L.A. Care
HEALTH PLAN
For All of L.A.

BOARD OF GOVERNORS

Executive Committee Meeting

August 23, 2023 • 2:00 PM

L.A. Care Health Plan

1055 W. 7th Street, Los Angeles, CA 90017

AGENDA
Executive Committee Meeting
Board of Governors

DRAFT

Wednesday, August 23, 2023, 2:00 P.M.
L.A. Care Health Plan, 1055 West 7th Street, Conference Room 1017-18
Los Angeles, CA 90017

Members of the Committee, staff and the public can attend the meeting in person at the address listed above. Public comment can be made live and in person at the meeting. A form will be available at the meeting to submit public comment.

To listen to the meeting via videoconference please register by using the link below:
https://lacare.webex.com/lacare/j.php?MTID=m1adcb62fc8dd918be7e2fcf2b52ccc28

To listen to the meeting via teleconference please dial: +1-213-306-3065
Meeting Number: 2494 345 5879 Password: lacare

Teleconference Site

Hilda Perez
L.A. Care Health Plan Community Resource Center
3200 E Imperial Hwy
Lynwood, CA 90262

For those not attending the meeting in person, public comments on Agenda items can be submitted in writing by e-mail to BoardServices@lacare.org, or by sending a text or voicemail to (213) 628-6420. Attendees who log on to lacare.webex using the URL above will be able to use "chat" during the meeting for public comment. You must be logged into WebEx to use the "chat" feature. The log in information is at the top of the meeting Agenda. The chat function will be available during the meeting so public comments can be made live and direct.

1. The "chat" will be available during the public comment periods before each item.
2. To use the "chat" during public comment periods, look at the bottom right of your screen for the icon that has the word, "chat" on it.
3. Click on the chat icon. It will open two small windows.
4. Select "Everyone" in the "To:" window,
5. The chat message must indicate if you wish to be identified or remain anonymous, and must also include the name of the item to which your comment relates.
6. Type your public comment in the box that says "Enter chat message here".
7. When you hit the enter key, your message is sent and everyone can see it.
8. L.A. Care staff will read the chat messages for up to three minutes during public comment so people who are on the phone can hear the comment.

You can also send your public comments by voicemail, email or text. If we receive your comments by 2:00 P.M. on August 23, 2023, it will be provided to the members of the Executive Committee in writing at the beginning of the meeting. The chat message, text, voicemail, or email must indicate if you wish to be identified or remain anonymous, and must include the name of the item to which your comment relates.

Once the meeting has started, public comment submitted in writing must be received before the agenda item is called by the Chair. If your public comment is not related to any of the agenda item topics, it will be read in the general public comment agenda item.

Please note that there may be delay in the digital transmittal of emails, texts and voicemail. The Chair will announce when public comment period is over for each item. If your public comments are not received

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on time for the specific agenda item you want to address, your public comments will be read at the public comment section prior to the board going to closed session.
The purpose of public comment is an opportunity for members of the public to inform the governing body about their views. The Executive Committee appreciates hearing the input as it considers the business on the Agenda. All public comments submitted will be read for up to 3 minutes during the meeting. The process for public comment is evolving and may change at future meetings. We thank you for your patience.

All votes in a teleconferenced meeting shall be conducted by roll call.

If you are an individual with a disability and need a reasonable modification or accommodation pursuant to the Americans with Disabilities Act (ADA) please contact L.A. Care Board Services staff prior to the meeting for assistance by text to 213 628-6420 or by email to BoardServices@lacare.org.

Welcome — Al Ballesteros, MBA, *Chair*

1. Approve today's Agenda — *Chair*
2. Public Comment *(Please read instructions above.)* — *Chair*
3. Approve June 28, 2023 meeting minutes p.6 — *Chair*
4. Chairperson's Report — *Chair*
5. Chief Executive Officer Report — John Baackes, *Chief Executive Officer*
   - Government Affairs Update p.17 — Cherie Compartore, *Senior Directors, Government Affairs*

Committee Issues

6. Delegation of authority to L.A. Care Chief Executive Officer, John Baackes, to negotiate and make any substantive changes to Amendment A40 to Contract 04-36069, between L.A. Care Health Plan and the California Department of Health Care Services **(EXE 100)** p.99 — Augustavia J. Haydel, Esq., *General Counsel*
7. Housing & Homelessness Incentive Program Investment agreement with the Los Angeles County Department of Public Health **(EXE 101)** p.101 — Karl Calhoun, *Director, Housing Initiatives*
8. Human Resources Policies **(EXE A)** p.109 — Terry Brown, *Chief Human Resources Officer*
9. Process for public comment at all meetings — Stephanie Booth, MD
10. Approve the list of items that will be considered on a Consent Agenda for September 7, 2023 Board of Governors Meeting. — *Chair*
    - July 27, 2023 Board of Governors Meeting Minutes
    - Delegation of authority to L.A. Care Chief Executive Officer, John Baackes, to negotiate and make any substantive changes to Amendment A40 to Contract 04-36069, between L.A. Care Health Plan and the California Department of Health Care Services
    - Quarterly Investment Report
    - Consolidated Allocation of Funds for Non-Travel Meals and Catering & Other Expenses

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- ixLayer, Inc. Contract to provide at-home test kits to members for diabetes A1c tests, colorectal cancer screenings and kidney health evaluations
- Collective Medical Technologies Contract to provide Care & Utilization Optimization (Acute Care), Member Activity Visibility (Acute & SNF Encounters) and Post-Acute Care Management, Enhanced Care Management (ECM) with PAC Management
- Provider Relations Advisory Committee Members
- Provider Relations Advisory Committee Charter
- Children's Health Consultant Advisory Committee Membership

11. Public Comment on Closed Session Items *(Please read instructions above.)* *Chair*

ADJOURN TO CLOSED SESSION (Est. time: 60 mins.) *Chair*

12. CONTRACT RATES
Pursuant to Welfare and Institutions Code Section 14087.38(m)
- Plan Partner Rates
- Provider Rates
- DHCS Rates
- Plan Partner Services Agreement

13. REPORT INVOLVING TRADE SECRET
Pursuant to Welfare and Institutions Code Section 14087.38(n)
Discussion Concerning New Service, Program, Technology, Business Plan
Estimated date of public disclosure: *August 2025*

14. CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION
Significant exposure to litigation pursuant to Section 54956.9(d)(2) of Ralph M. Brown Act:
Four Potential Cases

15. CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION
Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act
- Department of Managed Health Care Enforcement Matter Numbers: 18-799, 20-063, 21-428, 21-509, 21-680
- Department of Health Care Services, Office of Administrative Hearings and Appeals, In the matter of: L.A. Care Health Care Plan Appeal No. MCP22-0322-559-MF

16. PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Pursuant to Section 54957 of the Ralph M. Brown Act
Title: Chief Executive Officer

17. CONFERENCE WITH LABOR NEGOTIATOR
Pursuant to Section 54957.6 of the Ralph M. Brown Act
Agency Designated Representative: Alvaro Ballesteros, MBA
Unrepresented Employee: John Baackes

RECONVENE IN OPEN SESSION

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ADJOURNMENT

Chair

The next Executive Committee meeting is scheduled on Wednesday, September 27 2023 at 2:00 p.m.

and may be conducted as a teleconference meeting.

The order of items appearing on the agenda may change during the meeting.

THE PUBLIC MAY SUBMIT COMMENTS TO THE EXECUTIVE COMMITTEE BEFORE DISCUSSION OF EACH ITEM LISTED ON THE AGENDA BY SUBMITTING THE COMMENT IN WRITING BY TEXT MESSAGE TO 213 628 6420, OR IN WRITING BY EMAIL TO BoardServices@lacare.org. Please follow additional instructions on the first page of this Agenda.

ACTION MAY NOT BE TAKEN ON ANY MATTER RAISED DURING THE PUBLIC COMMENT PERIODS UNTIL THE MATTER IS SPECIFICALLY LISTED ON A FUTURE AGENDA, according to California Govt Code Section 54954.2 (a)(3) and Section 54954.3.

NOTE: THE EXECUTIVE COMMITTEE CURRENTLY MEETS ON THE FOURTH TUESDAY OF MOST MONTHS AT 2:00 P.M. AGENDA and PRINTED MEETING MATERIALS ARE AVAILABLE FOR INSPECTION AT http://www.lacare.org/about-us/public-meetings/board-meetings **and by email request to BoardServices@lacare.org**

Any documents distributed to a majority of the Board Members regarding any agenda item for an open session after the agenda has been posted will be available for public inspection at 1055 W. 7th Street, Los Angeles, CA, in the reception area in the main lobby or at http://www.lacare.org/about-us/public-meetings/board-meetings **and can be requested by email to BoardServices@lacare.org. An audio recording of the meeting is made to assist in writing the minutes and is retained for 30 days.**

Meetings are accessible to people with disabilities. Individuals who may require any accommodations (alternative formats - i.e., large print, audio, translation of meeting materials, interpretation, etc.) to participate in this meeting and wish to request an alternative format for the agenda, meeting notice, and meeting packet may contact L.A. Care's Board Services Department at (213) 628 6420. Notification at least one week before the meeting will enable us to make reasonable arrangements to ensure accessibility to the meetings and to the related materials.

BOARD OF GOVERNORS
Executive Committee
Meeting Minutes – June 28, 2023
1055 West 7th Street, 10th Floor, Los Angeles, CA 90017

Members
Al Ballesteros, *Chairperson*
Ilan Shapiro MD, MBA, FAAP, FACHE, *Vice Chairperson* *
Stephanie Booth, MD, *Treasurer*
John G. Raffoul, *Secretary*
Hilda Perez **

** Absent*
*** Via Teleconference*

Management/Staff
John Baackes, *Chief Executive Officer*
Sameer Amin, MD, *Chief Medical Officer*
Terry Brown, *Chief of Human Resources*
Augustavia Haydel, *General Counsel*
Jeff Ingram, *Deputy Chief Financial Officer*
Tom MacDougall, *Chief Technology & Information Officer*
Thomas Mapp, *Chief Compliance Officer*
Noah Paley, *Chief of Staff*

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Alvaro Ballesteros, *Chairperson,* called to order the regular meetings of the L.A. Care Executive Committee and the L.A. Care Joint Powers Authority Executive Committee regular meetings at 2:27 p.m. The meetings were held simultaneously. He welcomed everyone to the meetings. • For those who provided public comment for this meeting by voice message or in writing, L.A. Care is glad that they provided input today. The Committee will hear their comments and the Committee also needs to finish the business on the Agenda today. • For people who have access to the internet, the meeting materials are available at the lacare.org website. If anyone needs information about how to locate the meeting materials, they can reach out to L.A. Care staff. • Information for public comment is on the Agenda available on the web site. Staff will read the comment received in writing from each person for up to three minutes. • Public comment will be heard before the Committee discusses an item. If the comment is not on a specific agenda item, it will be read at the general Public Comment. He provided information on how to submit a comment in-person, or using the "chat" feature.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
APPROVE MEETING AGENDA	The Agenda for today's meeting was approved.	**Approved unanimously by roll call. 4 AYES (Ballesteros, Booth, Perez, and Raffoul)**
PUBLIC COMMENT	There were no public comments.	
APPROVE MEETING MINUTES	The minutes of the May 24, 2023 meeting were approved as submitted.	**Approved unanimously by roll call. 4 AYES**
CHAIRPERSON'S REPORT	There was no Chairperson's report.	
CHIEF EXECUTIVE OFFICER REPORT	John Baackes, *Chief Executive Officer*, noted he was not attending in person as he was in Sacramento for the California Safety Net Coalition (CSNC) meeting. CSNC is the organization that grew out of efforts made at L.A. Care over a year ago to create a Los Angeles County safety net coalition for the purpose of increasing the State share in Medi-Cal funds and increase reimbursement to providers. California Legislators adopted the Governor's Budget for 2023-24, with 100% bipartisan support for a provision in the budget to reinstitute the Managed Care Organization (MCO) tax. That provision will provide $2.6 billion annually in additional Medi-Cal funding. The prime goal of CSNC is to increase Medi-Cal funding using the MCO tax. CSNC represents a coalition of a variety of stakeholders in the healthcare field, including hospitals, doctors, federally qualified health clinics (FQHCs), health plans, and SEIU workers. CSNC participants are delighted and all are in support of this initiative. The adoption of the MCO in the Budget is considered historic because the State has not increased the base rate for Medi-Cal in over 20 years. At the CSNC meeting today, participants re-affirmed the goal of seeking a ballot initiative in November 2024 to make this a permanent change in Medi-Cal funding. Having it adopted as part of the budget is a victory, but it means that next year's legislature could make a decision to reverse and divert the money. In previous reiterations, the MCO tax was used to draw down matching federal funds for the general fund. The goal of the CSNC was to reinstitute the MCO tax on managed care organizations and use the money to supplement Medi-Cal funding. CSNC is going ahead with the ballot initiative. Once accomplished, it will make a permanent	

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	improvement in Medi-Cal funding. This is only the beginning, this is not a fantasy, but it will not solve all the problems. Not all participants in the coalition are treated equally in a sense because not every constituent group got something out of this. Mr. Baackes added that he thinks that everyone realized that as a result of the CSNC participants coming together and getting this far, they should stick together to take this to an even better solution – by doing it through a ballot initiative. The Medi-Cal eligibility redetermination process started with beneficiaries that have June renewal dates. Those that did not requalify or failed to return the application will be terminated as of July 1. Preliminary data showed that L.A. Care may have a net loss of between 19-30,000 members (which is 13% as budgeted in L.A. Care's forecast). Of those 19-30,000 members, there may be many who are able to reclaim eligibility during the next 90 days. Once L.A. Care gets the list of the terminated members, L.A. Care will conduct outreach to help them complete the process and restore their benefits, retroactive to July 1. The terminations will appear in the data L.A. Care receives from the state and those members will be on hold for 90 days. L.A. Care is encouraged by the first numbers, but we don't know how many of them will fail to complete the process and fall into what is called "procedural disenrollment". Up to 45% of people in Los Angeles County who had June renewal dates were automatically re-determined in an ex parte process by the Los Angeles County Department of Public Social Services (DPSS). DPSS has access to other databases that can support eligibility, and those members do not have to go through the process. Board Member Booth asked if L.A. Care received the recognition for its effort for getting the rate increase. Mr. Baackes noted that the Chair of CSNC and all the participants in the coalition acknowledged L.A. Care's leadership for getting this started. Mr. Baackes added that L.A. Care is getting credit for its efforts.	
• Community Health Investment Fund Annual Summary FY 2021-22	Mr. Baackes asked Shavonda Webber-Christmas, *Director, Community Benefits*, to present the Community Health Investment Fund (CHIF) Annual Summary FY 2021-22. *(A copy of the report may be requested by contacting Board Services.)* In FY 2021-22, the Board approved four new priorities to support elimination of health disparities. Staff launched the Generating African American Infant and Nurturers' Survival (GAAINS) initiative as the core funding initiative under the End Disparities portfolio. Other initiatives were poised to address the continued effects of COVID-19 pandemic.	

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	Annual grant making investments shifted as the needs of the communities changed throughout the COVID-19 pandemic. In 2019-20, there was substantial demand to reach and educate hard hit communities of color, provide personal protective equipment and address the needs of people experiencing homelessness. In 2020-21, vaccine administration was underway while many communities were hesitant, and because few dental clinics were open, Oral Health funding was suspended. By 2021-22, many organizations returned to in-person service delivery and deep investments were required to help providers restore and maintain staffing levels. These priorities shape CHIF's grant portfolios, guide the design of Request for Applications, and influence the selection of projects for each initiative. 1. Support the health care safety net to improve infrastructure and address racial inequities/Healthcare Infrastructure 2. Address social determinants of health that result in inequities/Address Social Determinants 3. Close Health Disparities Gaps/End Disparities 4. Empower and invest in health and social determinants of health related organizations that address systemic racism/Address Systemic Racism <u>CHIF Grant Approval and Administrative Processes</u> • CHIF applications undergo a rigorous process that includes submission of standardized applications and internal vetting. • Initiatives are evaluated by a panel of 24 community and internal evaluators. Ad hoc applications are also vetted and reviewed by an internal committee. • CHIF awards are approved by the Board of Governors, in accordance with Grants and Sponsorships Policy 603, including potential conflicts of interests. • Recommendations for all grant awards up to $250,000 were referred to L.A. Care's CEO for approval. Award recommendations above $250,000 were brought to the Board of Governors for approval. • Community Benefits work with internal business units to ensure that awards are executed based on contracting standards and terms. They also follow organizational protocols to ensure award disbursement is timely, accurately issued, and expenses are in compliance with allocations. In FY 2021-22, Community Benefits managed a cumulative CHIF portfolio in the amount of $30,652,150 and executed 166 grants.	

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	L.A. Care's grant making has made an impact with small and large organizations. The approaches provide opportunities to launch new programs and/or sustain critical services for at-risk populations. 83% of grantees surveyed and interviewed were very satisfied with the program structure. Board Member Perez asked of the CBOs that applied for grants, how many received the funding, and would L.A. Care provide more funding to the same agencies or extend the fund to benefit more agencies. Ms. Webber-Christmas responded that the data is not readily available, and Staff will get back to her with the data. Over 75% of those that applied for grants received a grant. Staff wants to make sure that the grant funding is used efficiently and to make sure L.A. Care is awarding the grant to organizations that will successfully do the right thing with the funds. Board Member Perez asked if staff is following up on the effectiveness of the funding for the projects they submitted. Ms. Webber-Christmas responded the organizations are required to submit a progress report every six months. Board Member Perez asked if grantees are asked to survey members how they are benefitting from the services. Ms. Webber-Christmas responded that there are some grant awardees that survey their programs as part of an evaluation. The grantees report on those surveys, but L.A. Care does not require grant awardees to survey their clients on the impact of their services to the community members they serve. Board Member Booth thanked Ms. Webber-Christmas and noted that she felt this report was much improved over previous reports because it clearly showed what the grantees do and how the money was spent. Board Member Booth noted that she does not think that L.A. Care received data on how the grant money was spent. The report is not specific to L.A. Care's awarded grant, but shows what the organization did in the past six months. Board Member Booth added that the Board could discuss further what was learned from the grant initiative. Mr. Baackes noted that the report that L.A. Care required was specific to the grant awarded. Board Member Perez asked how L.A. Care is following up with grantees regarding the use of the grant money. An organization can come up with a report, but when you survey members, it can be a different story.	

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	Mr. Baackes objected to Board Member Perez' statements as they do not reflect how this program is being administered. There is a very diligent process in awarding grants and following up with the grantors about what they did with the money. Mr. Baackes thought that the comments characterize unethical practice, and this is not a hallmark of this program. When L.A. Care awards a grant, such as dental chairs and accessible equipment for exam rooms for FQHCs, you can see the equipment which result from the grant. Board Member Perez stated that her statements were whether L.A. Care has the opportunity to check on the results. Mr. Baackes responded that L.A. Care does go to these organizations to inspect results. Board Member Perez responded she did not know that, and asked the extent L.A. Care attempts make sure that the money is being utilized effectively. She added that her questions and comments are on behalf of the members, not her personal point of view. She added that she's seen funding allocated to agencies and when she talks to the members, their observations do not correlate with the report. Her comments are on behalf of the members and in an effort to make sure that the money is well allocated and is well utilized. Mr. Baackes noted that L.A. Care does a good job at awarding and overseeing grant making. L.A. Care does not just hand out money without following up. Board Member Booth thanked Ms. Webber-Christmas for the great report. She added that Board Member Perez is asking how follow up is done to make sure that the money is awarded effectively. Board Chairperson Ballesteros noted that before L.A. Care makes subsequent payments, grantees must be compliant in reporting the initial funding before they get additional funding. L.A. Care is doing a great job in tracking and ensuring that the dollars are being spent in the proper manner. Board Chairperson Ballesteros acknowledged the hard work and the good job by Ms. Webber-Christmas and her team. The health centers that he interacts with very much appreciate this program. All these grants can make a big difference. Some of the health centers utilize it in ways that they would not have an opportunity to, if this program did not exist.	

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	Board Member Raffoul commented on the great job done with L.A. Care's grant funding program. He suggested that maybe L.A. Care can invite some of the grantees and showcase what have they done with the grant award. Mr. Baackes thanked Mr. Raffoul for the great idea for future meetings at the Board of Governors meeting and the Consumer Advisory Committees.	
COMMITTEE ISSUES		
Government Affairs Update	Cherie Compartore, *Senior Director, Government Affairs,* reported: <u>State Budget</u> • The budget trailer bills maintains most of what was contained in the May Revise. The budget provided $15 million to Los Angeles County for the care court implementation cost. L.A. Care advocated with Los Angeles County for some additional funding but there is not additional money for care court specific to Los Angeles County. However, they doubled the hours of legal services for participants to get 40 hours, instead of 20 that was contained in the prior budget. There are some additional requirements for counties to have to report information on various cases as a result of care court implementation. As a reminder, Los Angeles County does not go live until the end of the year. • Covered California Individual Mandate Penalty Revenue Fund. In 2019, California created a fine for those that did not have health insurance to be put it in a reserve fund. The agreement between the Legislature and the Governor was that the funds will used to offset state subsidies and future costs in Covered California. However, the Governor wanted to take the majority of the reserve fund to offset the General Fund. After negotiations with the Legislature, it was decided that the reserve fund will loan the administration, $600 million to help backfill the general fund with that loan repayment due in 25-26 years. Covered CA will retain the $334 million in the reserve fund to help the state subsidies in future years. As a reminder, the federal enhanced subsidies are currently set to expire in December 31, 2025. • The budget contains additional funding in Covered California for the following: o $2 million to support striking workers that are in a labor dispute to allow them enroll in Covered CA if their employer terminates their health care coverage which they are allowed to do in some instances in California. o $350 million for the $1 PMPM to cover the California Premium credit cost	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Not part of the budget, there are two bills making their way through the Legislature that would create a housing component for a bond in the March 2024 ballot that will create 10,000 new behavioural health clinics beds in order to serve those with severe mental needs, substance abuse disorders, and homeless, and with specific inclusion for veterans. The other bill basically repeals Prop 63, the mental health services act language. This ballot initiative was passed nearly 20 years ago. They want to revise the legislation to reflect current behavioural health needs and the environment we are in. This would be in the March 2024 ballot initiative. <u>Redeterminations and State Fair Hearings</u> Centers for Medicaid/Medicare Services (CMS) approved California's request that extends the timeframe for Medi-Cal beneficiaries to request a state fair hearing from the current 90-day requirement to 120 days, to be able to file a state fair hearing if it was determined that a member does not agree with the termination of Medi-Cal, or any other type of state fair hearing, retroactive to April 1, 2023. This was done because of the huge amount of redeterminations that they are anticipating as a result of all the people being redetermined. This extension will be terminated on of October 1, 2024. The Department of Healthcare Services (DHCS) is also applying for CMS to consider some additional flexibilities related to huge caseload due to redetermination. They are asking for ex parte renewals for those that are under a 100% of the federal poverty level. And they want to suspend the requirement to apply for other benefits as a condition of eligibility and to re-instate Medi-Cal back to the date of disenrollment during the 90-day cure period.	
Approve Revision to Human Resources Policy & Procedure HR 108 (Holidays)	Terry Brown, *Chief Human Resources Officer*, presented the revised Human Resources Policy HR 108 (Holidays). L.A. Care provides a work environment where time off is allowed for the observance of L.A. Care recognized holidays. L.A. Care currently observes 11 holidays when the offices are normally closed to official business. Staff is requesting approval to revise Human Resources Policy & Procedure HR-108 (Holidays), adding Cesar Chavez Day and Veterans' Day as additional holidays for eligible employees. These two additional holidays will bring L.A. Care to a total of 13 holidays, consistent with our Local Initiative peers and Los Angeles County.	

<table>
<tr><th>AGENDA ITEM/PRESENTER</th><th>MOTIONS / MAJOR DISCUSSIONS</th><th>ACTION TAKEN</th></tr>
<tr><td></td><td><u>Motion EXE A.0623</u>
To approve the Human Resources Policy & Procedure HR 108 (Holidays), as presented.</td><td>Approved unanimously by roll call. 4 AYES</td></tr>
<tr><td>Approve Revisions to Human Resources Policies HR 203 (Attendance & Punctuality), HR 232 (Bereavement Leave), HR 302 (Employment-General Statement), HR 306 (Equal Employment Opportunity) and HR 308 (Job Posting)</td><td>Mr. Brown summarized the revised policies. L.A. Care Policy HR-501 requires that the Executive Committee annually review substantial changes to the Human Resources Policies. The revised policies are written to comply with changes to Regulatory, Legislative and Judicial changes, and reflect changes in L.A. Care's practices.
<table>
<tr><th>Policy Number</th><th>Policy</th><th>Section</th><th>Description of Modification</th></tr>
<tr><td>HR-203</td><td>Attendance and Punctuality</td><td>Employee Relations</td><td>Occurrence chart added and new definitions added Tardy, Pattern Attendance and KinCare.</td></tr>
<tr><td>HR-232</td><td>Bereavement Leave</td><td>Employee Relations</td><td>Revision: AB1949 signed into law by Governor Newsom on September 29, 2022 indicate that eligible employees will receive up to 5 days of bereavement leave (3 paid and 2 unpaid) and that employees may use PTO for any unpaid bereavement time off.</td></tr>
<tr><td>HR-302</td><td>Employment – General Statement</td><td>Employment</td><td>DEI statement added due to NCQA standards</td></tr>
<tr><td>HR-306</td><td>Equal Employment Opportunity</td><td>Employment</td><td>DEI statement added due to NCQA standards</td></tr>
<tr><td>HR-308</td><td>Job Posting</td><td>Employment</td><td>pay range and gender neutrality requirements added to fulfill NCQA standards</td></tr>
</table>
<u>Motion EXE B.0623</u>
To approve the above Human Resources Policies as presented.</td><td>Approved unanimously by roll call. 4 AYES</td></tr>
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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Approve Consent Agenda	Approve the list of items that will be considered on a Consent Agenda for the July 27, 2023 Board of Governors Meeting. • June 1, 2023 Board of Governors Meeting Minutes • North Star Alliances Contract Amendment • CCI Network Services Contract • Infosys Limited Contract Amendment • Cognizant Technology Solutions Contract Amendment	**Approved unanimously by roll call. 4 AYES**
PUBLIC COMMENTS	There were no public comments.	
ADJOURN TO CLOSED SESSION	The Joint Powers Authority Executive Committee meeting adjourned at 3:20 pm. Augustavia J. Haydel, Esq., *General Counsel* announced the items to be discussed in closed session. She announced there is no report anticipated from the closed session. The meeting adjourned to closed session at 3:22 pm. CONTRACT RATES Pursuant to Welfare and Institutions Code Section 14087.38(m) • Plan Partner Rates • Provider Rates • DHCS Rates • Plan Partner Services Agreement REPORT INVOLVING TRADE SECRET Pursuant to Welfare and Institutions Code Section 14087.38(n) Discussion Concerning New Service, Program, Business Plan Estimated date of public disclosure: *June 2025* CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act • L.A. Care Health Plan's Notice of Contract Dispute under Contract No. 04-36069 Department of Health Care Services (Case No. Unavailable) CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION Significant exposure to litigation pursuant to Section 54956.9(d)(2) of Ralph M. Brown Act: Four Potential Cases CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act • Department of Managed Health Care Enforcement Matter Numbers: 18-799, 20-063, 21-428, 21-509, 21-680 • Department of Health Care Services, Office of Administrative Hearings and Appeals, In the matter of: L.A. Care Health Care Plan Appeal No. MCP22-0322-559-MF PUBLIC EMPLOYEE PERFORMANCE EVALUATION Pursuant to Section 54957 of the Ralph M. Brown Act Title: Chief Executive Officer CONFERENCE WITH LABOR NEGOTIATOR Pursuant to Section 54957.6 of the Ralph M. Brown Act Agency Designated Representative: Alvaro Ballesteros, MBA Unrepresented Employee: John Baackes	
RECONVENE IN OPEN SESSION	The meeting reconvened in open session at 4:25 pm. No reportable actions were taken during the closed session.	
ADJOURNMENT	The meeting adjourned at 4:26 pm.	

Respectfully submitted by:
Linda Merkens, *Senior Manager, Board Services*
Malou Balones, *Board Specialist III, Board Services*
Victor Rodriguez, *Board Specialist II, Board Services*

APPROVED BY:

_____
Alvaro Ballesteros, MBA, *Board Chairperson*
Date: _____

Legislative Matrix 8.10.2023

Last Updated: August 10, 2023

Bills by Issue

2023 Legislation (84)

Bill Number	Status	Position
AB 4	In Senate	Monitor

Title
Covered California: expansion.

Description
AB 4, as amended, Arambula. Covered California: expansion.
Existing federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. Existing state law creates the California Health Benefit Exchange, also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Existing law requires the Exchange to apply for a federal waiver to allow persons otherwise not able to obtain coverage through the Exchange because of their immigration status to obtain coverage from the Exchange.This bill would delete that requirement and would instead require the Exchange to administer a program to allow persons otherwise not able to obtain coverage by reason of immigration status to enroll in health insurance coverage in a manner as substantially similar to other Californians as feasible given existing federal law and rules. The bill would require the Exchange to undertake outreach, marketing, and other efforts to ensure enrollment. The bill would also require the Exchange to adopt an annual program design for each coverage year to implement the program, and would require the Exchange to provide appropriate opportunities for stakeholders, including the Legislature, and the public to consult on the design of the program.

Primary Sponsors
Joaquin Arambula, Sabrina Cervantes, Maria Durazo

Organizational Notes

Last edited by Joanne Campbell at May 12, 2023, 9:13 PM
L.A. Care, Health Access California (co-sponsor), California Immigrant Policy Center (co-sponsor): Support

Bill Number	Status	Position
AB 85	In Senate	Monitor

Title

Social determinants of health: screening and outreach.

Description

AB 85, as amended, Weber. Social determinants of health: screening and outreach. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plans and health insurers to include coverage for screening for various conditions and circumstances, including adverse childhood experiences. Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services and 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.This bill would, upon specified appropriations by the Legislature, require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to include coverage for screenings for social determinants of health, as defined. The bill would require providers to use specified tools or protocols when documenting patient responses to questions asked in these screenings.The bill would, upon appropriation, require a health care service plan or health insurer to provide physicians who provide primary care services with adequate access to community health workers, peer support specialists, lay health workers, community health representatives, or social workers in counties where the health care service plan or health insurer has enrollees or insureds, as specified. The bill would, upon appropriation, authorize the respective departments to adopt guidance to implement its provisions. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.The bill would, upon appropriation, make social determinants of health screenings a covered benefit for Medi-Cal beneficiaries and would require the State Department of Health Care Services or a Medi-Cal managed care plan to provide reimbursement for those screenings, as specified.Existing law establishes the Department of Health Care Access and Information, under the control of the Director of the Department of Health Care Access and Information, to administer programs relating to areas including health policy and planning.This bill would, upon appropriation, require the department to convene a working group, with specified membership, to determine standardized methods of data documentation to be used in recording social determinants of health screening responses, to create a standardized model... (click bill link to see more).

Primary Sponsors

Akilah Weber

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 5:51 PM
California Association of Health Plans: Oppose

Bill Number	Status	Position
AB 102	**Enacted**	**Monitor**

Title
Budget Act of 2023.

Description
AB 102, Ting. Budget Act of 2023. The Budget Act of 2023 made appropriations for the support of state government for the 2023–24 fiscal year.This bill would amend the Budget Act of 2023 by amending, adding, and repealing items of appropriation and making other changes.This bill would declare that it is to take effect immediately as a Budget Bill.

Primary Sponsors
Phil Ting

Bill Number	Status	Position
AB 103	**Enacted**	**Monitor**

Title
Budget Acts of 2021 and 2022.

Description
AB 103, Ting. Budget Acts of 2021 and 2022. The Budget Act of 2021 and Budget Act of 2022 made appropriations for the support of state government for the 2021–22 and 2022–23 fiscal years. This bill would amend the Budget Act of 2021 and Budget Act of 2022 by amending and adding items of appropriation and making other changes. The bill would declare that it is to take effect immediately as a Budget Bill.

Primary Sponsors
Phil Ting

Bill Number	Status	Position
AB 112	Enacted	Monitor

Title
Distressed Hospital Loan Program.

Description
AB 112, Committee on Budget. Distressed Hospital Loan Program. The California Health Facilities Financing Authority Act authorizes the California Health Facilities Financing Authority to, among other things, make loans from the continuously appropriated California Health Facilities Financing Authority Fund to participating health institutions, as defined, for financing or refinancing the acquisition, construction, or remodeling of health facilities.This bill would create the Distressed Hospital Loan Program, until January 1, 2032, for the purpose of providing loans to not-for-profit hospitals and public hospitals, as defined, in significant financial distress or to governmental entities representing a closed hospital to prevent the closure or facilitate the reopening of a closed hospital. The bill would require the Department of Health Care Access and Information to administer the program and would require the department to enter into an interagency agreement with the authority to implement the program. The bill would require the department, in collaboration with the State Department of Health Care Services, the Department of Managed Health Care, and the State Department of Public Health, to develop a methodology to evaluate an at-risk hospital's potential eligibility for state assistance from the program, as specified. The bill would require a hospital or a closed hospital to provide the authority and the department with financial information demonstrating the hospital's need for assistance due to financial hardship. The bill would additionally require that the department, in consultation with the authority, develop an application and approval process for loan forgiveness or modification of loan terms, as specified.This bill would create the Distressed Hospital Loan Program Fund, a continuously appropriated fund, for use by the department and the authority to administer the loan program, as specified. The bill would authorize both the authority and the department to recover administrative costs from the fund. The bill would authorize the Department of Finance to transfer funds from the General Fund to the Distressed Hospital Loan Program Fund between state fiscal years 2022–23 and 2023–24 to implement the bill, as specified. The bill would authorize the department and the authority to require any hospital receiving a loan under the program to provide the department and the authority with an independent financial audit of the hospital's operations for any fiscal year in which a loan is outstanding. The bill would abolish the fund on December 31, 2031, and would require any remaining balance, assets, liabilities, and encumbrances of the fund to revert to the General Fund. By creating a continuously appropriated fund, the ... (click bill link to see more).

Primary Sponsors
House Budget Committee

Bill Number	Status	Position
AB 118	Enacted	Monitor

Title
Budget Act of 2023: health.

Description
AB 118, Committee on Budget. Budget Act of 2023: health.
(1) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law requires a health care service plan to provide disclosures regarding the benefits, services, and terms of the plan contract, as specified, to provide the public, subscribers, and enrollees with a full and fair disclosure of the provisions of the plan.This bill would require the department to develop standard templates for the disclosure form and evidence of coverage, to include, among other things, standard definitions, benefit descriptions, and any other information that the director determines, consistent with the goals of providing fair disclosures of the provisions of a health care service plan. The bill would require the department to consult with the Department of Insurance and interested stakeholders in developing the standard templates. The bill would require health care service plans, beginning January 1, 2025, to use the standard templates for any disclosure form or evidence of coverage published or distributed, except as specified. Because a willful violation of these requirements is a crime, the bill would impose a state-mandated local program.This bill would authorize the department to develop standard templates for a schedule of benefits, an explanation of benefits, a cost-sharing summary, or any similar document. The bill would authorize the department to require health care service plans to use the standard templates, except as specified, and would authorize the director to require health care service plans to submit forms the health care service plan created based on the department's templates for the purpose of compliance review. The bill would additionally specify that the department may implement these provisions by issuing and modifying templates and all-plan letters or similar instructions, without taking regulatory action. The bill would also update cross-references in various provisions.
(2) Existing law requires a health care service plan contract or disability insurance policy to cover mental health and substance use disorder treatment, including medically necessary treatment of a mental health or substance use disorder provided by an in-network or out-of-network 988 center or mobile crisis team. Existing law prohibits a health care service plan or insurer from requiring prior authorization for medically necessary treatment of a mental health or substance use disorder provided by a 988 center or mobile crisis team.This bill would instead specify that mental health and substance use disorder trea... (click bill link to see more).

Primary Sponsors
House Budget Committee

Bill Number	Status	Position
AB 119	Enacted	Monitor

Title
Medi-Cal: managed care organization provider tax.

Description
AB 119, Committee on Budget. Medi-Cal: managed care organization provider tax. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, one of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care plans.Existing law, inoperative on January 1, 2023, and to be repealed on January 1, 2024, imposed a managed care organization (MCO) provider tax, administered and assessed by the department, on licensed health care service plans and managed care plans contracted with the department to provide full-scope Medi-Cal services. Those provisions set forth taxing tiers and corresponding per enrollee tax amounts for the 2019–20, 2020–21, and 2021–22 fiscal years, and the first 6 months of the 2022–23 fiscal year. Under those provisions, all revenues, less refunds, derived from the tax were deposited into the State Treasury to the credit of the Health Care Services Special Fund, and continuously appropriated to the department for purposes of funding the nonfederal share of Medi-Cal managed care rates, as specified.Those inoperative provisions authorized the department, subject to certain conditions, to modify or make adjustments to any methodology, tax amount, taxing tier, or other provision relating to the MCO provider tax to the extent the department deemed necessary to meet federal requirements, to obtain or maintain federal approval, or to ensure federal financial participation was available or was not otherwise jeopardized. Those provisions required the department to request approval from the federal Centers for Medicare and Medicaid Services (CMS) as was necessary to implement those provisions.This bill would repeal those inoperative provisions. The bill would restructure the MCO provider tax, with certain modifications to the above-described provisions, including changes to the taxing tiers and tax amounts, for purposes of the tax periods of April 1, 2023, through December 31, 2023, and the 2024, 2025, and 2026 calendar years. The bill would create the Managed Care Enrollment Fund to replace the Health Care Services Special Fund. Under the bill, moneys deposited into the fund would, upon appropriation, be available to the department for the purpose of funding the following subcomponents to support the Medi-Cal program: (1) the nonfederal share of increased capitation payments to Medi-Cal managed care plans; (2) the nonfederal share of Medi-Cal managed care rates for health care services; and (3) transfers to the Medi-Cal Pro... (click bill link to see more).

Primary Sponsors
House Budget Committee

Bill Number	Status	Position
AB 120	Enacted	Monitor

Title
Human services.

Description
AB 120, Committee on Budget. Human services. (1) Existing law, the California Community Care Facilities Act, provides for the licensing and regulation of community care facilities, including group home facilities, short-term residential therapeutic programs (STRTPs), and adult residential facilities (ARFs), by the State Department of Social Services. Under existing law, the department similarly regulates residential care facilities for the elderly. A violation of provisions relating to these facilities is a misdemeanor. Existing law requires administrators of these facilities, with specified exemptions, to complete a department-approved certification program, uniformly referred to as administrator certification training programs. Under existing law, these programs require a specified minimum number of hours, depending on the facility type, of classroom instruction that provides training on a uniform core of knowledge in specified areas. Existing law also requires administrator certificates to be renewed every 2 years, conditional upon the certificate holder submitting documentation of a specified number of hours of continuing education, based on the facility type. Existing law permits up to one-half of the required continuing education hours to be satisfied through online courses, and the remainder to be completed in a classroom instructional setting, as prescribed.This bill would revise those provisions by deleting the classroom instruction requirement for initial certification and continuing education purposes, and instead would require instruction that is conducive to learning and allows participants to simultaneously interact with each other as well as with the instructor. The bill would authorize up to one-half of continuing education hours to be satisfied through self-paced courses, rather than online courses. The bill would make various conforming changes.Existing law authorizes the department to license as ARFs, subject to specified conditions, adult residential facilities for persons with special health care needs (ARFPSHNs), which provide 24-hour services to up to 5 adults with developmental disabilities who have special health care and intensive support needs, as defined. Existing law requires the department to ensure that an ARFPSHN meets specified administrative requirements, including requirements related to fingerprinting and criminal records.This bill additionally would require an ARFPSHN to meet the administrator certification requirements of an ARF, including, but not limited to, completing a department-approved administrator certification training program requiring a designated minimum number of hours of instruction conducive to learning, in which participants are able to simultaneously interact wi... (click bill link to see more).

Primary Sponsors
House Budget Committee

Bill Number	Status	Position
AB 129	Enacted	Monitor

Title
Housing.

Description
AB 129, Committee on Budget. Housing. (1) Existing law establishes the Department of Housing and Community Development (HCD) in the Business, Consumer Services, and Housing Agency for purposes of carrying out state housing policies and programs, and creates in HCD the California Housing Finance Agency.This bill would remove the California Housing Finance Agency from within HCD. This bill would continue the existence of the California Housing Finance Agency in the Business, Consumer Services, and Housing Agency.This bill would also make technical, conforming changes and would delete obsolete references.(2) Existing federal law authorizes the United States Secretary of Agriculture to extend financial assistance through multifamily housing direct loan and grant programs to serve very low, low-, and moderate-income households, including, among other programs, Section 515 Rural Rental Housing Loans, which are mortgages to provide affordable rental housing for very low, low-, and moderate-income families, elderly persons, and persons with disabilities.Existing law establishes a low-income housing tax credit program pursuant to which the California Tax Credit Allocation Committee provides procedures and requirements for the allocation, in modified conformity with federal law, of state insurance, personal income, and corporation tax credit amounts to qualified low-income housing projects that have been allocated, or qualify for, a federal low-income housing tax credit and farmworker housing. Existing law requires not less than 20% of the low-income housing tax credits available annually to be set aside for allocation to rural areas. Existing law defines “rural area” for purposes of the low-income housing tax credit program as an area, which, on January 1 of any calendar year, satisfies any number of certain criteria, including being eligible for financing under the Section 515 program, or successor program, of the United States Department of Agriculture Rural Development. This bill would expand the above-described criteria relating to Section 515 eligibility to instead include eligibility for financing under a multifamily housing program, as specified, or successor program, of the United States Department of Agriculture Rural Development. Existing law also includes in the definition of “rural area” an unincorporated area that adjoins a city having a population of 40,000 or less, provided that the city and its adjoining unincorporated area are not located within a census tract designated as an urbanized area by the United States Census Bureau.This bill would revise the definition of “rural area” to include an unincorporated area that adjoins a city having a population of 40,000 or less, provided that the unincorporated area i... (click bill link to see more).

Primary Sponsors
House Budget Committee

Bill Number	Status	Position
AB 254	In Senate	Monitor

Title
Confidentiality of Medical Information Act: reproductive or sexual health application information.

Description
AB 254, as amended, Bauer-Kahan. Confidentiality of Medical Information Act: reproductive or sexual health application information. The Confidentiality of Medical Information Act (CMIA) prohibits a provider of health care, a health care service plan, a contractor, or a corporation and its subsidiaries and affiliates from intentionally sharing, selling, using for marketing, or otherwise using any medical information, as defined, for any purpose not necessary to provide health care services to a patient, except as provided. The CMIA makes a business that offers software or hardware to consumers, including a mobile application or other related device that is designed to maintain medical information in order to make the information available to an individual or a provider of health care at the request of the individual or a provider of health care, for purposes of allowing the individual to manage the individual's information or for the diagnosis, treatment, or management of a medical condition of the individual, a provider of health care subject to the requirements of the CMIA. Existing law makes a violation of these provisions that results in economic loss or personal injury to a patient punishable as a misdemeanor.This bill would revise the definition of "medical information" to include reproductive or sexual health application information, which the bill would define to mean information about a consumer's reproductive or sexual health collected by a reproductive or sexual health digital service, as specified. The bill would make a business that offers a reproductive or sexual health digital service to a consumer for the purpose of allowing the individual to manage the individual's information, or for the diagnosis, treatment, or management of a medical condition of the individual, a provider of health care subject to the requirements of the CMIA. Because the bill would expand the scope of a crime, it would impose a state-mandated local program.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.

Primary Sponsors
Rebecca Bauer-Kahan, Dawn Addis, Laura Friedman

Bill Number	Status	Position
AB 269	Enacted	Monitor

Title
Public health: COVID-19 testing and dispensing sites.

Description
AB 269, Berman. Public health: COVID-19 testing and dispensing sites. Existing law, the California Emergency Services Act, authorizes the Governor to declare a state of emergency during conditions of disaster or extreme peril to persons or property, including epidemics. Pursuant to this authority, on March 4, 2020, the Governor declared a state of emergency relating to the novel coronavirus 2019 (COVID-19) pandemic, and ordered, among other things, that the certification and licensure requirements as specified in statute and regulation be suspended to all persons who meet the requirements under the Clinical Laboratory Improvement Amendments (CLIA) for high complexity testing and who are performing analysis of samples to test for SARS-CoV-2, the virus that causes COVID-19, in any certified public health laboratory or licensed clinical laboratory, and that the California Health and Human Services Agency is required to identify and make available medical facilities and other facilities that are suitable for use as medical facilities as necessary for treating individuals who test positive for COVID-19. This bill would authorize a person to perform an analysis of samples to test for SARS-CoV-2 in a clinical laboratory or a city, county, or city and county public health laboratory if they meet the requirements under CLIA for high complexity testing. The bill would, until January 1, 2024, authorize an entity contracted with and approved by the State Department of Public Health to operate a designated COVID-19 testing and dispensing site to acquire, dispense, and store COVID-19 oral therapeutics, as defined, at or from a designated site.This bill would declare that it is to take effect immediately as an urgency statute.

Primary Sponsors
Marc Berman

Bill Number	Status	Position
AB 274	In Senate	Monitor

Title
CalWORKs: CalFresh: eligibility: income exclusions.

Description
AB 274, as amended, Bryan. CalWORKs: CalFresh: eligibility: income exclusions. Existing federal law provides for allocation of federal funds to eligible states through the federal Temporary Assistance for Needy Families (TANF) block grant program. Existing state law provides for the California Work Opportunity and Responsibility to Kids (CalWORKs) program under which, through a combination of state and county funds and federal funds received through the TANF program, each county provides cash assistance and other benefits to qualified low-income families. Under existing law, certain types of payments received by recipients of aid under the CalWORKs program, including, among others, an award or scholarship provided by a public or private entity to, or on behalf of, a dependent child are exempt from consideration as income for purposes of determining eligibility and aid amount.Existing federal law provides for the Supplemental Nutrition Assistance Program (SNAP), known in California as CalFresh, under which supplemental nutrition assistance benefits allocated to the state by the federal government are distributed to eligible individuals by each county. Existing law requires the eligibility of households to be determined to the extent permitted by federal law. Existing federal regulation provides states with the option to exclude, for purposes of calculating a household's income under SNAP, any type of income that the state excludes when determining eligibility or benefits for TANF cash assistance.This bill would exempt any grant, award, scholarship, loan, or fellowship benefit provided to any assistance unit member for educational purposes from consideration as income for purposes of determining CalWORKs eligibility or grant amounts. The bill would also require, to the extent permitted by federal law, regulation, or guidance, or a waiver thereof, the State Department of Social Services to exercise a federal option to exclude, for purposes of calculating a household's income under CalFresh, any type of income that the department excludes when determining eligibility or benefits for CalWORKs. This bill would require the department to implement these provisions through an all-county letter or similar instruction until regulations are adopted. By expanding the scope of eligibility for CalWORKs and CalFresh, the bill would impose a state-mandated local program.Existing law continuously appropriates moneys from the General Fund to defray a portion of county costs under the CalWORKs program.This bill would provide that the continuous appropriation would not be made for purposes of implementing the bill.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by t... (click bill link to see more).

Primary Sponsors
Isaac Bryan, Lisa Calderon

Bill Number	Status	Position
AB 317	Passed Senate	Monitor

Title
Pharmacist service coverage.

Description
AB 317, as amended, Weber. Pharmacist service coverage. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care under authority of the Director of the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law authorizes health care service plans and certain disability insurers, that offer coverage for a service that is within the scope of practice of a duly licensed pharmacist, to pay or reimburse the cost of the service performed by a pharmacist for the plan or insurer if the pharmacist otherwise provides services for the plan or insurer.This bill would instead require a health care service plan and certain disability insurers that offer coverage for a service that is within the scope of practice of a duly licensed pharmacist to pay or reimburse the cost of services performed by a pharmacist at an in-network pharmacy or by a pharmacist at an out-of-network pharmacy if the health care service plan or insurer has an out-of-network pharmacy benefit. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.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.

Primary Sponsors
Akilah Weber

Bill Number	Status	Position
AB 352	In Senate	Monitor

Title
Health information.

Description
AB 352, as amended, Bauer-Kahan. Health information. Existing law, the Reproductive Privacy Act, provides that every individual possesses a fundamental right of privacy with respect to their personal reproductive decisions. Existing law prohibits the state from denying or interfering with a person's right to choose or obtain an abortion prior to viability of the fetus, or when the abortion is necessary to protect the life or health of the person.Existing law, the Confidentiality of Medical Information Act (CMIA), generally prohibits a provider of health care, a health care service plan, or a contractor from disclosing medical information regarding a patient, enrollee, or subscriber without first obtaining an authorization, unless a specified exception applies. The CMIA requires every provider of health care, health care service plan, pharmaceutical company, or contractor who, among other things, maintains or stores medical information to do so in a manner that preserves the confidentiality of the information contained therein. The CMIA also prohibits a provider of health care, a health care service plan, a contractor, or an employer from releasing medical information that would identify an individual or related to an individual seeking or obtaining an abortion in response to a subpoena or a request or to law enforcement if that subpoena, request, or the purpose of law enforcement for the medical information is based on, or for the purpose of enforcement of, either another state's laws that interfere with a person's rights to choose or obtain an abortion or a foreign penal civil action. Existing law makes a violation of the CMIA that results in economic loss or personal injury to a patient punishable as a misdemeanor.This bill would require specified businesses that electronically store or maintain medical information on the provision of sensitive services on behalf of a provider of health care, health care service plan, pharmaceutical company, contractor, or employer to develop capabilities, policies, and procedures, on or before July 1, 2024, to enable certain security features, including limiting user access privileges and segregating medical information related to sensitive services, as specified. The bill would additionally prohibit a provider of health care, health care service plan, contractor, or employer from cooperating with any inquiry or investigation by, or from providing medical information to, an individual, agency, or department from another state or, to the extent permitted by federal law, to a federal law enforcement agency that would identify an individual or that is related to an individual seeking or obtaining an abortion or abortion-related services that are lawful under the laws of this state, u... (click bill link to see more).

Primary Sponsors
Rebecca Bauer-Kahan

Bill Number	Status	Position
AB 365	**In Senate**	**Monitor**

Title
Medi-Cal: diabetes management.

Description
AB 365, as amended, Aguiar-Curry. Medi-Cal: diabetes management. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law sets forth a schedule of benefits under the Medi-Cal program. This bill would add continuous glucose monitors and related supplies required for use with those monitors as a covered benefit under the Medi-Cal program, subject to utilization controls. The bill would require the department, by July 1, 2024, to review and update, as appropriate, coverage policies for continuous glucose monitors, as specified. The bill would authorize the department to require a manufacturer of a continuous glucose monitor to enter into a rebate agreement with the department. The bill would limit its implementation to the extent that any necessary federal approvals are obtained and federal financial participation is not otherwise jeopardized. The bill would make related findings and declarations.

Primary Sponsors
Cecilia Aguiar-Curry

Bill Number	Status	Position
AB 425	**In Senate**	**Monitor**

Title
Medi-Cal: pharmacogenomic testing.

Description
AB 425, as amended, Alvarez. Medi-Cal: pharmacogenomic testing. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law sets forth a schedule of covered benefits under the Medi-Cal program.This bill would add pharmacogenomic testing as a covered benefit under Medi-Cal, as specified. The bill would define pharmacogenomic testing as laboratory genetic testing that includes, but is not limited to, a panel test, to identify how a person’s genetics may impact the efficacy, toxicity, and safety of medications, including medications prescribed for behavioral or mental health, oncology, hematology, pain management, infectious disease, urology, reproductive or sexual health, neurology, gastroenterology, or cardiovascular diseases.The bill would also make related legislative findings.

Primary Sponsors
David Alvarez

Bill Number	Status	Position
AB 469	In Senate	Monitor

Title
California Public Records Act Ombudsperson.

Description
AB 469, as amended, Vince Fong. California Public Records Act Ombudsperson. The California Public Records Act requires state and local agencies to make their records available for public inspection, unless an exemption from disclosure applies. The act declares that access to information concerning the conduct of the people's business is a fundamental and necessary right of every person in this state.Existing law creates the California State Auditor's Office, which is independent of the executive branch and legislative control, to examine and report annually upon the financial statements prepared by the executive branch. Existing law establishes, within the State Treasury, the State Audit Fund, which is a continuously appropriated fund, for the expenses of the California State Auditor.This bill would establish, within the California State Auditor's Office, the California Public Records Act Ombudsperson. The bill would require the California State Auditor to appoint the ombudsperson subject to certain requirements. The bill would require the ombudsperson to receive and investigate requests for review, as defined, determine whether the denials of original requests, as defined, complied with the California Public Records Act, and issue written opinions of its determination, as provided. The bill would require the ombudsperson to create a process to that effect, and would authorize a member of the public to submit a request for review to the ombudsperson consistent with that process. The bill would require the ombudsperson, within 30 days from receipt of a request for review, to make a determination, as provided, and would require the state agency to provide the public record if the ombudsperson determines that it was improperly denied. The bill would require the ombudsperson to create a process through which a person whose information is contained in a record being reviewed may intervene to assert their privacy and confidentiality rights, and would otherwise require the ombudsperson to maintain the privacy and confidentiality of records, as provided. The bill would require the ombudsperson to report to the Legislature, on or before March 31, 2025, and annually thereafter, on, among other things, the number of requests for review the ombudsperson has received in the prior year.By expanding the duties of the California State Auditor's Office, this bill would create an appropriation.

Primary Sponsors
Vince Fong

Bill Number	Status	Position
AB 531	**In Senate**	**Monitor**

Title
The Behavioral Health Infrastructure Bond Act of 2023.

Description
AB 531, as amended, Irwin. The Behavioral Health Infrastructure Bond Act of 2023. Existing law, the Bronzan-McCorquodale Act, contains provisions governing the operation and financing of community mental health services in every county through locally administered and locally controlled community mental health programs. Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 in the November 2, 2004, statewide general election, establishes the Mental Health Services Fund to fund various county mental health programs.This bill would enact the Behavioral Health Infrastructure Bond Act of 2023 which, if approved by the voters, would authorize the issuance of bonds in the amount of $4,680,000,000 to finance grants for the acquisition of capital assets for, and the construction and rehabilitation of, unlocked, voluntary, and community-based treatment settings and residential care settings and also for housing for veterans and others who are experiencing homelessness or are at risk of homelessness and are living with a behavioral health challenge.The bill would provide for the submission of the bond act to the voters at the March 5, 2024, statewide primary election.

Primary Sponsors
Jacqui Irwin, Susan Eggman

Bill Number	Status	Position
AB 551	**In Senate**	**Monitor**

Title
Medi-Cal: specialty mental health services: foster children.

Description
AB 551, as amended, Bennett. Medi-Cal: specialty mental health services: foster children. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services (department), 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. Under existing law, specialty mental health services include federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services provided to eligible Medi-Cal beneficiaries under 21 years of age. Existing law requires each local mental health plan to establish a procedure to ensure access to outpatient specialty mental health services, as required by the EPSDT program standards, for youth in foster care who have been placed outside their county of adjudication, as described.Existing law requires the department to issue policy guidance on the conditions for, and exceptions to, presumptive transfer of responsibility for providing or arranging for specialty mental health services to a foster youth from the county of original jurisdiction to the county in which the foster youth resides, as prescribed. On a case-by-case basis, and when consistent with the medical rights of children in foster care, existing law authorizes the waiver of presumptive transfer, with the responsibility for the provision of specialty mental health services remaining with the county of original jurisdiction if certain exceptions exist. Under existing law, the county probation agency or the child welfare services agency is responsible for determining whether waiver of the presumptive transfer is appropriate, with notice provided to the person requesting the exception.Under existing law, commencing July 1, 2023, in the case of placement of foster children in short-term residential therapeutic programs, community treatment facilities, or group homes, or in the case of admission of foster children to children’s crisis residential programs, the county of original jurisdiction is required to retain responsibility and presumptive transfer provisions apply only if certain circumstances exist.This bill, for purposes of foster children placed or admitted in those specific settings, would delay, until July 1, 2024, the requirement on the county of original jurisdiction to retain responsibility and the limitation on the presumptive transfer provisions. By extending the period during which a county agency is responsible for making determinations about presumptive transfer waivers and making certain notifications, the bill would impose a state-mandated local program.Existing law conditions implementation of the above-described provisions on the availability of fede... (click bill link to see more).

Primary Sponsors
Steve Bennett

Bill Number	Status	Position
AB 557	In Senate	Monitor

Title
Open meetings: local agencies: teleconferences.

Description
AB 557, as amended, Hart. Open meetings: local agencies: teleconferences. (1) Existing law, the Ralph M. Brown Act, requires, with specified exceptions, that all meetings of a legislative body of a local agency, as those terms are defined, be open and public and that all persons be permitted to attend and participate. The act contains specified provisions regarding providing for the ability of the public to observe and provide comment. The act allows for meetings to occur via teleconferencing subject to certain requirements, particularly that the legislative body notice each teleconference location of each member that will be participating in the public meeting, that each teleconference location be accessible to the public, that members of the public be allowed to address the legislative body at each teleconference location, that the legislative body post an agenda at each teleconference location, and that at least a quorum of the legislative body participate from locations within the boundaries of the local agency's jurisdiction. The act provides an exemption to the jurisdictional requirement for health authorities, as defined.Existing law, until January 1, 2024, authorizes the legislative body of a local agency to use teleconferencing without complying with those specified teleconferencing requirements in specified circumstances when a declared state of emergency is in effect. Those circumstances are that (1) state or local officials have imposed or recommended measures to promote social distancing, (2) the legislative body is meeting for the purpose of determining whether, as a result of the emergency, meeting in person would present imminent risks to the health or safety of attendees, or (3) the legislative body has previously made that determination. If there is a continuing state of emergency, or if state or local officials have imposed or recommended measures to promote social distancing, existing law requires a legislative body to make specified findings not later than 30 days after the first teleconferenced meeting, and to make those findings every 30 days thereafter, in order to continue to meet under these abbreviated teleconferencing procedures.Existing law requires a legislative body that holds a teleconferenced meeting under these abbreviated teleconferencing procedures to give notice of the meeting and post agendas, as described, to allow members of the public to access the meeting and address the legislative body, to give notice of the means by which members of the public may access the meeting and offer public comment, including an opportunity for all persons to attend via a call-in option or an internet-based service option. Existing law prohibits a legislative body that holds a teleconferenced ... (click bill link to see more).

Primary Sponsors
Gregg Hart

Bill Number	Status	Position
AB 576	In Senate	Monitor

Title
Medi-Cal: reimbursement for abortion.

Description
AB 576, as amended, Weber. Medi-Cal: reimbursement for abortion. Existing law establishes 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. Existing law provides that abortion is a covered benefit under Medi-Cal. Existing regulation authorizes reimbursement for specified medications used to terminate a pregnancy through the 70th day from the first day of the recipient's last menstrual period.This bill would require the department, by March 1, 2024, to review and update Medi-Cal coverage policies for medication abortion to align with current evidence-based clinical guidelines. After the initial review, the bill would require the department to update its Medi-Cal coverage policies for medication abortion as needed to align with evidence-based clinical guidelines.The bill would require the department to allow flexibility for providers to exercise their clinical judgment when services are performed in a manner that aligns with one or more evidence-based clinical guidelines.

Primary Sponsors
Akilah Weber

Bill Number	Status	Position
AB 608	In Senate	Monitor

Title
Medi-Cal: comprehensive perinatal services.

Description
AB 608, as amended, Schiavo. Medi-Cal: comprehensive perinatal services. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including comprehensive perinatal services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, a pregnant individual or targeted low-income child who is eligible for, and is receiving, health care coverage under any of specified Medi-Cal programs is eligible for full-scope Medi-Cal benefits for the duration of the pregnancy and for a period of one year following the last day of the individual's pregnancy.This bill, during the one-year postpregnancy eligibility period, and as part of comprehensive perinatal services under Medi-Cal, would require the department to cover additional comprehensive perinatal assessments and individualized care plans and to provide additional visits and units of services in an amount, duration, and scope that are at least proportional to those available on July 27, 2021, during pregnancy and the initial 60-day postpregnancy period in effect on that date. The bill would require the department, in coordination with the State Department of Public Health, to consider input from certain stakeholders, as specified, in determining the specific number of additional comprehensive perinatal assessments, individualized care plans, visits, and units of services to be covered.The bill would require the department to cover comprehensive perinatal services that are rendered by a nonlicensed perinatal health worker in a beneficiary's home or other community setting away from a medical site, as specified. The bill would also require the department to allow a nonlicensed perinatal health worker rendering those services to be supervised by a community-based organization (CBO) or a local health jurisdiction (LHJ). For these purposes, the bill would require a CBO or LHJ supervising a nonlicensed perinatal health worker to provide those services under contract with a Comprehensive Perinatal Services Program provider.The bill would condition implementation of the provisions above on receipt of any necessary federal approvals and the availability of federal financial participation. The bill would authorize the department to implement these provisions by all-county letters or similar instructions until regulations are adopted.

Primary Sponsors
Pilar Schiavo, Joaquin Arambula, Sabrina Cervantes

Bill Number	Status	Position
AB 614	In Senate	Monitor

Title
Medi-Cal.

Description
AB 614, as amended, Wood. Medi-Cal. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.This bill would make a change to an obsolete reference to the former Healthy Families Program, whose health services for children have been transitioned to the Medi-Cal program. The bill would make a change to an obsolete reference to the former Access for Infants and Mothers Program and would revise a related provision to instead refer to the successor Medi-Cal Access Program. The bill would delete, within certain Medi-Cal provisions, obsolete references to a repealed provision relating to nonprofit hospital service plans.Existing law establishes, under Medi-Cal, the County Health Initiative Matching Fund, a program administered by the department, through which an applicant county, county agency, local initiative, or county organized health system that provides an intergovernmental transfer, as specified, is authorized to submit a proposal to the department for funding for the purpose of providing comprehensive health insurance coverage to certain children. The program is sometimes known as the County Children's Health Initiative Program (CCHIP).This bill would revise certain provisions to rename that program as CCHIP.Existing law requires the Director of Health Care Services to enter into contracts with managed care plans under Medi-Cal and related provisions, including health maintenance organizations, prepaid health plans, or other specified entities, for the provision of medical benefits to all persons who are eligible to receive medical benefits under publicly supported programs.This bill would delete that list of entities and would instead specify that the director would be required to enter into contracts with managed care plans licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975, except as otherwise authorized under the Medi-Cal program. The bill would require the director, prior to issuing a new request for proposal or entering into new contracts, to provide an opportunity for interested stakeholders to provide input to inform the development of contract provisions.The bill would also make technical changes to some of the provisions described above.

Primary Sponsors
Jim Wood

Bill Number	Status	Position
AB 616	**In Senate**	**Monitor**

Title
Medical Group Financial Transparency Act.

Description
AB 616, as amended, Rodriguez. Medical Group Financial Transparency Act. Existing law establishes the Office of Health Care Affordability within the Department of Health Care Access and Information to analyze the health care market for cost trends and drivers of spending, develop data-informed policies for lowering health care costs for consumers and purchasers, and create a state strategy for controlling the cost of health care. Existing law requires the office to collect data and other information it deems necessary from health care entities to carry out the functions of the office, and requires the office to require providers and physician organizations to submit audited financial reports or comprehensive financial statements, as specified. Existing law requires those reports and statements to be kept confidential, and specifies that they are not required to be disclosed under the California Public Records Act.Existing law requires the office to obtain information about health care service plans from the Department of Managed Health Care. Existing law requires a contract between a health care service plan and a risk-bearing organization to include provisions concerning the risk-bearing organization's administrative and financial capacity. Existing law requires the director of the Department of Managed Health Care to adopt regulations regarding, among other things, periodic reports from a health care service plan that include information concerning the risk-bearing organizations and the type and amount of financial risk they have assumed.Existing law establishes, within the office, the Health Care Affordability Board, composed of 8 members, appointed as prescribed. This bill, the Medical Group Financial Transparency Act, would authorize the disclosure of audited financial reports and comprehensive financial statements of providers and physician organizations collected by the Office of Health Care Affordability and financial and other records of risk-bearing organizations made available to the Department of Managed Health Care. This bill would authorize the board, members of the board, the office, the department, and the employees, contractors, and advisors of the office and the department to use confidential audited financial reports and comprehensive financial statements only as necessary to carry out functions of the office. The bill would also require certain physician organizations, as specified, to produce or disclose audited financial reports and comprehensive financial statements to the office, subject to these provisions. The bill would require the audited financial reports and comprehensive financial statements produced or disclosed to the office to be made available to the public, by the office, as specified.... (click bill link to see more).

Primary Sponsors
Freddie Rodriguez

Bill Number	Status	Position
AB 620	In Senate	Monitor

Title
Health care coverage for metabolic disorders.

Description
AB 620, as amended, Connolly. Health care coverage for metabolic disorders. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of disability insurers, including health insurers, by the Department of Insurance. Existing law requires a health care service plan contract and disability insurance policy that provides coverage for hospital, medical, or surgical expenses and is issued, amended, delivered, or renewed on and after July 1, 2000, to provide coverage for the testing and treatment of phenylketonuria, including coverage for the formulas and special food products that are part of a prescribed diet, as specified.This bill would require a health care service plan contract and disability insurance policy that provides coverage for hospital, medical, or surgical expenses and is issued, amended, delivered, or renewed on and after January 1, 2024, to provide coverage for the testing and treatment of other chronic digestive diseases and inherited metabolic disorders, as specified. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.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.

Primary Sponsors
Damon Connolly

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 5:51 PM
California Association of Health Plans: Oppose

Bill Number	Status	Position
AB 632	In Senate	Monitor

Title
Health care coverage: prostate cancer screening.

Description
AB 632, as amended, Gipson. Health care coverage: prostate cancer screening. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires an individual and group health care service plan contract or health insurance policy to provide coverage for the screening and diagnosis of prostate cancer when medically necessary and consistent with good professional practice. Under existing law, the application of a deductible or copayment for those services is not prohibited.This bill would instead require that coverage when medically necessary and consistent with nationally recognized, evidence-based clinical guidelines. The bill would prohibit a health care service plan or a health insurance policy issued, amended, renewed, or delivered on or after January 1, 2024, from applying a deductible, copayment, or coinsurance to coverage for prostate cancer screening services for an enrollee or insured who is at a high risk of prostate cancer, consistent with specified guidelines and is either 55 years of age or older or 40 years of age or older and high risk, as determined by the attending or treating health care provider. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.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.

Primary Sponsors
Mike Gipson

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 5:52 PM
California Association of Health Plans: Oppose

Bill Number	Status	Position
AB 659	In Senate	Monitor

Title
Cancer Prevention Act.

Description
AB 659, as amended, Aguiar-Curry. Cancer Prevention Act. Existing law prohibits the governing authority of a school or other institution from unconditionally admitting any person as a pupil of any private or public elementary or secondary school, childcare center, day nursery, nursery school, family daycare home, or development center, unless prior to their admission to that institution they have been fully immunized. Existing law requires the documentation of immunizations for certain diseases, including, among others, measles, mumps, pertussis, and any other disease deemed appropriate by the State Department of Public Health, as specified. Existing law authorizes certain exemptions from these provisions subject to specified conditions.This bill, the Cancer Prevention Act, would declare the public policy of the state that pupils are recommended to be fully immunized against human papillomavirus (HPV) before admission or advancement to the 8th grade level of any private or public elementary or secondary school. The bill would, upon a pupil's admission or advancement to the 6th grade level, require the governing authority to submit to the pupil and their parent or guardian a notification containing a statement about that public policy and advising that the pupil be fully immunized against HPV before admission or advancement to the 8th grade level. The bill would incorporate that notification into existing provisions relating to notifications by school districts. By creating new notification duties for school districts, the bill would impose a state-mandated local program.Existing law requires the Trustees of the California State University and, subject to a resolution, the Regents of the University of California to require the first-time enrollees at those institutions who are 18 years of age or younger to provide proof of full immunization against the hepatitis B virus prior to enrollment, with certain exemptions.This bill would declare the public policy of the state that students who are 26 years of age or younger are recommended to be fully immunized against HPV before first-time enrollment at an institution of the California State University, the University of California, or the California Community Colleges. The bill would make a conforming change to a consultation-related provision.Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or health insurance policy issued, amended, or renewed... (click bill link to see more).

Primary Sponsors
Cecilia Aguiar-Curry

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 5:52 PM
California Association of Health Plans: Oppose

Bill Number	Status	Position
AB 663	In Senate	Monitor

Title
Pharmacy: mobile units.

Description
AB 663, as amended, Haney. Pharmacy: mobile units. Existing law, the Pharmacy Law, requires the California State Board of Pharmacy within the Department of Consumer Affairs to license and regulate the practice of pharmacy, including pharmacists, pharmacy technicians, and pharmacies. Existing law authorizes a county, city and county, or special hospital authority, as defined, to operate a mobile unit as an extension of a pharmacy license held by the county, city and county, or special hospital authority to provide prescription medication within its jurisdiction to specified individuals, including those individuals without fixed addresses. Existing law authorizes a mobile unit to dispense prescription medication pursuant to a valid prescription if the county, city and county, or special hospital authority meets prescribed requirements for licensure, staffing, and operations, including a prohibition on carrying or dispensing controlled substances.Existing law, the California Uniform Controlled Substances Act, classifies certain controlled substances into Schedules I to V, inclusive.This bill would instead authorize a county, city and county, or special hospital authority to operate one or more mobile units as an extension of a pharmacy license held by the county, city and county, or special hospital authority, as described above. The bill would require the pharmacist-in-charge to determine the number of mobile units that are appropriate for a particular pharmacy license. The bill would additionally authorize a mobile unit to provide prescription medication within its jurisdiction to city-and-county-operated housing facilities.This bill would exempt from the above-described prohibition on carrying or dispensing controlled substances Schedule III, Schedule IV, or Schedule V controlled substances approved by the United States Food and Drug Administration for the treatment of opioid use disorder. The bill would require any controlled substance for the treatment of opioid use disorder carried or dispensed in accordance with that exemption to be carried in reasonable quantities based on prescription volume and stored securely in the mobile pharmacy unit.

Primary Sponsors
Matt Haney

Bill Number	Status	Position
AB 712	**Enacted**	**Support**

Title
CalFresh: hot and prepared foods.

Description
AB 712, Wendy Carrillo. CalFresh: hot and prepared foods. Existing law establishes various public social services programs, including, among others, the California Work Opportunity and Responsibility to Kids (CalWORKs) program, CalFresh, and the Medi-Cal program. Existing federal law provides for the federal Supplemental Nutrition Assistance Program (SNAP), known in California as CalFresh, under which supplemental nutrition assistance benefits allocated to the state by the federal government are distributed to eligible individuals by each county.This bill would require the State Department of Social Services to seek all available federal waivers and approvals to maximize food choices for CalFresh recipients, including hot and prepared foods ready for immediate consumption.

Primary Sponsors
Wendy Carrillo

Organizational Notes

Last edited by Joanne Campbell at Jun 6, 2023, 3:17 PM
California Association of Food Banks (co-sponsor), GRACE/End Child Poverty CA (co-sponsor)

Bill Number	Status	Position
AB 716	**In Senate**	**Monitor**

Title
Ground medical transportation.

Description
AB 716, as amended, Boerner. Ground medical transportation. Existing law creates the Emergency Medical Services Authority to coordinate various state activities concerning emergency medical services. Existing law requires the authority to report specified information, including reporting ambulance patient offload time twice per year to the Commission on Emergency Medical Services.This bill would require the authority to annually report the allowable maximum rates for ground ambulance transportation services in each county, including trending the rates by county, as specified.Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires that health care service plan contracts and health insurance policies provide coverage for certain services and treatments, including medical transportation services, and requires a policy or contract to provide for the direct reimbursement of a covered medical transportation services provider if the provider has not received payment from another source.This bill would delete that direct reimbursement requirement and would require a health care service plan contract or a health insurance policy issued, amended, or renewed on or

after January 1, 2024, to require an enrollee or insured who receives covered services from a noncontracting ground ambulance provider to pay no more than the same cost-sharing amount that the enrollee or insured would pay for the same covered services received from a contracting ground ambulance provider. The bill would prohibit a noncontracting ground ambulance provider from sending to collections a higher amount, would limit the amount an enrollee or insured owes a noncontracting ground ambulance provider to no more than the in-network cost-sharing amount, and would prohibit a ground ambulance provider from billing an uninsured or self-pay patient more than the established payment by Medi-Cal or Medicare fee-for-service amount, whichever is greater. The bill would require a plan or insurer to directly reimburse a noncontracting ground ambulance provider for ground ambulance services the difference between the in-network cost-sharing amount and an amount described, as specified, unless it reaches another agreement with the noncontracting ground ambulance provider. Because a willful violation of the bill's requirements relative to a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to ... (click bill link to see more).

Primary Sponsors
Tasha Boerner Horvath

Organizational Notes

Last edited by Joanne Campbell at Jul 14, 2023, 6:35 PM
California Association of Health Plans - Oppose

Bill Number	Status	Position
AB 719	In Senate	Monitor

Title
Medi-Cal: nonmedical and nonemergency medical transportation.

Description
AB 719, as amended, Boerner. Medi-Cal: nonmedical and nonemergency medical transportation. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes a schedule of benefits under the Medi-Cal program, including medical transportation and nonmedical transportation for a beneficiary to obtain covered Medi-Cal services. Existing law requires nonmedical transportation to be provided by the beneficiary's managed care plan or by the department for a Medi-Cal fee-for-service beneficiary.This bill would require the department to require Medi-Cal managed care plans that are contracted to provide nonmedical transportation or nonemergency medical transportation to contract with public paratransit service operators who are enrolled Medi-Cal providers for the purpose of establishing reimbursement rates for nonmedical and nonemergency medical transportation trips provided by a public paratransit service operator. The bill would require the rates reimbursed by the managed care plan to the public paratransit service operator to be based on the department's fee-for-service rates for nonmedical and nonemergency medical transportation service, as specified. The bill would condition implementation of these provisions on receipt of any necessary federal approvals and the availability of federal financial participation.

Primary Sponsors
Tasha Boerner Horvath

Organizational Notes

Last edited by Joanne Campbell at Jun 5, 2023, 8:55 PM
Local Health Plans of California, California Association of Health Plans: Oppose

Bill Number	Status	Position
AB 816	In Senate	Monitor

Title
Minors: consent to medical care.

Description
AB 816, as introduced, Haney. Minors: consent to medical care. Existing law authorizes a minor who is 12 years of age or older to consent to medical care and counseling relating to the diagnosis and treatment of a drug- or alcohol-related problem. Existing law exempts replacement narcotic abuse treatment, as specified, from these provisions.This bill would authorize a minor who is 16 years of age or older to consent to replacement narcotic abuse treatment that uses buprenorphine.

Primary Sponsors
Matt Haney

Bill Number	Status	Position
AB 866	In Senate	Monitor

Title
Food assistance for nonminor dependents.

Description
AB 866, as amended, Blanca Rubio. Food assistance for nonminor dependents. Existing federal law provides for the federal Supplemental Nutrition Assistance Program (SNAP), known in California as CalFresh, under which nutrition assistance benefits are distributed to eligible individuals by the counties. Existing law establishes eligibility and benefit level requirements for receipt of CalFresh benefits.Existing law establishes the Aid to Families with Dependent Children-Foster Care (AFDC-FC) program, under which counties provide payments to foster care providers on behalf of qualified children in foster care. The program is funded by a combination of federal, state, and county funds. In order to be eligible for AFDC-FC, existing law requires a child or nonminor dependent to be placed in one of several specified placements, including, for nonminor dependents, a supervised independent living placement or a transitional living setting.This bill would require the State Department of Social Services to establish a state-funded food assistance program to provide assistance for a nonminor dependent, as defined, who is residing in a supervised independent living placement or a transitional living setting, as specified. The bill would require the program to utilize the existing CalFresh and electronic benefits transfer system infrastructure to implement the program, to the extent permissible under federal law. The bill would specify the amount of assistance a nonminor dependent would receive, based on whether or not the nonminor dependent is a custodial parent. The bill would authorize counties to screen the nonminor dependent for eligibility for CalFresh benefits and if the nonminor dependent is eligible for those benefits, the amount of assistance pursuant to the bill would be the difference between the nonminor dependent's CalFresh payment and the maximum benefit allotted for their household size. The bill would terminate food assistance payments to the minor on the last day of the month in which the nonminor dependent no longer lives in a supervised independent living placement or transitional living setting, as specified. The bill would require the department to work with the County Welfare Directors Association of California and the California Statewide Automated Welfare System (CalSAWS) to develop and implement the necessary system changes to implement its provisions, and would require the payment to be automated on the later of January 1, 2025, or the date the department notifies the Legislature that CalSAWS can perform the necessary automation. By increasing county duties, the bill would impose a state-mandated local program. The bill would authorize the State Department of Social Services to implement and administ... (click bill link to see more).

Primary Sponsors
Blanca Rubio

Bill Number	Status	Position
AB 904	In Senate	Monitor

Title
Health care coverage: doulas.

Description
AB 904, as amended, Calderon. Health care coverage: doulas. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan or health insurer to develop a maternal mental health program designed to promote quality and cost-effective outcomes. Existing law encourages a plan or insurer to include coverage for doulas.This bill would require a health care service plan or health insurer, on or before January 1, 2025, to develop a maternal and infant health equity program that addresses racial health disparities in maternal and infant health outcomes through the use of doulas. The bill would require the Department of Managed Health Care, in consultation with the Department of insurance, to collect data and submit a report describing the doula coverage and the above-described programs to the Legislature by January 1, 2027. Because a willful violation of the provisions relative to health care service plans would be a crime, the bill would impose a state-mandated local program.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.

Primary Sponsors
Lisa Calderon, Sabrina Cervantes

Bill Number	Status	Position
AB 907	In Senate	Monitor

Title
Coverage for PANDAS and PANS.

Description
AB 907, as amended, Lowenthal. Coverage for PANDAS and PANS. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law sets forth specified coverage requirements for health care service plan contracts and health insurance policies, and limits the copayment, coinsurance, deductible, and other cost sharing that may be imposed for specified health care services.This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2024, to provide coverage for the prophylaxis, diagnosis, and treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) that is prescribed or ordered by the treating physician and surgeon. The bill would prohibit coverage for PANDAS and PANS from being subject to a copayment, coinsurance, deductible, or other cost sharing that is greater than that applied to other benefits. The bill would prohibit a plan or insurer from denying or delaying coverage for PANDAS or PANS therapies because the enrollee or insured previously received treatment for PANDAS or PANS or was diagnosed with or received treatment for the condition under a different diagnostic name. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.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.

Primary Sponsors
Josh Lowenthal

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 5:54 PM
California Association of Health Plans: Oppose

Bill Number	Status	Position
AB 931	In Senate	Monitor

Title
Prior authorization: physical therapy.

Description
AB 931, as amended, Irwin. Prior authorization: physical therapy. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law sets forth specified prior authorization limitations for health care service plans and health insurers.This bill would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, that provides coverage for physical therapy from imposing prior authorization for the initial 12 treatment visits for a new episode of care for physical therapy. The bill would require a physical therapy provider to verify an enrollee's or an insured's coverage and disclose their share of the cost of care, as specified. The bill would require a physical therapy provider to disclose if the provider is not in the network of the enrollee's plan or the insured's policy, and if so, to obtain the enrollee's or the insured's consent in writing to receive services from the noncontracting provider prior to initiating care. Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program.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.

Primary Sponsors
Jacqui Irwin

Organizational Notes

Last edited by Joanne Campbell at Jun 6, 2023, 7:51 PM
California Association of Health Plans: Oppose Unless Amended

Bill Number	Status	Position
AB 948	In Senate	Monitor

Title
Prescription drugs.

Description
AB 948, as amended, Berman. Prescription drugs. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law prohibits the copayment, coinsurance, or any other form of cost sharing for a covered outpatient prescription drug for an individual prescription from exceeding $250 for a supply of up to 30 days, except as specified. Existing law requires a health care service plan contract or health insurance policy for a nongrandfathered individual or small group product that maintains a drug formulary grouped into tiers, and that includes a 4th tier, to define each tier of the drug formulary, as specified. Existing law defines Tier 4 to include, among others, drugs that are biologics. Existing law repeals these provisions on January 1, 2024.This bill would delete drugs that are biologics from the definition of Tier 4. The bill would require a health care service plan or a health insurer, if there is a generic equivalent to a brand name drug, to ensure that an enrollee or insured is subject to the lowest cost sharing that would be applied, whether or not both the generic equivalent and the brand name drug are on the formulary. The bill also would delete the January 1, 2024, repeal date of the above provisions, thus making them operative indefinitely. Because extension of the bill's requirements relative to health care service plans would extend the existence of a crime, the bill would impose a state-mandated local program.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.

Primary Sponsors
Marc Berman, Scott Wiener

Bill Number	Status	Position
AB 952	Enacted	Monitor

Title
Dental coverage disclosures.

Description
AB 952, Wood. Dental coverage disclosures. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law imposes specified coverage and disclosure requirements on health care service plans and health insurers, including specialized plans and insurers, that cover dental services.This bill would require a health care service plan or health insurer that issues, sells, renews, or offers a contract covering dental services, including a specialized health care service plan or specialized health insurer covering dental services, to disclose whether an enrollee's or insured's dental coverage is "State Regulated" through a provider portal, if available, or otherwise upon request, on or after January 1, 2025. The bill would require a plan or insurer to include the statement "State Regulated," if the enrollee's or insured's dental coverage is subject to regulation by the appropriate department, on an electronic or physical identification card, or both if available, for contracts covering dental services issued on or after January 1, 2025. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.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.

Primary Sponsors
Jim Wood

Bill Number	Status	Position
AB 988	Passed Senate	Monitor

Title
Miles Hall Lifeline and Suicide Prevention Act: veteran and military data reporting.

Description
AB 988, as amended, Mathis. Miles Hall Lifeline and Suicide Prevention Act: veteran and military data reporting. Existing federal law, the National Suicide Hotline Designation Act of 2020, designates the 3-digit telephone number “988” as the universal number within the United States for the purpose of the national suicide prevention and mental health crisis hotline system operating through the 988 Suicide and Crisis Lifeline, maintained by the Assistant Secretary for Mental Health and Substance Use, and the Veterans Crisis Line, which is maintained by the Secretary of Veterans Affairs.Existing law creates a separate surcharge, beginning January 1, 2023, on each access line for each month, or part thereof, for which a service user subscribes with a service supplier. Existing law sets the 988 surcharge for the 2023 and 2024 calendar years at $0.08 per access line per month and beginning January 1, 2025, at an amount based on a specified formula not to exceed $0.30 per access line per month. Existing law authorizes the 911 and 988 surcharges to be combined into a single-line item, as described. Existing law provides for specified costs to be paid by the fees prior to distribution to the Office of Emergency Services.Existing law, the Miles Hall Lifeline and Suicide Prevention Act, creates the 988 State Suicide and Behavioral Health Crisis Services Fund and requires the fees to be deposited along with other specified moneys into the fund. Existing law provides that, upon appropriation by the Legislature, the funds be used for specified purposes and in accordance with specified priorities. Existing law requires the Office of Emergency Services to require an entity seeking moneys available through the fund to annually file an expenditure and outcomes report containing specified information, including, among other things, the number of individuals served and the outcomes for individuals served, if known.This bill would require an entity seeking moneys from the fund to also include the number of individuals who used the service and self-identified as veterans or active military personnel in its annual expenditure and outcomes report.

Primary Sponsors
Devon Mathis, Buffy Wicks

Bill Number	Status	Position
AB 1005	In Senate	Monitor

Title
In-home supportive services: terminal illness diagnosis.

Description
AB 1005, as amended, Alvarez. In-home supportive services: terminal illness diagnosis. Existing law establishes the In-Home Supportive Services (IHSS) program, administered by the State Department of Social Services and counties, under which qualified aged, blind, or disabled persons are provided with supportive services in order to permit them to remain in their own homes.As a condition of receiving services under the IHSS program, existing law requires an applicant or recipient to obtain a certification from a licensed health care professional declaring that the applicant or recipient is unable to perform some activities of daily living independently, and that without services to assist the applicant or recipient with activities of daily living, the applicant or recipient is at risk of placement in out-of-home care. Existing law requires that the certification be received prior to service authorization, except under certain circumstances. Existing law requires the department to develop a standard certification form, as specified, and to identify alternative documentation, including, but not limited to, hospital or nursing facility discharge plans, containing the required information.Existing law sets forth various provisions relating to end-of-life care. When a health care provider makes a diagnosis that a patient has a terminal illness, existing law generally requires the health care provider, upon request, to provide the patient or another person authorized to make health care decisions with comprehensive information and counseling regarding legal end-of-life care options.This bill would, before the discharge from an acute care hospital of a Medi-Cal beneficiary, require the hospital's designated case manager or discharge planner to evaluate the patient's need for posthospital services and ability to access those services. This bill would require the hospital's case manager or discharge planner to ask the patient or authorized person if they are interested in receiving information about the IHSS program if that patient is anticipated to need in-home personal care. If interest is expressed, the bill would require the hospital's case manager or discharge planner to provide to the patient or authorized person the information, including how to initiate the application process and the option for a family member to provide care as an IHSS provider subject to the IHSS provider enrollment conditions.If the patient seeks to apply for services under the IHSS program, the bill would require the hospital case manager or discharge planner to communicate to the patient's primary care physician the patient's interest in applying for IHSS services to support the timely completion of the health care certification form.Exi... (click bill link to see more).

Primary Sponsors
David Alvarez

Bill Number	Status	Position
AB 1085	In Senate	Monitor

Title
Medi-Cal: housing support services.

Description
AB 1085, as amended, Maienschein. Medi-Cal: housing support services. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Existing law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, authorizes a Medi-Cal managed care plan to elect to cover community supports approved by the department as cost effective and medically appropriate in a comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services. Under existing law, community supports that the department is authorized to approve include, among other things, housing transition navigation services, housing deposits, and housing tenancy and sustaining services.Existing law, subject to an appropriation, requires the department to complete an independent analysis to determine whether network adequacy exists to obtain federal approval for a covered Medi-Cal benefit that provides housing support services. Existing law requires that the analysis take into consideration specified information, including the number of providers in relation to each region's or county's number of people experiencing homelessness. Existing law requires the department to report the outcomes of the analysis to the Legislature by January 1, 2024.This bill would require the department, if the independent analysis finds that the state has sufficient network capacity to meet state and federal guidelines to create a new housing support services benefit, to seek any necessary federal approvals for a Medi-Cal benefit to cover housing support services within 6 months of the completion of the analysis. The bill would require the department to report the outcomes of the analysis to the Legislature by July 1, 2024. Under the bill, subject to receipt of those federal approvals, a Medi-Cal beneficiary would be eligible for those services if they either experience homelessness or are at risk of homelessness, as specified. Under the bill, the services would include housing transition and navigation services, housing deposits, and housing tenancy and sustaining services, as defined.If the evaluation finds that the state has insufficient network capacity to meet state and federal guidelines to create a new housing support services benefit, the bill would require the department to provide recommendations for building capacity and a timeline for implementation consistent with the analysis findings.

Primary Sponsors
Brian Maienschein

Bill Number	Status	Position
AB 1092	In Senate	Monitor

Title
Health care service plans: consolidation.

Description
AB 1092, as amended, Wood. Health care service plans: consolidation. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law requires a health care service plan that intends to merge with, consolidate with, or enter into an agreement resulting in its purchase, acquisition, or control by, an entity, to give notice to, and secure prior approval from, the Director of the Department of Managed Health Care. Existing law authorizes the director to disapprove the transaction or agreement if the director finds it would substantially lessen competition in health care service plan products or create a monopoly in this state. Existing law authorizes the director to conditionally approve the transaction or agreement, contingent upon the health care service plan's agreement to fulfill one or more conditions to benefit subscribers and enrollees of the health care service plan, provide for a stable health care delivery system, and impose other conditions specific to the transaction or agreement, as specified.This bill would additionally require a health care service plan that intends to acquire or obtain control of an entity, as specified, to give notice to, and secure prior approval from, the director. Because a willful violation of this provision would be a crime, the bill would impose a state-mandated local program. The bill would also authorize the director to disapprove a transaction or agreement if it would substantially lessen competition in the health system or among a particular category of health care providers, and would require the director to provide information related to competition to the Attorney General. The bill would revise the director's authority to conditionally approve a transaction or agreement, including authorizing the director to review information from federal agencies and other state agencies, including agencies in other states, that is relevant to any of the parties to the transaction, as specified. With respect to a conditional approval, the bill would also authorize the director to contract with an independent entity to monitor compliance with the established conditions and report to the department. The bill would prohibit the director from waiving, or delaying implementation of, certain requirements imposed under existing law and the bill, notwithstanding a specified provision.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 ... (click bill link to see more).

Primary Sponsors
Jim Wood

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 6:12 PM
California Association of Health Plans: Oppose

Bill Number	Status	Position
AB 1110	In Senate	Monitor

Title
Public health: adverse childhood experiences.

Description
AB 1110, as amended, Arambula. Public health: adverse childhood experiences. Existing law requires the Office of the Surgeon General to, among other things, raise public awareness and coordinate policies governing scientific screening and treatment for toxic stress and adverse childhood experiences (ACEs).This bill would, subject to an appropriation and until January 1, 2027, require the office and the State Department of Health Care Services, while administering the ACEs Aware initiative and in collaboration with subject matter experts, to review available literature on ACEs, as defined, and ancestry or ethnicity-based data disaggregation practices in ACEs screenings, develop guidance for culturally and linguistically competent ACEs screenings through improved data collection methods, post the guidance on the department's internet website and the ACEs Aware internet website, and make the guidance accessible, as specified. The bill would make legislative findings and declarations.

Primary Sponsors
Joaquin Arambula

Bill Number	Status	Position
AB 1122	In Senate	Monitor

Title
Medi-Cal provider applications.

Description
AB 1122, as amended, Bains. Medi-Cal provider applications. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Existing law generally requires an applicant that currently is not enrolled in the Medi-Cal program, a provider applying for continued enrollment, or a provider not currently enrolled at a location where the provider intends to provide services, goods, supplies, or merchandise to a Medi-Cal beneficiary, to submit a complete application package for enrollment, continuing enrollment, or enrollment at a new location or a change in location, as specified.Existing law requires an applicant or provider, for new or continued enrollment in the Medi-Cal program, to disclose all information as required in federal Medicaid regulations and any other information required by the department, as specified.This bill would require the Director of Health Care Services to develop a process to allow an applicant or provider to submit an alternative type of primary, authoritative source documentation to meet the requirement of submitting the above-described information. The bill would require the department to document each case of an applicant or provider submitting an alternative type of primary, authoritative source documentation, as specified. The bill would condition implementation of these provisions on lack of conflict with federal law or regulation, federal financial participation not being jeopardized, and receipt of any necessary federal approvals.Existing law authorizes the department to make unannounced visits to an applicant or provider for the purpose of determining whether enrollment, continued enrollment, or certification is warranted, or as necessary for the administration of the Medi-Cal program. Existing law requires, at the time of the visit, the applicant or provider to demonstrate an established place of business appropriate and adequate for the services billed or claimed to the Medi-Cal program, as specified.This bill would authorize the applicant or provider to submit its application for enrollment up to 30 days before having an established place of business and have its application considered by the department, to the extent not in conflict with federal law.

Primary Sponsors
Jasmeet Bains

Bill Number	Status	Position
AB 1157	In Senate	Monitor

Title
Rehabilitative and habilitative services: durable medical equipment and services.

Description
AB 1157, as amended, Ortega. Rehabilitative and habilitative

services: durable medical equipment and services. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service plans and makes a willful violation of the act a crime. Other existing law requires the Department of Insurance to regulate health insurers. Existing law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, to include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act. Under existing law, essential health benefits includes, among other things, rehabilitative and habilitative services. Existing law requires habilitative services and devices to be covered under the same terms and conditions applied to rehabilitative services and devices under the plan contract or policy, and defines habilitative services to mean health care services and devices that help a person keep, learn, or improve skills and functioning for daily living.This bill would specify that coverage of rehabilitative and habilitative services and devices under a health care service plan or health insurance policy includes durable medical equipment, services, and repairs, if the equipment, services, or repairs are prescribed or ordered by a physician, surgeon, or other health professional acting within the scope of their license. The bill would define "durable medical equipment" to mean devices, including replacement devices, that are designed for repeated use, and that are used for the treatment or monitoring of a medical condition or injury in order to help a person to partially or fully acquire, improve, keep, or learn, or minimize the loss of, skills and functioning of daily living. The bill would prohibit coverage of durable medical equipment and services from being subject to financial or treatment limitations, as specified.The bill would require the Secretary of California Health and Human Services to communicate to the federal Center for Consumer Information and Insurance Oversight that the coverage of durable medical equipment is necessary to comply with federal requirements for purposes of being considered essential health benefits not subject to defrayal payments. If the center overrules the state's determination that the additional coverage subjects the state to defrayal payments, the bill would require the secretary to reevaluate California's essential health benefits benchmark plan to incorporate the coverage without triggering the defrayal requirement. The bill would require the secretary, no later than one year… (click bill link to see more).

Primary Sponsors
Liz Ortega, Lori Wilson

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 5:55 PM
California Association of Health Plans: Oppose

Bill Number	Status	Position
AB 1202	In Senate	Monitor

Title
Medi-Cal: health care services data: children and pregnant or postpartum persons.

Description
AB 1202, as amended, Lackey. Medi-Cal: health care services data: children and pregnant or postpartum persons. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services through various health care delivery systems, including managed care pursuant to Medi-Cal managed care plan contracts. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Existing law establishes, until January 1, 2026, certain time or distance and appointment time standards for specified Medi-Cal managed care covered services, consistent with federal regulations relating to network adequacy standards, to ensure that those services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner, as specified. Existing law sets forth various limits on the number of miles or minutes from the enrollee's place of residence, depending on the type of service or specialty and, in some cases, on the county.This bill would require the department, no later than January 1, 2025, to prepare and submit a report to the Legislature that includes certain information, including an analysis of the adequacy of each Medi-Cal managed care plan's network for pediatric primary care, including the number and geographic distribution of providers and the plan's compliance with the above-described time or distance and appointment time standards.Under the bill, the report would also include data, disaggregated as specified, on the number of children and pregnant or postpartum persons who are Medi-Cal beneficiaries receiving certain health care services during the 2021–22, 2022–23, and 2023–24 fiscal years. The report would also include additional information regarding the department's efforts to improve access to pediatric preventive care, as specified. The bill would require that the report be made publicly available through its posting on the department's internet website.The bill would repeal these reporting provisions on January 1, 2029.

Primary Sponsors
Tom Lackey

Bill Number	Status	Position
AB 1241	Passed Senate	Monitor

Title
Medi-Cal: telehealth.

Description
AB 1241, as amended, Weber. Medi-Cal: telehealth. Existing law establishes 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.Under existing law, in-person, face-to-face contact is not required when covered health care services are provided by video synchronous interaction, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual communication modalities, when those services and settings meet certain criteria.Existing law requires a provider furnishing services through video synchronous interaction or audio-only synchronous interaction, by a date set by the department, no sooner than January 1, 2024, to also either offer those services via in-person contact or arrange for a referral to, and a facilitation of, in-person care, as specified.This bill would instead require, under the above-described circumstance, a provider to maintain and follow protocols to either offer those services via in-person contact or arrange for a referral to, and a facilitation of, in-person care. The bill would specify that the referral and facilitation arrangement would not require a provider to schedule an appointment with a different provider on behalf of a patient.

Primary Sponsors
Akilah Weber

Bill Number	Status	Position
AB 1282	In Senate	Monitor

Title
Mental health: impacts of social media.

Description
AB 1282, as amended, Lowenthal. Mental health: impacts of social media. Existing law, the Mental Health Services Act, an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the Mental Health Services Oversight and Accountability Commission, and authorizes the commission to take specified actions, including advising the Governor or the Legislature regarding actions the state may take to improve care and services for people with mental illness.This bill would require the commission to report to specified policy committees of the Legislature, on or before July 1, 2025, a statewide strategy to understand, communicate, and mitigate mental health risks associated with the use of social media by children and youth. The bill would require the report to include, among other things, (1) the degree to which individuals negatively impacted by social media are accessing and receiving mental health services and (2) recommendations to strengthen children and youth resiliency strategies and California's use of mental health services to reduce the negative outcomes that may result from untreated mental illness, as specified. The bill would require the commission to explore, among other things, the persons and populations that use social media and the negative mental health risks associated with social media and artificial intelligence, as defined. The bill would repeal these provisions on January 1, 2029.

Primary Sponsors
Josh Lowenthal

Bill Number	Status	Position
AB 1288	In Senate	Monitor

Title
Health care coverage: Medication-assisted treatment.

Description
AB 1288, as amended, Rendon. Health care coverage: Medication-assisted treatment. Existing law, the Knox–Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law authorizes health care service plans and health insurers that cover prescription drugs to utilize reasonable medical management practices, including prior authorization and step therapy, consistent with applicable law. This bill would prohibit a medical service plan and a health insurer from subjecting a naloxone product, or another opioid antagonist approved by the United States Food and Drug Administration, a buprenorphine product, methadone, or long-acting injectable naltrexone for detoxification or maintenance treatment of a substance use disorder to prior authorization or step therapy. Because a willful violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program.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.

Primary Sponsors
Anthony Rendon

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 5:56 PM
California Association of Health Plans: Oppose

Bill Number	Status	Position
AB 1331	**In Senate**	**Monitor**

Title
California Health and Human Services Data Exchange Framework.

Description
AB 1331, as amended, Wood. California Health and Human Services Data Exchange Framework. Existing law establishes the Center for Data Insights and Innovation within the California Health and Human Services Agency to ensure the enforcement of state law mandating the confidentiality of medical information. Existing law, subject to an appropriation in the annual Budget Act, requires the California Health and Human Services Agency to establish the California Health and Human Services Data Exchange Framework on or before July 1, 2022, to govern and require the exchange of health information among health care entities and government agencies.This bill would require the Center for Data Insights and Innovation to take over establishment, implementation, and all the functions related to the California Health and Human Services Data Exchange Framework on or before January 1, 2024, subject to an appropriation in the annual Budget Act. The bill would require the center to establish the CalHHS Data Exchange Board, with specified membership, to develop recommendations and to review, modify, and approve any modifications to the Data Exchange Framework data sharing agreement, among other things. The bill would require the center to submit an annual report to the Legislature that includes required signatory compliance with the data sharing agreement, assessment of consumer experiences with health information exchange, and evaluation of technical assistance and other grant programs. The bill would require the center, by July 1, 2024, to establish a process to designate qualified health information organizations according to specified criteria.

Primary Sponsors
Jim Wood

Bill Number	Status	Position
AB 1437	In Senate	Monitor

Title
Medi-Cal: serious mental illness.

Description
AB 1437, as amended, Irwin. Medi-Cal: serious mental illness. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Existing law sets forth a schedule of benefits under the Medi-Cal program, including specialty and nonspecialty mental health services through different delivery systems, in certain cases subject to utilization controls, such as prior authorization. Under existing law, prior authorization is approval of a specified service in advance of the rendering of that service based upon a determination of medical necessity. Existing law sets forth various provisions relating to processing, or appealing the decision of, treatment authorization requests, and provisions relating to certain services requiring or not requiring a treatment authorization request.After a determination of cost benefit, existing law requires the Director of Health Care Services to modify or eliminate the requirement of prior authorization as a control for treatment, supplies, or equipment that costs less than $100, except for prescribed drugs, as specified.Under this bill, a prescription refill for a drug for serious mental illness would automatically be approved for a period of 365 days after the initial prescription is dispensed.The bill would condition the above-described provisions on the prescription being for a person 18 years of age or over, and on the person not being within the transition jurisdiction of the juvenile court, as specified.

Primary Sponsors
Jacqui Irwin, Sharon Quirk-Silva

Bill Number	Status	Position
AB 1451	In Senate	Monitor

Title
Urgent and emergency mental health and substance use disorder treatment.

Description
AB 1451, as amended, Jackson. Urgent and emergency mental health and substance use disorder treatment. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan or health insurer that provides hospital, medical, or surgical coverage shall provide coverage for medically necessary treatment of mental health and substance use disorders, under the same terms and conditions applied to other medical conditions, as specified. Existing law also includes requirements for timely access to care, including mental health services, including a requirement that a health care service plan or health insurer provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's or insured's condition consistent with good professional practice.This bill would require a health care service plan contract or health insurance policy issued, amended, renewed, or delivered on or after January 1, 2024, to provide coverage for treatment of urgent and emergency mental health and substance use disorders. The bill would require the treatment to be provided without preauthorization, and to be reimbursed in a timely manner, pursuant to specified provisions. The bill's provisions would only be implemented upon appropriation by the Legislature for administrative costs of the departments. The bill would clarify that it would not relieve a health plan or insurer of existing obligations, as specified. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.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.

Primary Sponsors
Corey Jackson

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 5:56 PM
California Association of Health Plans: Oppose

Bill Number	Status	Position
AB 1470	In Senate	Monitor

Title
Medi-Cal: behavioral health services: documentation standards.

Description
AB 1470, as amended, Quirk-Silva. Medi-Cal: behavioral health services: documentation standards. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including behavioral health services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes the California Advancing and Innovating Medi-Cal (CalAIM) initiative, subject to receipt of any necessary federal approvals and the availability of federal financial participation, in order to, among other things, improve quality outcomes and reduce health disparities.The bill, as part of CalAIM, and with respect to behavioral health services provided under the Medi-Cal program, would require the department to standardize data elements relating to documentation requirements, including, but not limited to, medically necessary criteria, and would require the department to develop standard forms containing information necessary to properly adjudicate claims pursuant to CalAIM Terms and Conditions. The bill would require the department to consult with representatives of specified associations and programs for purposes of implementing these provisions.The bill would require the department to conduct, on or before July 1, 2025, regional trainings for personnel and provider networks of applicable entities, including county mental health plans, Medi-Cal managed care plans, and entities within the fee-for-service delivery system, on proper completion of the standard forms. The bill would require each applicable entity to distribute the training material and standard forms to its provider networks, and to commence, no later than July 1, 2025, using the standard forms. The bill would require providers of applicable entities to use those forms, as specified. The bill would authorize the department to restrict the imposition of additional documentation requirements beyond those included on standard forms, as specified.The bill would require the department to conduct an analysis on the status of utilization of the standard forms by applicable entities, and on the status of the trainings and training material, in order to determine the effectiveness of implementation of the above-described provisions. The bill would require the department to prepare a report containing findings from the analysis no later than July 1, 2026, and a followup report no later than July 1, 2028, and to submit each report to the Legislature and post it on the department’s internet website.

Primary Sponsors
Sharon Quirk-Silva

Bill Number	Status	Position
AB 1637	In Senate	Monitor

Title
Local government: internet websites and email addresses.

Description
AB 1637, as amended, Irwin. Local government: internet websites and email addresses. (1) The California Constitution authorizes cities and counties to make and enforce within their limits all local, police, sanitary, and other ordinances and regulations not in conflict with general laws and further authorizes cities organized under a charter to make and enforce all ordinances and regulations in respect to municipal affairs, which supersede inconsistent general laws.The California Public Records Act requires a local agency to make public records available for inspection and allows a local agency to comply by posting the record on its internet website and directing a member of the public to the internet website, as specified.This bill, no later than January 1, 2029, would require a local agency, as defined, that maintains an internet website for use by the public to ensure that the internet website utilizes a ".gov" top-level domain or a ".ca.gov" second-level domain and would require a local agency that maintains an internet website that is noncompliant with that requirement to redirect that internet website to a domain name that does utilize a ".gov" or ".ca.gov" domain. This bill, no later than January 1, 2029, would also require a local agency that maintains public email addresses to ensure that each email address provided to its employees utilizes a ".gov" domain name or a ".ca.gov" domain name. By adding to the duties of local officials, the bill would impose a state-mandated local program.(2) The bill would include findings that changes proposed by this bill address a matter of statewide concern rather than a municipal affair and, therefore, apply to all cities, including charter cities.(3) 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, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Primary Sponsors
Jacqui Irwin

Bill Number	Status	Position
AB 1645	In Senate	Monitor

Title
Health care coverage: cost sharing.

Description
AB 1645, as amended, Zbur. Health care coverage: cost sharing. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a group or individual nongrandfathered health care service plan contract or health insurance policy to provide coverage for, and prohibits a contract or policy from imposing cost-sharing requirements for, specified preventive care services and screenings.This bill would prohibit a group or individual health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2024, from imposing a cost-sharing requirement for office visits for the above-described preventive care services and screenings and for items or services that are integral to their provision. The bill would prohibit large group contracts and policies issued, amended, or renewed on or after January 1, 2024, and an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, from imposing a cost-sharing requirement, utilization review, or other specified limits on a recommended sexually transmitted infections screening, and from imposing a cost-sharing requirement for any items and services integral to a sexually transmitted infections screening, as specified. The bill would require a plan or insurer to directly reimburse a nonparticipating provider or facility of sexually transmitted infections screening that meets specified criteria for screening tests and integral items and services rendered, as specified, and would prohibit a nonparticipating provider from billing or collecting a cost-sharing amount for a sexually transmitted infections screening from an enrollee or insured. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.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.

Primary Sponsors
Rick Zbur

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 5:57 PM
California Association of Health Plans: Oppose

Bill Number	Status	Position
SB 70	In Assembly	Monitor

Title
Prescription drug coverage.

Description
SB 70, as amended, Wiener. Prescription drug coverage. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or health insurer to use utilization review, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Existing law prohibits a health care service plan contract that covers prescription drug benefits or a specified health insurance policy from limiting or excluding coverage for a drug on the basis that the drug is prescribed for a use that is different from the use for which it was approved by the federal Food and Drug Administration if specified conditions are met. Existing law also prohibits a health care service plan that covers prescription drug benefits from limiting or excluding coverage for a drug that was previously approved for coverage if an enrollee continues to be prescribed that drug, as specified.This bill would additionally prohibit limiting or excluding coverage of a drug, dose of a drug, or dosage form of a drug that is prescribed for off-label use if the drug has been previously covered for a chronic condition or cancer, as specified, regardless of whether or not the drug, dose, or dosage form is on the plan's or insurer's formulary. The bill would prohibit a health care service plan contract or health insurance policy from requiring additional cost sharing not already imposed for a drug that was previously approved for coverage. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.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.

Primary Sponsors
Scott Wiener

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 5:57 PM
California Association of Health Plans: Oppose

Bill Number	Status	Position
SB 90	In Assembly	Monitor

Title
Health care coverage: insulin affordability.

Description
SB 90, as amended, Wiener. Health care coverage: insulin affordability. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or disability insurance policy issued, amended, delivered, or renewed on or after January 1, 2000, that covers prescription benefits to include coverage for insulin if it is determined to be medically necessary.This bill would prohibit a health care service plan contract or a disability insurance policy, as specified, issued, amended, delivered, or renewed on or after January 1, 2024, or a contract or policy offered in the individual or small group market on or after January 1, 2025, from imposing a copayment of more than $35 for a 30-day supply of an insulin prescription drug or imposing a deductible, coinsurance, or other cost sharing on an insulin prescription drug, and would prohibit a high deductible health plan from imposing a deductible, coinsurance, or other cost sharing on an insulin prescription drug, as specified. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.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.

Primary Sponsors
Scott Wiener

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 5:58 PM
California Association of Health Plans: Oppose

Bill Number	Status	Position
SB 238	In Assembly	Monitor

Title
Health care coverage: independent medical review.

Description
SB 238, as amended, Wiener. Health care coverage: independent medical review. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of disability insurers by the Department of Insurance. Existing law establishes the Independent Medical Review System within each department, under which an enrollee or insured may seek review if a health care service has been denied, modified, or delayed by a health care service plan or disability insurer and the enrollee or insured has previously filed a grievance that remains unresolved after 30 days.This bill, commencing July 1, 2024, would require a health care service plan or a disability insurer that modifies, delays, or denies a health care service, based in whole or in part on medical necessity, to automatically submit within 24 hours a decision regarding a disputed health care service to the Independent Medical Review System, as well as the information that informed its decision, without requiring an enrollee or insured to submit a grievance, if the decision is to deny, modify, or delay specified services relating to mental health or substance use disorder conditions for an enrollee or insured up to 26 years of age. The bill would require a health care service plan or disability insurer, within 24 hours after submitting its decision to the Independent Medical Review System to provide notice to the appropriate department, the enrollee or insured or their representative, if any, and the enrollee's or insured's provider. The bill would require the notice to include notification to the enrollee or insured that they or their representative may cancel the independent medical review at any time before a determination, as specified.The bill would apply specified existing provisions relating to mental health and substance use disorders for purposes of its provisions, and would be subject to relevant provisions relating to the Independent Medical Review System that do not otherwise conflict with the express requirements of the bill. With respect to health care service plans, the bill would specify that its provisions do not apply to Medi-Cal managed care plan contracts. The bill would authorize the Insurance Commissioner to promulgate regulations subject to the Administrative Procedure Act to implement and enforce the bill, and to issue interim guidance, as specified. Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse... (click bill link to see more).

Primary Sponsors
Scott Wiener

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 6:11 PM
Local Health Plans of California: Oppose California Association of Health Plans: Oppose

Bill Number	Status	Position
SB 257	In Assembly	Monitor

Title
Health care coverage: diagnostic imaging.

Description
SB 257, as introduced, Portantino. Health care coverage: diagnostic imaging. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract issued, amended, delivered, or renewed on or after January 1, 2000, or an individual or group policy of disability insurance or self-insured employee welfare benefit plan to provide coverage for mammography for screening or diagnostic purposes upon referral by specified professionals. Under existing law, mammography performed pursuant to those requirements or that meets the current recommendations of the United States Preventive Services Task Force is provided to an enrollee or an insured without cost sharing.This bill would require a health care service plan contract, a policy of disability insurance that provides hospital, medical, or surgical coverage, or a self-insured employee welfare benefit plan issued, amended, or renewed on or after January 1, 2025, to provide coverage without imposing cost sharing for, among other things, screening mammography and medically necessary diagnostic breast imaging, including diagnostic breast imaging following an abnormal mammography result and for an enrollee or insured indicated to have a risk factor associated with breast cancer, except as specified.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.

Primary Sponsors
Anthony Portantino

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 5:58 PM
California Association of Health Plans: Oppose

Bill Number	Status	Position
SB 282	In Assembly	Support

Title
Medi-Cal: federally qualified health centers and rural health clinics.

Description
SB 282, as amended, Eggman. Medi-Cal: federally qualified health centers and rural health clinics. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including federally qualified health center (FQHC) services and rural health clinic (RHC) services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, to the extent that federal financial participation is available, FQHC and RHC services are reimbursed on a per-visit basis, as specified. “Visit” is defined as a face-to-face encounter between a patient of an FQHC or RHC and a physician or other specified health care professionals. Under existing law, “visit” also includes an encounter using video or audio-only synchronous interaction or an asynchronous store and forward modality, as specified.This bill would authorize reimbursement for a maximum of 2 visits that take place on the same day at a single site, whether through a face-to-face or telehealth-based encounter, if after the first visit the patient suffers illness or injury that requires additional diagnosis or treatment, or if the patient has a medical visit and either a mental health visit or a dental visit, as defined. The bill would require the department, by July 1, 2024, to submit a state plan amendment to the federal Centers for Medicare and Medicaid Services reflecting those provisions.The bill would include a licensed acupuncturist within those health care professionals covered under the definition of a “visit.” The bill would also make a change to the provision relating to physicians and would make other technical changes.

Primary Sponsors
Susan Eggman, Mike McGuire, Cecilia Aguiar-Curry, Jim Wood

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 7:27 PM
Local Health Plans of California: Support L.A. Care: Support

Bill Number	Status	Position
SB 311	In Assembly	Support

Title
Medi-Cal: Part A buy-in.

Description
SB 311, as introduced, Eggman. Medi-Cal: Part A buy-in. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires the State Department of Health Care Services, to the extent required by federal law, for Medi–Cal recipients who are qualified Medicare beneficiaries, to pay the Medicare premiums, deductibles, and coinsurance for certain elderly and disabled persons. Existing federal law authorizes states to pay for Medicare benefits for specified enrollees pursuant to either a buy-in agreement to directly enroll and pay premiums or a group payer arrangement to pay premiums.This bill would require the department to submit a state plan amendment no later than January 1, 2024, to enter into a Medicare Part A buy-in agreement with the federal Centers for Medicare and Medicaid Services. To the extent that the bill would increase duties for a county, the bill would create a state-mandated local program.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, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Primary Sponsors
Susan Eggman

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 6:24 PM
Local Health Plans of California: Support L.A. Care: Support

Bill Number	Status	Position
SB 324	In Assembly	Monitor

Title
Health care coverage: endometriosis.

Description
SB 324, as amended, Limón. Health care coverage: endometriosis. (1) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or health insurer to use prior authorization and other utilization review functions, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity.This bill would prohibit a health care service plan contract or health insurance policy issued, amended, delivered, or renewed on or after January 1, 2024, from requiring prior authorization or other utilization review for any clinically indicated treatment for endometriosis, as determined by the treating physician and consistent with nationally recognized evidence-based clinical guidelines. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. (2) Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law sets forth a schedule of benefits under the Medi-Cal program.This bill would add any clinically indicated treatment for endometriosis, as determined by the treating physician and consistent with nationally recognized evidence-based clinical guidelines, as a covered benefit under Medi-Cal without prior authorization or other utilization review.(3) 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.

Primary Sponsors
Monique Limon

Organizational Notes

Last edited by Joanne Campbell at Apr 17, 2023, 4:45 PM
California Association of Health Plans: Oppose

Bill Number	Status	Position
SB 326	In Assembly	Monitor

Title
The Behavioral Health Services Act.

Description
SB 326, as amended, Eggman. The Behavioral Health Services Act. (1) Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, funds a system of county mental health plans for the provision of mental health services. Existing law authorizes the MHSA to be amended by a 2/3 vote of the Legislature if the amendments are consistent with and further the intent of the MHSA. Existing law authorizes the Legislature to add provisions to clarify procedures and terms of the MHSA by majority vote.If approved by the voters at the March 5, 2024, statewide primary election, this bill would delete the provision that establishes vote requirements to amend the MHSA, requiring all amendments of the MHSA to be approved by the voters. The bill would recast the MHSA by, among other things, renaming it the Behavioral Health Services Act (BHSA), expanding it to include treatment of substance use disorders, changing the county planning process, and expanding services for which counties and the state can use funds. The bill would revise the distribution of MHSA moneys, including allocating up to $36,000,000 to the department for behavioral health workforce funding. The bill would authorize the department to require a county to implement specific evidence-based practices.This bill would require a county, for behavioral health services eligible for reimbursement pursuant to the federal Social Security Act, to submit the claims for reimbursement to the State Department of Health Care Services (the department) under specific circumstances. The bill would require counties to pursue reimbursement through various channels and would authorize the counties to report issues with managed care plans and insurers to the Department of Managed Health Care or the Department of Insurance.The MHSA establishes the Mental Health Services Oversight and Accountability Commission and requires it to adopt regulations for programs and expenditures for innovative programs and prevention and early intervention programs established by the act. Existing law requires counties to develop plans for innovative programs funded under the MHSA.This bill would rename the commission the Behavioral Health Services Oversight and Accountability Commission and would change the composition and duties of the commission, as specified. The bill would delete the provisions relating to innovative programs and instead would require the department to establish the priorities and a program, which would be administered by counties, to provide housing interventions. The bill would provide that “low rent housing project,” as defined, does not apply to the development of urban or rural... (click bill link to see more).

Primary Sponsors
Susan Eggman

Bill Number	Status	Position
SB 339	In Assembly	Monitor

Title
HIV preexposure prophylaxis and postexposure prophylaxis.

Description
SB 339, as amended, Wiener. HIV preexposure prophylaxis and postexposure prophylaxis. Existing law, the Pharmacy Law, provides for the licensure and regulation of pharmacists by the California State Board of Pharmacy. Existing law authorizes a pharmacist to furnish at least a 30-day supply of HIV preexposure prophylaxis, and up to a 60-day supply of those drugs if certain conditions are met. Existing law also authorizes a pharmacist to furnish postexposure prophylaxis to a patient if certain conditions are met.This bill would authorize a pharmacist to furnish up to a 90-day course of preexposure prophylaxis, or preexposure prophylaxis beyond a 90-day course, if specified conditions are met. The bill would require the California State Board of Pharmacy to adopt emergency regulations to implement these provisions by July 1, 2024.Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law prohibits a health care service plan or health insurer from covering preexposure prophylaxis that has been furnished by a pharmacist in excess of a 60-day supply once every 2 years.Existing law provides for the Medi-Cal program administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services pursuant to a schedule of benefits. The existing schedule of benefits includes coverage for preexposure prophylaxis as pharmacist services, limited to no more than a 60-day supply furnished by a pharmacist once every 2 years, and includes coverage for postexposure prophylaxis, subject to approval by the federal Centers for Medicare and Medicaid Services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.This bill would require a health care service plan and health insurer to cover preexposure prophylaxis and postexposure prophylaxis furnished by a pharmacist, including costs for the pharmacist's services and related testing ordered by the pharmacist, and to pay or reimburse the cost of the service performed by a pharmacist at an in-network pharmacy or a pharmacist at an out-of-network pharmacy if the health care service plan or health insurer has an out-of-network pharmacy benefit. The bill would include preexposure prophylaxis furnished by a pharmacist as pharmacist services on the Medi-Cal schedule of benefits. Because a willful violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated local pro... (click bill link to see more).

Primary Sponsors
Scott Wiener, Mike Gipson

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 5:59 PM
California Association of Health Plans: Oppose

Bill Number	Status	Position
SB 348	In Assembly	Support

Title
Pupil meals.

Description
SB 348, as amended, Skinner. Pupil meals. (1) Existing law establishes a system of public elementary and secondary schools in this state. This system is composed of local educational agencies throughout the state that provide instruction to pupils in kindergarten and grades 1 to 12, inclusive, at schoolsites operated by these agencies. Existing law, commencing with the 2022–23 school year, requires each school district and county superintendent of schools maintaining kindergarten or any of grades 1 to 12, inclusive, and each charter school to provide 2 nutritiously adequate school meals free of charge during each schoolday, regardless of the length of the schoolday, to any pupil who requests a meal without consideration of the pupil's eligibility for a federally funded free or reduced-price meal, as specified, with a maximum of one free meal for each meal service period. Existing law requires the department to develop and maintain nutrition guidelines for school lunches and breakfasts, and for all food and beverages sold on public school campuses. Existing law requires a school district, county superintendent of schools, or charter school to provide each needy pupil with one nutritionally adequate free or reduced-price meal during each schoolday, except as provided.This bill would revise and recast provisions regarding school meals for needy pupils by, among other things, instead requiring each school district, county superintendent of schools, and charter school to make available a nutritionally adequate breakfast, as defined, and a nutritionally adequate lunch, as defined, free of charge during each schoolday, as defined, to any pupil who requests a meal, without consideration of the pupil's eligibility for a federally funded free or reduced-price meal, as provided. The bill would require each school district, county office of education, or charter school that offers independent study to meet the above meal requirements for any pupil on any schoolday that the pupil is scheduled for educational activities, as provided. The bill would require the State Department of Education to submit a waiver request to the United States Department of Agriculture to allow for one meal to be provided during a schoolday lasting 4 hours or less to be served in a noncongregate manner. The bill would authorize each school district, county superintendent of schools, and charter school to make available either a nutritionally adequate breakfast or a nutritionally adequate lunch, as defined, in a noncongregate manner, as provided, if the State Department of Education receives approval for the federal noncongregate waiver. The bill would require each school district, county superintendent of schools, and charter school to provide pu... (click bill link to see more).

Primary Sponsors
Nancy Skinner

Organizational Notes

Last edited by Joanne Campbell at Apr 17, 2023, 3:56 PM
L.A. Care, Local Health Plans of California: Support

Bill Number	Status	Position
SB 363	In Assembly	Monitor

Title
Facilities for inpatient and residential mental health and substance use disorder: database.

Description
SB 363, as amended, Eggman. Facilities for inpatient and residential mental health and substance use disorder: database. Existing law generally requires the State Department of Public Health to license, inspect, and regulate health facilities, defined to include, among other types of health facilities, an acute psychiatric hospital. Existing law generally requires the State Department of Social Services to license, inspect, and regulate various types of care facilities, including, among others, a community crisis home. Existing law requires the State Department of Health Care Services to license and regulate facilities that provide residential nonmedical services to adults who are recovering from problems related to alcohol, drug, or alcohol and drug misuse or abuse, and who need alcohol, drug, or alcohol and drug recovery treatment or detoxification services.This bill would require, by January 1, 2026, the State Department of Health Care Services, in consultation with the State Department of Public Health and the State Department of Social Services, and by conferring with specified stakeholders, to develop a real-time, internet-based database to collect, aggregate, and display information about beds in specified types of facilities, such as chemical dependency recovery hospitals, acute psychiatric hospitals, and mental health rehabilitation centers, among others, to identify the availability of inpatient and residential mental health or substance use disorder treatment. The bill would require the database to include a minimum of specific information, including the contact information for a facility's designated employee, the types of diagnoses or treatments for which the bed is appropriate, and the target populations served at the facility, and have the capacity to, among other things, enable searches to identify beds that are appropriate for individuals in need of inpatient or residential mental health or substance use disorder treatment.This bill would authorize the department to impose a plan of correction or assess penalties against a facility that fails to submit data accurately, timely, or as otherwise required and would establish a process for facilities to appeal these penalties. The bill would create the Available Care for Inpatient and Residential Mental Health or Substance Use Disorder Treatment Database Maintenance and Oversight Fund for the receipt of any penalties. Because the bill would continuously appropriate moneys in the fund for administrative costs of implementing the database, it would create an appropriation.

Primary Sponsors
Susan Eggman

Bill Number	Status	Position
SB 411	In Assembly	Monitor

Title
Open meetings: teleconferences: neighborhood councils.

Description
SB 411, as amended, Portantino. Open meetings: teleconferences: neighborhood councils. Existing law, the Ralph M. Brown Act, requires, with specified exceptions, that all meetings of a legislative body, as defined, of a local agency be open and public and that all persons be permitted to attend and participate. The act generally requires for teleconferencing that the legislative body of a local agency that elects to use teleconferencing post agendas at all teleconference locations, identify each teleconference location in the notice and agenda of the meeting or proceeding, and have each teleconference location be accessible to the public. Existing law also requires that, during the teleconference, at least a quorum of the members of the legislative body participate from locations within the boundaries of the territory over which the local agency exercises jurisdiction. The act provides an exemption to the jurisdictional requirement for health authorities, as defined.Existing law, until January 1, 2024, authorizes the legislative body of a local agency to use alternate teleconferencing provisions during a proclaimed state of emergency or in other situations related to public health that exempt a legislative body from the general requirements (emergency provisions) and impose different requirements for notice, agenda, and public participation, as prescribed. The emergency provisions specify that they do not require a legislative body to provide a physical location from which the public may attend or comment.Existing law, until January 1, 2026, authorizes the legislative body of a local agency to use alternative teleconferencing in certain circumstances related to the particular member if at least a quorum of its members participate from a singular physical location that is open to the public and situated within the agency's jurisdiction and other requirements are met, including restrictions on remote participation by a member of the legislative body.This bill, until January 1, 2028, would authorize an eligible legislative body to use alternate teleconferencing provisions related to notice, agenda, and public participation, as prescribed, if the city council has adopted an authorizing resolution and 2/3 of an eligible legislative body votes to use the alternate teleconferencing provisions. The bill would define "eligible legislative body" for this purpose to mean a neighborhood council that is an advisory body with the purpose to promote more citizen participation in government and make government more responsive to local needs that is established pursuant to the charter of a city with a population of more than 3,000,000 people that is subject to the act. The bill would require an eligible legislative body authorized un... (click bill link to see more).

Primary Sponsors
Anthony Portantino

Bill Number	Status	Position
SB 427	In Assembly	Monitor

Title
Health care coverage: antiretroviral drugs, devices, and products.

Description
SB 427, as amended, Portantino. Health care coverage: antiretroviral drugs, devices, and products. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally prohibits a health care service plan or health insurer from subjecting antiretroviral drugs that are medically necessary for the prevention of HIV/AIDS, including preexposure prophylaxis or postexposure prophylaxis, to prior authorization or step therapy. Under existing law, a health care service plan or health insurer is not required to cover all the therapeutically equivalent versions of those drugs without prior authorization or step therapy if at least one is covered without prior authorization or step therapy.This bill would prohibit a health care service plan or health insurer from subjecting antiretroviral drugs, devices, or products that are either approved by the United States Food and Drug Administration (FDA) or recommended by the federal Centers for Disease Control and Prevention (CDC) for the prevention of HIV/AIDS, to prior authorization or step therapy, but would authorize prior authorization or step therapy if at least one therapeutically equivalent version is covered without prior authorization or step therapy and the insurer provides coverage for a noncovered therapeutic equivalent antiretroviral drug, device, or product without cost sharing pursuant to an exception request. The bill would prohibit a nongrandfathered or grandfathered health care service plan contract or health insurance policy from imposing any cost-sharing or utilization review requirements for antiretroviral drugs, devices, or products that are either approved by the FDA or recommended by the CDC for the prevention of HIV/AIDS. The bill would require a nongrandfathered or grandfathered health care service plan contract or health insurance policy to provide coverage for those drugs, devices, or products, and would require a plan or insurer to provide coverage under the outpatient prescription drug benefit for those drugs, devices, or products, including by supplying participating providers directly with a drug, device, or product, as specified. Because a willful violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program. 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 reimburse... (click bill link to see more).

Primary Sponsors
Anthony Portantino

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 6:00 PM
California Association of Health Plans: Oppose

Bill Number	Status	Position
SB 496	In Assembly	Monitor

Title
Biomarker testing.

Description
SB 496, as amended, Limón. Biomarker testing. (1) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plan contract or health insurance policy issued, amended, delivered, or renewed on or after July 1, 2000, to provide coverage for all generally medically accepted cancer screening tests, and prohibits that contract or policy issued, amended, delivered, or renewed on or after July 1, 2022, from requiring prior authorization for biomarker testing for certain enrollees or insureds. Existing law applies the provisions relating to biomarker testing to Medi-Cal managed care plans, as prescribed.This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after July 1, 2024, to provide coverage for medically necessary biomarker testing, as prescribed, including whole genome sequencing, for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's or insured's disease or condition to guide treatment decisions, as prescribed. The bill would specify that it does not require a health care service plan or health insurer to cover biomarker testing for screening purposes unless otherwise required by law. The bill would subject restricted or denied use of biomarker testing for the purpose of diagnosis, treatment, or ongoing monitoring of a medical condition to state and federal grievance and appeal processes. This bill would apply these provisions relating to biomarker testing to the Medi-Cal program, including Medi-Cal managed care plans, as specified. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.(2) Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services pursuant to a schedule of benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law includes Rapid Whole Genome Sequencing as a covered benefit for any Medi-Cal beneficiary who is one year of age or younger and is receiving inpatient hospital services in an intensive care unit.Subject to the extent that federal financial participation is available and not otherwise jeopardized, and any necessary federal approvals have been obtained, this bill, by July 1, 2024, would expand the Medi-Ca... (click bill link to see more).

Primary Sponsors
Monique Limon

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 6:00 PM
California Association of Health Plans: Oppose

Bill Number	Status	Position
SB 502	In Assembly	Monitor

Title
Medi-Cal: children: mobile optometric office.

Description
SB 502, as amended, Allen. Medi-Cal: children: mobile optometric office. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions, with specified coverage for eligible children and pregnant persons funded by the federal Children's Health Insurance Program (CHIP). Existing federal law authorizes a state to provide services under CHIP through a Medicaid expansion program, a separate program, or a combination program.Existing federal CHIP provisions require federal payment to a state with an approved child health plan for expenditures for health services initiatives (HSI) under the plan for improving the health of children, as specified. As part of limitations on expenditures not used for Medicaid or health insurance assistance, existing federal law, with exceptions, prohibits the amount of payment that may be made for a fiscal year for HSI expenditures and other certain costs from exceeding 10% of the total amount of CHIP expenditures, as specified.Pursuant to existing state law, the department established a 3-year pilot program, from 2015 through 2017, in the County of Los Angeles that enabled school districts to allow students enrolled in Medi-Cal managed care plans to receive vision care services at the schoolsite through the use of a mobile vision service provider, limited to vision examinations and providing eyeglasses.Existing law authorizes an applicant or provider that meets the requirements to qualify as a mobile optometric office to be enrolled in the Medi-Cal program as either a mobile optometric office or within any other provider category for which the applicant or provider qualifies. Existing law defines "mobile optometric office" as a trailer, van, or other means of transportation in which the practice of optometry is performed and which is not affiliated with an approved optometry school in the state. Under existing law, the ownership and operation of a mobile optometric office is limited to a nonprofit or charitable organization, as specified, with the owner and operator registering with the State Board of Optometry.This bill would require the department to file all necessary state plan amendments to exercise the HSI option made available under CHIP provisions to cover vision services provided to low-income children statewide through a mobile optometric office, as specified.The bill would condition implementation of these provisions on receipt of any necessary federal approvals and the availability of federal financial participation. Under the bill, the federal financial... (click bill link to see more).

Primary Sponsors
Ben Allen

Bill Number	Status	Position
SB 525	In Assembly	Monitor

Title
Minimum wage: health care workers.

Description
SB 525, as amended, Durazo. Minimum wage: health care workers. Existing law generally requires the minimum wage for all industries to not be less than specified amounts to be increased until it is $15 per hour commencing January 1, 2022, for employers employing 26 or more employees and commencing January 1, 2023, for employers employing 25 or fewer employees. Existing law makes a violation of minimum wage requirements a misdemeanor. Commencing June 1, 2024 and until June 1, 2025, this bill would require a health care worker minimum wage of $21 per hour for hours worked in covered health care employment, as defined. Commencing June 1, 2025, the bill would require a health care minimum wage of $25 per hour for hours worked in covered health care employment, as defined, subject to adjustment, as prescribed. The bill would provide that the health care worker minimum wage constitutes the state minimum wage for covered health care employment for all purposes under the Labor Code and the Wage Orders of the Industrial Welfare Commission. The health care worker minimum wage would be enforceable by the Labor Commissioner or by a covered worker through a civil action, through the same means and with the same relief available for violation of any other state minimum wage requirement. By establishing a new minimum wage, the violation of which would be a crime, the bill would impose a state-mandated local program.This bill would require, for covered health care employment where the employee is paid on a salary basis, that the employee earn a monthly salary equivalent to no less than 150% of the health care worker minimum wage for full-time employment in order to qualify as exempt from the payment of minimum wage and overtime.This bill would make legislative findings and declarations as to the necessity of a special statute for health care workers.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.

Primary Sponsors
Maria Durazo

Bill Number	Status	Position
SB 541	In Assembly	Monitor

Title
Sexual health: contraceptives: immunization.

Description
SB 541, as amended, Menjivar. Sexual health: contraceptives: immunization. (1) Existing law, the California Healthy Youth Act, requires school districts, defined to include county boards of education, county superintendents of schools, the California School for the Deaf, the California School for the Blind, and charter schools, to ensure that all pupils in grades 7 to 12, inclusive, receive comprehensive sexual health education and human immunodeficiency virus (HIV) prevention education, as specified.This bill would, in order to prevent and reduce unintended pregnancies and sexually transmitted infections, on or before the start of the 2024–25 school year, require each public school, including schools operated by a school district or county office of education, charter schools, and state special schools, to make internal and external condoms available to all pupils in grades 9 to 12, inclusive, free of charge, as provided. The bill would require these public schools to, at the beginning of each school year, inform pupils through existing school communication channels that free condoms are available and where the condoms can be obtained on school grounds. The bill would require a public school to post at least one notice regarding these requirements, as specified. The bill would require this notice to include certain information, including, among other information, information about how to use condoms properly. The bill would require each public school serving any of grades 7 to 12, inclusive, to allow the distribution of condoms during the course of, or in connection with, educational or public health programs and initiatives, as provided. The bill would authorize a state agency, the State Department of Education, or a public school to accept gifts, grants, and donations from any source for the support of a public school carrying out these provisions, including, but not limited to, the acceptance of condoms from a manufacturer or wholesaler. The bill would, in order to comply with these provisions, encourage public schools to explore partnerships, including, but not limited to, partnerships with local health jurisdictions, as defined, community health centers, nonprofit organizations, and the State Department of Public Health. By imposing additional duties on public schools, the bill would impose a state-mandated local program. The bill would additionally prohibit a public school, as defined, maintaining any combination of classrooms from grades 7 to 12, inclusive, a school district, the State Department of Education, or a county office of education from prohibiting certain school-based health centers, as defined, from making internal and external condoms available and easily accessible to pupils at the school-ba... (click bill link to see more).

Primary Sponsors
Caroline Menjivar

Bill Number	Status	Position
SB 582	In Assembly	Monitor

Title
Health information.

Description
SB 582, as amended, Becker. Health information. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plans and health insurers to establish and maintain specified application programming interfaces (API), including patient access API, to facilitate patient and provider access to health information and for the benefit of enrollees, insureds, and contracted providers. Existing law authorizes the departments to require a plan or insurer to establish and maintain specified API, including provider access API.This bill would instead require the departments to require the plans and insurers to establish and maintain these specified API. The bill would exclude from the requirements of these provisions dental or vision benefits offered by a plan or insurer, including a specialized plan or insurer. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.Existing law establishes the California Health and Human Services Agency (CHHSA), which includes departments charged with administration of health, social, and human services. Existing law establishes the California Health and Human Services Data Exchange Framework that includes a single data sharing agreement and common set of policies and procedures that govern and require the exchange of health information among health care entities and government agencies in California. Existing law requires specified entities to execute the framework data sharing agreement on or before January 31, 2023. This bill would, contingent on the stakeholder advisory group developing standards for including EHR vendors, as defined, require EHR vendors to execute the framework data sharing agreement. The bill would require any fees charged by an EHR vendor to enable compliance with the framework to comply with specified federal regulations and to be sufficient to include the cost of enabling the collection and sharing of all data required, as specified. The bill would authorize CHHSA to establish administrative oversight and enforcement authority, including fines, if fees charged by EHR vendors to specified entities are not in compliance with federal standards.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 reimbur... (click bill link to see more).

Primary Sponsors
Josh Becker

Bill Number	Status	Position
SB 598	In Assembly	Monitor

Title

Health care coverage: prior authorization.

Description

SB 598, as amended, Skinner. Health care coverage: prior authorization. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or health insurer to use prior authorization and other utilization review or utilization management functions, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Existing law requires a health care service plan or health insurer, including those plans or insurers that delegate utilization review or utilization management functions to medical groups, independent practice associations, or to other contracting providers, to comply with specified requirements and limitations on their utilization review or utilization management functions. Existing law requires the criteria or guidelines used to determine whether or not to authorize, modify, or deny health care services to be developed with involvement from actively practicing health care providers.On or after January 1, 2025, this bill would prohibit a health care service plan or health insurer from requiring a contracted health professional to complete or obtain a prior authorization for any covered health care services if the plan or insurer approved or would have approved not less than 90% of the prior authorization requests they submitted in the most recent one-year contracted period. The bill would set standards for this exemption and its denial, rescission, and appeal. The bill would authorize a plan or insurer to evaluate the continuation of an exemption not more than once every 12 months, and would authorize a plan or insurer to rescind an exemption only at the end of the 12-month period and only if specified criteria are met. The bill would require a plan or insurer to provide an electronic prior authorization process. The bill would also require a plan or insurer to have a process for annually monitoring prior authorization approval, modification, appeal, and denial rates to identify services, items, and supplies that are regularly approved, and to discontinue prior authorization on those services, items, and supplies that are approved 95% of the time. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.The California Constitution requ... (click bill link to see more).

Primary Sponsors

Nancy Skinner

Organizational Notes

Last edited by Joanne Campbell at Jun 5, 2023, 8:59 PM
Local Health Plans of California: Oppose Unless Amended

Last edited by Joanne Campbell at Apr 17, 2023, 4:46 PM
California Association of Health Plans: Oppose

Bill Number	Status	Position
SB 621	In Assembly	Monitor

Title
Health care coverage: biosimilar drugs.

Description
SB 621, as amended, Caballero. Health care coverage: biosimilar drugs. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law authorizes a health care service plan or health insurer that provides coverage for prescription drugs to require step therapy if there is more than one drug that is clinically appropriate for the treatment of a medical condition, but requires a plan or insurer to expeditiously grant a step therapy exception request if specified criteria are met. Existing law does not prohibit a plan, insurer, or utilization review organization from requiring an enrollee or insured to try an AB-rated generic equivalent or interchangeable biological product before providing coverage for the equivalent branded prescription drug.This bill would specify that a plan, insurer, or utilization review organization is also not prohibited from requiring an enrollee or insured to try a biosimilar before providing coverage for the equivalent branded prescription drug, but that the requirement to try biosimilar, generic, and interchangeable drugs does not prohibit or supersede a step therapy exception request.

Primary Sponsors
Anna Caballero

Bill Number	Status	Position
SB 628	In Assembly	Monitor

Title
State Healthy Food Access Policy.

Description
SB 628, as amended, Hurtado. State Healthy Food Access Policy. Existing law establishes various food assistance programs, including, among others, the federal Supplemental Nutrition Assistance Program (SNAP), known in California as CalFresh, under which supplemental nutrition assistance benefits allocated to the state by the federal government are distributed to eligible individuals by each county. This bill would declare that it is the established policy of the state that every human being has the right to access sufficient affordable and healthy food. The bill would require all relevant state agencies to consider this state policy when revising, adopting, or establishing policies, regulations, and grant criteria when those policies, regulations, and grant criteria are pertinent to the distribution of sufficient affordable food. The bill would also require, by January 1, 2026, the State Department of Social Services, in consultation with the Department of Food and Agriculture and the Department of Conservation, to submit a report to the Legislature relating to food access and recommendations to increase the availability of sufficient affordable and healthy food, and to consult with higher education institutions and collect relevant data for purposes of preparing that report.

Primary Sponsors
Melissa Hurtado

Bill Number	Status	Position
SB 667	In Assembly	Monitor

Title
Healing arts: pregnancy and childbirth.

Description
SB 667, as amended, Dodd. Healing arts: pregnancy and childbirth. (1) Existing law, the Nursing Practice Act, establishes the Board of Registered Nursing within the Department of Consumer Affairs for the licensure and regulation of the practice of nursing. A violation of the act is a crime. Existing law requires the board to issue a certificate to practice nurse-midwifery to a person who meets specified qualifications. Existing law authorizes a certified nurse-midwife to attend cases of low-risk pregnancy and childbirth and to provide prenatal, intrapartum, and postpartum care, including interconception care, family planning care, and immediate care for the newborn, as specified. Existing law authorizes a certified nurse-midwife to practice with a physician and surgeon under mutually agreed-upon policies and protocols, as specified, to provide a patient with care outside of that scope of services or to provide intrapartum care to a patient who has had a prior cesarean section or surgery that interrupts the myometrium.This bill would revise and recast those provisions to, among other things, authorize a certified nurse-midwife, pursuant to policies and protocols that are mutually agreed upon with a physician and surgeon, as specified, to provide a patient with care outside of that scope of services, to provide intrapartum care to a patient who has had a prior cesarean section or surgery that interrupts the myometrium, or to furnish or order a Schedule II or III controlled substance, as specified. The bill would include care for common gynecologic conditions, as specified, in the scope of services a certified nurse-midwife is authorized to perform without policies and protocols that are mutually agreed upon with a physician and surgeon. The bill would additionally authorize a general acute care hospital, as defined, or a special hospital specified as a maternity hospital, as defined, to grant privileges to a certified nurse-midwife, allowing them to admit and discharge patients upon their own authority if in accordance with organized medical staff bylaws of that facility and within the nurse-midwife's scope of practice.Existing law generally authorizes a certified nurse-midwife to furnish drugs or devices incidentally to the provision of care and services described above that the certified nurse-midwife is authorized to perform and care rendered to persons within certain settings, subject to specified requirements and exceptions. Among those requirements is that a certified nurse-midwife follow standardized procedures or protocols if they furnish or order Schedule IV or V controlled substances or drugs or devices for services other than attending cases of low-risk pregnancy and childbirth or providing prenatal, intrapart... (click bill link to see more).

Primary Sponsors
Bill Dodd

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 5:48 PM
Local Health Plans of California: Support

Bill Number	Status	Position
SB 694	In Assembly	Monitor

Title
Medi-Cal: self-measured blood pressure devices and services.

Description
SB 694, as amended, Eggman. Medi-Cal: self-measured blood pressure devices and services. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Existing law sets forth a schedule of benefits under the Medi-Cal program, including pharmacy benefits (Medi-Cal Rx) and durable medical equipment. The department announced that, effective June 1, 2022, personal home blood pressure monitoring devices, and blood pressure cuffs for use with those devices, are a covered benefit under Medi-Cal Rx as a pharmacy-billed item.This bill would make self-measured blood pressure (SMBP) devices and SMBP services, as defined, covered benefits under the Medi-Cal program subject to utilization controls. The bill would state the intent of the Legislature that those covered devices and services be no less in scope than the devices and services that are recognized under specified existing billing codes or their successors. The bill would condition implementation of that coverage on receipt of any necessary federal approvals and the availability of federal financial participation.

Primary Sponsors
Susan Eggman

Bill Number	Status	Position
SB 729	In Assembly	Monitor

Title
Health care coverage: treatment for infertility and fertility services.

Description
SB 729, as amended, Menjivar. Health care coverage: treatment for infertility and fertility services. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of disability insurers by the Department of Insurance. Existing law imposes various requirements and restrictions on health care service plans and disability insurers, including, among other things, a requirement that every group health care service plan contract or disability insurance policy that is issued, amended, or renewed on or after January 1, 1990, offer coverage for the treatment of infertility, except in vitro fertilization.This bill would require large group, small group, and individual health care service plan contracts and disability insurance policies issued, amended, or renewed on or after January 1, 2024, to provide coverage for the diagnosis and treatment of infertility and fertility services. The bill would revise the definition of infertility, and would remove the exclusion of in vitro fertilization from coverage. The bill would also delete a requirement that a health care service plan contract and disability insurance policy provide infertility treatment under agreed-upon terms that are communicated to all group contractholders and policyholders. The bill would prohibit a health care service plan or disability insurer from placing different conditions or coverage limitations on fertility medications or services, or the diagnosis and treatment of infertility and fertility services, than would apply to other conditions, as specified.With respect to a health care service plan, the bill would not apply to a specialized health care service plan contract or Medi-Cal managed care health care service plan contracts or any entity that enters into a contract with the State Department of Health Care Services for the delivery of health care services pursuant to specified provisions. With respect to a disability insurer, the bill would not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, or specialized disability insurance policies.Because the violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.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.

Primary Sponsors
Caroline Menjivar, Buffy Wicks

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 6:01 PM
California Association of Health Plans: Oppose

Bill Number	Status	Position
SB 770	In Assembly	Monitor

Title
Health care: unified health care financing.

Description
SB 770, as amended, Wiener. Health care: unified health care financing. Prior state law established the Healthy California for All Commission for the purpose of developing a plan towards the goal of achieving a health care delivery system in California that provides coverage and access through a unified health care financing system for all Californians, including, among other options, a single-payer financing systemThis bill would direct the Secretary of the California Health and Human Services Agency to pursue waiver discussions with the federal government with the objective of a unified health care financing system that incorporates specified features and objectives, including, among others, a comprehensive package of medical, behavioral health, pharmaceutical, dental, and vision benefits, and the absence of cost sharing for essential services and treatments. The bill would further require the secretary to establish a Waiver Development Workgroup comprised of members appointed by the Governor, Speaker of the Assembly, and President Pro Tempore of the Senate, as specified. The bill would require the workgroup to include stakeholders representing various specified interests, including consumers, patients, health care professionals, labor unions, government agencies, and philanthropic organizations. The bill would require the secretary to provide quarterly reports to the chairs of the Assembly and Senate Health Committees on the status and outcomes of waiver discussions with the federal government and the progress of the workgroup. The bill would also require the secretary to submit a complete set of recommendations regarding the elements to be included in a formal waiver application, as specified, by no later than June 1, 2024. The bill would also include findings and declarations of the Legislature related to the implementation of a unified health care financing system.

Primary Sponsors
Scott Wiener, Mike McGuire

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 6:17 PM
California Association of Health Plans: Oppose

Bill Number	Status	Position
SB 805	In Assembly	Monitor

Title
Health care coverage: pervasive developmental disorders or autism.

Description
SB 805, as amended, Portantino. Health care coverage: pervasive developmental disorders or autism. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or a health insurance policy to provide coverage for behavioral health treatment for pervasive developmental disorder or autism, and defines “behavioral health treatment” to mean specified services and treatment programs, including treatment provided pursuant to a treatment plan that is prescribed by a qualified autism service provider and administered either by a qualified autism service provider or by a qualified autism service professional or qualified autism service paraprofessional who is supervised as specified. Existing law defines a “qualified autism service professional” to refer to a person who meets specified educational, training, and other requirements and is supervised and employed by a qualified autism service provider. Existing law defines a “qualified autism service paraprofessional” to mean an unlicensed and uncertified individual who meets specified educational, training, and other criteria, is supervised by a qualified autism service provider or a qualified autism service professional, and is employed by the qualified autism service provider.This bill would expand the criteria for a qualified autism service professional to include a behavioral health professional and a psychology associate, an associate marriage and family therapist, an associate clinical social worker, or an associate professional clinical counselor, as specified. The bill would expand the criteria for a qualified autism service paraprofessional to include a behavioral health paraprofessional, as specified.Existing law, the Lanterman Developmental Disabilities Services Act, requires the State Department of Developmental Services to contract with regional centers to provide services and supports to individuals with developmental disabilities and their families. Existing law defines developmental disability for these purposes to include, among other things, autism. This bill would require the department to adopt emergency regulations to address the use of behavioral health professionals and behavioral health paraprofessionals in group practice provider behavioral intervention services. The bill would require the department to establish rates and the educational or experiential qualifications and professional supervision requirements necessary for these p... (click bill link to see more).

Primary Sponsors
Anthony Portantino

Bill Number	Status	Position
SB 819	In Assembly	Monitor

Title
Medi-Cal: certification.

Description
SB 819, as amended, Eggman. Medi-Cal: certification. Existing law requires the State Department of Public Health to license and regulate clinics. Existing law exempts from those licensing provisions certain clinics that are directly conducted, maintained, or operated by federal, state, or local governmental entities, as specified. Existing law also exempts from those licensing provisions a clinic that is operated by a primary care community or free clinic, that is operated on separate premises from the licensed clinic, and that is only open for limited services of no more than 40 hours per week.Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services (department) and 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.Existing law sets forth various procedures, including the submission of an application package, for providers to enroll in the Medi-Cal program. Under existing law, an applicant or provider that is a government-run license-exempt clinic as described above is required to comply with those Medi-Cal enrollment procedures.Under existing law, an applicant or provider that is operated on separate premises and is license exempt, including an intermittent site or mobile health care unit that is operated by a licensed primary care clinic that provides all staffing, protocols, equipment, supplies, and billing services, is not required to enroll in the Medi-Cal program as a separate provider or comply with the above-described enrollment procedures, if the licensed primary care clinic has notified the department of its separate locations, premises, intermittent sites, or mobile health care units.This bill would additionally exempt from the Medi-Cal enrollment procedures an intermittent site or mobile health care unit that is operated by the above-described government-run license-exempt clinic if that clinic has notified the department of its separate locations, premises, sites, or units.The bill would make legislative findings stating that this bill is declaratory of existing law, as specified.

Primary Sponsors
Susan Eggman

Bill Number	Status	Position
SB 873	In Assembly	Monitor

Title
Prescription drugs: cost sharing.

Description
SB 873, as introduced, Bradford. Prescription drugs: cost sharing. (1) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care under authority of the Director of the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance under the authority of the Insurance Commissioner. Existing law limits the maximum amount an enrollee or insured may be required to pay at the point of sale for a covered prescription drug to the lesser of the applicable cost-sharing amount or the retail price.This bill, commencing no later than January 1, 2025, would require an enrollee's or insured's defined cost sharing for each prescription drug to be calculated at the point of sale based on a price that is reduced by an amount equal to 90% of all rebates received, or to be received, in connection with the dispensing or administration of the drug. The bill would require a health care service plan or health insurer to, among other things, pass through to each enrollee or insured at the point of sale a good faith estimate of the enrollee's or insured's decrease in cost sharing. The bill would require a health care service plan or health insurer to calculate an enrollee's or insured's defined cost sharing and provide that information to the dispensing pharmacy, as specified. The bill would require the department and the commissioner to submit an annual report on the impact of these provisions to the appropriate policy committees of the Legislature, as specified. The bill would make these provisions inoperative on January 1, 2027.(2) Existing law requires a health care service plan or health insurer that files certain rate information to report to the appropriate department specified cost information regarding covered prescription drugs, including generic drugs, brand name drugs, and specialty drugs, dispensed as provided.This bill, until January 1, 2027, would require a health care service plan or health insurer to report additional information on the above-described point of sale provision.(3) Because a willful violation of the bill's provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.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.

Primary Sponsors
Steve Bradford

Organizational Notes

Last edited by Joanne Campbell at Apr 17, 2023, 4:06 PM
California Association of Health Plans: Oppose

Bill Number	Status	Position
HR 3068	In House	Support

Title
Equal Health Care for All Act

Primary Sponsors
Adam Schiff

Board of Governors
MOTION SUMMARY

Date: August 23, 2023 **Motion No. EXE 100.0923**

Committee: Executive **Chairperson:** Alvaro Ballesteros, MBA

Issue: Execute a Housing & Homelessness Incentive Program Investment agreement with the Los Angeles County Department of Public Health (DPH). DPH shall provide field-based clinical services for people experiencing homelessness, an environment health homeless encampment assessment program, and Medi-Cal enrollment and redetermination assistance for people experiencing homelessness.

☒ **New Contract** ☐ **Amendment** ☐ **Sole Source** ☐ **RFP/RFQ was conducted in** <<year>>

Background: As of 2022, L.A. Care opted to participate in the Department of Health Care Services (DHCS) Housing and Homelessness Incentive Program (HHIP), which has two overarching goals:

1. Ensuring that Managed Care Plans (MCPs) have the necessary capacity and partnerships to connect their members to needed housing services; and
2. Reducing and preventing homelessness.

HHIP is a MCP incentive program through which MCPs may earn incentive funds for improving health outcomes and access to whole person care services by addressing homelessness and housing insecurity as social drivers of health and health disparities. The HHIP rewards MCPs for developing the necessary capacity and partnerships to connect their members to needed housing services and taking active steps to reduce and prevent homelessness.

In order to align with HHIP goals and to help meet HHIP metrics and thus draw down funds, L.A. Care staff requests approval to execute a contract with Los Angeles County Department of Public Health (DPH) for period of twenty four months, in an amount up to $2,500,000. This investment represents 70% of the costs and will be jointly funded with Health Net for the remaining 30%.

With this HHIP investment, DPH will implement three initiatives:

1. Field-based street medicine services delivered to unsheltered people experiencing homelessness in their lived environments. These services will be coordinated with other homeless outreach and street medicine teams.
2. Disease control services for unsheltered people experiencing homelessness, such as environmental assessments of encampments to address unsanitary or safety issues that arise due to the condition of the encampment and the environment.
3. Medi-Cal redetermination and application assistance for people experiencing homelessness. Services will be delivered by adding staff to DPH's Community Health Outreach Initiative grantees who will conduct field-based outreach and enrollment help for people experiencing homelessness.

L.A. Care selected DPH because of their experience and position to quickly build capacity and coordinate the required services for vulnerable communities throughout Los Angeles. L.A. Care did not conduct a request for proposal for this vendor because of their experience and required timing for making the HHIP

investment in order to meet DHCS goals within the current reporting period (January 1, 2023 – October 31, 2023) and earn future HHIP funding.

Member Impact: L.A Care members will benefit from this motion as it will help increase access to street medicine services, reduce the risk of unsanitary conditions for unsheltered members experiencing homelessness, and provide Medi-Cal redetermination assistance for members experiencing homelessness.

Budget Impact: The cost was anticipated and included in the approved budget for the Housing and Homeless Incentive Program and will use HHIP funds already received by L.A. Care.

Motion: **To authorize staff to execute an HHIP investment agreement in the amount of up to $2,500,000 with the Los Angeles County Department of Public Health to perform field-based clinical services, Medi-Cal enrollment work and environmental assessments of homeless encampments for a twenty four month period.**

Board of Governors
MOTION SUMMARY

Date: August 23, 2023 **Motion No. EXE 101.0923**

Committee: Executive **Chairperson:** Alvaro Ballesteros, MBA

Issue: Request to delegate authority to negotiate and execute Amendment 40 to L.A. Care's Medi-Cal contract (contract number 04-36069) with the Department of Health Care Services (DHCS).

☐ **New Contract** ☒ **Amendment** ☐ **Sole Source** ☐ **RFP/RFQ was conducted**

Background: L.A. Care received A40 from DHCS on July 31, 2023; this is the final version of draft amendment 2022-D. This amendment contains technical changes as well as updates to the following:

- Subcontract Network Certification
- Updated Reporting Requirements
- Community Health Care Workers Services
- Cognitive Health
- Updated Grievance and Appeals
- Asthma Preventive Services

The due date for submission of the executed amendment to DHCS is September 11, 2023.

Member Impact: Member impact is under investigation.

Budget Impact: Finance is reviewing for any impact on relevant budgets.

Motion: **To delegate authority to L.A. Care Chief Executive Officer, John Baackes, to negotiate and make any substantive changes to Amendment A40 to Contract 04-36069, between L.A. Care Health Plan and the California Department of Health Care Services, which may be made or negotiated by the Chief Executive Officer and/or his designees, and to execute Amendment A40.**

IV. Exhibit A, Attachment 6, PROVIDER NETWORK, is amended to read:

12. Subcontractor Reports

A. Contractor shall submit to DHCS, a quarterly report containing the names of all Subcontractors, including health maintenance organizations, independent physician associations, medical groups, and FQHCs and their contracting health maintenance organizations, independent physician associations, medical groups, and FQHCs. The report must be sorted by Subcontractor type, indicating the county or counties in which Members are served. In addition, the report should also indicate where relationships or affiliations exist between direct and indirect Subcontractors. The report shall be submitted within 30 calendar days following the end of the reporting quarter.

B. Subcontractor Network Certification

1) Contractor must develop, implement, and maintain a process to annually certify its Subcontractors' Networks that provide Medi-Cal Covered Services for compliance with Provider Network requirements set forth in Exhibit A, Attachment 6, Provision 2, Network Composition, and Provision 3, Provider to Member Ratios, Provision 4, Physician Supervisor to Non-Physician Medical Practitioner Ratios, and Exhibit A, Attachment 9, Provision 4, Access Standards.

2) Contractor must submit complete and accurate Network Provider and Subcontractors' Network Provider data, as set forth in Exhibit A, Attachment 3, Management Information System, Provision 7, Program Data Reporting.

3) Contactor must have a process in place to impose Corrective Action and sanctions and report to DHCS, as specified by DHCS, when a Subcontractor's Network that provides Medi-Cal Covered Services fails to meet Network adequacy standards as set forth in APL 21-006. Contractor must ensure all Members assigned to a Subcontractor's Network that is under a Corrective Action continue to receive access to Medically Necessary Covered Services within timely access standards and applicable time or distance standards as set forth in Exhibit A, Attachment 9, Access and Availability, Provision 4, Access Standards, by supplementing the Subcontractor's Network until the Corrective Action is resolved.

4) Contractor must submit the results of its Subcontractor Network certification to DHCS annually in a format specified

by DHCS and post its submitted certification on its website.

V. Exhibit A, Attachment 10, SCOPE OF SERVICES, is amended to read:

6. Services for Adults

B. Adult Preventive Services

Contractor shall cover and ensure the delivery of all preventive services and Medically Necessary diagnostic and treatment services for adult Members.

3) Contractor must ensure the provision of an annual cognitive health assessment for Members who are 65 years of age or older, and are otherwise ineligible to receive a similar assessment as part of a Medicare annual wellness visit.

8. Services for All Members

J. Asthma Preventive Services

Contractor must ensure availability of Asthma Preventive Services (APS), including clinic-based and home-based asthma self-education, and in-home environmental trigger assessments for all Members with a diagnosis of asthma. APS may be provided by a Physician or a Non-Physician Medical Practitioner, or a licensed practitioner of the healing arts within their scope of practice. APS may also be provided by unlicensed Providers, which may include Community Health Workers (CHW), who have met the qualifications of an APS Provider and are providing these services under a supervising Physician or Non-Physician Medical Practitioner, clinic, hospital, local health jurisdiction, or community-based organization.

K. Community Health Workers Services

1) Contractor must ensure availability of CHW Services to all Members that meet the eligibility criteria in accordance with 42 CFR section 440.130(c).

2) Contractor must adhere to DHCS guidance on service definitions, eligible populations, and CHW provider parameters as stated in APL 22-016.

3) CHW Provider and Supervising Provider Requirements

a) Contractor must determine, verify, and validate CHW providers can provide CHW Services in an effective manner consistent with culturally and linguistically appropriate care.

b) CHW providers must have lived experience that aligns with and provides a connection between CHW and the Member population being served in accordance with APL 22-016.

c) Contractor must contract with a Supervising Provider to oversee CHW providers and the services delivered to Members. CHW providers can be supervised by a community-based organization (CBO) or a local health jurisdiction (LHJ) that does not have a licensed Provider on staff in alignment with the Provider Manual and APL 22-016.

d) Contractor must ensure that Network Providers and Subcontractors contracting with or employing CHWs to provide Covered Services have adequate supervision and training.

e) Contractor must ensure CHW providers demonstrate, and Supervisor Providers maintain evidence of, minimum qualifications through the CHW certificate pathway, Violence Prevention certificate pathway, or Work experience pathway, as described in APL 22-016.

f) Contractor must have a process for verifying qualifications and experience of Supervising Providers, which must extend to individuals employed by, or

delivering CHW Services on behalf of, the Supervising Provider.

g) Contractor must ensure Supervising Providers and CHW providers comply with all applicable State and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters.

L. Community Health Workers Provider Capacity

1) Contractor must ensure and monitor appropriate, adequate Provider Networks within its Service Area, including for CHW Services as stated in APL 21-006.

2) Contractor must use data-driven approaches to determine and understand priority populations eligible for CHW Services, including but not limited to, using past and current Member utilization/encounters, frequent hospital admissions or emergency department visits, demographic and Social Drivers of Health data, referrals from the community, and needs assessments.

M. Identifying Members for Community Health Workers

1) Contractor must require a referral for CHW Services submitted by a Physician or other licensed practitioner of the healing arts within their scope of practice under State law.

2) Contractor must accept recommendations for CHW Services from other licensed practitioners, whether they are in the Network or Out-of-Network Providers, within their scope of practice, including physician assistants, nurse practitioners, clinical nurse specialists, podiatrists, nurse midwives, licensed midwives, registered nurses, public health nurses, psychologists, licensed marriage and family therapists, licensed clinical social workers, licensed professional clinical counselors, dentists, registered dental hygienists, licensed educational psychologists, licensed vocational nurses, and pharmacists.

VI. Exhibit A, Attachment 14, MEMBER GRIEVANCE AND APPEAL SYSTEM, is amended to read:

1. Member Grievance and Appeal System

Contractor shall have in place a system in accordance with 28 CCR ~~S~~**s**ection**s** 1300.68 and 1300.68.01, 22 CCR ~~S~~**s**ection 53858, Exhibit A, Attachment 13, Provision 3, Paragraph F.13), and 42 CFR **sections 438.228 and** 438.402~~2~~**0**-424. Contractor shall follow Grievance and Appeal requirements, and use all notice templates included in APL 21-011. Contractor shall ensure that its Grievance and Appeal system meets the following requirements:

3. Grievance and Appeal Log and Monthly ~~Quarterly~~ Grievance and Appeal Report

A. Contractor ~~shall accurately~~ **must** maintain **records of Grievances and Appeals in a manner** ~~and make~~ accessible to DHCS, and ~~have available for~~ **to the Centers for Medicare and Medicaid Services (**CMS**),** upon request~~, Grievance and Appeal logs, including copies of Grievance and Appeal logs of any Subcontractor delegated responsibility to maintain and resolve Grievances. Grievance and Appeal logs shall include all the required information set forth in Title 22 CCR Section 53858(e). B. The report shall include Grievances and Appeals handled by Subcontractors.~~ **The record of each Grievance or Appeal must contain, at a minimum, all information set forth in 42 CFR section 438.416(b).** Contractor ~~shall~~ **must** ensure that all documents **and records, whether in written or electronic format,** generated or obtained by Contractor in the course of responding to Adverse Benefit Determinations **(ABD)**, Grievances, Appeals, and Independent Medical Reviews **(IMR),** are retained for at least **ten (**10**)** years pursuant to 42 CFR **section** 438.3(u).

~~C~~**B**. Contractor shall submit **to DHCS** a monthly Grievance and Appeal report for Medi-Cal Members only in the form that is required by and submitted to **Department of Managed Health Care (**DMHC**)**, as set forth in ~~Title~~ 28 CCR ~~S~~**s**ection 1300.68(f), with additional information required by DHCS per 42 CFR **section** 438.416 and 22 CCR section 53858(e).

~~D~~**C**. Contractor shall submit complete, accurate, and timely Grievance and Appeal data within ten (10) calendar days following the end of each month under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS and as required in Exhibit A, Attachment 3, Provision 7, Program Data. Contractor shall certify all Network data as set forth in 42 CFR section 438.606.

D. Contractor must comply with the requirements set forth in Exhibit A, Attachment 3, Management Information System, of this Contract for the reporting of Grievance and Appeal data.

VII. Exhibit A, Attachment 17, REPORTING REQUIREMENTS, is amended to read:

Contract Section	Requirement	Frequency
Attachment 6 PROVIDER NETWORK		
12. **A.** Subcontractors Report **B. Subcontractor Network Certification**	Subcontractors Report **SN Certification**	Quarterly **Annually**
Attachment 14 MEMBER GRIEVANCE AND APPEAL SYSTEM		
3. Grievance and Appeal Log and ~~Quarterly~~ **Monthly** Grievance and Appeal Report	Grievance and Appeal Repo rt	~~Quarterly~~ **Monthly**

VIII. Exhibit A, Attachment 18, IMPLEMENTATION PLAN AND DELIVERABLES, is amended to read:

10. Scope of Services

L. Submit policies and procedures for the provision of:

6) Asthma Preventive Services

P. Contractor must submit to DHCS, for review and approval, a CHW Integration Plan describing the strategies for supporting CHW integration and its approach for building sustainable infrastructure and supports.

14. Member Grievance and Appeal System

C. Submit format for ~~Quarterly~~ **Monthly** Grievance and Appeal Log and Report.

IX. Exhibit A, Attachment 20, BEHAVIORAL HEALTH SERVICES, is amended to read:

4. Non-Specialty Mental Health Care Services Providers

B. In order to determine whether NSMHS and substance use disorder services are Medically Necessary, Contractor shall apply the criteria of Medical Necessity as stated in APL ~~17-016~~**21-014** and ~~17-018~~**22-006**.

X. Exhibit E, Attachment 1, DEFINTIONS, is amended to read:

Asthma Preventive Services (APS) means preventive health services delivered to prevent asthma that include evidence-based asthma self-management education and in-home environmental trigger assessments, consistent with the National Institutes of Health's Guidelines for the Diagnosis and Management of Asthma.

Community Health Worker (CHW) means an individual known by a variety of job titles, such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, and as set forth in APL 22-016.

CHW Services means preventive health services delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health. CHW Services can be provided in individual or group sessions. CHW Services may be provided virtually or in-person with locations in any setting including, but not limited to, outpatient clinics, hospitals, homes, or community settings. CHW Services do not include any service that requires a license.

Federally Qualified Health Center (FQHC) means an entity defined in Section 1905 of the Social Security Act (42 **United States Code (**USC**)** ~~S~~**s**ection 1396d(l)(2)(B)).

Partial Dual Eligible Member means a Member who is 21 years of age or older and is eligible for Medi-Cal~~,~~ and who is also eligible for benefits under either Medicare Part A (42 ~~U.S.C. Sec.~~ **USC section**1395c et seq.) or Medicare Part B (42 ~~U.S.C. Sec.~~ **USC section** 1395j et seq.).

Social Drivers of Health (SDOH) means the conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning, and quality-of-life outcomes and risk.

Subcontractor Network means a Provider Network of a Subcontractor or downstream Subcontractor, wherein the Subcontractor or downstream Subcontractor is delegated risk and is responsible for arranging for the provision of and paying for Covered Services as stated in their Subcontractor or downstream Subcontractor Agreement

Supervising Provider means a licensed Provider, a hospital, an outpatient clinic, a local health jurisdiction (LHJ), or a community-based organization (CBO).

XI. All rights, duties, obligations and liabilities of the parties hereto otherwise remain unchanged.

Board of Governors
MOTION SUMMARY

Date: August 23, 2023 **Motion No. EXE A.0823**

Committee: Executive **Chairperson:** Alvaro Ballesteros, MBA

Issue: L.A. Care Policy HR-501 requires that the Executive Committee annually review substantial changes to the Human Resources Policies.

☐ **New Contract** ☐ **Amendment** ☐ **Sole Source** ☐ **RFP/RFQ was conducted**

Background: The revised policies are written to comply with changes to Regulatory, Legislative and Judicial changes, and reflect changes in L.A. Care's practices.

Policy Number	Policy	Section	Description of Modification
HR-103	**Employee Assistance Program**	Benefits	Updated and Review, clarify Eligible Employee Definition
HR-104	**Employee Benefit General Statement**	Benefits	Review, clarified temporary staff benefits and variable hour employees.
HR-109	**Jury Duty and Witness Subpoenas**	Benefits	Updated Reporting section to standard verbiage
HR-207	**Employee Communications**	Employee Relations	Retire policy, HR-209 Internal Organizational Communication Systems was recently approved BOG

Member Impact: L.A. Care members will benefit from this motion by receiving more efficient service from L.A. Care staff members, who will be thoroughly versed on L.A. Care Human Resource policies

Budget Impact: None

Motion: To approve revisions to the Human Resources Policies as presented.

	EMPLOYEE ASSISTANCE PROGRAM (EAP)	**HR-103**

DEPARTMENT	HUMAN RESOURCES
Supersedes Policy Number(s)	6105

DATES					
Effective Date	8/29/2006	Review Date	8/16/2023	Next Annual Review Date	8/16/2024
Legal Review Date	Click here to enter a date.	Committee Review Date	Click here to enter a date.		

LINES OF BUSINESS

☐ Cal MediConnect ☐ L.A. Care Covered ☐ L.A. Care Covered Direct ☐ MCLA
☐ PASC-SEIU Plan ☒ Internal Operations

DELEGATED ENTITIES / EXTERNAL APPLICABILITY

☐ PP – Mandated ☐ PP – Non-Mandated ☐ PPGs/IPA ☐ Hospitals
☐ Specialty Health Plans ☐ Directly Contracted Providers ☐ Ancillaries ☐ Other External Entities

ACCOUNTABILITY MATRIX

ATTACHMENTS

ELECTRONICALLY APPROVED BY THE FOLLOWING

	OFFICER	**DIRECTOR**
NAME	Terry Brown	Sarah Viloria Diaz
DEPARTMENT	Human Resources	Human Resources
TITLE	Chief Human Resources Officer	Director, Human Resources Total Rewards

AUTHORITIES
➢ HR-501, "Executive Committee of the Board: HR Roles and Responsibilities" ➢ California Welfare & Institutions Code §14087.9605

REFERENCES

HISTORY	
REVISION DATE	**DESCRIPTION OF REVISIONS**
April 2014	Review
6/27/2018	Revision, Eligible Household Members added and defined.
8/16/2023	Updated and Review, clarify Eligible Employee Definition

DEFINITIONS

1.0 OVERVIEW:

1.1 L.A. Care Health Plan (L.A. Care) provides an Employee Assistance Program (EAP) benefit to all its Eligible Employees and members of their household.

2.0 DEFINITIONS:

Whenever a word or term appears capitalized in this policy and procedure, the reader should refer to the "Definitions" below.

2.1 **Eligible Employee -** All regular and Assignment of Limited Duration (ALD), full time and part time employees, are eligible. Temporary employees on L.A. Care's payroll, who are scheduled to work 30 or more hours per week, are eligible. Student interns and per diem employees are ineligible unless they meet full-time equivalency for health care benefits under the Affordable Care Act (ACA).

2.2 **Eligible Household Member(s) -** the spouse, domestic partner, dependents, and others whose place of residence is the same as the Eligible Employee, and/or those dependents who do not share the same residence as the Eligible Employee but due to applicable state law or court order are required to be covered under the benefit.

3.0 POLICY:

3.1 The EAP provides professional consultation and referrals for personal situations which have or may have an adverse impact on the lives and/or work performance of Eligible Employees and their Eligible Household Members.

4.0 PROCEDURES:

4.1 An Eligible Employee and his/her Eligible Household Members are eligible for the EAP benefit while the employee is actively employed or on an approved Leave of Absence. Eligibility will begin on the first of the month following employment.

4.2 An Eligible Employee or his/her Eligible Household Members may self-refer to the EAP.

4.3 Voluntary use of the EAP by Eligible Employees and Eligible Household Members is confidential and will not be released to L.A. Care unless the Eligible Employee and/or Eligible Household Members authorize the release of specific information to L.A. Care. The sole exception to this confidentiality is when an employee or any of his/her Eligible Household Members verbalize the intent to hurt himself/herself or another individual or as otherwise required by applicable laws. L.A. Care shall be notified in accordance with the prevailing law.

5.0 MONITORING:

5.1 Human Resources shall review its policies routinely to ensure they are updated appropriately and have processes in place to ensure the appropriate required steps are taken under this policy.

6.0 REPORTING:

6.1 Any suspected violations to this policy should be reported to your Human Resources Business Partner or the Human Resources Department.

7.0 L.A. Care reserves the right to modify, rescind, delete, or add to this policy at any time, with or without notice.

	EMPLOYEE BENEFITS GENERAL STATEMENT	HR-104

DEPARTMENT	HUMAN RESOURCES
Supersedes Policy Number(s)	6106

DATES					
Effective Date	8/29/2006	Review Date	8/16/2023	Next Annual Review Date	8/16/2024
Legal Review Date		Committee Review Date	1/28/2019		

LINES OF BUSINESS

- ☐ Cal MediConnect
- ☐ L.A. Care Covered
- ☐ L.A. Care Covered Direct
- ☐ MCLA
- ☐ PASC-SEIU Plan
- ☒ Internal Operations

DELEGATED ENTITIES / EXTERNAL APPLICABILITY

- ☐ PP – Mandated
- ☐ PP – Non-Mandated
- ☐ PPGs/IPA
- ☐ Hospitals
- ☐ Specialty Health Plans
- ☐ Directly Contracted Providers
- ☐ Ancillaries
- ☐ Other External Entities

ACCOUNTABILITY MATRIX

ATTACHMENTS

ELECTRONICALLY APPROVED BY THE FOLLOWING

	OFFICER	DIRECTOR
NAME	Terry Brown	Sarah Viloria Diaz
DEPARTMENT	Human Resources	Human Resources
TITLE	Chief Human Resources Officer	Director, HR Total Rewards

AUTHORITIES
➢ HR-501, 'Executive Committee of the Board: HR Roles and Responsibilities' ➢ California Welfare & Institutions Code §14087.9605 ➢ L.A. Care By-Laws, §10.1 Purchasing, Hiring, Personnel etc. ➢ The Patient Protection and Affordable Care Act, 26 U. S. C. §5000A

REFERENCES
➢ HR-125 Sick Leave for Per-Diem, Part Time, and Non-Regular Employees

HISTORY	
REVISION DATE	**DESCRIPTION OF REVISIONS**
11/10/2016	Review
3/28/2018	Review
1/28/2018	Revision, temporary staff benefits included. Regular and variable staff benefit coverage clearly defined.
7/30/2020	Review, updated Monitoring and Reporting sections with standard verbiage
8/16/2023	Review, clarified temporary staff benefits and variable hour employees.

DEFINITIONS

1.0 OVERVIEW:

1.1 The purpose of this policy is to define the established employee benefits programs that L.A. Care Health Plan ("L.A. Care") has for its benefit-eligible employees. Employee benefit programs include, but are not limited to, medical, vision, dental, life insurance, accidental death and disability ("AD&D") insurance, short term disability, long term disability, paid time off ("PTO"), retirement benefits, and voluntary plans. L.A Care reserves the right to make plan changes for its employees at any time.

2.0 DEFINITIONS:

Whenever a word or term appears capitalized in this policy and procedure, the reader should refer to the "Definitions" below.

2.1 Eligible Employee – All regular and Assignment of Limited Duration (ALD) employees, who are scheduled to work 30 or more hours per week, are eligible. Temporary employees on L.A. Care's payroll, who are scheduled to work 30 or more hours per week, are eligible. Regular part-time employees are eligible for the Employee Assistance Program (EAP). Student interns and per diem employees are ineligible for benefits unless they meet full-time equivalency for health care benefits under the Affordable Care Act (ACA).

3.0 POLICY:

3.1 L.A. Care strives to offer a variety of health and welfare benefit programs that are designed to optimize choice of coverage, promote cost effectiveness, and avoid duplication of coverage.

3.2 The benefits program is reviewed annually by the Chief Human Resources Officer ("CHRO") and/or Human Resources delegates to ensure adequate coverage, cost effectiveness, and consistency with L.A. Care's organizational values and business objectives.

3.3 While it is the intention of L.A. Care to continue these benefits, the organization reserves the right, in an individual case and more generally, to modify, curtail, reduce or eliminate any benefit, in whole or in part, with or without notice. Neither the benefit programs nor their descriptions are intended to create any guarantees of employment.

3.4 Employees in positions classified as "regular" or "Assignment of Limited Duration" (ALD) who are regularly scheduled to work 30 hours or more per week are eligible to participate in all employee benefit programs.

3.5 Temporary employees on L.A. Care's payroll who are scheduled to work 30 hours or more per week are eligible for medical, dental, vision, EAP, flexible spending and health savings accounts. Temporary employees are not eligible for life,

disability and voluntary insurance plans. These employees are not eligible for employer-contributory retirement benefits, unless otherwise provided under applicable plan document(s). Temporary employees do not accrue PTO, but accrue sick leave based upon hours worked. (see policy HR-125, Sick Leave for Per-Diem, Part-Time, and Non-Regular Employees).

3.6 Per diems, student interns, and part time regular employees who are scheduled to work less than 30 hours per week, and who meet full-time equivalency under the Affordable Care Act ("ACA"), will be offered health coverage and EAP. Otherwise, these employees are not eligible for medical, dental, vision, life, disability, EAP, and voluntary insurance plans. However, all regular part-time employees are eligible for EAP benefits. These employees are not eligible for employer-contributory retirement benefits, unless otherwise provided by applicable plan document(s). These employees do not accrue PTO, but they do accrue sick leave based upon hours worked (see policy HR-125, Sick Leave for Per-Diem, Part-Time and Non-Regular Employees).

3.7 All employees are eligible to participate in the voluntary 457(b) Deferred Compensation Retirement Plan regardless of classification; however, employer contributions toward the 401(a) Retirement Benefit Plan are contingent upon eligibility pursuant to the applicable plan document(s).

4.0 PROCEDURES:

4.1 N/A

5.0 MONITORING:

5.1 Human Resources shall review its policies routinely to ensure they are updated appropriately and have processes in place to ensure the appropriate required steps are taken under this policy.

6.0 REPORTING:

6.1 Any suspected violations to this policy should be reported to your Human Resources Business Partner or the Human Resources Department.

7.0 L.A. Care reserves the right to modify, rescind, delete, or add to this policy at any time, with or without notice.

	JURY DUTY AND WITNESS SUBPOENAS	HR-109

DEPARTMENT	HUMAN RESOURCES
Supersedes Policy Number(s)	6111

DATES					
Effective Date	5/30/1996	Review Date	8/16/2023	Next Annual Review Date	8/16/2024
Legal Review Date	6/17/2019	Committee Review Date			

LINES OF BUSINESS

☐ Cal MediConnect ☐ L.A. Care Covered ☐ L.A. Care Covered Direct ☐ MCLA
☐ PASC-SEIU Plan ☒ Internal Operations

DELEGATED ENTITIES / EXTERNAL APPLICABILITY

☐ PP – Mandated ☐ PP – Non-Mandated ☐ PPGs/IPA ☐ Hospitals
☐ Specialty Health Plans ☐ Directly Contracted Providers ☐ Ancillaries ☐ Other External Entities

ACCOUNTABILITY MATRIX

ATTACHMENTS

ELECTRONICALLY APPROVED BY THE FOLLOWING

	OFFICER	DIRECTOR
NAME	Terry Brown	Sarah Viloria Diaz
DEPARTMENT	Human Resources	Human Resources
TITLE	Chief Human Resources Officer	Director, Human Resources Total Rewards

AUTHORITIES

- HR-501, "Executive Committee of the Board: HR Roles and Responsibilities"
- California Welfare & Institutions Code §14087.9605

REFERENCES

HISTORY

REVISION DATE	DESCRIPTION OF REVISIONS
2/24/2007	Revision
4/2014	Review
8/12/2019	Review
8/16/2023	Updated Reporting section to standard verbiage

DEFINITIONS

1.0 OVERVIEW:

1.1 L.A. Care Health Plan (L.A. Care) provides pay to eligible employees and/or allowed time off when they are called to serve on jury duty or are required to appear as a witness in response to a subpoena.

2.0 DEFINITIONS:

Whenever a word or term appears capitalized in this policy and procedure, the reader should refer to the "Definitions" below.

2.1 **Benefit-Eligible Employee –** Employees in positions who are scheduled to work 60 hours or more per two-week pay period or 30 hours or more per week.

3.0 POLICY:

3.1 Participation in court processes is an important civic responsibility for which L.A. Care will provide pay when an employee is called to serve.

3.2 Benefit-Eligible Employees serving on jury duty receive full pay when ordered to serve on a jury. Jury duty leave continues as long as the employee is required to serve. Note that jury duty leave provides only for time off from work for jury service. No extra leave time or overtime is provided for employees who report for jury service.

3.3 Employees in non-benefit eligible positions receive two days (16 hours) of paid jury duty leave per year if they accumulated 200 days (1600 hours) or more of active service during the prior calendar year. If these employees do not meet this active service requirement, they receive one day (eight hours) paid jury duty leave per year. This leave may not be accumulated.

3.4 Normally, prospective jurors serve a court-prescribed maximum number of days, some of which may be in an on-call capacity where employees are released but must telephone as instructed to find out whether they are needed. If, however, they are part of a jury on a case which extends beyond this time limit, they serve until the case is concluded.

3.5 Service on any County's criminal grand jury is covered, but service on a civil grand jury is not covered, because such service is entirely voluntary. An employee may serve on a County civil grand jury if the employee's supervisor approves an unpaid leave of absence, but the employee does not receive his or her regular pay or jury duty leave.

3.6 Any Benefit-Eligible Employee is eligible for witness leave if the employee is subpoenaed to appear in court or hearing provided the court appearance is not as an expert witness or as a party to the case being heard. "A party to the case" is defined as being either the plaintiff, defendant, cross-complainant or cross-defendant in a civil matter, or the defendant in a criminal matter. Benefit-Eligible Employees will

be allowed the time necessary to be absent from work and will receive full pay when subpoenaed.

3.7 Employees in non-benefit eligible positions receive one day (eight hours) of paid witness leave per year if they accumulate 200 days (1600 hours) or more of active service during the prior calendar year and are not appearing as an expert witness or as a party to the case being heard. If these employees do not meet this active service requirement, they receive four hours of paid witness leave per year. This leave may not be accumulated.

4.0 PROCEDURES:

4.1 Employees must notify their supervisor immediately upon notification from the court.

4.2 To receive jury duty leave pay or witness leave pay, the employee must turn over any fees received to the Payroll department. The employee may keep reimbursements for mileage, as determined by the court.

4.3 Employees who are asked to call the court to determine if they should appear for jury duty should report to work at their normal starting times. If they are asked to appear, they should record the balance of hours scheduled for the day as "jury duty" in Payroll's automated time management system.

4.4 If an employee is excused from jury service for a day (or part of a day) the employee must report to work during this period, so long as the employee could work at least one hour on the job.

4.5 If the employee becomes ill during jury service and is excused by the court from jury duty for that period of time, the absence is charged to paid time off (PTO).

4.6 Employees placed on call by the jury supervisor are expected to report to work until they are actually instructed to report for jury service.

4.7 The request for witness leave must be the result of a subpoena from a court or commission legally empowered to issue subpoenas.

4.8 Employees ordered to appear as a witness on their regular days off do not receive any pay from L.A. Care. In such a case, the employee may keep the witness fees.

4.9 Employees serving on jury duty must report in the automated time management system as "jury duty" the hours/days served on jury duty. Employees must provide proof of jury service and report to Payroll any jury fees received before payment is authorized.

4.10 Employees required to appear in court as a witness must report the hours/days on witness leave in the automated time record system. Employees must provide a copy

of the subpoena and report to Payroll any witness fees received before payment is authorized.

4.11 Jury duty leave pay and witness leave pay are not included in the calculation of any overtime pay.

5.0 MONITORING:

5.1 Human Resources reviews its policies routinely to ensure they are updated appropriately and has processes in place to ensure the appropriate required steps are taken under this policy.

6.0 REPORTING:

6.1 Any suspected violations to this policy should be reported to your Human Resources Business Partner or the Human Resources Department.

7.0 L.A. Care reserves the right to modify, rescind, delete, or add to this policy at any time with or without notice.