LEGISLATIVE UPDATE

Alliance of Catholic Health Care

Week of April 8, 2019

State Issues	
Legislative Hearings	It was an exceptionally busy at the Capitol with key legislative hearings this week. On Thursday, the Legislature recessed for its Spring Recess and will return on April 22. That will leave only a few days to hear all remaining bills still in their policy committees before the April 26 deadline to report out bills. It is expected that Assembly Health will have nearly 70 bills to be heard in that week's hearing. Also when the Legislature reconvenes, there will be a couple key bills that are set to be heard in the Senate the week of April 22: **SB 758 (Portantino): Hospitals: Seismic Safety** is the California Hospital Association (CHA) sponsored bill that is designed to update and revise the 2030 hospital seismic standards to better reflect what our communities need from our hospital facilities just after a disaster. Currently, the bill in print requires all hospitals that currently do not comply with the 2030 standards to report on the services provided in each of the buildings in the acute care inpatient hospital. CHA is actively working with members on additional amendments for the bill as it continues to move through the legislative process. The Alliance will lend its support when SB 758 is heard in its first policy committee hearing on April 24 in Senate Health. The Alliance will be opposing **SB 567 (Caballero): Workers Compensation: hospital employees** when it is heard on April 24 in Senate Public Employment and Retirement Committee. SB 567 would expand the definition of "injury" — for the purposes of workers' compensation — for a hospital employee who provides direct patient care in an acute care hospital to include infectious disease, cancer, musculoskeletal injuries, post-traumatic stress disorder, and respiratory diseases. The bill would relieve employees from having to demonstrate that these conditions arose from their work environment. This would impact situations in which employees seek a full range of workers' compensation benefits, which can reach hundreds of thousands of dollars in indemnity payments and medical costs for a single case.
Alliance Legislative Summary and Status	Attached is the most recent Alliance Legislative Summary and Status report on bills of interest to the Catholic health care ministry.

(more)

Federal Issues	
Sanders "Medicare for All"	While it's a long road from bill introduction to approval, presidential candidate and Vermont Senator Bernie Sanders introduced his "Medicare for All" plan this week. His plan proposes a total restructuring of the national health care system that would eliminate employer sponsored insurance and other government program like Medicaid. While his Medicare for All legislation does not come with the cost or what specific tax increases would be needed to pay for the proposal, it is reported that analysts project costs to be more than $30 trillion over 10 years. *The attached provides a brief summary of Sanders' Medicare for All plan.*
Medicaid DSH Cuts	The hospital community is advocating for Congress to delay cuts to the Medicaid Disproportionate Share Hospital program (DSH) that are scheduled to go into effect this fall. As reported by the Catholic Health Association of the U.S. (CHA-us) since 2013, Congress has recognized the importance of Medicaid DSH payments by delaying cuts to the program four different times. Most recently, the Bipartisan Budget Act of 2018 delayed the start of the reductions until FY 2020. If Congress does not delay the cuts scheduled to begin on October 1, safety net hospitals will face a financial shortfall of $4 billion in FY 2020 growing to $8 billion in FY 2021. A sign-on letter urging House leaders to delay the cuts is currently circulating among House members. While Congress is on break over the next two weeks, CHA-us encourages hospitals to ask their representatives to add their signature to this letter by May 3.
Medicaid and CHIP Coverage Act	The hospital community also is supporting legislation in the House and Senate to provide a 12-month continuous enrollment period in Medicaid and the Children's Health Insurance Program (CHIP). The Stabilize Medicaid and CHIP Coverage Act would allow beneficiaries to maintain their coverage and minimize disruptions in their care. The legislation also alleviates the added paperwork burden placed on state agencies, providers and health plans caused by fluctuations in a family's or an individual's monthly income. By transitioning to a 12-month continuous enrollment, the administrative costs associated with recertification, enrollment processing and re-processing will decrease making Medicaid and CHIP a more efficient program to administer.

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From abortion to immigration, things you didn't know were in Medicare for All

By Alice Miranda Ollstein , Joanne Kenen

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The Medicare for All bill unveiled by Sen. Bernie Sanders on Wednesday would provide universal health care coverage, swallowing both the current public programs like Medicare and Obamacare, as well as private health insurance, into one new unified system.

Progressives embrace the plan because the coverage is free, streamlined and fair. They believe it will save money by squeezing out the profit-driven model of care. Opponents counter that one-size-fits-all, government-run health care would balloon the country's health spending and limit access to care — or both.

Medicare for All legislation in the House and Senate does more than cover people. The bills swiftly transform the entire $3.7 trillion health care system, touching on everything from building primary and rural health care capacity to addressing socioeconomic disparities to getting all health care providers to use the same electronic billing format. And they wade into some of the biggest political fights of our era, including abortion, drug prices and immigration.

Here are 14 elements of the bills that you may not know were in there.

1. U.S. "residents" get free health care. The HHS secretary decides who qualifies.

Any "resident" of the United States is entitled to all the services covered by Medicare for All, and the head of HHS is tasked with writing rules on who counts as a resident. The legislation says that medical tourism, travel to the U.S. for the sole purpose of seeking no-charge medical care, will be banned. (Foreigners could presumably come and pay for care.)

But the bill does not explicitly rule out coverage for undocumented immigrants. That's a touchy issue given the intensity of the immigration debate today — even a decade ago, it was the topic that provoked Rep. Joe Wilson's infamous "You lie!" outburst during President Barack Obama's 2009 health care speech to a joint session of Congress. (The bill text is intended to be inclusive of undocumented immigrants, even though HHS writes the final rules.)

2. The old and the young will get covered first.

People younger than 19 and older than 55 will be enrolled first in the new Medicare for All program after one year, though they can choose to remain on their current insurance during the transition period — two years in the House bill, H.R. 1384 (116), and four in the Senate version. Everyone else can buy into a Medicare for All option on the Obamacare insurance marketplaces one year after the bill is passed, and employers can also buy a public plan for their employees during this time. After the transition period ends, everyone will be automatically enrolled in the new system.

3. Abortion is covered — even if the bill doesn't quite come out and say that.

Free coverage of "comprehensive reproductive, maternity, and newborn care" is included in the House and Senate bills. Though the word "abortion" does not appear anywhere in the text, its authors have confirmed that it's covered. The bill also notes that restrictions on federal funding for reproductive health services —

namely, the Hyde Amendment's longstanding ban on federal funding for abortion — would not apply to the new Medicare for All Trust Fund.

The bill does not address any limit on when in a pregnancy an abortion could occur, but it does leaves room for restrictions by noting that the HHS secretary can determine what services are "medically necessary or appropriate." (The Supreme Court has upheld restrictions after fetal viability.)

4. Long-term care is included.

Long-term services and supports — both in institutions like nursing homes and, wherever possible, in home- and community-based settings — would be covered. Medicaid already pays a big share of the cost for low-income people or people who have spent most of their savings on care. But this would be a significant expansion of government health spending, and that expense is why Congress has never been able to come up with a better system for long-term care despite the demand and aging population.

The Congressional Research Service estimated that the cost of long-term care was $366 billion in 2016 — not counting the hours put in by unpaid family caregivers, which is billions of dollars more. The House bill would cover all long-term care; in the Senate version, Medicare for All would cover home- and community-based options, and a remaining portion of Medicaid would finance nursing homes. There are some policies to be worked out here. It's possible that some form of private long-term care insurance could still have a role for those who get institutional care under Medicaid, a congressional aide said.

5. You might get free coverage for reiki.

The HHS secretary will choose which complementary and integrative medicine practices (sometimes called alternative medicine) to include in the benefits package, as well as what "experimental" treatments to cover. HHS would also "identify" and "overcome" barriers to incorporating such care. Some insurers now do cover some such treatments, such as acupuncture, but this would potentially broaden the scope sharply. Recommendations would draw on the advice of assorted experts in complementary medicine plus the FDA commissioner.

6. Nurse-to-patient ratios could be mandated. (House version only)

The National Nurses United labor union has been a major driver for Medicare for All, and the bill includes multiple provisions addressing one of its biggest priorities: limits on the number of hospital patients a nurse may care for at a time. Under the bill, HHS can dictate standards that may include "mandatory minimum safe registered nurse-to-patient staffing ratios and optimal staffing levels for physicians and other health care practitioners." The bill also requires providers to report their nurse-to-patient ratios to HHS each year. Hospitals have long fought these mandates, arguing it would unnecessarily drive up costs, while the nurses unions argue that the under-staffing puts patients at risk. Only one state, California, has a staffing ratio law on the books.

7. It will be illegal for private insurance to cover what Medicare for All covers.

The bill would all but abolish the private insurance market by banning employers or insurers from offering plans that cover the same services as the national single-payer system. Many other countries with government-run universal health plans allow supplemental private insurance to cover things like dental care, but because the benefits outlined in the Medicare for All bill are so generous, private health insurers would only be able to offer supplemental services like cosmetic surgery.

The bill does, however, allow providers to enter into private contracts with patients for services that are covered by Medicare for All as long as the patient pays the whole cost out of pocket and neither patient nor provider seeks reimbursement from the government.

8. Health care institutions would be subject to "global budgeting." (House version only)

Hospitals, skilled nursing facilities, federally qualified health centers, home health agencies and dialysis centers would operate under a global budget. That's basically a fixed fee, not unlike a block grant, that would cover all approved patient care, including drugs, devices, imaging and more. There would be a separate review process for capital expenditures, with an emphasis on more equity for underserved areas. The budget would be set by region and adjusted quarterly.

9. Doctor payments would be overhauled. (House version only)

Physicians could be salaried by hospitals or similar facilities as part of the global budget, or they could get paid per service they provide, under a new federal pay scale. Federal pay-for-performance programs would end, as would value-based purchasing, the current meaningful use Electronic Health Record rules, and the other payment systems for Medicare such as the Merit-based Incentive Payment System that was part of a 2015 law overhauling Medicare physician pay.

10. The Indian Health Service and Veterans Health Administration remain in place.

The United States already has two examples of "socialized medicine" — for the nation's veterans and tribal members — and those would remain untouched. Veterans and Native Americans can, however, opt to receive care through Medicare for All. Any provider already qualified to provide health care services through the Department of Veterans Affairs or Indian Health Service is also automatically approved to participate in Medicare for All.

Additionally, under the House bill, each regional office tasked with setting budgets and overseeing health care providers would have a senior official representing that area's Native American population.

11. The government would bargain for cheaper drugs.

The government would negotiate directly with companies on the price of pharmaceuticals, medical supplies, medical technologies and medically necessary equipment. If they can't reach an agreement, the HHS secretary can set the price at the rate the VA currently pays — typically far cheaper than private coverage. The system will also prioritize lower-cost generic medications "to the greatest extent possible" and discourage the use of "excessively costly medications," though that's not defined by the legislation.

In the House version, the government has an additional option. It if can't negotiate an appropriate price for a covered drug, it can take the exclusive patent or clinical trial data and use it to manufacture the drug in-house as long as the company is given "reasonable compensation."

12. Some would get free rides to medical appointments.

Low-income and disabled people would get free transportation to medical care — addressing what's known as a "social determinant of health." Some government and private health plans already cover some transport for doctors' appointments, dialysis sessions and the like.

The thinking is that if people get timely care, they are less likely to end up in hospitals — and an ambulance costs a whole lot more than a van or car ride. But this proposal appears broader than current practice — and runs counter to CMS Administrator Seema Verma's offer for state Medicaid programs to cut some non-emergency transportation services.

13. The two-year wait for Medicare disability coverage would be abolished.

Medicare is usually thought of as health care for people 65 and older, but it also covers younger people with disabilities who meet certain criteria. But even after qualifying for Social Security Disability Insurance, people currently have to wait 24 months for the Medicare coverage to kick in. That would no longer be true under Medicare for All.

14. It cracks down on conflicts of interest.

The conflict of interest rules are much stricter than those that govern the health care industry today. Board members, executives and administrators would be barred from being compensated by, investing in, or being on the board of "any entity that contracts with or provides items or services, including pharmaceutical products and medical devices or equipment, to such provider."

Alliance of Catholic Health Care
Legislative Summary and Status 4/12/2019

Access / Health Care Reform

AB 4 **(Bonta D) Medi-Cal: eligibility.**
Location: 4/9/2019-A. APPR.
Summary: Federal law prohibits payment to a state for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Current law requires that individuals under 19 years of age enrolled in restricted-scope Medi-Cal at the time the Director of Health Care Services makes a determination that systems have been programmed for implementation of these provisions to be enrolled in the full scope of Medi-Cal benefits, if otherwise eligible, pursuant to an eligibility and enrollment plan, which includes outreach strategies. This bill would extend eligibility for full-scope Medi-Cal benefits to individuals of all ages, if otherwise eligible for those benefits, but for their immigration status, and would delete provisions delaying eligibility and enrollment until the director makes the determination as specified

Position
Support

AB 174 **(Wood D) Health care coverage: financial assistance.**
Location: 4/9/2019-A. APPR.
Summary: Currentstate law creates the California Health Benefit Exchange, also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Existing law specifies the powers of the Exchange's executive board, including the power to assist in the administration of subsidies for individuals with coverage made available through the Exchange. This bill would require the board to administer enhanced premium assistance to individuals with household incomes below 400% of the federal poverty level, reduce premiums to zero for individuals with household incomes at or below 138% of the federal poverty level, reduce premiums for individuals with household incomes at or between 401% and 800% of the federal poverty level and who are ineligible for federal advanced premium tax credits so their premiums do not exceed a specified percentage of their household incomes, and administer specified additional cost-sharing financial assistance for individuals with household incomes below 400% of the federal poverty level and who are eligible for premium tax credits.

Position
Support

AB 414 **(Bonta D) Healthcare coverage: minimum essential coverage.**
Location: 4/9/2019-A. APPR.
Summary: Current federal law, the Patient Protection and Affordable Care Act (PPACA), enacts various healthcare coverage market reforms as of January 1, 2014. PPACA generally requires individuals, and any dependents of the individual, to maintain minimum essential coverage, as defined, and, if an individual fails to maintain minimum essential coverage, PPACA imposes on the individual taxpayer a penalty. This provision is referred to as the individual mandate. This bill would require a California resident to ensure that the resident and the resident's dependents are covered under minimum essential coverage for each month beginning after 2019. The bill would impose a penalty for the failure to maintain minimum essential coverage.

Position
Support

SB 29 **(Durazo D) Medi-Cal: eligibility.**
Location: 3/20/2019-S. APPR.
Calendar: 4/22/2019 10 a.m. - John L. Burton Hearing Room (4203)
SENATE APPROPRIATIONS, PORTANTINO, Chair
Summary: The federal Medicaid program provisions prohibit payment to a state for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Current law requires individuals under 19 years of age enrolled in restricted-scope Medi-Cal at the time the Director of Health Care Services makes a determination that systems have been programmed for implementation of these provisions to be enrolled in the full scope of Medi-Cal benefits, if otherwise eligible, pursuant to an eligibility and enrollment plan, which includes outreach strategies. This bill would extend eligibility for full-scope Medi-Cal benefits to individuals of all ages who are otherwise eligible for those benefits but for their immigration status, and would delete provisions delaying implementation until the director makes the determination as specified.

Position

Support

SB 65 **(Pan D) Health care coverage: financial assistance.**
Location: 4/10/2019-S. APPR.
Summary: Would require the California Health Benefit Exchange, only to the extent that the Legislature appropriates funding for these purposes, to administer a program of financial assistance, to be known as the Affordable Care Access Plus Program, to help low-income and middle-income Californians access affordable health care coverage with respect to individual coverage that is made available through the Exchange. The bill would require the program to provide financial assistance to California residents with household incomes below 600% of the federal poverty level, and would authorize the program to provide other appropriate subsidies designed to make health care more accessible and affordable for individuals and households.

Position
Support

SB 66 **(Atkins D) Medi-Cal: federally qualified health center and rural health clinic services.**
Location: 4/8/2019-S. APPR. SUSPENSE FILE
Summary: Current law provides that federally qualified health center (FQHC) services and rural health clinic (RHC) services, as defined, are covered benefits under the Medi-Cal program, to be reimbursed, to the extent that federal financial participation is obtained, to providers on a per-visit basis. "Visit" is defined as a face-to-face encounter between a patient of an FQHC or RHC and specified health care professionals, including a physician and marriage and family therapist. Under existing law, "physician," for these purposes, includes, but is not limited to, a physician and surgeon, an osteopath, and a podiatrist. This bill would authorize reimbursement for a maximum of 2 visits taking place on the same day at a single location if after the first visit the patient suffers illness or injury requiring additional diagnosis or treatment, or if the patient has a medical visit and a mental health visit or a dental visit, as defined.

Position
Support

SB 175 **(Pan D) Health care coverage: minimum essential coverage.**
Location: 4/10/2019-S. GOV. & F.
Summary: Would create the Minimum Essential Coverage Individual Mandate to require a California resident to ensure that the resident, and any dependent of the resident, is covered under minimum essential health coverage, as defined, for each month beginning on January 1, 2020, except as specified. The bill would require the Exchange to grant exemptions from the mandate for reason of hardship or religious conscience, and would require the Exchange to establish a process for determining eligibility for an exemption.

Position
Support

SB 260 **(Hurtado D) Automatic health care coverage enrollment.**
Location: 4/3/2019-S. APPR.
Calendar: 4/22/2019 10 a.m. - John L. Burton Hearing Room (4203)
SENATE APPROPRIATIONS, PORTANTINO, Chair
Summary: Would require the Exchange, beginning no later than July 1, 2020, to enroll an individual in the lowest cost silver plan or another plan, as specified, upon receiving the individual's electronic account from a county, or upon receiving information from the State Department of Health Care Services regarding an individual terminated from department-administered health coverage. The bill would require enrollment to occur before Medi-Cal coverage or coverage administered by the State Department of Health Care Services is terminated, and would prohibit the premium due date from being sooner than the last day of the first month of enrollment.

Position
Support

Behavorial Health

AB 43 **(Gloria D) Mental health.**
Location: 3/25/2019-A. HEALTH
Calendar: 4/23/2019 1:30 p.m. - State Capitol, Room 4202 ASSEMBLY HEALTH, WOOD, Chair
Summary: Current law authorizes the Mental Health Services Act (MHSA) to be amended by a 2/3 vote of the Legislature if the amendments are consistent with, and further the intent of, the act. Current law authorizes the Legislature to add provisions to clarify procedures and terms of the act by majority vote. This bill would clarify that the planning process for innovative programs is to be completed in

collaboration with stakeholders and is to comply with open meetings laws.

Position
Watch

AB 563 **(Quirk-Silva D) Mental health: funding.**
Location: 3/21/2019-A. HEALTH
Calendar: 4/23/2019 1:30 p.m. - State Capitol, Room 4202 ASSEMBLY HEALTH, WOOD, Chair
Summary: Would appropriate $16,000,000 from the General Fund to the State Department of Health Care Services to distribute to the North Orange County Public Safety Task Force. The bill would require 1/2 of the moneys to be distributed on January 1, 2020, and 1/2 to be distributed on January 1, 2021, and would require the moneys to be used to provide a range of programs, services, and activities designed to assist individuals and families experiencing mental health crises.

Position
Watch

AB 682 **(Eggman D) Health facilities: residential mental health or substance use disorder treatment.**
Location: 4/3/2019-A. APPR. SUSPENSE FILE
Summary: Would require the State Department of Public Health, in consultation with specified entities, to develop and submit a proposal to solicit a grant under the federal 21st Century Cures Act to develop a real-time, Internet-based database to collect, aggregate, and display information about the availability of beds in inpatient psychiatric facilities, crisis stabilization units, residential community mental health facilities, and licensed residential alcoholism or drug abuse recovery or treatment facilities for treatment purposes.

Position
Watch

AB 1055 **(Levine D) Publicly funded technology projects.**
Location: 3/7/2019-A. HEALTH
Summary: Would require a public agency undertaking a publicly funded major technology project that is estimated to cost $100,000,000 or more to form an oversight committee subject to the Ralph M. Brown Act or the Bagley-Keene Open Meeting Act, as applicable, and to develop and use risk management plans throughout the course of the project. The bill would require the oversight committee to be composed of specified members selected by the public agency undertaking the project. The bill would require the oversight committee to act as the authority for critical decisions regarding the project and to have sufficient staff to support decision making.

Position
Watch

AB 1572 **(Chen R) Mental health services: gravely disabled.**
Location: 3/14/2019-A. HEALTH
Summary: Current law, for the purposes of involuntary commitment and conservatorship, defines "gravely disabled." This bill would change the definition of "gravely disabled" for these purposes to read, in part, a condition in which a person, as a result of a mental health disorder, is incapable of making informed decisions about, or providing for, the person's own basic personal needs for food, clothing, shelter, or medical care without significant supervision and assistance from another person and, as a result of being incapable of making these informed decisions, the person is at risk of substantial bodily harm, dangerous worsening of a concomitant serious physical illness, significant psychiatric deterioration, or mismanagement of essential needs that could result in bodily harm.

Position
Pending Review

SB 596 **(Stern D) Mental health.**
Location: 2/22/2019-S. RLS.
Summary: The Lanterman-Petris-Short Act provides for the involuntary commitment and treatment of a person who is a danger to themselves or others or who is gravely disabled. Current law requires a person who receives evaluation or treatment pursuant to the act to be given a choice of physician or other professional person providing those services, in accordance with the policies of each agency providing those services, and within the limits of available staff in the agency. This bill would instead make that provision applicable to a person receiving both evaluation and treatment under the act.

Position
Pending Review

SB 640 **(Moorlach R) Mental health services: gravely disabled.**
Location: 3/14/2019-S. HEALTH
Summary: Tthe Lanterman-Petris-Short Act provides for the involuntary commitment and treatment of

a person who is a danger to themself or others or who is gravely disabled. This bill would change the definition of "gravely disabled" for these purposes to read, in part, a condition in which a person, as a result of a mental health disorder, is incapable of making informed decisions about, or providing for, the person's own basic personal needs for food, clothing, or shelter without significant supervision and assistance from another person and, as a result of being incapable of making these informed decisions, the person is at risk of substantial bodily harm, dangerous worsening of a concomitant serious physical illness, significant psychiatric deterioration, or mismanagement of the person's essential needs that could result in bodily harm.

Position
Pending Review

Hospital Operations and Finance

AB 149 **(Cooper D) Controlled substances: prescriptions.**
Location: 3/11/2019-A. CHAPTERED
Summary: Current law classifies certain controlled substances into designated schedules. Current law requires prescription forms for controlled substance prescriptions to be obtained from security printers approved by the department, as specified. Current law requires those prescription forms to be printed with specified features, including a uniquely serialized number. This bill would delay the requirement for those prescription forms to include a uniquely serialized number until a date determined by the Department of Justice that is no later than January 1, 2020. The bill would require, among other things, the serialized number to be utilizable as a barcode that may be scanned by dispensers.

Position
Support

AB 389 **(Santiago D) Substance use disorder treatment: peer navigators.**
Location: 2/5/2019-A. HEALTH
Summary: Would require the State Department of Health Care Services to either establish a pilot program or expand an existing pilot program for purposes of measuring the efficacy and cost avoidance of utilizing trained substance use disorder peer navigators and behavioral health peer navigators in the emergency department of an acute care hospital, as described, if Funds for this purpose are appropriated in the annual Budget Act. The bill would provide that an acute care hospital may be eligible to receive funding under the pilot program to fund peer navigator positions.

Position
Watch

AB 714 **(Wood D) Opioid prescription drugs: prescribers.**
Location: 4/9/2019-A. APPR.
Summary: Current law requires a prescriber, as defined, to offer to a patient a prescription for naloxone hydrochloride or another drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid depression when certain conditions are present, including if the patient presents with an increased risk for overdose or a history of substance use disorder, and to provide education on overdose prevention to patients receiving a prescription and specified other persons. This bill would make those provisions applicable only to a patient receiving a prescription for an opioid or benzodiazepine medication, and would make the provisions specific to opioid-induced respiratory depression, opioid overdose, opioid use disorder, and opioid overdose prevention, as specified.

Position
Watch

AB 774 **(Reyes D) Health facilities: reporting.**
Location: 4/2/2019-A. THIRD READING
Summary: Current law requires hospitals to file an Emergency Care Data Record for each patient encounter in a hospital emergency department with the Office of Statewide Health Planning and Development. Current law requires the record to contain specified patient and health data information, including the service date and the disposition of the patient.This bill would additionally require the report, until January 1, 2027, to include the time of registration and the date and time of admission, transfer, or discharge, as well as the location of the discharge or transfer, including the name of the facility, if applicable.

Position
Watch

AB 844 **(Irwin D) Health facilities: mandated hospital services and activities.**
Location: 3/4/2019-A. HEALTH

Summary: Current law, until July 1, 2020, requests that the University of California to establish the California Health Benefit Review Program to assess legislation proposing to mandate a benefit or service of a health care service plan or health insurer or proposing to repeal an existing mandated benefit or service of a health care service plan or health insurer. Current law requests that the university provide that analysis to the appropriate policy and fiscal committees of the Legislature not later than 60 days after receiving a request for the analysis. This bill would establish an independent, nonpartisan body to advise the Governor and Legislature on the financial impact of proposed mandated hospital services and activities.

Position
Support

AB 910 **(Wood D) General acute care hospitals: consolidated licensing.**
Location: 3/4/2019-A. HEALTH
Summary: Would require the State Department of Public Health, on or before January 1, 2021, to report to the Legislature the name, location, and license identification of every general acute care hospital operating under a single consolidated license that operates 2 or more physical plants located more than 15 miles apart. The bill would further require the department, on or before January 1, 2022, and annually thereafter, to update the report, as specified. The bill would also make technical changes to these provisions.

Position
Pending Review

AB 962 **(Burke D) Hospitals: procurement contracts: disclosures.**
Location: 4/2/2019-A. APPR.
Summary: Would require a licensed hospital with operating expenses of $25,000,000 or more to annually submit a report to the office on its minority, women, LGBT, and veteran-owned business enterprise procurement efforts, as specified. The bill would require each report to be submitted on July 1, 2020, and then annually thereafter. The bill would impose specified civil penalties for a failure to submit that report. The bill would require the office to maintain a link on the office's internet website that provides public access to the content of those reports, as specified.

Position
Watch

AB 1014 **(O'Donnell D) Health facilities: notices.**
Location: 4/11/2019-A. THIRD READING
Summary: Current law requires a hospital that provides emergency medical services to, as soon as possible, but not later than 90 days prior to a planned reduction or elimination of the level of emergency medical services, provide notice of the intended change to the department, other specified entities, and the public. Current law requires a health facility implementing a downgrade or change to make reasonable efforts to ensure that the community it serves is informed of the downgrade or closure. Current law also requires a health facility to provide public notice, as specified, not less than 30 days prior to closing the facility, eliminating a supplemental service, as defined, or relocating the provision of supplemental services to a different campus. This bill would require a hospital that provides emergency medical services or a health facility to provide notice, as specified, at least 180 days before making the changes described above.

Position
Watch

AB 1404 **(Santiago D) Department of Managed Health Care: Financial Solvency Standards Board.**
Location: 3/14/2019-A. HEALTH
Calendar: 4/23/2019 1:30 p.m. - State Capitol, Room 4202 ASSEMBLY HEALTH, WOOD, Chair
Summary: Current law establishes, within the Department of Managed Health Care, the Financial Solvency Standards Board, which is comprised of the director of the department and 7 members, appointed by the director. Current law authorizes the 7 appointed members to be from specified subject areas or fields, including, but not limited to, medical and health care economics, accountancy, with experience in integrated or affiliated health care delivery systems, and management and administration in integrated or affiliated health care delivery systems. This bill would add 2 appointed members to the board. The bill would also include large group health insurance purchasing and a representative of health care consumers in the list of subject areas or fields from which the director may choose board members.

Position
Watch

AB 1495 **(O'Donnell D) Hospitals: seismic safety.**
Location: 3/21/2019-A. HEALTH
Summary: Would specify that if a hospital submitted a seismic compliance plan based on a removal

plan, but also submitted a timely seismic compliance plan or plans based on one or more of the other methods of seismic compliance, the extension may be granted for the seismic compliance plan or plans based on the methods other than the removal plan.

Position
Watch

AB 1544 **(Gipson D) Community Paramedicine or Triage to Alternate Destination Act.**
Location: 4/9/2019-A. APPR.
Summary: Would establish within the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act until January 1, 2030, the Community Paramedicine or Triage to Alternate Destination Act of 2019. The bill would authorize a local EMS agency to develop a community paramedicine or triage to alternate destination program, as defined, to provide specified community paramedicine services. The bill would require the authority to develop regulations to establish minimum standards for a program, and would further require the Commission on Emergency Medical Services to review and approve those regulations.

Position
Watch

AB 1611 **(Chiu D) Emergency hospital services: costs.**
Location: 3/14/2019-A. HEALTH
Calendar: 4/23/2019 1:30 p.m. - State Capitol, Room 4202 ASSEMBLY HEALTH, WOOD, Chair
Summary: Would require a health care service plan contract or insurance policy issued, amended, or renewed on or after January 1, 2020, to provide that if an enrollee or insured receives covered services from a noncontracting hospital, the enrollee or insured is prohibited from paying more than the same cost sharing that the enrollee or insured would pay for the same covered services received from a contracting hospital. The bill would require a health care service plan or insurer to pay a noncontracting hospital for emergency services rendered to an enrollee or insured pursuant to a specified formula, would require a noncontracting hospital to bill, collect, and make refunds in a specified manner, and would provide a dispute resolution procedure if any party is dissatisfied with payment.

Position
Oppose Unless Amend

AB 1630 **(Irwin D) Medical billing task force.**
Location: 3/18/2019-A. HEALTH
Summary: Would require OSHPD, in consultation with the Insurance Commissioner, to establish a medical billing task force on or before April 1, 2020. The bill would require the task force to, among other things, engage interested parties in the development of a system to improve the readability of medical bills and create a standard medical billing form. The bill would require OSHPD, on or before December 1, 2020, to submit a report to the Legislature on the task force's efforts.

Position
Watch

SB 343 **(Pan D) Healthcare data disclosure.**
Location: 4/3/2019-S. APPR.
Calendar: 4/22/2019 10 a.m. - John L. Burton Hearing Room (4203)
SENATE APPROPRIATIONS, PORTANTINO, Chair
Summary: Would eliminate alternative reporting requirements for a plan or insurer that exclusively contracts with no more than 2 medical groups or a health facility that receives a preponderance of its revenue from associated comprehensive group practice prepayment health care service plans and would instead require those entities to report information consistent with any other health care service plan, health insurer, or health facility, as appropriate. The bill would also eliminate the authorization for hospitals to report specified financial and utilization data to OSHPD, and file cost data reports with OSHPD, on a group basis.

Position
Pending Review

SB 758 **(Portantino D) Hospitals: seismic safety.**
Location: 4/3/2019-S. HEALTH
Calendar: 4/24/2019 1:30 p.m. - John L. Burton Hearing Room (4203) SENATE HEALTH, PAN, Chair
Summary: The Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983 requires, before January 1, 2020, the owner of an acute care inpatient hospital whose building does not substantially comply with described seismic safety regulations or standards to submit to the office an attestation that the board of directors of that hospital is aware that the hospital building is required to meet a specified deadline for substantial compliance with those regulations and standards. This bill would require, on or before

January 1, 2021, the owner of an acute care inpatient hospital to update the above-described submission by reporting the services provided in each building of the acute care inpatient hospital.

Position
Support

Not for Profit

AB 204 **(Wood D) Hospitals: community benefits plan reporting.**
Location: 4/10/2019-A. APPR. SUSPENSE FILE
Summary: Would require the Office of Statewide Health Planning and Development, by no later than July 1, 2020, to develop regulations to standardize the calculation of the economic value of community benefits and community benefit plan reporting, as specified. The bill would require the office, upon implementation of the regulations, to annually prepare a report on community benefits, as specified, and post the report and the community benefit plans submitted by the hospitals on its Internet Web site. The bill would authorize the office to impose fines not to exceed an unspecified amount on hospitals that fail to adopt, update, or submit community benefit plans.

Position
Pending Review

Social Determinants of Health

AB 816 **(Quirk-Silva D) California Flexible Housing Subsidy Pool Program.**
Location: 3/4/2019-A. H. & C.D.
Calendar: 4/24/2019 9:15 a.m. - State Capitol, Room 126 ASSEMBLY HOUSING AND COMMUNITY DEVELOPMENT, CHIU, Chair
Summary: Would establish the California Flexible Housing Subsidy Pool Program within the Department of Housing and Community Development for the purpose of making grants available to applicants, defined to include a city, county, city and county, or continuum of care, for eligible activities including, among other things, rental assistance, operating subsidies in new and existing affordable or supportive housing units, and specified outreach services. The bill would continuously appropriate $450,000,000 from the General Fund every fiscal year to the department for purposes of the program, and set forth how these funds must be allocated.

Position
Pending Review

Workforce

AB 329 **(Rodriguez D) Hospitals: assaults and batteries.**
Location: 2/11/2019-A. PUB. S.
Calendar: 4/23/2019 9 a.m. - State Capitol, Room 126 ASSEMBLY PUBLIC SAFETY, JONES-SAWYER, Chair
Summary: Would make an assault committed on the property of a public or private hospital punishable by imprisonment in a county jail not exceeding one year, by a fine not exceeding $2,000, or by both that fine and imprisonment. By expanding the scope of a crime, this bill would impose a state-mandated local program.

Position
Support

AB 890 **(Wood D) Nurse practitioners: scope of practice: unsupervised practice.**
Location: 4/9/2019-A. APPR.
Summary: Would authorize a nurse practitioner who holds a certification as a nurse practitioner from a national certifying body recognized by the Board of Registered Nursing who practices in certain settings to perform specified functions without supervision by a physician and surgeon, including ordering and interpreting diagnostic procedures, certifying disability, and prescribing, administering, dispensing, and administering controlled substances.

Position
Support

SB 227 **(Leyva D) Health and care facilities: inspections and penalties.**
Location: 4/10/2019-S. APPR.

Summary: Current law specifically requires the State Department of Public Health to adopt regulations that require a general acute care hospital, an acute psychiatric hospital, and a special hospital to meet minimum nurse-to-patient ratios and assign additional staff according to a documented patient classification system for determining nursing care requirements. Current law also generally requires the department to periodically inspect every health facility for which a license or special permit has been issued for compliance with state laws and regulations. This bill would require the periodic inspections of these specified health facilities to include reviews of compliance with the nurse-to-patient ratios and staff assignment regulations described above.

Position
Oppose

SB 567 **(Caballero D) Workers' compensation: hospital employees.**
Location: 3/7/2019-S. L., P.E. & R.
Calendar: 4/24/2019 9:30 a.m. - Rose Ann Vuich Hearing Room (2040) SENATE LABOR, PUBLIC EMPLOYMENT AND RETIREMENT, HILL, Chair
Summary: Would define "injury," for a hospital employee who provides direct patient care in an acute care hospital, to include infectious diseases, cancer, musculoskeletal injuries, post-traumatic stress disorder, and respiratory diseases. The bill would create rebuttable presumptions that these injuries that develop or manifest in a hospital employee who provides direct patient care in an acute care hospital arose out of and in the course of the employment. The bill would extend these presumptions for specified time periods after the hospital employee's termination of employment. The bill would also make related findings and declarations.

Position
Oppose

SB 697 **(Caballero D) Physician assistants: practice agreement: supervision.**
Location: 3/14/2019-S. B., P. & E.D.
Calendar: 4/22/2019 12 p.m. and upon adjournment of Session - Room 3191 SENATE BUSINESS, PROFESSIONS AND ECONOMIC DEVELOPMENT, GLAZER, Chair
Summary: This bill except as specified, would remove the limit on the number of physician assistants that a physician and surgeon may supervise. The bill would remove the requirements that the medical record identify the responsible supervising physician and surgeon and that those written guidelines for adequate supervision be established. The bill would instead authorize a physician assistant to perform various medical services if certain requirements are met including that the medical services are rendered pursuant to a signed delegation of services agreement or a practice agreement, as defined, and the physician assistant is competent to perform the medical services.

Position
Watch

Total Measures: 37
Total Tracking Forms: 37