SENATE COMMITTEE ON HEALTH
Senator Akilah Weber Pierson, Chair

BILL NO: AB 2282
AUTHOR: Alanis
VERSION: June 22, 2026
HEARING DATE: July 1, 2026
CONSULTANT: Vincent D. Marchand

SUBJECT: Health facilities: emergency medical services

SUMMARY: Requires the California Department of Public Health to issue a waiver for a publicly owned general acute care hospital, located within the City of Patterson, to provide emergency stabilization services at a rural emergency stabilization care unit that is neither inside nor contiguous to the applicant hospital, if certain requirements are met, including that the locations meets regulatory requirements applicable to emergency departments, as specified.

Existing law:
1) Licenses general acute care hospitals under the California Department of Public Health (CDPH). Defines "general acute care hospitals" as hospitals that provide 24-hour inpatient care, including the following basic services: medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services. [HSC §1250(a)]

2) Permits general acute care hospitals, in addition to the basic services all hospitals are required to offer, to be approved by CDPH to offer special services, including, but not limited to, a radiation therapy department, a burn center, an emergency center, a hemodialysis center or unit, psychiatric services, intensive care newborn nursery, cardiac surgery, cardiac catheterization laboratory, and renal transplant. [HSC §1255]

3) Establishes, in regulation, requirements for different levels of emergency services that a hospital can be approved to provide as a special service, including "Basic Emergency Medical Service, Physician on Duty," "Comprehensive Emergency Medical Service," and "Standby Emergency Medical Service, Physician on Call." [22 CCR §70411 et seq., §70451 et seq., and §70651 et seq.]

4) Prohibits any person or public agency to advertise itself as, or hold itself out as, providing emergency medical services, by using any words which suggest that it is staffed and equipped to provide emergency medical services unless the person or public agency meets one of the following two requirements:
   a) Is a general acute care hospital providing approved standby, basic, or comprehensive emergency medical services; or,
   b) Meets specified minimum standards, including having emergency services available in the facility seven days a week, 24 hours a day, has equipment, medication and personnel experienced in the provision of services needed to treat life-threatening conditions, and diagnostic radiology and clinical laboratory services are provided by persons on duty or on call and available when needed. [HSC §1798.175]

5) Permits, in rural areas, when the use of a hospital having a basic emergency department (ED) is precluded because of geographic or other extenuating circumstances, the local emergency medical services agency (LEMSA) to authorize another facility to receive patients requiring emergency medical services (EMS) if the facility has adequate staff and equipment to

provide these services, as determined by the medical director of the LEMSA. [HSC §1798.101]

6) Requires CDPH to issue a single consolidated license to a general acute care hospital that includes more than one physical plant maintained and operated on separate premises or that has multiple licenses for a single health facility on the same premises if the general acute care hospital meets certain criteria and applicable requirements of licensure. Requires the physical plants to be covered by the single consolidated license to be located no more than 15 miles apart, with certain exceptions, including if one of the physical plants is located in a rural area. [HSC §1250.8]

7) Requires CDPH to issue a special permit to allow a general acute care hospital to offer emergency stabilization services at a location in the town of Paradise within Butte County, serving the same area previously served by Feather River Hospital that was destroyed by the Camp Fire in 2018, at a location that is neither inside nor contiguous to the applicant hospital, if the hospital meets certain requirements, as specified. States that it is not the intent of the Legislature to establish a model for a freestanding ED, which is currently, and remains, prohibited by state law. Sunsets these provisions on January 1, 2028. [HSC §1251.6]

This bill:

1) Requires CDPH, notwithstanding any other law, to issue a waiver for a general acute care hospital, so long as it is publicly owned and operated, in collaboration with the Del Puerto Health Care District (District) in Stanislaus County, to provide emergency stabilization services at a rural emergency stabilization care unit that is neither inside nor contiguous to the applicant hospital.

2) Defines "rural emergency stabilization care unit" as a facility operated by the District that is not licensed as a hospital, is not located inside or contiguous to a hospital, and provides 24-hour emergency medical screening, stabilization, and triage services for unscheduled patients who present with emergency medical conditions.

3) Requires CDPH to waive the general acute care hospital licensure requirements that require inpatient beds, inpatient nursing units, or other services that cannot be provided onsite at the emergency stabilization care unit, but are provided in a noncontiguous setting, if all of the following conditions are met:
   a) The location is within the City of Patterson in the County of Stanislaus and is intended to serve the same general population as is served by the District;
   b) The location meets specified regulatory requirements applicable to EDs described in specified provisions of California Title 22 regulations (though not all requirements, as described in Comment 4) below);
   c) The location complies with the hospital's existing collective bargaining agreements;
   d) The location is open 24 hours a day, 7 days a week;
   e) The location provides medical, pharmacy, nursing, clinical laboratory, and radiological services onsite in compliance with existing regulations, as specified;
   f) The location complies with the federal Emergency Medical Treatment and Labor Act and similar California provisions of law which require hospitals and EDs to provide emergency screening and stabilization services without regard to the patient's insurance status or ability to pay;

g) The location has informed the LEMSA about the types of medical conditions and injuries that the facility cannot treat and for which the patient needs to be transported directly to a general acute care hospital ED;
h) The wording of exterior signs states "EMERGENCY STABILIZATION SERVICES, PHYSICIAN ON DUTY;"
i) The location stabilizes for transport or releases a patient within 24 hours of registration. Requires the location to report to CDPH any failure to stabilize a patient for transfer or release of the patient within 24 hours;
j) The location provides a patient, upon registration, with a written notice that the patient should consult with the health care coverage carrier about which services may be covered and for which copayments and charges the patient may be responsible;
k) The location posts information identifying the three nearest hospitals ranked by estimated driving time from the nearest to the farthest away;
l) The location posts a sign, at or near any public entrance of the location, stating that patients requiring surgery, trauma care, or an inpatient bed will be transported to the nearest hospital;
m) The location meets the physical plant requirements and has received clearance from the Department of Health Care Access and Information (HCAI) as appropriate for the setting and services being provided at the location; and,
n) The applicant hospital has submitted and received approval on an application that meets the requirements of 4) below.

4) Requires the application to be submitted to CDPH pursuant to the application requirements of existing law, as specified, and to include all of the following:
   a) A plan of operation that, at a minimum, addresses the location's plan for patient care, infection control, waste disposal, and linen services;
   b) The policy and procedure that the location will implement for the emergency transportation of patients that cannot be served by the facility. Requires this policy to comply with the standards of practice and to include how the patient will be transported to the nearest hospital ED, the timeframe for transfer, and how the location will ensure patient safety during the transfer;
   c) A written transfer agreement with all hospitals within a 25-mile radius with an ED;
   d) A community outreach and education plan to ensure the community is informed of the types of services that the facility is capable of providing, including instructions indicating the types of injuries or conditions for which a patient should be transported directly to the nearest hospital ED; and,
   e) A triage algorithm that the location developed and will implement in collaboration with the LEMSA to determine appropriate patients for transport to the location.

5) Requires a waiver issued pursuant to this bill to expire two years from the date of its issuance, and permits the waiver to be renewed every two years, for a combined period not to exceed 10 years from the initial date of issuance. However, if prior to the expiration of the waiver, the District has submitted complete construction documents to HCAI for review of a hospital to be located within the District, requires CDPH to extend the waiver until the issuance of a certificate of occupancy for that hospital.

6) Permits CDPH to deny a request for approval or renewal of the waiver if the location fails to meet the requirements of this bill, or suspend or revoke the waiver, pursuant to provisions of existing law.

7) Requires a hospital issued a waiver under this bill to report all of the following:
   a) For purposes of the Annual Report of Hospitals, as required under existing law, to report bed and service utilization data separately by each facility;
   b) Hospital adverse event reports and reportable disease reports, as specified; and,
   c) By March 1 of each year, a detailed report on the types of services, number of patients served, and any adverse patient outcomes during the prior calendar year.

8) Permits CDPH, without taking regulatory action, to implement, interpret, or make specific this bill by means of an All Facilities Letter or similar instruction.

9) Specifies that the provisions of this bill will only remain operative until a hospital building is completed within a five-mile radius of the emergency stabilization care unit or within ten years from the initial issuance of the waiver, unless the District has submitted complete hospital construction documents to the HCAI for review or has commenced vertical construction of that hospital, in which case the provisions of this bill will remain operative until issuance of a certificate of occupancy for the hospital.

10) Makes legislative findings and declarations that a special statute is necessary because of all of the following:
   a) Residents, workers, and visitors in the City of Patterson face comparable, and in many cases more burdensome, access conditions to emergency medical services when compared to other designated areas;
   b) Average travel distances from Patterson to the nearest full-service acute care hospital or trauma center are approximately 21 miles, with average drive times of 36 minutes or more;
   c) These access delays are driven by persistent geographic isolation, limited roadway options, agricultural and freight traffic, rail crossings, State Highway 33 congestion, and weather-related disruptions, including fog and flooding; and,
   d) The access challenges in Patterson reflect structural constraints and ongoing gaps in timely emergency medical services in a rural, medically underserved community, rather than temporary emergencies such as wildfires.

FISCAL EFFECT: According to the Assembly Appropriations Committee analysis of a prior version of this bill, costs to CDPH of an unknown, but likely minor and absorbable, amount (Licensing and Certification Fund). HCAI estimates one-time General Fund costs of approximately $650,000 for consulting and professional services expertise and adoption of emergency regulations, including entries for federal Centers for Medicare and Medicaid Services regulations and other state and federal requirements, as well as updates to its eServices Portal. HCAI states it also needs $672,000 in fiscal year 2026-27 and ongoing for two positions: one Senior Architect to develop and implement the Emergency Regulations for a new building category designation and to perform plan review, and one structural engineer to ensure seismic safety compliance.

PRIOR VOTES:

Assembly Floor:	76 - 0
Assembly Appropriations Committee:	15 - 0
Assembly Health Committee:	16 - 0

COMMENTS:

1) *Author's statement.* According to the author, this bill helps ensure families in Patterson have access to emergency care when they need it most. Today, individuals experiencing medical emergencies must travel more than 20 miles to reach the nearest hospital. When someone is suffering a heart attack, stroke, or traumatic injury, those extra miles can mean the difference between life and death. This bill provides a practical and temporary solution by allowing a licensed hospital to operate a 24/7 rural emergency stabilization care unit in the community, while a permanent hospital facility is being planned and constructed. Every Californian deserves timely access to emergency medical services, regardless of where they live. This bill will help close a critical gap in care, improve health outcomes, and bring life-saving services closer to our residents who need them most.

2) *Del Puerto Health Care District.* Del Puerto Health Care District was originally established in 1946 as the Patterson Hospital District. In 1949-1950, it opened a hospital in downtown Patterson, and in 1976 launched its own ambulance service, Patterson District Ambulance. According to the District, the hospital was forced to close in 1998 due to financial challenges, doctor shortages, and the restructuring of medical insurance networks. At this time, the District was renamed the Del Puerto Health Care District. It opened the Del Puerto Health Center in 2003, which is a community clinic open Monday through Friday from 8:00 am to 5:00 pm, with urgent care on Tuesdays and Thursdays from 5:00 pm to 8:00 pm. The Patterson District Ambulance provides 24-hour emergency medical services to Patterson and the surrounding communities, including Event Standby Services. The District has developed a Mixed-Use Campus Master Plan that would consolidate a number of primary care and support services into a coordinated system, and would include a critical access hospital.

3) *Hospitals closest to the District.* The City of Patterson is located in western Stanislaus County, along a stretch of Interstate 5 without freeway access to any nearby hospitals. The closest hospitals require heading east along surface streets or smaller highways to Emanuel Medical Center in Turlock, about 19 miles/30 minutes away without traffic according to Google Maps, or one of several hospitals in Modesto, where the closest hospital is Doctor's Medical Center, which is about 21 miles/32 minutes away without traffic.

   This bill requires a licensed hospital to apply for a waiver to work with the District to offer the rural emergency stabilization care unit. The licensed hospital is required to be publicly owned and operated. The closest publicly owned and operated hospital is Oak Valley Hospital in Oakdale, operated by the Oak Valley Hospital District. Oak Valley Hospital is about 35 miles/50 minutes away with no traffic. However, this bill still requires transfer agreements with all hospitals with EDs within a 25-mile radius.

4) *Description of regulations this bill requires the emergency stabilization care unit to meet.* Among other requirements, this bill requires the rural emergency stabilization care unit location to meet certain specified regulatory requirements. These regulatory requirements are to the "basic" level of a hospital ED, which requires an emergency physician on duty at all times. The specified regulations include almost all the requirements of a regular hospital ED except for the requirement to physically be in a hospital. However, it excludes the requirement to have surgical services immediately available along with postanesthesia recovery services, or to have intensive care service capabilities.

5) *Modeled on legislative authorization for Adventist Health to operate an emergency stabilization service at the site of the former Feather River Hospital destroyed by 2018 Camp Fire never implemented.* Following the destruction of the Feather River Hospital in the town

of Paradise by the 2018 Camp Fire, SB 156 (Nielsen, Chapter 839, Statutes of 2019) was enacted to require CDPH to issue a special permit to allow Adventist Health to offer emergency stabilization services at the site of the former Feather River Hospital in Paradise for up to six years, without being attached to hospital, if certain requirements were met. The intent was to provide the community of Paradise with access to emergency stabilization services as it began the rebuilding process, and to provide a temporary period of time to assess whether and to what extent the town of Paradise will return and make construction of a new hospital viable. This bill is closely modeled on SB 156, including the specific emergency room regulations that these emergency stabilization services are required to meet.

While the provisions enacted by SB 156 are still in statute until the sunset date of January 1, 2028, Adventist Health ultimately decided not to move forward with this option. According to information provided by Adventist Health, the area does not have the necessary volume of population, providers, or medical needs to support a freestanding ED or a full-scale hospital. Additionally, Adventist Health pointed out that following the passage of the bill, the COVID-19 pandemic began, which represented a major shift in the health care delivery system, health care financing, health care staffing, and community needs.

6) *Background on freestanding EDs (FEDs).* There are currently no FEDs licensed in California, although they do operate in other states. In California, in order to offer emergency medical services, a facility must provide certain services, such as intensive care, radiology, and surgical services that are immediately available for life-threatening situations, which essentially require an ED to be part of a full-fledged hospital. In other states, FEDs generally fall into two categories: those that are part of a hospital system and must be within 35 miles of the affiliated hospital (often called satellite FEDs), and those that are independent and are not affiliated with a hospital. As an example of the latter, First Choice ER is a for-profit chain of freestanding, 24-hour emergency rooms that operate in Texas and Colorado. The Centers for Medicare and Medicaid Services (CMS) only certifies hospital-affiliated FEDs for Medicare and Medicaid, so independent FEDs are not eligible for federal reimbursement. This also means that independent FEDs are not subject to the federal Emergency Medical Treatment and Labor Act (EMTALA), which requires hospitals with EDs and emergency physicians to provide emergency treatment to everyone regardless of their ability to pay. FEDs that are part of a hospital system, however, are subject to EMTALA.

The California Health Care Foundation (CHCF) published an issue brief in July of 2009, entitled "Freestanding Emergency Departments: Do They Have a Role in California?" According to the CHCF report, the growth of FEDs has prompted discussions regarding their regulation and effect on the health care system. The CHCF report states that these facilities differ from urgent care centers in that they can accommodate additional procedures such as defibrillation, intubation, and conscious sedation. Additionally, most FEDs are staffed by trained emergency physicians and nurses, and some have been permitted to receive ambulance patients.

Both satellite and independent FEDs have undergone massive growth in the past 20 years or so. According to a 2019 article in the Annals of Emergency Medicine, entitled "Freestanding Emergency Departments: What is Their Role in Emergency Care?" there were 80 operational FEDs in the U.S. in 2007, and 91% of those were affiliated with a hospital. In September 2015, the Medicare Payment Advisory Commission reported 559 FEDs, with 69% being hospital affiliated, and 31% independent FEDs. Texas has by far the highest number of FEDs, with Colorado and Ohio also reporting having a significant number. In March 2024,

researchers at Texas A&M University School of Public Health published a paper in the journal Health Services Research that examined the characteristics of patient visits to FEDs in Texas compared to traditional hospital-based EDs. According to this article, as of May 2023, Texas had 338 FEDs, of which 211 were independent, and 127 were satellites of a hospital. According to the researchers, about 24% of all ED visits in Texas occurred at FEDs and that "these patients were younger, healthier, and less likely to be identified as non-Hispanic Black or Hispanic. They also were more likely to have private insurance and their visits were more likely to be due to issues that could have been managed in a primary care setting." The health issues of patients visiting satellite and independent FEDs were more likely to be moderate and low intensity and potentially avoidable.

7) *EDs cost more than urgent care.* When a patient is seen in an ED, there is the physician services fee, a technical component that might include any diagnostic tests, and a facility fee to cover the cost of the facility itself. All of these are higher in EDs; Medi-Cal, for example, pays a higher rate for medical and surgery services when the service is provided in an ED. A study published in the Annals of Emergency Medicine in December of 2017, "Comparing Utilization and Costs of Care in Freestanding Emergency Departments, Hospital Emergency Departments, and Urgent Care Centers," compared utilization, price per visit, and the types of care delivered across FEDs, hospital-based EDs, and urgent care centers in Texas. According to this article, in 2015, the average price per visit for a hospital-based ED was $2,259, and almost as much in FEDs ($2,199). However, the average price per visit in an urgent care center was only $168. There was a 75% overlap in the 20 most common diagnoses at FEDs versus urgent care centers, and 60% overlap for hospital-based EDs and urgent care centers. However, prices for patients with the same diagnosis were on average almost ten times higher at freestanding and hospital-based EDs relative to urgent care centers. The study author's conclusion was that higher prices at FEDs and hospital-based EDs relative to urgent care centers, despite substantial overlap in services delivered, imply potential inefficient use of emergency facilities.

8) *Recent federal authorization for "Rural Emergency Hospitals."* CMS published a final rule, effective January 1, 2023, establishing a new Medicare provider type called "Rural Emergency Hospitals" (REHs), which is basically a type of FED. As more rural hospitals across the country closed, and with ongoing concern about the financial viability of the remaining rural facilities, the creation of REHs was intended to reinforce access to outpatient medical services and reduce health disparities in areas that may not be able to sustain a full-service hospital. Under the final rule, struggling rural hospitals could continue to operate with outpatient and emergency services only, instead of closing. Eligibility is limited to facilities that were operating as a Critical Access Hospital (rural hospitals with no more than 25 beds) or as a rural hospital with no more than 50 beds, as of December 27, 2020. So, if a small rural hospital had recently closed, it can reopen to provide emergency services as an REH, or an existing small rural hospital can convert to an REH. However, an REH is required to meet applicable state licensing, staffing and other requirements. Since California does not permit FEDs, REHs are not permitted in California.

9) *Pilot project at Centinela Airport Clinic.* Using statutory authority that permits a LEMSA to "approve or conduct any scientific or trial study of the efficacy of the pre-hospital emergency use of any drug, device, or treatment procedure within the local EMS system," the Los Angeles County LEMSA approved a two-year pilot project beginning in 2004 to allow the Centinela Airport Clinic at Los Angeles International Airport to receive 911 transports of basic life-support patients. Some people cite this example as California's first and only

attempt at permitting a FED. However, both CDPH and the state Emergency Medical Services Agency disagreed that the LEMSA had the authority to permit the operation of such a facility. Ultimately, this FED pilot project ended after one year, partly as a result of the low volume that resulted from a restrictive county ambulance triage policy that limited the severity of patients that could be transported to this location.

10) *Alternative method of providing urgent/emergency care in rural areas.* One example of a rural region's approach to provide urgent medical care services is on the North Coast of California. The Coast Life Support District (CLSD) was established in 1986 to provide EMS in portions of Sonoma and Mendocino Counties, covering 60 miles of coastline. There are no hospitals within the district. From its center, the closest medical facilities with 24-hour medical care are a minimum of 90 minutes to two hours travel time traversing the coast highway. These are some of the longest transports in California to tertiary care. CLSD provides ambulance transport (both a 24-7 advanced life support ambulance and an on-call basic life support ambulance), as well as emergency response training for fire departments, and CPR/AED training to the community. CLSD has entered into, or funded, contracts with health care professionals and otherwise augmented the provision of urgent and immediate care services in Gualala (where the district is headquartered), as well as EMS throughout CLSD. Care is provided at Redwood Coast Medical Services (RCMS), which is a Federally Qualified Health Center (FQHC). Because this FQHC is in a rural area, it also provides immediate and urgent care services that are more expansive than their urban counterparts. RCMS has been approved as an Alternative EMS Receiving Facility for the Coastal Valleys EMS Region (the LEMSA for that region), which means it can receive 911 ambulance transports for patients that meet criteria eligible to be seen at RCMS. CLSD uses the proceeds from a local benefit assessment to contract with RCMS to provide urgent care from 8:00 a.m. to 6:00 p.m., seven days a week.

11) *Prior legislation.* SB 588 (Ochoa Bogh of 2025) would have required the Department of Health Care Access and Information to conduct a comprehensive feasibility study on the implementation of freestanding EDs in rural, disadvantaged, and underserved areas with limited access to emergency care, and to report its findings and recommendations to the Legislature by January 1, 2027. *SB 588 was heard for testimony in this Committee on April 30, 2025, but no vote was taken.*

SB 156 (Nielsen, Chapter 839, Statutes of 2019) required CDPH to issue a special permit to a hospital to offer emergency stabilization services at the site of the former Feather River Hospital in Paradise for up to six years, if certain requirements were met.

SB 787 (Bates of 2015) and AB 911 (Brough of 2015) would have permitted Saddleback Memorial Medical Center to operate an ED at its San Clemente campus, subject to approval by CDPH, even if the San Clemente campus stopped providing acute care services (thereby permitting an FED), subject to specified conditions. *SB 787 failed passage in the Senate Health Committee. AB 911 failed passage in the Assembly Health Committee.*

AB 717 (Gordon of 2005) would have allowed the Centinela Airport Clinic to receive private and government reimbursement rates equivalent to that of a contiguous ED of a general acute care hospital if certain specified requirements were met. *AB 717 failed passage in the Senate Health Committee.*

AB 1050 (Gordon of 2005) would have created a demonstration project that required the

Department of Health Services to issue a special permit to up to four general acute care hospital applicants in Los Angeles County to operate freestanding emergency receiving centers. *AB 1050 was not heard in the Assembly Health Committee.*

12) *Support.* This bill is co-sponsored by the Del Puerto Health Care District and the Association of California Healthcare Districts, and supported by a number of organizations. According to proponents, Patterson is one of California's fastest-growing and most medically underserved rural cities. With a population of more than 25,000, Patterson residents face a stark reality: when a medical emergency strikes, there is no local emergency room. They must endure a minimum 25-minute ambulance ride to reach the nearest hospital ED, where high demand can contribute to delays in patient handoff and placement. Access to care has been identified as Stanislaus County's number one health issue. Supporters note that this bill does not ask California to fund a new facility, create a new regulatory framework, or make a permanent change to state law. Instead, it authorizes a single, narrowly scoped special permit to allow the District to operate an emergency stabilization unit while its permanent hospital campus is under development. The sponsors state that a campus groundbreaking is anticipated in 2027, and a full hospital expected between 2035 and 2040.

13) *Opposition.* The California Chapter of the American College of Emergency Physicians (California ACEP) states in opposition that FEDs are facilities that provide urgent care but are not attached to acute care hospitals. California ACEP has historically opposed legislative efforts to allow FEDs to operate in California out of concern for jeopardizing patient safety and their impacts to the emergency care safety net. FEDs threaten the precarious financial stability of hospital-based care, because when an FED is built, it changes the payer mix of existing hospitals in the surrounding region and can jeopardize their fragile funding. Given the passage of HR 1 and the loss of Medi-Cal coverage to an estimated 2 million Californians, now is not the time to pursue policy changes that may further undermine the fragility of hospital-based care in our communities.

SUPPORT AND OPPOSITION:

Support: Del Puerto Health Care District (sponsor)
American Nurses Association/California
Association of California Healthcare Districts
California Ambulance Association
California Special Districts Association
City of Patterson
City of Patterson Fire Department
Desert Healthcare District and Foundation
National Alliance on Mental Illness - Stanislaus
Patterson Joint Unified School District
Stanislaus County Deputy Sheriff's Association
Stanislaus Latino Chamber of Commerce
United Steelworkers District 12

Oppose: California Chapter of the American College of Emergency Physicians

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