Date of Hearing: April 13, 2021

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
AB 370 (Arambula) – As Introduced February 1, 2021

SUBJECT: Ambulatory surgical centers.

SUMMARY: Enacts the California Outpatient Cardiology Patient Safety, Cost Reduction and Quality Improvement Act, authorizing the Department of Public Health (DPH), within the Elective Percutaneous Coronary Intervention (PCI) Program, to certify an ambulatory surgical center (ASC) to provide elective cardiac catheterization laboratory services that meet certain requirements, to perform scheduled, elective percutaneous transluminal coronary angioplasty and stent placement for eligible patients. Specifically, **this bill**:

1) Authorizes DPH, within the PCI Program, to certify an ASC to provide elective cardiac catheterization laboratory services, and to perform scheduled, elective percutaneous transluminal coronary angioplasty and stent placement for eligible patients.

2) Requires DPH to certify an eligible ASC that meets all of the following requirements:

    a) Demonstrates that the ASC complies with the recommendations of the Society for Cardiovascular Angiography and Interventions (SCAI), the American College of Cardiology Foundation, and the American Heart Association for the performance of PCI without onsite cardiac surgery, as those recommendations may evolve over time;
    b) Provides evidence showing the full support from the ASC administration in fulfilling the necessary institutional requirements, including, but not limited to, appropriate support services such as respiratory care and blood banking;
    c) Participates in, and provides timely submission of data to, the American College of Cardiology National Cardiovascular Data Registry;
    d) Confers rights to transfer the data submitted pursuant to c), above, to the Office of Statewide Health Planning and Development (OSHPD); and,
    e) Any additional requirements DPH deems necessary to protect patient safety or ensure quality of care.

3) Requires an eligible ASC to submit an application to DPH to obtain certification to participate in the Elective PCI Program. Requires the application to include sufficient information, as determined by DPH, to demonstrate compliance with the standards of the PCI Program, and to also include the effective date for initiating elective PCI service, the general service area, a description of the population to be served, a description of the services to be provided, a description of backup emergency services, the availability of comprehensive care, and the qualifications of the eligible ASC. Authorizes DPH to require that additional information be submitted with the application.

4) Specifies that failure to submit any criteria or additional information required by DPH disqualifies the applicant from the application process and from consideration for participation in the PCI Program. Authorizes DPH to deny an ASC PCI Program application pursuant to the requirements of the PCI Program, as described in 2) in Existing Law, below.

5) Requires OSHPD, using the data transferred pursuant to 2) c) above, to annually develop and make available to the public a report regarding each certified ASC's performance on mortality and stroke rates of ASCs certified to participate in the PCI Program.

6) Authorizes DPH to retain experts or establish one or more committees to analyze a report issued pursuant to 5) above, and to advise DPH on recommendations to improve the performance on mortality and stroke rates of certified ASCs.

7) Authorizes DPH to suspend or revoke the certification issued to an ASC, if, at any time, the ASC fails to meet the criteria for being a certified ASC or fails to safeguard patient safety, as determined by DPH. Specifies that an ASC whose certification is revoked may request an appeal and is not precluded from reapplying for certification.

8) Authorizes DPH to charge a certified ASC a fee for the reasonable regulatory costs to the state for issuing licenses and permits, performing investigations, inspections, and audits, and the administrative enforcement and adjudication thereof.

9) Authorizes DPH to contract with a professional entity with medical program knowledge to meet the requirements of this bill.

10) Defines the following for purposes of this bill:

    a) "Certified ASC" means an eligible ASC that is certified by DPH pursuant to this bill;
    b) "Elective Percutaneous Coronary Intervention (elective PCI)" means scheduled percutaneous transluminal coronary angioplasty and stent placement service approved by the Medicare Program under the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.);
    c) "Eligible ASC" means an ASC certified to participate in the Medicare program that does not have onsite cardiac surgery, and is in substantial compliance with all applicable state and federal laws and regulations; and,
    d) "Interventionist" means a licensed cardiologist who meets all of the requirements for performing an elective PCI.

11) Authorizes an ASC certified to participate in the Medicare program to perform cardiac catheterization laboratory services pursuant to this bill, only if all of the following requirements are met:

    a) The ASC maintains a current written transfer agreement, which includes all of the following:
        i) Provisions for emergency and routine transfer of patients;
        ii) Provisions that specify cardiac surgery staff and facilities shall be immediately available to the patient upon notification of an emergency; and,
        iii) Provisions that specify the cardiac catheterization staff shall have responsibility for arranging transportation to the receiving hospitals.
    b) The ASC complies with certain regulations as they existed on January 1, 2021 that specify how a PCI program must operate, including:
        i) Requiring written policies and procedures to be developed and maintained by the person responsible for the service in consultation with other appropriate health professionals;

ii) Recommended minimum of 260 cardiac catheterizations per year;
iii) Requiring supportive diagnostic services with trained personnel to be available;
iv) Require all persons operating or supervising the operation of X-ray machines to comply with Radiologic Technology Regulations; and,
v) Periodically require an appropriate committee of the medial staff to evaluate the services provided and make appropriate recommendations to the executive committee of the medical staff and administration.

c) The ASC has a system for the ongoing evaluation of its operations and the services it provides that includes a written plan for evaluating the efficiency and effectiveness of its health care services describing all of the following:
i) The scope of services provided;
ii) Measurement indictors regarding the processes and outcomes of the services provided;
iii) The assignment of responsibility when the data from the measurement indicators demonstrates the need for action;
iv) A mechanism to ensure follow-up evaluation of the effectiveness of the actions taken; and,
v) An annual evaluation of the plan.

12) Limits the application of this bill to ASCs only performing procedures on adults in an outpatient basis and requires the ASC to define patient characteristics that are appropriate for the safe performance of procedures in the ASC, including evaluation of these criteria in its quality assurance process.

13) Allows only the following diagnostic procedures to be performed in the ASC:

a) Right heart catherization and angiography;
b) Right and left heart catherization and angiography;
c) Left heart catherization and angiography;
d) Coronary angiography;
e) Electrophysiology studies; and,
f) Myocardial biopsy.

14) Makes findings and declarations regarding PCI, including, that SCAI stated that elective, nonemergent percutaneous coronary angioplasty and coronary stenting procedures have relatively low complication rates, are not expected to pose a significant risk to Medicare beneficiaries, and do not typically require inpatient-level care following the procedure.

15) Makes the provisions of this bill effective on January 1, 2022 and specifies that DPH is not required to adopt regulations.

EXISTING LAW:

1) Establishes the PCI Program in DPH, for the purpose of allowing DPH to certify general acute care hospitals (GACHs) that are licensed to provide urgent and emergent cardiac catheterization laboratory service in California, that meet certain requirements, to perform scheduled, elective percutaneous transluminal coronary angioplasty and stent placement for eligible patients.

2) Requires DPH to, at a minimum, adopt standards and regulations that specify that only diagnostic services, and what diagnostic services, may be offered by a GACH or a multispecialty clinic that is approved to provide cardiac catheterization laboratory service but is not also approved to provide cardiac surgery service. Requires a cardiac catheterization laboratory service to be located in a GACH that is either licensed to perform cardiovascular procedures requiring extracorporeal coronary artery bypass that meets all of the applicable licensing requirements relating to staff, equipment, and space for service, or, at a minimum, have a licensed intensive care service and coronary care service and maintain a written agreement for the transfer of patients to a GACH that is licensed for cardiac surgery.

3) Defines the following terms:

   a) "Certified hospital" means an eligible hospital that is certified by the DPH to participate in the PCI Program;
   b) "Elective PCI" means scheduled percutaneous transluminal coronary angioplasty and stent placement. Excludes from this definition elective urgent or emergent PCI that is scheduled on an ad hoc basis;
   c) "Eligible hospital" means a GACH that has an approved cardiac catheterization laboratory, does not have onsite cardiac surgery, and is in substantial compliance with all applicable state and federal licensing laws and regulations. Defines "GACH" as a health facility having a duly constituted governing body with overall administrative and professional responsibility and an organized medical staff that provides 24-hour inpatient care, including the following basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services. Includes as a GACH, more than one physical plant maintained and operated on separate premises. States that a GACH that exclusively provides acute medical rehabilitation center services, including at least physical therapy, occupational therapy, and speech therapy, may provide for the required surgical and anesthesia services through a contract with another acute care hospital;
   d) "Interventionalist" means a licensed cardiologist who meets the requirements for performing elective PCI; and,
   e) "Outpatient setting" means any facility, clinic, unlicensed facility, clinic, unlicensed clinic, center, office, or other setting that is not part of a general acute care facility, and where anesthesia, except local anesthesia or peripheral nerve blocks, or both, is used in compliance with the community standard of practice, in doses that, when administered have the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes.

4) Establishes the Medical Board of California (MBC), which, among other functions, adopts standards for accreditation of physician owned outpatient settings (including physician owned ASCs), and, in approving accreditation agencies to perform accreditation of outpatient settings, which at a minimum include standards for the following aspects of the settings' operations:

   a) Require outpatient setting allied health staff to be licensed or certified to the extent required by state or federal law;
   b) Require outpatient settings to have a system for facility safety and emergency training requirements;

c) Require onsite equipment, medication, and trained personnel to facilitate handling of services sought or provided and to facilitate handling of any medical emergency that may arise in connection with services sought or provided;
d) Require for procedures to be performed, an outpatient setting to do one of the following:
   i) Have a written transfer agreement with a local accredited or licensed acute care hospital, approved by the facility's medical staff; or,
   ii) Permit surgery only by a licensee who has admitting privileges at a local accredited or licensed GACH, with the exception that licensees who may be precluded from having admitting privileges by their professional classification or other administrative limitations, must have a written transfer agreement with licensees who have admitting privileges at local accredited or licensed acute care hospitals.
e) Submit for approval by an accrediting agency a detailed procedural plan for handling medical emergencies that must be reviewed at the time of accreditation. Requires that no reasonable plan be disapproved by the accrediting agency.

5) Specifies that certificates of accreditation issued to outpatient settings by an accreditation agency are valid for not more than three years. Requires the MBC to ensure that accreditation agencies inspect outpatient settings no less often than once every three years, and authorizes an accreditation agency that determines an outpatient setting is not in compliance with the standards under which it was approved to do any of the following:
   a) Require correction of any identified deficiencies within a set timeframe. Failure to comply shall result in the accrediting agency issuing a reprimand or suspending or revoking the outpatient setting's accreditation;
   b) Issue a reprimand;
   c) Place the outpatient setting on probation, during which time the setting shall successfully institute and complete a plan of correction, approved by the board or the accreditation agency, to correct the deficiencies; or,
   d) Suspend or revoke the outpatient settings certification of accreditation.

6) Requires ASCs to comply with federal certification standards specified in federal regulation.

7) Establishes OSPHD as the single state agency to collect essential data from health facilities. Specifies that the data be collected, to the extent practical, on consolidated, multipurpose report forms for use by all state agencies.

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

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, ASCs are becoming an increasingly important healthcare setting for many types of surgical procedures. The author states that for patients who have been screened by their physician as generally low-risk, and for procedures that are minimally invasive and do not require an overnight stay, the ASC setting represents an excellent option that delivers high quality patient care in a highly efficient environment, at a fraction of the cost incurred in other sites of service. The author notes that, in this era of needing to increase access to care, while also bending the cost-curve of that care and based on a proven track record of safety, California should now at least catch-up to Medicare and allow ASCs to perform diagnostic and interventional therapeutic cardiology procedures. The

author concludes that Medicare approved these cardiology procedures because they are not expected to pose a significant risk to patient safety when performed in an ASC.

2) BACKGROUND.

a) PCI. Coronary angioplasty, also called PCI, is a procedure used to open clogged heart arteries. PCI uses a tiny balloon catheter that is inserted in a blocked blood vessel to help widen it and improve blood flow to the heart. PCI is often combined with the placement of a small wire mesh tube called a stent. The stent helps prop the artery open, decreasing its chance of narrowing again. Most stents are coated with medication to help keep the artery open (drug-eluting stents). PCI can improve symptoms of blocked arteries, such as chest pain and shortness of breath. PCI done under emergency circumstances is referred to as "primary" PCI. Other PCI procedures, such as those done to unblock an artery before a heart attack occurs, are referred to as "elective" PCI.

b) ASCs. ASCs are facilities for surgical patients who do not need to be admitted to a hospital and remain on site for less than 24 hours. According to a 2018 California Health Care Foundation (CHCF) report, "California's Ambulatory Surgery Centers: A Black Box of Care," the number of freestanding ASCs in California has increased over the past 11 years from 626 to 791. However, a 2007 court case, "*Capen v. Shewry*" decision was interpreted to mean that ASCs with physician ownership come under the oversight of the MBC, not DPH, thereby removing any requirement for these ASCs to report data to OSHPD. This resulted in a rapid drop-off in the number of licensed ASCs reporting: only 34 in 2016. The CHCF report notes that the vast majority of freestanding ASCs in California and the United States (U.S.) are investor-owned, many by physicians. Only 3% of ASCs in California and the U.S. are nonprofit, and an additional 2% in California and 3% in the US are owned by the government.

An ASC must be certified under the Medicare program to participate in Medicare. They must demonstrate compliance with state licensure law, and ongoing compliance with Medicare standards designed to ensure patient safety and the quality of services provided. Medicare also limits the scope of surgical procedures reimbursed to elective procedures with short anesthesia and operating times. DPH is the certifying agency in California for the Medicare program. According to information supplied by the California Ambulatory Surgery Association (CASA), the sponsor of this bill, California is one of only 11 states that explicitly limit the site of service where PCI/cardiology procedures can be performed, including Maine, Massachusetts, New York, Pennsylvania, Ohio, Michigan, Mississippi, and Alabama.

According to DPH there are 820 Medicare-certified ASCs in California.

c) Recent Medicare approval for diagnostic cardiology procedures in ASCs. The Centers for Medicare and Medicaid Services (CMS) recently approved the addition of total knee replacement, diagnostic cardiology procedures and several interventional therapeutic cardiology procedures such as angioplasties and stents to be performed in the ASC setting. In their final rule, CMS stated that they do not believe these procedures pose a significant risk when performed in an ASC. According to an Ambulatory Surgery Center Association study, "Medicare Cost Savings Tied to ASCs," the Medicare program currently reimburses ASCs at 58% of the Hospital Out Patient Department rate. The

study used UC Berkeley analysis of data from 2008 to 2011, which showed that every procedure performed in an ASC saved the Medicare program 40% percent and Medicare beneficiaries 50 to 60% in their co-payments.

d) Medicare guidelines on physician owned ASCs. Medicare certification under federal regulations (42 CFR Part 416.50(b)) requires disclosure of physician financial interest or ownership. The ASC must also disclose, and where applicable, provide a list of physicians who have financial interest or ownership in the ASC facility. Disclosure of this information must be in writing. The Medicare Interpretive Guidelines state:

"An ASC that has physician owners or investors must provide written notice to the patient, the patient's representative or surrogate, prior to the start of the surgical procedure, that the ASC has physician-owners or physicians with a financial interest in the ASC." CMS considers the disclosure of physician financial interest or ownership to be part of the overall "patient rights information" that is now required to be given prior to the start of the procedure. ASCs that meet the physician ownership and control threshold must disclose their physician ownership to patients and provide them with a list of physicians who have a financial interest or ownership in the ASC. The intent of this disclosure requirement is to assist the patient in making an informed decision about their care by making the patient, or the patient's representative or surrogate, aware when physicians who refer their patients to the ASC for procedures, or physicians who perform procedures in an ASC also have an ownership or financial interest in the ASC. The written notice must disclose, in a manner designed to be understood by all patients, that physicians have an ownership or financial interest in the ASC. Information should be provided in a manner that is not only technically correct, but also easily understood by persons not familiar with financial statements, legal documents, or technical language.

e) May 2020 Society for Cardiovascular Angiography and Interventions Position statement (SCAI position statement) on the performance of PCI in ASCs. SCAI is a nonprofit medical society representing invasive and interventional cardiology. The SCAI position statement notes that SCAI supported CMS' proposal to reimburse elective PCI in the ASC setting during the public comment period in 2019, however this support is contingent on the maintenance of high- quality standards as patients undergoing PCI in an ASC should receive the same quality of care as those receiving PCI as an outpatient in the hospital.

SCAI states that the ability to perform PCI in an ASC has been made possible due to the outcomes data from observational studies and randomized controlled trials supporting same day discharge (SDD) after PCI. In appropriately selected patients for outpatient PCI, clinical outcomes for SDD or routine overnight observation were comparable without any difference in short- term or long- term adverse events. SDD was associated with a lower cost of care in both the Early Discharge After Transradial Stenting of Coronary Arteries randomized clinical trial and observational registries. SCAI states that these studies provide the framework and justification for performing PCI in an ASC.

SCAI states that the value proposition for performing outpatient PCI in an ASC versus the hospital outpatient environment, while dependent on consistent procedural efficacy and safety, offers improved efficiency of care, increased access to care, better patient satisfaction, and reduced cost. Advances in clinical decision making, adjunctive

pharmacotherapy, and procedural technology have continuously improved the safety profile of outpatient PCI. Data from the National Cardiovascular Data Registry from 1,612 hospitals reveal that major complications after PCI are rare, and exceedingly so for elective PCI. Cautious case selection based on patient and lesion characteristics can further reduce the risk of complication in the ASC setting.

SCAI also notes that, while there are potential benefits of outpatient PCI in the ASC setting, it is important to consider the drawbacks. There are extensive published data on the safety of outpatient PCI in a hospital setting, but none available for outpatient PCI safety in an ASC setting. The shift in procedural volume from hospitals to ASCs will have financial implications for hospitals that could potentially impact their ability to provide other necessary services. Although it is expected that PCI in an ASC would decrease overall expenditure, it is possible that the actual number of PCI procedures performed may increase.

f) California Elective PCI Program. According to DPH there are currently 22 hospitals certified in the Elective PCI Program to perform elective PCIs without onsite surgical backup. A list of these hospitals and their locations follows:

FACILITY NAME	City
Adventist Health Simi Valley	Simi Valley
Chino Valley Medical Center	Chino
Clovis Community Medical Center	Clovis
Corona Regional Medical Center	Corona
Emanuel Medical Center	Turlock
Highland Hospital	Oakland
John F. Kennedy Memorial	Indio
Kaiser Foundation Hospital - Orange County - Irvine	Irvine
Kaiser Foundation Oakland/Richmond	Oakland
Kaiser Foundation Hospital - Roseville	Roseville
Kaiser Foundation Hospital - South Sacramento	Sacramento
Kaiser Foundation Hospital-San Jose	San Jose
Kaiser Foundation Hospital - Walnut Creek	Walnut Creek
Kaiser Foundation Hospital & Rehab Center - Vallejo	Vallejo
Los Alamitos Medical Center	Los Alamitos
Mercy Medical Center	Sacramento
Sherman Oaks Hospital	Sherman Oaks
St. Rose Hospital	Hayward
Sutter Delta Medical Center	Antioch
Sutter Roseville Medical Center	Roseville
Desert Valley Hospital	Victorville
Sierra View Medical Center	Porterville

Current law requires hospitals certified by DPH to participate in the PCI program to report outcomes to OSHPD and for OSHPD to provide a PCI Program Report, including information on the quality of elective PCIs at California general acute care hospitals certified to perform elective PCIs without on-site cardiac surgery. The findings from the 2018 report are as follows:

i) **Mortality Findings:** The elective PCI mortality rate for certified hospitals was 0.13% compared to a statewide elective PCI mortality rate of 0.30%. There was one death for the 13 certified hospitals in 2018 compared to four deaths for the 12 certified hospitals in 2017;
ii) **Post-PCI Stroke Findings:** The elective PCI stroke rate for certified hospitals was zero percent compared to a statewide rate of 0.11%. There were zero strokes for the certified hospitals in 2018 and 2017; and,
iii) **Post-PCI Emergency Coronary Artery Bypass Grafting Surgery Findings:** There were no emergency CABGs for the 13 certified hospitals in 2018. There was one emergency CABG for the 12 certified hospitals in 2017.

3) **SUPPORT.** CASA is the sponsor of this bill and states that it will provide significant savings to the California health care system. For example, UC Berkeley research has shown that every procedure performed in an ASC saves the Medicare program 40% and saves Medicare beneficiaries 50% to 60% in their copayments. CASA notes that the American College of Cardiology (ACC) states that, "Allowing these cardiac catheterization and concomitant procedures to be performed in an ASC is in line with CMS' goals to expand access to services and encourage the delivery of care in the lowest cost setting." These elective cardiology procedures are being performed by the same physicians on the same patients but just in a different non-traditional site of service. CASA also states that Medicare recently allowed ASCs to perform these procedures because they are safe and have low rates of complication. CASA points to the SCAI statement: "We feel that elective, non-emergent percutaneous coronary angioplasty and coronary stenting procedures have relatively low complication rates and are not expected to pose a significant risk to Medicare beneficiary safety and do not typically require inpatient-level care following the procedure."

   The California Chapter of the American College of Cardiology (CA-ACC) supports this bill and states that CA-ACC was actively involved in SB 906 (Correa) from 2014 that allowed hospitals to perform certain elective cardiac procedures without having surgical backup. The program was structured around hospitals meeting certain requirements as laid out in joint guidelines developed by the American College of Cardiology, the American Heart Association, and SCAI. This structure helped ensure patients received quality care in a safe environment. This program has successfully expanded access and reduced the amount of time to cardiac surgical care for many Californians. CA-ACC believes this structure is appropriate for allowing ASCs to perform these cardiac procedures and will create more access to cardiac procedures which will benefit patients with reduced waiting times while not putting them at any greater risk.

4) **OPPOSE UNLESS AMENDED.** The Service Employees International Union (SEIU California) is opposed to this bill unless it is amended. SEIU California states that due to potential complications associated with performing these procedures, which include heart attack, stroke, damage to the artery, and excessive bleeding, hospitals are the only setting with the proper staffing and equipment to handle these procedures. ASCs, with their lack of reporting, insufficient regulatory oversight, and the potential for perverse financial incentives, create unnecessary risks for patients. The nurses and technologists who work in hospitals providing cardiac catherization procedures are highly trained and qualified to deliver care. Regular training and exposure to a variety of cases helps to ensure that the care team is prepared for any eventually that may arise during a case. By moving care into ASCs, some members of these highly trained care teams would likely be forced to move to ASCs

for less pay or leave for other employment opportunities. SEIU concludes that while they agree that it is necessary to expand access to care, they must oppose the bill in its current form because it would put patients' lives at risk with insufficient guardrails for patient safety, little transparency, and no protections from financial self-dealing.

5) PREVIOUS LEGISLATION.

a) SB 906 (Correa), Chapter 368, Statutes of 2014, creates the PCI Program in DPH to certify an unlimited number of GACHs licensed to provide cardiac catheterization laboratory service in California, and that meet prescribed, additional criteria, to perform scheduled, elective PCI. SB 906 also authorizes a hospital that was participating in the Elective PCI Pilot Program as of December 31, 2014, to continue to perform elective PCI but required the hospital to obtain a certification, as specified, by January 1, 2016.

b) SB 357 (Correa), Chapter 202, Statues of 2013, extends the January 1, 2014 sunset date for the PCI Pilot Program to January 1, 2015, and requires the final report by the oversight committee to be completed by November 30, 2013, rather than at the conclusion of the pilot program.

c) SB 891 (Correa), Chapter 295, Statues of 2008, establishes the PCI Pilot Program, until 2014, which authorizes six acute care hospitals, licensed to provide cardiac catheterization laboratory services, to perform elective PCI without onsite back-up cardiac surgery services.

6) SUGGESTED AMENDMENTS.

a) Because the shift in procedural volume from hospitals to ASCs may have financial implications for hospitals that could potentially impact their ability to provide other necessary services, the Committee may wish to amend this bill to limit number of new ASCs DPH may approve to provide elective PCI to 50.

b) In order to evaluate what the effect of allowing ASCs to provide elective PCI will be on patients and hospitals, the Committee may wish to amend this bill to sunset after 10 years.

REGISTERED SUPPORT / OPPOSITION:

Support

California Ambulatory Surgery Association (sponsor)
Advanced Medical Technology Association (ADVAMED)
American College of Cardiology
Azura Vascular
California Chapter American College of Cardiology
California Chronic Care Coalition
California Medical Association
Central Valley Surgical Center
Chronic Disease Coalition
Digestive Care Center
Fresenius Medical Care North America

Golden Triangle Surgicenter
Latino Coalition for a Healthy California
Mixteco Indigena Community Organizing Project (MICOP)
Orange County Vascular Access Center
Philips Electronics North America
Sacramento Heart Ambulatory Surgery Center, INC.
Society for Cardiovascular Angiography and Interventions
Surgical Care Affiliates
Surgical Center of San Diego
Numerous individuals

Opposition

None on file.

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