hospital, when providing notice of elimination of a supplemental service of either inpatient psychiatric services or maternity services, to submit the impact analysis report to DPH and to the board of supervisors of the county in which the health facility is located. AB 1895 (Weber) as passed by this Committee requires HCAI, in conjunction with DPH, to conduct a community impact

assessment regarding the closure of maternity services. Moving forward the author may wish to work with the author of AB 1895 to ensure that the two bills are not in conflict.

REGISTERED SUPPORT / OPPOSITION:

Support

National Alliance on Mental Illness (sponsor)
Alum Rock Counseling Center
American Federation of State, County and Municipal Employees, AFL-CIO
Asian Americans for Community Involvement
Bel Air Congregate Living
Bill Wilson Center
California Council of Community Behavioral Health Agencies
California Labor Federation, AFL-CIO
California Nurses Association
California State Association of Psychiatrists
City of San Jose
County of Santa Clara
Health Access California
The Law Foundation of Silicon Valley
Western Center on Law & Poverty, INC.

Opposition

California Hospital Association
John Muir Health
Stanford Health Care

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

Date of Hearing: June 18, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1319 (Wahab) – As Amended May 16, 2024

SENATE VOTE: 39-0

SUBJECT: Skilled nursing facilities: approval to provide therapeutic behavioral health programs.

SUMMARY: Permits a skilled nursing facility (SNF), that is applying to provide therapeutic behavioral health programs in a physically separate unit of a SNF and is required to receive approvals from multiple departments, to apply simultaneously to those departments, and requires those departments to work jointly to develop processes to allow applications to be reviewed simultaneously to minimize the total approval time for all departments. Specifically, **this bill**:

1) Permits a SNF proposing to provide therapeutic behavioral health programs in an identifiable and physically separate unit of a SNF, as specified, that is required to submit an application and receive approvals from multiple departments, including the Department of Public Health (DPH), the Department of Health Care Access and Information (HCAI), and the Department of Health Care Services (DHCS), to apply simultaneously to those departments for review and approval of application materials.

2) Permits a SNF, if it is unable to complete the approval process from a department identified in 1) above because the applicant has not obtained required approvals and documentation from one or both of the other departments, to submit all available forms and supporting documentation, along with a letter estimating when the remaining materials will be submitted.

3) Requires departments that receive documents pursuant to 2) above to initiate review of the application, but prohibits final approval of the application from being granted until all required documentation has been submitted by the applicant to each department from which approval is required.

4) Requires DHCS, DPH, and HCAI to work jointly to develop processes to allow applications to be reviewed simultaneously and in a coordinated manner in order to streamline the determination process for approvals and to minimize the total approval time for all departments.

EXISTING LAW:

1) Provides for the licensure of health facilities, including SNFs, by DPH, and defines a SNF as a health facility that provides skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. [Health and Safety Code (HSC) §1250(c)]

2) Defines a "special treatment program service unit distinct part" as an identifiable and physically separate unit of a SNF that provides therapeutic programs to an identified population group of persons with mental health disorders. [HSC §1276.9(b)]

3) Requires health care providers seeking to be a Medi-Cal provider to submit a complete application package to DHCS, which is referred to as Medi-Cal Provider Enrollment. [Welfare and Institutions Code §14043 *et seq*.]

4) Requires the governing authority of a hospital, before adopting any plans for the hospital building, to submit the plans to HCAI for approval. For purposes of this requirement, "hospital building" includes any building that is used for a health facility that is required to be licensed, which includes SNFs, with certain exceptions. [HSC §129725, §129760]

FISCAL EFFECT: According to the Senate Appropriations Committee, DPH estimates one-time costs of $78,000 between 2025-26 and 2027-28 for staffing resources to collaborate with the other departments to jointly develop a simultaneous application review (Licensing and Certification Fund). HCAI estimates unknown costs, depending on the design and implementation of the joint processes developed by the departments (Hospital Building Fund). Unknown, potential General Fund costs for DHCS to develop and implement the joint processes.

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, our state is facing a behavioral health crisis and California suffers from minimal treatment facilities. The author states that this bill is part an approach to expand treatment for opioid addiction and other substance use disorders, including the facilitation of converting or expanding unused facilities into behavioral health facilities in a timely manner. Our growing senior population is most at risk, making up the fastest growing population in homelessness and substance abusers. The author concludes that this bill is a part of the Safer California Plan and is a strategic approach that will make our communities both healthier and safer – and it advances changes that are absolutely critical.

2) BACKGROUND.

a) Special treatment programs (STPs). STPs, pursuant to regulations governing these units (22 California Code of Regulations §72443), are SNFs that have a mental health program approved by DHCS. STPs provide programs to serve patients who have a chronic psychiatric impairment and whose adapted functioning is moderately impaired. STP services are those therapeutic services, including prevocational preparation and prerelease planning that are provided to mentally disordered persons having special needs in one or more of the following general areas: self-help skills, behavior adjustment, or interpersonal relationships. To be eligible for STP services, the patient's condition is required to be responsive to STP services and prohibitive to placement in a regular SNF. There are currently 65 approved STPs among the approximately 1,100 licensed SNFs in California.

b) STP approval process. There are three departments that have a role in approving an STP service unit of a SNF:

i) DPH: As the primary licensing entity for SNFs, any time there is a change in beds or service offered, a SNF needs to submit the necessary application to DPH to approve the change of service. The checklist for this application includes a number of required documents, including an approval document from HCAI if any construction is required, a floor plan, and a fire safety inspection request, among other requirements.

According to DPH, if facility construction is involved, which is likely when a distinct part unit is added, the HCAI-approved building plans must be included. If the submission is incomplete, the applicant is given a brief period to remedy the matter, but DPH's policy is to complete processing of a change of service application within 100 days. DPH states that it maintains communications with DHCS while the two departments are processing the respective applications.

ii) **HCAI**: According to information provided by the California Association of Health Facilities (CAHF) as well as HCAI, in order for a health care facility to change any portion of its space to a different type of occupancy (called a "change of use"), the facility would need to seek review and approval from HCAI to certify that the buildings meet the requirements for that new purpose. For example, a traditional SNF does not have locked doors, but a behavioral health unit may need delayed egress which is similar to a locked unit. Those delayed egress components must all be designed by an architect or engineer and the plans need to be approved by HCAI before occupancy can be changed. The Americans with Disabilities Act requirements also need to be addressed concurrently, driving complexity in older buildings. Once the permit is approved, the facility would then need to hire an inspector who would provide progress reports to HCAI throughout the project, with an HCAI compliance officer inspecting the final work and providing a certificate of occupancy if all has been done correctly. HCAI notes that for an applicant that had been previously licensed as a SNF but allowed its license to lapse, a project applicant wishing to get a new license as a SNF STP would have to ensure the facility is brought up to current Title 24 building standards.

iii) **DHCS**: SNFs are prohibited from accepting, for care, any mentally disordered patient who has an identified program need unless DHCS has approved the SNF's STP. The application for DHCS approval of these special treatment plans requires the SNF to submit various documents, including a letter of attestation from the local mental health director indicating the facility has a minimum of 30 patients whose need for special treatment program services has been reviewed and approved by the local mental health director. Additionally, the required documentation includes proposed staffing schedules, a description of the population groups to be served, a description of services to be provided, a detailed Policy and Procedure Manual that includes a variety of processes and protocols, job descriptions and resumes of proposed staff, and templates to be utilized by the program.

3) **SUPPORT**. CAHF is the sponsor of this bill and states that California continues to face a shortage of beds for individuals in need of behavioral health services across several types of settings. SNFs are licensed facilities that provide 24-hour care to residents whose primary need is for availability of skilled nursing care on an extended basis. SNFs serve an elderly and/or disabled population, most of whom are Medi-Cal and/or Medicare beneficiaries. CAHF notes that there is also a segment of SNFs that provide behavioral health services in addition to traditional SNF care to residents that have co-occurring behavioral health needs in addition to their physical nursing needs. There is a significant demand for behavioral health SNF services, but it can be challenging for SNF providers who wish to expand or convert existing SNF facilities to provide behavioral health care and skilled nursing services. CAHF states that in addition to the physical facility modifications that are required to offer SNF behavioral health services, the process for obtaining the necessary approvals from the

multiple state departments that regulate different aspects of the process can be time-consuming and delay the provision of much-needed services in the community. CAHF notes that allowing applicants to submit required documents to multiple state agencies at the same time will reduce the total time required to complete the entire process of obtaining approval to operate a behavioral health SNF. This bill does not require the specified state departments to change their application requirements for approving behavioral health SNFs. It does however, direct the departments to work together to develop a more efficient and streamlined process. CAHF concludes that reducing the administrative barriers to establishing and operating a behavioral health SNF will attract more Medi-Cal providers to provide this much-needed care.

4) **RELATED LEGISLATION**. SB 1354 (Wahab) requires a long-term care (LTC) facility participating in the Medi-Cal program to provide aid, care, service, or other benefits available under Medi-Cal-to-Medi-Cal recipients in the same manner, by the same methods, and at the same scope, level, and quality as provided to the general public, regardless of payment source. Requires LTC facilities to post a daily resident census on their website and provide resident census information upon request. SB 1354 is pending in the Assembly Health Committee.

5) **PREVIOUS LEGISLATION**.

   a) AB 1502 (Muratsuchi and Wood), Chapter 578, Statutes of 2022, revised the licensure application and approval process for SNFs, and prohibits any person, including an applicant for licensure, or change of ownership, or change of management, from acquiring, either directly or indirectly, an ownership interest in a SNF, or from operating, establishing, managing, conducting, or maintaining an SNF, prior to DPH review, approval, and issuance of a license.

   b) AB 1695 (Carrillo), Chapter 832, Statutes of 2019, requires a freestanding SNF to give a written notice to all residents of the facility 90 days prior to a transfer of management or a change of ownership, and requires all employees to be retained for a 60-day transition employment period.

   c) AB 275 (Wood), Chapter 185, Statutes of 2017, revised the procedures for when a long-term health care facility plans to close or there is otherwise a change in the status of their license resulting in a need to transfer residents by, among other things, requiring written notice to residents to be made 60 days in advance, rather than 30; requiring the facility to hold a community meeting for residents; and adding requirements to the proposed relocation plans that facilities are required to have approved by DPH, including identifying the number of affected residents and identifying the availability of alternative beds within the community as part of the proposed relocation plan.

REGISTERED SUPPORT / OPPOSITION:

Support

California Association of Health Facilities (sponsor)
Mayor Todd Gloria, City of San Diego
California Alliance for Youth and Community Justice
California State Association of Counties

California State Association of Psychiatrists (CSAP)
Californians for Safety and Justice
Californians United for A Responsible Budget
Communities United for Restorative Youth Justice (CURYJ)
Ella Baker Center for Human Right
Felony Murder Elimination Project
Friends Committee on Legislation of California
Initiate Justice
Prosecutors Alliance Action
Prosecutors Alliance of California, a Project of Tides Advocacy
Rubicon Programs
Santa Cruz Barrios Unidos
Smart Justice California, a Project of Tides Advocacy
Steinberg Institute
Vera Institute of Justice
Young Women's Freedom Center
Youth Leadership Institute

Opposition

None on file.

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

Date of Hearing: June 18, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1333 (Eggman) – As Amended June 4, 2024

SENATE VOTE: 37-0

SUBJECT: Communicable diseases: HIV reporting.

SUMMARY: Revises and recasts existing law to permit the Department of Public Health (DPH) and local health departments (LHDs) to disclose personally identifying information in public health records for the coordination of, linkage to, or reengagement in care, as determined by DPH or a LHD. Specifically, this bill:

1) Authorizes DPH and LHDs to disclose personally identifying information in public health records for the coordination of, linkage to, or reengagement in care, as determined by DPH or a LHD.

    a) Removes the limitations on disclosure described in 4) b) through d) of existing law, below.

    b) Removes the requirement that the disclosure is for the purpose of enhancing the completeness of reporting to the Centers for Disease Control and Prevention (CDC) of human immunodeficiency virus (HIV)/acquired immunodeficiency virus (AIDS) and coinfection with certain diseases.

2) Authorizes LHD HIV surveillance staff to disclose information to a health care provider who provides care to the HIV-positive person who is the subject of the record for the purpose of facilitating appropriate case management or care coordination or delivery of medical care and treatment.

3) Requires DPH and LHD employees and their contractors to sign confidentiality agreements annually, rather than signing the agreements once, and deletes the requirement that DPH and LHDs review the agreements annually.

4) Finds and declares the following:

    a) According to DPH, more than 142,700 people in California are living with diagnosed HIV infection.

    b) Approximately 73.7 % of people living with diagnosed HIV infection in California are in HIV care and 64.7 % have achieved viral suppression.

    c) The goals of the Ending the HIV Epidemic in the U.S. plan include increasing linkage to care and viral suppression to 95 % by 2025.

    d) Evidence-based data sharing practices allow state and LHDs to leverage public health and health care systems data to more effectively serve people living with HIV.

e) States the intent of the Legislature to enhance data sharing practices concerning people living with HIV, while continuing to prioritize privacy and safety measures to ensure responsible dissemination of sensitive health data and coordination of, linkage to, or reengagement in care.

EXISTING LAW:

1) Requires DPH to establish a list of diseases and conditions to be reported by local health officers (LHOs) to DPH. Requires DPH to specify the timeliness requirements related to the reporting of each disease and condition, and the mechanisms required for, and the content to be included in, reports made. Permits the list to include both communicable and non-communicable diseases. Permits the list to be modified at any time by DPH, after consultation with the California Conference of Local Health Officers. [Health and Safety Code (HSC) §120130]

2) Requires health care providers and laboratories to report cases of HIV infection to the LHO using patient names on a form developed by DPH. Requires DPH and LHD employees and contractors to sign confidentiality agreements, which include information related to the penalties for a breach of confidentiality and the procedures for reporting a breach of confidentiality, prior to accessing confidential HIV-related public health records. Requires those agreements to be reviewed annually by either DPH or the appropriate LHD. [HSC §121022]

3) Prohibits public health records relating to HIV/AIDS containing personally identifying information from being disclosed, except for public health purposes or pursuant to a written authorization by the person who is the subject of the record or by the person's guardian or conservator. Permits DPH or an LHD, or their agent, to disclose personally identifying information in public health records to other local, state, or federal public health agencies or to corroborating medical researchers, when the confidential information is necessary to carry out the duties of the agency or researcher in the investigation, control, or surveillance of disease, as determined by DPH or an LHD. [HSC §121025]

4) Permits the following disclosures for the purpose of enhancing the completeness of reporting to the CDC of HIV/AIDS and coinfection with certain diseases:

   a) LHD HIV surveillance staff may disclose the information to the health care provider who provides HIV care to the HIV-positive person who is the subject of the record;

   b) LHD tuberculosis control staff may disclose the information to DPH tuberculosis control staff, who may further disclose the information, without disclosing patient identifying information, to the CDC, to the extent the information is requested by the CDC and permitted for purposes of the investigation, control, or surveillance of HIV and tuberculosis coinfections;

   c) LHD sexually transmitted disease (STD) control staff may disclose the information to DPH STD control staff, who may further disclose the information, without disclosing patient identifying information, to the CDC, to the extent it is requested for the purposes of the investigation, control, or surveillance of HIV and syphilis, gonorrhea, or chlamydia coinfection; and,

d) For purposes of the investigation, control, or surveillance of HIV and its coinfection with hepatitis B, hepatitis C, and meningococcal infection, LHD communicable disease staff may disclose the information to DPH staff, who may further disclose the information, without disclosing patient identifying information, to the CDC to the extent the information is requested. [HSC §121025 (c)(1)]

5) Permits certain LHD staff, for the purpose of facilitating appropriate medical care and treatment of persons coinfected with HIV and tuberculosis, syphilis, gonorrhea, chlamydia, hepatitis B, hepatitis C, or meningococcal infection, to further disclose the information to DPH or LHD STD, communicable disease control, and tuberculosis control staff; the HIV-positive person who is the subject of the record; or, the health care provider who provides their HIV, tuberculosis, hepatitis B, hepatitis C, meningococcal infection, and sexually transmitted disease care. [HSC §121025 (c)(3)]

FISCAL EFFECT: According to the Senate Appropriations Committee, DPH estimates minor and absorbable costs. Unknown costs to LHDs to annually obtain signed confidentiality agreements. Cost to counties for administration would be potentially reimbursable by the state, subject to a determination by the Commission on State Mandates.

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, California law only allows state and local public health personnel to communicate with each other or with health care providers about a person's HIV status to facilitate medical care and treatment if the person has HIV alone or has HIV coinfection with specific diseases (tuberculosis, hepatitis B, hepatitis C, meningococcal infection, chlamydia, gonorrhea, syphilis, or meningococcal infection). Sharing of information for other reportable communicable disease, such as hepatitis A, monkeypox (Mpox), or Shigella, is not allowed. The author continues that during the 2022 Mpox outbreak, DPH could not disclose a patient's HIV status to an LHD or health care provider even when responding to an urgent request for clinical consultation on a complex Mpox case, potentially resulting in more fragmented patient care and delaying appropriate treatment, risking more severe infections. Not being able to record an Mpox case's HIV status in the secure and confidential data systems for Mpox investigations meant that LHDs were also unable to determine whether people diagnosed with Mpox needed linkages to HIV care or prevention services, resulting in missed opportunities to prevent HIV transmission. The author contends that California laws limiting the sharing of HIV data has seriously hindered the ability of LHDs and health care providers to triage Mpox cases and delivery of timely, client-centered Mpox services for the people at highest risk of Mpox complications. The author concludes that this bill will improve California's ability to ensure timely, quality health care for people with HIV and other reportable communicable diseases.

2) **BACKGROUND**.

   a) **Prevalence of diagnosed HIV infection in California.** According DPH, the prevalence of diagnosed HIV infection was 355.6 per 100,000 population in 2022, compared to 343.1 per 100,000 in 2018 – an increase of 3.7%. Of the 142,772 people living with diagnosed HIV infection in 2022, 73.7% were in HIV care and 64.7% achieved viral suppression. Among all racial/ethnic groups, African Americans are the most disproportionately affected by HIV. While Latinx and white individuals make up the

largest percentage of persons living with diagnosed HIV, the rate of HIV among African Americans is substantially higher (1,012.3 per 100,000 population, versus 319.5 per 100,000 among whites and 364.8 per 100,000 among Latinx). The rate of new HIV diagnoses among African Americans is 4.4 times higher than whites among men and 5.7 times higher among women. Latinx are also disproportionately affected by HIV with rates of new HIV diagnoses 2.7 times higher than white among men and 1.6 times higher among women. Most of California's living HIV cases are attributed to male-to-male sexual transmission (66.3%; 8.2% of living cases are attributable to high-risk heterosexual contact; 6% to men who have sex with men who also inject drugs; 5.3% to injection drug use; 1.9% to transgender sexual contact; 0.5% to perinatal exposure and 11.9% to other or unknown sources including other heterosexual contact).

b) **HIV/Mpox coinfection.** According to DPH, the recent Mpox outbreak disproportionately affected people with HIV. The CDC estimates 38% of Mpox infections nationally from May through July 2022 were among people with HIV. According to the CDC, people with HIV, particularly people whose HIV is not virally suppressed, are more likely to be hospitalized and can be at the highest risk of severe Mpox infection and death if they are infected with Mpox compared with people who are infected with Mpox who do not have HIV. Through March 2024, 40.2% of Mpox infections in California have occurred in people with HIV. All three of the Mpox deaths in California during the recent outbreak were among people with advanced AIDS. People with advanced HIV are most likely to experience severe manifestations of their Mpox infection; these are also the patients about whom DPH was most often consulted on at the height of the Mpox outbreak in 2022. People with HIV whose viral load is not fully suppressed have a greater clinical need both for Mpox vaccination and for Mpox treatment due to increased risk for severe disease and death. CDC recommends considering administration of Mpox treatment for people with HIV who are not virally suppressed, and knowing this information is critical to facilitate prompt treatment which can prevent severe health outcomes of HIV/Mpox coinfection, including death.

c) **Impact of statutory limitations on Public Health's response to the Mpox outbreak in California**. DPH indicates that because Mpox is not included on the list of conditions under existing law that can be cross referenced with HIV data in the state's electronic surveillance system, public health officials were unable to document and understand whether people with Mpox were infected with HIV in our surveillance systems. This delayed public health's ability to understand that this population, which we now know is at greater risk of severe complications and death, was adversely impacted by Mpox and consequently delayed DPH's ability to develop the specific guidance and outreach that would have more promptly enabled local public health and clinical partners to prevent severe Mpox disease in this population. DPH indicates that not being able to record an Mpox case's HIV status in the secure and confidential data systems used by nearly all local health jurisdictions in California (California Reportable Disease Information Exchange and CalCONNECT) for Mpox investigations meant LHDs are unable to determine whether people diagnosed with Mpox also needed linkages to HIV care or prevention services, resulting in missed opportunities to prevent HIV transmission. DPH further indicates that existing law limiting the sharing of HIV data has seriously hindered the ability of LHDs and health care providers to triage Mpox cases and delivery of timely, client-centered Mpox services for the people at highest risk of Mpox complications. Knowing an individual's HIV status is critical to timely and

comprehensive Mpox case investigation, including to identify priority cases for follow up and to guide their care and facilitate prompt treatment. People with HIV whose viral load is not fully suppressed have a greater clinical need both for Mpox vaccination and treatment due to increased risk for severe disease and death. DPH indicates that due to statutory limitations DPH was not able to use all of the data that could have been available to make public health decisions.

This bill allows confidential HIV reporting and data sharing for all reportable communicable diseases between public health officials and health care providers in order to facilitate the care of patients with HIV.

3) **SUPPORT**. According to APLA Health, Equality California, and the San Francisco AIDS Foundation, cosponsors, this bill will allow confidential HIV reporting and data sharing between public health officials and health care providers for all reportable diseases to promote the health and wellbeing of people with HIV, without needing to amend California law for each new or existing reportable infection. Expanding the sharing of HIV data for all reportable diseases will allow DPH to respond quickly to an emerging disease affecting people with HIV, including during a public health emergency, and promote improved health outcomes for people with HIV. Strong federal and state privacy laws will remain in place to protect the confidentiality and privacy rights of patients while better addressing the health needs of people with HIV.

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

REGISTERED SUPPORT / OPPOSITION:

Support

Amador County Arts Council
APLA Health
Asian Americans Advancing Justice Southern California
Bienestar Human Services
California Democratic Party
California Transcends
Christie's Place
City and County of San Francisco
County Health Executives Association of California (CHEAC)
Courage California
El/la Para TransLatinas
Equality California
Glide
Health Officers Association of California
Los Angeles LGBT Center
National Center for Lesbian Rights
Parivar Bay Area
PRC
Radiant Health Centers
San Francisco AIDS Foundation

San Joaquin Pride Center
Somos Familia Valle
The Pride Panthers Coalition INC
The Source LGBT+ Center
TransFamily Support Services
TransYouth Liberation

Opposition

None on file.

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

Date of Hearing: June 18, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1382 (Glazer) – As Amended March 20, 2024

SENATE VOTE: 37-0

SUBJECT: Community and rural health clinics: building standards.

SUMMARY: Prohibits construction standards for community clinics or rural health clinics, as defined, established by the Department of Health Care Access and Information (HCAI) and established or applied by a city or county, from being more restrictive than comparable construction standards established or otherwise applied to clinics exempt from licensure. Repeals a provision of existing law prohibiting building standards for the construction or alteration of buildings used for outpatient clinical services of a hospital from being more restrictive or comprehensive than comparable building standards established, or otherwise applied, to licensed clinics.

EXISTING LAW:

1) Licenses and regulates clinics, including primary care clinics (PCCs) and specialty clinics, by the Department of Public Health (DPH). [Health and Safety Code (HSC) §1200, et seq.]

2) Defines a PCC as either a "community clinic," which is required to be operated by a non-profit corporation and to use a sliding fee scale to charge patients based on their ability to pay, or, as a "free clinic," which is also required to be operated by a non-profit but is not allowed to directly charge patients for services rendered or for any drugs, medicines, or apparatuses furnished. [HSC §1204]

3) Exempts various types of clinics from licensure and regulation by DPH, including the following:
   a) Any place or establishment operated as a clinic or office by one or more licensed health care practitioners and used as an office for the practice of their profession, within the scope of their license;
   b) Clinics operated by the federal government, the state, counties, cities, or federally recognized Indian tribes on tribal land;
   c) A clinic operated by any institution of learning that teaches a healing art;
   d) Medical foundation clinics; and,
   e) The offices of physicians in group practice who provide the preponderance of their services to members of a health plan. [HSC §1206]

4) Exempts from DPH licensure an intermittent clinic that is operated by a licensed primary care community clinic on separate premises from the licensed clinic and is only open for limited services of no more than 40 hours each week. Requires an intermittent clinic operated under this exemption to meet all other requirements of law, including administrative regulations and requirements, pertaining to fire and life safety. [HSC §1206(h)]

5) Requires HCAI, in consultation with the Community Clinics Advisory Committee, to prescribe minimum construction standards of adequacy and safety for the physical plant of

clinics as found in the California Building Standards Code, known as "OSHPD 3," because it is regulated by the Office of Statewide Hospital Planning and Development (OSHPD) within HCAI. [HSC §1226(b)]

6) Prohibits the construction standards for buildings where outpatient clinical services of a hospital are provided, that is separate from a building in which hospital services are provided, from being more restrictive or comprehensive than the building standards established for licensed clinics. Limits these buildings from providing more than 25% of the total outpatient services to inpatients of the hospital. [HSC §129725, §129885]

7) Establishes the Community Clinics Advisory Committee (committee), which is required to meet on an ad hoc basis and to be comprised of at least 15 individuals who are employed by, or under contract to provide service to, a community clinic on a full-time basis, either directly or as a representative of a clinic association. Requires members of the committee to be appointed by the three statewide primary clinic associations in California that represent the greatest number of community or free clinic sites. [HSC §1226.2]

FISCAL EFFECT: According to the Senate Appropriations Committee, HCAI estimates costs of $192,590 in 2025-26 and $201,590 in 2026-27 (Hospital Building Fund). This estimate includes the expertise of a technical team to research, develop, and repeal or propose for adoption building standards specific to PCCs in a future Title 24 Code Adoption Cycle. Participation with the committee, the Hospital Building Safety Board, as well as public stakeholder meetings would be required to develop the building standards.

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, this bill right-sizes building and construction standards that PCCs must comply with by allowing these clinics to follow their city and county clinic building standards, like federal clinics and doctor's offices, rather than more onerous OSHPD 3 standards. OSHPD 3 standards require more complex electrical, plumbing, ventilation, and mechanical systems. These standards are more appropriate for hospital clinics because 25% of their care can be inpatient services, where a hospital admits a patient overnight. In comparison, PCCs only provide primary care outpatient services, like reproductive care and wellness checkups. This bill ensures that patient safety is not jeopardized while reducing barriers preventing the expansion of crucial healthcare services to our states most vulnerable and underserved rural and urban populations. The author notes that over 1,270 PCCs provide critical, high-quality healthcare services to more than one in five Californians, regardless of their ability to pay, immigration status, or other individual circumstances. The author concludes that current law requires PCCs to adhere to the same building and property acquisition standards as their larger in-patient counterparts, hindering their ability to grow and meet the needs of their communities.

2) **BACKGROUND**.

   a) **OSHPD 3 building code requirements vs. building requirements for unlicensed clinic settings.** While PCCs are not required to comply with seismic safety standards that apply to hospitals, licensed clinics are required to meet certain building code requirements, known as OSHPD 3 requirements. In addition to PCCs, OSHPD 3 requirements also apply to outpatient clinical services of a hospital, but do not apply to

unlicensed settings, such as intermittent clinics or other exempted clinics, or doctor's offices. Building codes are updated on a triennial basis, and for a long time, the changes to OSHPD 3 requirements were modest and minor. In the triennial cycle that resulted in the publication of the 2013 building codes, however, OSHPD pushed to bring the OSHPD 3 requirements into conformance with the national model code. The resulting update was a big change in requirements, and led to complaints from clinics and hospitals about the expense of expanding or purchasing a new clinic/outpatient facility.

OSHPD 3 requirements include a number of specific requirements, including minimum space for examination rooms, minimum requirements for handwashing stations, specific ventilation requirements, among many others building code requirements relating to electrical, mechanical, and plumbing systems. According to a survey that the California Primary Care Association conducted of its member clinics in 2017, the most difficult requirements of OSHPD 3 were related to mechanical ventilation requirements. Clinics reported that the average increase in project costs was 112%, and one clinic reported that it had specifically not opened a new facility in an area of high demand for services, due to the costs of complying with OSHPD 3. According to HCAI's OSHPD 3 checklist, all new buildings and additions, alterations or repairs to existing buildings, and conversion of space to a clinic use within existing buildings, are required to comply with OSHPD 3 and other applicable building code requirements. However, HCAI's checklist states that existing clinic facilities that have architectural conditions, such as room size or corridor width, that fail to meet the requirements of OSHPD 3 but were compliant at the time of their construction, may be considered acceptable, even if the clinical space is being reused under a new tenant/owner, if the use does not change.

This bill seeks to apply the same building code standards that currently apply to county clinics to all licensed clinics. Because county clinics are exempt from licensure (as noted in 3) c) of existing law, above), they are exempt from OSHPD 3. According to OSHPD, settings that are exempt from OSHPD 3, such as medical office buildings and county clinics, still have to meet all other state and local building code requirements that apply to office buildings generally, but are not subject to healthcare-specific standards adopted by HCAI.

The ability to avoid having to comply with OSHPD 3 requirements was one of the motivating factors for the recent expansion in the number of hours an "intermittent clinic" could be open and still be exempt from licensure (and therefore exempt from compliance with OSHPD 3). As noted in Previous Legislation below, legislation in 2015 increased the hours that an intermittent clinic could be open from 20 to 30 hours per week, and in 2018, it was increased a second time to 40 hours per week.

b) Standards for PCCs linked to those of hospital-based clinics. As noted above, OSHPD 3 requirements apply to clinics that are licensed by DPH, including PCCs, as well as outpatient clinical services that are part of a hospital's license. There is a provision of law that prohibits the standards for hospital-based outpatient clinical services from being higher than those established for licensed clinics. However, as the author points out, hospital-based clinical settings can provide as much as 25% of their care to inpatients, which are typically of a higher acuity level than those seen at PCCs. As stated by HCAI, current statute "requires free standing PCCs, that are unaffiliated with a hospital and that will never provide inpatient services, to nonetheless meet higher

building standards applied to facilities that must be prepared to provide inpatient services." The author argues that this statutory link is what is stopping HCAI from modifying their PCC standards to the appropriate acuity level for a primary care setting. The author and sponsor point out that private physician offices, and even county clinics, since they are exempt from licensure, are permitted to operate without meeting OSHPD 3 requirements, without any documented risk to public health and safety. If a PCC acquires one of these unlicensed settings, they are required to meeting OSHPD 3 standards, even though the site was providing the same services to patients previously without complying with OSHPD 3.

c) **Community Clinics Advisory Committee (CAC)**. Under existing law, OSHPD 3 requirements are required to be established by HCAI "in consultation with the Community CAC." However, the CAC had not been convened when the 2013 update to OSHPD 3 (which caused concern among the clinic community) was adopted. It has since been convened, and HCAI states the CAC has been meeting for approximately four years and continues to meet quarterly. With HCAI's guidance, the CAC has worked to better align the needs of PCCs when they are converting an existing clinic or clinic building into an OSHPD 3 building. As part of this effort, HCAI has restructured the Plan of Modernization (POM) program to be more flexible with the sequencing of achieving OSHPD 3 compliance. The POM program allows clinics three years to meet OSHPD 3 standards and operate as a clinic while they correct any deficiencies. This means that the clinic space can be put in operation prior to completion of the work necessary to bring it into compliance. With the revisions to the POM, the path to meet OSHPD 3 has more flexibility to achieve compliance. The revisions also allow PCCs to know what is expected, which in turn, helps estimate the costs prior to acquiring or leasing an existing space for their clinical needs.

   HCAI states that it has also restructured the clinic checklists and guides providing local jurisdictions more guidance when reviewing existing clinics that are converting into an OSHPD 3 setting. These revisions include providing a tolerance or some limited flexibility with OSHPD 3 requirements for existing room sizes and some utilities.

d) **Affiliate clinic licensure**. SB 442 (Ducheny), Chapter 502, Statutes of 2010, streamlined provisions related to PCC affiliate licensure. Under SB 442, a PCC that has held a license for five years with no history of repeated or uncorrected violations can apply for an "affiliate clinic" license to establish a PCC at an additional site. An affiliate license application does not require an initial onsite survey, and is a more simplified and streamlined process than applying for a new stand-alone license. Additionally, PCCs operating under a single corporation utilizing the affiliate licensing option are entitled to consolidate certain administrative functions such as billing and related financial functions, purchasing functions, and offsite storage and maintenance of certain patient and personnel records. However, affiliate clinic sites must still provide evidence of compliance with OSHPD 3.

3) **SUPPORT**. The California Primary Care Association (CPCA) supports this bill and states that it modernizes licensing and building standard requirements for community health centers (CHCs) while continuing to provide necessary patient protection by tying requirements to the existing standards for county clinics. Current building standards apply to both CHCs, and clinical services of a general acute care hospital. This is problematic because in the CHC

setting only outpatient services are provided, while hospital clinics are allowed to provide up to 25% of their care as inpatient services. Subsequently these standards are tailored to address the higher acuity needs of inpatient services allowed for hospital-based clinics. Existing law is stopping the state from modifying CHC standards to the appropriate acuity level for a primary care outpatient clinic setting. As a critical component to California's healthcare delivery system, CHCs provide quality healthcare services to low-income individuals and families that are often uninsured or underinsured or living in healthcare deserts. Current standards result in barriers to access patient care because CHCs are required to utilize funds for unnecessary construction costs rather than expanding healthcare services or opening additional clinics in underserved communities. Private physician offices and county clinics who provide the same services as CHCs, currently operate outside of the hospital-based construction requirements without any documented risk to public health and safety or environmental protections. CPCA concludes that this bill will ensure health centers can successfully meet rising inflationary costs and continue providing innovative, quality, community-based, equitable care to their 7.7 million patients.

4) PREVIOUS LEGISLATION.

a) AB 1612 (Pacheco) of 2023 would have permitted a PCC, with a license in good standing for the preceding five years, to construct a new outpatient clinic, acquire ownership or control of an accredited outpatient setting, acquire ownership or control of a license-exempt clinic or office, or acquire ownership or control of a previously licensed PCC, and deems these constructed or acquired facilities to be compliant with the minimum construction standards of adequacy and safety known as OSHPD 3 building code requirements. AB 1612 was vetoed by the Governor, who stated:

"I support the author's goal to encourage the expansion of PCCs to increase their capacity to provide care. However, this bill removes important health and safety protections for patients, clinic staff, and the public. Every PCC, regardless of location, should meet the applicable state licensing standards and building codes. This bill exempts certain facilities from those safety measures."

b) SB 779 (Stern), Chapter 505, Statutes of 2023, adds intermittent clinics that are exempt from licensure to an existing requirement that clinics file an annual report to HCAI with specified information. Additionally, creates new reporting requirements for all PCCs, including intermittent clinics, to report various types of data to HCAI, including a labor report and a workforce development report.

c) AB 899 (Wood) of 2019 proposed to exempt buildings acquired by a licensed PCC under either the affiliate licensure process or the consolidated licensure process from the requirement to meet minimum construction standards of adequacy and safety, known as OSHPD 3, if the building, prior to being acquired, was an outpatient setting or a previously licensed PCC that was actively seeing patient within the previous 18 months. AB 899 was vetoed by the Governor, who stated:

"This bill would eliminate the primary clinic licensure process for certain acquired clinics. I support the stated goal of this bill, which is to encourage an increase in the number of primary clinics in California; however, the bill's proposed method for

accomplishing that goal removes important health and safety protections for patients, clinic staff, and the public."

d) AB 2204 (Gray), Chapter 279, Statutes of 2018, extends the limit on the number of hours an intermittent PCC can operate, from 30 to 40 hours per week, and still be exempt from licensure.

e) AB 2053 (Gonzalez and Gray), Chapter 639, Statutes of 2016, requires DPH, upon written notification by a licensed PCC or an affiliate clinic that it is adding an additional physical plant maintained and operated on separate premises, to issue a single consolidated license to the clinic.

f) AB 1130 (Gray), Chapter 412, Statutes of 201,5 expands the licensure exemption for intermittent clinics that are operated by licensed clinics on separate premises by permitting these intermittent clinics to be open for up to 30 hours per week, instead of only 20 hours per week.

g) AB 941 (Wood), Chapter 502, Statutes of 2015, expanded a licensure exemption for tribal clinics, which were previously exempted if located on tribal land, by exempting tribal clinics regardless of the location of the clinic, if the clinic is operated under a contract with the U.S. pursuant to the Indian Self-Determination and Education Assistance Act.

h) SB 442 streamlined the administrative requirements for a clinic corporation to apply for licensure for an affiliate PCC.

i) SB 937 (Ducheny), Chapter 602, Statutes of 2003, revised provisions relating to the licensure and operation of PCCs; permitted a PCC to add a service or remodel a site without first having to apply for a new license from DPH; and, required DPH to issue an affiliate license to a PCC to allow it to open a clinic at an additional site, under specified conditions.

5) POLICY COMMENT. The burden and costs of compliance with OSHPD 3 building requirements for licensed clinics, and the lack of this requirement for primary care settings that are exempt from clinic licensure has been an ongoing issue before the Legislature, as illustrated in Previous Legislation, above. Because OSHPD 3 only applies to clinics that are required to obtain a license from DPH, various work-arounds have been proposed, including expanding the number of hours that an "intermittent clinic" (which is an additional location operated by clinic that has a licensed site at another location) could operate and still be exempt from needing a license. More recently, AB 1612 and AB 899 sought to exempt existing clinic buildings from OSHPD 3.

Both of these bills were vetoed by the Governor who stated that they removed important health and safety protections for patients and clinic staff. While this bill uses different language (tying building standards to those that apply to county clinics that are exempt from licensure and therefore exempt from OSHPD 3) the end result is the same: exempting licensed clinics from OSHPD 3. However, Section 2 of this bill, which was included in AB 1612, removes the requirement that licensed clinics have the same building standard requirements as hospital-based clinics that might see patients with a higher acuity level. This

provision, rather than exempting clinics from a standard, would give HCAI the discretion to reduce standards for community clinics without reducing standards for hospital-based clinics, and potentially avoid a Governors' veto. Moving forward, the author may wish to consider amending this bill to remove Section 1.

REGISTERED SUPPORT / OPPOSITION:

Support

Alameda Health Consortium - San Leandro, CA
APLA Health
Arroyo Vista Family Health Center
Asian Americans for Community Involvement
Asian Health Services
CA Partnership for Health
Central Valley Health Network
Chapa-De Indian Health
CommuniCare+OLE
Community Clinic Association of Los Angeles County (CCALAC)
CPCA Advocates, Subsidiary of The California Primary Care Association
Dientes Community Dental
El Proyecto Del Barrio, INC.
Elica Health Centers
Family Health Care Centers of Greater Los Angeles, INC.
Family Health Centers of San Diego
Friends of Family Health Center
Golden Valley Health Centers
Health Alliance of Northern California
Health and Life Organization, Inc.
Health Center Partners of Southern California
Hill Country Community Clinic
Hurtt Family Health Clinic
Inland Family Community Health Center
Lifelong Medical Care
Neighborhood Healthcare
North Coast Clinics Network
North East Medical Services
Northeast Valley Health Corporation
Saban Community Clinic
Samuel Dixon Family Health Center, INC.
San Diego Regional Chamber of Commerce
San Francisco Community Clinic Consortium
San Ysidro Health
Santa Rosa Community Health
Share Ourselves
Shasta Community Health Center
Sierra Family Health Center
St. John's Community Health
St. Jude Neighborhood Health Center

Tarzana Treatment Centers, INC.
TCC Family Health
Tiburcio Vasquez Health Center, INC.
TrueCare

Opposition

None on file.

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

Date of Hearing: June 18, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1397 (Eggman) – As Amended April 15, 2024

SENATE VOTE: 37-0

SUBJECT: Behavioral health services coverage.

SUMMARY: Requires a health plan contract or health insurance policy to comply with specified requirements for services delivered by a county behavioral health agency covered under the Full Service Partnership (FSP) Service Category, including utilization review (UR) and reimbursement. Specifically, **this bill**:

1) Applies to medically necessary mental health (MH) and substance use disorder (SUD) services covered under the FSP Category regulated pursuant to 10) of existing law below and provided to an enrollee or insured.

2) Requires a health plan contract or insurance policy, issued, amended, renewed, or delivered on or after July 1, 2025, that covers medically necessary MH and SUD services to comply with this bill for services provided to an enrollee or insured referred or agreed to by the plan or insurer or a plan provider with approval from the plan or insurer, when delivered by a county behavioral health agency that complies with 12) below.

3) Authorizes a health plan or insurer to conduct a postclaim review to determine appropriate payment of a claim. Allows payment for services subject to this bill to be denied only if the health plan or insurer reasonably determines the enrollee or insurer was not enrolled with the plan or insurer at the time the services were rendered, the services were never performed, or the services were not provided by a health care provider appropriately licensed or authorized to provide the services pursuant to 1) above.

4) Allows a health plan or insurer to require prior authorization for services as permitted by the Department of Managed Health Care (DMHC) or California Department of Insurance (CDI) pursuant to 9) below.

5) Requires a referral or authorization by a health plan or insurer for services provided by a behavioral health agency under this bill to constitute authorization for coverage of any services provided under the FSP Service Category identified in the Individual Services and Supports Plan (ISSP), pursuant to 10) of existing law below.

6) Requires a health plan or insurer reimburse a county behavioral health agency for services pursuant to this bill, other than prescription drugs, at the greater of either of the following amounts:
   a) The health plan or insurer's contracted rate with the county behavioral health agency; or,
   b) The fee-for-service or case reimbursement rate paid in the Medi-Cal specialty behavioral health program for the same or similar services as identified by the Department of Health Care Services (DHCS).

7) Requires a health plan or insurer to reimburse a county behavioral health agency for prescription drugs provided to an enrollee or insured pursuant to this bill at the health plan or insurer's in-network rate.

8) Requires a health plan or insurer to reimburse a county behavioral health agency for services provided pursuant to this bill in compliance with the requirements for existing timely reimbursement of claims.

9) Authorizes the DMHC or CDI, no later than April 1, 2025, to issue guidance to health plans or insurers regarding compliance with this bill. Prohibits guidance from being subject to the Administrative Procedure Act (APA) and guidance effective only until DMHC or CDI adopts regulations pursuant to the APA.

10) Specifies that this bill does not exempt a health plan or insurer from complying with existing MH and SUD UR requirements, pursuant to 2) under existing law below.

11) Exempts Medi-Cal managed care (MCMC) contracts from the provisions of this bill.

12) Requires a county behavioral health agency to, unless the enrollee or insured is referred or authorized by the plan or insurer, contact the plan or insurer before initiating services to determine whether the enrollee or insured needs an urgent or nonurgent appointment and to facilitate a referral to the plan or insurer's network providers, as appropriate and consistent with professionally recognized standards of practice.

13) Requires the plan or insurer's designated behavioral health professional to facilitate referral to the plan or insurer's network providers if the plan or insurer is able to offer the enrollee or insured an appointment within 48 hours for an urgent care appointment or within 10 business days for a nonurgent appointment.

14) Provides that if the plan or insurer is unable to offer the enrollee or insured an appointment within 48 hours for an urgent care appointment or within 10 business days for a nonurgent appointment, except as provided in 15) below, the health plan or insurer to authorize the services and the county behavioral health agency to initiate and complete the treatment.

15) Allows the applicable waiting time for a particular appointment to be extended if the referring or treating licensed behavioral health provider, or the health professional providing triage or screening services, as applicable, acting within the scope of the individual's practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the enrollee or insured.

16) Prohibits the county behavioral health services agency from billing the enrollee or insured more than the in-network cost sharing, if any.

17) Allows the plan or insurer to submit a dispute to the DMHC or CDI, and requires the health plan or insurer to comply with existing requirements for timely reimbursement, including for services or amounts in dispute, if the plan or insurer disputes the services provided or the billed charges. Requires the DMHC or CDI to have trained staff available to address any disputes arising from this bill.

18) Requires in-network cost sharing for MH and SUD services and prescription drugs to apply to services subject to this bill and cost sharing to accrue to a plan or insurer's in-network deductible, if any, and in-network out-of-pocket maximum.

EXISTING LAW:

1) Establishes DMHC to regulate health plans and CDI to regulate health insurers. [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]

3) Requires a health plan and a health insurer, including a MCMC plan, to ensure that an enrollee or insured that is undergoing a course of treatment for an ongoing MH or SUD condition is able to get a follow-up appointment with a nonphysician MH care or SUD provider within 10 business days of the prior appointment. Requires that a referral to a specialist by another provider meet the timely access standards. Requires the health plan, including a MCMC plan, to arrange coverage for the provision of specialty services from specialists outside the plan's contracted network if a health plan is operating in a service area that has a shortage of providers and is not able to meet the geographic and timely access standards for providing MH or SUD services with an in-network provider. [HSC §1367.03 and INS §10133.53]

4) 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*.]

5) Requires DHCS to fund counties with integrated service agencies or countywide systems of care, and requires counties to use available state and matching funds for the client target population. [WIC §5805]

6) Establishes the Mental Health Services Act (MHSA) to provide funds to county MH programs to expand services, develop innovative programs, and integrate service plans for mentally ill children, adults, and older adults through a 1% income tax on personal income above $1 million. Establishes the Mental Health Services Fund to fund the various programs. [WIC §5813.5 and §5890 and Revenue and Tax Code §17043]

7) Amends the MHSA to the Behavioral Health Services Act (BHSA) to be provided at sufficient levels to ensure counties can provide each adult and older adult served with the medically necessary MH and SUD treatment services and medications identified during the service planning process as specified, which are applicable client clinical record. [WIC §5813.5]

8) Requires a county to seek reimbursement for a behavioral health service, supportive service, housing intervention, or other related activity that is covered by or can be paid from another available funding source, including other MH funds, SUD funds, public and private insurance, and other local, state, and federal funds. [WIC §5813.5]

9) Requires each county to establish and administer a FSP program that include specified MH services, supportive services, and SUD treatment services. Requires FSP services to be provided pursuant to a whole-person approach that is trauma informed, age appropriate, and in partnership with families or an individual's natural supports and requires services to be provided in a streamlined and coordinated manner so as to reduce any barriers to services. [WIC §5887]

10) Requires counties to develop and operate programs to provide services under the FSP Service Category. Allows the services to be provided for each client with whom the county has a FSP agreement to include the Full Spectrum of Community Services necessary to attain the goals identified in ISSP. Includes services the county, in collaboration with the client, and when appropriate the client's family, believe are necessary to address unforeseen circumstances in the client's life that could be, but have not yet been included in the ISSP. Specifies that the Full Spectrum of Community Services consists of the following:

    a) MH services and supports including, but not limited to: MH treatment; peer support; ISSP development; and Crisis intervention/stabilization services;

    b) Non-MH services and supports including, but not limited to: food; clothing; and, housing; and,

    c) Wrap-around services to children, as specified. [Title 9 of the California Code of Regulations §3620]

11) Allows a county to report to DMHC and CDI, as appropriate, complaints about a health plan's or a health insurer's failure to make a good faith effort to contract or enter into a single case agreement or other agreements to obtain reimbursement with the county, and, also report a failure by a health plan or insurer to timely reimburse the county for services the plan or insurer must cover as required by state or federal law. [WIC §5813.5]

FISCAL EFFECT: According to the Senate Appropriations Committee, unknown costs for the DMHC for state administration (Managed Care Fund). CDI estimates costs of $1,238,000 in 2024-25, $481,000 in 2025-26, and $451,000 in 2026-27 and ongoing thereafter for state administration (Insurance Fund).

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, over the last few years, the state has focused on maximizing funding for behavioral health services through the California Advancing and Innovating Medi-Cal program Behavioral Health Initiative and the anticipated passage of Proposition 1, which modernizes and amends the existing MHSA to include treatment for those with SUDs, while prioritizing care for those with the most serious mental illness (SMI). The bond proposal allocated $6.38 billion for construction of behavioral health treatment, residential care settings and permanent supportive housing. These investments and legislative proposals have historically increased accessibility and redesigned vital behavioral health care for consumers who are seeking behavioral health or substance use treatment. The California Mental Health Parity Act of SB 855 (Wiener), Chapter 151, Statutes of 2020, requires commercial health plans and disability insurers to cover all medically necessary treatment for MH and SUDs at parity with physical health care

services. Commercial health plans have struggled to meet the behavioral health needs of their consumers within their network. When this occurs, plans must arrange for out-of-network MH or SUD treatment care. The author concludes that this bill is simply assuring that counties that provide behavioral health services through an FSP within the county system will be timely reimbursed for their services at the contracted rate or the fee-for-service or case reimbursement rate paid in the Medi-Cal specialty behavioral health program for the same or similar services as identified by DHCS.

2) BACKGROUND.

a) Behavioral Health Transformation. Approved by voters in 2004, the MHSA places a 1% tax on personal income over $1 million and dedicates the associated revenues to mental health services. The vast majority of MHSA revenues, at least 95%, goes directly to counties, which use it to support a variety of services for individuals with or at risk of mental illness. The MHSA establishes broad categories for how counties can spend the funding: Community Services and Supports, which funds direct service provision with the bulk of the funds used for FSPs; Prevention and Early Intervention, which funds services that prevent mental illness before it becomes severe; and Innovation, which encourages counties to experiment with new approaches to addressing mental illness. In 2023, Governor Newsom signed significant legislation to address the growing crisis of homelessness and incarceration among those living with a MH disorder, with one in 20 adults living with a SMI and one in 10 Californians meeting the criteria for a SUD.

i) Reform. SB 326 (Eggman), Chapter 790, Statutes of 2023, reforms the MHSA funding to provide services to those with the most serious illness and to treat SUDs and to rename the MHSA to the BHSA. The reforms include expanding services to include treatment for those with SUDs, prioritizing care for those with the most SMI, providing ongoing resources for housing and workforce, continuing investments in prevention and early intervention, and focusing on outcomes, accountability, and equity. Under the BHSA, 35% of the county's total BHSA revenue will fund FSPs. Housing provided as part of a FSP are to be funded through the Housing Intervention.

ii) Infrastructure. AB 531 (Irwin), Chapter 789, Statute of 2023, as part of the infrastructure solution, funds behavioral health treatment beds, supportive housing, and community sites. AB 531 directs funding for housing for veterans with behavioral health needs.

b) FSP. According to DHCS, FSP programs have been a core investment of the MHSA over the last 20 years and are a key component of California's behavioral health continuum of care. FSP programs under the MHSA are designed to be team-based and recovery-focused, with participants receiving services and supports tailored to their needs through a "whatever it takes" approach. Prior to the BHSA, FSPs were defined in regulation, and are now defined in statute and include a number of MH services, supportive services, SUD treatment services (including Medication-Assisted Treatment), housing, and other evidence-based practices, including Assertive Community Treatment and Forensic Assertive Community Treatment. The FSP establishes a standard of care with levels based on criteria for step-down into the least intensive level of care. Small county exemptions are subject to DHCS approval. In addition to MH services under the FSP

Service Category, other non-MH services under this category include food, clothing, and housing (rent subsidies, housing vouchers, house payments, residence in a drug/alcohol rehabilitation program, and transitional and temporary housing). According to the Mental Health Services Oversight & Accountability Commission, FSPs have demonstrated effectiveness at achieving the goals of lower criminal justice involvement, fewer emergency visits and psychiatric inpatient stays, and improved housing stability.

c) Mental Health Parity. SB 855 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. A health plan cannot limit benefits or coverage for MH or SUD treatments or services when medically necessary.

The author states that county behavioral health agencies are primarily focused on serving Medi-Cal beneficiaries but often serve the commercially insured who are unable to access specialty services. Counties are only able to fund these services to commercially insured individuals to the extent funds are available as they must prioritize the Medi-Cal population. Requiring commercial insurance health plans and insurers to reimburse counties for their FSP services allows counties the flexibility to continue to serve commercially insured individuals.

3) SUPPORT. The California State Association of Counties, Urban Counties of California, and Rural County Representatives of California write that this bill establishes a mechanism for county behavioral health agencies to recoup reimbursement from commercial plans for privately insured clients referred to services through FSPs. FSPs provide comprehensive, intensive, community-based services and case management to those facing severe MH conditions and play a critical role in preventing long-term institutionalization. Although the primary focus of county behavioral health agencies is to serve Medi-Cal beneficiaries, counties often serve the commercially insured who are unable to access certain specialty behavioral services through their commercial insurance, including crisis intervention services, first episode psychosis, FSPs, or other critical behavioral health services. Although counties fund services to individuals with commercial plans to the extent resources are available, counties must prioritize their Medi-Cal plan responsibilities. The Counties conclude that this bill will create a reimbursement mechanism for county behavioral health agencies to recover the costs of providing lifesaving behavioral health services to commercially insured clients through FSPs.

The County Behavioral Health Directors of California (CBHDA) states that counties are fulfilling a public expectation and a deeply felt responsibility that specialty care be available to those who need it, regardless of insurance status. Counties fund services to individuals with commercial insurance only to the extent resources are available, and must prioritize their Medi-Cal plan responsibilities. However, in far too many cases, highly profitable commercial health plans have come to rely on counties and the public, taxpayer funded safety net as a backstop for care they do not have available or will not provide. In some cases, CBHDA have learned of commercial plans actively encouraging clients to drop their commercial coverage so they can become Medi-Cal eligible, in order to receive needed services. In other cases, commercial plans directly refer their beneficiaries to county programs and services without offering to pay for these services, with the expectation that county funding, including MHSA funds, will absolve them of their payer responsibilities.

According to CBHDA, this bill will align with regulations for SB 855, which require health plans to cover intensive community-based treatment, including Assertive Community Treatment and intensive case management, both of which are included in the FSP umbrella of services. CBHDA concludes that following the passage of Proposition 1, the BHSA, counties will now be tasked with a new set of safety net obligations and have less funding to draw from as more is diverted to the state. Now more than ever, it is critical that the public behavioral health safety net be fairly reimbursed by health plans for the services they provide to commercial members.

4) **RELATED LEGISLATION**. SB 1320 (Wahab) 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 MH and 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. SB 1320 is pending in the Assembly Appropriations Committee.

5) **PREVIOUS LEGISLATION**.

   a) SB 326 recasts the MHSA as the BHSA and modifies local and state spending priorities under the BHSA, including requiring 30% of all local BHSA funds to be spent on housing interventions, as specified; eliminating allocations for local MH prevention-based programs and recasting other local spending categories; and, adding a state-level population-based prevention and stigma reduction program and statewide workforce program. Allows BHSA funding to be used to provide services to individuals with substance use disorders regardless of whether they have additional MH diagnoses or needs. Makes most changes subject to voter approval on the March 5, 2024, primary election ballot (combined with AB 531, the Behavioral Health Infrastructure Bond Act).

   b) AB 531 funds behavioral health treatment beds, supportive housing, and community sites. Directs funding for housing for veterans with behavioral health needs.

   c) SB 855 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.

6) **COMMENT.** This bill allows for the reimbursement of services delivered by a county behavioral health agency, agreed to by the plan, when delivered by a county behavioral health agencies covered under FSP. It should be noted that the FSP Service Category referenced in this bill includes non-MH services and supports like food, clothing, and housing. As this bill moves forward, the author should clarify that the health plan only has to pay for or cover services for which it contracts, or if there is a Medi-Cal rate identified by DHCS.

REGISTERED SUPPORT / OPPOSITION:

Support

California State Association of Counties (CSAC)
County Behavioral Health Directors Association of California
County of Fresno
County of Monterey
Disability Rights California
Mental Health America of California
Rural County Representatives of California (RCRC)
Urban Counties of California (UCC)

Opposition

None on file.

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

Date of Hearing: June 18, 2024

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1447 (Durazo) – As Amended April 29, 2024

SENATE VOTE: 38-0

SUBJECT: Hospitals: seismic compliance: Children's Hospital Los Angeles.

SUMMARY: Grants Children's Hospital Los Angeles (CHLA) with a three-year extension, to January 1, 2033, of the seismic safety requirement that hospitals be capable of continued operation following a major earthquake. Permits CHLA to request an additional extension, up to January 1, 2038, if it meets certain specified criteria. Specifically, **this bill**:

1) Requires CHLA to comply with seismic safety requirements as described in 3) of existing law, below, no later than January 1, 2033, or a later date as approved by the Department of Health Care Access and Information (HCAI), pursuant to 2) below.

2) Authorizes CHLA to apply to HCAI for an extension of up to five additional years, to no later than January 1, 2038, upon the submission of a seismic compliance plan no later than January 1, 2026, and a demonstration by CHLA of one or more of the following:
   a) The complexity of the hospital's seismic compliance plan detailing why the requested extension is necessary, and specifically how the hospital intends to meet the requested deadline;
   b) Demonstration that compliance will result in a loss of health care capacity that may not be provided by other general acute care hospitals (GACHs) within a reasonable proximity;
   c) The hospital owner demonstrates lack of financial capacity to substantially comply with the seismic safety regulations or standards described in 3) of existing law below, by the January 1, 2033, deadline; or,
   d) HCAI determines by means of a health impact assessment that removal of the building or buildings from service may significantly diminish the availability or accessibility of health care services in the community.

3) Requires CHLA, as a condition of approval of an extension pursuant to 2) above, as applicable, to submit to HCAI both of the following:
   a) The hospital building plans and extension schedule that includes building permitting, construction commencement, and completion; and,
   b) A construction timeline for the building demonstrating the hospital's intent and ability to meet the applicable deadline. Requires the timeline to include all of the following:
      i) The projected construction start date;
      ii) The projected construction completion date; and,
      iii) Identification of the contractor.

4) Requires CHLA and HCAI, using the projected construction start and completion date, to identify at least two major milestones relating to the seismic compliance plan that will be used as the basis for determining whether CHLA is making adequate progress towards meeting the seismic compliance deadline.

5) Authorizes HCAI to grant an adjustment to the extensions of time approved pursuant to 3) above, or the milestones pursuant to 4) above, or both, as necessary to deal with contractor, labor, or material delays, with acts of God, or with governmental entitlements, experienced by CHLA, up to the final compliance date of January 1, 2038. Requires CHLA, if one or more adjustments is granted, to submit a revised seismic compliance plan, including, but not limited to, a revised construction schedule.

EXISTING LAW:

1) Licenses and regulates health facilities, including GACHs, by the 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 (Seismic Safety Act), to ensure that hospital buildings are designed and constructed to resist the forces generated by earthquakes. 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 (which has since been extended for various hospitals to various dates), and a requirement that hospitals must also 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 (to 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 in 4) above, for up to 30 months (to July 1, 2022) for hospitals that plan to replace or retrofit a building to meet the 2020 standard, and up to five years (to January 1, 2025) for hospitals that plan to rebuild to a standard that meets the 2030 requirement. [HSC §130062]

6) Requires the owner of a 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]

7) Establishes the Small and Rural Hospital Relief Program within HCAI for the purpose of funding seismic safety compliance with respect to small hospitals, rural hospitals, and critical access hospitals. Requires HCAI to provide grants to small, rural, and critical access hospital applicants that meet certain criteria, including that seismic safety compliance, as defined, imposes a financial burden on the applicant that may result in hospital closure. [HSC §130075, §130076, §130078]

FISCAL EFFECT: According to the Senate Appropriations Committee, unknown costs for the HCAI for state administration (Hospital Building Fund).

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, CHLA serves as a critical element of the availability of pediatric hospital beds for treating children in the Los Angeles region and beyond, including at least 60% of Medi-Cal patients occupying those beds on a daily basis, while also serving as a key primary teaching hospital for the Los Angeles region. An extension to meet seismic safety retrofit standards will allow CHLA to continue serving the critical pediatric healthcare needs of the region and also allow sufficient time for CHLA to plan for, fund, and become compliant with the necessary seismic retrofit upgrades.

2) **BACKGROUND**. The original Seismic Safety Act was passed in 1973, following the 1971 San Fernando Valley (also known as Sylmar) earthquake, and required all new hospital construction to meet seismic safety standards. The Seismic Safety Act did not apply to existing buildings with the expectation that older buildings would be replaced with conforming buildings over time. By the time of the Northridge earthquake in 1994, however, 80% of hospital beds were still in pre-1973 non-conforming buildings. The Northridge earthquake caused significant structural damage to a number of hospitals, with at least two hospitals needing to be evacuated. What also became apparent in the Northridge earthquake was that nonstructural damage was also a threat to patient safety, with damage to heating and ventilation systems and sprinklers, forcing evacuations.

   Following the Northridge earthquake, the Legislature updated the Seismic Safety Act with SB 1953 (Alquist), Chapter 740, Statutes of 1994, which required HCAI (at that time Office of Statewide Health Planning and Development) to establish earthquake performance categories for hospitals. SB 1953 also established a January 1, 2008 deadline by which GACH must be retrofitted or replaced so that they do not pose a risk of collapse in the event of an earthquake (which has been repeatedly extended by subsequent legislation for most hospitals), and a January 1, 2030, deadline by which they must be capable of remaining operational following an earthquake.

   Specifically, SB 1953 required HCAI to create SPCs, as well as nonstructural performance categories (NPCs) for "nonstructural systems that are critical to providing basic services to hospital inpatients and the public after a disaster." Each hospital building receives both an SPC and an NPC rating. According to HCAI, the SPC requirements can be thought of as protecting the skeleton, while NPC requirements ensure the organs and other tissues that are necessary for a human body to function will remain safely attached to the skeleton. It is important to note that a licensed facility, or hospital, is often made up of several buildings on its campus. Many hospitals may have one or more buildings that are 2030 compliant, while other buildings still need to be retrofitted, replaced, or changed to a use that is not associated with acute care services.

   a) **Description of SPC ratings.** Following the enactment of SB 1953, HCAI adopted regulations that initially created five SPC ratings, with a sixth category (SPC-4D) added more recently. The SPC ratings are as follows:

i) **SPC-1** – These are pre-1973 buildings (built prior to the adoption of the Seismic Safety Act standards) that are at significant risk of collapse and that represent a danger to the public. These buildings were originally required to be brought up to SPC-2 level or removed from service by 2008, but there have been a number of extensions. Most recently, AB 2190 (Reyes), Chapter 673, Statutes of 2018, provided for an extension until July 1, 2022 for hospitals that plan to replace or retrofit to SPC-2, and up to January 1, 2025 for hospitals that plan to retrofit to SPC 4D or replace with a new SPC-5 building.

ii) **SPC 2** – These are also pre-1973 buildings, but were in substantial compliance with pre-1973 California Building Standards Codes, and while they may not be repairable or functional following an earthquake, they will not significantly jeopardize life. These buildings are permitted to remain in service only until January 1, 2030, at which point they need to have been replaced by an SPC-5 building, have the acute care services relocated to a conforming building (SPC-3, 4, or 5), or be retrofitted to SPC-4D.

The following categories are 2030 compliant, and can continue operating indefinitely:

iii) **SPC-3** – These buildings are in compliance with the original 1973 Seismic Safety Act, but were constructed under a permit issued prior to October 25, 1994, and utilized steel movement-resisting frames. These buildings may experience structural damage during an earthquake, which does not significantly jeopardize life, but may not be repairable or functional following strong ground motion.

iv) **SPC-4** – These are buildings constructed in compliance with the Seismic Safety Act under building permits issued between 1973 and 1989, but may experience structural damage, which may inhibit the ability to provide services to the public following strong ground motion.

v) **SPC-4D** – This is a new category created to allow SPC 2 buildings to be retrofitted to a standard that is 2030 compliant. Because SPC 2 buildings were constructed prior to 1973, they can never reach SPC 3, 4 or 5, since these categories required construction to have started after the adoption of the 1973 standards. SPC 4D became effective on January 1, 2017.

vi) **SPC-5** – These are buildings constructed after 1989, and are considered reasonably capable of providing services to the public following strong ground motion.

b) **Description of NPC ratings**. The NPC requirements, unlike SPC requirements, are cumulative, and not different options. For example, a hospital is first required to achieve NPC-2, which ensures that the nonstructural components that are necessary for a safe evacuation are braced and anchored. Next, a hospital is required to achieve NPC-3 status, which ensures that at a minimum the critical care areas are able to continue to function following an earthquake, and so on. The NPC standards are as follows:

i) **NPC-1** – The building does not meet any bracing and anchorage requirements.

ii) **NPC-2** – The following systems in the building are braced or anchored according to the California Building Standards Code: communications systems, emergency power supply, bulk medical gas systems, fire alarm systems, and emergency lighting equipment and signs in the means of egress**. Hospitals had to meet at least the NPC-2 standard by January 1, 2002.**

iii) **NPC-3** – This standard requires NPC-2 compliance, plus specified additional bracing and anchorage requirements in critical care areas, clinical laboratory services spaces, pharmaceutical service spaces, radiological service spaces, and central and sterile supply areas. Hospitals had to meet this standard by January 1, 2008, unless an extension or exemption was approved**. Extensions generally tracked the extensions given to SPC 1 buildings, so some buildings are not required to achieve NPC-3 until January 1, 2024.**

iv) **NPC-4** – This standard requires NPC-3 compliance, plus all architectural, mechanical, electrical systems, components and equipment, and hospital equipment to meet bracing and anchorage requirements. **Hospitals are required to meet this standard by January 1, 2024 or 2030 depending on the building's seismic risk category and extension request requirements.**

v) **NPC-4D** – This is a new category assigned to existing hospital buildings that are in compliance with NPC-3 requirements, and have additionally achieved one of three levels with regards to emergency preparedness. NPC-4D became effective on January 1, 2017. **Hospitals are required to meet this standard by January 1, 2030.**

vi) **NPC-5** – This final standard requires the hospital building to meet NPC-4 or NPC-4D, plus have onsite supplies of water and holding tanks for sewage and liquid waste, sufficient to support 72 hours of emergency operations, which are required to be integrated into the plumbing systems. Additionally, an onsite emergency system, as defined in the California Electrical Code, must be incorporated in the building electrical system for critical care areas, and the system is required to provide for radiological service and onsite fuel supply for 72 hours of acute care operation. **Hospitals are required to meet this standard by January 1, 2030.**

c) **Seismic status of CHLA**. According to information provided by HCAI, CHLA is comprised of 13 buildings in use for general acute care services at their main campus on Sunset Boulevard. The hospital relies on all buildings for ongoing care delivery or support functions. Four of the buildings provide the bulk of direct care services, including Duque, McAllister, Anderson, and Surgery Center. While Anderson and Surgery Center are both SPC-5 and NPC-4, Duque and McAllister are SPC-2 and must retrofit or be removed from acute care use starting by 2030. According to HCAI, in December 2022 and again in December 2023, the facility informed HCAI that six general acute care buildings in one contiguous grouping will be converted to non-acute functions by 2030, including Duque and McAllister. HCAI states that they have received NPC-4 and NPC-5 evaluations for the buildings that will remain in service beyond 2030, no NPC evaluations were required for the six buildings that CHLA intends to remove from acute care services. According to HCAI, based on CHLA's plans, CHLA will be compliant with seismic safety requirements related to structural integrity by 2030. By January 1, 2026, to comply with regulatory requirements, CHLA is required to submit to HCAI their

plan for removing and relocating acute care services from the six buildings that they have stated they intend to remove from service.

According to CHLA, it has actually met the primary earthquake retrofit structural standards required for 2030. The next set of retrofit standards applicable to CHLA are aimed at the various "infrastructure" improvements to assure that the hospital and its campus have adequate water, sewer, power generation, and other infrastructure to independently support operation of the hospital and its campus for a minimum of 72 hours (these are the NPC requirements). CHLA states that while it has been working to both plan for and achieve compliance with these updates, CHLA also has a primary role to provide acute healthcare for the region's children, regardless of the family's ability to pay. CHLA services a minimum of 70% or more Medi-Cal recipients and nearly 60% of their inpatient population are children eligible for the California Children's Services (CCS) program. CHLA states that providing this high level of patient care requires significant investments, and CHLA experienced an annual $80 million reduction of CCS funding, which required a prioritization of focus to day-to-day patient care. CHLA states that it has a plan for feasibility, permitting, construction, and financing to reach the seismic goal, and the extension in this bill will allow for both the financing plan and the completion of the required seismic infrastructure projects.

d) Children's Hospital Bond funding. There have been three voter-approved Children's Hospital Bond acts over the past 20 years, providing general obligation bonds to fund specified children's hospitals. In 2004, California voters passed Proposition 61 to issue $750 million in general obligations bonds, of which CHLA was awarded $72 million. In 2008, Proposition 3 enabled the issuance of an additional $980 million in bonds, of which CHLA was awarded $97.4 million. In 2018, voters passed Proposition 4 to issue $1.5 billion in bonds, of which the initiative allocated $135 million to CHLA. From this most recent 2018 bond program, CHLA has already been awarded nearly $90 million in grant funding, spread across four projects. CHLA has approximately $45 million in grant fund eligibility remaining for future awards. Of the $90 million grant funds already awarded from the 2018 bond program, the two largest are: $22 million to fund the renovation, furnishing, and equipping of a vacated space in the Duque building to create a dedicated space for pediatric cardiac imaging services, including two new magnetic resonance imaging (MRI) machines; and, a $44.5 million project to fund the renovation, equipping, and furnishing of an existing space in CHLA's radiology department in the Duque building, to expand its Post Anesthesia Care Unit and to relocate and expand its Positron Emission Tomography and Computed Tomography (PET/CT), Nuclear Medicine, and MRI departments, including one PET/CT machine, two nuclear medicine gamma cameras, and one MRI machine.

e) Building code requirements account for regional variation of seismic risk. According to HCAI, compared to rest of the nation, California, in general, has high seismicity throughout the state. Parts of the state have **very high** seismicity in areas of close proximity to the major earthquake faults. Other areas of the state still have **high** seismicity. Additionally, each facility has a seismicity value based on their location. This location-specific seismic value is used to evaluate and design buildings at that site. Therefore, the evaluation for a building located in an area with a very high seismicity value will require a stronger building that can resist stronger earthquakes when compared to the evaluation for a building in a high seismicity value area. The evaluation based on

location-specific seismicity values addresses the narrow differences in seismicity levels in California. Therefore, an SPC-2 building near a fault will need to be stronger to be life-safe than an SPC-2 building located significantly farther away from a fault line.

f) **Status of hospital seismic safety compliance**. According to HCAI, as of February of 2024, there are a total of 3,340 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. Of the 658 SPC-2 buildings, 151 have SPC-4D upgrade projects submitted. It is unclear how many of these 151 SPC-2 building upgrade projects will be in construction. The SPC-4D option has only been available since 2017; it is not known whether that will be utilized for the remaining buildings, or whether hospitals will choose to construct new replacement buildings.

Regarding NPC compliance, the vast majority of buildings have not yet met 2030 standards. More than half of all hospital buildings are still NPC-2. Only about 6% of all hospital buildings have achieved NPC-5 and are fully 2030 compliant. Another 34% have met NPC-4 requirements. The deadline to submit NPC construction projects is January 1, 2026, followed by an NPC construction permit deadline of January 1, 2028.

g) **RAND report on estimated costs of seismic compliance**. The California Hospital Association commissioned the RAND Corporation to update a prior estimate of the cost of future seismic safety compliance with a particular focus on the 2030 deadline. RAND published its report in 2019, and estimated that collectively, California hospitals faced (at that time) a range of $34 billion to $143 billion in compliance costs, depending on assumptions regarding retrofit versus new construction and future cost escalation. RAND stated that a significant proportion of hospitals were already experiencing some degree of financial distress, and the burden of future compliance is likely to exacerbate this stress.

3) **SUPPORT**. CHLA is the sponsor of this bill and states that complying with the seismic safety retrofit standards will require a significantly burdensome capital outlay expenditure of at least $230 million. The extension provided in this bill will allow CHLA to achieve a comprehensive plan for both funding and construction of the seismic upgrades, while also ensuring the hospital beds that are so critical to serving the children of the Los Angeles region and beyond are maintained. CHLA notes that it has 121 licensed beds that would be shuttered in 2030 because they are located in buildings that will be excluded from housing acute care, and that this number represents 10% of pediatric beds in Los Angeles County. Furthermore, an additional 317 licensed beds in seismically compliant buildings would also be at risk due to the $100+ million investment required to relocate acute care supporting

services into them and the upgrades to nonstructural elements that this necessitates. This impact to pediatric acute care capacity underscores the urgency of this request. Supporters, including the Boys & Girls Club Metro Los Angeles and the Los Angeles Area Chamber of Commerce, state that CHLA is a beacon of hope and healing for children and families, and the financial strain of seismic compliance threatens not just the hospital's stability, but directly impacts the availability of essential pediatric beds for our community's children

4) **OPPOSE UNLESS AMENDED**. The California Professional Firefighters are opposed to this bill unless the seismic safety compliance extension is shortened to two years or less. CPF notes that evacuating any hospital that has lost the basic functions necessary for patient care poses a significant challenge, but evacuating the patients of Los Angeles Children's Hospital to a similarly equipped facility is additionally difficult given profile of the patients they serve. Firefighters and other emergency responders tasked with saving lives in the wake of a disaster would be diverted to instead rescuing the youngest and most vulnerable patients from a hospital and transporting them to another children's facility. Given the risks posed to these young patients it is even more important that Los Angeles Children's meet the 2030 deadline for the hospital seismic standard, not less.

   Service Employees International Union California State Council and Professional Engineers in California Government also oppose unless the bill is amended to limit the extension to two years and note that California hospitals have known for 30 years that they face the requirement to be fully operational after a major seismic event.

5) **OPPOSITION**. The California Labor Federation (CLF) opposes this bill and states that any longer extension is an unacceptable delay to the requirement that CHLA be functional and not at risk of evacuation after a major earthquake. CLF notes that in 1994, the California Legislature passed, and Republican Governor Pete Wilson signed, the law requiring that California hospitals be operational after an earthquake. This legislation was a compromise between those who sought immediate protection in the wake of an earthquake that closed numerous hospitals, with hospital workers evacuating patients, including newborn babies, in the dark down staircases to parking lots. CLF points out that the requirement to be operational after a major quake has been delayed and modified numerous times in the decades since. For example, the standards for small and rural hospitals were modified to reflect their risk. Other modifications have also been made. Similarly, hospitals that rebuilt to this higher standard were not required to retrofit to meet the lower standard of "collapse-hazard," but subject to evacuation post-quake. The existing requirements for hospitals to be operational after a major earthquake include such basic safety protections as electricity, elevators, water, sewage, oxygen, and other requirements for a functional modern hospital. As of October 2023, almost 80% of hospital buildings comply with the structural requirements that must be met by the year 2030. The potential of having to evacuate their patients at CHLA presents unique challenges due to the types of patients they serve. Other nearby hospitals in California may not have the appropriate supplies to quickly accommodate an influx of young patients. CLF also highlights the fact that bond funds have been made available to this hospital to be able to come into compliance, which as of this time have not been utilized. CLF encourages the Legislature to take steps to ensure that the hospital takes steps to come into compliance.

   The California Nurses Association/National Nurses United (CNA) opposes this bill and states that California must continue to hold CHLA accountable to our state's high seismic

safety standards with no extension of the 2030 compliance deadline. CHLA has had over 30 years to implement seismic safety requirements that would ensure the hospital can stay open and functional in the event of a major earthquake. Circumventing these seismic safety requirements now with yet another delay in deadlines endangers patients, nurses, and other health care workers. CNA concludes that nurses and other health care workers who care for patients know first-hand that in the event of an earthquake, hospitals must stand ready to not only treat patients injured during the course of an earthquake, but also to ensure that no serious interruption to patient care occurs.

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 in Senate Health Committee.

b) SB 1432 (Caballero) extends the seismic compliance deadline for hospitals to be capable of continued operations from January 1, 2030, to January 1, 2038, creates an abeyance by which a rural hospital or critical access hospital will not be required to meet these requirements until adequate funding is made available to the hospital, and requires the hospital to submit a seismic compliance master plan by January 1, 2027, among other provisions. SB 1432 is pending in the Assembly Health Committee.

c) 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 GACH 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 GACHs 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 Seismic Safety 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.

7) **POLICY COMMENT**. As noted above, AB 869 (Wood) and SB 1432 (Caballero) seek to create statewide standards for hospitals to come into compliance with 2030 seismic safety requirements. The Legislature may wish to consider whether a separate exemption for one hospital is appropriate.

REGISTERED SUPPORT / OPPOSITION:

Support

Children's Hospital Los Angeles (sponsor)
AltaMed Health Services
Boys & Girls Club Metro Los Angeles
California Children's Hospital Association
First Day Foundation
Inland Coalition for Immigrant Justice
Los Angeles Area Chamber of Commerce
Los Angeles County Business Federation (BIZFED)
Saban Community Clinic
Valley Industry and Commerce Association (VICA)

Opposition

California Labor Federation, AFL-CIO
California Nurses Association

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