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California State Assembly

HEALTH



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AGENDA

Tuesday, March 14, 2023
1:30 p.m. -- 1021 O Street, Room 1100

Adoption of Committee Rules

Bills Heard in File Order

Testimony may be Limited:

2 Witnesses Per Side, 3 Minutes Each

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|-----|--------|---------------|--|
| 1. | AB 236 | Holden | Health care coverage: provider directories. |
| 2. | AB 289 | Holden | Mental health services: representation. |
| 3. | AB 385 | Ta | Alzheimer's disease: public awareness campaign. |
| 4. | AB 48 | Aguiar-Curry | Nursing Facility Resident Informed Consent Protection Act of 2023. |
| 5. | AB 387 | Aguiar-Curry | Alzheimer's disease. |
| 6. | AB 70 | Rodriguez | Emergency response: trauma kits. |
| 7. | AB 254 | Bauer-Kahan | Confidentiality of Medical Information Act: reproductive or sexual health application information. |
| 8. | AB 283 | Jim Patterson | Mental Health Services Oversight and Accountability Commission. |
| 9. | AB 512 | Waldron | Mental health and substance use disorders: database of facilities. |
| 10. | AB 242 | Wood | Critical access hospitals: employment. |

All witness testimony will be in person; there will be no phone testimony option for this hearing. You can find more information at www.assembly.ca.gov/committees.

Date of Hearing: March 14, 2023

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
AB 236 (Holden) – As Amended February 14, 2023

SUBJECT: Health care coverage: provider directories.

SUMMARY: Requires a health care service plan (health plan) or insurer to annually audit and delete inaccurate listings from its provider directories, and requires a provider directory to be 60% accurate on January 1, 2024 and 95% accurate on or before January 1, 2027. Subjects a health plan or insurer to administrative penalties for failure to meet the prescribed benchmarks and for each inaccurate listing in its directories. Requires the health plan or insurer to delete the provider from its directory beginning July 1, 2024, if a plan or insurer has not financially compensated a provider in the prior year unless specified criteria applies. Requires a health plan or insurer to provide information about in-network providers to enrollees and insureds upon request, and limits the cost-sharing amounts an enrollee or insured is required to pay for services from those providers under specified circumstances. Specifically, **this bill**:

- 1) Requires the online provider directory to be verified and accurate, as specified.
- 2) Specifies that beginning July 1, 2024, for a health plan contract or insurance policy issued, renewed, or amended on January 1, 2024, the plan or insurer cannot confirm that the plan or insurer has financially compensated the provider for the purpose of providing covered benefits to enrollees or insureds for the designated network in the prior year unless one of the following applies:
 - a) The plan or insurer has newly contracted with the provider within the prior six months;
 - b) The plan or insurer has a newly approved network approved within the prior six months;
 - c) A special circumstance requires inclusion of the provider in the directory consistent with regulations or other guidance by Department of Managed Health Care (DMHC) or California Department of Insurance (CDI); or,
 - d) A special circumstance occurs particular to a specific provider and subject to prior approval of the DMHC or CDI at least 30 days before the inclusion of the provider in the directory.
- 3) Defines financially compensated in 2) above as having paid five or more claims to a provider for that network or otherwise demonstrably financially compensated that provider for the purposes of providing covered benefits to enrollees or insureds covered by the relevant network.
- 4) Makes clarifications to provider directory information, including provider's telephone number and the population served, meaning adult, pediatric, or both. Adds to the provider directory, the provider's contract termination date, if any. Requires the plan or insurer to delete the provider from the directory within five days after the termination date of the provider's contract if there is a termination date. Adds to the provider directory if the provider has affirmed that they offer and have provided gender-affirming services.
- 5) Requires the provider to be removed from the directory at the next required update if the plan cannot verify that the required information in the listing is accurate. Prohibits deleted

provider information from being used for timely access monitoring, solicitation, network adequacy reporting, including time and distance standards, or compliance.

- 6) Requires the plan or insurer to be responsible for maintaining an accurate provider directory, and that the accuracy percentage of a directory to be determined by the percentage of providers for which all information as required is accurate. Specifies that if there is one error on a listing for a provider, that listing is considered inaccurate.
- 7) Requires the following accuracy on a plan or insurer's directories:
 - a) On January 1, 2024, a plan or insurer's directories to be at least 60% accurate;
 - b) On or before January 1, 2025, a plan or insurer's directories to be at least 80% accurate;
 - c) On or before January 1, 2026, a plan or insurer's directories to be at least 90% accurate; and,
 - d) On or before January 1, 2027, a plan or insurer's directories to be at least 95% accurate.
- 8) Requires a plan or insurer to annually audit and verify its provider directories for accuracy of all of the required information. Requires the DMHC and CDI to develop procedures and policies on the audits. Requires the plan and insurer, in addition to verifying the information required, to do all of the following:
 - a) In verifying the accuracy of information in the provider directory or directories, determine whether a provider has submitted claims or otherwise been compensated for covered benefits for enrollees in that product or network. Requires the plan or insurer to remove that provider from their directory pursuant to 2) above if the provider received no compensation in the last year for that product or network;
 - b) Submit its accuracy audit reports annually to the DMHC or CDI to ensure compliance with this bill; and,
 - c) Publicly post its accuracy audit reports annually on its internet website.
- 9) Specifies that failure to meet the required benchmarks in 7) above to result in an administrative penalty of up to five thousand dollars (\$5,000) per 1,000 enrollees, and failure to meet the benchmark in the subsequent year to result in an administrative penalty of up to ten thousand dollars (\$10,000) per 1,000 enrollees or insured for each year following the first year that the plan or insurer failed to meet the benchmark.
- 10) Makes the plan or insurer liable for an administrative penalty of up to one thousand dollars (\$1,000) for each inaccurate listing in its directory. Defines an inaccurate listing to be a listing with at least one error in the required information.
- 11) Requires the DMHC Director or CDI, when assessing administrative penalties against a health plan or insurer, to determine the appropriate penalty amount for each violation based on one or more factors as applicable, as specified.
- 12) Specifies that the penalty amounts to be adjusted based on the average rate of change in premium rates for the individual and small group markets, and weighted by enrollment, since the previous adjustment beginning January 1, 2028, and every five years thereafter.
- 13) Requires the health plan or insurer to respond in writing or electronic format no later than one business day after receiving the request if an enrollee or insured, by telephone call or electronic means, requests information on whether or not a provider is contracted as an in-

network provider to provide covered benefits. Requires the plan or insurer to also provide information on whether or not the provider is accepting new patients. Requires the plan or insurer to retain a record of the request and the plan or insurer's response in the enrollee or insured's file for at least two years after the date of the request.

- 14) Requires the enrollee or insured to pay no more than in-network cost sharing, for covered benefits, if an enrollee or insurer obtained information through the plan or insurer's online directory or a request consistent with 13) above that a provider was an in-network provider, if any of the following apply:
 - a) The provider is not contracting with the health plan or insurer as an in-network provider for that product;
 - b) The contracting provider is not accepting new patients for that product;
 - c) The information provided is otherwise materially inaccurate, misleading, or incomplete; or,
 - d) The online provider directory is not accessible to enrollees or insureds at the time the enrollee or insured seeks information and the enrollee or insured requests information consistent with 13) above.
- 15) Requires the plan or insurer to document the cost-sharing tier that the provider is contracted to accept and to provide that information to the enrollee or insured when the enrollee or insured seeks information about the provider if the health plan contract or insurance policy includes more than one tier of cost sharing. Prohibits the enrollee or insured from owing more than the cost sharing for the cost-sharing tier included in the information received by the enrollee or insured from the plan or insurer of the plan or insurer provides information indicating that a provider is on a lower cost-sharing tier and that information is not accurate.
- 16) Specifies the in-network cost sharing amount for a contracted provider includes copayments, deductibles, coinsurance, and any other form of cost sharing. Requires the lowest cost-sharing tier to apply if the health plan contract or insurance policy includes more than one tier of cost sharing and if the enrollee or insured was not informed accurately of the applicable cost-sharing tier.

EXISTING LAW:

- 1) Establishes the DMHC to regulate health plans and CDI to regulate health insurance. [Health and Safety Code (HSC) §1340, *et seq.*; Insurance Code (INS) §106, *et seq.*]
- 2) Requires the DMHC and CDI to develop uniform provider directory standards, as well as requires health plans to perform regular updates and an annual review of their directories. Requires a health plan or insurer to provide coverage for health care services in the event an enrollee or insured reasonably relied upon inaccurate information within the health plan's directory. [HSC §1367.27 and INS §10133.15]
- 3) Requires health plans to ensure that all services be readily available at reasonable times to each enrollee consistent with good professional practice, and to the extent feasible, a health plan to make all services readily accessible to all enrollees consistent with existing law on timely access to health care services. [HSC §1367]

- 4) Requires DMHC to develop and adopt regulations to ensure that enrollees have access to health care services in a timely manner, regarding:
 - a) Waiting times for appointments, including primary and specialty care physicians;
 - b) Care in an episode of illness, including timeliness of referrals and obtaining other services, as needed; and,
 - c) Waiting time to speak to a physician, registered nurse, or other qualified health professional trained to screen or triage. [HSC §1367.03]
- 5) Requires, in developing these standards, DMHC to consider the clinical appropriateness, the nature of the specialty, the urgency of care, and the requirements of law governing utilization review. [HSC §1367.03]
- 6) Requires CDI to promulgate regulations applicable to health insurers to ensure access to health care in a timely manner, and designed to ensure adequacy of the number of locations of institutional facilities and professional providers, adequacy of number of professional providers, and license classifications, consistent with standards of good health care and clinically appropriate care, and that contracts are fair and reasonable. [INS §10133.5]
- 7) Requires, in designing the regulations, CDI to consider regulations promulgated by DMHC and all other relevant guidelines in an effort to accomplish maximum accessibility within a cost efficient system of indemnification. [INS §10133.5]

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

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, despite California having one of the nation's strongest laws on health plan provider directories, compliance is at an unbelievable low. Recent studies have found that some health plans have inaccuracy rates as high as 80%, and major plans like Anthem and Kaiser have inaccurate information for 20%-38% of providers. According to the author, these inaccuracies in provider referral lists are often referred to as 'ghost networks' because the referrals simply do not exist. As a result, consumers bear the responsibility of sorting through these grossly inaccurate lists, sifting through directories in an effort to find care, calling provider after provider, only to be told the provider is no longer in-network, no longer accepting new patients, or even no longer in practice. This is especially harmful to those already suffering from health care inequity, such as those with limited English proficiency and persons with disabilities. The author concludes that ghost networks contribute to inequity in health care by leaving Californians to fend for themselves in their most vulnerable time.

2) BACKGROUND.

- a) *Existing Network Adequacy Requirements.* California law sets forth various network adequacy requirements on health plans and insurers. For example, health plans are subject to the following:
 - i) **Timely Access.** Timely Access Laws and Regulations require that health plans meet a set of standards which include specific time frames under which enrollees must be

able to access care. These requirements generally include the following standards for appointment availability:

- (1) *Urgent care without prior authorization*: **within 48 hours**;
- (2) *Urgent care with prior authorization*: **within 96 hours**;
- (3) *Non-urgent primary care appointments*: **within 10 business days**;
- (4) *Non-urgent specialist appointments*: **within 15 business days**;
- (5) *Non-Urgent mental health (MH) appointments*: **within 15 business days** for psychiatrist, **within 10 business days** for non-physician MH provider; and,
- (6) *Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness or other health condition*: **within 15 business days**.

- b) **Geographic Access.** Health plans are also generally required to ensure geographic access such that there are a sufficient number of providers located within a reasonable distance from where each enrollee lives or works. For example, primary care physicians (PCPs) and hospitals should be **located within 15 miles or 30 minutes** from work or home.

Health plans must also ensure provider capacity such that health plan networks have enough of each of the right types of providers to deliver the volume of services needed. For example, plan networks should include **one PCP for every 2,000 beneficiaries**.

- c) *Timely Access Report.* DMHC recently published its Timely Access Report for Measurement Year 2021 and include the following:
 - i) **Key Survey Findings for Full Service Health Plans:** For non-urgent and urgent appointments combined, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 94% to a low of 47%. For non-urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 96% to a low of 56%. For urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 92% to a low of 37%.
 - ii) **Key Survey Findings for Behavioral Health Plans:** For non-urgent and urgent appointments combined, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 76% to a low of 65%. For non-urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 83% to a low of 73%. For urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 70% to a low of 56%.
- d) *California's Provider Directory.* Provider directories help patients identify clinicians based on specialty, location, and hours. California was one of the first states to enact laws related to provider directories, in SB 137 (Hernandez), Chapter, Statutes of 2015, which

requires health plans and insurers to maintain accurate online and paper directories as of July 1, 2016. SB 137 also requires some of the following:

- i) DMHC and CDI to develop uniform provider directory standards and to take appropriate steps to ensure the accuracy of the information contained in the plan or health insurer's directory or directories, and requires the plan or insurer, at least annually, to review and update the entire provider directory or directories for each product offered;
 - ii) A plan or insurer, at least weekly, to update its online provider directory or directories, and requires a plan or insurer, at least quarterly, to update its printed provider directory or directories; and,
 - iii) A plan or insurer to reimburse an enrollee or insured for any amount beyond what the enrollee or insured would have paid for in-network services, if the enrollee or insured reasonably relied on the provider directory and authorizes a plan or health insurer to delay payment or reimbursement owed to a provider or provider group, as specified, if the provider or provider group fails to respond to the plan's or health insurer's attempts to verify the provider's or provider group's information.
- e) *Federal Provider Directory Requirements.* According to the Kaiser Family Foundation, regulators evaluate plans against quantitative network adequacy standards using network directory data, which often contain errors. Plans offered on HealthCare.gov (federal exchange marketplace) are required to include directory links showing providers' location, contact information, specialty, and whether they are accepting new patients. Issuers are required to update directories at least monthly. Oversight of appointment wait-time standards also rely on directory data. In a secret shopper Health Affairs study of California qualified health plans (QHPs) (offered on Covered California – California's state based exchange) in 2015, 73% of calls to providers listed in network directories were unable to secure appointments. Failures generally related to inaccurate phone numbers or addresses for listed providers, inaccurate specialty listings, or listed providers who were not actually in the network. As part of its annual compliance review, the Centers for Medicare & Medicaid Services (CMS) selects a small sample of issuers and reviews the machine-readable provider directory to verify accuracy. The 2020 Plan Year Federally-Facilitated Exchange Issuer Compliance Review Summary Report found inaccuracies in all directories examined in 2020, with similar compliance problems observed in prior years.

Beginning in 2022, the federal No Surprises Act (NSA) requires all private health plans, including QHPs, to maintain accurate provider directories and requires providers to regularly update plans about any changes in their information. Plans must verify and update directories at least every 90 days and, on an ongoing basis, post any changes within 2 business days. Plans are also required to apply in-network cost sharing for covered services provided by facilities or providers mistakenly listed as in-network. However, enforcement will be delayed because implementing regulations have not yet been published. CMS expects plans to make good faith efforts to comply with new requirements beginning in 2022. It should be noted, that according to the California Association of Dental Plans (CADP), the NSA does not apply to dental with respect to the provision requiring plans to respond in one business day to a provider network status

request and the plan is responsible for cost-sharing above the in-network costs if the consumer relies on this information and the provider is later determined to be out-of-network.

Provider directories are commonly posted online as PDFs or other “flat file” formats. Most QHPs require that they be available in machine-readable formats, which can be easily downloaded and read by computers to identify information that is likely incorrect. A 2019 Commonwealth Fund–supported study compared the accuracy of four sources of provider information from five U.S. counties: i) machine-readable directories from QHPs; ii) Medicare Advantage (MA) plan directories with traditional flat-file directories; iii) online information from Google Places, which is self-reported by physicians; and, iv) files from CMS’s National Plan and Provider Enumeration System, a national Medicare file for nearly all U.S. providers. The study found the following:

- i) Extensive inaccuracies were found across all four sources of information. The inaccuracy rate for phone numbers, meanwhile, ranged from 25 % to 48 %;
 - ii) Insurance carriers offering both MA and exchanges did not report the same addresses 31 % of the time;
 - iii) Google was the most accurate source for a provider’s name, address, and phone number;
 - iv) Directories for marketplace plans, which are machine readable, were slightly less accurate than traditional, flat-file MA directories;
 - v) Machine-readable directories can be downloaded and used for analysis vastly more cheaply compared to flat-file conventional directories; and,
 - vi) Interviews with stakeholders identified reasons other than directory file type for inaccuracies. These included the low priority some providers place on maintaining correct information; a lack of consistent definitions and standards; and lack of a coordinated national approach for resolving the accuracy issue.
- f) *Enforcement.* The *Yale Law & Policy Review (Yale Review)* entitled, “Laying ghost networks to rest: Combatting deceptive health plan provider directories,” also revealed high error rates. Even the lowest error rate, 21%, means that one out of five provider listings will lead enrollees seeking care to a dead end. At the high end, more than half of all provider listings lead to a dead end. While consumers can theoretically seek out correct addresses and phone numbers, search engines are at best a partial replacement for accurate directories. Furthermore, the provider directories examined had higher error rates for psychiatrists than for other types of specialists, underlining the particular burden placed on people who need behavioral care. According to the *Yale Review*, when states do carry out enforcement actions, they tend to result in minimal or no fines, removing any incentive for insurers to increase the accuracy of their plans. Despite SB 137’s broad scope and detailed requirements, the *Yale Review* indicated that California continues to have high levels of directory errors. California does not directly collect data about directory errors. However, to comply with California’s timely access standards, health plans regulated by the DMHC must submit yearly surveys of

all providers that take appointments from enrollees to assess how soon an appointment can be scheduled. According to the *Yale Review*, DMHC only uses this data to compile timely access reports, but this survey also functions as a directory accuracy survey: the raw data notes when providers could not complete the timely access questionnaire because their address was incorrect, their phone number was incorrect, their specialty was incorrect, they do not take appointments at that location, they are not actually in-network, or they are no longer practicing. This bill builds upon California's provider directory by requiring plans and insurers to annually audit, delete inaccurate listings, and requires a 95% accuracy by January 1, 2027. Failure to meet these required benchmarks will result increased administrative penalties.

- 3) **SUPPORT.** Health Access California (HAC), sponsors of this bill, references the same *Yale Review* study cited above that found the following: Kaiser was 12-38% inaccurate; Molina was 54-80% inaccurate; Blue Cross 20-25% inaccurate; and, CenCal Health Plan was 39-62% inaccurate. According to HAC, consumers depend on a provider directory to find an in-network provider whether it be a doctor, specialist, dentist, hospital, laboratory, imaging center, or another provider. A consumer's right to timely access to care is affected by a provider directory; if a consumer is unable to find a provider, they waste necessary time simply searching for one. According to HAC, timely access to care monitoring by DMHC routinely finds that 20%-30% of providers are unreachable by the health plan, often because of inaccuracies in the health plan's own provider directory. If a provider directory is replete with doctors and other professionals who are not actually seeing patients covered by that health plan, it raises serious questions about the plan's assertions about an adequate network of doctors and other providers that are available to provide timely access to care. In addition, to assess network adequacy, provider surveys are required and such surveys need accuracy. According to HAC, existing law has failed to fully ensure the accuracy of these directories. Audits by the Department of Health Care Services in 2019 have shown that Kaiser and CenCal Health Plan failed to even include mental health (MH) providers in their provider directories. HAC concludes that California's laws and regulations on provider directories and network adequacy are, on paper, some of the strongest in the country, yet they are falling short and this bill would address ghost networks and provider inaccuracies.

America's Physician Groups (APG) states that SB 137 was enacted due to rampant inaccuracies in the Covered California exchange online provider directory, which made it frustratingly difficult for prospective enrollees to find network providers with open practices accepting new patients. DMHC conducted an investigation of plan directories and found as much as 40% inaccuracies. The DMHC levied significant fines against the plans. Over the past several years since SB 137 was enacted, provider directory accuracy has improved marginally. According to APG, the market place lacks a culture of compliance at both the payor and provider level. It is a harsh assessment, but time has been wasted. This bill addresses some of the problems that have plagued the advancement of provider directory accuracy by requiring a graduated level of thresholds, beginning at 60% accuracy in 2024 and progressing to 95% accuracy by 2027. These thresholds can drive adoption of better systems for the development of timely and accurate directories. APG concludes that accurate provider directories can and must be developed in order to support compliance with statutory network adequacy requirements and patient access to care.

- 4) **OPPOSITION.** CADP contends that due to undefined or unclear terms used in this bill, the new provisions in this bill and the current regulatory requirements, consumers would lose

access to dental providers as dental plans would be unable to meet access requirements and could be forced to withdraw from service areas including vulnerable rural areas.

Additionally, this bill states any “one error” in a directory makes the entire provider listing inaccurate and requires removal or deletion from the provider directory. According to CADP, this “one error” could include an erroneous suite number, zip code, or simple misspelling, i.e., items that would not be detrimental to the consumer obtaining needed dental services from a provider. These non-detrimental errors have no bearing on the providers’ willingness to provide dental services to consumers and availability to a consumer on the dental plans’ network. Errors not detrimental to the consumer receiving dental services would impact the overall accuracy of the directory and make dental plans subject to significant fines.

Additionally, there are many instances where a specialty dental provider, especially in rural areas, may be available to a consumer but might not submit a certain number of claims in a 12-month period. Furthermore, the potential suppression that leads to a plan being forced to withdraw from a service area impacts smaller dental plans much more than larger dental plans. The larger plans have significantly larger networks that can absorb the changes while leaving smaller regional plans at a disadvantage with regards to their networks. CADP concludes that with significant numbers of providers not responding to the required provider directory outreach, the additional requirement of this bill will significantly increase the percentage of providers who would be removed/deleted from provider directories leading to loss of access in service areas for consumers.

The California Association of Health Plans (CAHP), the Association of California Life and Health Insurance Companies (ACLHIC), and America’s Health Insurance Plans (AHIP) state that provider directories act as an essential guide that health plans and insurers rely upon to help our enrollees and insureds access timely and appropriate care but state that this bill does nothing to address the root cause of the issue, and instead simply places the full responsibility of the database accuracy on health plans and insurers, without fully appreciating that this endeavor was always intended to be a shared responsibility between contracted providers and health plans/insurers. Without that consideration being included in this bill, plans and insurers will continue to struggle to meet the expectations set forth by the Legislature. Additionally, this bill does not recognize the existing work being done by both the DMHC and the Integrated Health Association around provider directory accuracy. The DMHC is still in the process of official rulemaking for SB 137, demonstrating how difficult it is to obtain accuracy. According to CAHP, ACLHIC, and AHIP, currently, commercial health plans and insurers spend over 2.1 billion dollars annually to maintain provider databases, clearly demonstrating the commitment health plans and insurers have to supporting accurate provider directories. Lastly, this bill attaches enormous financial penalties solely on health plans and insurers if the directories are inaccurate, even when a provider fails to disclose updated or accurate information to the plan or insurer.

5) RELATED LEGISLATION.

- a) AB 1331 (Wood) establishes the Data Exchange Framework governing board and require the board to approve any modifications to that data sharing agreement and its policies and procedures. AB 1331 is pending in Assembly Health Committee.
- b) AB 815 (Wood) extends the period within which a health plan or disability insurer is required to assess and verify the qualifications of a health care provider from 60 days to

90 days after receiving a completed provider credentialing application. AB 815 is currently pending in Assembly Health Committee.

- c) SB 598 (Skinner) prohibits a health plan or insurer from requiring a contracted health professional to complete or obtain a prior authorization for any health care services if the plan or insurer approved or would have approved not less than 90% of the prior authorization requests they submitted in the most recent one-year contracted period. Sets standards for this exemption and its denial, rescission, and appeal. Authorizes a plan or insurer to evaluate the continuation of an exemption not more than once every 12 months, and authorizes a plan or insurer to rescind an exemption only at the end of the 12-month period and only if specified criteria are met. SB 598 is currently pending in Senate Health Committee.

6) PREVIOUS LEGISLATION.

- a) SB 858 (Wiener), Chapter 985, Statutes of 2022, increases the base amount of the civil penalty from \$2,500 per violation to not more than \$25,000 per violation, and authorizes a lower, proportionate penalty for specialized dental and vision health care service plans. Adjusts the civil penalty base amount annually commencing January 1, 2028, and every five years thereafter, as specified. Doubles the minimum and maximum amounts of the civil and administrative penalties described above, and, commencing January 1, 2028, and every five years thereafter, adjusts these civil and administrative penalties, as specified. Authorizes the DMHC Director to impose a corrective action plan to require future compliance with the act, under certain circumstances.
- b) SB 221 (Wiener), Chapter 724, Statutes of 2021, codifies existing timely access to care standards for health plans and insurers, applies these requirements to Medi0Cal Managed Care plans, and adds a standard for non-urgent follow-up appointments for nonphysician MH care or substance use disorder (SUD) providers that is within 10 business days of the prior appointment.
- c) AB 133 (Committee on Budget), Chapter 143, Statutes of 2021, requires the California Health and Human Services Agency, and in consultation with stakeholders and local partners through an established Stakeholder Advisory Group, to establish a Data Exchange Framework by July 1, 2022.
- d) AB 1131 (Wood) of 2021 would have established the statewide health information network governing board, an independent public entity not affiliated with an agency or department with specified membership, to provide the data infrastructure needed to meet California's health care access, equity, affordability, public health, and quality goals, as specified. AB 1131 was held in the Assembly Suspense Committee.
- e) SB 855 (Wiener), Chapter 151, Statutes of 2020, revises and recasts California's Mental Health Parity provisions, and requires a health plan contract or disability insurance policy issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of MH and SUD, as defined, under the same terms and conditions applied to other medical conditions and prohibits a health plan or disability insurer from limiting benefits or coverage for MH and SUD to short-term or acute treatment. Specifies that if services for the medically necessary treatment of a MH and

SUD are not available in network within the geographic and timely access standards in existing law, the health plan or insurer is required to arrange coverage to ensure the delivery of medically necessary out of network services and any medically necessary follow up services, as specified.

- f) SB 137 (Hernandez), Chapter 649, Statutes of 2015, requires a health plan or insurer to make available a provider directory or directories that provide information on contracting providers, including those that accept new patients and prohibits a provider directory from including information on a provider that does not have a current contract with the plan or insurer.
- g) SB 964 (Hernandez), Chapter 573, Statutes of 2014, requires a health plan to annually report specified network adequacy data to DMHC as a part of its annual timely access compliance report, and requires DMHC to review the network adequacy data for compliance.
- h) AB 2179 (Cohn), Chapter 797, Statutes of 2002, requires DMHC and CDI to develop and adopted regulations to ensure that enrollees have access to needed health care services.

7) AUTHOR AMENDMENTS. To address concerns related to unclear terms, the author is proposing to amend this bill as follows:

- a) Require the plan or insurer to delete and remove a provider from the directories upon specified circumstances;
- b) Specify that special circumstances include but are not limited to providers in rural areas or high specialized specialists; and,
- c) Include paid capitation to the definition of financially compensated.

8) COMMENTS.

- a) *Improving provider directory data quality to lessen consumer and administrative burden.* Provider directories poses many administrative challenges, similar to prior authorization and provider credentialing, as providers and plans share different information depending upon the different contractual relationships. According to CMS and after it completed its third round of MA online provider directory reviews between November 2017 and July 2018, CMS noted that it has become clear that a centralized repository for provider data is a key component missing from the accurate provider directory equation. CMS is currently looking at the provider data CMS collects to determine how it may be used to foster a collaborative industry approach to achieving a centralized location for provider data. According to CMS, this approach would make data collection and verification more efficient and less burdensome for MA plans and providers, and result in more accurate and timely data sharing. Moreover, a centralized database could allow the current inward facing MA plan efforts to have a broader impact. For example, when an MA plan identifies a directory error, it is fixed only for their own directory, whereas a corrected error in a centralized database would improve directory accuracy for all MA plans using that system. As this bill moves forward, the author may wish to consider a similar approach to review opportunities for interoperability and data standards that can be leveraged, to streamline the flow of accurate provider directory data between health plans and practices and within each organization.

- b) *Provider responsibility and information verification.* Existing law allows the health plan to delay payment or reimbursement owed to a provider if the provider fails to respond to the plan's attempts to verify information. This bill deletes a provider from the network if the plan has not paid claims five or more claims to a provider and allows the plan to delete the provider if the plan can not verify information. Concerns have been raised that provisions in this bill do not adequately incentivize providers to provide updates in a timely manner. It is unclear to what extent providers have been engaged in provider directory discussions but the reliability of the provider directory involves providers updating their information to the plan in a timely manner. As such, the author may wish to address these concerns, such as reviewing incentives and penalties for providers to ensure accurate and timely data sharing.

REGISTERED SUPPORT / OPPOSITION:

Support

Health Access California (sponsor)
 American Cancer Society Cancer Action Network
 America's Physician Groups
 California LGBTQ Health and Human Services Network
 California Pan - Ethnic Health Network
 California State Council of Service Employees International Union (SEIU California)
 Justice in Aging
 National Multiple Sclerosis Society, MS-CAN
 National Union of Healthcare Workers (NUHW)
 Steinberg Institute
 Western Center on Law & Poverty, INC.

Opposition

Aetna, INC.
 America's Health Insurance Plans (AHIP)
 Anthem Bluecross
 Association of California Life & Health Insurance Companies
 Blue Shield of California
 California Association of Dental Plans (CADP)
 California Association of Health Plans
 California Dental Network
 Cigna
 Delta Dental of California
 Dental Health Services
 Guardian Life Insurance Company of America; the
 Health Net
 Liberty Dental Plan
 Metlife Safeguard Health Plan of Ca.
 Principal First Dental Health
 Smile Brands INC.
 Sun Life Financial (UDC of California)
 United Concordia

United Healthcare Services, INC.
Unum Dental HMO Plan
Western Dental Services, INC.

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

Date of Hearing: March 14, 2023

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
AB 289 Holden – As Amended March 7, 2023

SUBJECT: Mental health services: representation.

SUMMARY: Expands the list of required stakeholders for purposes of county development of a three-year plan and annual updates under the Mental Health Services Act (MHSA) to include youths or youth mental health organizations. Requires stakeholders to include sufficient participation of individuals representing diverse viewpoints, including representatives from youth from historically marginalized communities, representatives from organizations specializing in work with underserved racially and ethnically diverse communities, and representatives from LGBTQ+ communities.

EXISTING LAW:

- 1) Establishes the Mental Health Services Oversight and Accountability Commission (MHSOAC) to oversee the implementation of the MHSA, enacted by voters in 2004 as Proposition 63, to provide funds to counties to expand services, develop innovative programs, and integrate service plans for mentally ill children, adults, and seniors through a one percent income tax on personal income above \$1 million. [Welfare and Institutions Code (WIC) §5845]
- 2) Permits the MHSOAC to perform various functions in carrying out its duties and responsibilities, such as:
 - a) Meeting at least once quarterly in locations convenient and open to the public;
 - b) Establishing technical advisory committees, such as a committee of consumers and family members;
 - c) Obtaining data and information from state or local entities that receive MHSA funds, as specified, to allow the MHSOAC to utilize in its oversight, review, training and technical assistance, accountability, and evaluation capacity, as specified;
 - d) Assisting in providing technical assistance to accomplish the purposes of the MHSA; and,
 - e) Working in collaboration with the Department of Health Care Services (DHCS), the California Behavioral Health Planning Council, and the County Behavioral Health Directors Association of California, as specified, to design a joint plan for a coordinated evaluation of client outcomes in the community-based mental health system, as specified. [WIC §5845]
- 3) Requires each county mental health department (CMHD) to prepare and submit a three-year program and expenditure plan, and annual updates, adopted by the county board of supervisors, to the MHSOAC and the DHCS based on available unspent MHSA funds and estimated revenue allocations provided by the state and in accordance with established stakeholder engagement and planning requirements, as specified. [WIC §5847]

- 4) Requires that each three-year program and expenditure plan and update be developed with local stakeholders, as specified. [WIC §5848]
- 5) Requires that counties demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations. [WIC §5848]

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

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, when making decisions for the future generation of Californians, it is critical that their voice and perspectives are heard. Listening and providing quality care that is youth informed helps the adults of tomorrow, today. The author concludes that youth voices, and the organizations that support their mental wellbeing, deserve to be heard in this process

2) BACKGROUND.

- a) **MHSA.** Proposition 63, the MHSA was passed by voters in November 2004. The MHSA imposes a 1% income tax on personal income in excess of \$1 million and creates the 16 member MHSAOAC charged with overseeing the implementation of MHSA. The MHSA addresses a broad continuum of prevention, early intervention and service needs as well as providing funding for infrastructure, technology, and training needs for the community mental health system.

The MHSA requires each CMHD to prepare and submit a three-year plan to DHCS that must be updated each year and approved by DHCS after review and comment by the MHSAOAC. In their three-year plans, counties are required to include a list of all programs for which MHSA funding is being requested and that identifies how the funds will be spent and which populations will be served. MHSA programs are divided into the following five categories:

- i) Community Services and Supports;
- ii) Prevention and Early Intervention;
- iii) Innovation;
- iv) Capital Facilities and Technological Needs; and,
- v) Workforce Education and Training.

Before the counties may spend certain categories of funding, including Prevention and Early Intervention and Innovation funds, their plans must be submitted for approval to the MHSAOAC.

- b) **MHSA Community Program Planning Process (CPPP).** The CPPP provides a structured process that counties are to use in partnership with stakeholders in determining how best to utilize funds that become available from the MHSA.

The county MSHA CPPP must adhere to the following general standards.

- i) Community Collaboration is a process by which clients and/or families receiving services, other community members, agencies, organizations, and businesses work together to share information and resources in order to fulfill a shared vision and goals;
- ii) Cultural Competence means that equal access is provided to equal quality of services to all racial/ethnic, cultural, and linguistic communities. Disparities are identified and strategies developed to eliminate disparities. Cultural competence means that program planning and service delivery takes into account diverse belief systems and the impact of historic forms of racism and discrimination on the mental health of community members. Services and supports utilize strengths and forms of healing that are unique to an individual's racial/ethnic, cultural, and linguistic community. Service providers are trained to understand and address the needs and values of the particular communities they serve, and strategies are developed and implemented to promote equal opportunities for those involved in service delivery who share the cultural characteristics of individuals with severe mental illness and/or severe emotional (SMI/SED) in the community;
- iii) Integrated Services Experience means the client, and when appropriate the client's family, accesses a full range of services provided by multiple agencies, programs and funding sources in a comprehensive and coordinated manner;
- iv) Client Driven means that the client has the primary decision-making role in identifying their needs, preferences and strengths and a shared decision-making role in determining the services and supports that are most effective and helpful for them. Client-driven programs/services use clients' input as the main factor for planning, policies, procedures, service delivery, evaluation, and the definition and determination of outcomes;
- v) Family Driven means that families of children and youth with SED a primary decision-making role in the care of their own children, including the identification of needs, preferences, and strengths, and a shared decision-making role in determining the services and supports that would be most effective and helpful for their children. Family-driven programs/services use the input of families as the main factor for planning, policies, procedures, service delivery, evaluation, and the definition and determination of outcomes; and,
- vi) Wellness, Recovery, and Resilience focused means that planning for services are consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers: "To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination. To promote consumer-operated services as a way to support recovery."

The MHSA CPPP must also include the following participants and processes:

- i) Clients and family members: Involvement of clients with SMI/SED and their family members in all aspects of the CPPP;
- ii) Broad-based constituents: Participation of stakeholders defined by WIC Section 5848(a) as adults and seniors with SMI, families of children, adults, and seniors with SMI, providers of services, law enforcement agencies, education, social services agencies, veterans, representatives from veterans organizations, providers of alcohol and drug services, health care organizations, and other important interests;

- iii) Underserved populations: participation from representatives of unserved and/or underserved populations and family members of unserved/underserved populations; and,
- iv) Diversity: Stakeholders that “reflect the diversity of the demographics of the County, including but not limited to, geographic location, age, gender, and race/ethnicity, and have the opportunity to participate in the CPPP.

The MHSA CPPP must also include: training; outreach to clients with SMI/SED, and their family members, to ensure the opportunity to participate; and a local review process prior to submitting the three-year program and expenditure plans or annual updates that includes a 30-day public comment period;

Counties must submit documentation of three-year program and expenditure plans or annual updates that includes:

- i) A description of methods used to circulate copies of the draft three-year program and expenditure plans or annual updates to representatives of stakeholders' interests and any other interested parties who request the draft for the purpose of public comment;
 - ii) Documentation that a public hearing was held by the local mental health board/commission, including the date of the hearing;
 - iii) A summary and analysis of any substantive recommendations; and,
 - iv) A description of any substantive changes made to the proposed three-year program and expenditure plan or annual update that was circulated.
- c) **Children and Youth Behavioral Health Initiative (CYBHI).** Enacted in 2021-22, the CYBHI is a \$4.7 billion, five-year initiative to “reimagine and transform the way California supports children, youth and families.” The CYBHI serves as the centerpiece of the Administrations’ Master Plan for Kids’ Mental Health. Since its inception the CYBHI, overseen by the California Health and Human Services Agency (CHHSA), has engaged over 1,000 organizations including 394 local, county and state government entities; 203 providers of health care, education and social services, and 70 child, youth and family organizations. The CYBHI has conducted over 300 listening sessions, stakeholder and expert interviews, as well as 75 roundtable, focus group and community engagement sessions. As an equity-focused and youth-centered initiative, the CYBHI is designed for and with children, youth and families. Their voices are informing every phase of the work from design to implementation and evaluation. Partner engagement efforts have focused on addressing equity by engaging with black, indigenous, and people of color (BIPOC), LGBTQ+ and low—income and underserved youth. The CYBHI focuses on four key strategic areas:
- i) Workforce Training and Capacity;
 - ii) Behavioral Health Ecosystem Infrastructure;
 - iii) Coverage Architecture; and,
 - iv) Public Awareness.

The work in these areas has been divided into 20 separate work streams, each one managed by one or more CHHSA departments or offices including the DHCS, Department of Health Care Access and Information, Department of Managed Health Care, Department of Public Health and the Office of the California Surgeon General. In

addition, CYBHI efforts are coordinated with other agencies such as the Department of Education, Department of Social Services, and the MHSOAC, engaging them as appropriate on the work to be undertaken.

- 3) **SUPPORT.** The Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), cosponsor of the bill, states that one of the goals of the MHSA was to reduce mental health disparities in this state. Unfortunately, since the passage of the MHSA, it has been difficult to detect significant reduction in disparities for racial, ethnic, and LGBTQ+ communities. The COVID pandemic only made this problem worse. REMHDCO concludes that getting representation from these communities involved with the community planning process should improve the chances that progress will be made in disparities being reduced.

Mental Health America of California (MHACa), also in a position of support states that the MHSA was written to transform California's public mental health system by prioritizing, among other things, extensive stakeholder involvement in the development, implementation, and evaluation of MHSA-funded county programs and services. The reasoning behind this is that each county has different community needs, and the stakeholders living in the community are the most knowledgeable about the needs and service gaps within their own communities. The behavioral health needs of Youth and Transition Age Youth require services that are often separate and distinct from the services utilized by adults. MHACa concludes by stating that to ensure that MHSA-funded services in each county are responsive to the needs of youth, it is important that youth and youth mental health organizations be required stakeholders in county MHSA planning.

- 4) **RELATED LEGISLATION.** AB 283 (Patterson) urges the Governor, when making appointments to the MHSOAC, to consider ensuring geographic representations among the 10 geographic regions of California as defined by the 2020 census. AB 283 is pending hearing in the Assembly Health Committee.

5) **PREVIOUS LEGISLATION.**

- a) AB 1668 (Patterson) of 2022, identical to AB 283, was vetoed by the Governor who indicated:

"I am committed to having boards and commissions that represent California's diversity, including regional representation, and I already consider these factors in the appointment process. In addition to being unnecessary, this bill overlooks the fact that other officials serve on, or can designate individuals to serve on, the MHSOAC. Therefore, I cannot sign this bill."

- b) SB 1283 (Bates) of 2022 would have amended the MHSA to provide the counties with more flexibility in shifting county MHSA money between programs and to include additional allowable services, including addiction treatment, case management, employment services, peer support, crisis intervention and stabilization, and family unification. SB 1283 was not heard in the Senate at the request of the author.
- c) AB 465 (Eggman), Chapter 544, Statutes of 2021, requires the MHSOAC to report to specified legislative committees the outcomes for people receiving community mental health services under a full service partnership (FSP) model, as specified, including any

barriers to receiving the data and recommendations to strengthen California's use of FSPs to reduce incarceration, hospitalization, and homelessness.

- d) AB 573 (Carrillo) of 2021 would have established the California Youth Mental Health Board within CHHSA. Would have required the MHSOAC by December 30, 2024, and every five years thereafter, to assess the extent to which the local youth boards have been established and to make recommendations on ways to strengthen the youth voice to support appropriate behavioral health services. AB 573 was held in the Assembly Appropriations Committee on the suspense file.
- e) AB 850 (Chau) of 2017 would have increased the membership of the MHSOAC to include an individual with knowledge and experience in reducing mental health disparities, especially for racial and ethnic communities, to be appointed by the Governor. AB 850 was vetoed by Governor Brown who indicated:

“This bill adds a member to the MHSOAC who has experience in reducing mental health disparities. I believe MHSOAC as currently constituted is up to the task entrusted to it.”

REGISTERED SUPPORT / OPPOSITION:

Support

The Children's Partnership (cosponsor)
Racial and Ethnic Mental Health Disparities Coalition (cosponsor)
California Alliance of Child and Family Services
California LGBTQ Health and Human Services Network
California Youth Empowerment Network
Californians for Justice
Cal Voices
Disability Rights California
Mental Health America of California
Southeast Asia Resource Action Center
Sycamores

Opposition

None on file.

Analysis Prepared by: Judith Babcock / HEALTH / (916) 319-2097

Date of Hearing: March 14, 2023

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
AB 385 (Ta) – As Introduced February 2, 2023

SUBJECT: Alzheimer’s disease: public awareness campaign.

SUMMARY: Requires the California Department of Public Health (DPH) to provide a public awareness campaign to educate health care providers, unpaid caregivers, family and friends who provide care to someone with Alzheimer’s disease (AD) or dementia. Requires DPH to be informed by its latest edition of the California Alzheimer’s Clinical Care Guideline.

EXISTING LAW:

- 1) Establishes DPH and sets forth its powers and duties, including, but not limited to, disease prevention and health promotion. [Health and Safety Code (HSC) §104100-106036]
- 2) Permits any postsecondary higher educational institution with medical center to establish diagnostic and treatment centers for AD subject to DPH’s grants review process. Requires DPH to administer grants to postsecondary higher educational institutions that establish diagnostic and treatment centers. [HSC §125280 (a)-(b)]
- 3) Requires the functions of the diagnostic and treatment centers to be designed to serve all of the following purposes:
 - a) To provide diagnostic and treatment services and improve the quality of care to victims of AD.
 - b) To increase research by faculty and students in discovering the cause of, and a cure for, AD.
 - c) To provide training, monitoring, consultation, and continuing education to the families of those who are affected by AD.
 - d) To increase the training of health care professionals with respect to AD and other acquired brain impairments to the extent that the centers have the requisite expertise. [HSC §125275 (c)]
- 4) Requires DPH to provide public and professional education on AD to educate consumers, caregivers, and health care providers and to increase public awareness. [HSC §125285]

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

COMMENTS:

- 1) **PURPOSE OF THIS BILL.** According to the author, this bill is needed to help educate the unpaid caretakers (i.e., a family or friend) who may not be aware of resources that are available to them. Unpaid caretakers have taken it upon themselves to bend over backward to provide all necessary care to a loved one suffering with AD. With 690,000 Californians living in our state today with AD and 1.1 million caregivers supporting them, this bill would

allow DPH to include unpaid caretakers in the awareness campaign, in order to educate those who may not be aware, about services that are offered, such as rides to appointments and specialized care to provide respite care allowing a break for the (family or friend) caring for a person with the AD.

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

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

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

- b) **AD and Dementia in California.** According to the January 2021 Related Dementia Facts and Figures in California: Current Status and Future Projections (report), in 2019, approximately 660,000 Californians over 65 years of age lived with AD, which accounted for approximately 11% of the nation's AD prevalence (5.8 million people). The report points out that between 2019 and 2040:
- i) The population of California will expand by 16%, whereas the population of people living with AD will expand by 127%;
 - ii) The number of Californians over 75 years of age living with AD will more than double, growing to over 1.3 million;
 - iii) The number of Californians between 55 and 74 years of age living with AD will increase 26%, growing to 194,975 people;
 - iv) The number of people living with AD in California's 15 most populous counties (those with a population of 700,000 or more) will at least double;
 - v) The number of Californians living with AD will increase 11% for women, growing to 917,482 people; and increase 8% for men, growing to 609,197 people;
 - vi) The number of people living with AD will more than triple for Californians who identify as Latino/Latina/Latinx (Latino/a/x) American, growing to 431,982 people; nearly triple for Californians who identify as Black/African American, growing to 91,071 people; and more than double for Californians who identify as Asian American/Pacific Islander, growing to 241,106 people;
 - vii) The number of people living with AD will more than double for Californians who identify as lesbian, gay, or bisexual, growing to 74,522 people; and,
 - viii) People with Down syndrome have an increased risk of developing AD. Estimates show that AD affects about 30% of people living with Down syndrome who are between 50 and 59 years of age and closer to 50% of people living with Down syndrome who are 60 years of age and older.
- c) **Caregiving for People with Dementia.** This bill includes in the public awareness campaign education for unpaid providers. According to the report, people with AD will need the help of others with basic activities of daily living. Caring for someone with AD is very difficult and poses physical, emotional and economic challenges, especially since most care is delivered at home by families. Dementia caregivers assume a wide range of responsibilities and provide more extensive assistance to people living with dementia compared to caregivers of people with other health conditions. Caregivers of people living with AD are more likely to provide help with emotional and mental health problems, such as confusion or belligerence; behavioral issues such as wandering; intimate activities of daily living, such as bathing and toileting; instrumental activities of daily living, such as housekeeping and handling finances; and more likely to perform medical/nursing tasks, such as catheter care or tube feedings. Dementia caregivers experience high levels of burden, which can take significant mental, physical, and even financial tolls on them. Below are some findings on caregiving for people with dementia:

- i) More than 1.6 million Californians provide unpaid care for a person with AD, which amounts to 1,849 million hours of care and has an estimated value of over \$24 billion in 2020;
 - ii) Most unpaid caregivers provide 20 or more hours of care per week to a friend or family member living with AD;
 - iii) California's caregivers of people 50 years of age and older are, on average, 60 years of age;
 - iv) California's caregivers are 60% female;
 - v) Approximately 67% of California family caregivers use their own money to care for a loved one, spending it on transportation (81%), assistive technology (51%), home modifications (48%), home health aide (28%), respite care (21%), or adult day care (12%); and,
 - vi) Approximately 520,000 In-Home Supportive Services (IHSS) caregivers provided paid care to over 550,500 recipients in California who are low-income older adults and people with disabilities in 2019. Among these IHSS recipients, approximately 30,000 have ADRDs, based on conservative estimates.
- d) **Master Plan for Aging (MPA):** In January of 2021, the Governor released his MPA. The MPA prioritizes the health and well-being of older Californians and the need for policies that promote healthy aging. The MPA serves as a blueprint for state government, local government, the private sector, and philanthropy to prepare the state for the coming demographic changes and continue California's leadership in aging, disability, and equity. The work plan laid out in the MPA two years after its release continues to highlight the urgent needs facing California's older adults, people with disabilities, their families, advocates and the workforce supporting these populations. The MPA outlines five bold goals and 23 strategies to build a California for All Ages by 2030. It also includes a Data Dashboard on Aging to measure progress. The Goals of the MPA are below and this bill is linked to some of these Goals:
- i) Goal One: Housing for All Ages and Stages;
 - ii) Goal Two: Health Reimagined;
 - iii) Goal Three: Inclusion and Equity, Not Isolation;
 - iv) Goal Four: Caregiving That Works; and,
 - v) Goal Five: Affording Aging.
- e) **Taskforce on Alzheimer's Disease Prevention and Preparedness:** In 2019, Governor Gavin Newsom formed the Task Force on Alzheimer's Disease Prevention, Preparedness and the Path Forward (Alzheimer's Taskforce). The purpose of the Alzheimer's Taskforce was to present recommendations to the Governor on how local communities, private organizations, businesses, government, and families can prevent and prepare for the rise in the number of cases of AD and all its consequences. Recommendations from

the Alzheimer's Taskforce were incorporated into the MPA.

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

- 3) **SUPPORT.** Supporters such as the California Commission on Aging and the AA state in support that education is among the most important tools that a caregiver can receive that will translate into better outcomes for those living with AD. Unpaid caregivers are at the frontline of caregiving for people with AD. However, often they do not have any support or programs to educate themselves on how to care for a loved one with AD. Supporters state this bill provides an important starting point for supporting unpaid caregivers who are often burdened with uncertainty.
- 4) **RELATED LEGISLATION.** AB 387 (Aguiar-Curry) expands the membership of the Alzheimer's Disease and Related Disorders Advisory Committee (AD Advisory Committee) from 14 to at least 21, but no more than 25, members. AB 387 is pending a hearing in Assembly Health Committee.

5) **PREVIOUS LEGISLATION.**

- a) AB 1684 (Voepel) of 2022 was substantially similar to the provisions of this bill and would have required DPH to implement a public awareness campaign, as specified. AB 1684 was held in Senate Appropriations Committee suspense file.
- b) AB 1618 (Aguiar-Curry) of 2022 would have expanded the membership of the AD Advisory Committee, and would have established the Office of the Healthy Brain Initiative at DPH. AB 1618 was held in the Senate Appropriations suspense file.
- c) SB 861 (Limon) of 2022 would have established, upon appropriation by the Legislature, the Dementia Care Navigator Grant Pilot Program under the California Department of Aging for the purpose of incentivizing local organizations to provide dementia care navigation training services. SB 861 was vetoed by Governor Newsom who indicated:

"The need for quality, culturally competent care is a priority of my administration. As an example of this commitment, the 2022 Budget Act included \$281.4 million over three years to recruit, train, and certify community health workers who can provide dementia care navigation, among other services. This bill creates more than \$6 million in General Fund cost pressures that were not accounted for in the budget.

With our state facing lower-than-expected revenues over the first few months of this fiscal year, it is important to remain disciplined when it comes to spending, particularly spending that is ongoing. We must prioritize existing obligations and priorities, including

education, health care, public safety and safety-net programs.

The Legislature sent measures with potential costs of well over \$20 billion in one-time spending commitments and more than \$10 billion in ongoing commitments not accounted for in the state budget. Bills with significant fiscal impact, such as this measure, should be considered and accounted for as part of the annual budget process.

While I am unable to sign this bill, I am directing the Department of Health Care Access and Information to work with stakeholders including those that work on dementia care as they begin to develop and implement the Community Health Worker program established by SB 184 (Committee on Budget and Fiscal Review, Chapter 47, Statutes of 2022), and funded by the Budget Act of 2022.”

REGISTERED SUPPORT / OPPOSITION:**Support**

Alzheimer's Association
Alzheimer's Greater Los Angeles
Alzheimer's Orange County
Alzheimer's San Diego
California Commission on Aging

Opposition

None on file.

Analysis Prepared by: Rosielyn Pulmano / HEALTH / (916) 319-2097

Date of Hearing: March 14, 2023

ASSEMBLY COMMITTEE ON HEALTH

Jim Wood, Chair

AB 48 (Aguiar-Curry) – As Introduced: December 5, 2022

SUBJECT: Nursing Facility Resident Informed Consent Protection Act of 2023.

SUMMARY: Creates the Nursing Facility Resident Informed Consent Protection Act of 2023 which requires a prescriber, prior to prescribing a psychotherapeutic drug for a resident of a skilled nursing facility (SNF) or intermediate care facility (ICF) to personally examine and obtain the informed written consent of the resident or the resident's representative. Specifically, **this bill:**

- 1) Requires a prescriber, prior to prescribing a psychotherapeutic drug for a SNF or ICF resident, to personally examine and obtain the informed written consent of the resident or the resident's representative.
- 2) Defines the following terms for the purposes of this bill:
 - a) "Informed consent" means the voluntary agreement of a resident or a resident's representative to accept a treatment or procedure after receiving specified information;
 - b) "Psychotherapeutic drug" means a drug to control behavior or to treat thought disorder processes, excluding antidepressants; and,
 - c) "Representative" means an individual who has authority to act on behalf of the resident, including, but not limited to, a conservator, guardian, person authorized as agent in the resident's advanced health care directive, the resident's spouse, registered domestic partner, or family member, a person designated by the resident, or other legally designated individual.
- 3) Requires the prescriber, for purposes of the requirement in 1) above, to communicate, and the written consent form to contain, in a language the resident understands, the information a reasonable person in the resident's condition and circumstances would consider material to a decision to accept or refuse the drug. Permits the written consent form to be provided in English if written translation services are not timely available. Requires the information and written consent form to be provided in an accessible format if the resident is hearing or vision impaired.
- 4) Requires the written consent form, for purposes of the requirement in 3) above, to be signed by the resident or the resident's representative, and to be signed by a health care professional who declares the resident or resident representative has been provided the material information. Requires copies of the signed consent form to be given to the resident and their representative.
- 5) Requires, if the signature of the resident or resident's representative cannot be obtained, a licensed nurse to sign the form and verify that they confirmed informed consent with the resident or resident's representative and to state the name of the person with whom they verified consent and the date.

- 6) Requires the SNF or ICF, within six months after the consent form is signed and every six months thereafter during which the resident receives a psychotherapeutic drug, to provide a written notice to the resident and the resident's representative, of any recommended dosage adjustments and the resident's right to revoke consent and to receive gradual dose reductions and behavioral interventions in an effort to discontinue the psychotherapeutic drug.
- 7) Authorizes the use of remote technology, including, but not limited to, telehealth, to allow a prescriber to examine and obtain informed written consent.
- 8) Requires the prescriber to provide, in addition to the information required in specified regulations governing informed consent in SNFs and ICFs, the following additional information material to an informed consent decision concerning the administration of a psychotherapeutic drug:
 - a) Possible non-pharmacologic approaches that could address the resident's needs;
 - b) Any current boxed warning labels and accompanying detailed information regarding contraindications, warning, and precautions required by the United States Food and Drug Administration (FDA);
 - c) Whether a proposed drug is being prescribed for a purpose that has not been approved by the FDA;
 - d) Possible interactions with other drugs the resident is receiving; and,
 - e) How the facility and prescriber will monitor and respond to any adverse side effects and inform the resident of side effects.
- 9) Requires facility staff, before initiating treatment with psychotherapeutic drugs, to verify that the resident's health record contains a written consent form with the required signatures. Requires facility staff, for a prescription written prior to the admission and encompassing the admission of the resident, to verify that the resident provided informed consent or refused treatment or a procedure pertaining to the administration of psychotherapeutic drugs.
- 10) Requires residents' rights policies and procedures established pursuant to this bill concerning informed consent to specify how the facility will verify that the resident provided informed consent or refused treatment or a procedure pertaining to the administration of psychotherapeutic drugs.
- 11) Prohibits this bill from being construed to require a facility to obtain informed consent each time a drug is administered unless material circumstances or risks change.
- 12) Requires the Department of Public Health (DPH) to inspect SNFs and ICFs for compliance with this bill during required periodic inspections and, as appropriate, during complaint investigations. Prohibits this inspection requirement from limiting DPH's authority in other circumstances to cite for violations or to inspect for compliance with this bill.
- 13) Deems a violation of the requirement in 9) above for facility staff to verify that a resident has a signed written consent form prior to the administration of psychotherapeutic drugs to have caused the affected residents harm and to constitute a class "B," "A," or "AA" violation pursuant to the standards under existing law for these violations.

- 14) Specifies that in addition to any other penalties, the willful or repeated violation of this bill is punishable as a misdemeanor unless there is an emergency as described in specified regulations.
- 15) Specifies that nothing in this bill impairs or otherwise alters other non-conflicting statutory or regulatory requirements, including but not limited to, requirements contained in specified regulations pertaining to initiating treatment without informed consent if an emergency exists in which immediate action is necessary for the prevention of serious bodily harm or to alleviate severe physical pain.
- 16) Requires DPH to develop a standardized informed consent form in consultation with interested stakeholders.
- 17) Specifies that SNFs and ICFs are not required to comply with this bill until the informed consent form is available as developed by DPH and requires DPH to have a final informed consent form available by December 31, 2024.
- 18) Authorizes DPH to implement the provisions of this bill by means of an All Facilities Letter, or similar instruction and specifies that nothing in this bill negates existing informed consent requirements in law or regulations.
- 19) Adds the following two requirements to the Skilled Nursing and Intermediate Care Facility Patient's Bill of Rights:
 - a) Requires a resident of a SNF or ICF to have the right to receive the information that is material to an individual's decision concerning whether to accept or refuse a proposed treatment or procedure, pursuant to specified regulations governing informed consent in SNFs. Requires the disclosure of material information for administration of psychotherapeutic drugs to also include the disclosures required by this bill in 8) above; and,
 - b) Requires a resident of a SNF or ICF to have the right to be free from psychotherapeutic drugs used for the purpose of resident discipline or convenience, and to have the right to be free from psychotherapeutic drugs used as a chemical restraint, except in an emergency that threatens to cause immediate injury to the resident or others. Requires, if a chemical restraint is administered during an emergency, the chemical restraint to only be a drug that is required to treat the emergency condition, after being deemed the least intrusive treatment alternative for the resident, and used only for a specified and limited period of time. Defines "chemical restraint," for purposes of this provision, as a drug used to control behavior and used in a manner not required to treat the resident's medical symptoms.
- 20) Makes various legislative findings and declarations, including that as of 2021, 22% of California nursing facility residents are given powerful antipsychotic drugs, which are a subset of psychotherapeutic drugs; that the FDA has issued black box warnings stating that antipsychotic drugs greatly increase the risk of death for seniors with dementia; and, that it is the intent of the Legislature to codify and expand rules that establish a resident's right to provide or withhold written informed consent concerning the use of psychotherapeutic drugs and the right to be free from chemical restraint.

EXISTING LAW:

- 1) Establishes DPH, which, among other functions, licenses and regulates SNFs and ICFs. Defines SNFs as health facilities that provide skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis, and ICFs as health facilities that provide inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision and need supportive care, but who do not require the availability of continuous skilled nursing care. [Health and Safety Code (HSC) §1250 (c) and (d)]
- 2) Permits an attending physician and a SNF or ICF to initiate a medical intervention for a resident of a SNF or ICF that requires informed consent, when the physician has determined the resident lacks the capacity to make health care decisions and there is no person with legal authority to make those decisions on behalf of the resident, in accordance with acceptable standards of practice. [HSC §1418.8 (b)]
- 3) Specifies that a resident lacks capacity to make a decision regarding their health care if the resident is unable to understand the nature and consequences of the proposed medical intervention, or is unable to express a preference regarding the intervention. Requires the physician, in making a determination regarding capacity, to interview the resident, review the resident's medical records, and consult with SNF or ICF staff, and family members and friends of the resident, if any have been identified. [*Id.*]
- 4) Specifies that a person with legal authority to make medical decisions on behalf of a resident is a person designated under a valid Durable Power of Attorney for Health Care, a guardian, a conservator, or next of kin. Requires a physician to interview the resident, review medical records, and consult with SNF or ICF staff, and with family members and friends, if identified, in order to determine the existence of a person with legal authority. [HSC §1418.8 (c)]
- 5) Requires a SNF or ICF to contact the Long-Term Care Patient Representative Program (PR Program) within 72 hours of a physician's determination pursuant to 3) above, if no family or friend is identified to serve as the patient representative. [*Id.*]
- 6) Requires a facility to conduct an interdisciplinary team review of the prescribed medical treatment prior to the administration of the medical intervention when a resident of a SNF or ICF has been prescribed a medical intervention that requires informed consent, and the physician determined that the resident lacked capacity to make decisions, and there is no legal decision-maker. Requires a notice to be provided to the resident and the patient representative. [HSC §1418.8 (d) and (e)]
- 7) Authorizes a SNF or ICF, in the case of an emergency and after obtaining a physician's order, to administer a medical intervention that requires informed consent prior to the facility issuing the notice described in 6) above, and prior to conducting an interdisciplinary team review. Requires the emergency to be documented in the resident's records, and for the facility to conduct the interdisciplinary team review within one week of the emergency. [HSC §1418.8 (h)]

- 8) Establishes a civil penalty structure for long term care (LTC) facilities, including SNFs and ICFs, categorized into “AA,” “A,” and “B” violations:
 - a) “A” violations are those which DPH determines the violation presents either imminent danger of death or serious harm, or a substantial probability that death or serious harm to residents would result;
 - b) “AA” violations (the most severe) are those that meet the criteria for a class “A” violation that DPH determines was a substantial factor (as defined) in the death of a resident of an LTC facility; and;
 - c) “B” violations are those that DPH determines have a direct or immediate relationship to the health, safety, or security of LTC facility residents. [HSC §1424]

Existing regulations:

- 1) Specify, for purposes of obtaining informed consent in SNFs and ICFs, that it is the responsibility of the attending licensed healthcare practitioner acting within the scope of their professional practice to determine what information a reasonable person in the patient’s condition and circumstances would consider material to a decision to accept or refuse a proposed treatment or procedure. [Title 22, California Code of Regulations (CCR) §72528(a)]
- 2) Require, for purposes of informed consent in SNFs and ICFs, that information material to a decision concerning the administration of a psychotherapeutic drug or physical restraint, or the prolonged use of a device that may lead to the inability of the patient to regain use of a normal bodily function, to include specified information, including the nature, degree, duration, and probability of side effects and significant risks, and reasonable alternative treatments and risks. [22 CCR §72528(b)]
- 3) Require, prior to initiating the administration of psychotherapeutic drugs, SNF or ICF staff to verify that the patient’s health record contains documentation that the patient has given informed consent to the proposed treatment. [22 CCR §72528(c)]
- 4) Define “psychotherapeutic drug,” for purposes of requirements pertaining to SNFs and ICFs, as a medication to control behavior or to treat thought disorder processes. [22 CCR §72092]

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

COMMENTS:

- 1) **PURPOSE OF THIS BILL.** According to the author, nursing facilities such as SNFs and ICFs have increasingly turned to psychotherapeutic drugs to sedate and control residents, especially those who display confused or agitated behaviors caused by dementia. The author notes that while these drugs are sometimes appropriately prescribed to treat mental health conditions, many of the psychotherapeutic drugs are being misused in nursing facilities. For example, antipsychotic drugs are designed to treat serious psychiatric disorders like schizophrenia, but are instead prescribed to residents with dementia, which can increase the risks of dangerous side effects and death without medical justification. The author states that this bill gives nursing home residents and their families’ tools to decide if a medication is right for them. The author concludes that this bill codifies existing regulations that establish a nursing home resident’s right to informed consent concerning the use of psychoactive drugs,

strengthens requirements for informed consent verification, and clarifies that DPH must inspect for compliance with informed consent requirements.

2) BACKGROUND.

- a) **Current informed consent requirements at SNFs and ICFs.** Under existing regulations for both SNFs and ICFs, there are a number of requirements governing informed consent, including specific requirements governing the administration of a psychotherapeutic drug or physical restraint. The regulations state that it is the responsibility of the attending physician to determine what information a reasonable person in the patient's condition and circumstances would consider material to a decision to accept or refuse a proposed treatment or procedure, and that the disclosure of the material information and obtaining informed consent is the responsibility of the licensed healthcare practitioner, acting within their scope of practice, who orders the treatment for which informed consent is required. For the administration of a psychotherapeutic drug or a physical restraint, or the prolonged use of a device that may lead to the inability of a patient to regain use of a normal bodily function, the material information required to be disclosed in order for the patient or the patient's representative to provide informed consent includes the following:
- i) The reason for the treatment and the nature and seriousness of the patient's illness;
 - ii) The nature of the procedures to be used in the proposed treatment, including their probable frequency and duration;
 - iii) The probable degree and duration (temporary or permanent) of improvement or remission, expected with or without such treatment;
 - iv) The nature, degree, duration and probability of the side effects and significant risks, commonly known by the health professions;
 - v) The reasonable alternative treatment and risks, and why the health professional is recommending this particular treatment; and,
 - vi) That the patient has the right to accept or refuse the proposed treatment, and if he or she consents, has the right to revoke his or her consent for any reason at any time.

Before initiating the administration of psychotherapeutic drugs, or physical restraints, facility staff is required to verify that the patient's health record contains documentation that the patient has given informed consent to the proposed treatment or procedure. The regulations permit the initiation of treatment without informed consent if there is documentation within the patient's record that an emergency exists where there is an unanticipated condition in which immediate action is necessary for the preservation of life or the prevention of serious bodily harm to the patient or others or to alleviate severe physical pain, and it is impractical to obtain the required consent. The regulations also permit the disclosure of risks of a proposed treatment or procedure to be withheld if there is documentation that the patient or patient's representative specifically requested that they not be informed of the risks, or when the licensed health care practitioner relied upon objective facts that would demonstrate to a reasonable person that the disclosure would have so seriously upset the patient that the patient would not have been able to rationally weigh the risks of refusing to undergo the recommended treatment and that, unless inappropriate, a patient's representative gave informed consent. A general consent form in a contract for admission can only encompass consent for routine nursing care or emergency care.

The requirements in this bill build off the requirements in regulations as described by, among other things, requiring the informed consent for psychotherapeutic drugs to be written and signed by both the prescriber and the patient or the patient's representative, requiring the prescriber to personally examine and obtain the written informed consent, and adding additional required disclosures such as whether a drug is being prescribed for a purpose that has not been approved by the FDA, and information related to black box warnings.

- b) **Background on informed consent.** With the exception of a medical emergency, all medical procedures require the consent of the patient. If the medical treatment is more involved, or if there are some risks involved, the patient needs to be informed of those risks or potential complications, and this "informed consent" must be documented in the patient's record. A patient must be capable of understanding those risks to be able to provide consent to the treatment. While a court can adjudicate a person to be incompetent to make medical decisions, even if this has not happened, a physician can still make a determination that a person lacks capacity to make health care decisions. Sometimes this is temporary, such as when a patient is unconscious, or it can be more permanent if caused by something like dementia. In most cases, the resident of the nursing home has a surviving spouse or child or other next of kin, or someone else previously designated as a surrogate decision maker, whether through a Durable Power of Attorney for Health Care, or some other mechanism. The problem is when the nursing home patient does not have anyone available to represent them. The Probate Code allows a physician or a health facility, among others, to file a petition in court to determine that a patient lacks capacity and to have the court authorize recommended medical treatment, or to appoint someone to make decisions on the patient's behalf.
- c) **The PR Program.** The PR Program is a new program within the California Department of Aging (DoA), which provides trained representatives for specified long-term care residents who may need medical treatment but lack the capacity to make health care decisions and have no legal surrogate authorized to make decisions on their behalf.

Under existing law, SNFs and ICFs may convene an interdisciplinary team to make medical decisions for residents who lack capacity and have no legal surrogate. These teams include the resident's physician, a registered nurse responsible for the resident's care, and other appropriate staff. In the past, the teams also sometimes included patient representatives, but this was not required. As the result of a court case, SNFs and ICFs will be required to include a patient representative when they convene an interdisciplinary team. This new requirement became effective January 27, 2023. The Office of the Long-Term Patient Representative began accepting referrals on January 27, 2023. As of March 1, 2023, the DoA has the following data available:

- i) The PR Program has received 136 referrals. These referrals are received directly from SNFs and ICFs via the California Patient Representative Information System database. These referrals are requests to have a public patient representative attend an interdisciplinary team (IDT) meeting. Of those referrals:
 - (1) One hundred and seven did not meet criteria (as defined in WIC § 9270) for an IDT meeting; and,
 - (2) Twelve were for emergency interventions.
- ii) Public patient representatives have attended 19 IDT meetings:
 - (1) Two of the 19 were an IDT for an emergency referral; and,

(2) There are 16 IDTs pending further review.

DoA is currently working out technical details associated with collection and reporting of the data. DoA is also providing technical assistance to facilities regarding their data submission requirements. The collected data will be made available to the public without any personally identifiable information.

If a facility makes a case an “emergency” they are still required to notify the PR Program Office of these interventions within 24 hours and an IDT is to be held within a week of the emergency notice. DPH has indicated that they will evaluate the compliance with these requirements through their survey and compliance process. DoA defers to DPH regarding any penalties if a resident does not receive the benefit of an IDT.

- d) **Black box warnings.** A “Black Box Warning” exists on the label of all antipsychotic drugs reading: “Elderly patients with dementia related psychosis treated with antipsychotic drugs are at an increased risk of death. Antipsychotics are not approved for the treatment of patients with dementia related psychosis.”

Psychotherapeutic agents are drugs that are used to treat problems in thought processes of individuals with both perceptual and behavioral disorders. These agents do not provide cure for psychoses but they help both adult and pediatric patients perform activities of daily living. Antipsychotic drugs are dopamine-receptor blockers used to treat disorders associated with problems in thought processes. These drugs are also referred to as neuroleptic agents because of their known neurological adverse effects. Previously, they were called major tranquilizers but later this was changed because their primary action is not sedation. Two classifications of antipsychotic drugs are: i) typical antipsychotics; and, ii) atypical antipsychotics. Typical antipsychotics are indicated for schizophrenia and manifestations of other psychotic disorders including hyperactivity, combative behavior, and severe behavioral problems.

However, antipsychotic drugs have been used for some time for “off label” use for patients with dementia. To use a drug “off label” means the prescription of a medication to treat a condition that has not been officially approved by the FDA for that purpose. Prescribing a drug for an “off label” reason is not illegal, and providers must use current research and standards to determine if such a use is beneficial.

- e) **2011 Office of Inspector General (OIG) Report, “Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents.”** In 2011, the OIG evaluated the extent to which elderly nursing home residents receive atypical antipsychotic drugs and the associated cost to Medicare due to concerns about atypical antipsychotic drugs prescribed for elderly nursing home residents with dementia. Side effects associated with these drugs include increased risk of death in elderly persons with dementia. Medicare requires that drugs be used for medically accepted indications supported by one or more of three compendia to be eligible for reimbursement. For the period January 1 through June 30, 2007, the OIG determined using medical record review that 51% of Medicare claims for atypical antipsychotic drugs were erroneous, amounting to \$116 million in costs. OIG also found that 14% of the 2.1 million elderly (i.e., age 65 and older) nursing home residents had at least one claim for these drugs. OIG determined using medical record review that 83% of Medicare claims for atypical antipsychotic drugs for elderly

nursing home residents were associated with off-label conditions and that 88% were associated with dementia.

In 2012, the Centers for Medicare & Medicaid Services (CMS) created the Partnership to Improve Dementia Care in Nursing Homes (the Partnership), in recognition of the unacceptably high prevalence of antipsychotic drug use in nursing homes. CMS tracks the progress of the Partnership by reviewing publicly reported measures. The official measure of the Partnership is the percentage of long-stay nursing home residents who are receiving an antipsychotic medication, excluding those residents diagnosed with schizophrenia, Huntington's disease, or Tourette's syndrome. In 2011Q4, 23.9% of long-stay nursing home residents were receiving an antipsychotic medication; since then there has been a decrease of 39.6% to a national prevalence of 14.4% in 2021Q2.

On January 18, 2023 CMS announced that it will start conducting targeted, off-site audits to determine whether nursing homes are accurately assessing and coding individuals with a schizophrenia diagnosis.

- f) **Changing diagnosis.** According to *New York Times* investigative reports published in October and November of 2021, the share of nursing home residents who are recorded as having schizophrenia has soared over the past decade. The 2012 CMS effort to reduce unnecessary antipsychotic drug use in nursing homes included an exemption for residents with schizophrenia. Since then, the diagnoses have grown by 70%. The impact of this has been more severe on Black residents. A September 2021 study in the *Journal of the American Geriatrics Society*, "Disproportionate increases in schizophrenia diagnoses among Black nursing home residents with Alzheimer's and related dementia" found that since the new rules went into place, Black Americans with dementia have been 1.7 times as likely as their white nursing home neighbors to be diagnosed with schizophrenia.
- 3) **SUPPORT.** California Advocates for Nursing Home Reform (CANHR) is the sponsor of this bill and states that antipsychotics and other psychotropic drugs are not only unsafe for elderly people with dementia, they often cause side effects that actually decrease a patient's cognitive abilities. The leading prescriber/pharmacy guide for reducing inappropriate drugging and adverse drug effects in elderly patients, the "Beers Criteria," lists nearly all psychotropic drugs in the "avoid" category, citing sedation, cognitive impairment, and increased risk of death. CANHR notes that significant amounts of research demonstrate that antipsychotics have minimal benefit, often outperformed by placebos or simple pain medications like Tylenol. The only benefits of antipsychotics for dementia patients – if they can be called benefits – are sedation and submission which increase fatigue and decrease activity. The resident's subsequent incapacity increases the patient's susceptibility to devastating falls, pressure sores, weight loss, and infection. These outcomes are what give antipsychotics, and other psychotropic drugs, their lethality for elderly people with dementia.

CANHR contends that despite the deep foundation of informed consent laws and protections that are specific in nursing homes, the process of obtaining informed consent is often meaningless. In 2011, DPH conducted an Antipsychotic Drugs Collaborative (the Collaborative) to evaluate the use of antipsychotics in nursing homes. DPH found 147 violations involving 41 different regulations in just 24 facilities, an average of 6.1 deficiencies per facility. Most of the violations involved the use of unnecessary drugs or drugs in excessive dosage and the failure to obtain informed consent. The Collaborative

investigations determined the majority of the sampled nursing homes had violated at least one rule regarding informed consent. The most common violation was the total failure to obtain the consent of the resident or a surrogate before administering a psychotropic drug while another common violation was the absence of the physician in the informed consent process. CANHR states that the use of mind-altering drugs without consent violates some of our most precious and fundamental human rights: the right to control what goes into our bodies, the right to our thoughts and expression, and the freedom to make our own decisions. CANHR concludes that informed consent lies at the heart of residents' ability to ultimately direct the course of their health care treatment and this bill ensures that their choices will be appropriately honored.

4) RELATED LEGISLATION.

- a) AB 486 (Kalra) removes the ability of a LTC facility to adjudicate the validity of a citation issued by DPH in a county superior court, and instead requires all citation appeals to be made through an administrative law judge. AB 486 is pending in the Assembly Health Committee.
- b) AB 1537 (Wood) requires, no later than July 1, 2024, the establishment of a direct patient-related services spending, reporting, and rebate requirement for skilled nursing facilities (SNFs), with certain exceptions. Requires that a minimum of 85% of a facility's total non-Medicare health revenues from all payer sources in each fiscal year be expended on residents' direct patient-related services, as defined.

5) PREVIOUS LEGISLATION.

- a) AB 1809 (Aguiar-Curry) of 2022 was substantially similar to this bill. AB 1809 was vetoed by Governor Newsom, who stated: "I support the author's goal of improving informed consent requirements and protecting long-term care residents from inappropriate uses of psychotherapeutic medications. However, this bill creates ambiguity as to whether long-standing informed consent requirements will continue to be required until a new standardized form is developed, which could put the health of long-term care residents in jeopardy. Furthermore, the State Health Facilities Citation Penalties Account is not an appropriate funding source for the development of this form because the funds in the account are by law reserved for the protection of health or property of residents of long-term health care facilities. I encourage the author to work with DPH to resolve these concerns in the next legislative session."
- b) AB 135 (Budget Committee), Chapter 85, Statutes of 2021, creates, among other provisions, the Long-Term Care Patient Representative Program (program) and the Office of the Long-Term Care Patient Representative in the Department of Aging to provide patient representatives to protect the rights of nursing home residents. Requires the program to assign a public patient representative if no family member or friend is available to serve in that capacity.
- c) AB 323 (Kalra), Chapter 458, Statutes of 2021, changes the standard DPH uses when issuing penalties against LTC facilities for violations that result in the death of a resident from "direct proximate cause" to "substantial factor" and the death was a result of the violation. Increases the amount of civil penalties assessed against LTC facilities.

- d) AB 849 (Reyes), Chapter 471, Statutes of 2021, clarifies that a LTC facility licensee is liable for up to \$500 per violation when a current or former resident, or patient, or the legal representative, personal representative, or successor in interest of a current or former resident or patient, of a LTC facility brings a civil action against the facility for violation of any rights of the resident or patient as set forth in the Patient's Bill of Rights or any other right provided for by federal or state law or regulation. Provides that the above per violation penalty applies to violations that occur on or after March 1, 2021.
 - e) SB 460 (Pan) of 2021 would have created the Office of the Patient Representative within DoA to train, certify, provide, and oversee patient representatives to protect the rights of SNF and ICF residents when a medical intervention is prescribed for residents who cannot provide informed consent, as specified. SB 460 would also have refined procedures for determining that residents of SNFs and ICFs lack capacity to provide informed consent for a medical intervention. SB 460 was not taken up for a vote on the Senate Floor.
 - f) SB 503 (Ed Hernandez) of 2016 would have made changes to the process for the prescribing or ordering of a medical intervention for a resident of a SNF or ICF who lacks capacity to make decisions involving their health care; modified the existing IDT review process required for such medical interventions; and established a new process for the administration of antipsychotic medication to residents of SNFs and ICFs. SB 503 was subsequently amended to address a different subject matter.
- 8) **DOUBLE REFERRAL.** This bill is double referred; upon passage in this Committee, this bill will be referred to the Assembly Judiciary Committee.
- 9) **TECHNICAL AMENDMENT.** The Committee recommends amending this bill to clarify that DPH will provide the final consent form to skilled nursing facilities, *and intermediate care facilities*, by December 31, 2024.

REGISTERED SUPPORT / OPPOSITION:

Support

California Advocates for Nursing Home Reform (sponsor)
A Voice for Choice Advocacy
AARP
Alzheimer's Greater Los Angeles
Alzheimer's Orange County
Alzheimer's San Diego
Berkeley City Council District 4, Office of Vice Mayor Kate Harrison
California Advocates for Nursing Home Reform
California Alliance for Retired Americans
California Commission on Aging
California Health Coalition Advocacy
Consumer Attorneys of California
Educate. Advocate.
Elder Law & Advocacy
Gray Panthers of San Francisco

Justice in Aging
Long Term Care Services of Ventura Co, Ombudsman
Oakland Privacy
The Geriatric Circle

Opposition

None on file.

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

Date of Hearing: March 14, 2023

ASSEMBLY COMMITTEE ON HEALTH

Jim Wood, Chair

AB 387 (Aguiar-Curry) – As Introduced February 2, 2023

SUBJECT: Alzheimer's disease.

SUMMARY: Increases the membership of the Alzheimer's Disease (AD) and Related Disorders Advisory Committee (Advisory Committee) within the California Health and Human Services Agency (CHHSA) from 14 to at least 21, but no more than 25, members. Specifically, **this bill:**

- 1) Increases the membership of the Advisory Committee from 14 to at least 21, but no more than 25 members. Adds the following members to the Advisory Committee:
 - a) One representing local health jurisdictions;
 - b) Additional one member representing a consumer organization representing persons living with AD or related disorders;
 - c) One representing first responders;
 - d) One commissioner from the California Commission on Aging who has expertise regarding AD or related disorders;
 - e) One representing primary care physicians;
 - f) Two ex officio, nonvoting members, one Senator appointed by the Senate Committee on Rules and one Member of the Assembly appointed by the Speaker of the Assembly. Requires these members to participate in the activities of the Advisory Committee to the extent that their participation is not incompatible with their respective positions as Members of the Legislature; and,
 - g) Up to four additional members selected by the Secretary of CHHSA.
- 2) Specifies that members described in 1) a) through e) and 1) g) above serve at the pleasure of their appointing authority. Specifies that the legislative members described in 1) f) serve at the pleasure of their appointing authority.
- 3) Clarifies that the Advisory Committee is to also consult with family members or informal caregivers. Makes other technical and clarifying changes.

EXISTING LAW:

- 1) Establishes the Advisory Committee within CHHSA to provide advice and assistance to the Administration and the Legislature as to the program needs and priorities of people diagnosed with AD or related disorder, and consisting of 14 members, as follows:
 - a) One representing the field of academic medical research;
 - b) One representing the field of social research;
 - c) One representing the field of mental health;

- d) One representing the AD or related disorders day care resource centers;
 - e) One representing the AD or related disorders diagnostic and treatment centers.
 - f) Two representing families of persons living with AD or related disorders;
 - g) Two representing organizations providing services to AD or related disorders patients;
 - h) One representing a consumer organization representing persons with AD or related disorders;
 - i) One representing a member of the State Bar who is familiar with the legal issues confronting those living with AD or related disorders and their families; and,
 - j) Two people who have been diagnosed with AD or a related disorder to serve one-year terms. [Health & Safety Code (HSC) §1568.17(a)]
- 2) Specifies that members of the Advisory Committee serve without compensation but are to receive reimbursement for travel and other necessary expenses actually incurred in the performance of their duties. [HSC§1568.17(c)]
- 3) Requires the Advisory Committee to do all of the following:
- a) Consult with a broad range of stakeholders, including, but not limited to, people diagnosed with AD, family caregivers, community-based and institutional providers, AD researchers and academicians, formal caregivers, the Alzheimer's Association (AA), the California Commission on Aging, and other state entities;
 - b) Consider the recommendations of other state plans, including, but not limited to, the Olmstead Plan, the Long-Range Strategic Plan on Aging, and the California Department of Aging's State Plan on Aging;
 - c) Consider cultural and linguistic factors that impact persons with AD and their families who are from diverse populations; and,
 - d) Review current state policies and practices concerning care and treatment related to AD and other dementia disorders, and develop recommendations concerning all of the following issues:
 - i) Community-based support for California's diverse people with AD and their family members;
 - ii) Choices for care and residence for persons with AD and their families;
 - iii) An integrated public health care management approach to AD in health care settings that makes full use of dementia care practices;
 - iv) The dementia competence of health care professionals; and,
 - v) Early identification and intervention through increasing public awareness of AD.
- [HSC §1568.17(d)-(e)]

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

COMMENTS:

- 1) PURPOSE OF THIS BILL.** According to the author, nearly 700,000 people aged 65 and older are currently living with AD in California. Of people aged 45 and older, nearly 12% have subjective cognitive decline. The Alzheimer's Disease and Related Disorders (ADRD) Advisory Committee was established in 1988 to provide ongoing advice and assistance on program needs and priorities of persons impacted by AD and related dementia disorders. Since its creation, the population of people living with AD is increasing, and the needs of the people affected along with our understanding of AD has changed. As the population of people living with AD continues to grow, it is important that the ADRD Advisory Committee

is updated to best represent them in their role of providing feedback as the state of California continues to do its best to investing in equity solutions and maximizing benefits for underserved and marginalized communities. Therefore, this bill expands the membership of the ADRD Advisory Committee to better reflect the needs of today. This bill also replaces outdated, stigmatizing language and allows committee members who have AD to serve longer terms consistent with improved outcomes thanks to modern medicine.

The author also points out that this bill overcomes stigma by removing unfair term limits for committee members living with AD or related dementias, broadens caregiver terminology to reflect the realities of informal caregiving and the removal of other harmful terminology. These changes allow the committee to represent and serve persons living with AD and their caregivers in the most respect as possible while uplifting them and giving them the equitable representation that they deserve. Additionally, low-income people are more likely to have informal caregivers and will be better represented in the committee members updates.

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

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

- i) In addressing dementia, public health should identify underserved populations and those who experience a disproportionate burden of disease;
- ii) Public health officials must learn about the impact of AD and other forms of dementia on these populations;

- iii) Public health must identify the local causes of these disparities and collaborate with community partners and stakeholders to develop initiatives to address them;
 - iv) Public health practitioners should be sure to identify culturally, linguistically, and age appropriate strategies for people living with AD and their caregivers; and,
 - v) Public health should collaborate with or lead initiatives to ensure that government agencies that serve these populations are trained in appropriate and effective strategies.
- b) **AD and Dementia in California.** According to the January 2021 Related Dementia Facts and Figures in California: Current Status and Future Projections (report), in 2019, approximately 660,000 Californians over 65 years of age lived with AD, which accounted for approximately 11% of the nation's AD prevalence (5.8 million people). The report points out that between 2019 and 2040:
- i) The population of California will expand by 16%, whereas the population of people living with AD will expand by 127%;
 - ii) The number of Californians over 75 years of age living with AD will more than double, growing to over 1.3 million;
 - iii) The number of Californians between 55 and 74 years of age living with AD will increase 26%, growing to 194,975 people;
 - iv) The number of people living with AD in California's 15 most populous counties (those with a population of 700,000 or more) will at least double;
 - v) The number of Californians living with AD will increase 11% for women, growing to 917,482 people; and increase 8% for men, growing to 609,197 people;
 - vi) The number of people living with AD will more than triple for Californians who identify as Latino/Latina/Latinx (Latino/a/x) American, growing to 431,982 people; nearly triple for Californians who identify as Black/African American, growing to 91,071 people; and more than double for Californians who identify as Asian American/Pacific Islander, growing to 241,106 people;
 - vii) The number of people living with AD will more than double for Californians who identify as lesbian, gay, or bisexual, growing to 74,522 people; and,
 - viii) People with Down syndrome have an increased risk of developing AD. Estimates show that AD affects about 30% of people living with Down syndrome who are between 50 and 59 years of age and closer to 50% of people living with Down syndrome who are 60 years of age and older.
- The 2021 Report also included discussions on living arrangements for people living with AD; caregiving for people with AD and the costs of caring for people with AD.
- c) **AD Program.** In 1984, legislation was enacted that established the AD Program. To meet the legislative mandates of relieving the human burden and economic cost of AD and related disorders, and to assist in ultimately discovering the cause and treatment of these diseases, the Program:
- i) Established and administers a statewide network of 10 California Alzheimer's Disease Centers (CADCs) at university medical centers. The CADCs are dedicated to improving the quality of life of persons affected with AD and their families by providing diagnostic and treatment services; professional training for medical

- residents, postdoctoral fellows, nurses, interns, and medical students; and community education, such as caregiver training and support; and,
- ii) Established and administers the Alzheimer's Disease Research Fund, which awards grants through a competitive process to scientists in California engaged in the study of ADRDs.

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

- d) **Master Plan for Aging (MPA):** In January of 2021, the Governor released his MPA. The MPA prioritizes the health and well-being of older Californians and the need for policies that promote healthy aging. The MPA serves as a blueprint for state government, local government, the private sector, and philanthropy to prepare the state for the coming demographic changes and continue California's leadership in aging, disability, and equity. The work plan laid out in the MPA two years after its release continues to highlight the urgent needs facing California's older adults, people with disabilities, their families, advocates and the workforce supporting these populations. The MPA outlines five bold goals and 23 strategies to build a California for All Ages by 2030. It also includes a Data Dashboard on Aging to measure progress. The Goals of the MPA are as follows:
 - i) Goal One: Housing for All Ages and Stages;
 - ii) Goal Two: Health Reimagined;
 - iii) Goal Three: Inclusion and Equity, Not Isolation;
 - iv) Goal Four: Caregiving That Works; and,
 - v) Goal Five: Affording Aging.
- e) **Taskforce on Alzheimer's Disease Prevention and Preparedness:** In 2019, Governor Gavin Newsom formed the Task Force on Alzheimer's Disease Prevention, Preparedness and the Path Forward (Alzheimer's Taskforce). The purpose of the Alzheimer's Taskforce was to present recommendations to the Governor on how local communities, private organizations, businesses, government, and families can prevent and prepare for the rise in the number of cases of AD and all its consequences. Recommendations from the Alzheimer's Taskforce were incorporated into the MPA.

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

- 3) **SUPPORT.** Supporters such as AA and the County Health Executives Association of California state in support of this bill that increasing the membership would expand partnerships, can support collective efforts to reduce the risk of cognitive decline amongst our residents, and ensure that the Advisory Committee can continue to advise on policies and programs with a comprehensive and diverse outlook.

The California Commission on Aging supports this bill and recommends amending the current language to read, “One commissioner from the California Commission on Aging who has expertise, background and/or lived experience regarding Alzheimer’s disease or related disorders.” Expanding membership to a commissioner to serve on this critically important advisory committee will tap the diverse backgrounds and lived experiences of devoted individuals who serve on the Commission on Aging.

4) **RELATED LEGISLATION.**

- a) AB 385 (Ta) would require DPH to implement a public awareness campaign and include education for unpaid caregivers. AB 385 is pending a hearing in Assembly Health Committee.
- b) AB 786 (Bains) would require, subject to an appropriation by the Legislature, the California Department of Aging to establish the Alzheimer’s and Dementia Caregiver Education and Support Grant Program, a five-year grant program to expand access to evidence-supported dementia caregiver education training and support, including, but not limited to, respite, support groups, and care counseling, for caregivers of persons with dementia, including AD, as prescribed. AB 786 is pending a hearing in Assembly Aging and Long-Term Care Committee.

5) **PREVIOUS LEGISLATION.**

- a) AB 1618 (Aguilar-Curry) of 2022 would have expanded the membership of the Advisory Committee and would have established the Office of the Healthy Brain Initiative at DPH. AB 1618 was held in Senate Appropriations Committee suspense file.
- b) AB 1684 (Voepel) of 2022 would have required DPH to implement a public awareness campaign on AD that includes education for unpaid caregivers, including family and friends who provide care to someone with AD or dementia. AB 1684 was held in Senate Appropriations Committee suspense file.
- c) SB 861 (Limon) of 2022 would have established, upon appropriation by the Legislature, the Dementia Care Navigator Grant Pilot Program under the California Department of Aging for the purpose of incentivizing local organizations to provide dementia care navigation training services. SB 861 was vetoed by Governor Newsom who indicated:

“The need for quality, culturally competent care is a priority of my administration. As an example of this commitment, the 2022 Budget Act included \$281.4 million over three years to recruit, train, and certify community health workers who can provide dementia care navigation, among other services. This bill creates more than \$6 million in General Fund cost pressures that were not accounted for in the budget.

With our state facing lower-than-expected revenues over the first few months of this fiscal year, it is important to remain disciplined when it comes to spending, particularly spending that is ongoing. We must prioritize existing obligations and priorities, including education, health care, public safety and safety-net programs.

The Legislature sent measures with potential costs of well over \$20 billion in one-time spending commitments and more than \$10 billion in ongoing commitments not accounted for in the state budget. Bills with significant fiscal impact, such as this measure, should be considered and accounted for as part of the annual budget process.

While I am unable to sign this bill, I am directing the Department of Health Care Access and Information to work with stakeholders including those that work on dementia care as they begin to develop and implement the Community Health Worker program established by SB 184 (Committee on Budget and Fiscal Review, Chapter 47, Statutes of 2022), and funded by the Budget Act of 2022.”

REGISTERED SUPPORT / OPPOSITION:**Support**

Alzheimer's Association (sponsor)
Alzheimer's Greater Los Angeles
Alzheimer's Orange County
Alzheimer's San Diego
California Commission on Aging
County Health Executives Association of California

Opposition

None on file.

Analysis Prepared by: Rosielyn Pulmano / HEALTH / (916) 319-2097

Date of Hearing: March 14, 2023

ASSEMBLY COMMITTEE ON HEALTH

Jim Wood, Chair

AB 70 (Rodriguez) – As Introduced December 12, 2022

SUBJECT: Emergency response: trauma kits.

SUMMARY: Applies the requirement for the placement of trauma kits in specified buildings to certain structures constructed prior to January 1, 2023, upon a modification, renovation, or tenant improvement. Specifically, **this bill:**

- 1) Applies existing requirements for the placement of trauma kits in specified buildings to certain structures constructed prior to January 1, 2023 upon a modification, renovation, or tenant improvement.
- 2) Requires a structure to be considered modified, renovated, or tenant improved for purposes of 1) above if the structure is subject to any of the following on or after January 1, 2024:
 - a) One hundred thousand dollars (\$100,000) of tenant improvements in one calendar year;
 - b) One hundred thousand dollars (\$100,000) of building renovations in one calendar year; or,
 - c) Any tenant improvement for places of assembly, including auditoriums and performing arts and movie theaters.
- 3) Provides that the provisions of this bill, except for structures specified in 2) above, do not apply to a structure that is vacant during construction or renovation.

EXISTING LAW:

- 1) Requires specified structures, including business buildings with an occupancy of 200 or more, assembly buildings with an occupancy of 300 or more, and residential buildings with an occupancy of 200 or more, constructed on or after January 1, 2017, or renovated subsequent to that date, to have an automated external defibrillator (AED) on the premises. Exempts structures that are owned or operated by a local government entity. [Health & Safety Code (HSC) §19300]
- 2) Provides, in the Civil Code (CIV), immunity from civil liability for the acts or omissions of any person who, in good faith and not for compensation, renders emergency care or treatment by the use of an AED at the scene of an emergency. Grants immunity to persons or entities who provide training to persons who use an AED, to persons or entities that acquire an AED, and to physicians or other health care professionals involved in the selection, placement, or installation of an AED. [CIV §1714.21]
- 3) Requires specified buildings with an occupancy of 200 persons or greater, constructed on or after January 1, 2023, to have a trauma kit on the premises of the building, and provides civil immunity for the acquisition, training, and use of trauma kit. [HSC §19310]
- 4) Defines “trauma kit,” as a first aid response kit that contains at least all of the following:
 - a) One tourniquet endorsed by the Committee on Tactical Combat Casualty Care;
 - b) One bleeding control bandage;

- c) One pair of nonlatex protective gloves and a marker;
 - d) One pair of scissors; and,
 - e) Instructional documents developed by the Stop the Bleed national awareness campaign of the United States Department of Homeland Security or the American College of Surgeons Committee on Trauma, the American Red Cross, the Committee for Tactical Emergency Casualty Care, or any other Partner of the United States Department of Defense. [*Ibid.*]
- 5) Requires the person or entity responsible for managing the building, facility, and tenants, to acquire and place at least six trauma kits, in an easily accessible and recognizable container located next to an AED, on the premises of the following buildings constructed on or after January 1, 2022:
- a) Assembly buildings, as defined, with an occupancy of greater than 300;
 - b) Business buildings, educational buildings, factory buildings, institutional buildings, and mercantile buildings, as each of these buildings are defined, and if they have occupancies of 200 or more; and,
 - c) Residential buildings with occupancy of 200 or more, excluding single-family and multi-family dwelling units. [*Id.*]
- 6) Specifically includes a structure that meets the definition of one of the buildings in 5) above that is owned or operated by a local government entity. [*Id.*]
- 7) Excludes a licensed hospital or skilled nursing facility, and excludes any structure that is vacant or under construction or renovation. [*Id.*]
- 8) Classifies, in the California Code of Regulations (CCR), all buildings and structures as to use and occupancy, and requires a room or space that is intended to be occupied at different times for different purposes to comply with all of the requirements that are applicable to each of the purposes for which the room or space will be occupied. [Title 24 CCR §301, *et seq.*]

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

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, last year's AB 2260 (Rodriguez), Chapter 586, Statutes of 2022, requires certain newly constructed buildings to have trauma kits on site. The author states that this bill will ensure we are prepared with the necessary tools to help 'STOP THE BLEED' in as many buildings as possible. The author notes that as a career first responder, he understands how critical the first few minutes are when a patient is experiencing blood loss. The author concludes that increasing the number of buildings equipped with trauma kits so that bystanders can serve as immediate responders will allow our state to be better prepared whenever and wherever tragedy strikes.

2) BACKGROUND.

- a) **CCR Building Classification.** This bill applies to specified building types that are defined in California's Building Standards Code, and further limits the application of this

bill to those with occupancy above 300 for Group A assembly buildings, and those with occupancy above 200 for all other buildings covered by this bill. The following describes how each of the types of buildings included in this bill are classified with respect to use and occupancy in the Building Standards Code:

- i) Assembly Group A occupancy as including, among others, the use of a building or structure, or portion thereof, for the gathering of persons for purposes such as civic, social, or religious functions; recreation, food, or drink consumption or motion picture and television production sound stages, approved production facilities and production locations;
 - ii) Business Group B occupancy as including, among others, the use of a building or structure, or portion thereof, for office, professional, or service-type transactions, including storage of records and accounts;
 - iii) Educational Group E occupancy as including, among others, the use of a building or structure, or portion thereof, by more than six persons at any one time for educational purposes through the 12th grade, except a residence used as a home school for the children who normally reside at the residence;
 - iv) Factory Industrial Group F occupancy as including, among others, the use of a building or structure, or portion thereof, for assembling, disassembling, fabricating, finishing, manufacturing, packaging, repair or processing operations that are not classified as a Group H hazardous or Group S storage occupancy;
 - v) Institutional Group I occupancy as including, among others, the use of a building or structure, or portion thereof, in which care or supervision is provided to persons who are or are not capable of self-preservation without physical assistance or in which persons are detained for penal or correctional purposes or in which the liberty of the occupants is restricted;
 - vi) Mercantile Group M occupancy as including, among others, the use of a building or structure, or portion thereof, for the display and sale of merchandise and involves stocks of goods, wares or merchandise incidental to such purposes and accessible to the public;
 - vii) Residential Group R occupancy as including, among others, the use of a building or structure, or portion thereof, for sleeping purposes when not classified as Group I occupancy or when not regulated by the California Residential Code; and,
 - viii) Storage Group S occupancy as including, among others, the use of a building or structure, or portion thereof, for storage that is not classified as a hazardous occupancy.
- b) **Work injuries.** The provisions of this bill apply to most of the places where people work. According to a December 16, 2022 Bureau of Labor Statistics report, private industry employers reported 2.6 million nonfatal workplace injuries and illnesses in 2021, a decrease of 1.8% from 2020. The decline in injury and illness cases was due to a drop in illness cases, with private industry employers reporting 365,200 nonfatal illnesses in 2021, down from 544,600 in 2020, a drop of 32.9%. This decrease was driven by a 37.1% decrease in employer reported respiratory illness cases in 2021 at 269,600, down from 428,700 in 2020.

There were 5,190 fatal work injuries recorded in the United States in 2021, an 8.9% increase from 4,764 in 2020. A worker died every 101 minutes from a work-related injury in 2021. The share of Black or African American workers fatally injured on the job

reached an all-time high in 2021, increasing from 11.4% of total fatalities in 2020 to 12.6% of total fatalities in 2021.

Assaults are the fifth leading cause of work-related deaths. Nonfatal work-related assault injuries decreased for the first time since current recordkeeping categories were established in 2011. In 2020, assaults resulted in 20,050 injuries and illnesses involving days away from work and 392 fatalities. Assaults are categorized as intentional injury inflicted by another person and include several types of events:

- i) Intentional shooting by another person;
- ii) Stabbing, cutting, slashing, or piercing;
- iii) Hitting, kicking, beating, and shoving;
- iv) Strangulation;
- v) Bombing and arson;
- vi) Rape and sexual assault; and,
- vii) Threats and verbal assault.

- c) **Stop the Bleed campaign.** According to its website, Stop The Bleed is the result of a collaborative effort led by the American College of Surgeons Committee on Trauma (ACS COT) to bring bleeding control to the public. After the wide adoption of tourniquets and tourniquet training by the military during the Iraq and Afghanistan conflicts, their use was reviewed and a clear survival benefit was identified. A follow-up study in 2014, led by the ACS COT emergency medical services subcommittee, showed similar benefits related to tourniquet use among civilians and further introduced direct pressure and wound packing to the list of simple but effective skills that could be used to control active bleeding in an emergency situation. It also became clear that time was a critical factor, and outcomes were directly related to how quickly bleeding control was achieved, and these findings helped establish the bystander as playing a critical role in saving lives due to severe bleeding. Curriculum was developed into what is known as the Bleeding Control Basic course (B-CON), released to the public in 2014, which is the foundation of today's Stop the Bleed course.
- d) **Tourniquet use by non-medical professionals.** Tourniquet use, especially by untrained Good Samaritans, has been controversial over the years because of the "fear that severe tissue ischemia [a restriction in blood supply to tissues, causing a shortage of oxygen that is needed to keep the tissue alive] could lead to amputation." (Clinical Queries: "What's the Stop the Bleed Campaign?," Nursing 2017, Volume 47, Number 12 (December 2017), p. 15.) If a tourniquet is left on too long or applied incorrectly, it can result in the loss of a limb. However, if the alternative is death, even the loss of a limb is a preferred outcome. For example, "in the case of massive bleeding caused by firearm or shrapnel wounds, the window of opportunity to save a life may be as little as five minutes." (*Id.*) Thus, in 2015, the American Heart Association Guidelines for first aid were updated to say that "because the rate of complications is low and the rate of hemostasis [bleeding to death] is high, first aid providers may consider the use of a tourniquet when standard first aid hemorrhage control does not control severe external limb bleeding." (*Ibid.*)

- 3) **SUPPORT.** The American Red Cross (RC) is a cosponsor of this bill, which would expand upon existing law and require private and public buildings to acquire and place trauma kits, should they meet a certain threshold. RC is supportive of increasing the availability of trauma kits, allowing for emergency medical care in the case of traumatic events. Accidents, natural

disasters, and shootings can happen without warning. Emergency situations like these turn average citizens into first responders in an instant. Trauma kits are an essential tool that can make a difference and potentially save lives. RC concludes that by requiring certain buildings to acquire and make available trauma kits, we increase the safety of tenants.

- 4) RELATED LEGISLATION.** AB 71 (Rodriguez) would require, commencing with the 2025–26 school year, the governing board of a school district or the governing body of a charter school that requires a course in health education for graduation from high school to include instruction in bleeding control. AB 71 is pending a hearing in the Assembly Education Committee.

5) PREVIOUS LEGISLATION.

- a) AB 2260 requires specified buildings with an occupancy of 200 persons or greater, constructed on or after January 1, 2023, to have a trauma kit on the premises of the building, and provides civil immunity for the acquisition, training, and use of trauma kit.
 - b) SB 687 (Hueso) of 2021 was substantially similar to AB 2260. SB 687 was held on the Assembly Appropriations Committee suspense file.
 - c) AB 2053 (Rodriguez) of 2020 was substantially similar to AB 2260. AB 2053 was not heard in Assembly Appropriations Committee.
 - d) AB 1708 (Rodriguez) of 2019 was also substantially similar to AB 2260. AB 1708 was held on the Assembly Appropriations Committee suspense file.
 - e) SB 1397 (Hill), Chapter 1014, Statutes of 2018, extended the requirement that certain buildings constructed on or after January 1, 2017 have an AED on the premises, to also apply this requirement to existing buildings that undergo a significant modification on or after January 1, 2020.
 - f) SB 287 (Hueso), Chapter 449, Statutes of 2015, requires certain buildings with capacities of 200 persons or greater, as specified, constructed on or after January 1, 2017, to have an AED on the premises.
- 6) DOUBLE REFERRAL.** This bill is double referred; upon passage in this Committee, this bill will be referred to the Assembly Judiciary Committee.

REGISTERED SUPPORT / OPPOSITION:

Support

American Red Cross California Chapter (cosponsor)
American College of Surgeons (cosponsors)

Opposition

None on file.

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

Date of Hearing: March 14, 2023

ASSEMBLY COMMITTEE ON HEALTH

Jim Wood, Chair

AB 254 (Bauer-Kahan) – As Introduced January 19, 2023

SUBJECT: Confidentiality of Medical Information Act: reproductive or sexual health application information.

SUMMARY: Revises the Confidentiality of Medical Information Act (CMIA) to include reproductive or sexual health application information into the definition of medical information. Deems a business that offers a reproductive or sexual health digital service to a consumer for the purpose of allowing the individual to manage the individual's information, or for the individual's diagnosis, treatment, or management of a medical condition, to be a provider of health care, as specified. Specifically, **this bill:**

- 1) Defines the following:
 - a) Medical information to include reproductive or sexual health application information;
 - b) Reproductive or sexual health application information to mean information related to a consumer's reproductive or sexual health collected by a reproductive or sexual health digital service; and,
 - c) Reproductive or sexual health digital service to mean a mobile-based application or internet website that collects reproductive or sexual health application information from a consumer, markets itself as facilitating reproductive or sexual health services to a consumer, and uses the information to facilitate reproductive or sexual health services to a consumer.
- 2) Deems any business that offers a reproductive or sexual health digital service to a consumer for the purpose of allowing the individual to manage the individual's information, or for the individual's diagnosis, treatment, or management of a medical condition, to be a provider of health care. Clarifies that this bill is not to be construed as making a business specified in this bill to be a provider of health care for purposes of any law other than this bill.

EXISTING LAW:

- 1) Establishes under federal law, the Health Information Portability and Accountability Act of 1996 (HIPAA), which sets standards for privacy of individually identifiable health information and security standards for the protection of electronic protected health information, including, through regulations, that a HIPAA covered entity may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of an authorization, except under specified circumstances. Provides that if HIPAA's provisions conflict with state law, the provision that is most protective of patient privacy prevails. [45 Code of Federal Regulations §164.500, *et. seq.*]
- 2) Prohibits, under the state CMIA, 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. [Civil Code (CIV) §56, *et. seq.*]

- 3) Defines, for purposes of the CMIA, medical information to mean any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient's medical history, mental health app information, mental or physical condition, or treatment. [CIV §56.05(i)]
- 4) Prohibits health care providers, health care service plans, or contractors, as defined, from sharing medical information without the patient's written authorization, subject to certain exceptions. [CIV §56.10(a)]
- 5) Deems any business organized for the purpose of maintaining medical information in order to make the information available to an individual or to a provider of health care at the request of the individual or the provider of health care, for purposes of allowing the individual to manage their information, or for the diagnosis and treatment of the individual, to be a health care provider subject to the requirements of the CMIA. [CIV §56.06(a)]
- 6) Deems any business that offers software or hardware to consumers, including a mobile application or other related device that is designed to maintain medical information in order to make the information available to an individual or a provider of health care at the request of the individual or a provider of health care, for purposes of allowing the individual to manage their information, or for the diagnosis, treatment, or management of a medical condition of the individual, to be deemed to be a health care provider subject to the requirements of the CMIA. [CIV §56.06(b)]
- 7) Deems any business that offers a mental health digital service to a consumer for the purpose of allowing the individual to manage the individual's information, or for the diagnosis, treatment, or management of a medical condition of the individual, to be deemed to be a health care provider. [CIV §5606 (d)]
- 8) Establishes the California Consumer Privacy Act of 2018 (CCPA) which grants a consumer a right to request a business to disclose the categories and specific pieces of personal information that it collects about the consumer, the categories of sources from which that information is collected, the business purposes for collecting or selling the information, and the categories of third parties with which the information is shared; and, the California Privacy Rights Act which amends and extends CCPA and creates the California Privacy Protection Agency to implement and enforce CCPA. [CIV §1798.100, *et seq.*]

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

COMMENTS:

- 1) **PURPOSE OF THIS BILL.** According to the author, reproductive and sexual health information is clearly health information, and is particularly sensitive given the

criminalization of almost any form of ending a pregnancy. The author points out that current data protections do not speak to the sensitivity of this data. Apps and websites that explicitly market themselves as providing menstrual and pregnancy tracking are creating an expectation of healthcare and the associated privacy of information. The author concludes that by adding CMIA protections for these services is a critical and common sense step to ensure a sufficient baseline of privacy to protect consumers.

- 2) **BACKGROUND.** The HIPAA Privacy Rule provides consumers with important privacy rights and protections with respect to their health information, including important controls over how their health information is used and disclosed by health plans and health care providers. Ensuring strong privacy protections is critical to maintaining individuals' trust in their health care providers and willingness to obtain needed health care services, and these protections are especially important where very sensitive information is concerned, such as mental health and reproductive health information.
 - a) **Federal guidance.** According to the U.S. Department of Health and Human Services Agency (HHS), the HIPAA Privacy Rule protects the privacy and security of medical and other health information when it is transmitted or maintained by covered entities (health plans, most health care providers, health care clearinghouses) and business associates (people and companies that provide certain services for covered entities). This information is referred to as protected health information (PHI), and it includes individually identifying information, such as name, address, age, social security number, and location, as well as information about health history, any diagnoses or conditions, current health status, and more. According to the HHS, the HIPAA Rules generally do not protect the privacy or security of health information when it is accessed through or stored on personal cell phones or tablets. The HIPAA Rules apply only when PHI is created, received, maintained, or transmitted by covered entities and business associates. For example, the HIPAA Rules do not protect the privacy of Internet search history, information voluntarily shared online, or geographic location information. In most cases, unless the app is provided by a covered entity or its business associate, the HIPAA Rules also do not protect the privacy of data downloaded or entered into mobile apps for personal use. The information that devices or apps collect about you may be viewed or collected by other entities or used by the device or app vendors to send specific ads. It may also be sold to a data broker, someone who obtains and shares consumer information without their knowledge, often selling it for marketing or other purposes. For specific apps, individual apps may have collected information about location and activities, including the name and location of doctor's office and the time and date of any visits. For example, apps for social media, directions and maps, and ride sharing often collect location or activity information.

In response to the Supreme Court ruling in *Dobbs vs. Jackson Women's Health Organization* (the Supreme Court Case that held that the Constitution does not confer a right to abortion; *Roe and Casey* are overruled; and the authority to regulate abortion is returned to the people and their elected representatives), HHS took action to protect access to sexual and reproductive health care, including abortion, pregnancy complications, and other related care. The HHS Office for Civil Rights (OCR) issued guidance to help protect patients seeking reproductive health care, as well as their providers. In general, the guidance does two things: i) addresses how federal law and regulations protect individuals' PHI relating to abortion and other sexual and

reproductive health care, making it clear that providers are not required to disclose private medical information to third parties; and, ii) addresses the extent to which private medical information is protected on personal cell phones and tablets, and provides tips for protecting individuals' privacy when using period trackers and other health information apps.

According to the HHS, many patients are concerned that period trackers and other health information apps on smartphones may threaten their right to privacy by disclosing geolocation data which may be misused by those seeking to deny care. The OCR guidance addresses the circumstances under which the HIPAA Privacy Rule permits disclosure of PHI without an individual's authorization. It explains that disclosures for purposes not related to health care, such as disclosures to law enforcement officials, are permitted only in narrow circumstances tailored to protect the individual's privacy and support their access to health care, including abortion care. Specifically, the guidance: i) reminds HIPAA covered entities and business associates that they can use and disclose PHI, without an individual's signed authorization, only as expressly permitted or required by the HIPAA Privacy Rule; and, ii) explains the HIPAA Privacy Rule's restrictions on disclosures of PHI when required by law, for law enforcement purposes, and to avert a serious threat to health or safety.

A 2022 *Los Angeles Times* article, entitled, "How data from period-tracking and pregnancy apps could be used to prosecute pregnant people" described a recent report indicating that many popular reproductive health apps are lacking when it comes to protecting users' data privacy and many of the apps had vague privacy policies that did not spell out what data could be shared with government agencies or law enforcement. According to the article, health data input into most period-tracking apps is not subject to HIPAA. A vague privacy policy can mean users will not know what data are being shared, with whom and under what circumstances, forcing users to blindly trust a company to protect their information. This bill would ensure that reproductive or sexual health digital service information is protected under the CMIA.

- 3) **SUPPORT.** Oakland Privacy writes that this bill will provide the express inclusion of privacy protections of reproductive and sexual health digital products and services under the CMIA. This privacy expansion is a vital and necessary component to protect consumer's personal health data, protect privacy, and reduce the potential of facing discrimination harms.
- 4) **CONCERNS.** ATA Action is concerned the broad definitions of "reproductive or sexual health application information" and "reproductive or sexual health digital service" don't provide enough clarity as to the types of information that are being targeted by these privacy provisions and is unsure as to which applications or websites fall under these definitions. The definition of "reproductive and sexual health digital service" uses vague and seemingly all-encompassing language that offers providers and entities in the reproductive or sexual health care space with little direction as to whether or not the requirements of this bill apply to them, raising many questions in the process and ATA Action suggests clarifying the language to limit the scope of the proposed legislation to information that has been inputted by the consumer into the reproductive or sexual health service.
- 5) **RELATED LEGISLATION.**

- a) AB 1432 (Carrillo) subjects a policy or certificate of group health insurance that is marketed, issued, or delivered to a California resident to any Insurance Code provisions requiring coverage of abortion, abortion-related services, and gender-affirming care, regardless of the situs of the contract or master group policyholder. AB 1432 is pending in Assembly Health Committee.
- b) AB 352 (Bauer-Kahan) states Legislative intent to enact legislation to protect reproductive and sexual health information. AB 352 is currently pending referral in Assembly Rules Committee.

6) PREVIOUS LEGISLATION.

- a) AB 2089 (Bauer-Kahan), Chapter 690, Statutes of 2022, amends the CMIA to include mental health application information. Defines mental health application information as information related to a consumer's inferred or diagnosed mental health or substance use disorder, as defined in existing law, collected by a mental health digital service; and, mental health digital service as a mobile-based application or internet website that collects mental health application information from a consumer, markets itself as facilitating mental health services to a consumer, and uses the information to facilitate mental health services to a consumer. Deems any business that offers a mental health digital service to a consumer for the purpose of allowing the individual to manage the individual's information, or for the diagnosis, treatment, or management of a medical condition of the individual, to be a health care provider, as specified. Requires any business that offers a mental health digital service to provide to the health care provider information regarding how to find data breaches reported, as specified, on the Attorney General website.
- b) AB 2091 (Bonta), Chapter 628, Statutes of 2022, prohibits compelling a person to identify or provide information that would identify or that is related to an individual who has sought or obtained an abortion in a state, county, city, or other local criminal, administrative, legislative, or other proceeding if the information is being requested based on another state's laws that interfere with a person's right to choose or obtain an abortion or a foreign penal civil action, as defined. Prohibits a provider of health care, a health care service plan, a contractor, or an employer from releasing medical information that would identify an individual or related to an individual seeking or obtaining an abortion in response to a subpoena or a request or to law enforcement if that subpoena, request, or the purpose of law enforcement for the medical information is based on, or for the purpose of enforcement of, either another state's laws that interfere with a person's rights to choose or obtain an abortion or a foreign penal civil action. AB 2091 also prohibits issuance of a subpoena if the submitted foreign subpoena relates to a foreign penal civil action and the submitted foreign subpoena would require disclosure of information related to sensitive services, as defined.
- c) AB 1184 (Chiu), Chapter 190, Statutes of 2021, revises and recasts provisions to require a health care service plan (health plan) or health insurer, effective July 1, 2022, to accommodate requests for confidential communication of medical information regardless of whether there is a situation involving sensitive services or a situation in which disclosure would endanger the individual. Prohibits a health plan or health insurer from requiring a protected individual, as defined, to obtain the policyholder, primary

subscriber, or other enrollee or insured's authorization to receive health care services or to submit a claim, if the protected individual has the right to consent to care. Requires the health plan or health insurer to direct all communications regarding a protected individual's receipt of sensitive health care services directly to the protected individual, and prohibits the disclosure of that information to the policyholder, primary subscriber, or any plan enrollees or insureds without the authorization of the protected individual, as provided. Expands the definition of sensitive services to identify all health care services related to mental health, reproductive health, sexually transmitted infections, substance use disorder, transgender health, including gender affirming care, and intimate partner violence, and includes services, as specified.

- d) AB 2167 (Chau) of 2018 would have amended CMIA to include within the definition of medical information, any information in possession of, or derived from, a digital health feedback system. AB 2167 would have required manufacturers or operators that sell devices or applications that may be used as part of these digital health feedback systems to equip them with reasonable security features, as specified. AB 2167 died on the Senate Floor.
- e) SB 1121 (Dodd), Chapter 735, Statutes of 2018, modifies the CCPA, by requiring a business that collects personal information about a consumer to disclose the consumer's right to delete personal information in a form that is reasonably accessible to consumers, as specified.
- f) AB 375 (Chau), Chapter 55, Statutes of 2018, enacts CCPA, and grants a consumer a right to request a business to disclose the categories and specific pieces of personal information that it collects about the consumer, the categories of sources from which that information is collected, the business purposes for collecting or selling the information, and the categories of third parties with which the information is shared.

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

REGISTERED SUPPORT / OPPOSITION:

Support

Oakland Privacy

Opposition

None on file.

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

Date of Hearing: March 14, 2023

ASSEMBLY COMMITTEE ON HEALTH

Jim Wood, Chair

AB 283 (Jim Patterson) – As Introduced January 24, 2023

SUBJECT: Mental Health Services Oversight and Accountability Commission.

SUMMARY: Urges the Governor when making appointments to the Mental Health Services Oversight and Accountability Commission (MHSOAC) to consider ensuring geographic representations among the 10 geographic regions of California as defined by the 2020 census.

EXISTING LAW:

- 1) Establishes the MHSOAC to develop strategies to overcome stigma, advise the Governor and the Legislature on mental health policy, and oversee the implementation of the Mental Health Services Act (MHSA), enacted by voters in 2004 as Proposition 63, which provides funds to counties to expand services and develop innovative programs and integrated service plans for mentally ill children, adults, and seniors through a 1% income tax on personal income above \$1 million. [Welfare and Institutions Code (WIC) §5845]
- 2) Requires the MHSOAC to consist of 16 voting members as follows:
 - a) The Attorney General or their designee;
 - b) The Superintendent of Public Instruction or their designee;
 - c) The Chair of the Senate Health, Chair of the Human Services Committee, or another member of the Senate selected by the President pro Tempore of the Senate;
 - d) The Chair of the Assembly Health Committee or another member of the Assembly selected by the Speaker of the Assembly; and,
 - e) Twelve members appointed by the Governor that include:
 - i) Two people with a severe mental illness;
 - ii) A family member of an adult or senior with a severe mental illness;
 - iii) A family member of a child who has or has had a severe mental illness;
 - iv) A physician specializing in alcohol and drug treatment;
 - v) A mental health professional;
 - vi) A county sheriff;
 - vii) A superintendent of a school district;
 - viii) A representative of a labor organization;
 - ix) A representative of an employer with less than 500 employees;
 - x) A representative of an employer with more than 500 employees; and
 - xi) A representative of a health care services plan or insurer. [WIC §5845]

FISCAL EFFECT: None.

COMMENTS:

- 1) **PURPOSE OF THIS BILL.** According to the author, there is no one-size-fits-all approach to mental health services, which is why it is critical that this bill be passed to strongly urge the Governor to include at least one representative from each of California's 10 regions. California is in the midst of a mental health crisis and we must work together to meet the needs of each community so that individuals facing mental health challenges receive the best

care possible. Ultimately, this bill will help address inequities suffered by vulnerable/underserved and marginalized communities. By having a representative from each region of the state, it will ensure that the issues faced by these communities are represented. The author concludes, it's these area representatives who have a unique knowledge of what each county needs to address mental health related issues.

2) BACKGROUND.

- a) **MHSA.** Proposition 63, the MHSA was passed by voters in November 2004. The MHSA imposes a 1% income tax on personal income in excess of \$1 million and creates the 16 member MHSAOAC charged with overseeing the implementation of MHSA. MHSA revenues of \$3.0 billion were estimated for 2020-21 with a forecast projected for annual revenues of \$3.7 billion for 2021-22 and \$3.8 billion for 2022-23. The MHSA addresses a broad continuum of prevention, early intervention and service needs as well as providing funding for infrastructure, technology, and training needs for the community mental health system.

The MHSA requires each county mental health department to prepare and submit a three-year plan to the Department of Health Care Services (DHCS) that must be updated each year and approved by the DHCS after review and comment by the MHSAOAC. In their three-year plans, counties are required to include a list of all programs for which MHSA funding is being requested and that identifies how the funds will be spent and which populations will be served. MHSA programs are divided into the following five categories:

- i) **Community Services and Supports:** Provides direct mental health services to the severely and seriously mentally ill, such as mental health treatment, cost of health care treatment, and housing supports. Regulation requires counties to direct the majority of its Community Services and Supports funds to Full-Service Partnerships (FSPs). FSPs are county coordinated plans, in collaboration with the client and the family to provide the full spectrum of community services. These services consist of mental health services and supports, such as peer support and crisis intervention services; and non-mental health services and supports, such as food, clothing, housing, and the cost of medical treatment.
- ii) **Prevention and Early Intervention:** Provides services to mental health clients in order to help prevent mental illness from becoming severe and disabling;
- iii) **Innovation:** Provides services and approaches that are creative in an effort to address mental health clients' persistent issues, such as improving services for underserved or unserved populations within the community;
- iv) **Capital Facilities and Technological Needs:** Creates additional county infrastructure such as additional clinics and facilities and/or development of a technological infrastructure for the mental health system, such as electronic health records for mental health services; and,
- v) **Workforce Education and Training:** Provides training for existing county mental health employees, outreach and recruitment to increase employment in the mental

health system, and financial incentives to recruit or retain employees within the public mental health system.

Counties must submit their plans for approval to the MHSOAC before the counties may spend certain categories of funding including Prevention and Early Intervention and Innovation funds.

- b) **MHSOAC:** The MHSA creates the 16 member MHSOAC appointed by the Governor and the Legislature. In carrying out its statutory duties and responsibilities, the MHSOAC may do all of the following:
- i) Meet at least once each quarter at any time and location convenient to the public, as it may deem appropriate. Requires all meetings of MHSOAC to be open to the public;
 - ii) Within the limit of funds allocated for these purposes, employ staff, including any clerical, legal, and technical assistance necessary. MHSOAC administers its operations separate and apart from DHCS and the California Health and Human Services Agency (CHHSA);
 - iii) Establish technical advisory committees, such as a committee of consumers and family members;
 - iv) Employ all other appropriate strategies necessary or convenient to enable it to fully and adequately perform its duties and exercise the powers expressly granted, notwithstanding any authority expressly granted to an officer or employee of state government;
 - v) Enter into contracts;
 - vi) Obtain data and information from DHCS, the Department of Health Care Access and Information, or other state or local entities that receive MHSA funds, for MHSOAC to utilize in its oversight, review, training and technical assistance, accountability, and evaluation capacity regarding projects and programs supported with MHSA funds;
 - vii) Participate in the joint state-county decision-making process, for training, technical assistance, and regulatory resources to meet the mission and goals of the state's mental health system;
 - viii) Develop strategies to overcome stigma and discrimination, and accomplish all other objectives of the MHSA;
 - ix) At any time, advise the Governor or the Legislature regarding actions the state may take to improve care and services for people with mental illness;
 - x) If MHSOAC identifies a critical issue related to the performance of a county mental health program, it may refer the issue to the DHCS;
 - xi) Assist in providing technical assistance to accomplish the purposes of the MHSA in collaboration with the DHCS and in consultation with the County Behavioral Health Directors Association of California (CBHDA);
 - xii) Work in collaboration with the DHCS and the California Behavioral Health Planning Council, and in consultation with the CBHDA, in designing a comprehensive joint plan for a coordinated evaluation of client outcomes in the community-based mental health system; requires the CHHSA to lead this comprehensive joint plan effort; and,
 - xiii) Establish a framework and voluntary standard for mental health in the workplace that serves to reduce mental health stigma, increase public, employee, and employer

awareness of the recovery goals of the MHSA, and provide guidance to California's employer community to put in place strategies and programs, as determined by MHOSOAC, to support the mental health and wellness of employees. Require MHOSOAC to consult with the Labor and Workforce Development Agency or its designee to develop the standard.

- c) **2020 Census California Regions.** During the 2020 Census, California launched a statewide effort to ensure an accurate and complete count of Californians. In order to accomplish this effort, California's 58 counties were grouped into 10 regions based on their hard-to-count populations, liked mindedness of the counties, capacity of community-based organization within the counties and state Census staff workload capabilities. The 10 regions are as follow:

Region	Name of Region	Counties Included in Region
1	Superior California	Butte, Colusa, El Dorado, Glenn, Lassen, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Siskiyou, Sutter, Tehama, Yolo, Yuba
2	North Coast	Del Norte, Humboldt, Lake, Mendocino, Napa, Sonoma, Trinity
3	San Francisco Bay Area	Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara, Solano
4	Northern San Joaquin Valley	Alpine, Amado, Calaveras, Madera, Mariposa, Merced, Mono, San Joaquin, Stanislaus, Tuolumne
5	Central Coast	Monterey, San Benito, San Luis Obispo, Santa Barbara, Santa Cruz, Ventura
6	Southern San Joaquin Valley	Fresno, Inyo, Kern, Kings, Tulare
7	Inland Empire	Riverside, San Bernardino
8	Los Angeles County	Los Angeles
9	Orange County	Orange
10	San Diego - Imperial	Imperial, San Diego

d) **Governor's Veto of AB 1668 (Patterson) of 2022.** AB 1668, is identical to this bill and was vetoed by Governor Newsom. In his veto message the Governor stated that: "I am committed to having boards and commissions that represent California's diversity, including regional representation, and I already consider these factors in the appointment process. In addition to being unnecessary, this bill overlooks the fact that other officials serve on, or can designate individuals to serve on, the MHOSOAC. Therefore, I cannot sign this bill."

- 3) **SUPPORT.** The California State Association of Psychiatrists (CSAP) in a support position states that this bill seeks to ensure that individuals facing mental health challenges are appropriately represented, regardless of where they live in the state. This bill recognizes that different regions may require different needs when it comes to mental health services, and there is no one-size-fits-all model. CSAP concludes by stating it is essential that the MHOSOAC have representatives from areas throughout the state, who know the needs of their region and who are passionate about getting individuals the help that they need. It is urgent that Californians with severe mental health challenges get on their path to recovery and the

best way to achieve that goal is to have representatives that come from various areas throughout the state.

- 4) **RELATED LEGISLATION.** AB 289 (Holden) would expand the local stakeholder group for development of the three-year program and expenditure plans under the MHSA to also require the inclusion of youths or youth mental health organizations. AB 289 is pending hearing in the Assembly Health Committee.

5) **PREVIOUS LEGISLATION.**

- a) AB 2281 (Lackey) of 2022 would have established the Mental Health Preschool Services Act to award grants to fund partnerships between qualified applicants and preschool and daycare programs for children from birth to five years of age, inclusive, to provide mental health services to those children, as specified. AB 2281 was vetoed by the Governor whose veto message stated in part:

“I share the author's concern about supporting youth mental health. Together with the Legislature, California has taken urgent action to address this crisis by investing over \$4.7 billion in the Children and Youth Behavioral Health Initiative to ensure all California kids, parents and communities have increased access to mental health and substance use services. While the goal of this proposed grant program is laudable, it requires tens to hundreds of millions of dollars that were not appropriated in this year's Budget Act.”

- b) SB 1283 (Bates) of 2022 would have amended the MHSA to provide the counties with more flexibility in shifting county MHSA money between programs and to include additional allowable services, including addiction treatment, case management, employment services, peer support, crisis intervention and stabilization, and family unification. SB 1283 was not heard in the Senate at the request of the author.
- c) AB 465 (Eggman), Chapter 544, Statutes of 2021, requires the MHSA to report to specified legislative committees the outcomes for people receiving community mental health services under a FSP model, as specified, including any barriers to receiving the data and recommendations to strengthen California's use of full service partnerships to reduce incarceration, hospitalization, and homelessness.
- d) AB 573 (Carrillo) of 2021 would have established the California Youth Mental Health Board within CHHSA; would have required the MHSA by December 30, 2024, and every five years thereafter, to assess the extent to which the local youth boards have been established and to make recommendations on ways to strengthen the youth voice to support appropriate behavioral health services. AB 573 was held in the Assembly Appropriations Committee.
- e) SB 604 (Bates) of 2019 would have required the MHSA to establish an indeterminate number of centers of excellence to provide counties with technical assistance to implement best practices related to elements of the MHSA as specified. SB 604 was held in Senate Appropriations.
- f) AB 850 (Chau) of 2017 would have increased the membership of the MHSA to include an individual with knowledge and experience in reducing mental health

disparities, especially for racial and ethnic communities, to be appointed by the Governor. AB 850 was vetoed by the Governor Brown who stated:

“This bill adds a member to the MHSOAC who has experience in reducing mental health disparities. I believe MHSOAC as currently constituted is up to the task entrusted to it.”

- 6) **POLICY COMMENT.** This bill is substantially similar to AB 1668 (Patterson) of 2022 which was vetoed by the Governor. The Committee may wish to inquire from the author how he plans to address the Governor’s veto as this bill moves forward.

REGISTERED SUPPORT / OPPOSITION:

Support

California State Association of Psychiatrists
Depression and Bipolar Support Alliance
Lighthouse Counselling and Family Resource Center
Madera County
Valley Children’s Healthcare

Opposition

None on file.

Analysis Prepared by: Judith Babcock / HEALTH / (916) 319-2097

Date of Hearing: March 14, 2023

ASSEMBLY COMMITTEE ON HEALTH

Jim Wood, Chair

AB 512 (Waldron) – As Introduced February 7, 2023

SUBJECT: Mental health and substance use disorders: database of facilities.

SUMMARY: Requires the California Health and Human Services Agency, either on its own or through the Behavioral Health Task Force established by the Governor, to create an ad hoc committee (the committee) to study how to develop a real-time, Internet-based database to display information about available treatment beds in specified facilities.

EXISTING LAW:

- 1) Requires the California Department of Public Health (DPH) to license and regulate hospitals, including a general acute care hospital and an acute psychiatric hospital. [Health and Safety Code (HSC) §1250, *et seq.*]
- 2) Requires the Department of Health Care Services (DHCS) to license and regulate residential alcoholism or drug abuse recovery or treatment facilities. [HSC §11834.02, *et seq.*]
- 3) Requires DHCS and counties to provide specialty mental health services for Medi-Cal beneficiaries through a county mental health plan, as specified, which may include crisis stabilization services and inpatient psychiatric care. [Welfare and Institutions Code (WIC) §14705 and §14712]
- 4) Requires the Department of Social Services to license community care facilities, including any facility, place, or building that is maintained and operated to provide nonmedical residential care, day treatment, adult day care, or foster family agency services for children, adults, or children and adults, including, but not limited to, the physically handicapped, mentally impaired, incompetent persons, and abused or neglected children, and may include crisis residential services. [HSC §1501, *et seq.*]
- 5) Establishes psychiatric health facilities (PHFs), licensed by DHCS, which provide 24-hour inpatient care for people with mental health disorders that includes, but is not limited to, the following basic services: psychiatry; clinical psychology; psychiatric nursing; social work; rehabilitation drug administration; and, appropriate food services for those persons whose physical health needs can be met in an affiliated hospital or in outpatient settings. [HSC §1250.2 and WIC §4080]
- 6) Establishes the Lanterman-Petris-Short Act, which authorizes a person to be involuntarily detained for a period of up to 72 hours for assessment, evaluation, and crisis intervention (known as a “5150” hold), when as a result of a mental disorder the person is a danger to self or others, or is “gravely disabled.” Defines “gravely disabled” as a condition in which a person, as a result of a mental disorder, is unable to provide for his or her basic personal needs for food, clothing, or shelter. [WIC §5008 and 5150]

- 7) Requires facilities, for the purposes of detaining a person for up to 72-hour treatment and evaluation, to be designated by a county and approved by DHCS, which may be a licensed psychiatric hospital, a licensed PHF, and a certified crisis stabilization unit. [WIC §5008]

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

COMMENTS:

- 1) **PURPOSE OF THIS BILL.** According to the author, when a mental health crisis occurs and care is needed immediately, psychiatric beds are essential infrastructure for meeting the needs of individuals with serious mental health conditions. Psychiatric beds serve several purposes, most importantly allowing for a safe and stable environment for persons having an acute mental health crisis, but also for those who are significantly impaired and require ongoing medical monitoring. This bill could help the homeless community, as they are often the ones suffering from mental health crises. Further, mental crises are not specific to any gender, ethnicity, or socio-economic class. By having these vulnerable communities able to go to facilities with open beds, their mental health needs can be better served. The problem, the author concludes, is that California has a well-documented shortage of vacant psychiatric beds. This bill would help clarify where these beds are available in real-time.

- 2) **BACKGROUND.**

- a) **Treatment beds in California.** The California HealthCare Foundation, in a 2022 publication entitled, “Mental Health in California: Waiting for Care” reported that the number of psychiatric beds per 100,000 population decreased 31% from 1998 through 2017 as 35 facilities either closed or eliminated their psychiatric units. These facilities have not been replaced despite the growing prevalence of mental illness. Additionally, there was significant geographic variation in the availability of beds for psychiatric inpatient care. Twenty-five counties had no adult acute psychiatric beds, and 43 counties had no acute psychiatric beds for children.

According to a 2021 RAND report, California requires 50.5 inpatient psychiatric beds per 100,000 adults: 26.0 per 100,000 at the acute level and 24.6 per 100,000 at the subacute level, or 7,945 and 7,518 total beds, respectively. At the community residential level, the estimated need is 22.3 beds per 100,000 adults. RAND estimated that California has a total of 5,975 beds at the acute level (19.5 per 100,000 adults) and 4,724 at the subacute level (15.4 per 100,000 adults), excluding state hospital beds. If state hospital beds are included, these figures increase to 7,679 (25.1 per 100,000 adults) and 9,168 beds (29.9 per 100,000 adults), respectively. RAND also observed large regional variation. For example, excluding state hospitals, acute bed capacity ranged from 9.1 beds per 100,000 adults in the Northern San Joaquin Valley to 27.9 beds per 100,000 adults in the Superior region. For subacute bed capacity, regional estimates ranged from 7.4 to 31.8 beds per 100,000 adults. At the community residential level, RAND estimated that California has 3,872 beds (12.7 per 100,000 adults). California has a shortfall of approximately 1,971 beds at the acute level (6.4 additional beds required per 100,000 adults) and a shortage of 2,796 beds at the subacute level (9.1 additional beds required per 100,000 adults), or 4,767 subacute and acute beds combined, excluding state hospital beds.

- b) **In-Patient Bed Tracking: State Responses to Need for Inpatient Care.** According to a 2019 report published by the U. S. Department of Health and Human Service's, Office of the Assistant Secretary for Planning and Evaluation (ASPE) entitled "In-Patient Bed Tracking: State Responses to Need for Inpatient Care," states have begun to collect and post information on bed availability (i.e., create bed registries or bed tracking systems) as a tool for providers, patients, and caregivers to identify open beds more efficiently. In the absence of a bed registry, emergency room staff, patients, or other providers must call multiple hospitals or residential settings to determine if there is a slot available that would be appropriate given the patient's needs. Little was known about state bed registries, their effectiveness, and challenges faced in their execution and utilization. As such, ASPE contracted with RTI International (an independent, nonprofit research institute dedicated to improving the human condition) to study whether states were making information on open beds available to consumers, the impact that inpatient bed tracking had on patient access, and the challenges that remain with inpatient bed tracking systems. To collect this information, RTI conducted an environmental scan including 13 interviews with 18 stakeholders in five states. Through the environmental scan and discussions with stakeholders, the authors found significant variation among states in how the registries were operating, the types of behavioral health providers they included, and perceptions of their usefulness.

In some states, systems to track the availability of psychiatric hospital beds have been challenged by the reluctance of hospitals to update information on open beds frequently enough to be useful given rapid patient turnover. Emergency department (ED) staff noted that the system does not negate the need for them to call hospitals to confirm there is still an open bed that is appropriate for the patient's needs. EDs reported that building relationships among hospitals and EDs and other crisis system staff may be more efficient than using bed registries. Some states did report that the registries were very helpful in locating open beds as well as in documenting the need for additional psychiatric beds. According to the ASPE report, there have been no formal evaluations of the effect of bed registries on access to care. Future research could help improve understanding of the characteristics and processes that make the bed registries most useful. Some avenues to explore include: how financial, regulatory, contractual, and policy levers can be used to encourage participation in bed registry systems; how many consumers are using the public registries and how to increase their usage; whether technology can substitute for human data entry to track available treatment beds; and, whether registries reduce the time and effort required to locate an appropriate inpatient or residential bed.

- c) **Behavioral Health Continuum Infrastructure Program (BHCIP).** DHCS was authorized through legislation in 2021, to establish the BHCIP with \$2.2 billion allocated to construct, acquire, and rehabilitate real estate assets or to invest in needed mobile crisis infrastructure to expand the community continuum of behavioral health treatment resources. The program provides grants through six competitive grant rounds. To date, four of the six anticipated rounds of BHCIP funding have been awarded as follows:

- i) \$45 million for mobile crisis infrastructure;
- ii) \$16 million for county and tribal planning grants;
- iii) \$519 million for "launch ready" projects; and,
- iv) \$481 million for projects targeted at children and youth.

Round five, a general-purpose round totaling \$480 million, is currently underway. Round six, totaling another \$481 million is intended to address remaining needs based on an assessment conducted by DHCS. Because of the current budget deficit projections, the Governor's 2023-24 budget has proposed delaying the sixth round of grants with half of the delayed funds to be provided in 2024-25 and the remaining amount provided in 2025-26.

At a recent joint hearing of the Assembly Health Committee and the Assembly Budget Subcommittee 1 on February 28, 2023, on the "Status of Mental Health Initiatives in California," DHCS representatives advised that the BHCIP is anticipated to result in the creation or renovation of 88 out-patient facilities with capacity to serve over 200,000 individuals and 65 residential facilities with an increase in bed capacity of 1,176 treatment beds.

- 3) **SUPPORT.** The California State Sheriff's Association (CSSA) in a support position states that law enforcement officers often encounter persons in the community who present a danger to themselves or others because of mental health disorders. Unfortunately, appropriate bed space for such persons is not always readily available and finding that bed space can be difficult. This bill will help address this problem by setting the stage for the development of an internet database that will streamline the identification of health facilities that have beds available for temporary placement and treatment. The CSSA concludes by stating that mental health patients will be more likely to be placed in an appropriate environment, while law enforcement and medical professionals will not have to take unnecessary steps to search for available beds.
- 4) **RELATED LEGISLATION.** SB 363 (Eggman) requires DPH, by January 1, 2025, to develop a real-time, internet-based database to collect, aggregate, and display information about available beds in designated facilities to identify the availability of inpatient and residential mental health or substance use disorder treatment. SB 363 is set to be heard in the Senate Health Committee on March 22, 2023.
- 5) **PREVIOUS LEGISLATION.**
 - a) AB 2768 (Waldron) of 2022 was identical to this bill. AB 2768 was held on the Senate Appropriations Committee suspense file.
 - b) SB 929 (Eggman), Chapter 539, Statutes of 2022, expanded DHCS's responsibility in current law to collect and publish information about involuntary detentions to include additional information, such as clinical outcomes, services provided, demographic data of those receiving care, and an assessment of all contracted beds.
 - c) AB 1154 (Eggman) of 2022, AB 682 (Eggman) of 2019, AB 1136 (Eggman) of 2018, and AB 2743 (Eggman) of 2016 were substantially similar to SB 363. SB 1154 was held on the Assembly Appropriations Committee suspense file. AB 682 was held on the Assembly Appropriations Committee suspense file. AB 1136 was held on the Senate Appropriations Committee suspense file. AB 2743 was held on the Assembly Appropriations Committee suspense file.
- 6) **POLICY COMMENTS.** AB 1131 (Wood) of 2021 would have established a statewide health information network governing board, an independent public entity not affiliated with an agency or department to provide the data infrastructure needed to meet California's health care access, equity, affordability, public health, and quality goals. AB 1131 was held in the

Assembly Suspense Committee. However, with the passage of AB 133 (Budget Committee), Chapter 143, Statutes of 2022, the Legislature committed to the establishment of a California Health and Human Services Data Exchange Framework that includes a single data sharing agreement and a common set of policies and procedures that will leverage and advance national standards for information exchange and data content, and that will also govern and require the exchange of health information among health care entities and government agencies in California. To further the state's goal of a Health Information Exchange (HIE) AB 1331 (Wood) of 2023 would establish the Data Exchange Framework governing board and require the board to approve any modifications to that data sharing agreement and its policies and procedures and requires the governing board to consist of five members, appoints as specified. The potential for the sharing of health care information could, as part of the HIE design, incorporate a standalone component that would encompass a repository of available beds in all participating entities (hospital, acute psychiatric hospitals, etc.).

- 7) **PROPOSED AMENDMENTS.** As currently drafted, this bill does not contain either a convening date or a reporting timeline. The Committee may wish to amend the bill to set some timelines for the convening of the committee and a date for submission of a report to the Legislature. The bill is proposed to be amended as follows:

Section 5760 is added to the Welfare and Institutions Code, to read:

*a) By July 1, 2024, the California Health and Human Services Agency, either on its own or through the Behavioral Health Task Force established by the Governor, shall create an ad hoc committee to study how to develop a real-time, internet-based system, usable by hospitals, clinics, law enforcement, paramedics and emergency medical technicians (EMTs), and other health care providers as deemed appropriate, to display information in real time about available beds in inpatient psychiatric facilities, crisis stabilization units, residential community mental health facilities, and residential alcoholism or substance abuse treatment facilities in order to facilitate the identification and designation of available facilities for the transfer to, and temporary treatment of, individuals in mental health or substance use disorder crisis. **The ad hoc committee shall submit a report of its findings to the Legislature no later than July 1, 2025.***

(b) A report submitted pursuant to subdivision (a) shall be submitted in compliance with Section 9795 of the Government Code.

(c) Pursuant to Section 102351.5 of the Government Code, this section is repealed on January 1, 2029.

REGISTERED SUPPORT / OPPOSITION:

Support

California State Sheriff's Association

Opposition

None on file.

Analysis Prepared by: Judith Babcock / HEALTH / (916) 319-2097

Date of Hearing: March 14, 2023

ASSEMBLY COMMITTEE ON HEALTH

Jim Wood, Chair

AB 242 (Wood) – As Introduced January 13, 2023

SUBJECT: Critical access hospitals: employment.

SUMMARY: Deletes the prohibition on the corporate practice of medicine (CPM) for federally certified critical access hospitals (CAHs) and the reporting requirements related to CAHs employing physicians.

EXISTING LAW:

- 1) Establishes an exemption, until January 1, 2024, from the prohibition on the CPM in order to allow federally certified CAHs to employ physicians and charge for those services. [Business and Professions Code (BPC) § 2401]
- 2) Prohibits, within the Medical Practice Act, corporations and other artificial legal entities from having any professional rights, privileges, or powers. Gives the Medical Board of California (MBC), discretion, to grant approval of the employment of physicians on a salary basis by licensed charitable institutions, foundations, or clinics, if no charge for professional services rendered to patients is made by any such institution, foundation, or clinic. This is known as the ban on the CPM. [BPC § 2400]
- 3) Establishes certain exemptions from the ban on the CPM, including the following:
 - a) Clinics and hospitals operated primarily for the purpose of medical education by a public or private nonprofit university medical school, are permitted to charge for professional services rendered to teaching patients by licensed physicians who hold academic appointments on the faculty of the university, if the charges are approved by the physician in whose name the charges are made;
 - b) Certain nonprofit clinics organized and operated exclusively for scientific and charitable purposes, that have been conducting research since before 1982, and that meet other specified requirements, are permitted to employ physicians and charge for professional services, but are prohibited from interfering with or directing a physician's professional judgment;
 - c) A narcotic treatment program regulated by the Department of Alcohol and Drug Programs is permitted to employ physicians and charge for professional services rendered by those physicians, but is prohibited from interfering with or directing a physician's professional judgment;
 - d) A hospital that is owned and operated by a licensed charitable organization that offers only pediatric subspecialty care, and that employed physicians prior to January 1, 2013, is permitted to charge for professional services, under certain specified conditions; and, [BPC § 2401]
 - e) Establishes in case law, an exemption from the ban on the CPM for county hospitals to employ physicians. [*Wickline v. State of California* (192 Cal. App. 3d 1630)]

- 4) Permits, under the Knox-Keene Health Care Service Plan Act of 1975, licensed health plans to employ or contract with health care professionals, including physicians, to deliver professional services, and requires health plans to demonstrate that medical decisions are rendered by qualified medical providers unhindered by fiscal and administrative management. Provides in regulation that the organization of a health plan must include separation of medical services from fiscal and administrative management. (HSC § 1340 *et seq.*)

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

COMMENTS:

- 1) **PURPOSE OF THIS BILL.** According to the author, while he is sympathetic to the concerns about interference with the clinical judgment of any health care provider, the ban on the CPM is not necessarily the best or only tool to assure physician autonomy in clinical decision-making. The number of exceptions allowed, combined with the growth of medical groups, independent practice associations and medical foundations, all represent the larger medical communities' response to pressures within the delivery system to reduce costs, improve patient outcomes and increase access. The author states that the private practice of medicine is a valuable component in our communities and should be preserved but preserving it to the exclusion of other modes of practice seems shortsighted. If younger physicians prefer or are comfortable in an employment setting, California should not limit it as an option for them. By doing so, California law may also be inadvertently limiting access in rural communities when it may not be financially viable to maintain a private practice. Rural hospitals struggle with many health care challenges, particularly as they relate to workforce and financial payer mix, which tends to be disproportionately Medi-Cal and Medicare. The author concludes that this bill provides an additional tool to rural, CAHs by providing them some workforce flexibility.

- 2) **BACKGROUND.**

- a) **Health Professional Shortage Areas (HPSAs).** Of the more than 7,200 federally designated HPSAs, which is defined as a geographic area, population, or facility with a shortage of primary care, dental, or mental health providers and services), three out of five are in rural regions. According to the National Rural Health Association, more than 25% of the U.S. population lives in rural areas, yet less than 10% of the country's physicians practice there. This could be because of the many obstacles they face in a rural setting, including a lack of access to resources and medical technology, the absence of a defined work schedule, a lower salary than their urban counterparts and the challenges of owning and operating a financially viable sole private practice in smaller communities.
- b) **Physician employment preferences.** A 2020 American Medical Association survey found that fewer physicians are opting to own and operate a private practice, with more seeking a career as an employee of a hospital or larger medical group. The survey also noted that many recent graduates of medical schools have significant debt and are more likely to choose employment, which offers financial stability and better work-life balance.

- c) **CAHs.** CAHs are licensed general acute care hospitals that are certified to receive cost-based reimbursement from Medicare, which is intended to reduce hospital closures in rural areas. To be certified as a CAH, a hospital can have no more than 25 beds and must be located in a rural area and: i) more than 35 miles from another hospital; or, ii) 15 miles from another hospital in mountainous terrain or an area with only secondary roads. Other requirements include operating an emergency department, and having an annual average length of stay of 96 hours or less per patient.
- d) **California Research Bureau (CRB) reports.** In 2007, the CRB published a report examining the status of the ban on the CPM, and it argued that exemptions had created a doctrine whose “power and meaning are now inconsistent.” The CRB also raised the idea that the many exemptions to the ban may “signal a change in public opinion.” The CRB report notes that although the CPM doctrine is generally not believed to be extremely detrimental, its present utility seems limited, as the evolution and erosion of the CPM prohibition over many decades has resulted in a doctrine that is far removed from its origin and lacks coherence and relevance in today’s health care landscape. Because the policy concerns that the CPM prohibition was meant to address are still important and have been raised in other contexts, California’s statutes and regulations now address these concerns more directly. The existence of these more focused safeguards, and the ability to enact others if needed, raise the question of whether maintaining the CPM doctrine still makes sense.

On April 12, 2016, the CRB released a new report, "The Corporate Practice of Medicine in a Changing Healthcare Environment," which reviewed the status of the ban in California and key policy issues associated with it, one of them being the effect of the ban on rural areas.

As the 2016 CRB report notes, attempting to address the rural healthcare gap, SB 376 (Chesbro), Chapter 411, Statutes of 2003, established a pilot project to allow qualified hospital districts to directly employ physicians. The pilot allowed each hospital district to hire two physicians, for a total of 20 physicians throughout the state. To qualify for the pilot project, a hospital district was required to have: been in a county with population of 750,000 or less; reported net losses in 2000-01; and, had at least 50% of combined patient days from Medicare, Medi-Cal, and uninsured patients.

SB 376 was sponsored by the Association of California Healthcare Districts, which argued that authorizing the employment of physicians could improve the ability of district hospitals to attract the physicians required to meet the needs of the communities and ensure the continued survival of district hospitals. Proponents hoped direct employment would provide the kind of economic security that might encourage physicians to choose a rural community, just as the State of California is able to offer when it directly hires physicians and staffs its rural prisons.

During the pilot project, five participating hospital districts recruited and hired six physicians, whose employment contract periods ran three to four years. The MBC sent letters to participating physicians, participating administrators, and also administrators in nonparticipating hospital districts to get their views on the project. All six participating physicians were positive about the employment experience. Responding administrators acknowledged it would have been more difficult to recruit the physicians without the

employment opportunity, and expressed support of the project. Responding nonparticipating administrators also generally supported the project as a means of recruiting physicians into rural areas. The MBC, in its assessment, stated there was not enough evidence to draw conclusions about the effectiveness of the program, but believed there might be justification to extend the pilot so a comprehensive analysis could be made. The MBC also noted that, “[f]rom the responses received to the Board’s queries about the pilot, there seems to be a universal belief that many physicians hesitate settling in California, especially rural areas of the state, because of the disincentive created by the laws governing the corporate practice of medicine – most physicians in California work as contractors, not employees.”

- e) **AB 2024 (Wood), Chapter 496, Statutes of 2016.** The provisions of SB 376 expired in 2011. AB 2024 established an exemption, until January 1, 2024, from the prohibition on CPM in order to allow federally certified CAHs to employ physicians and charge for those services. According to the Department of Health Care Access and Information (HCAI), of the 36 CAHs in California, half have hired physicians between 2017 and 2023, as follows:

Hospital Name	Total Physician Hires from 2017-23
Adventist Health Clearlake (St. Helena Hospital)	0
Adventist Health Mendocino Coast (Mendocino Coast District Hospital)	0
Adventist Health Howard Memorial (Willits Hospital)	1
Adventist Health Tehachapi Valley	0
Bear Valley Healthcare System	0
Banner Hospital	0
Catalina Island Medical Center	1
Colorado River Medical Center	0
Eastern Plumas District Hospital	2
Fairchild Medical Center	0
Glenn Medical Center	1
Hazel Hawkins Memorial Hospital	0
Healdsburg Hospital (North Sonoma Healthcare)	10
Jerold Phelps Community Hospital	0
John C. Fremont Healthcare District	0
Kern Valley Hospital District	0
Mammoth Hospital	0
Mark Twain St. Joseph’s Hospital	16
Mayers Memorial Hospital	3
Mercy Medical Center, Mt. Shasta	4
Modoc Medical Center	4
Northern Inyo Hospital	0
Ojai Valley Community Hospital (Community Memorial Health System)	2
Orchard Hospital	5
Plumas District Hospital	0
Redwood Memorial Hospital	0
Ridgecrest Regional Hospital	6

San Bernardino Mountains Community Hospital District	1
Santa Ynez Valley Cottage Hospital	3
Seneca Healthcare District	0
Southern Inyo Healthcare District	0
Surprise Valley Community Hospital	0
Sutter Lakeside Hospital	6
Tahoe Forest Hospital District	54
Trinity Hospital (Formally Mountain Communities)	2
George L. Mee Memorial Hospital	2
	123

- 3) SUPPORT.** The California Hospital Association (CHA) supports this bill and states that, California continues to face serious challenges meeting the physician needs of its population, particularly in primary care. This challenge is even more pronounced in parts of the state known as HPSAs, which is defined as a geographic area, population, or facility with a shortage of primary care, dental, or mental health providers and services. CHA notes that it is estimated that 28% of California's population lives in an HPSA and concludes, with this in mind, the CHA strongly supports this bill.

The Association of California Healthcare Districts (ACHD) supports this bill and states that there are 33 district hospitals in the state of California, 17 of which have critical access designation. Since the enactment of the pilot program under AB 2024, several of these hospitals have successfully used this tool to recruit and retain physicians to underserved areas of the state. Those that have not yet utilized this ability have long awaited its permanency to ensure they would not lose valuable providers once they were employed. ACHD notes that California is facing a severe workforce shortage, of both primary and specialty care providers. The ability to employ physicians allow CAHs to offer benefits and guaranteed salaries, making serving these areas more financially attractive. ACHD concludes that it is essential to closing provider gaps, ensuring Californians continue to receive care in rural and remote communities.

Tahoe Forest Hospital District supports this bill and states that since the enactment of AB 2024, CAHs, including Tahoe Forest Hospital have benefited greatly from the direct hire of primary care and specialty physicians, and this bill will ensure access to high-quality health care is equitable at Tahoe Forest Hospital and hospitals across the state.

- 4) OPPOSE UNLESS AMENDED.** The California Medical Association (CMA) is opposed to this bill unless it is amended. CMA notes that in 2016, the author's bill, AB 2024, established the pilot program and required a report to be created by HCAI to determine the usage and efficacy of the program and its impact on patient care. That report is due in July 2023. CMA states that until HCAI publishes its report regarding the impact the program has had on patient care, they would request that the sunset on the program be extended for five years and not made permanent.

5) PREVIOUS LEGISLATION.

- a) AB 2024 established an exemption, until January 1, 2024, from the prohibition on the CPM in order to allow federally certified critical access hospitals to employ physicians

and charge for those services.

- b) SB 1274 (Wolk), Chapter 793, Statutes of 2012, permits a hospital that is owned and operated by a charitable organization and offers only pediatric subspecialty care to begin billing health carriers for physician services rendered, notwithstanding the prohibition in the CPM if specified conditions are met.
- c) AB 824 (Chesbro) of 2012 would have established a pilot project to permit certain rural hospitals to directly employ physicians and surgeons. AB 824 was never heard in Assembly Health Committee.
- d) AB 648 (Chesbro) of 2009 would have established a demonstration project to permit rural hospitals, as defined, whose service area includes a medically underserved or federally designated shortage area and which meet certain specified requirements, to directly employ physicians and surgeons. AB 648 failed passage in the Senate Business, Professions and Economic Development Committee.
- e) AB 646 (Swanson) of 2009 would have permitted health care districts and certain public hospitals, independent community nonprofit hospitals, and clinics, as specified, to directly employ physicians and surgeons. AB 646 failed passage in the Senate Business, Professions and Economic Development Committee.
- f) SB 726 (Ashburn) of 2009 would have revised and extended the MBC pilot project that allows qualified district hospitals, as defined, to employ a physician, if the hospital does not interfere with, control, or otherwise direct the professional judgment of the physician. SB 726 failed passage in the Senate Business, Professions and Economic Development Committee.
- g) AB 1944 (Swanson) of 2008 would have allowed health care districts to employ a physician. AB 1944 failed passage in the Senate Committee on Health.
- h) SB 1294 (Ducheny) of 2008 would have expanded the pilot project enabling health care districts to directly employ physicians. SB 1294 failed passage in the Assembly Appropriations Committee.
- i) SB 376 authorized, until January 1, 2011, a hospital owned and operated by a health care district meeting specified criteria to employ a physician, and to charge for professional services rendered by the physician if the physician approves the charges.

REGISTERED SUPPORT / OPPOSITION:

Support

Adventist Health
Association of California Healthcare Districts; the
Avalon Medical Development Corporation
Banner Lassen Medical Center
California Hospital Association
Cottage Health

Dignity Health
District Hospital Leadership Forum
Fairchild Medical Center
Kern Valley Healthcare District
Mee Memorial Healthcare System
Mountain Communities Healthcare District
Providence
Rural County Representatives of California (RCRC)
Sohum Health
Tahoe Forest Hospital District

Opposition

None on file.

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