LEGISLATIVE UPDATE

Alliance of Catholic Health Care

Week August 8, 2022

State Issues	
Legislative Deadlines and Status of Bills	This was the last week for the Senate and Assembly Appropriations Committee to pass or hold bills on its Suspense File. We now enter the last weeks of the Legislative session with Floor sessions only. If there will be bills amended on the floor, the deadline to do so is August 25. The last day to pass bills is August 31. Attached is the most recent Alliance Legislative Summary and Status report on bills of interest to the Catholic health care ministry.
Hospital Retention Pay	This week the Department of Health Care Services (DHCS) issued another brief notice regarding the upcoming implementation of the retention pay proposal included by the Governor Newsom's in the 2022-2023 State Budget. While we continue to wait for the detailed implementation document from DHCS that outlines all of the technical answers and provides direction to hospitals on the rules for distributing the funds, on Thursday they issued a notice with two important pieces of information. 1) The "date of record" will be November 28, 2022. This helps define who is (or not) eligible for a bonus and is 45 days after the "qualifying work period." 2) The date that hospitals and SNFs must submit their lists of staff who have qualified for which level of bonus has been set to December 30, 2022. This is much later than the Administration had originally hoped for and speaks to how complicated this process is for all involved.
November Ballot Initiatives	This week, the Legislature held a mandatory hearing on Proposition 29: *Establishes State Requirements for Kidney Dialysis Clinics. Requires On-Site Medical Professional. Initiative Statute.* For the past few elections, the health care unions have introduced ballot initiatives on this topic – with all of them resoundingly failing. This year marks another attempt. If passed, the initiative: ▪ Requires at least one licensed physician on site during treatment at outpatient kidney dialysis clinics; authorizes California Department of Public Health to exempt clinics from this requirement if there is a shortage of qualified licensed physicians and the clinic has at least one nurse practitioner or physician assistant on site. ▪ Requires clinics to report dialysis-related infection data to state and federal governments. ▪ Prohibits clinics from closing or reducing services without state approval. ▪ Prohibits clinics from refusing to treat patients based on the source of payment for care. *(more)*

November Ballot Initiatives *(continued)*	The concern from the opponents is that these provisions are unnecessary for patient safety, will add unnecessary costs to the provision of dialysis care, and may result in dialysis clinics closing that may result in forcing patients to travel longer distances and endure longer wait times to access care. To that end, at the hearing the California Legislative Analyst's Office indicated in their analysis that this measure would cost several hundred thousand dollars annually per clinic, totally $229-$459 million annually for all dialysis centers statewide. All materials related to this ballot initiative and the Legislative hearing are attached.

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Alliance of Catholic Health Care
Legislative Summary and Status 8/12/2022

Access

AB 4 **(Arambula D) Medi-Cal: eligibility.**
Location: 8/5/2022-S. APPR. SUSPENSE FILE
Summary: Would, effective January 1, 2022, extend eligibility for full scope Medi-Cal benefits to anyone regardless of age, and who is otherwise eligible for those benefits but for their immigration status, pursuant to an eligibility and enrollment plan. The bill would delete the specified provisions regarding individuals who are under 25 years of age or 65 years of age or older and delaying implementation until the director makes the determination described above. The bill would require the eligibility and enrollment plan to ensure that an individual maintains continuity of care with respect to their primary care provider, as prescribed, would provide that an individual is not limited in their ability to select a different health care provider or Medi-Cal managed care health plan, and would require the department to provide monthly updates to the appropriate policy and fiscal committees of the Legislature on the status of the implementation of these provisions

Position
Support

AB 32 **(Aguiar-Curry D) Telehealth.**
Location: 8/11/2022-S. THIRD READING
Calendar: 8/15/2022 #534 SENATE ASSEMBLY BILLS - THIRD READING FILE
Summary: The Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Current law requires a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2021, to specify that coverage is provided for health care services appropriately delivered through telehealth on the same basis and to the same extent as in-person diagnosis, consultation, or treatment. Current law generally exempts county organized health systems that provide services under the Medi-Cal program from Knox-Keene. This bill would subject county organized health systems, and their subcontractors, that provide services under the Medi-Cal program to the above-described Knox-Keene requirements relative to telehealth. The bill would authorize a provider to enroll or recertify an individual in specified Medi-Cal programs through telehealth and other forms of virtual communication, and would authorize a county eligibility worker to determine eligibility for, or recertify eligibility for, the Medi-Cal Minor Consent program remotely through virtual communication, as specified.

Position
Support

AB 1878 **(Wood D) California Health Benefit Exchange: affordability assistance.**
Location: 8/2/2022-S. APPR. SUSPENSE FILE
Summary: Current law requires the California Health Benefit Exchange, in consultation with stakeholders and the Legislature, to develop options for providing cost-sharing reduction subsidies to reduce cost sharing for low- and middle-income Californians, and requires the Exchange to report the developed options on or before January 1, 2022. Current law requires the options to include, among other things, options for all Covered California enrollees with income up to 400 percent of the federal poverty level to reduce cost sharing, including copays, deductibles, coinsurance, and maximum out-of-pocket costs. This bill would require the Exchange to implement those options for providing health care affordability assistance. The bill would require the affordability assistance to reduce cost sharing, including copays, coinsurance, and maximum out-of-pocket costs, and to eliminate deductibles for all benefits. The bill would specify the actuarial value of cost-sharing assistance based on the income level of an enrollee, and would require the Exchange to adopt standard benefit designs consistent with these specifications.

Position
Support

AB 2530 **(Wood D) California Health Benefit Exchange: financial assistance.**
Location: 8/11/2022-S. THIRD READING
Calendar: 8/15/2022 #513 SENATE ASSEMBLY BILLS - THIRD READING FILE
Summary: Would, upon appropriation by the Legislature, require the California Health Benefit Exchange (Exchange) to administer a program of financial assistance beginning July 1, 2023, to help Californians obtain and maintain health benefits through the Exchange if they lose employer-provided health care coverage as a result of a labor dispute. Under the bill, if specified eligibility requirements are met, an individual who has lost minimum essential coverage from an employer or joint labor

management trust fund as a result of a strike, lockout, or other labor dispute would receive the same premium assistance and cost-sharing reductions as an individual with a household income of 138% of the federal poverty level, and, beginning January 1, 2024, would also not pay a deductible for any covered benefit if the standard benefit design for a household income of 138% of the federal poverty level has zero deductibles.

Position
Support

SB 944 **(Pan D) California Health Benefit Exchange: affordability assistance.**
Location: 8/3/2022-A. APPR. SUSPENSE FILE
Calendar: 8/15/2022 #159 ASSEMBLY SECOND READING FILE -- SENATE BILLS
Summary: Current law requires the California Health Benefit Exchange, in consultation with stakeholders and the Legislature, to develop options for providing cost-sharing reduction subsidies to reduce cost sharing for low- and middle-income Californians, and requires the Exchange to report the developed options on or before January 1, 2022. Current law requires the options to include, among other things, options for all Covered California enrollees with income up to 400 percent of the federal poverty level to reduce cost sharing, including copays, deductibles, coinsurance, and maximum out-of-pocket costs. This bill would require the Exchange to implement those options for providing health care affordability assistance. The bill would require the affordability assistance to reduce cost-sharing, including copays, coinsurance, and maximum out-of-pocket costs, and to eliminate deductibles for all benefits.

Position
Support

End of Life/Palliative Care

AB 1852 **(Patterson R) Health facilities: automated drug delivery systems.**
Location: 7/19/2022-A. CHAPTERED
Summary: Current law authorizes the use of automated drug delivery systems, as defined, for pharmacy services in nursing, skilled nursing, and intermediate care facilities. Current law requires the pharmacy at these facilities to be responsible for the drugs contained within, and the operation and maintenance of, the automated drug delivery system. Current law makes a violation of these provisions a crime. This bill would add licensed hospice facilities to the list of facilities authorized to use an automated drug delivery system, and would expressly include an automated unit dose system within the definition of an automated drug delivery system.

Position
Watch

AB 2288 **(Choi R) Advance health care directives: mental health treatment.**
Location: 6/16/2022-A. CHAPTERED
Summary: The Health Care Decisions Law, authorizes an adult having capacity to give an individual health care instruction. Current law authorizes the individual instruction to be limited to take effect only if a specified condition arises. Current law authorizes a written advance health care directive to include the individual's nomination of a conservator of the person or estate or both, or a guardian of the person or estate or both, for consideration if protective proceedings for the individual's person or estate are thereafter commenced. Current law also authorizes an adult having capacity to execute a power of attorney for health care to authorize an agent to make health care decisions for the principal, and authorizes the power of attorney to include individual health care instructions. Current law authorizes the principal in a power of attorney for health care to grant authority to make decisions relating to the personal care of the principal, including, but not limited to, determining where the principal will live, providing meals, or hiring household employees. Current law defines "health care decision" and "health care" for these purposes to mean any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a patient's physical or mental condition. This bill would clarify that health care decisions under those provisions include mental health conditions.

Position
Watch

AB 2338 **(Gipson D) Health care decisions: decisionmakers and surrogates.**
Location: 6/30/2022-S. THIRD READING
Calendar: 8/15/2022 #293 SENATE ASSEMBLY BILLS - THIRD READING FILE
Summary: Current law authorizes an adult having capacity to give an individual health care instruction and to designate a health care decisionmaker, including an agent designated in a power of attorney to make health care decisions on the person's behalf. Current law also authorizes a patient to designate an adult as a surrogate to make health care decisions by personally informing the supervising health care provider. Existing law authorizes a patient to disqualify a person, including a family member, from

acting as the patient's surrogate. This bill would authorize the patient to designate an adult as a surrogate to make health care decisions by also personally informing a designee of the health care facility caring for the patient. The bill would authorize legally recognized health care decisionmakers, in an order of priority, to make health care decisions on a patient's behalf if the patient lacks the capacity to make a health care decision. If a patient does not have a legally recognized health care decisionmaker, the bill would specify individuals who may be chosen by a health care provider or a designee of the health care facility caring for the patient as a surrogate if the patient lacks the capacity to make a health care decision.

Position
Neutral

Hospital Operations and Finance

AB 35 **(Reyes D) Civil damages: medical malpractice.**
Location: 5/23/2022-A. CHAPTERED
Summary: Current law, referred to as the Medical Injury Compensation Reform Act of 1975 (MICRA), prohibits an attorney from contracting for or collecting a contingency fee for representing any person seeking damages in connection with an action for injury or damage against a health care provider based upon alleged professional negligence in excess of specified limits. This bill would recast those provisions and base the amount of contingency fee that may be contracted for upon whether recovery is pursuant to settlement agreement and release of all claims executed before a civil complaint or demand for arbitration is filed, or pursuant to settlement, arbitration, or judgment after a civil complaint or demand for arbitration is filed, as specified. The bill would add and revise definitions for these purposes.

Position
Support

AB 1882 **(Rivas, Robert D) Hospitals: seismic safety.**
Location: 8/8/2022-S. THIRD READING
Calendar: 8/15/2022 #388 SENATE ASSEMBLY BILLS - THIRD READING FILE
Summary: The Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983 requires an owner of a general acute care inpatient hospital, no later than January 1, 2030, to either demolish, replace, or change to nonacute care use all hospital buildings not in substantial compliance with the regulations and standards developed pursuant to the act, or seismically retrofit all acute care inpatient hospital buildings so that they are in substantial compliance with those regulations and standards. Current law requires, within 60 days following the department's approval of a report relating to a general acute care hospital owner's plan to comply with those regulations and standards, a general acute hospital building owner to include all pertinent information regarding the building's expected earthquake performance in emergency training, response, and recovery plans, and in capital outlay plans. This bill would instead require general acute hospital building owners, commencing July 1, 2023, to take those actions annually until each of the hospital buildings owned by that owner is compliant with those regulations and standards.

Position
Oppose Unless Amend

AB 2724 **(Arambula D) Medi-Cal: alternate health care service plan.**
Location: 6/30/2022-A. CHAPTERED
Summary: Current law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services through various delivery systems, including managed care pursuant to Medi-Cal managed care plan contracts. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. This bill would authorize the department to enter into one or more comprehensive risk contracts with an alternate health care service plan (AHCSP), as defined, to serve as a primary Medi-Cal managed care plan for certain eligible beneficiaries in geographic regions designated by the department, as specified. The bill would authorize the department to contract with an AHCSP as a Medi-Cal managed care plan in any geographic region of the state for which federal approval is available, for which the AHCSP maintains appropriate licensure or an approved exemption from the Department of Managed Health Care, and in which the AHCSP already provides commercial coverage in the individual, small group, or large group market.

Position
Watch

SB 923 **(Wiener D) Gender-affirming care.**
Location: 8/3/2022-A. APPR. SUSPENSE FILE

Calendar: 8/15/2022 #156 ASSEMBLY SECOND READING FILE -- SENATE BILLS
Summary: Would require a Medi-Cal managed care plan, a PACE organization, a health care service plan, or a health insurer, as specified, to require its staff to complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care, as defined, for individuals who identify as transgender, gender diverse, or intersex (TGI). The bill would specify the required components of the training and would make use of any training curricula subject to approval by the respective departments. The bill would require an individual to complete a refresher course if a complaint has been filed, and a decision has been made in favor of the complainant, against that individual for not providing trans-inclusive health care, or on a more frequent basis if deemed necessary.

Position
Watch

SB 988 **(Hueso D) Compassionate Access to Medical Cannabis Act or Ryan's Law.**
Location: 8/4/2022-S. CONCURRENCE
Calendar: 8/15/2022 #184 SENATE UNFINISHED BUSINESS
Summary: Current law requires a health care facility to, among other requirements regarding medicinal cannabis, reasonably restrict the manner in which a patient stores and uses medicinal cannabis to ensure the safety of other patients, guests, and employees of the health care facility, compliance with other state laws, and the safe operations of the health care facility. Current law requires that health care facilities permitting patient use of medical cannabis comply with other drug and medication requirements, as specified, and makes those facilities subject to enforcement actions by the State Department of Public Health. This bill would repeal the requirement that health care facilities permitting patient use of medical cannabis comply with other drug and medication requirements, as specified. The bill would require a health facility to require a patient or a primary caregiver, as defined, to be responsible for acquiring, retrieving, administering, and removing medicinal cannabis and would require medicinal cannabis to be stored securely at all times. The bill would require the patient or the patient's primary caregiver to, upon discharge, remove all remaining medicinal cannabis and, if a patient cannot remove the medicinal cannabis and does not have a primary caregiver, would require the storage of the product in a locked container until it is disposed of, as specified.

Position
Watch

SB 1339 **(Pan D) Hospitals.**
Location: 8/3/2022-A. APPR. SUSPENSE FILE
Summary: Current law requires, by January 1, 2030, owners of all acute care inpatient hospitals to either seismically retrofit all acute care inpatient hospitals, or demolish, replace, or change to nonacute care use all hospital buildings not in substantial compliance with regulations and standards developed by the department in accordance with the act, as specified. This bill would require an acute care hospital in a building with a specified rating to submit to the Department of Health Care Access and Information the estimated cost for the hospital to comply with the 2030 seismic requirements. The bill would require the department to provide the Legislature with a report containing specified information that would provide, among other things, the Legislature with an assessment of projected costs to retrofit each hospital building in order to meet the 2030 seismic requirements. The bill would authorize the department to rely on the cost estimates submitted by the hospitals, and if the department relies on the estimates, the bill would require the department to clearly state in the report that the information was provided by the hospital and not verified by the department.

Position
Support if Amended

Maternal Health

AB 2176 **(Wood D) Live birth registration.**
Location: 6/21/2022-A. CHAPTERED
Summary: Current law requires each live birth to be registered with the local registrar of births and deaths for the district in which the birth occurred within 10 days following the date of the event. This bill would instead require each live birth to be registered with the local registrar within 21 days following the date of the event.

Position
Support

AB 2199 **(Wicks D) Birthing Justice for California Families Pilot Project.**
Location: 8/11/2022-S. THIRD READING

Calendar: 8/15/2022 #613 SENATE ASSEMBLY BILLS - THIRD READING FILE

Summary: Would establish the Birthing Justice for California Families Pilot Project, which would include a 3-year grant program to provide grants to specified entities, including community-based doula groups, to provide full-spectrum doula care to members of communities with high rates of negative birth outcomes who are not eligible for Medi-Cal and incarcerated people. The bill would require the State Department of Public Health to take specified actions with regard to awarding grants, including awarding grants to selected entities on or before January 1, 2024. The bill would require a grant recipient to use grants funds to pay for the costs associated with providing full-spectrum doula care to eligible individuals and establishing, managing, or expanding doula services. The bill would require a grant recipient, in setting the payment rate for a doula being paid with grant funds, to comply with specified parameters, including that the payment rate not be less than the Medi-Cal reimbursement rate for doulas or the median rate paid for doula care in existing local pilot projects providing doula care in California, whichever is higher. The bill would require the department to utilize a portion of the funds allocated for administrative purposes to arrange for or provide, at no cost to the participants, training on the core competencies for doulas to people who want to become doulas, and community-based doulas in need of additional training to maintain competence, and who are from communities experiencing the highest burden of birth disparities in the state.

Position
Watch

Mental and Behavioral Health

AB 2242 **(Santiago D) Mental health services.**

Location: 8/11/2022-S. SECOND READING

Calendar: 8/15/2022 #89 SENATE ASSEMBLY BILLS - SECOND READING FILE

Summary: This bill, on or before July 1, 2023, would require the State Department of Health Care Services to convene a stakeholder group of entities, including the County Behavioral Health Directors Association of California and the California Hospital Association, among others, to create a model care coordination plan to be followed when discharging those held under temporary holds or a conservatorship. The bill would require the model care coordination plan and process to outline who would be on the care team and how the communication would occur to coordinate care. Among other components, the bill would require the model care coordination plan to require that an individual exiting a temporary hold or a conservatorship be provided with a detailed plan that includes a scheduled first appointment with a behavioral health professional. The bill would declare the intent of the Legislature that counties and hospitals implement the care coordination plan by February 1, 2024.

Position
Watch

AB 2275 **(Wood D) Mental health: involuntary commitment.**

Location: 8/11/2022-S. SECOND READING

Calendar: 8/15/2022 #96 SENATE ASSEMBLY BILLS - SECOND READING FILE

Summary: Under the Lanterman-Petris-Short Act, when a person, as a result of a mental health disorder, is a danger to others, or to themselves, or gravely disabled, the person may, upon probable cause, be taken into custody and placed in a facility designated by the county and approved by the State Department of Health Care Services for up to 72 hours for evaluation and treatment. If certain conditions are met after the 72-hour detention, the act authorizes the certification of the person for a 14-day maximum period of intensive treatment and then a 30-day maximum period of intensive treatment after the 14-day period. Current law requires a certification review hearing to be held when a person is certified for a 14-day or 30-day intensive treatment detention, except as specified, and requires it to be within 4 days of the date on which the person is certified. Existing law, after the involuntary detention has begun, prohibits the total period of detention, including intervening periods of voluntary treatment, from exceeding the total maximum period during which the person could have been detained, if the person had been detained continuously on an involuntary basis, from the time of initial involuntary detention. This bill would, among other things, specify that the 72-hour period of detention begins at the time when the person is first detained.

Position
Watch

SB 929 **(Eggman D) Community mental health services: data collection.**

Location: 8/10/2022-A. APPR. SUSPENSE FILE

Calendar: 8/15/2022 #157 ASSEMBLY SECOND READING FILE -- SENATE BILLS

Summary: Current law requires the State Department of Health Care Services to collect and publish annually quantitative information concerning the operation of various provisions relating to community mental health services, including the number of persons admitted for evaluation and treatment for certain periods, transferred to mental health facilities, or for whom certain conservatorships are

established, as specified. Current law requires each local mental health director, and each facility providing services to persons under those provisions, to provide the department, upon its request, with any information, records, and reports that the department deems necessary for purposes of the data collection and publication. This bill would additionally require the department to report to the Legislature, on or before May 1 of each year, quantitative information relating to, among other things, the number of persons detained for 72-hour evaluation and treatment, clinical outcomes for individuals placed in each type of hold, services provided in each category, waiting periods prior to receiving an evaluation or care, demographic data of those receiving care, and an assessment of all contracted beds. The bill would specify that the information be from each county for some of those data.

Position
Watch

SB 1019 **(Gonzalez D) Medi-Cal managed care plans: mental health benefits.**
Location: 8/10/2022-A. APPR. SUSPENSE FILE
Calendar: 8/15/2022 #66 ASSEMBLY SECOND READING FILE -- SENATE BILLS
Summary: Would require a Medi-Cal managed care plan to conduct annual outreach and education for its enrollees, based on an annual plan that the Medi-Cal managed care plan develops and submits to the State Department of Health Care Services, regarding the mental health benefits that are covered by the Medi-Cal managed care plan, and to also develop an annual outreach and education plan to inform primary care providers regarding those mental health benefits.

Position
Support

SB 1154 **(Eggman D) Facilities for mental health or substance use disorder crisis: database.**
Location: 8/10/2022-A. APPR. SUSPENSE FILE
Summary: Would require, by January 1, 2024, the State Department of Public Health, in consultation with the State Department of Health Care Services and the State Department of Social Services, and by conferring with specified stakeholders, to develop a real-time, internet-based database to collect, aggregate, and display information about beds in inpatient psychiatric facilities, crisis stabilization units, residential community mental health facilities, and licensed residential alcoholism or drug abuse recovery or treatment facilities in order to facilitate the identification and designation of facilities for the temporary treatment of individuals in mental health or substance use disorder crisis. The bill would require the database to include a minimum of specific information, including the contact information for a facility's designated employee, and have the capacity to, among other things, enable searches to identify beds that are appropriate for the treatment of individuals in a mental health or substance use disorder crisis.

Position
Watch

SB 1207 **(Portantino D) Health care coverage: maternal and pandemic-related mental health conditions.**
Location: 8/4/2022-A. THIRD READING
Calendar: 8/15/2022 #339 ASSEMBLY THIRD READING FILE - SENATE BILLS
Summary: Current law requires health care service plans and health insurers to provide specified mental health and substance use disorder coverage, and requires a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2021, that provides hospital, medical, or surgical coverage to provide coverage for medically necessary treatment of mental health and substance use disorders, under the same terms and conditions applied to other medical conditions, as specified. Current law requires health care service plans and health insurers, by July 1, 2019, to develop, consistent with sound clinical principles and processes, a maternal mental health program designed to promote quality and cost-effective outcomes, as specified. This bill would make findings and declarations relating to the effect of the COVID-19 pandemic on mental health in California and the importance of outreach, education, and access to quality mental health treatment. The bill would extend the deadline for establishment of the maternal mental health program to July 1, 2023.

Position
Watch

SB 1238 **(Eggman D) Behavioral health services: existing and projected needs.**
Location: 8/10/2022-A. APPR. SUSPENSE FILE
Calendar: 8/15/2022 #206 ASSEMBLY SECOND READING FILE -- SENATE BILLS
Summary: Current law authorizes the State Department of Health Care Services to award competitive grants to expand the community continuum of behavioral health treatment resources. This bill would require the department, commencing January 1, 2024, and at least every 5 years thereafter, to conduct a review of, and produce a report regarding, the current and projected behavioral health care infrastructure and service needs in each region of the state. The bill would require the department to consult with the council of governments, cities, counties, and cities and counties regarding the assumptions and methodology to be used by the department, and would require local governments to provide specified data for the region. The bill would require the department to share this data and its

report with the Mental Health Services Oversight and Accountability Commission.

Position
Watch

Social Determinants of Health

AB 1816 **(Bryan D) Reentry Housing and Workforce Development Program.**
Location: 8/11/2022-S. THIRD READING
Calendar: 8/15/2022 #574 SENATE ASSEMBLY BILLS - THIRD READING FILE
Summary: Current law establishes the Department of Housing and Community Development in the Business, Consumer Services, and Housing Agency and makes the department responsible for administering various housing programs throughout the state, including, among others, the Multifamily Housing Program, the Housing for a Healthy California Program, and the California Emergency Solutions Grants Program. Upon appropriation by the Legislature for this express purpose, this bill would require the department to create the Reentry Housing and Workforce Development Program, and would require the department to take specified actions to provide grants to applicants, as defined, for innovative or evidence-based housing, housing-based services, and employment interventions to allow people with recent histories of incarceration to exit homelessness and remain stably housed.

Position
Support

AB 2360 **(Arambula D) Emergency response advisory working group.**
Location: 6/27/2022-S. APPR. SUSPENSE FILE
Summary: Would, subject to an appropriation of funds, require the Office of Health Equity to convene an advisory working group, consisting of specified stakeholders, to develop tools and protocols for the future allocation of funds to reduce racial disparities in recovery, response, and repair efforts following state and local emergencies. Additionally, the bill would require the advisory working group to submit a report with its findings and recommendations to the Legislature on or before January 1, 2025, and make that report available to the public by posting it on the State Department of Public Health's internet website. The bill would require the advisory working group in preparing the report to evaluate the unmet needs among various communities during the COVID-19 pandemic and with respect to up to five other recent emergency funding allocations stratified by local health jurisdiction, county, and Senate and Assembly legislative district. These provisions would be repealed on January 1, 2029.

Position
Support

AB 2419 **(Bryan D) Environmental justice: federal Infrastructure Investment and Jobs Act: Justice40 Advisory Committee.**
Location: 8/2/2022-S. APPR. SUSPENSE FILE
Summary: The federal Infrastructure Investment and Jobs Act (IIJA) provides additional federal funds to rebuild the nation's infrastructures. Executive orders issued by President Biden established the federal Justice40 Initiative with the goal that 40% of the overall federal benefits flow to disadvantaged communities and stating that the implementation of the IIJA should prioritize investing public dollars equitably, including through the Justice40 Initiative. This bill would require a minimum of 40% of funds received by the state under the IIJA and certain other federal funds to be allocated to projects that provide direct benefits to disadvantaged communities and disadvantaged unincorporated communities and, except as specified, a minimum of an additional 10% be allocated for projects that provide direct benefits to low-income households and low-income communities, as provided. The bill would require state agencies administering those federal funds to perform specified tasks related to the expenditure of those federal funds.

Position
Support

AB 2420 **(Arambula D) Perinatal and infant children health: extreme heat.**
Location: 8/11/2022-S. THIRD READING
Calendar: 8/15/2022 #504 SENATE ASSEMBLY BILLS - THIRD READING FILE
Summary: Would, subject to an appropriation of funds by the Legislature in the annual Budget Act or another statute for this purpose, require the Department of Public Health, in consultation with subject matter experts, to review available literature on adverse effects of extreme heat on perinatal health, develop guidance for safe conditions and health considerations for pregnant individuals and infant children, and provide guidance to the Legislature by submitting a report that includes legislative or policy recommendations on best practices for connecting perinatal patients with the appropriate health and well-being information relating to extreme heat.

Position

Watch

AB 2483 **(Maienschein D) Housing for individuals experiencing homelessness.**
Location: 8/11/2022-S. SECOND READING
Calendar: 8/15/2022 #115 SENATE ASSEMBLY BILLS - SECOND READING FILE
Summary: Current law establishes the Department of Housing and Community Development and requires it to administer various programs intended to promote the development of housing, including the Multifamily Housing Program, pursuant to which the department provides financial assistance in the form of deferred payment loans to pay for the eligible costs of development of specified types of housing projects.This bill would require the department, by December 31, 2023, to award incentives, as specified, to Multifamily Housing Program project applicants that agree to set aside at least 20% of the project's units, or no more than 50% of the projects units if the project includes more than 100 units, for individuals that are either experiencing homelessness or eligible to receive specified services, including, among others, those received under the Program of All-Inclusive Care for the Elderly. The bill would also require the department to partner with the State Department of Health Care Services to determine the most effective way to align qualifying services in housing projects funded by the Multifamily Housing Program. The bill would require the department to assess tenant outcomes and engage with an evaluator to identify specified information with respect to projects receiving incentives under these provisions, including the number and demographics, including age, race, or ethnicity, and presubsidy housing status, of people being served.

Position
Watch

AB 2548 **(Nazarian D) California Kids Investment and Development Savings Program.**
Location: 8/11/2022-S. SECOND READING
Calendar: 8/15/2022 #121 SENATE ASSEMBLY BILLS - SECOND READING FILE
Summary: Current law, upon appropriation by the Legislature, requires the Scholarshare Investment Board to establish one or more Scholarshare 529 accounts and make a seed deposit of moneys from the fund into a Scholarshare 529 account established under the KIDS Program in an amount of at least $25, as determined by the board. Specifically, those moneys are deposited in KIDS Accounts, one designated for each California resident child born on or after July 1, 2022. Existing law requires the board to provide awards from these KIDS Accounts, as specified, for each recipient child's qualified higher education expenses at an eligible institution of higher education. This bill, commencing with the 2023–24 fiscal year, would increase the amount of seed deposits in KIDS Accounts to at least $100.

Position
Support

AB 2553 **(Grayson D) Human trafficking Act: California Multidisciplinary Alliance to Stop Trafficking (California MAST).**
Location: 8/2/2022-S. APPR. SUSPENSE FILE
Summary: Would, upon appropriation by the Legislature, establish the California Multidisciplinary Alliance to Stop Trafficking Act (California MAST) to review collaborative models between governmental and nongovernmental organizations for protecting victims and survivors of trafficking, among other related duties. The task force would be comprised of specified state officials or their designees and specified individuals who have expertise in human trafficking or providing services to victims of human trafficking, as specified. The bill would require the task force to hold its first meeting no later than July 1, 2023, and would require the task force to meet at least 4 times. The bill would require the task force to report its findings and recommendations to the Office of Emergency Services, the Governor, the Attorney General, and the Legislature by January 1, 2025. The bill would make related findings and declarations.

Position
Watch

AB 2724 **(Arambula D) Medi-Cal: alternate health care service plan.**
Location: 6/30/2022-A. CHAPTERED
Summary: Current law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services through various delivery systems, including managed care pursuant to Medi-Cal managed care plan contracts. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. This bill would authorize the department to enter into one or more comprehensive risk contracts with an alternate health care service plan (AHCSP), as defined, to serve as a primary Medi-Cal managed care plan for certain eligible beneficiaries in geographic regions designated by the department, as specified. The bill would authorize the department to contract with an AHCSP as a Medi-Cal managed care plan in any geographic region of the state for which federal approval is available, for which the AHCSP maintains appropriate licensure or an approved exemption from the Department of Managed Health Care, and in which the AHCSP already provides commercial coverage in the individual, small group, or large group market.

Position
Watch

AB 2790 **(Wicks D) Reporting of crimes: mandated reporters.**
Location: 8/2/2022-S. APPR. SUSPENSE FILE
Summary: Current law requires a health practitioner, as defined, to make a report to law enforcement when they suspect a patient has suffered physical injury that is either self-inflicted, caused by a firearm, or caused by assaultive or abusive conduct, including elder abuse, sexual assault, or torture. A violation of these provisions is punishable as a misdemeanor.This bill would, on and after January 1, 2024, remove the requirement that a health practitioner make a report to law enforcement when they suspect a patient has suffered physical injury caused by assaultive or abusive conduct.

Position
Watch

AB 2817 **(Reyes D) House California Challenge Program.**
Location: 8/11/2022-S. THIRD READING
Calendar: 8/15/2022 #531 SENATE ASSEMBLY BILLS - THIRD READING FILE
Summary: Would, upon appropriation of funds by the Legislature, establish the House California Challenge Program, to be administered by the department, in partnership with the California Health and Human Services Agency, for the purpose of providing direct rental assistance to help persons who are experiencing homelessness obtain housing. The bill would require the department, upon appropriation of those funds by the Legislature, to allocate $1,000,000,000 for purposes of the program each fiscal year for 5 years, beginning with the 2022–23 fiscal year. The bill would require 10% of the funds to be awarded as grants to recipients, as defined, for the purpose of helping participants locate and obtain permanent housing and would require 80% of the funds to be allocated by the department for specified uses, including long-term rental assistance, master leasing of units, and short-term funds for prevention, self-resolution, and diversion services, as specified. The bill would authorize up to 10% of the funds to be used for administrative costs. Under the bill, and to the extent allowable under federal law, any assistance, services, or supports received pursuant to the program would not be considered income or a resource of the participant for purposes of determining eligibility for, or benefits pursuant to, any public assistance program.

Position
Support

SB 17 **(Pan D) Office of Racial Equity.**
Location: 6/29/2022-A. APPR. SUSPENSE FILE
Calendar: 8/15/2022 #2 ASSEMBLY SECOND READING FILE -- SENATE BILLS
Summary: Would, until January 1, 2029, would establish in state government an Office of Racial Equity, an independent public entity not affiliated with an agency or department, governed by a Racial Equity Advisory and Accountability Council. The bill would authorize the council to hire an executive director to organize, administer, and manage the operations of the office. The bill would task the office with coordinating, analyzing, developing, evaluating, and recommending strategies for advancing racial equity across state agencies, departments, and the office of the Governor. The bill would require the office, in consultation with state agencies, departments, and public stakeholders, as appropriate, to develop a statewide Racial Equity Framework that includes a strategic plan with policy and inclusive practice recommendations, guidelines, goals, and benchmarks to reduce racial inequities, promote racial equity, and address individual, institutional, and structural racism.

Position
Support

SB 907 **(Pan D) Electronic benefits transfer systems: farmers' markets.**
Location: 8/3/2022-A. APPR. SUSPENSE FILE
Calendar: 8/15/2022 #39 ASSEMBLY SECOND READING FILE -- SENATE BILLS
Summary: Would establish the Local, Equitable Access to Food (LEAF) Program and would require, upon an appropriation by the Legislature for these purposes, the Department of Food and Agriculture, with support from the State Department of Social Services, to establish a noncompetitive grant program designed to expand the use of EBT acceptance systems at California certified farmers' markets and tribe-operated farmers' markets on Indian reservations. The bill would, as part of that grant program, require grants to be provided to certified farmers' market operators or farmers' markets operated by tribal governments. The bill would limit the use of grant funds for specified activities relating to expanding the use of EBT acceptance systems at farmers' markets, including, among others, scaling and improving EBT processes at existing certified farmers' markets. The bill would create certain additional requirements for certified farmers' markets that use grant funds to hire an individual, or to contract with a third party, to operate an EBT acceptance system, including a requirement that the person operating the EBT acceptance system be available at all times the certified farmers' market is open to the public.

Position

Support

SB 1145 **(Laird D) California Global Warming Solutions Act of 2006: greenhouse gas emissions: dashboard.**
Location: 6/29/2022-A. APPR. SUSPENSE FILE
Calendar: 8/15/2022 #191 ASSEMBLY SECOND READING FILE -- SENATE BILLS
Summary: The California Global Warming Solutions Act of 2006 requires the State Air Resources Board to prepare and approve a scoping plan for achieving the maximum technologically feasible and cost-effective reductions in greenhouse gas emissions and to update the scoping plan at least once every 5 years. This bill would require the state board to create, and maintain on its internet website, a greenhouse gas emissions dashboard that provides updated publicly available information regarding how the state is progressing toward meeting its statewide climate change goals.

Position
Watch

Workforce

AB 1751 **(Daly D) Workers' compensation: COVID-19: critical workers.**
Location: 8/11/2022-S. THIRD READING
Calendar: 8/15/2022 #470 SENATE ASSEMBLY BILLS - THIRD READING FILE
Summary: Current law creates a disputable presumption that specified injuries sustained in the course of employment of a specified member of law enforcement or a specified first responder arose out of and in the course of the employment. Current law governs the procedures for filing a claim for workers' compensation, including filing a claim form, and provides that an injury is presumed compensable if liability is not rejected within 90 days after the claim form is filed, as specified. Current case law provides for how certain presumptions may be rebutted. Existing law defines "injury" for an employee to include illness or death resulting from the 2019 novel coronavirus disease (COVID-19) under specified circumstances, until January 1, 2023. Current law create a disputable presumption, as specified, that the injury arose out of and in the course of the employment and is compensable, for specified dates of injury. Current law requires an employee to exhaust their paid sick leave benefits and meet specified certification requirements before receiving any temporary disability benefits or, for police officers, firefighters, and other specified employees, a leave of absence. Existing law also make a claim relating to a COVID-19 illness presumptively compensable, as described above, after 30 days or 45 days, rather than 90 days. Current law, until January 1, 2023, allows for a presumption of injury for all employees whose fellow employees at their place of employment experience specified levels of positive testing, and whose employer has 5 or more employees. This bill would extend the above-described provisions relating to COVID-19 until January 1, 2025.

Position
Watch

SB 979 **(Dodd D) Health emergencies.**
Location: 8/8/2022-A. THIRD READING
Calendar: 8/15/2022 #351 ASSEMBLY THIRD READING FILE - SENATE BILLS
Summary: When the Governor declares a state of emergency, existing law requires a health care service plan and a health insurer to provide an enrollee or insured who has been displaced or has the immediate potential to be displaced by that emergency access to medically necessary health care services. Current law requires health care service plans and health insurers operating in a county included in a declaration of emergency to notify the Department of Managed Health Care and the Department of Insurance whether the plan has experienced or expects to experience a disruption to its operation, among other things. Current law provides for health care service plans and health insurers to take specified actions, including relaxing time limits for prior authorization, precertification, or referrals. This bill would revise those provisions to specifically apply to a declaration by the Governor of a state of emergency, or a health emergency declared by the State Public Health Officer, that displaces, or has the immediate potential to displace, enrollees, insureds, or health care providers, that otherwise affects the health of enrollees or insureds, or that otherwise affects or that may affect health care providers. The bill would authorize the Director of the Department of Managed Care and the Insurance Commissioner to issue guidance to health care service plans and health insurers regarding compliance with the bill's requirements during the first 3 years following the declaration of emergency, or until the emergency is terminated, as specified.

Position
Support

Total Measures: 38
Total Tracking Forms: 38

SENATE
CALIFORNIA LEGISLATURE

STATE CAPITOL
SACRAMENTO, CALIFORNIA
95814

Joint Initiative Hearing:

Senate and Assembly Health Committees

Overview of Proposition 29: Requires On-Site Licensed Medical Professional at Kidney Dialysis Clinics and Establishes other State Requirements. Initiative Statute (21-0013)

Monday, August 8, 2022 - 10:30 a.m.
State Capitol, Senate Chambers

Agenda

I. Opening Remarks from Committee Chairs and Members

II. Initiative Overview

Sonja Petek, *Principal Fiscal and Policy Analyst,* Legislative Analyst's Office

III. Supporters

Cecilia Gomez-Gonzalez*, Dialysis Patient Advocate*

Emanuel Gonzales*, Dialysis Patient Care Technician*

Joan Allen*, SEIU-UHW Government Relations Advocate (technical questions only)*

IV. Opponents

DeWayne Cox, *Dialysis Patient, Los Angeles*

Dr. Bryan Wong, *Nephrologist, Oakland*

V. Public Comment

AUGUST 8, 2022

Proposition 29: Requires On-Site Licensed Medical Professional at Kidney Dialysis Clinics and Establishes Other State Requirements. Initiative Statute.

PRESENTED TO:

Senate Committee on Health
Hon. Richard Pan, Chair

Assembly Committee on Health
Hon. Jim Wood, Chair

LEGISLATIVE ANALYST'S OFFICE

LAO Role in Initiative Process

Fiscal Analysis Prior to Signature Collection

- State law requires our office to work with the Department of Finance to prepare a joint impartial fiscal analysis of each initiative before it can be circulated for signatures.
- State law requires that this analysis provide an estimate of the measure's fiscal impact on the state and local governments.
- A summary of the estimated fiscal impact is included on petitions that are circulated for signatures.

Analyses for Qualified Measures

- State law requires our office to provide impartial analyses of all statewide ballot propositions for the statewide voter information guide. This analysis includes a description of the proposition and its fiscal effects.

Background

Dialysis Treatment

- When a person's kidneys no longer function properly, the person either needs a kidney transplant or process called dialysis. Dialysis mimics what healthy kidneys do, filtering out waste and extra fluid from the blood supply.
- Patients typically require three dialysis treatments per week and each treatment typically lasts about four hours.
- Patients most often receive dialysis at clinics. California has about 650 licensed chronic dialysis clinics, which serve roughly 80,000 patients per month.
- A patient's own physician develops and oversees the course of dialysis treatment and must visit the patient at the clinic at least once per month during treatment.
- Various entities own and operate dialysis clinics. Two companies own or operate nearly 75 percent of clinics. Some owners and operators with multiple clinics can use a high-earning clinic to help support a clinic operating at a loss, however, this might not be sustainable in the long term.

Background

(Continued)

Paying for Dialysis

A few main sources pay for dialysis:

- ***Medicare.*** Federal law generally makes people with kidney failure eligible for Medicare coverage regardless of age or disability status. Medicare pays for dialysis treatment for the majority of people on dialysis in California.
- ***Medi-Cal.*** For people enrolled only in Medi-Cal, Medi-Cal alone pays for dialysis. For people who qualify for both Medicare and Medi-Cal, Medicare covers most of the payment for dialysis as the main payer and Medi-Cal covers the rest.
- ***Group and Individual Health Insurance.*** When a person with group or individual insurance develops kidney failure, that person can usually transition to Medicare coverage. Federal law requires a group insurer to be the main dialysis payer for the first 30 months of treatment. Group and individual health insurers typically pay higher rates for dialysis than government programs.

State government, including its two public university systems, and many local governments provide group health insurance for their current workers, eligible retired workers, and their families.

How Chronic Dialysis Clinics Are Regulated

- The California Department of Public Health (CDPH) licenses clinics to operate in California. It also certifies dialysis clinics on behalf of the federal government, which enables clinics to receive Medicare and Medi-Cal payments.
- Federal regulations require each clinic to have a medical director who is a board-certified physician, but do not require medical directors to spend a set amount of time at each clinic. The regulations state that this position generally reflects about one-quarter of a full-time position.
- Dialysis clinics must report infection-related information to the federal government.

Proposal

- ***Requires On-Site Medical Professional.*** Requires each dialysis clinic to have a physician, nurse practitioner, or physician assistant—with at least six months of experience providing care to kidney patients—on-site during all patient treatment hours. If the clinic is in an area with a shortage of these professionals, it can request a one-year exception from CDPH to fulfill the requirement via telehealth.
- ***Requires Regular Reporting by Clinics.*** Requires clinics to regularly report the following information and if they fail to do so, allows CDPH to assess a penalty of up to $100,000:
  - Reporting to CDPH of infection-related information, which must be posted on the CDPH website.
  - Reporting to patients about physicians who own at least 5 percent of the clinic.
  - Reporting to CDPH about persons who own at least 5 percent of the clinic. This information must be posted online by CDPH and the clinic.
- ***Requires CDPH to Consent to a Clinic Closure.*** Clinics must notify and obtain consent from CDPH before closing or substantially reducing services.
- ***Prohibits Clinics From Refusing Care to a Patient Based on Payer.*** Clinics must provide the same quality of care and cannot refuse care to patients based on who pays for their treatment.

Fiscal Effects

Increased Costs for Dialysis Clinics Could Increase Government-Funded Health Care Costs

Increased Costs for Clinics. Having a physician, nurse practitioner, or physician assistant on-site during all patient treatment hours would increase costs for each clinic by several hundred thousand dollars annually on average.

Clinics Generally Would Respond to Higher Costs in Various Ways. We assume clinics generally would respond to the proposition as follows:

- ***Negotiate Increased Rates With Some Payers.*** Clinic owners and operators may be able to negotiate higher rates with private commercial insurance companies and to a lesser extent with Medi-Cal managed care plans, particularly if many clinics were to close otherwise.
- ***Continue Current Operations, With Lower Profits.*** Some owners and operators may continue to operate with reduced income, but without closing any clinics.
- ***Close Some Clinics.*** Some owners and operators may decide to seek consent from CDPH to close some of their clinics that are operating at a loss.

Fiscal Effects

(Continued)

Increased Health Care Costs for State and Local Governments, Likely in the Tens of Millions of Dollars Annually. These clinic responses could increase state Medi-Cal costs and state and local employee and retiree health insurance costs due to:

- Owners and operators negotiating higher payment rates.
- Some patients requiring treatment in costlier settings like hospitals if some clinics closed in response to the proposition's requirements.

We estimate Proposition 29 would lead to increased costs for state and local governments likely in the tens of millions of dollars annually.

Increased CDPH Administrative Costs, Covered by Fees

The cost of CDPH's new regulatory responsibilities imposed by the proposition likely would not exceed the low millions of dollars annually. The proposition requires fees paid by clinics to cover these costs.

LAO

PROPOSITION 29

Requires On-Site Licensed Medical Professional at Kidney Dialysis Clinics and Establishes Other State Requirements. Initiative Statute.

ANALYSIS OF MEASURE

BACKGROUND

Dialysis Treatment

Kidney Failure. Healthy kidneys remove waste and extra fluid from a person's blood. Kidney disease happens when a person's kidneys do not work properly. Over time, a person may develop kidney failure. This means the kidneys no longer work well enough for the person to live without a kidney transplant or ongoing treatment called dialysis.

Dialysis Mimics What a Normal Kidney Does. Dialysis copies what healthy kidneys do. Most people on dialysis undergo hemodialysis. This form of dialysis removes blood from the body, filters it through a machine to remove waste and extra fluid, then returns it to the body. A single treatment lasts about four hours and happens about three times per week.

Most Dialysis Patients Receive Treatment in Clinics. Most people with kidney failure receive dialysis at chronic dialysis clinics (clinics), although some may receive dialysis at hospitals or in their own homes. About 650 licensed clinics in California provide dialysis to roughly 80,000 patients each month. Given how often patients need dialysis and how long treatments last, clinics often offer treatments six days per week and often are open outside of typical business operating hours.

Patient's Own Physician Oversees Treatment. When a patient has kidney failure, the patient's physician develops a plan of care, which could include a referral for dialysis. The physician designs the dialysis treatment plan, including specific aspects such as frequency, duration, and associated medicines. Clinics carry out the treatment. The physician continues to oversee the patient's care. Under federal rules, the physician must visit the patient during dialysis treatment at the clinic at least once per month.

Various Entities Own and Operate Dialysis Clinics. Two private for-profit companies—DaVita, Inc. and Fresenius Medical Care—own or operate nearly 75 percent of licensed clinics in California. A variety of nonprofit organizations and for-profit companies own or operate the other clinics. Most of these other owners and operators have multiple clinics in California, while a small number own or operate a single clinic. In recent years, the majority of clinics' revenues exceed costs, while a smaller

share of clinics operate at a loss. Some owners and operators with multiple clinics can use their higher-earning clinics to help support their clinics that operate at a loss. However, an owner or operator may be less likely to keep an individual clinic open over the longer term if that clinic is likely to keep operating at a loss.

Paying for Dialysis

Few Main Sources Pay for Dialysis. We estimate that clinics have total revenues of around $3.5 billion each year (annually) from their operations in California. These revenues consist of payments for dialysis from a few main sources, or payers:

- ***Medicare*.** This federally funded program provides health coverage to most people ages 65 and older and certain younger people who have disabilities. Federal law generally makes people with kidney failure eligible for Medicare coverage regardless of age or disability status. Medicare pays for dialysis treatment for the majority of people on dialysis in California.
- ***Medi-Cal.*** The federal-state Medicaid program, known as Medi-Cal in California, provides health coverage to eligible low-income California residents. The state and federal governments share the costs of Medi-Cal. Some people qualify for both Medicare and Medi-Cal. For these people, Medicare covers most of the payment for dialysis as the main payer and Medi-Cal covers the rest. For people enrolled only in Medi-Cal, the Medi-Cal program alone pays for dialysis.
- ***Group and Individual Health Insurance.*** Many people in the state have group health insurance coverage through an employer or another organization (such as a union). Other people purchase health insurance individually. When an insured person develops kidney failure, that person can usually transition to Medicare coverage. Federal law requires a group insurer to be the main payer for dialysis treatment for the first 30 months of treatment.

The California state government, the state's two public university systems, and many local governments in California provide group health insurance coverage for their current workers, eligible retired workers, and their families.

Group and Individual Health Insurers Typically Pay Higher Rates for Dialysis Than Government Programs. The rates that Medicare and Medi-Cal pay for a dialysis treatment are fairly close to the average cost for clinics to provide a dialysis treatment. Government regulations largely decide what these rates are. In contrast, group and individual health insurers negotiate with clinic owners and operators to set rates. On average, group and individual health insurers pay multiple times what government programs pay for a dialysis treatment.

How Chronic Dialysis Clinics Are Regulated

California Department of Public Health (CDPH) Licenses and Certifies Dialysis Clinics. CDPH licenses clinics to operate in California. CDPH also certifies clinics on behalf of the federal government. Certification allows clinics to receive payment from Medicare and Medi-Cal. Currently, California relies primarily on federal regulations as the basis for its licensing program.

Federal Regulations Require a Medical Director at Each Dialysis Clinic. Federal regulations require each clinic to have a medical director who is a board-certified physician. The medical

director is responsible for quality assurance, staff education and training, and development and implementation of clinic policies and procedures. Federal regulations do not require medical directors to spend a set amount of time at the clinic. Federal guidelines, however, consider the position to reflect about one-quarter of a full-time position.

Dialysis Clinics Must Report Infection-Related Information to a National Network. To receive payments from Medicare, clinics must report specific dialysis-related infection information to the National Healthcare Safety Network at the federal Centers for Disease Control and Prevention. For example, clinics must report when a patient develops a bloodstream infection and the suspected cause of the infection.

PROPOSAL

Proposition 29 includes several requirements affecting clinics, as discussed below. It gives duties to CDPH to implement and administer the proposition, including adopting regulations within one year after the law takes effect.

Requires Each Dialysis Clinic to Have a Physician, Nurse Practitioner, or Physician Assistant On-Site During All Treatment Hours. Proposition 29 requires each clinic to have, at its expense, at least one physician, nurse practitioner, or physician assistant on-site during all the hours patients receive treatments at that clinic. This individual must have at least six months of experience providing care to kidney patients and is responsible for patient safety and the provision and quality of medical care. A clinic may ask CDPH to grant an exception from this requirement if there are not enough physicians, nurse practitioners, or physician assistants in the clinic's area. If CDPH approves the exception, the clinic can meet the requirement through telehealth. The exception lasts for one year.

Requires Dialysis Clinics to Report Infection-Related Information to CDPH. Proposition 29 requires clinics to report dialysis-related infection information to CDPH every three months. CDPH must specify which information clinics should report, and how and when to report the information. CDPH must post each clinic's infection information on the CDPH website, including the name of the clinic's owner or operator.

Requires Dialysis Clinics to Say Who Its Owners Are. Proposition 29 requires a clinic to give patients a list of all physicians who own at least 5 percent of the clinic. The clinic must give a patient this list when the patient is starting treatment, each year after that, or any time a patient (or potential patient) asks for it. The proposition also requires clinics to report to CDPH every three months persons who own at least 5 percent of the clinic. Both CDPH and clinics (or their owners or operators) must post this information on their websites.

Charges Penalties if Dialysis Clinics Do Not Report Required Information. If a clinic or its owner or operator does not report required information or reports inaccurate information, CDPH may issue a penalty of up to $100,000 against the clinic. The clinic may request a hearing if it disagrees with the penalty. Any penalties collected would be used by CDPH to implement and enforce laws concerning clinics.

Requires Dialysis Clinics to Notify and Obtain Consent From CDPH Before Closing or Substantially Reducing Services. If a clinic plans to close or substantially reduce its services, Proposition 29 requires the clinic or its owner or operator to notify CDPH in writing and obtain

CDPH's written consent. The proposition allows CDPH to determine whether or not to consent. It allows CDPH to base its decision on such information as the clinic's financial resources and the clinic's plan for making sure patients have uninterrupted dialysis care. A clinic may dispute CDPH's decision by requesting a hearing.

Prohibits Dialysis Clinics From Refusing Care to a Patient Based on Who Is Paying for the Patient's Treatment. Under Proposition 29, clinics are required to offer the same quality of care to all patients. Clinics cannot refuse to offer or provide care to patients based on who pays for patients' treatments. The payer could be the patient, a private entity, the patient's health insurer, Medi-Cal, or Medicare.

FISCAL EFFECTS

Increased Costs for Dialysis Clinics Affect State and Local Costs

Proposition 29 Increases Costs for Dialysis Clinics. Overall, the proposition would increase costs for clinics. In particular, the proposition's requirement that each clinic have a physician, nurse practitioner, or physician assistant on-site during all treatment hours would increase each clinic's costs by several hundred thousand dollars annually on average. Other requirements of the proposition would not significantly increase clinic costs.

Clinics Could Respond to Higher Costs in Different Ways. The cost to have a physician, nurse practitioner, or physician assistant on-site would affect individual clinics differently depending on their finances. For example, the additional cost could cause some clinics to operate at a loss, or at a greater loss than previously. As noted earlier, an owner or operator might be able to support these clinics with its higher-earning clinics. However, the owner or operator might not be willing or able to do this over the longer term. Owners and operators might respond to Proposition 29 in one or more of the following ways:

- ***Negotiate Increased Rates With Payers.*** Owners and operators might try to negotiate higher rates from payers to cover some of the costs. Specifically, owners and operators may be able to negotiate higher rates with private commercial insurance companies and, to a lesser extent, with Medi-Cal managed care plans.
- ***Continue Current Operations, but With Lower Profits.*** For some owners and operators, the higher costs would reduce their profits, but they still could operate at current levels without closing clinics.
- ***Close Some Clinics.*** Given the higher costs a clinic would face, some owners and operators may decide to seek consent from CDPH to close some of their clinics that are operating at a loss.

Proposition 29 Could Increase Health Care Costs for State and Local Governments. Under the proposition, state Medi-Cal costs, and state and local employee and retiree health insurance costs, could increase due to:

- Owners and operators negotiating higher payment rates.

- Some patients requiring treatment in costlier settings like hospitals if some clinics closed in response to the proposition.

Overall, we assume that clinic owners and operators generally would: (1) be able to negotiate with some payers to receive higher payment rates to cover some of the new costs imposed by the proposition, particularly if many clinics were to close otherwise; (2) continue to operate some clinics with reduced income; and (3) close some clinics, with the consent of CDPH. This scenario would lead to **increased costs for state and local governments likely in the tens of millions of dollars annually.** (State and local governments currently spend more than $65 billion on Medi-Cal and employee and retiree health coverage.) This amount is less than one-half of 1 percent of the state's total General Fund spending. (The General Fund is the state's main operating account, which pays for education, prisons, health care, and other public services.)

In the less likely event that a relatively large number of clinics would close due to this proposition, having obtained consent from CDPH, state and local governments could have additional costs in the short run. These additional costs are highly uncertain.

Increased Administrative Costs for CDPH Covered by Dialysis Clinic Fees

Proposition 29 imposes new regulatory responsibilities on CDPH. The annual cost of these new responsibilities likely would not exceed the low millions of dollars annually. The proposition requires CDPH to adjust the annual licensing fee paid by clinics to cover these costs.

YES/NO STATEMENT

A **YES** vote on this measure means: Chronic dialysis clinics would be required to have a physician, nurse practitioner, or physician assistant on-site during all patient treatment hours.

A **NO** vote on this measure means: Chronic dialysis clinics would not be required to have a physician, nurse practitioner, or physician assistant on-site during all patient treatment hours.

SUMMARY OF LEGISLATIVE ANALYST'S ESTIMATE OF NET STATE AND LOCAL GOVERNMENT FISCAL IMPACT

- Increased state and local government costs likely in the tens of millions of dollars annually.

BALLOT LABEL

Fiscal Impact: Increased state and local government costs likely in the tens of millions of dollars annually.

August 25, 2021

Direct: (213) 452-6576

Anabel Renteria
Initiative Coordinator
Office of the Attorney General
1300 I Street, 17th Floor
Sacramento, CA 95814-2919

Re: **Request for Circulating Title and Summary**
"Protect the Lives of Dialysis Patients Act"

Dear Ms. Renteria:

We serve as counsel for the proponents of the enclosed proposed statewide initiative, the "Protect the Lives of Dialysis Patients Act (2022)." The proponents of the proposed initiative are:

- Sean Fleming
- Jonathan Everhart

On their behalf, I am enclosing the following documents:

- Proponents' Request for Circulating Title and Summary
- Proponent certifications pursuant to Elections Code section 9001(b)
- Proponent certifications pursuant to Elections Code section 9608
- A check in the amount of $2,000.00
- Text of the "Protect the Lives of Dialysis Patients Act (2022)" Initiative

All inquiries or correspondence relative to this proposed initiative, should be directed to:

George M. Yin
Kaufman Legal Group
777 S. Figueroa Street, Suite 4050
Los Angeles, CA 90017
Tel: (213) 452-6565

If you have any questions, please do not hesitate to contact me.

Very truly yours,

George Yin

George M. Yin

Enclosures

August 24, 2021

Anabel Renteria
Initiative Coordinator
Office of the Attorney General
P.O. Box 944255
Sacramento, CA 94244-2550

Re: Request for Title and Summary for Proposed Initiative

Dear Ms. Renteria:

Pursuant to Article II, Section 10(d) of the California Constitution, I submit the attached proposed Initiative, entitled "Protect the Lives of Dialysis Patients Act (2022)," to your office and request that your office prepare a title and summary. Included with this submission is the required proponent certifications pursuant to sections 9001 and 9608 of the California Elections Code, along with a check for $2,000.00.

All inquiries or correspondence relative to this initiative should be directed to George Yin at Kaufman Legal Group, APC, 777 S. Figueroa St., Suite 4050, Sacramento, CA, (213) 452-6576.

Thank you for your assistance.

Very truly yours,

SEAN FLEMING

JONATHAN EVERHART

This initiative measure is submitted to the People in accordance with the provisions of Article II, Section 8, of the California Constitution.

This initiative measure adds sections to the Health and Safety Code; therefore, new provisions proposed to be added are printed in *italic* type to indicate that they are new.

SEC. 1. Name

This Act shall be known as the "Protect the Lives of Dialysis Patients Act."

SEC. 2. Findings and Purposes

This Act, adopted by the People of the State of California, makes the following Findings and has the following Purposes:

A. The People make the following findings:

(1) Kidney dialysis is a life-saving process in which blood is removed from a patient's body, cleaned of toxins, and then returned to the patient. It must be done at least three times a week for several hours a session, and the patient must continue treatment for the rest of their life or until they can obtain a kidney transplant.

(2) In California, nearly 80,000 people undergo dialysis treatment.

(3) Just two multinational, for-profit corporations operate or manage nearly three-quarters of dialysis clinics in California and treat more than 75 percent of dialysis patients in the state. These two multinational corporations annually earn billions of dollars from their dialysis operations, including close to $450 million a year in California alone.

(4) Studies have found that compared to patients at non-profit dialysis clinics, patients at for-profit clinics are less likely to get kidney transplants, more likely to be hospitalized, and more likely to die.

(5) Many dialysis clinics are operated as joint ventures between for-profit corporations and physicians. A physician who owns a stake in a dialysis clinic may also be serving as the kidney patient's primary doctor, creating a potential conflict of interest. More transparency is necessary for researchers to study the impact of physician ownership on patient care and whether these ownership interests influence decisions regarding dialysis care approaches, patients' choice of clinics, and when to start or discontinue dialysis.

(6) Dialysis patients can make better decisions about their own care when they are informed about whether their physician has an ownership interest in the clinic where they receive dialysis.

(7) The dialysis procedure and side effects from the treatments present several dangers to patients, and many dialysis clinics in California have been cited for failure to maintain proper standards of care. Failure to maintain proper standards can lead to patient harm, hospitalizations, and even death.

(8) Dialysis clinics are currently not required to maintain a doctor or other advanced practitioner on site to oversee quality, ensure the patient plan of care is appropriately followed, and monitor safety protocols. Patients should have access to a physician or advanced practitioner on site whenever dialysis treatment is being provided.

(9) Dialysis treatments involve direct access to the bloodstream, which puts patients at heightened risk of getting dangerous infections. Proper reporting and transparency of infection rates encourages clinics to improve quality and helps patients make the best choice for their care.

(10) When health care facilities like hospitals and nursing homes close, California regulators are able to take steps to protect patients from harm. Likewise, strong protections should be provided to vulnerable patients when dialysis clinics close.

(11) Dialysis corporations have lobbied against efforts to enact protections for kidney dialysis patients in California, spending over $100 million in 2020 to influence California voters.

B. Purposes:

This Act is intended to:

(1) ensure that outpatient kidney dialysis clinics provide quality and affordable patient care to people suffering from end-stage renal disease;

(2) provide the government information it needs to supervise dialysis clinics to ensure all dialysis clinic owners and physicians provide patients with appropriate care;

(3) provide dialysis patients with information about dialysis clinics and physicians' financial interests so patients can make informed choices about their care; and

(4) be budget neutral for the State to implement and administer.

SEC. 3. Section 1226.7 is added to the Health and Safety Code, to read:

1226.7. (a) Chronic dialysis clinics shall provide the same quality of care to their patients without discrimination on the basis of who is responsible for paying for a patient's treatment. Further, chronic dialysis clinics shall not refuse to offer or to provide care on the basis of who is responsible for paying for a patient's treatment. Such prohibited discrimination includes, but is not limited to, discrimination on the basis that a payer is an individual patient, private entity, insurer, Medi-Cal, Medicaid, or Medicare. This section shall also apply to a chronic dialysis clinic's governing entity, which shall ensure that no discrimination prohibited by this section occurs at or among clinics owned or operated by the governing entity.

(b) For purposes of this section, the following definitions shall apply:

(1) "Chronic dialysis clinic" has the same meaning as in Section 1204.

(2) "Governing entity" means a person, firm, association, partnership, corporation, or other entity that owns or operates a chronic dialysis clinic for which a license has been issued, without respect to whether the person or entity itself directly holds that license.

SEC. 4. Section 1226.8 is added to the Health and Safety Code, to read:

1226.8. (a) Every chronic dialysis clinic must maintain, at the chronic dialysis clinic's expense, at least one licensed physician, nurse practitioner, or physician assistant present on site during all times that in-center dialysis patients are being treated. This on-site clinician shall have authority and responsibility over patient safety and to direct the provision and quality of medical care.

(1) The physician, nurse practitioner, or physician assistant present on site shall have at least 6 months of experience providing care to patients with end-stage renal disease.

(2) A chronic dialysis clinic may apply to the department for an exception to the requirement in subdivision (a) on the grounds that a bona fide shortage of qualified physicians, nurse practitioners, or physician assistants prevents it from satisfying the requirement. Upon such a showing, the department may grant an exception that permits the clinic to satisfy the requirement in subdivision (a) by having at minimum, at the chronic dialysis clinic's expense, a physician, nurse practitioner, or physician assistant available to provide care through telehealth at all times that in-center dialysis patients are being treated, provided that the telehealth clinician has at least 6 months of experience providing care to patients with end-stage renal disease.

(3) The duration of an exception granted by the department pursuant to paragraph (2) shall be one calendar year from the date the clinic is notified of the department's determination.

(b) For each chronic dialysis clinic, the clinic or its governing entity shall quarterly report to the department, on a form and schedule prescribed by the department, dialysis clinic health care associated infection ("dialysis clinic HAI") data, including the incidence and type of dialysis clinic HAIs at each chronic dialysis clinic in California and such other information as the department shall deem appropriate to provide transparency on dialysis clinic HAI infection rates and promote patient safety. The chief executive officer or other principal officer of the clinic or governing entity shall certify under penalty of perjury that he or she is satisfied, after review, that the dialysis clinic HAI report submitted to the department is accurate and complete. The department shall post on its website the dialysis clinic HAI data from this report, at the same level of detail as provided in the report. The posted information shall include information identifying the governing entity of each chronic dialysis clinic.

(c) A chronic dialysis clinic shall provide to patients a list of physicians who have an ownership interest or indirect ownership interest in the clinic totaling 5 percent or more. Disclosure of this information must be in writing and must be provided to patients when they begin receiving treatment at the clinic, annually thereafter, and at any other time at the patient's request, as well as to prospective patients at their request.

(1) For each chronic dialysis clinic, the clinic or its governing entity shall quarterly report to the department, on a form and schedule prescribed by the department, persons with an ownership interest or indirect ownership interest in the clinic totaling 5 percent or more, including percentage of ownership interest and nature of ownership interest. The department shall post on its website the forms submitted for each chronic dialysis clinic.

(2) For each chronic dialysis clinic, the governing entity shall post on its website the ownership form as submitted to the department.

(d) In the event the department determines that a chronic dialysis clinic or governing entity failed to maintain the information or timely submit a report required under this section, or that the report submitted was inaccurate or incomplete, the department shall assess a penalty against the chronic dialysis clinic or governing entity not to exceed one hundred thousand dollars ($100,000). The department shall determine the amount of the penalty based on the severity of the violation, the materiality of the inaccuracy or omitted information, and the strength of the explanation, if any, for the violation. Penalties collected pursuant to this paragraph shall be used by the department to implement and enforce laws governing chronic dialysis clinics.

(e) For purposes of this section, the following definitions shall apply:

(1) "Chronic dialysis clinic" has the same meaning as in Section 1204.

(2) "Dialysis clinic HAI" means a bloodstream infection, local access site infection, or vascular access infection related to a dialysis event as defined by the National Healthcare Safety Network of the federal Centers for Disease Control and Prevention, or any appropriate additional or alternative definition that the department defines by regulation.

(3) "Governing entity" has the same meaning as in Section 1226.7.

(4) "Licensed physician" means a nephrologist or other physician licensed by the state pursuant to Chapter 5 of Division 2 of the Business and Professions Code.

(5) "Indirect ownership interest" means an ownership interest in a person or entity that has an ownership interest in the chronic dialysis clinic. This term includes an ownership interest in any person or entity that has an indirect ownership interest in the chronic dialysis clinic.

(6) "Nurse practitioner" means a registered nurse licensed pursuant to Chapter 6 of Division 2 of the Business and Professions Code and certified as a nurse practitioner by the Board of Registered Nursing.

(7) "Ownership interest" means an interest through equity, debt, or other means, including the possession of equity in the capital, stock, or profits of a chronic dialysis clinic; an interest in the revenue of a chronic dialysis clinic; partnership shares; limited liability company memberships; or an interest in any mortgage, deed of trust, note, or other obligation secured by a chronic dialysis clinic.

(8) "Person" means a natural person, firm, association, organization, partnership, business trust, company, joint stock company, corporation, limited liability company, joint venture, or other organizations of persons.

(9) "Physician assistant" means a physician assistant licensed pursuant to Chapter 7.7 of Division 2 of the Business and Professions Code.

SECTION 5. Section 1226.9 is added to the Health and Safety Code, to read:

1226.9. (a) Prior to closing a chronic dialysis clinic, or substantially reducing or eliminating the level of services provided by a chronic dialysis clinic, the clinic or its governing entity must provide written notice to, and obtain the written consent of, the department.

(b) The department shall have discretion to consent to, give conditional consent to, or not consent to, any proposed closure or substantial reduction or elimination of services. In making its determination, the department may take into account information submitted by the clinic, its governing entity, and any other interested party, and shall consider any factors that the department considers relevant, including, but not limited to, the following:

(1) The effect on the availability and accessibility of health care services to the affected community, including but not limited to the clinic's detailed plan for ensuring patients will have uninterrupted access to care.

(2) Evidence of good faith efforts by the clinic or governing entity to sell, lease, or otherwise transfer ownership or operations of the clinic to another entity that would provide chronic dialysis care.

(3) The financial resources of the clinic and its governing entity.

(c) For purposes of this section, the following definitions shall apply:

(1) "Chronic dialysis clinic" has the same meaning as in Section 1204.

(2) "Governing entity" has the same meaning as in Section 1226.7.

SEC. 6. Section 1226.10 is added to the Health and Safety Code, to read:

1226.10. (a) If a chronic dialysis clinic or governing entity disputes a determination by the department pursuant to Sections 1226.8 or 1226.9, the chronic dialysis clinic or governing entity may, within 10 working days, request a hearing pursuant to Section 131071. A chronic dialysis clinic or governing entity shall pay all administrative penalties when all appeals have been exhausted if the department's position has been upheld.

(b) For purposes of this section, the following definitions shall apply:

(1) "Chronic dialysis clinic" has the same meaning as in Section 1204.

(2) "Governing entity" has the same meaning as in Section 1226.7.

SEC. 7. Section 1266.3 is added to the Health and Safety Code, to read:

1266.3. It is the intent of the People that California taxpayers not be financially responsible for implementation and enforcement of the Protect the Lives of Dialysis Patients Act. In order to effectuate that intent, when calculating, assessing, and collecting fees imposed on chronic dialysis clinics pursuant to Section 1266, the department shall take into account all costs associated with implementing and enforcing Sections 1226.7 through 1226.10.

SEC. 8. Nothing in this Act is intended to affect health facilities licensed pursuant to subdivision (a), (b), or (f) of Section 1250 of the Health and Safety Code.

SEC. 9. (a) The State Department of Public Health is authorized to and, within one year following the Act's effective date, shall adopt regulations implementing Sections 1226.8 and 1226.9 of the Health and Safety Code to further the purposes of this Act.

(b) If the Department is unable to adopt the required final regulations within one year following the Act's effective date, the adoption of emergency implementing regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare, in which case the Department shall adopt initial emergency implementing regulations no later than one year following the Act's effective date, or as soon thereafter as is practicable. If such emergency regulations are adopted, the Department shall adopt the required final regulations by the time the emergency regulations expire.

SEC. 10. Pursuant to subdivision (c) of Section 10 of Article II of the California Constitution, this Act may be amended either by a subsequent measure submitted to a vote of the People at a statewide election; or by a statute validly passed by the Legislature and signed by the Governor, but only to further the purposes of the Act.

SEC. 11 (a) In the event that this initiative measure and another initiative measure or measures relating to the regulation of chronic dialysis clinics or the treatment and care of dialysis patients appear on the same statewide election ballot, the other initiative measure or measures shall be deemed to be in conflict with this measure. In the event that this initiative measure receives the highest number of affirmative votes, the provisions of this measure shall prevail in their entirety, and the provisions of the other initiative measure or measures shall be null and void.

(b) If this initiative is approved by the voters but superseded in whole or in part by any other conflicting ballot measure approved by the voters at the same election, and such conflicting measure is later held invalid, this measure shall be self-executing and given full force and effect.

SEC. 12. The provisions of this Act are severable. If any provision of this Act or its application is held invalid, that invalidity shall not affect the remaining portions of this Act or any application that can be given effect without the invalid provision or application. The People of the State of California hereby declare that they would have adopted this Act and each and every portion, section, subdivision, paragraph, clause, sentence, phrase, word, and application not declared invalid or unconstitutional without regard to whether any portion of this Act or application thereof would be subsequently declared invalid.

- **Quality of care will improve, lowering costs for payers and improving outcomes for dialysis patients.**
- **Dialysis clinics will absorb the costs of meeting the onsite clinician requirement, without clinic closures.**
- **Medi-Cal, Medicare, and commercial payer costs will likely not increase.**

Key provisions of the Protect the Lives of Dialysis Patients Act

Clinics Prohibited from Discriminating Against Patients Based on Payer

Insurance-based discrimination is unfortunately common in healthcare and has been associated with patients being denied care or receiving suboptimal care.[i]

Current law does not protect patients seeking dialysis care from discrimination based on type of payor. The fact that private insurers reimburse dialysis clinics at much higher rates than Medicare and Medicaid[ii] raises concerns that clinics will turn away or otherwise discriminate against patients who are less profitable, especially as higher quality of care standards such as those this Act would require are implemented for clinics. Discrimination may include refusing to treat a patient, moving a patient to a less preferable time slot, or providing inferior care to certain patients based on their payor. For example, workers have described clinics giving preference to commercial patients over Medi-Cal and Medicare patients when choosing dialysis shifts.

More Transparency Around Ownership and Physician Joint Ventures

Increasingly, physicians have direct financial interests in clinics through joint ventures with dialysis clinics' governing entities.[iii] Nephrologists with a financial interest in a dialysis clinic may have an incentive to "cherry-pick" patients in better health for their own clinic while avoiding referring patients that are socioeconomically disadvantaged or otherwise high risk. Nephrologists who are joint venture partners may also have an incentive to start a patient earlier on dialysis rather than conservatively manage the disease, or may promote in-center hemodialysis over home dialysis or transplantation. These potential conflicts of interest may influence patients' ability to make informed decisions about their care.[iv]

Reliable and accurate information on joint venture partnerships in the dialysis industry is currently difficult to obtain, both from federal and state regulators. Academic researchers have tried unsuccessfully in the past to obtain comprehensive information through Freedom of Information Act requests,[v] and lack of information has hindered research into the costs and benefits of joint venture arrangements.[vi]

Requiring clinics to disclose to patients the names of physician owners of clinics will provide patients and prospective patients with information about whether the physician(s) directing their care have a significant financial interest in the chronic dialysis clinic, which may better enable these patients to make informed healthcare choices. Requiring clinics to report standardized, comprehensive information on ownership to the Department of Public Health ("DPH") and publicly on their websites will provide

valuable information to stakeholders beyond the clinics' and physicians' patients – including payors, regulators, and researchers.

Maintaining Physicians or Other Advanced Practitioners Onsite During Treatment Hours Will Improve Quality of Care

Under the Act, the onsite clinician has "authority and responsibility over patient safety and to direct the provision and quality of medical care." The sponsors expect that DPH may further define or provide regulatory guidance regarding the onsite clinicians' responsibilities. Generally, the sponsors expect that the onsite clinician will supervise other staff to ensure patients receive high-quality care, which may include working closely with patients' care teams, monitoring quality improvement activities and safety measures, and assisting with medical emergencies. This will benefit patients by providing physicians or other advanced practitioners with "greater opportunities to improve patient communication and build trust, monitor treatments, and detect new medical problems."[vii]

Dialysis Patients Experience High Levels of Complications, Hospitalizations and Emergency Visits

Better patient outcomes will lead to savings for payors and will increase capacity elsewhere in the healthcare system. Dialysis patients are at high risk for complications such as infections and cardiovascular disease which result in emergency department visits, hospitalizations, and death. In 2019, Medicare patients receiving dialysis in California visited the emergency room almost 90,000 times, and 45 percent of those visits resulted in hospitalization.[viii] By contrast, 29 percent of emergency department visits by Medicare patients in the general population resulted in admissions.[ix] Moreover, Medicare patients receiving dialysis in California had on average two hospital admissions per year and spent 12 days in the hospital.[x] This rate of hospitalization is much higher than the general Medicare population in California, which had on average 0.1 hospital stays per year and spent on average 2 days in the hospital per year.[xi]

Patients with ESRD are immunocompromised and at increased risk of infection. The invasive nature of dialysis heightens this risk. For example, patients commonly develop chills and fever after onset of dialysis and should be assessed for infection. It is recommended that patients undergo a physical examination to check for signs and symptoms of infection, and to identify the source of the infection. Patients would ideally be given antibiotics as soon as possible.[xii] Patients in this and similar scenarios could be more quickly assessed and appropriately treated when an advanced clinician is present onsite at all times during treatment hours.

California Dialysis Clinics Generally Operate 18 to 24 Treatment Shifts Per Week, and Medical Director Presence is Minimal

California dialysis clinics typically perform three treatment shifts a day for three to four hours per shift,

six days per week. Out of 650 licensed clinics, 146 perform a late shift.[xiii] Assuming a clinic without a late shift is open 6 days per week for 12 hours per day, and a clinic with a late shift is open 6 days per week for 16 hours per day, California clinics are open an average of approximately 77 hours per week.

Currently clinics are required by CMS to have a medical director who has completed a board-approved training program in nephrology and has at least 12 months of experience providing care to patients receiving dialysis.[xiv] In addition, clinics must have a nurse manager who is an RN with at least 12 months of experience in clinical nursing, and an additional 6 months of experience in providing nursing care to patients on maintenance dialysis.[xv] A typical clinic is staffed by patient care technicians who are supervised by a charge nurse.

We understand that medical directors typically spend time at clinics only when they briefly attend (or "round with") their own patients or attend meetings. Meeting attendance varies by clinic and medical director –for example, some medical directors may attend each weekly and monthly team meeting while others do not. The total time spent rounding with patients also varies – the medical director may be the nephrologist for most of the clinic's patients, or for just a few or none at all.

Evidence Links Physician-Patient Contact to Quality Outcomes

Studies have linked frequency of physician contact with better quality of care and lower mortality rates for dialysis patients.

1. More patient-doctor contact during hemodialysis treatments is associated with lower patient mortality and fewer hospitalizations.[xvi]
2. More frequent physician visits following hospital discharge are estimated to reduce rehospitalizations in patients undergoing hemodialysis.[xvii]
3. Japan, which has one of the best survival rates in the world for patients on dialysis, requires a patient to be seen by a doctor at every dialysis session.[xviii]
4. Patient-physician contact during every dialysis session is associated with achieving clinical targets.[xix]

Nurse Practitioners and Physician Assistants Onsite Will Also Improve Patient Outcomes

Advanced practitioners such as Nurse Practitioners ("NPs") and Physician Assistants ("PAs") play an important role in dialysis and nephrology care. These types of advanced practitioners often round with patients in dialysis clinics and may have responsibilities including patient assessment, helping to design care plans, and management of treatment and medication.[xx] Studies show that nurse practitioners, working in collaboration with a nephrologist or general practitioner, have positive impacts on outcomes of patients with chronic kidney disease.[xxi]

Nurse Practitioners and Physician Assistants in California are supervised by and work in collaboration with a physician who determines their scope of practice.[xxii] We anticipate the specific duties of a PA or NP fulfilling the requirements of the Act will depend upon the procedures of the clinic and the

relationship between the NP or PA and their medical director or other supervising position but that they will be able to fulfill all the requirements of the Act, including patient assessment, real-time response to patient needs, and having "authority and responsibility over patient safety and to direct the provision and quality of medical care." The Act is also drafted with adequate flexibility to take account of the ways California regulations over these practitioners' scope of practice may develop in future.

Dialysis Clinics Will Absorb the Costs of Maintaining Clinicians Onsite and Clinic Closures in Response to the Act Are Not Anticipated

Our analysis is that dialysis clinics are likely to be able to minimize or even eliminate any additional costs of the Act's requirement that a physician or other advanced practitioner be onsite while patients are being dialyzed, including in the following ways.

Nephrology Practices and Medical Directors Could Play a More Active Role in Clinics

First, nephrologists who are financially interested in chronic dialysis clinics through joint ventures and medical directorships may spend more time onsite at the clinic as a way to reduce costs. Governing entities can reduce the costs of having an onsite physician by contractually requiring the medical director to be onsite during the 25% of a standard workweek that they are expected to spend on their clinic-related duties. Alternatively, clinics could require the medical director to work full-time at the clinic.

Nephrology practices often already employ NPs or PAs – between 2004 and 2013, 75% of nephrology practices added an advanced practitioner.[xxiii] Practices that own clinics and employ NPs and PAs may structure these clinicians' work in a way that meets the requirements of the Act.

Clinics May Earn More Through Better Quality Ratings

Second, clinics with physicians onsite are likely to be able to improve payments through improving quality. CMS' ESRD Quality Improvement Program (QIP) links facility payment to performance on quality improvement measures. CMS calculates a Total Performance Score based on scores for individual quality measures. Clinic payments are reduced by up to 2% for the year if the Total Performance Score does not meet or exceed performance standards.[xxiv] Performance measures include indicators for hospitalization, dialysis adequacy, bloodstream infections, ultrafiltration rate, and other measures.[xxv] For the 2021 payment year, 234 of 598 California dialysis clinics received payment reductions between 0.5% and 2% because they did not meet minimum quality targets.[xxvi]

Clinics Spread Costs Between High and Low Earning Facilities

Third, as noted in the LAO's initial analysis of the 2020 "Protect the Lives of Dialysis Patients Act", the large dialysis companies---as "governing entities"—can absorb negative operating margins at individual clinics.

Dialysis clinics are unlikely to close in response to the Act, as the LAO recognized in its 2020 analysis,

because the more clinics that a governing entity operates the greater its market power. For example, it is our understanding from conversations with payers that DaVita engages in all-or-nothing contracting in which plans are required to contract with all or a group of the company's clinics, even if there are lower-priced alternatives in the market.

A State Approval Process Before Dialysis Clinics Close or Substantially Reduce Services Is Appropriate

The Act will require that CDCs obtain written consent from DPH before closing or substantially reducing or eliminating services. In making its decision about whether to approve a closure or reduction in services, the Department may consider any factors it deems relevant, including 1) the impact on access to dialysis treatment for the clinic's patients, 2) efforts by the current owner to transfer ownership of the clinic in order to maintain adequate access to care for patients, and 3) the financial status of the clinic and its governing entity.

The closure notice and approval requirement will ensure that there is a process to protect patient welfare by giving DPH authority to intervene if a dialysis company decides to reduce or eliminate services without considering the impact on patients' welfare. While the proponent is not aware of other California statutes that require state approval before closing a medical facility or other business, there are other laws that ensure the state can act to protect vulnerable patients' continuity of care, such as the long-term health care facility receivership process.[xxvii] The Act's closure approval process is also consistent with approaches taken by other states that require approval by a state agency before certain health care facilities can close or cut services. For example, many types of medical facilities in New York must obtain the Department of Health's approval before closing.[xxviii] Similarly, hospitals and other health facilities in a number of other states, including Connecticut, Illinois, Rhode Island, and New Jersey, require approval by their state departments of health or other state agencies before closing pursuant to their Certificate of Need (CON) programs.[xxix]

The proponent drafted the initiative to ensure that CDPH has the flexibility not only to determine what factors it will consider when making determinations about proposed closures and reductions in service, but what processes it will follow when making such determinations. For example, the Department may choose to establish an appeal process that would permit it to review its original determination and consider additional information submitted by the clinic or governing entity.

The Act is Not Likely to Increase Costs to State and Local Governments

In the private market, reimbursements are determined by market power, not patient care costs. Dialysis clinics which operate in a concentrated, uncompetitive market,[xxx] already maximize revenue with commercial insurers, who pay on average almost four times the cost of a treatment.[xxxi] Thus, we believe that CalPERS and other commercial insurance rates paid by state and local governments will not increase in response to the ballot initiative.

We do not expect Medicare reimbursement rates to change in the near future in response to the initiative. Adjustments to the wage index for the ESRD PPS per treatment amount must be budget neutral,[xxxii] therefore an increase in California reimbursement rates would require a decrease elsewhere.

Furthermore, the ESRD PPS wage index is based on the hospital wage index,[xxxiii] which will not change in response to the initiative. Prices paid by Medicare Advantage plans are linked closely to traditional Medicare rates and we don't expect the initiative to change this dynamic.[xxxiv] [xxxv]

Finally, we do not expect Medi-Cal reimbursement rates to increase. Our understanding is that dialysis fee-for-service rates have not meaningfully increased since at least the year 2001, despite numerous regulatory changes (such as substantial increases to the minimum wage). The dialysis clinics have not negotiated higher rates despite their substantial market power, and nothing in the Act would provide increased negotiating power to the dialysis clinics.

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[i] Han X., Call K.T., Pintor J.K., Alarcon-Espinoza G., Simon A.B., Reports of insurance-based discrimination in health care and its association with access to care. Am J Public Health. 2015;105 Suppl 3(Suppl 3):S517-S525. doi:10.2105/AJPH.2015.302668 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4455519/

[ii] Childers C, et al., A Comparison of Payments to a For-profit Dialysis Firm From Government and Commercial Insurers. JAMA Internal Medicine. August 2019. Volume 176 Number 8.

[iii] https://www.davita.com/physicians/partnerships/joint-ventures-acquisitions (DaVita more than doubled the number of joint venture clinics from 2008 to 2018).

[iv] Glickman A., Lin E., Berns J.S., Conflicts of interest in dialysis: A barrier to policy reforms. Semin Dial. 2020;33(1):83-89. doi:10.1111/sdi.12848

[v] J.S. Berns et al., "Dialysis-Facility Joint-Venture Ownership — Hidden Conflicts of Interest" The New England Journal of Medicine 379;14, October 4, 2018.

[vi] Glickman, et al.

[vii] L. C. Plantinga, et al., "Frequency of patient–physician contact in chronic kidney disease care and achievement of clinical performance targets" International Journal for Quality in Health Care 2005; Volume 17, Number 2: pp. 115–121.

[viii] Dialysis Facility Report data and documentation is publicly available here: https://data.cms.gov/dialysis-facility-reports. Patients included in the hospitalization summary include patients who received dialysis in the facility and satisfied the Medicare payment criterion as Medicare patients.

[ix] OSHPD 2019 Hospital Emergency Department - Characteristics by Facility (Pivot Profile). Where expected payer source is Medicare, ED Admit as a percent of Total ED.

[x] 2019 Dialysis Facility Reports Hospitalization Summary for California. Dialysis Facility Report data and documentation is publicly available here: https://data.cms.gov/dialysis-facility-reports. Patients included in the hospitalization summary include patients who received dialysis in the facility and satisfied the Medicare payment criterion as Medicare patients.

[xi] Data from the Kaiser Family Foundation available here: https://www.kff.org/medicare/state-indicator/medicare-service-use-hospital-inpatient-services/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[xii] Nguyen D.B., Arduino M.J., Patel P.R., Hemodialysis-Associated Infections. Chronic Kidney Disease, Dialysis, and Transplantation. 2019;389-410.e8. doi:10.1016/B978-0-323-52978-5.00025-2 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7152337/pdf/main.pdf page 399.

[xiii] DPH current healthcare facilities; late shift information from CMS certified facility listing.

[xiv] 42 C.F.R. § 494.140(a).

[xv] 42 C.F.R. § 494.140(b).

[xvi] Kawaguchi, Takehiko, et al., "Associations of frequency and duration of patient-doctor contact in hemodialysis facilities with mortality." Journal of the American Society of Nephrology : JASN vol. 24,9 (2013): 1493-502. doi:10.1681/ASN.2012080831 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3752943/.

[xvii] Erickson, Kevin F, et al., "Physician visits and 30-day hospital readmissions in patients receiving hemodialysis." Journal of the American Society of Nephrology : JASN vol. 25,9 (2014): 2079-87. doi:10.1681/ASN.2013080879 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4147977/ .

[xviii] Global Dialysis Perspective: Japan, Norio Hanafusa and Masafumi Fukagawa, Kidney360 May 2020, 1 (5) 416-419; DOI: https://doi.org/10.34067/KID.0000162020.

[xix] Plantinga L.C., et al., *supra.*

[xx] https://www.kidney.org/sites/default/files/NNI0818pgs2628-29_ADVPRCTNEWS.pdf (page 28).

[xxi] McCrory G., Patton D., Moore Z., O'Connor T., Nugent L., The impact of advanced nurse practitioners on patient outcomes in chronic kidney disease: a systematic review. Journal of Renal Care (2018).

[xxii] https://www.rn.ca.gov/pdfs/regulations/npr-b-23.pdf (page 1); CA Business and Professions Code § 3502.

[xxiii] Zuber K., Davis J., Erickson K. Nephrology Advanced Practitioners in the United States, 2010-2018 CJASN Sep 2019, 14 (9) 1381-1382; DOI: 10.2215/CJN.0160021https://cjasn.asnjournals.org/content/14/9/1381

[xxiv] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ESRDQIP

[xxv] https://www.cms.gov/files/document/esrd-qip-summary-payment-years-2021-2024.pdf

[xxvi] ESRD QIP - Total Performance Scores - Payment Year 2021. Our analysis eliminated hospital-based clinics and those providing only home-based dialysis

[xxvii] *See* Health and Safety Code §§ 1325-1335.

[xxviii] N.Y. Comp. Codes R. & Regs. tit. 10, § 401.3; N.Y. Comp. Codes R. & Regs. tit. 18, § 485.5. *See also* https://www.health.ny.gov/professionals/nursing_home_administrator/docs/dal_nh_17-06_revised_nh_closure_guidelines_att.pdf (summarizing requirements for DOH approval of nursing home closures); https://www.health.ny.gov/facilities/cons/more_information/ (approval from the Department of Public Health required before "[a]dding or deleting services" at hospitals, treatment centers, hospitals and other clinics).

[xxix] *See* https://portal.ct.gov/DSS/Health-And-Home-Care/Reimbursement-and-Certificate-of-Need/Certificate-of-Need (under Connecticut's CON process, approval is required before "[t]ermination of a health service including facility closure or a substantial decrease in total bed capacity"); https://www2.illinois.gov/sites/hfsrb/CONProgram/Pages/default.aspx (entities subject to Illinois's CON program, including dialysis centers, must seek an "exemption" from the state review board in order to close or discontinue a category of service); 23 R.I. Gen. Laws Ann. § 23-17.14-18 (hospitals that have been open for one year and that serve uninsured or underinsured patients may be "eliminated or significantly reduced" without first obtaining approval of the Director of the Rhode Island Department of Health); N.J. Admin. Code § 8:33-3.2 (closure of a general hospital in New Jersey must be approved by stated under CON process).

[xxx] Blue Sky report, provided herewith.

[xxxi] Childers C, et al., *supra*.

[xxxii] https://www.cms.gov/newsroom/fact-sheets/end-stage-renal-disease-esrd-prospective-payment-system-pps-calendar-year-cy-2021-proposed-rule-cms

[xxxiii] http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_20_dialysis_final_sec.pdf?sfvrsn=0 page 2

[xxxiv] Trish E., Ginsburg P., Gascue L., Joyce G., Physician Reimbursement in Medicare Advantage Compared With Traditional Medicare and Commercial Health Insurance. JAMA Intern Med. 2017;177(9):1287-1295. doi:10.1001/jamainternmed.2017.2679

[xxxv] Berenson R. et al., Why Medicare Advantage Plans Pay Hospitals Traditional Medicare Prices. Health Affairs. August 2015. https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1427

CALIFORNIA BALLOT INITIATIVE FOR THE NOVEMBER 2022 GENERAL ELECTION:

PROTECT THE LIVES OF DIALYSIS PATIENTS ACT

In our fight to ensure safe conditions in clinics for all patients, we have filed the Protect the Lives of Dialysis Patients Act for the November 2022 ballot. The ballot initiative will strengthen patient care by:

Improving transparency. Dialysis providers must publish infection rates for each clinic and disclose clinic ownership to patients and state regulators.

Guaranteeing equal treatment. Dialysis providers cannot discriminate based on the type of insurance a patient has (private or government-provided). They must treat all patients and provide the same quality of care regardless of type of insurance.

Strengthening patient safety. A doctor, nurse practitioner, or physician assistant must be on site at all times when patients are being treated in dialysis clinics. The California Department of Public Health may allow a remote doctor, nurse practitioner, or physician assistant if the clinic is in a shortage area.

Ensuring access to care. Dialysis providers must get approval from the California Department of Public Health before closing any clinics.

SEIU-UHW United Healthcare Workers West

www.seiu-uhw.org fb.com/unitedhealthcareworkers @seiu_uhw @seiuuhw

Ad paid for by Californians for Kidney Dialysis Patient Protection, sponsored by Service Employees International Union – United Healthcare Workers West. Committee major funding from:
Service Employees International Union – United Healthcare Workers West
Funding details at http://www.fppc.ca.gov/

NO PROP 29

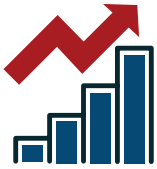
NoProp29.com

Stop Yet *Another* Dangerous Dialysis Prop

SEIU-UHW has a long history of abusing the ballot initiative process and putting patients at risk. Despite overwhelmingly being rejected by voters in the last two election cycles, they're back a third time with yet another dangerous and costly dialysis proposition. Prop 29 is nearly identical to Proposition 23, which 63% of voters overwhelmingly rejected in 2020. This latest proposition will again jeopardize access to care, worsen our health care provider shortage and increase health care costs for all Californians. Here's why a broad coalition opposes Prop 29:

Prop 29 Puts Dialysis Patient Lives at Risk

- Approximately 80,000 Californians need dialysis treatments three days a week to stay alive. Dialysis does the job of failed kidneys, removing toxins from the body. Dialysis is not optional. Missing even a single treatment increases a patient's risk of death by 30%.
- Prop 29 mandates that every dialysis clinic in California have a physician, nurse practitioner or physician assistant during all operating hours. These new positions would have no role in patient care and would likely end up with administrative duties only.
- A study by the Berkeley Research Group (BRG) found that Prop 29 would increase dialysis clinic costs by up to $445 million annually or between $376,000 and $731,000 per clinic, per year.
- **Nearly half of all of California's 600 dialysis clinics could be forced to cut back services or close** –making it more difficult for dialysis patients to access their life-saving treatments and putting patient lives at risk.



Prop 29 Increases Health Care Cost for Taxpayers and Consumers

- The BRG analysis also found Prop 29 would increase costs to the State of California by hundreds of millions of dollars annually for the treatment of patients on state-funded health care programs.
- That will increase costs for all of us in the form of higher insurance premiums and higher taxes for government-sponsored health care.

Prop 29 Worsens Emergency Room Overcrowding and the Health Care Provider Shortage

- Amid health care practitioner shortages, Prop 29 would move thousands of doctors, nurses, and physician assistants away from patients that need care into administrative roles at dialysis clinics where they will not be providing care.
- If clinics shut down, dialysis patients who miss treatment will get very ill and wind up in the emergency room. Forcing tens of thousands of vulnerable dialysis patients into emergency rooms will exacerbate overcrowding and reduce capacity to deal with other health emergencies and pandemics like the coronavirus.
- The pandemic has already put a significant strain on our health care system, and the last thing we need is to make the provider shortage worse.

A Long Line of Ballot Abuse by SEIU-UHW

- Since 2012, UHW has wasted $82 million of its members' dues money funding 60 failed ballot initiatives across the country – many of which put patients and their members at risk.
- **That amounts to more than $700 per UHW member that they've wasted on these failed and reckless efforts**.
- This is the third ballot measure since 2018 sponsored by UHW targeting dialysis providers. Voters rejected Prop 8 in 2018 by 60% and Prop 23 in 2020 by 63%.
- It's shameful that this union would continue to use vulnerable patients as pawns to advance their political agenda.

Ad paid for by No on 29: Stop Yet Another Dangerous Dialysis Proposition,
sponsored by patients, doctors, nurses and dialysis providers
Committee major funding from
DaVita
Fresenius Medical Care
U.S. Renal Care
Funding details at www.fppc.ca.gov

NO PROP 29

NoProp29.com

Prop 23 vs Prop 29

Prop 29 is nearly identical to Prop 23, which 63% of voters overwhelmingly rejected in 2020. Prop 29 will again jeopardize access to care, worsen our health care provider shortage and increase health care costs for all Californians.

Prop 23	Prop 29
Requires physician on site at all times ■ No ESRD experience ■ Exception for NP, PA granted by Department if shortage exists	Requires **physician, NP, PA** on site at all times ■ **6 months experience in ESRD** ■ **Exception for telehealth** – must be granted by Department
Prohibits clinics from refusing treatment based on payment source	Prohibits clinics from refusing treatment based on payment source
Prohibits clinics from closing or reducing services without prior state approval	Prohibits clinics from closing or reducing services without prior state approval
Quarterly reporting to Department of HAI (infection) data	Quarterly reporting to Department of HAI (infection) data
	Requires disclosure to patients and public list of any physicians who have 5% or more ownership interest in clinic

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Funding details at www.fppc.ca.gov

We Oppose Prop 29, the Dangerous Dialysis Proposition

As of July 13, 2022

Prop 29 Jeopardizes the Lives of Dialysis Patients, Reduces Access to Our Doctors & Increases Health Care Costs for All

Health

California Medical Association
American Nurses Association\California
American Academy of Nephrology PAs
Minority Health Institute
National Hispanic Medical Association
Network of Ethnic Physician Organizations
Chronic Disease Coalition
Renal Physicians Association
California Dialysis Council
Renal Support Network
Renal Healthcare Association
Dialysis Patient Citizens
California Association of Health Facilities
California Medical Transportation Association
Indian Physicians Association of Central California
Alameda-Contra Costa Medical Association
Central Coast Medical Association
Fresno-Madera Medical Society
Imperial County Medical Society
Kern County Medical Society
Los Angeles County Medical Association
Merced-Mariposa Medical Society
Napa-Solano Medical Society
Orange County Medical Association
Placer-Nevada County Medical Society
Riverside County Medical Association
San Bernardino County Medical Society
San Diego County Medical Society

Health (continued)

San Francisco-Marin Medical Society
San Joaquin Medical Society
San Mateo County Medical Association
Santa Clara County Medical Association
Yuba-Sutter-Colusa Medical Society

Seniors

California Senior Advocates League

Business

California Chamber of Commerce
Los Angeles County Business Federation
Antelope Valley Hispanic Chamber of Commerce
Bell Gardens Association of Merchants & Commerce
Downey Chamber of Commerce
Filipino-American Chamber of Commerce Business Network
Gateway Chambers Alliance
Lodi Chamber of Commerce
Los Angeles South Chamber of Commerce
Norwalk Chamber of Commerce
Southwest California Legislative Council
West Ventura County Business Alliance

Taxpayers

California Taxpayer Protection Committee
Placer County Taxpayers Association
Ventura County Taxpayers Association

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CALIFORNIA LEGISLATURE

SENATE RULES COMMITTEE

TONI G. ATKINS
CHAIR

May 12, 2022

Senate Health Committee
1021 O Street, Room 3310
Sacramento, CA 95814

RE: REQUIRES ON-SITE LICENSED MEDICAL PROFESSIONAL AT KIDNEY DIALYSIS CLINICS AND ESTABLISHES OTHER STATE REQUIREMENTS. INITIATIVE STATUTE #1907

Pursuant to Section 9034 of the Elections Code, the Senate Rules Committee is assigning the above named initiative to the Senate Health Committee for the purpose of a public hearing.

Senate Bill 1253 (Ch. 697, Statutes of 2014) amended Elections Code section 9034 to require that once proponents of a proposed initiative measure have gathered 25% of the number of signatures required, proponents must immediately certify they have done so under penalty of perjury to the Secretary of State.

Upon receipt of the certification, the Secretary of State must provide copies of the proposed initiative measure and the circulating title and summary to the Senate and the Assembly. Each house is required to assign the proposed initiative measure to its appropriate committees and hold a joint public hearing, at least 131 days before the date of the election at which the measure is voted on. **The 131-day deadline for the November 8, 2022 General Election is June 30, 2022.** The statute does not permit the Legislature to alter the measure or prevent it from appearing on the ballot.

Sincerely,

ERIKA CONTRERAS
Secretary of the Senate