EXECUTIVE COMMITTEE MEETING
Board of Governors

June 22, 2020 • 2:00 PM
L.A. Care Health Plan
1055 W. 7th Street, Los Angeles, CA 90017
AGENDA
Executive Committee Meeting
Board of Governors
Monday, June 22, 2020, 2:00 P.M.
L.A. Care Health Plan, 1055 West 7th Street, 10th Floor, Los Angeles

California Governor issued Executive Order No. N-29-20, which among other provisions amends the Ralph M. Brown Act. Accordingly, members of the public should now listen to this meeting via teleconference as follows:

Teleconference Call-In Information/Site
Call (844) 907-7272 or (213) 438-5597
Participant Access Code #73259739

Members of the Executive Committee or staff may also participate in this meeting via teleconference. The public may listen to the Executive Committee’s meeting by teleconference. The public is encouraged to submit its public comments or comments on Agenda items in writing. You can e-mail public comments to BoardServices@lacare.org, or send a text or voicemail to: 213 628-6420.

The text, voicemail, or email 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. Comments received by voicemail, email or text by 2:00 pm on June 22, 2020 will be provided in writing to the members of the Board of Governors that serve on the Executive Committee. Public comments submitted will be read for 3 minutes.

Once the meeting has started, voicemails, emails and texts for public comment should be submitted before the item is called by the meeting Chair. If you wish to submit public comment on an item, you must submit it at any time prior to the time the Chair announces the item and asks for public comment. The Chair will announce when public comment period is over.

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

1. Approve today’s meeting Agenda

2. Public Comment (please see instructions above)

3. Approve May 26, 2020 Meeting Minutes

4. Chair’s Report

5. Chief Executive Officer Report
   • Social Justice statement

COMMITTEE ITEMS

6. Government Affairs Update
   • Legislative Matrix

Hector De La Torre, Chair
John Baackes, Chief Executive Officer
Cherie Compartore, Senior Director, Government Affairs
7. Approve the list of items that will be considered on a Consent Agenda for July 30, 2020 Board of Governors Meeting
   - Minutes of June 4, 2020 Board of Governors meeting
   - NTT America Solutions, Inc. Contract

**ADJOURN TO CLOSED SESSION (Est. time: 30 mins.)**

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

9. 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 2022

10. CONFERENCE WITH LABOR NEGOTIATOR
    Pursuant to Section 54957.6 of the Ralph M. Brown Act
    Agency Designated Representative: John Baackes
    Unrepresented Employee: All L.A. Care Employees

11. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION
    Significant exposure to litigation pursuant to Section 54956.9(d) (2) of Ralph M. Brown Act
    Three Potential Cases

**RECONVENE IN OPEN SESSION**

**ADJOURN**

The next Executive Committee is scheduled on **Monday, August 24, 2020 at 2:00 p.m.**

Public comments will be read for three minutes or less.

The order of items appearing on the agenda may change during the meeting.
If a teleconference location is listed at the top of this agenda, the public can listen to the meeting by calling the teleconference call number provided. If teleconference arrangements are listed at the top of this Agenda, note that the arrangements may change prior to the meeting.

**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 Government Code Section 54954.2 (a)(3) and Section 54954.3.

**NOTE: THE EXECUTIVE COMMITTEE CURRENTLY MEETS ON THE FOURTH MONDAY OF MOST MONTHS AT 2:00 P.M. POSTED AGENDA and MEETING MATERIALS ARE AVAILABLE FOR INSPECTION AT [www.lacare.org](http://www.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 at [www.lacare.org](http://www.lacare.org).

**AN AUDIO RECORDING OF THE MEETING MAY BE 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) 694-1250. 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.
California Governor issued Executive Order No. N-29-20, which among other provisions amends the Ralph M. Brown Act. Members of the public can listen to this meeting via teleconference.

<table>
<thead>
<tr>
<th>AGENDA ITEM/PRESENTER</th>
<th>MOTIONS / MAJOR DISCUSSIONS</th>
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| CALL TO ORDER         | Hector De La Torre, *Chairperson*, called the meetings to order for L.A. Care Executive Committee and L.A. Care’s Joint Powers Authority Executive Committee at 2:05 p.m. The meetings were held simultaneously. He welcomed everyone to the meetings and invited the members of the Committees, staff and guests to introduce themselves. Chair De La Torre summarized the process for this teleconference meetings as reflected on the meeting agenda.  
  - Public comments received by voicemail, email or text received by 2:00 p.m. today were provided in writing to the Executive Committee members. Public comments will be read for 3 minutes during the meeting.  
  - Once the meeting has started, emails and texts for public comment should be submitted before the item is called by the meeting Chair. If you wish to submit public comment on an item, you must submit it at any time prior to the time the Chair starts consideration of the item. The Chair will ask for public comment and will announce the item. The Chair will announce when public comment period is over. |
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<tr>
<td>APPROVE MEETING AGENDA</td>
<td>The Agenda for today’s meeting was approved.</td>
<td>Approved unanimously by roll call. 4 AYES (Booth, Curry, De La Torre, and Perez)</td>
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<td>PUBLIC COMMENTS</td>
<td>There were no public comments.</td>
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<td>APPROVE MEETING MINUTES</td>
<td>The minutes of the April 27, 2020 meeting were approved, as submitted.</td>
<td>Approved unanimously by roll call. 4 AYES</td>
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<td>CHAIRPERSON’S REPORT</td>
<td>Chair De La Torre clarified that Health and Human Services programs are funded by discretionary funding so that is among the first places the Legislature cuts costs to balance a budget. This year there is a rainy day fund to use but there will be a funding shortfall for a few years. (Member Gonzalez joined the meeting.)</td>
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| CHIEF EXECUTIVE OFFICER REPORT | John Baackes, Chief Executive Officer, reported: <ul><li>Received information about the Medi-Cal cuts for the new budget revisions.</li><li>In anticipation, staff has scheduled a series of town hall meetings to talk with a variety of providers to review budget proposals</li></ul> <p>(Member Ballesteros joined the meeting.)</p> Highlights of the Governor’s Budget May Revise include:<ul><li>The State has projected a $54 billion deficit.</li><li>Expecting volatility in member enrollment.</li><li>1.5% cut across all programs. Does not affect maternal, behavioral and Coordinated Care Initiative (CCI) categories. There will not be claw backs for providers.</li><li>Beginning 2021 Medi-Cal plans will be limited to underwriting gain of 1.5%.<ul><li>Changes to rates for hospitals are under consideration regarding the APR-DRG.</li><li>Does not apply to county or UC hospitals.</li><li>No impact on directed payments or governmental transfers.</li></ul>• Proposition 56 supplemental programs will end ($1.2 billion). Those funds will be used for home health and Medi-Cal expansion.</li><li>Some specialty services will be eliminated.</li></ul>
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<td></td>
<td>• In-Home Support Services (IHSS) hours will be cut.</td>
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<td>• Community Based Adult Services (CBAS) and Multipurpose Senior Services (MSSP) Programs will be eliminated.</td>
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<td>• Elimination of Adult optional benefits.</td>
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<td>• Legislators are working to get a budget approved for signature of the Governor by the end of this week.</td>
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<td>• No information is available about prioritization of triggered cuts that may be restored.</td>
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Member Booth asked if Proposition 56 funds will continue to support health programs. Chair De La Torre noted that Proposition 56 was negotiated between California Medical Association (CMA) and the Governor.

Member Perez asked if there will be written CEO report. Mr. Baackes noted that a written report will be included in the Board Meeting materials for June 4.

Cherie Compartore, Senior Director, Government Affairs, noted that a summary of the May Budget Revise is included in the meeting packet.

<table>
<thead>
<tr>
<th>COVID-19 Medicaid Relief Leadership Letter</th>
<th>Mr. Baackes reviewed the four items requested in the COVID-19 Medicaid Relief letter by health plan leadership that is included in the meeting material. <em>(A copy of the letter may be requested by contacting Board Services.)</em> L.A. Care is taking a lead role of advocacy for members and for providers.</th>
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<td>The four items were:</td>
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<td>• Stable Medicaid Funding. Increase the federal share of Medicaid spending and to commit to at least two-year period of Medicaid funding for states.</td>
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<td>• Medicaid Fiscal Accountability Proposed Rule (MFAR). MFAR must not be finalized during the COVID-19 crisis. Due to the devastating financial impact on states that the Rule would have, it was proposed that the rule be suspended until more analysis is done by Centers for Medicaid and Medicare Services (CMS) to understand the policy and financial impacts the proposed rule would have on states and in particular, the Medicaid delivery system and beneficiaries.</td>
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<td>• Cease Implementation of the Public Charge Rule. The Public Charge Rule should be fully suspended until the COVID-19 emergency has subsided.</td>
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<td>Presumptive Eligibility (PE). Extend PE to all applicants that appear to be Medicaid eligible (based on initial income screening by a qualified entity); expand the types of entities qualified to perform PE screening; allow qualified entities to utilize online/telephonic applications and online/telephonic signatures for PE applications; and disallow any maximum limitation amounts that would prohibit a person from applying for PE more than once in a twelve-month period.</td>
<td>Ms. Compartore noted that L.A. Care is continuing to work on preserving access and benefits for plan members. Mr. Baackes noted that America’s Health Insurance Plans (AHIP) expects nothing to pass until early July.</td>
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<td>2020-21 Governor's May Budget Revise Summary</td>
<td>See CEO report. <em>(A copy of the summary may be requested by contacting Board Services.)</em></td>
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<td>Government Affairs Update</td>
<td>Ms. Compartore reported:  - The legislature continues to work through the issues on the budget.  - The State assembly will hear reports from California departments on the budget.  - There will not be a conference committee meeting on the budget. The process and potential revisions are unclear at this time.</td>
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<td>Revised Human Resources Policy HR 114 (Paid Time Off)</td>
<td>Terry Brown, <em>Chief Human Resources Officer,</em> presented a motion to revise Human Resources Policy HR 114-Paid Time Off (PTO). On April 2, 2020, the Board approved motion EXE 102.0420 to provide the use of emergency PTO for certain COVID-19 related circumstances to mitigate potentially severe financial impacts on employees who would suffer a loss of income if they were unable to work, and to incorporate the paid sick leave requirements under the Families First Coronavirus Response Act.</td>
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<td>He received an inquiry from staff about PTO pay out in the event of an unforeseeable financial emergency during a natural disaster such as a pandemic. He recognized that employees may experience an unforeseen and severe financial hardship resulting from their circumstances. Staff is proposing additional revisions to HR-114, as presented, to provide financial relief through the payment of accrued, unused PTO in the event of an unforeseeable emergency.</td>
<td><strong>Motion EXE A.0520</strong> To approve the Human Resources Policy &amp; Procedure HR-114, as presented.</td>
<td>Approved unanimously by roll call. 6 AYES</td>
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<tr>
<td>Approve the Consent Agenda for June 4, 2020 Board of Governors meeting</td>
<td>• Minutes of May 7, 2020 Board of Governors meeting • Edifees Contract Amendment • Change Healthcare Contract Amendment • Cognizant Contract Amendment</td>
<td>Approved unanimously by roll call. 6 AYES</td>
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<tr>
<td>PUBLIC COMMENTS</td>
<td>There were no public comments.</td>
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<td>ADJOURN TO CLOSED SESSION</td>
<td>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 2:42 p.m.</td>
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**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: *May 2022*

**CONFERENCE WITH LABOR NEGOTIATOR**
Pursuant to Section 54957.6 of the Ralph M. Brown Act
Agency Designated Representative: John Baackes
Unrepresented Employee: All L.A. Care Employees
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<td>CONFERENCES WITH LEGAL COUNSEL – ANTICIPATED LITIGATION</td>
<td>Significant exposure to litigation pursuant to Section 54956.9(d) (2) of Ralph M. Brown Act</td>
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<td>One Potential Case</td>
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<td>RECONVENE IN OPEN SESSION</td>
<td>The meeting reconvened in open session at 3:12 pm. No reportable actions were taken during the closed session.</td>
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<tr>
<td>ADJOURNMENT</td>
<td>The meeting adjourned at 3:12 p.m.</td>
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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:
Hector De La Torre, Chair
Date: ___________________________
The following is a list of priority legislation currently tracked by Government Affairs that has been introduced during the 2020-2021 Legislative Session and is of interest to L.A. Care. If there are any questions, please contact Cherie Compartore, Senior Director of Government Affairs at ccompartore@lacare.org or extension 5481.

In response to COVID-19, the state legislature voted to recess in order to allow members and staff to observe social distancing until May, resulting in a compressed legislative calendar. Additionally, COVID-19 has reduced the state's 2020-2021 revenues and increased emergency spending the budget will be “slimmed down” since the state's needs, resources and available time have changed. As a result, the Assembly and Senate leadership have directed their members to only carry bills that directly relate to COVID-19 and to drop all other bills that do not directly relate to the crisis and to run them next year. However, there has been no official direction from Senate and Assembly leadership on what bills will move through the process; and members have are justifying their bill packages even though some of the issues are only tangentially related to COVID-19. The legislative matrix includes the bills that could directly impact L.A. Care and have not been confirmed dropped by the author.

Direct Impact Bills

**Bill State: CA (58)**

<table>
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<tr>
<th>State</th>
<th>Bill Number</th>
<th>Status</th>
<th>Position</th>
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<tbody>
<tr>
<td>CA</td>
<td>AB 74</td>
<td>Enacted</td>
<td>None</td>
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**Title**


**Description**

AB 74, Ting. Budget Act of 2019. This bill would make appropriations for the support of state government for the 2019-20 fiscal year. This bill would declare that it is to take effect immediately as a Budget Bill.

**Primary Sponsors**

Phil Ting

**Introduction Date:** 2018-12-03

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<tr>
<th>State</th>
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<th>Status</th>
<th>Position</th>
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<tr>
<td>CA</td>
<td>AB 648</td>
<td>In Senate</td>
<td>Oppose</td>
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**Title**

Wellness programs.

**Description**

AB 648, as amended, Nazarian. Wellness programs. (1) Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacted various health care coverage market reforms that took effect January 1, 2014. Among other things, PPACA sets forth various requirements related to wellness programs, which encompass programs of health promotion or disease prevention. 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
(department) and makes a willful violation of the act a crime. Existing law also provides for the regulation of various insurers by the Department of Insurance, headed by the Insurance Commissioner. This bill would prohibit health care service plans and insurers from sharing any personal information or data collected through a wellness program, except as specified, and would prohibit health care service plans or insurers from taking any adverse action, as defined, against an enrollee or member, or insured (individual), if the action of the health care service plans or insurers is in response to an individual's election to not participate in a wellness program. The bill would establish and impose upon health care service plans and insurers various requirements related to a wellness program, such as requiring a health care service plan or insurer to post a written explanation that is reasonably likely to be understood by an individual on its internet website concerning its policies and practices pertaining to wellness programs, as specified. The bill would require a health care service plan or insurer, for purposes of administering and operating a wellness program, to limit its collection, dissemination, retention, and use of any personal information of an individual to only information that is reasonably necessary to operate a wellness program, except as specified, and would extend various requirements, to the extent that they are applicable, to any entity that the health care service plan or insurer contracts with for purposes of administering or operating a wellness program on their behalf. The bill would authorize the commissioner to assess penalties on an insurer for any violation of these provisions, as specified. Because a willful violation of these requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program. (2) Existing law establishes the Division of Labor Standards Enforcement, headed by the Labor Commissioner, within the Department of Industrial Relations, for the purpose of enforcing labor laws, including those relating to employer retaliation. This bill would, among other things, prohibit...

Primary Sponsors
Adrin Nazarian

Organizational Notes
Last edited by Joanne Campbell at Jun 17, 2020, 5:08 PM
Organizational Sponsor: Consumer Reports California Association of Health Plans - Oppose LHPC - Oppose
California Consumer Privacy Act of 2018.

Existing law, the California Consumer Privacy Act of 2018 (CCPA), grants a consumer various rights with regard to personal information relating to that consumer collected by a business, including the right to know the categories and the specific pieces of personal information that have been collected and to opt out of the sale of personal information. The act also grants a consumer the right to request a business to delete any personal information about the consumer collected by the business and requires a business to do so upon receipt of a verified request, except as specified. The act excepts certain categories of personal information and entities from its provisions, including medical information, as specified. This bill would except from the CCPA information that was deidentified in accordance with specified federal law, or was derived from medical information, protected health information, individually identifiable health information, or identifiable private information, consistent with specified federal policy, as provided. The bill also would except from the CCPA a business associate of a covered entity, as defined, that is governed by federal privacy, security, and data breach notification rules if the business associate maintains, uses, and discloses patient information in accordance with specified requirements. The bill would further except information that is collected for, used in, or disclosed in research, as defined, and information that is used and disclosed only for public health activities and purposes, as described. The bill would define terms for these purposes. This bill would additionally prohibit a business or other person from reidentifying information that was deidentified, unless a specified exception is met. The bill would, beginning January 1, 2021, require a contract for the sale or license of deidentified information to include specified provisions relating to the prohibition of reidentification, as provided. (2) The CCPA requires a business to make certain disclosures to consumers, in a specified form, in its online privacy policy, if the business has an online privacy policy, and in any California-specific description of consumers' privacy rights, or, if the business does not maintain an online privacy policy or policies, on its internet website, and to update that information at least once every 12 months. This bill would require a business that sells or discloses information that was deidentified in accordance with specified federal law, was derived from protected health information, individually identifiable health information, or identifiable private information to also disclose whether the business discloses... (click bill link to see more).

Primary Sponsors
Kevin Mullin
standardized procedures.

Description
AB 890, as amended, Wood. Nurse practitioners: scope of practice: practice without standardized procedures. Existing law, the Nursing Practice Act, provides for the certification and regulation of nurse practitioners by the Board of Registered Nursing. Existing law authorizes the implementation of standardized procedures that authorize a nurse practitioner to perform certain acts that are in addition to other authorized practices, including certifying disability after performing a physical examination and collaboration with a physician and surgeon. A violation of the act is a misdemeanor. This bill, until January 1, 2026, would establish the Advanced Practice Registered Nursing Board within the Department of Consumer Affairs, which would consist of 9 members. The bill would require the board, by regulation, to define minimum standards for a nurse practitioner to transition to practice without the routine presence of a physician and surgeon. The bill would authorize a nurse practitioner who meets certain education, experience, and certification requirements to perform, in certain settings or organizations, specified functions without standardized procedures, including ordering, performing, and interpreting diagnostic procedures, certifying disability, and prescribing, administering, dispensing, and furnishing controlled substances. The bill would also authorize a nurse practitioner to perform those functions without standardized procedures outside of specified settings or organizations in accordance with specified conditions and requirements if the nurse practitioner holds an active certification issued by the board. The bill would require the board to issue that certification to a nurse practitioner who meets additional specified education and experience requirements. The bill would also require the board to request the department’s Office of Professional Examination Services, or an equivalent organization, to perform an occupational analysis of nurse practitioners performing certain functions. The bill would require the board to take specified measures to identify and assess competencies. The bill would require the board to identify and develop a supplemental examination for licensees if needed based on the assessment, as provided. Existing law makes it unlawful for specified healing arts practitioners, including physicians and surgeons, psychologists, and acupuncturists, to refer a person for certain services, including laboratory, diagnostic nuclear medicine, and physical therapy, if the physician and surgeon or their immediate family has a financial interest with the person or in the entity that receives the referral. A violation of those provisions is a misdemeanor and subject to specified civil penalties a... (click bill link to see more).

Primary Sponsors
Jim Wood

Organizational Notes
Last edited by Joanne Campbell at May 27, 2020, 3:40 PM
LHPC - Support
Title
Health care service plans: regulations: exemptions.

Description
AB 1124, as amended, Maienschein. Health care service plans: regulations: exemptions. Existing federal law defines a voluntary employees' beneficiary association as an organization composed of a voluntary association of employees that provides for the payment of life, sick, accident, or similar benefits to members, their dependents, or designated beneficiaries. Existing federal law defines a welfare plan as any plan, fund, or program established or maintained by an employer or employee organization, or both, for the purpose of providing participants or their beneficiaries specified benefits, such as medical, surgical, or hospital care or benefits. Existing law further defines a multiemployer plan as a plan to which more than one employer is required to contribute, that is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer, and that meets other specified requirements. 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 the willful violation of the act a crime. Existing law exempts specified persons or plans from the requirements of the act and authorizes the Director of the Department of Managed Health Care (director) to exempt additional specified persons or plans if the director finds, among other things, that the exemption is in the public interest. Under existing law, upon the request of the Director of Health Care Services, the director must exempt a county-operated pilot program contracting with the State Department of Health Care Services, and may exempt a noncounty-operated pilot program, subject to any conditions the Director of Health Care Services deems appropriate. Existing law also exempts a health care service plan operated by a city, county, city and county, public entity, political subdivision, or public joint labor management trust that satisfies certain criteria, including that the plan requires providers to be reimbursed solely on a fee-for-service basis. This bill would authorize the director, no later than an unspecified date, to authorize 2 pilot programs, one in northern California and one in southern California, under which providers approved by the department may undertake risk-bearing arrangements with a voluntary employees' beneficiary association with enrollment of more than 100,000 lives, notwithstanding the fee-for-service requirement described above, or a trust fund that is a welfare plan and a multiemployer plan with enrollment of more than 25,000 lives, if certain criteria are met, including that each risk-bearing provider is registered with the department as a r... (click bill link to see more).

Primary Sponsors
Brian Maienschein
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<thead>
<tr>
<th>Title</th>
<th>Introduction Date: 2020-01-08</th>
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<tbody>
<tr>
<td>Healing arts licensees: virginity examinations or tests.</td>
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**Description**

AB 1909, as introduced, Gonzalez. Healing arts licensees: virginity examinations or tests. Existing law establishes the Department of Consumer Affairs in the Business, Consumer Services, and Housing Agency. The department is composed of boards for purposes of licensing and regulating various professions and vocations, including healing arts licensees. The boards are established for the purpose of ensuring that those private businesses and professions deemed to engage in activities that have potential impact upon the public health, safety, and welfare are adequately regulated in order to protect the people of California. Existing law makes certain acts by a healing arts licensee, including, but not limited to, sexual abuse, misconduct, or relations with a patient, unprofessional conduct and grounds for disciplinary action. This bill would prohibit a healing arts licensee, as defined, from performing an examination or test on a patient for the purpose of determining whether the patient is a virgin. The bill would also make a violation of its provisions unprofessional conduct and grounds for disciplinary action by the licensing board for the healing arts licensee.

**Primary Sponsors**

Lorena Gonzalez Fletcher
Prescription drugs: 340B discount drug purchasing program.

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 federal law requires the United States Secretary of Health and Human Services to enter into an agreement with each manufacturer of covered drugs that are not subject to a rebate under an agreement between the state Medicaid program and the manufacturer under which the amount required to be paid to the manufacturer for covered drugs purchased by a covered entity does not exceed an amount equal to the average manufacturer price for the drug under the federal Medicaid program in the preceding calendar quarter, reduced by the rebate received pursuant to the Medicaid agreement. This program is commonly referred to as the 340B Drug Pricing program or 340B program. Existing state law requires a covered entity to dispense only the above-described drugs to Medi-Cal beneficiaries, authorizes a covered entity that is unable to purchase the above-described drugs to dispense a drug purchased at regular drug wholesale rates to a Medi-Cal beneficiary if the covered entity maintains documentation of their inability to obtain the drugs, and requires a not-for-profit hospital that participates in the drug discount program established under federal law to enter into an agreement with the department that includes specified terms, including that the not-for-profit hospital continues its historic commitment to the provision of charity care. This bill would define a “designated entity” as a nonprofit organization, including any subsidiary of that organization, that individually or collectively with one or more of its subsidiaries meets specified requirements, including that the designated entity is a licensed managed care organization that has previously contracted with the department as a primary care case management organization, contracts with the federal Centers for Medicare and Medicaid Services to provide services in the Medicare Program as a Medicare special needs plan, and participates in the 340B program. The bill would prohibit a designated entity from using any revenue from a contract with the department, a contract with the federal Centers for Medicare and Medicaid Services, and from the 340B program on specified activity, such as funding litigation under the California Environmental Quality Act. The bill would require a designated entity, and any subsidiary of that entity, to annually report on its internet website specified information, including the amount.

Primary Sponsors
Evan Low, Susan Eggman, Scott Wiener
Family Planning, Access, Care, and Treatment (Family PACT) Program.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law also establishes the Family Planning, Access, Care, and Treatment (Family PACT) Program, administered by the Office of Family Planning within the department, under which comprehensive clinical family planning services are provided to a person who has a family income at or below 200% of the federal poverty level, and who is eligible to receive these services. Existing law provides that comprehensive clinical family planning services under the program includes preconception counseling, maternal and fetal health counseling, and general reproductive health care, among other things. This bill would expand comprehensive clinical family planning services under the program to include the human papillomavirus (HPV) vaccine for persons of reproductive age.

Primary Sponsors
Cecilia Aguiar-Curry
Health care coverage: abortion services: cost sharing.

AB 1973, as amended, Kamlager. Health care coverage: abortion services: cost sharing. Existing law, the Reproductive Privacy Act, provides that the state may not deny or interfere 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. The act defines “abortion” as a medical treatment intended to induce the termination of a pregnancy except for the purpose of producing a live birth. Existing law also provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services through, among other things, managed care plans licensed under the act that contract with the State Department of Health Care 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 also provides for the regulation of health insurers by the Department of Insurance. Existing law requires group and individual health care service plan contracts and disability insurance policies to cover contraceptives, without cost sharing, as specified. This bill would prohibit a health care service plan or an individual or group policy of disability insurance that is issued, amended, renewed, or delivered on or after January 1, 2021, from imposing a deductible, coinsurance, copayment, or any other cost-sharing requirement on coverage for all abortion services, as specified, and additionally would prohibit cost sharing from being imposed on a Medi-Cal beneficiary for those services. The bill would apply the same benefits with respect to an enrollee's or insured's covered spouse and covered nonspouse dependents. The bill would not require an individual or group health care service plan contract or disability insurance policy to cover an experimental or investigational treatment. Because a violation of the bill 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
Sydney Kamlager-Dove
Eligibility.

Description
AB 1994, as amended, Holden. Eligibility. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law provides for the suspension of Medi-Cal benefits to an inmate of a public institution, which ends on the date they are no longer an inmate of a public institution or one year from the date they become an inmate of a public institution, whichever is sooner. Existing law requires county welfare departments to notify the department within 10 days of receiving information that an individual who is receiving Medi-Cal is or will be an inmate of a public institution. Existing law generally requires a county to redetermine a Medi-Cal beneficiary's eligibility to receive Medi-Cal benefits every 12 months and whenever the county receives information about changes in a beneficiary's circumstances that may affect their eligibility for Medi-Cal benefits. Existing federal law, the SUPPORT for Patients and Communities Act, prohibits a state from terminating Medi-Cal eligibility for an eligible juvenile if they are an inmate of a public institution, authorizes the suspension of Medicaid benefits to that eligible juvenile, and requires a state to conduct a redetermination of Medicaid eligibility or process an application for medical assistance under the Medicaid program for an eligible juvenile who is an inmate of a public institution. This bill would instead require the suspension of Medi-Cal benefits to an inmate of a public institution to end on the date they are no longer an inmate of a public institution or 3 years from the date they become an inmate of a public institution, whichever is sooner. The bill would conform state law with those specified federal provisions, and would impose those responsibilities on county welfare departments. The bill would require the county welfare department to suspend Medi-Cal benefits to an eligible juvenile in conformity with the above-specified suspension standard. Because counties are required to make Medi-Cal eligibility determinations, and the bill would expand Medi-Cal determinations of eligibility for eligible juveniles of public institutions, 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, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs... (click bill link to see more).

Primary Sponsors
Chris Holden, Blanca Rubio
Title

Description
AB 2007, as introduced, Salas. Medi-Cal: federally qualified health center: rural health clinic: telehealth. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services, 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. FQHC and RHC services are reimbursed, to the extent that federal financial participation is obtained, to providers on a per-visit basis, and a “visit” is defined as a face-to-face encounter between a patient of an FQHC or RHC and specified health care professionals, including dental providers. Existing law prohibits a requirement of in-person contact between a health care provider and a Medi-Cal patient when the service may be provided by telehealth, and, for purposes of telehealth, prohibits the department from limiting the type of setting where Medi-Cal services are provided. Existing law authorizes, to the extent that federal financial participation is available, the use of health care services by store and forward under the Medi-Cal program, subject to billing and reimbursement policies developed by the department, and prohibits a requirement of in-person contact between a health care provider and a Medi-Cal patient when these services are provided by store and forward. This bill would provide that an FQHC or RHC “visit” includes an encounter between an FQHC or RHC patient and a health care provider using telehealth by synchronous real time or asynchronous store and forward. The bill would clarify, for purposes of an FQHC or RHC visit, that face-to-face contact between a health care provider and a patient is not required for an FQHC or RHC to bill for telehealth by synchronous real time or asynchronous store and forward if specified requirements are met, including that a billable provider in the Medi-Cal program, and who is employed by the FQHC or RHC, supervises or provides the services for that patient via telehealth by synchronous real time or asynchronous store and forward.

Primary Sponsors
Rudy Salas

Organizational Notes
Last edited by Cherie Compartore at Mar 10, 2020, 9:23 PM
Organization Sponsor: California Primary Care Association, Children's Partnership, Children Now, and California Health + Advocates, California Dental Assoc.
Mental illness and substance use disorder: restorative care program: pilot projects.

AB 2025, as amended, Gipson. Mental illness and substance use disorder: restorative care program: pilot projects. Existing law, the Bronzan-McCorquodale Act, governs the organization and financing of community mental health services for persons with mental disorders in every county through locally administered and locally controlled community mental health programs. Existing law authorizes the State Department of Health Care Services, in its discretion, to permit new programs to be developed and implemented without complying with licensure requirements established pursuant to existing state law, except for requirements relating to fire and life safety of persons with mental illness. This bill would also include within that exception, requirements relating to fire and life safety of persons with alcohol or substance use disorder. The bill would, subject to the above licensing provisions, authorize the County of Los Angeles to establish a pilot project for up to 6 years to develop a restorative care program for community-based care and treatment that addresses the interrelated and complex needs of individuals suffering from mental illness and substance use disorder, along with other medical comorbidities, and homelessness. The bill would authorize the department to require the County of Los Angeles to remit a specified fee in lieu of licensure or certification fees for a facility or program licensed or certified by the department as part of the pilot project. The bill would require the department, in conjunction with the Los Angeles County Director of Mental Health, to report to the Legislature within 2 years of the commencement of the operation of the initial facility regarding the progress and cost-effectiveness demonstrated by the pilot project. Under the bill, authorization for the pilot projects would be repealed as of January 1, 2026. This bill would declare that it is to take effect immediately as an urgency statute.

Primary Sponsors
Mike Gipson
Description
AB 2032, as amended, Wood. Medi-Cal: medically necessary 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 medically necessary health care services, including specified mental health and substance use disorder services, pursuant to a schedule of benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, for individuals 21 years of age and older, a service is “medically necessary” if it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. Existing law provides that for individuals under 21 years of age, “medically necessary” or “medical necessity” standards are governed by the definition in federal law. This bill would provide that the above-specified medical necessity standards do not preclude coverage for, and reimbursement of, a clinically appropriate and covered mental health or substance use disorder assessment, screening, or treatment service before a provider renders a diagnosis.

Primary Sponsors
Jim Wood
Title
Specialty mental health services and substance use disorder treatment.

Description
AB 2055, as amended, Wood. Specialty mental health services and substance use disorder treatment. (1) 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, including behavioral health services, which encompass specialty mental health services and substance use disorder treatment that are provided under the Medi-Cal Specialty Mental Health Services Program, the Drug Medi-Cal Treatment Program, and the Drug Medi-Cal organized delivery system, respectively. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions, and specialty mental health services and substance use disorder treatment are funded through certified public expenditures. Existing law requires the department to implement managed mental health care for purposes of delivering specialty mental health services to Medi-Cal beneficiaries through contracts with county mental health plans. Existing law, the Medi-Cal 2020 Demonstration Project Act, requires the department to implement specified components of a Medi-Cal demonstration project, including the Global Payment Program, the Whole Person Care pilot program, and the Dental Transformation Initiative, consistent with the Special Terms and Conditions approved by the federal Centers for Medicare and Medicaid Services. Pursuant to existing law, the department has created a multiyear initiative, the Medi-Cal Healthier California for All initiative, for purposes of building upon the outcomes of various Medi-Cal pilots and demonstration projects, including the Medi-Cal 2020 demonstration project. This bill would require the department to establish, implement, and administer the Behavioral Health Quality Improvement Program to assist county mental health plans and counties that administer the Drug Medi-Cal Treatment Program or the Drug Medi-Cal organized delivery system for purposes of preparing those entities for implementation of the behavioral health components included in the Medi-Cal Healthier California for All initiative, and would establish in the State Treasury the Behavioral Health Quality Improvement Account to fund those efforts. The bill would require the department to determine the methodology and distribution of funds appropriated to those entities. The bill would authorize the department to implement these provisions by various means, including provider bulletin, without taking regulatory action, and to enter into contracts that would be exempt from specified provisions of state contracting requirements. The bill would condition the implementation of these provisions to the extent that the department determines that federal fin... (click bill link to see more).

Primary Sponsors
Jim Wood

(1) Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services and under which health care services are provided to qualified low-income persons pursuant to a schedule of benefits, which includes pharmacy benefits, through various health care delivery systems, including fee-for-service and managed care. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law authorizes the department to enter into various types of contracts for the provision of services to beneficiaries, including contracts with a managed care plan. Existing law generally requires Medi-Cal managed care plan contractors to be licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975. The Knox-Keene Health Care Service Plan Act provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Under this act, a health care service plan is required to provide an external, independent review process, which meets prescribed standards, to examine the plan’s coverage decisions on experimental or investigational therapies for an enrollee who meets specified criteria, including that the enrollee was denied coverage by the plan for a drug, device, procedure, or other therapy recommended or requested. Existing law requires the Department of Managed Health Care to establish the Independent Medical Review System, which generally serves to address grievances involving disputed health care services. By executive order, the Governor directed the department to transition pharmacy services for Medi-Cal managed care to a fee-for-service benefit by January 1, 2021. Existing law requires the department to convene an advisory group to receive feedback on the changes, modifications, and operational timeframes on the implementation of pharmacy benefits offered in the Medi-Cal program, and to provide regular updates on the pharmacy transition, including a description of changes in the division of responsibilities between the department and managed care plans relating to the transition of the outpatient pharmacy benefit to fee-for-service. This bill would require the department to establish the Independent Prescription Drug Medical Review System (IPDMRS), commencing on January 1, 2021, which generally models the above-described requirements of the Knox-Keene Health Care Service Plan Act. The bill would provide that any Medi-Cal beneficiary grievance involving a disputed health care service is eligible for review under the IPDMRS, and would define “disputed health care service” as any outpatient prescription drug eligible for coverage and payment by the Medi-Cal prog... (click bill link to see more).

Primary Sponsors
Jim Wood

Organizational Notes
Last edited by Cherie Compartore at Mar 3, 2020, 7:07 PM
Organization Sponsor: CA Pharmacists Association, Western Center on Law & Poverty
Title
Health care service plans and health insurers: reporting requirements.

Description
AB 2118, as amended, Kalra. Health care service plans and health insurers: reporting requirements. 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 offering a contract or policy in the individual, small, and large group markets to file specified information, including total earned premiums and total incurred claims for each contract or policy form, with the appropriate department at least 120 days before implementing a rate change. Existing law requires a large group market health care service plan or insurer to report additional information relating to cost sharing and specified aggregate rate information. Existing law requires the Department of Managed Health Care and the Department of Insurance to conduct an annual public meeting regarding large group rates. This bill would expand reporting requirements for health care service plans and health insurers, for products in the individual and small group markets to include, for rates effective during the 12-month period ending January 1 of the following year, specified information on premiums, cost sharing, benefits, enrollment, and trend factors as reported in all rate filings for the health care service plan or insurer, including both price and utilization. The bill would exclude specified information from the reporting requirements until January 1, 2023. The bill would require each department, beginning in 2022, to annually present the information required by the bill at the meeting regarding large group rates and at a public meeting of the board of Covered California, as specified. Because a violation of the bill 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
Ash Kalra

Organizational Notes
Last edited by Joanne Campbell at May 18, 2020, 9:16 PM
Organization Sponsor: Health Access CAHP: Opposed Unless Amended
Health care coverage: step therapy.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene), 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 authorizes a health insurer to require step therapy if there is more than one drug that is appropriate for the treatment of a medical condition, and authorizes a health care service plan to utilize step therapy consistent with Knox-Keene.

Under existing law, if a health care service plan, health insurer, or contracted physician group fails to respond to a completed prior authorization request from a prescribing provider within a specified timeframe, the prior authorization request is deemed to have been granted. This bill would clarify that a health care service plan may require step therapy if there is more than one drug that is appropriate for the treatment of a medical condition. The bill would require a health care service plan or health insurer to expeditiously grant a step therapy exception if specified criteria are met. The bill would authorize an enrollee or insured or their designee, guardian, primary care physician, or health care provider to file an appeal of a prior authorization or the denial of a step therapy exception request, and would require a health care service plan or health insurer to designate a clinical peer to review those appeals. The bill would require a health care service plan, health insurer, or utilization review organization to annually report specified information about their step therapy exception requests and prior authorization requests to the Department of Managed Health Care or the Department of Insurance, as appropriate. The bill would require a prior authorization request or step therapy exception request to be deemed to have been granted if a health care service plan, health insurer, or contracted physician group fails to send an approval or denial within a specified timeframe. 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.
Title
Health care coverage: independent dispute resolution process.

Description
AB 2157, as introduced, Wood. Health care coverage: independent dispute resolution process. Existing law provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and provides for the regulation of health insurers by the Department of Insurance. Existing law requires each department to establish an independent dispute resolution process to resolve a claim dispute between a health care service plan or health insurer, as appropriate, and a noncontracting individual health professional, and sets forth requirements and guidelines for that process, including contracting with an independent organization for the purpose of conducting the review process. Existing law requires each department to establish uniform written procedures for the submission, receipt, processing, and resolution of these disputes, as specified. Existing law requires the independent organization, in deciding the dispute, to base its decision regarding the appropriate reimbursement on all relevant information. This bill would require the procedures established by each department to include a process for each party to submit into evidence information that will be kept confidential from the other party, in order to preserve the confidentiality of the source contract. The bill would specifically require the independent organization to conduct a de novo review of the claim dispute, based solely on the information and documents timely submitted into evidence by the parties. The bill would require the independent organization to assign reviewers to each case based on their relevant education, background, and medical claims payment and clinical experience.

Primary Sponsors
Jim Wood

Introduction Date: 2020-02-10
Health care coverage.

Description
AB 2158, as introduced, Wood. Health care coverage. Existing federal law, the Patient Protection and Affordable Care Act (PPACA), enacts various health care market reforms. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a group or individual health care policy issued, amended, renewed, or delivered on or after September 23, 2010, to comply with the requirements of the PPACA, and any rules or regulations issued under the PPACA, that require a group health plan and health insurance issuer offering group or individual health insurance coverage to, at a minimum, provide coverage for specified preventive services, and prohibits the plan or health insurance issuer from imposing any cost-sharing requirements for those preventive services. Existing law requires a health insurer to comply with those provisions to the extent required by federal law. This bill would delete the requirement that a health insurer comply with the requirement to cover preventive health services without cost sharing to the extent required by federal law, and would instead require a group or individual health insurance policy to, at a minimum, provide coverage for specified preventive services without any cost-sharing requirements for those preventive services, thereby indefinitely extending those requirements.

Primary Sponsors
Jim Wood
Health care coverage.

AB 2159, as introduced, Wood. Health care coverage. The federal Patient Protection and Affordable Care Act (PPACA) enacts various health care market reforms. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health insurer that issues, sells, renews, or offers plan contracts for health care coverage in the state to comply with the requirements of the PPACA, and any rules or regulations issued under the PPACA, that generally prohibit a health insurer offering group or individual coverage from imposing lifetime or annual limits on the dollar value of benefits for an insured. Existing law requires an insurer to comply with those provisions to the extent required by federal law. This bill would delete the requirement that a health insurer comply with the prohibition on lifetime or annual limits to the extent required by federal law, and would instead prohibit an individual or group health insurance policy from establishing lifetime or annual limits on the dollar value of benefits for an insured, thereby indefinitely extending the prohibitions on lifetime or annual limits.

Primary Sponsors
Jim Wood
Title
Telehealth.

Description
AB 2164, as amended, Robert Rivas. Telehealth. Existing law provides for the Medi-Cal program, which is administered by the department, 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. FQHC and RHC services are reimbursed, to the extent that federal financial participation is obtained, to providers on a per-visit basis, and a "visit" is defined as a face-to-face encounter between a patient of an FQHC or RHC and specified health care professionals, including dental providers. Existing law prohibits a requirement of in-person contact between a health care provider and a Medi-Cal patient when the service may be provided by telehealth, and, for purposes of telehealth, prohibits the department from limiting the type of setting where Medi-Cal services are provided. Existing law authorizes, to the extent that federal financial participation is available, the use of health care services by store and forward under the Medi-Cal program, subject to billing and reimbursement policies developed by the department, and prohibits a requirement of in-person contact between a health care provider and a Medi-Cal patient when these services are provided by store and forward. This bill would provide that an FQHC or RHC "visit" includes an encounter between an FQHC or RHC patient and a health care provider using telehealth by synchronous real time or asynchronous store and forward. The bill would clarify, for purposes of an FQHC or RHC visit, that face-to-face contact between a health care provider and a patient is not required for an FQHC or RHC to bill for telehealth by synchronous real time or asynchronous store and forward if specified requirements are met, including that a billable provider in the Medi-Cal program, and who is employed by the FQHC or RHC, supervises or provides the services for that patient via telehealth by synchronous real time or asynchronous store and forward.

Primary Sponsors
Robert Rivas, Rudy Salas, Jim Wood

Organizational Notes
Last edited by Joanne Campbell at Jun 17, 2020, 5:05 PM
LHPC - Support
Eligibility: redetermination.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law provides for the suspension of Medi-Cal benefits to an inmate of a public institution, and requires county welfare departments to notify the department within 10 days of receiving information that an individual who is receiving Medi-Cal is or will be an inmate of a public institution. Existing law generally requires a county to redetermine a Medi-Cal beneficiary's eligibility to receive Medi-Cal benefits every 12 months and whenever the county receives information about changes in a beneficiary's circumstances that may affect their eligibility for Medi-Cal benefits. This bill would require a county welfare department to conduct a redetermination of eligibility for the Medi-Cal program for any juvenile who is either detained at a juvenile detention center or an inmate of a public institution, and would provide that Medi-Cal eligibility be restored upon their release from that facility if they meet eligibility requirements. Because counties are required to make Medi-Cal eligibility determinations, and the bill would expand Medi-Cal determinations of eligibility for eligible juveniles in public institutions, 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, 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
Blanca Rubio

Title
Eligibility: redetermination.

Description
AB 2170, as introduced, Blanca Rubio. Eligibility: redetermination. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law provides for the suspension of Medi-Cal benefits to an inmate of a public institution, and requires county welfare departments to notify the department within 10 days of receiving information that an individual who is receiving Medi-Cal is or will be an inmate of a public institution. Existing law generally requires a county to redetermine a Medi-Cal beneficiary's eligibility to receive Medi-Cal benefits every 12 months and whenever the county receives information about changes in a beneficiary's circumstances that may affect their eligibility for Medi-Cal benefits. This bill would require a county welfare department to conduct a redetermination of eligibility for the Medi-Cal program for any juvenile who is either detained at a juvenile detention center or an inmate of a public institution, and would provide that Medi-Cal eligibility be restored upon their release from that facility if they meet eligibility requirements. Because counties are required to make Medi-Cal eligibility determinations, and the bill would expand Medi-Cal determinations of eligibility for eligible juveniles in public institutions, 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, 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
Blanca Rubio
Title
Insulin cost-sharing cap.

Description
AB 2203, as amended, Nazarian. Insulin cost-sharing cap. 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 requires every health care service plan contract that covers hospital, medical, or surgical expenses to include coverage for specified equipment and supplies for the management and treatment of diabetes. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health insurance policy issued, amended, delivered, or renewed on or after January 1, 2000, to include coverage for specified equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes as medically necessary, even if the items are available without a prescription. Existing law requires a health insurance policy issued, amended, delivered, or renewed on or after January 1, 2000, that covers prescription benefits to include coverage for specified diabetes management prescription items, including insulin and glucagon. This bill would prohibit a health care service plan contract or a health insurance policy that is issued, amended, delivered, or renewed on or after January 1, 2021, from imposing cost sharing on a covered insulin prescription, except for a copayment not to exceed $50 per 30-day supply of insulin, and no more than $100 total per month, regardless of the amount or type of insulin. The bill would apply these cost-sharing limitations until January 1, 2024. The bill would also authorize the Attorney General to investigate pricing of prescription insulin drugs to ensure adequate pricing protections for consumers, and would authorize the Attorney General, by November 1, 2022, to issue and make publicly available a report detailing its findings from any insulin pricing investigations. The bill would exempt trade secret or proprietary business information submitted to the Attorney General pursuant to these provisions from specified disclosure requirements. The bill would make these provisions applicable until January 1, 2024. Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest. This bill would make legislative findings to that effect. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions... (click bill link to see more).

Primary Sponsors
Adrin Nazarian

Organizational Notes
Last edited by Joanne Campbell at May 18, 2020, 9:15 PM
Organization Sponsor: American Diabetes Association CAHP: Opposed
Title
Transgender Wellness and Equity Fund.

Description
AB 2218, as amended, Santiago. Transgender Wellness and Equity Fund. Existing law establishes an Office of Health Equity in the State Department of Public Health for purposes of aligning state resources, decisionmaking, and programs to accomplish certain goals related to health equity and protecting vulnerable communities. Existing law requires the office to develop department-wide plans to close the gaps in health status and access to care among the state's diverse racial and ethnic communities, women, persons with disabilities, and the lesbian, gay, bisexual, transgender, queer, and questioning communities, as specified. This bill would establish the Transgender Wellness and Equity Fund, under the administration of the office, for the purpose of funding grants, upon appropriation by the Legislature, to transgender-led (Trans-led) organizations and hospitals, health care clinics, and other medical providers that provide gender-conforming health care services and have an established partnership with a Trans-led organization, to create, or fund existing, programs focused on coordinating trans-inclusive health care, as defined, for people that identify as transgender, gender nonconforming, or intersex.

Primary Sponsors
Miguel Santiago, Scott Wiener

Introduction Date: 2020-02-12
Title
Medi-Cal: Blood lead screening tests.

Description
AB 2276, as amended, Reyes. Medi-Cal: Blood lead screening tests. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law authorizes the department to enter contracts with managed care plans to provide Medi-Cal services, and imposes requirements on the Medi-Cal managed care plans, including network adequacy standards. Under existing law, Medi-Cal covers early and periodic screening, diagnostic, and treatment for individuals under 21 years of age, consistent with federal law. This bill would require the department to ensure that a Medi-Cal beneficiary who is a child receives blood lead screening tests at specified ages consistent with state regulatory standards, and would require a contract between the department and a Medi-Cal managed care plan to ensure that the Medi-Cal managed care plan and its contracting health care providers who are responsible for performing a periodic health assessment of a child meet specified standard of care requirements relating to blood lead testing. The bill would require the department to report its progress toward blood lead screening tests for Medi-Cal beneficiaries who are children, as specified, annually on its internet website. The bill would require each Medi-Cal managed care plan to establish a monitoring system related to blood lead screening tests, to require its contracting health care providers who are responsible for performing a periodic health assessment of a child to test each child pursuant to specified standards of care for lead testing, to inform a child's parent, parents, guardian, or other person charged with their support and maintenance with specified information, including the risks and effects of lead exposure, and to notify a child's health care provider when that child has missed a required blood lead screening test. The bill would provide that it is the goal of the state that children at risk of lead exposure receive blood lead screening tests.

Primary Sponsors
Eloise Reyes, Cristina Garcia, Bill Quirk, Rudy Salas, Connie Leyva
Title
Medi-Cal: Blood lead screening tests.

Description
AB 2277, as amended, Salas. Medi-Cal: Blood lead screening tests. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law authorizes the department to enter contracts with managed care plans to provide Medi-Cal services. Under existing law, Medi-Cal covers early and periodic screening, diagnostic, and treatment services for individuals under 21 years of age, consistent with federal law. This bill would require any contract between the department and a Medi-Cal managed care plan to impose requirements on the Medi-Cal managed care plan to identify every enrollee who does not have a record of completing those tests at 12 and 24 months of age, and to remind the contracting health care provider who is responsible for performing a periodic health assessment of a child of the need to perform those tests. The bill would require the department to develop and implement procedures, and take enforcement action, as prescribed, to ensure that a Medi-Cal managed care plan performs those duties. If a Medi-Cal managed care plan enrollee who is a child misses a required blood lead screening test at 12 and 24 months of age, the bill would require the Medi-Cal managed care plan to notify specified individuals responsible for that child, including the parent or guardian, about those missed blood lead screening tests, and would require that notification to be included as part of an annual notification on preventive services.

Primary Sponsors
Rudy Salas, Cristina Garcia, Bill Quirk, Eloise Reyes, Connie Leyva
Title
Lead screening.

Description
AB 2278, as amended, Quirk. Lead screening. Existing law requires the State Department of Public Health to maintain an electronic database to support electronic laboratory reporting of blood lead tests, management of lead-exposed children, and assessment of sources of lead exposures. Existing law requires a laboratory that performs a blood lead analysis on human blood drawn in California to report specified information, including the test results and the name, birth date, and address of the person tested, to the department for each analysis on every person tested. Existing law authorizes the department to share the information reported by a laboratory with, among other entities, the State Department of Health Care Services for the purpose of determining whether children enrolled in Medi-Cal are being screened for lead poisoning and receiving appropriate related services. This bill also would additionally require a laboratory that performs a blood lead analysis to report to the department, among other things, the Medi-Cal identification number and medical plan identification number, if available, for each analysis on every person tested.

Primary Sponsors
Bill Quirk, Cristina Garcia, Tim Grayson, Eloise Reyes, Rudy Salas, Connie Leyva
Title
Information privacy: digital health feedback systems.

Description
AB 2280, as introduced, Chau. Information privacy: digital health feedback systems. Existing law, the Confidentiality of Medical Information Act, generally prohibits a provider of health care, a health care service plan, or a contractor from disclosing medical information regarding a patient of the provider of health care or an enrollee or subscriber of a health care service plan without first obtaining an authorization, except as otherwise specified. Existing law defines “medical information” for purposes of these provisions to mean certain individually identifiable health information in possession of or derived from a provider of health care, among others. 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 define “personal health record information” for purposes of the act to mean individually identifiable information, in electronic or physical form, about an individual's mental or physical condition that is collected by an FDA-approved commercial internet website, online service, or product that is used by an individual at the direction of a provider of health care with the primary purpose of collecting the individual's individually identifiable personal health record information through a direct measurement of an individual's mental or physical condition or through user input regarding an individual's mental or physical condition. The bill would provide that a business that offers personal health record software or hardware to a consumer, in order to make information available to an individual or provider of health care at the request of the individual or provider of health care, for purposes of allowing the individual to manage their information, or for the diagnosis, treatment, or management of a medical condition of the individual, shall be deemed to be a provider of health care subject to the requirements of the Confidentiality of Medical Information Act. Because the bill would expand the definition 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
Ed Chau
**Title**
Nursing programs: state of emergency.

**Description**
AB 2288, as amended, Low. Nursing programs: state of emergency. Existing law, the Nursing Practice Act, provides for the licensure and regulation of the practice of nursing by the Board of Registered Nursing and requires an applicant for licensure to have completed a nursing program at a school of nursing that is approved by the board. Existing regulatory law sets forth curriculum requirements for nursing programs, including preceptorships and clinical practice hours, and also requirements for clinical facilities that may be used for clinical experience. This bill would authorize the director of an approved nursing program to use a clinical setting without meeting specified requirements, including approval by the board, when the Governor declares a state of emergency in the county in which the facility is located. The bill would also authorize the director to use preceptorships without having to maintain written policies on specified matters that would otherwise be required, and to request that the approved nursing program be allowed to substitute up to an additional 25% of clinical practice hours in a course not in direct patient care, subject to specified conditions and requirements. The bill would make those provisions subject to approval by a board nurse education consultant and would require the board nurse education consultant to use a uniform standard for granting approvals.

**Primary Sponsors**
Evan Low

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**Introduction Date:** 2020-02-14
Health care coverage: financial assistance.

AB 2347, as amended, Wood. Health care coverage: financial assistance. 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 (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. Until January 1, 2023, existing law requires the Exchange to administer a program of financial assistance, and authorizes the program to provide assistance, including premium assistance subsidies, to program participants with household incomes at or below 600% of the federal poverty level. This bill, contingent upon an appropriation by the Legislature, would reduce premiums to zero for program participants with household incomes at or below 138% of the federal poverty level, and would scale the premium assistance subsidy amount for program participants with household incomes of 139% to 600%, inclusive, of the federal poverty level pursuant to the program design adopted by the board of the Exchange.

Primary Sponsors
Jim Wood

Organizational Notes
Last edited by Cherie Compartore at Feb 20, 2020, 9:50 PM
Organization Sponsor: Health Access
Title
Pharmacy benefit management.

Description
AB 2348, as amended, Wood. Pharmacy benefit management.
Existing law provides for the regulation of health care service plans by the Department of Managed Health Care. A willful violation of those provisions is a crime. Existing law requires health care service plans that cover prescription drug benefits and contract with pharmacy providers and pharmacy benefit managers to meet specified requirements, including requiring pharmacy benefit managers with whom they contract to register with the department and exercise good faith and fair dealing, among other requirements. Existing law provides for the registration and regulation of pharmacy benefit managers, as defined, that contract with health care service plans to manage their prescription drug coverage. Under existing law, a pharmacy benefit manager is required to submit specified information to the department to apply to register with the department. This bill would require a pharmacy benefit manager to, beginning October 1, 2021, annually report specified information to the department regarding the covered drugs dispensed at a pharmacy and specified information about the pharmacy benefit manager’s revenue, expenses, health care service plan contracts, the scope of services provided to the health care service plan, and the number of enrollees that the pharmacy benefit manager serves. The bill would require the department to compile this reported information and make the report publicly available, as specified, but would exempt records other than the report from public disclosure. The bill would include in the requirements that health care service plans are required to impose on a pharmacy benefit manager with which they contract, the requirement that the pharmacy benefit manager comply with these reporting requirements. 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. Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest. This bill would make legislative findings to that effect.

Primary Sponsors
Jim Wood
Title
Telehealth: mental health.

Description
AB 2360, as amended, Maienschein. Telehealth: mental health.
Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of that act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plan contracts and health insurance policies that provide hospital, medical, or surgical coverage to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses, as defined, of a person of any age. Existing law also requires health care service plans and health insurers, by July 1, 2019, to develop maternal mental health programs, as specified. This bill would require health care service plans and health insurers, by January 1, 2021, to establish a telehealth consultation program that provides providers who treat children and pregnant and postpartum persons with access to a psychiatrist, as specified, in order to more quickly diagnose and treat children and pregnant and postpartum persons suffering from mental illness. The bill would require the consultation to be done by telephone or telehealth video, and would authorize the consultation to include guidance on providing triage services and referrals to evidence based treatment options, including psychotherapy. The bill would require health care service plans and insurers to communicate information relating to the telehealth program at least twice a year in writing. The bill would require health care service plans and health insurers to maintain records and data pertaining to the utilization of the program and the availability of psychiatrists in order to facilitate ongoing changes and improvements, as necessary. The bill would exempt certain specialized health care service plans and health insurers from these provisions. Because a willful violation of the bill's requirement 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
Brian Maienschein

Organizational Notes
Last edited by Joanne Campbell at May 18, 2020, 9:15 PM
Organization Sponsor: 2020 Mom CAHP: Opposed
Title
Lead testing.

Description
AB 2422, as introduced, Grayson. Lead testing. Existing law, the Childhood Lead Poisoning Prevention Act of 1991, requires the State Department of Public Health to adopt regulations establishing a standard of care at least as stringent as the most recent United States Centers for Disease Control and Prevention screening guidelines, whereby all children are evaluated for risk of lead poisoning by health care providers during each child's periodic health assessment. Existing law requires the standard of care for a child who is determined to be "at risk" for lead poisoning to include the screening of that child. Existing regulations require every health care provider who performs a periodic health assessment of a child to order a child who receives services from a publicly funded program for low-income children to be screened for lead poisoning. Existing law requires a laboratory that performs a blood lead analysis on a specimen of human blood drawn in California to report specified information to the department for each analysis on every person tested. Existing law requires that all information reported be confidential, except that the department is authorized to share the information for the purpose of surveillance, case management, investigation, environmental assessment, environmental remediation, or abatement with the local health department, environmental health agency, or building department, so long as the entity receiving the information otherwise maintains the confidentiality of the information, as specified. Existing law requires the State Department of Public Health to implement and administer a program to meet the requirements of the federal Residential Lead-Based Paint Hazard Reduction Act of 1992. Among other things, the program requires the department to establish certification requirements for persons conducting lead-related construction work, abatement, or lead hazard evaluation. Existing regulations require specified information relating to hazard evaluations for public and residential buildings to be provided to the department. This bill would add to the information that a laboratory is required to provide the Medi-Cal identification number, or other equivalent medical identification number of the person tested. The bill would require, if the person tested is a minor, that the laboratory include the person's contact information and a unique identifier, in a form to be determined by the department, as specified. This bill would require the department to develop and maintain on its internet website a public registry of lead-contaminated locations reported to the department pursuant to the provisions relating to lead hazards in buildings. The bill would require the department to ensure that personally identifiable... (click bill link to see more).

Primary Sponsors
Tim Grayson
Title
Emergency ground medical transportation.

Description
AB 2625, as introduced, Boerner Horvath. Emergency ground medical transportation. 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 emergency medical transportation services. This bill would require a health care service plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2021, that offers coverage for emergency ground medical transportation services to include those services as in-network services and would require the plan or insurer to pay those services at the contracted rate pursuant to the plan contract or policy. 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 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
Tasha Boerner Horvath
Title: Medi-Cal: presumptive eligibility.

Description:
AB 2729, as introduced, Bauer-Kahan. Medi-Cal: presumptive eligibility. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing federal law, as a condition of receiving federal Medicaid funds, requires states to provide health care services to specified individuals. Existing federal law authorizes states to provide presumptive eligibility to pregnant women or children, and existing state law requires the department to provide presumptive eligibility to pregnant women and children, as specified. Under existing law, a minor may consent to pregnancy prevention or treatment services without parental consent. Under existing law, an individual under 21 years of age who qualifies for presumptive eligibility is required to go to a county welfare department office to obtain approval for presumptive eligibility. This bill would expand the presumptive eligibility for pregnant women to all pregnant people, renaming the program “Presumptive Eligibility for Pregnant People” (PE4PP). The bill would make a presumptively eligible pregnant person eligible for coverage of all medical care, services, prescriptions, and supplies available under the Medi-Cal program, except for inpatient services and institutional long-term care. The bill would also require the department to ensure that a pregnant person receiving coverage under PE4PP who applies for full-scope Medi-Cal benefits within 60 days receives coverage under PE4PP until their full-scope Medi-Cal application is approved or denied, as specified. The bill would allow a pregnant individual under 26 years of age who can consent to services without parental approval to receive presumptive eligibility by a qualified hospital. The bill would also make conforming changes. Because counties are required to make eligibility determinations, and this bill would expand Medicaid eligibility, 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, 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
Rebecca Bauer-Kahan
Title
Timely access to health care.

Description
AB 2775, as introduced, Ting. Timely access to health care. 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 also provides for the regulation of health insurers by the Department of Insurance. Existing law requires each department to develop and adopt regulations to ensure that enrollees and insureds have access to needed health care services in a timely manner, and existing regulations set forth these timely access standards for specified health care appointments. This bill would declare the intent of the Legislature to ensure that patients receive timely access to health care services, including nonemergency followup appointments with mental health care providers within 10 business days.

Primary Sponsors
Phil Ting

Organizational Notes
Last edited by Cherie Compartore at Mar 3, 2020, 7:41 PM
Organization Sponsor: National Union of Healthcare Workers
Title
Health Care Payments Data Program.

Description
AB 2830, as amended, Wood. Health Care Payments Data Program. Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene), provides for licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of that act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law, the Information Practices Act of 1977, regulates the collection and disclosure of personal information regarding individuals by state agencies, except as specified. Under existing law, a person who willfully requests or obtains a record containing personal information from an agency under false pretenses or a person who intentionally discloses medical, psychiatric, or psychological information held by an agency is guilty of a misdemeanor. Existing law states the intent of the Legislature to establish the Health Care Cost Transparency Database to collect information on the cost of health care, and requires the Office of Statewide Health Planning and Development to convene a review committee to advise the office on the establishment and implementation of the database. Existing law requires, subject to appropriation, the office to establish, implement, and administer the database by July 1, 2023. Existing law requires certain health care entities, including a health care service plan, to provide specified information to the office for collection in the database. This bill would delete those provisions relative to the Health Care Cost Transparency Database and would instead require the office to establish the Health Care Payments Data Program to implement and administer the Health Care Payments Data System, which would include health care data submitted by health care service plans, health insurers, a city or county that offers self-insured or multiemployer-insured plans, and other specified mandatory and voluntary submitters. The bill would require the Department of Managed Health care and the Department of Insurance to take appropriate action to bring a plan or insurer into compliance if the office notifies the appropriate department of a plan or insurer's failure to submit required data, and would specify that the failure of a health care service plan to submit required data is a violation of Knox-Keene. Because a willful violation of these provisions by a health care service plan would be a crime, and because a city or county that offers self-insured or multiemployer-insured plans would be required to submit health care data to the office, the bill would impose a state-mandated local program. This bill would require the office to use the above-described data to produce publicly available information, including data p... (click bill link to see more).

Primary Sponsors
Jim Wood

Organizational Notes
Last edited by Joanne Campbell at May 18, 2020, 9:17 PM
CAHP: Opposed Unless Amended
Title
Medi-Cal: substance use disorder services: reimbursement rates.

Description
AB 2871, as introduced, Fong. Medi-Cal: substance use disorder services: reimbursement rates. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services, including specialty mental health services and substance use disorder services that are delivered through the Medi-Cal Specialty Mental Health Services Program, the Drug Medi-Cal Treatment Program (Drug Medi-Cal), and the Drug Medi-Cal organized delivery system (DMC-ODS). The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under Drug Medi-Cal, the department is authorized to enter into contracts with counties for various drug treatment services to Medi-Cal recipients, or is required to directly arrange for these services if a county elects not to do so. Existing law specifies the method of determining the maximum allowable reimbursement rates for Drug Medi-Cal and group outpatient drug free services. Existing law requires the department to implement the Medi-Cal 2020 demonstration project, including the DMC-ODS that provides alcohol and drug use services to eligible persons and authorizes the department to enter into a DMC-ODS contract with a county for the provision of those services within a county service area. This bill would require the department, in establishing reimbursement rates for services under Drug Medi-Cal and capitated rates for a Medi-Cal managed care plan contract that covers substance use disorder services to ensure that those rates are equal to the reimbursement rates for similar services provided under the Medi-Cal Specialty Mental Health Services Program. The bill would also require the department to require its managed care contractors that cover substance use disorder services to set reimbursement rates for those services at equal rates to similar services provided under the Medi-Cal Specialty Mental Health Services Program.

Primary Sponsors
Vince Fong
Title
Pharmacies: automatic refills.

Description
AB 2983, as amended, Holden. Pharmacies: automatic refills. Existing law, the Pharmacy Law, provides for the licensure and regulation of pharmacists and pharmacies by the California State Board of Pharmacy, and makes a willful violation of those provisions a misdemeanor. Existing law prohibits a prescription for any dangerous drug or dangerous device to be refilled except upon authorization of the prescriber. This bill would, commencing January 1, 2022, prohibit a pharmacy from using an automated computer system to contact a prescriber to authorize a prescription for any dangerous drug or device to be refilled for more than a 30-day supply unless the prescriber or patient has authorized the pharmacy to do so. The bill would prohibit a pharmacy from requesting more than the number of refills authorized in the original prescription. The bill would exempt certain pharmacies owned or operated by a nonprofit health care service plan, as specified. Because the bill would expand the scope 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
Chris Holden
Title
Prescription drug cost sharing.

Description
AB 2984, as amended, Daly. Prescription drug 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 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 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 prohibit a health care service plan, health insurer, or a plan's or insurer's agents from publishing or otherwise revealing information regarding the actual amount of rebates the health care service plan or health insurer receives on a product-specific, manufacturer-specific, or pharmacy-specific basis. 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
Tom Daly
Medically supportive food.

Description
AB 3118, as amended, Bonta. Medically supportive food. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services, including enteral nutrition products, pursuant to a schedule of benefits, and subject to utilization controls, such as prior authorization. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law, until January 1, 2021, or as otherwise specified, requires the department to establish a 3-year pilot program in specified counties, including the Counties of Alameda and Sonoma, to provide medically tailored meals, as defined, to Medi-Cal participants with specified health conditions, such as cancer and renal disease. This bill would require the department to establish, no earlier than January 1, 2021, a pilot program for a 3-year period in the County of Alameda to provide medically supportive food, such as healthy food vouchers or renewable food prescriptions, as a covered benefit for a Medi-Cal beneficiary who has a specified chronic health condition, including diabetes or heart disease, when utilizing evidence-based practices that demonstrate the prevention, reduction, or reversal of those specified diseases. The bill would authorize the department, in consultation with stakeholders, to establish utilization controls, including the limitation on the number of services, and to enter into contracts for purposes of implementing the pilot program. The bill would require the department to evaluate the pilot program upon its conclusion, to report to the Legislature on those findings, and to implement these provisions by various means, including provider bulletins, without taking regulatory action. The bill would condition the implementation of these provisions to the extent permitted by federal law, the availability of federal financial participation, and the department securing federal approval, and would repeal these provisions on January 1, 2026. This bill would make legislative findings and declarations as to the necessity of a special statute for the County of Alameda.

Primary Sponsors
Rob Bonta
Title
Medi-Cal: antipsychotic drugs.

Description
AB 3285, as introduced, Irwin. Medi-Cal: antipsychotic drugs.
Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services and under which health care services are provided to qualified low-income persons pursuant to a schedule of benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law provides for the provision of prescription drugs as a Medi-Cal benefit, subject to the list of contract drugs and utilization controls. Existing law limits prescribed drugs under the Medi-Cal program to 6 drugs per month, unless prior authorization is obtained, and except under specified circumstances. This bill would prohibit requiring prior authorization for an antipsychotic drug to treat the serious mental illness of a Medi-Cal enrollee for 365 days after the initial prescription has been dispensed, and would require automatic approval of an antipsychotic drug to treat the serious mental illness of a Medi-Cal enrollee if the department verifies a paid claim that documents a diagnosis of a serious mental illness within 365 days before the date of that prescription. The bill would exclude an antipsychotic drug to treat serious mental illness from the Medi-Cal program’s limit of 6 drugs per month. The bill would require the department to allow a pharmacist to dispense a 90-day supply or early refill of a prescribed antipsychotic drug if specified criteria are met.

Primary Sponsors
Jacqui Irwin
Title
Homelessness: California Access to Housing and Services Act.

Description
AB 3300, as amended, Santiago. Homelessness: California Access to Housing and Services Act. Existing law establishes the Homeless Housing, Assistance, and Prevention program for the purpose of providing jurisdictions with one-time grant funds to support regional coordination and expand or develop local capacity to address their immediate homelessness challenges informed by a best-practices framework focused on moving homeless individuals and families into permanent housing and supporting the efforts of those individuals and families to maintain their permanent housing. Upon appropriation, existing law requires the Business, Consumer Services, and Housing Agency to distribute $650,000,000 among continuums of care, cities, and counties pursuant to the program. By executive order, the Governor required the Department of Finance to establish the California Access to Housing and Services Fund, administered by the State Department of Social Services, to provide funding for additional affordable housing units, providing rental and operating subsidies, and stabilizing board and care homes. This bill, the California Access to Housing and Services Act, would establish the California Access to Housing and Services Fund in the State Treasury and continuously appropriate moneys in the fund solely for the purpose of implementing and administering the bill's provisions. The bill, for the 2020–21 fiscal year and each fiscal year thereafter, would require, upon appropriation by the Legislature, the Controller to transfer up to $2,000,000,000 from the General Fund to the fund and require the Department of Housing and Community Development and the State Department of Social Services to jointly administer the fund pursuant to a memorandum of understanding, as provided. The bill would provide that deposits into the fund may also include, but are not limited to, other state funds; private, nonprofit, or philanthropic donations; local government contributions; and any recoveries or reversions resulting from activities pursuant to the act. The bill would require the departments, in collaboration with the California Health and Human Services Agency and after deduction for administrative costs and certain allocations to the Governor's Office to End Homelessness, if the bill establishing that office is enacted, to allocate 55% of the moneys in the fund to counties and continuums of care that apply jointly, 45% to large cities, and 5% to developers operating in unincorporated areas and cities that are not eligible for an allocation. The bill would define various terms for these purposes. The bill would require that recipients and subrecipients ensure that any expenditure of moneys allocated to them serve the eligible population, as defined,... (click bill link to see more).

Primary Sponsors
Miguel Santiago, Richard Bloom, Rob Bonta, Mike Gipson, Sharon Quirk-Silva, Buffy Wicks, Wendy Carrillo, Todd Gloria, Ash Kalra, Adrin Nazarian
Medi-Cal: federally qualified health centers and rural health clinics.

Description
AB 3344, as introduced, Gloria. Medi-Cal: federally qualified health centers and rural health clinics. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law provides that federally qualified health center (FQHC) services and rural health clinic (RHC) services, as defined, are covered benefits under the Medi-Cal program, to be reimbursed, to the extent that federal financial participation is obtained, to providers on a per-visit basis. This bill would make technical, nonsubstantive changes to those provisions.

Primary Sponsors
Todd Gloria