March 22, 2024

The Honorable Richard Roth
Chair, Senate Health Committee
1021 O St., Room 1200
Sacramento, CA 95814

SUBJECT: SB 1300 (Cortese) — OPPOSE

Dear Senator Roth:

There is no greater priority for California's hospitals than caring for their communities and ensuring access to high-quality health care. However, hospitals are facing many challenges that are forcing them to eliminate or reduce services just to keep their doors open. The California Hospital Association (CHA) supports policy changes and payment reform that can improve access to care. Unfortunately, Senate Bill (SB) 1300 does not address the underlying challenges that might force a hospital to make the difficult decision to close services—in fact, SB 1300 will likely make the problem worse.

For these reasons, CHA, on behalf of more than 400 hospital and health system members, opposes SB 1300, which would place new requirements on hospitals that close inpatient psychiatric or labor and delivery (L&D) units.

Specifically, SB 1300 expands existing public noticing requirements from 90 days to 120 days, requires hospitals to pay for the completion of a report analyzing impacts to the surrounding community, obtain certification of the report from California Department of Health Care Access and Information (HCAI), and encourage the County Board of Supervisors to hold a public hearing.

According to the author, SB 1300 empowers the California Department of Public Health (CDPH) to work with county policy makers to mitigate the impact of a health facility's closure or elimination of its inpatient psychiatric or L&D unit. However, hospitals already provide a 90 day public notification and a 90 day notification to CDPH when closing or reducing a service; it is unclear how an additional 30 days for public noticing will mitigate the effects of service closure, nor prevent the closure from occurring. CHA is concerned that increasing the public noticing requirements will exacerbate the situation as health care providers and staff leave their jobs after learning that a facility is closing. Hospitals already experience this challenge with the 90 day notification requirement; service lines will often have to operate at an even more reduced rate than initially expected or close sooner than 90 days due to a lack of staff.

Additionally, SB 1300 would require facilities to provide an impact analysis report (paid for by the hospital) to HCAI for review and certification before issuing the 120 day notice of the proposed closure or elimination. The bill does not specify how HCAI will "review and certify" the impact analysis report and there is no specified deadline for HCAI to conclude this evaluation and certification process. Consequently, a hospital might have to indefinitely await HCAI's assessment before submitting its 120 day notice, thereby exacerbating the strain on hospital resources.

The impact analysis report also requires information on several items that hospitals would not be able to provide. For example, in section 2 (d)(1), the analysis must include "the projected annual increased costs to the county for providing additional inpatient psychiatric care or maternity care, for a period of ____ years, resulting from the reduction of available psychiatric or maternity beds due to the elimination of the hospital's inpatient psychiatric service or maternity service." Hospitals would not be able to determine this information nor do counties provide *additional* inpatient psychiatric care or maternity care when another hospital is forced to reduce or eliminate these services. It is also unclear how hospitals would determine "The impact of the elimination of beds on the continuum of care capacity for the county." Additionally, hospitals do not know the income of patients served. Much of the other information that is required to be in the impact analysis is already provided by hospitals to HCAI and is publicly available. As an alternative, HCAI could be required to provide the information to the county since they already collect data on hospital finances and patients.

The fact that Californians lack adequate access to inpatient psychiatric treatment is not up for dispute - residents in 24 of California's 58 counties have *no* in-county access to inpatient psychiatric care, regardless of the type of insurance they have. There are numerous strategies hospitals support that could prevent potential closures of inpatient psychiatric capacity and encourage expanded access. For one, Medi-Cal reimbursement for psychiatric inpatient services must cover the actual cost to provide life-saving care to an individual in crisis. When hospitals have eliminated inpatient psychiatric services over the past decade, they have most frequently cited inadequate Medi-Cal reimbursement levels as the primary reason.

Regarding labor and delivery unit closures, the reasons a hospital may choose to discontinue this service are complex and finances are only one piece of the puzzle. In addition to inadequate Medi-Cal reimbursement rates, California's birth rate is at its lowest level in almost 100 years. As one example, Plumas District Hospital made the difficult decision to close its L&D unit in 2021, having delivered only 64 babies the year before. Low birth rates can also impact quality of care—clinical evidence has shown that hospitals that perform higher numbers of deliveries have better outcomes for both birthing persons and babies. The state is also facing workforce recruitment challenges. Rural communities, in particular, are experiencing a shortage in obstetrics staff while the entire state is projected to have a shortage of more than 1,100 obstetricians by 2030.

None of these issues will be helped by the additional requirements in SB 1300.

CHA appreciates the strides the Legislature and Administration have made to address the need to increase inpatient psychiatric reimbursement rates, including pursing a Medicaid Section 1115 Demonstration Waiver (BH-CONNECT), earmarking Managed Care Organization tax revenues, and requesting federal approval to amend the Medicaid State Plan to remove rate maximums. But more must

be done to achieve equitable access to acute care for psychiatric emergencies compared to other medical emergencies. For instance, California requires health plans and counties to demonstrate they have adequate networks of mental health providers within reasonable geographic distance. But we do not require them to develop adequate networks for crisis and inpatient psychiatric services nor labor and delivery units.

One provision of the bill that can have a positive effect is the requirement that CDPH must "prioritize and expedite" the licensing of additional beds to replace the number of lost beds. However, given the current shortage of inpatient psychiatric care, CDPH should already be licensing beds as quickly as possible, it should not take service line closures for licensing to be completed quicker.

CHA remains committed to collaborative efforts toward effective solutions. However, SB 1300 does not improve access to care and may actually worsen the situation for hospitals working to avoid service closures.

For these reasons, CHA requests your "NO" vote on SB 1300.

Sincerely,

Vanessa Gonzalez

Vanessa Gonzalez
Vice President, State Advocacy

cc: The Honorable Dave Cortese
The Honorable Members of the Senate Health Committee
Vince Marchand, Consultant Senate Health Committee
Joe Parra, Consultant, Senate Republican Caucus
Jessica Cruz, Chief Executive Officer, NAMI California