AB-1316 Emergency services: psychiatric emergency medical conditions. (2023-2024)

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Assembly Bill No. 1316

CHAPTER 632

An act to amend Sections 1317.1, 1317.2a, 1317.4a, 1317.4b, and 1317.7 of the Health and Safety Code, and to add Section 14132.025 to the Welfare and Institutions Code, relating to health care.

[Approved by Governor September 27, 2024. Filed with Secretary of State September 27, 2024.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1316, Irwin. Emergency services: psychiatric emergency medical conditions.

Existing law, the Lanterman-Petris-Short Act, provides for the involuntary commitment and treatment of a person who is a danger to themselves or others or who is gravely disabled, as defined.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Pursuant to a schedule of covered benefits, existing law requires Medi-Cal coverage for inpatient hospital services, subject to utilization controls, and with respect to fee-for service beneficiaries, coverage for emergency services and care necessary for the treatment of an emergency medical condition and medical care directly related to the emergency medical condition, as specified.

Existing law provides for the licensing and regulation of health facilities by the State Department of Public Health and makes a violation of those provisions a crime. Existing law defines “psychiatric emergency medical condition,” for purposes of providing treatment for emergency conditions, as a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either an immediate danger to the patient or to others, or immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder. Existing law includes various circumstances under which a patient is required to be treated by, or may be transferred to, specified health facilities for treatment that is solely necessary to relieve or eliminate a psychiatric emergency medical condition.

This bill would revise the definition of “psychiatric emergency medical condition” to make that definition applicable regardless of whether the patient is voluntary, or is involuntarily detained for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment, under prescribed circumstances. The bill would make conforming and clarifying changes to provisions requiring facilities to provide that treatment. By expanding the definition of a crime with respect to those facilities, the bill would impose a state-mandated local program.

The bill would require the Medi-Cal program to cover emergency services and care necessary to treat an emergency medical condition, as defined, including poststabilization care services required under specified federal law, emergency room professional services, and facility charges for emergency room visits.

The bill would require coverage for emergency services necessary to relieve or eliminate a psychiatric emergency medical condition, regardless of whether the beneficiary is voluntary, or involuntarily detained for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment, as specified. The bill would require a Medi-Cal managed care plan, as defined, to be responsible for covering, and reimbursing providers for furnishing, those emergency services and care. The bill would specify that those requirements do not limit or reduce the scope of covered emergency services and care for fee-for-service beneficiaries, as described in the bill.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.
Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1317.1 of the Health and Safety Code is amended to read:

1317.1. Unless the context otherwise requires, the following definitions shall control the construction of this article and Section 1371.4:

(a) (1) “Emergency services and care” means medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a physician and surgeon, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person’s license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.

(2) (A) “Emergency services and care” also means an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.

(B) The care and treatment necessary to relieve or eliminate a psychiatric emergency medical condition may include admission or transfer to a psychiatric unit within a general acute care hospital, as defined in subdivision (a) of Section 1250, or to an acute psychiatric hospital, as defined in subdivision (b) of Section 1250, pursuant to subdivision (k). This subparagraph does not permit a transfer that is in conflict with the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code), or the federal Emergency Medical Treatment and Labor Act (Section 1395dd of Title 42 of the United States Code).

(C) For the purposes of Section 1371.4, emergency services and care as defined in subparagraph (A) shall not apply to Medi-Cal managed care plan contracts entered into with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), and Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code, to the extent that those services are excluded from coverage under those contracts.

(D) This paragraph does not expand, restrict, or otherwise affect the scope of licensure or clinical privileges for clinical psychologists or other medical personnel.

(b) “Emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(1) Placing the patient’s health in serious jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction of any bodily organ or part.

(c) “Active labor” means a labor at a time at which either of the following would occur:

(1) There is inadequate time to effect safe transfer to another hospital prior to delivery.

(2) A transfer may pose a threat to the health and safety of the patient or the fetus.

(d) “Hospital” means all hospitals with an emergency department licensed by the state department.

(e) “State department” means the State Department of Public Health.

(f) “Medical hazard” means a material deterioration in medical condition in, or jeopardy to, a patient’s medical condition or expected chances for recovery.

(g) “Board” means the Medical Board of California.

(h) “Within the capability of the facility” means those capabilities that the hospital is required to have as a condition of its emergency medical services permit and services specified on Services Inventory Form 7041 filed by the hospital with the Department of Health Care Access and Information.

(i) “Consultation” means the rendering of an opinion or advice, prescribing treatment, or the rendering of a decision regarding hospitalization or transfer by telephone or other means of communication. When determined to be medically necessary, jointly by the treating physician and surgeon, or by other appropriate licensed persons acting within their scope of licensure, under the supervision of a physician and surgeon, and the consulting physician and surgeon, “consultation” includes review of the patient’s medical record, examination, and treatment of the patient in person by a consulting physician and surgeon, or by other appropriate licensed persons acting within their scope of licensure under the supervision of a consulting physician and surgeon, who is qualified to give an opinion or render the necessary treatment in order to stabilize the patient. A request for consultation shall be made by the treating physician and surgeon, or by other appropriate licensed persons acting within their scope of licensure under the supervision of a treating physician and surgeon, provided the request is made with the contemporaneous approval of the treating physician and surgeon. The treating physician and surgeon may request to communicate directly with the consulting physician and surgeon, and when determined to be medically necessary, jointly by the treating physician and surgeon and the consulting physician and surgeon, the consulting physician and surgeon shall examine and treat the patient in person. The consulting physician and surgeon is ultimately responsible for providing the necessary consultation to the patient, regardless of who makes the in-person appearance.

(j) A patient is “stabilized” or “stabilization” has occurred when, in the opinion of the treating physician and surgeon, or other appropriate licensed persons acting within their scope of licensure under the supervision of a treating physician and surgeon, the patient’s medical condition is such that, within reasonable medical probability, no material deterioration of the patient’s condition is likely to result from, or occur during, the release or transfer of the patient as provided for in Section 1317.2, Section 1317.2a, or other pertinent statute.

(k) (1) “Psychiatric emergency medical condition” means a mental health disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following, regardless of whether the patient is voluntary or involuntarily detained for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment pursuant to the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code):

(A) An immediate danger to themselves or to others.

(B) Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental health disorder.

(2) This subdivision does not expand, restrict, or otherwise affect the scope of licensure or clinical privileges for clinical psychologists or medical personnel.

(l) This section does not expand the scope of licensure for licensed persons providing services pursuant to this section.

(m) This section does not require a transfer or admission that is in conflict with the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code) or with the requirements of the federal Emergency Medical Treatment and Labor Act (42 U.S.C. Sec. 1395dd).

SEC. 2. Section 1317.2a of the Health and Safety Code is amended to read:

1317.2a. (a) A hospital that has a legal obligation, whether imposed by statute or by contract, to the extent of that contractual obligation, to any third-party payor, including, but not limited to, a health maintenance organization, health care service plan, nonprofit hospital service plan, insurer, or preferred provider organization, a county, or an employer to provide care for a patient under the circumstances specified in Section 1317.2 shall receive that patient to the extent required by the applicable statute or by the terms of the contract, or, when the hospital is unable to accept a patient for whom it has a legal obligation to provide care whose transfer will not create a medical hazard as specified in Section 1317.2, it shall make appropriate arrangements for the patient’s care.

(b) A county hospital shall accept a patient whose transfer will not create a medical hazard as specified in Section 1317.2 and who is determined by the county to be eligible to receive health care services required under Part 5 (commencing with Section 17000) of Division 9 of the Welfare and Institutions Code, unless the hospital does not have appropriate bed capacity, medical personnel, or equipment required to provide care to the patient in accordance with accepted medical practice. When a county

hospital is unable to accept a patient whose transfer will not create a medical hazard as specified in Section 1317.2, it shall make appropriate arrangements for the patient's care. The obligation to make appropriate arrangements as set forth in this subdivision does not mandate a level of service or payment, modify the county's obligations under Part 5 (commencing with Section 17000) of Division 9 of the Welfare and Institutions Code, create a cause of action, or limit a county's flexibility to manage county health systems within available resources. However, the county's flexibility shall not diminish a county's responsibilities under Part 5 (commencing with Section 17000) of Division 9 of the Welfare and Institutions Code or the requirements contained in Chapter 2.5 (commencing with Section 1440).

(c) The receiving hospital shall provide personnel and equipment reasonably required in the exercise of good medical practice for the care of the transferred patient.

(d) Any third-party payor, including, but not limited to, a health maintenance organization, health care service plan, nonprofit hospital service plan, insurer, or preferred provider organization, or employer that has a statutory or contractual obligation to provide or indemnify emergency medical services on behalf of a patient shall be liable, to the extent of the statutory or contractual obligation to the patient, for the reasonable charges of the transferring hospital and the treating physicians for the emergency services provided pursuant to this article, except that the patient shall be responsible for uncovered services, or any deductible or copayment obligation. Notwithstanding this section, the liability of a third-party payor that has contracted with health care providers for the provision of these emergency services shall be set by the terms of that contract. Notwithstanding this section, the liability of a third-party payor that is licensed by the Insurance Commissioner or the Director of the Department of Managed Health Care and has a contractual obligation to provide or indemnify emergency medical services under a contract that covers a subscriber or an enrollee shall be determined in accordance with the terms of that contract and shall remain under the sole jurisdiction of that licensing agency.

(e) A hospital that has a legal obligation to provide care for a patient as specified by subdivision (a) of Section 1317.2a to the extent of its legal obligation, imposed by statute or by contract to the extent of that contractual obligation, which does not accept transfers of, or make other appropriate arrangements for, medically stable patients in violation of this article or regulations adopted pursuant thereto shall be liable for the reasonable charges of the transferring hospital and treating physicians for providing services and care that should have been provided by the receiving hospital.

(f) Subdivisions (d) and (e) do not apply to county obligations under Section 17000 of the Welfare and Institutions Code.

(g) This section does not require a hospital to make arrangements for the care of a patient for whom the hospital does not have a legal obligation to provide care.

SEC. 3. Section 1317.4a of the Health and Safety Code is amended to read:

1317.4a. (a) (1) Notwithstanding subdivision (j) of Section 1317.1, a patient may be transferred for admission to a psychiatric unit within a general acute care hospital, as defined in subdivision (a) of Section 1250, or an acute psychiatric hospital, as defined in subdivision (b) of Section 1250, for care and treatment that is solely necessary to relieve or eliminate a psychiatric emergency medical condition, as defined in subdivision (k) of Section 1317.1, provided that, in the opinion of the treating provider, the patient's psychiatric emergency medical condition is such that, within reasonable medical probability, no material deterioration of the patient's psychiatric emergency medical condition is likely to result from, or occur during, a transfer of the patient.

(2) A provider shall notify the patient's health care service plan, or the health plan's contracting medical provider of the need for the transfer if identification of the plan is obtained pursuant to paragraph (1) of subdivision (b).

(b) A hospital that transfers a patient pursuant to subdivision (a) shall do both of the following:

(1) Seek to obtain the name and contact information of the patient's health care service plan. The hospital shall document its attempt to ascertain this information in the patient's medical record. The hospital's attempt to ascertain the information shall include requesting the patient's health care service plan member card, asking the patient, the patient's family member, or other person accompanying the patient if they can identify the patient's health care service plan, or using other means known to the hospital to accurately identify the patient's health care service plan.

(2) Notify the patient's health care service plan or the health plan's contracting medical provider of the transfer, provided that the identification of the plan was obtained pursuant to paragraph (1). The hospital shall provide the plan or its contracting medical provider with the name of the patient, the patient's member identification number, if known, the location and contact information, including a telephone number, for the location where the patient will be admitted, and the preliminary diagnosis.

(c) (1) A hospital shall make the notification described in paragraph (2) of subdivision (b) by either following the instructions on the patient's health care service plan member card or by using the contact information provided by the patient's health care service plan. A health care service plan shall provide all noncontracting hospitals in the state to which one of its members would be

transferred pursuant to paragraph (1) of subdivision (b) with specific contact information needed to make the contact required by this section. The contact information provided to hospitals shall be updated as necessary, but no less than once a year.

(2) A hospital making the transfer pursuant to subdivision (a) shall not be required to make more than one telephone call to the health care service plan, or its contracting medical provider, provided that in all cases the health care service plan, or its contracting medical provider, shall be able to reach a representative of the provider upon returning the call, should the plan, or its contracting medical provider, need to call back. The representative of the hospital who makes the telephone call may be, but is not required to be, a physician and surgeon.

(d) If a transfer made pursuant to subdivision (a) is made to a facility that does not have a contract with the patient's health care service plan, the plan may subsequently require and make provision for the transfer of the patient receiving services pursuant to this section and subdivision (a) of Section 1317.1 from the noncontracting facility to a psychiatric unit within a general acute care hospital, as defined in subdivision (a) of Section 1250, or an acute psychiatric hospital, as defined in subdivision (b) of Section 1250, that has a contract with the plan or its delegated payer, provided that in the opinion of the treating provider the patient's psychiatric emergency medical condition is such that, within reasonable medical probability, no material deterioration of the patient's psychiatric emergency medical condition is likely to result from, or occur during, the transfer of the patient.

(e) Upon admission, the hospital to which the patient was transferred shall notify the health care service plan of the transfer, provided that the facility has the name and contact information of the patient's health care service plan. The facility shall not be required to make more than one telephone call to the health care service plan, or its contracting medical provider, provided that in all cases the health care service plan, or its contracting medical provider, shall be able to reach a representative of the facility upon returning the call, should the plan, or its contracting medical provider, need to call back. The representative of the facility who makes the telephone call may be, but is not required to be, a physician and surgeon.

(f) A provider is not required to seek prior authorization to provide emergency services and care, as defined in paragraph (2) of subdivision (a) of Section 1317.1, or to make a transfer pursuant to subdivision (a) for a patient who has a psychiatric emergency medical condition, as defined in subdivision (k) of Section 1317.1, that is not otherwise required by law.

SEC. 4. Section 1317.4b of the Health and Safety Code is amended to read:

1317.4b. (a) A psychiatric unit within a general acute care hospital, as defined in subdivision (a) of Section 1250, a psychiatric health facility of more than 16 beds, as defined in Section 1250.2 and subject to subdivision (d), or an acute psychiatric hospital, as defined in subdivision (b) of Section 1250, shall accept a transfer of a person with a psychiatric emergency medical condition, as defined in subdivision (k) of Section 1317.1, from a health facility licensed under this chapter that maintains and operates an emergency department and the receiving facility shall provide emergency services and care to that person consistent with paragraph (2) of subdivision (a) of Section 1317.1, regardless of whether the person is voluntary or involuntarily detained for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment pursuant to the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code), or whether the facility operates an emergency department, if all of the following requirements are met:

(1) The treating physician at the sending facility has determined that the patient is medically stable and appropriate for treatment in a psychiatric setting and has included that determination in the patient's medical record.

(2) The facility has an available bed.

(3) The facility has appropriate facilities and qualified personnel available to provide the services or care.

(b) A facility accepting a transfer of a person with a psychiatric emergency medical condition pursuant to subdivision (a) shall comply with the requirements of subdivisions (b), (d), and (f) of Section 1317.

(c) This section shall not apply to a facility listed in Section 4100 of the Welfare and Institutions Code.

(d) This section shall not apply to a psychiatric health facility that is county owned and operated.

SEC. 5. Section 1317.7 of the Health and Safety Code is amended to read:

1317.7. (a) This article does not preempt any county or any other governmental agency acting within its authority from regulating emergency care or patient transfers, including the imposition of more specific duties, consistent with the requirements of this article and its implementing regulations. Any inconsistent requirements imposed by the Medi-Cal program shall preempt this article with respect to Medi-Cal beneficiaries. To the extent hospitals and physicians enter into contractual relationships with county or other governmental agencies that impose more stringent transfer requirements, those contractual agreements shall control.

(b) Notwithstanding subdivision (a), those duties or contractual agreements shall not unreasonably delay or deny the provision of medically necessary care to a patient with a psychiatric emergency medical condition, as defined in subdivision (k) of Section 1317.1, regardless of whether the patient is voluntary or involuntarily detained for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment pursuant to the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code).

SEC. 6. Section 14132.025 is added to the Welfare and Institutions Code, to read:

14132.025. (a) Notwithstanding any other law, emergency services and care necessary for the treatment of an emergency medical condition, as defined in subdivision (b) of Section 1317.1 of the Health and Safety Code, are a covered benefit. For purposes of this section, “emergency services and care” has the same meaning as defined in Section 438.114 of Title 42 of the Code of Federal Regulations and paragraph (1) of, and subparagraph (A) of paragraph (2) of, subdivision (a) of Section 1317.1 of the Health and Safety Code.

(b) For a beneficiary with a psychiatric emergency medical condition, as defined in subdivision (k) of Section 1317.1 of the Health and Safety Code, emergency services and care necessary to relieve or eliminate that condition are covered, regardless of whether the beneficiary is voluntary, or involuntarily detained for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment pursuant to the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code).

(c) (1) A Medi-Cal managed care plan, as defined in subdivision (j) of Section 14184.101, shall be responsible for covering, and reimbursing providers furnishing, the emergency services and care described in subdivisions (a) and (b), and any poststabilization care services required under Section 438.114 of Title 42 of the Code of Federal Regulations, for its enrolled Medi-Cal beneficiaries, excluding any Medi-Cal specialty mental health services provided once an enrolled beneficiary is admitted for inpatient psychiatric care.

(2) This subdivision does not limit or reduce the scope of covered emergency services and care described in subdivisions (a) and (b) for Medi-Cal fee-for-service beneficiaries.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-plan letters, information notices, plan or provider bulletins, or similar instructions until the department can promulgate any necessary regulations.

(e) For purposes of this section, emergency services and care includes emergency room professional services and facility charges for emergency room visits.

(f) This section shall be implemented in a manner consistent with federal law and only to the extent federal financial participation is available and not otherwise jeopardized.

(g) The Legislature finds and declares that this section is intended to clarify, and not expand, the scope of Medi-Cal covered benefits.

SEC. 7. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.