EXECUTIVE COMMITTEE MEETING

Board of Governors

April 26, 2021 • 2:00 PM

L.A. Care Health Plan

1055 W. 7th Street, Los Angeles, CA 90017
California Governor issued Executive Orders No. N-25-20 and N-29-20, which among other provisions amend the Ralph M. Brown Act. Accordingly, members of the public should now listen to this meeting via teleconference as follows:

To join and LISTEN ONLY via videoconference please register by using the link below:
https://lacare.webex.com/lacare/j.php?MTID=m1faf9dd65d18b167a6188483413e236f

To join and LISTEN ONLY via teleconference please dial: (213) 306-3065 or (415) 655-0002
Access code: 123 159 3631   Password: lacare

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 April 26, 2021 will be provided 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 agenda item is called by the meeting Chair. If you wish to submit public comment on a specific agenda item, you must submit it at any time prior to the time the Chair announces the item and asks for public comment. Please take note that if your public comment is not related to any of the agenda item topics, your public comment will be read in the general public comment agenda item.

Please note that there could be a delay in the digital transmittal of emails, texts and voicemail. The Chair will announce when public comment period is over. If your public comments are not received on time for the specific agenda item you want to address, your public comments will be read at the public comment section prior to the board going to closed session.

The purpose of public comment is that it is an opportunity for members of the public to inform the governing body about their views concerning items on the Agenda. The Board appreciates hearing the input as it considers the business on the Agenda.

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

Hector De La Torre, Chair

1. Approve today’s meeting Agenda
2. Public Comment (please see instructions above)   Chair
3. Approve March 22, 2021 Meeting Minutes p.5   Chair
4. Chair’s Report

5. Chief Executive Officer Report
   - Strategic Vision Progress Report

COMMITTEE ITEMS

6. Government Affairs Update

7. Revisions to Legal Services Policy LS-007 (Legal Hold of Records, Documents; Preservation of Evidence) (EXE 100)

8. Approve Funding to support Charles R. Drew University of Medicine and Science (EXE 101)

9. AB 2589 – Annual Disclosure of Broker Fees

10. Approve the list of items that will be considered on a Consent Agenda for May 6, 2021

   Board of Governors Meeting
   - Minutes of April 1, 2021 Board of Governors Meeting
   - Revisions to Legal Services Policy LS-007 (Legal Hold of Records, Documents; Preservation of Evidence)
   - Quarterly Investment Report
   - Microsoft Agreement Renewal

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

11. CONTRACT RATES

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

12. 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: April 2023

13. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION

   Significant exposure to litigation pursuant to Section 54956.9(d)(2) of Ralph M. Brown Act
   Two Potential Cases

14. CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION

   Significant exposure to litigation pursuant to Section 54956.9(d)(2) of Ralph M. Brown Act:
   One Potential case
RECONVENE IN OPEN SESSION

ADJOURN

The next Executive Committee is scheduled on Monday, May 24, 2021 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 in 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.

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.

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-25-20 and N-29-20, which among other provisions amend 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>
<th>ACTION TAKEN</th>
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| CALL TO ORDER         | Hector De La Torre, *Chairperson*, called to order the L.A. Care Executive Committee and the L.A. Care Joint Powers Authority Executive Committee meetings at 2:17 p.m. The meetings were held simultaneously. He welcomed everyone to the meetings.  
  • For those who provided public comment for this meeting by voice message or in writing, we are really glad that you provided input today. The Committee will hear your comments and we also have to finish the business on our Agenda today.  
  • If you have access to the internet, the materials for today’s meeting are available at the lacare.org website. If you need information about how to locate the meeting materials, please let us know.  
  • Information for public comment is on the Agenda available on the web site. Staff will read the comment from each person for up to three minutes.  
  • The Chairperson will invite public comment before the Committee starts to discuss the item. If the comment is not on a specific agenda item, it will be read at the general Public Comment item 2 on today’s agenda. |
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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. 6 AYES (Ballesteros, Booth, Curry, De La Torre, Gonzalez and Perez)</td>
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<td>PUBLIC COMMENTS</td>
<td>A public comment was removed at the request of the submitter.</td>
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<tr>
<td>APPROVE MEETING MINUTES</td>
<td>The minutes of the February 22, 2021 meeting were approved as submitted.</td>
<td>Approved unanimously by roll call. 6 AYES</td>
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<td>CHAIRPERSON’S REPORT</td>
<td>There was no report from the Chairperson.</td>
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<td>CHIEF EXECUTIVE OFFICER REPORT</td>
<td>John Baackes, Chief Executive Officer, reported:</td>
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<td>• L.A. Care has obtained and arranged for 16,000 doses of the Johnson &amp; Johnson COVID-19 vaccine to be administered. Beginning April 7, 2021, L.A. Care will conduct vaccination two-day clinics in the vicinity of each of L.A. Care’s Community Resource Centers (CRCs). Because of the number of the vaccines to be administered on a daily basis, the CRCs do not have capacity to handle the traffic, and L.A. Care has arranged for the clinics to be conducted at suitable locations which are near the CRCs. This came about through diligent effort by Richard Seidman, MD. MPH, Chief Medical Officer, with the Los Angeles County Department of Health, Yana Paulson, L.A. Care’s pharmacy Director, and the USC School of Pharmacy. The USC School of Pharmacy also helped L.A. Care administer flu vaccines last fall. Francisco Oaxaca, Chief of Communications and Community Relations, is working out a communication plan to members of L.A. Care’s Executive Community Advisory Committee (ECAC) and Regional Community Advisory Committees (RCACs), so they can avail themselves of the opportunity to receive a vaccine if qualified, and so they can help spread the word. This is a good step forward.</td>
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<td>• L.A. Care has had two months of good financial performance, which will be reported at the April 1 Board Meeting. Through February, 2021, there is a net gain of $68 million. An operating loss of $21 million had been projected. The positive financial report is the result of a lot of work by staff to efficiently manage L.A. Care’s expenses. All of the energy to reorganize for efficiency, eliminating redundancy</td>
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<td>across the organization, is moving along well. Those efforts will continue through the end of the year, and hope it will result in a positive outcome.</td>
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<td>The American Rescue Plan, a much-touted $1.9 trillion economic stimulus package, included an important item for the Covered California members, with provisions for increased premium subsidies. All eligible members, those with income up to 600% of the federal poverty level, will see an increase in the federal subsidy provided to help them pay the health coverage premium. L.A. Care is preparing for the changes in premium billing for all of the more than 100,000 L.A. Care Covered members, which will begin in April. This is good news for those members. Covered California, the statewide program, has extended the open enrollment period through December, 2021. This is also excellent news for anyone who needs to enroll for health coverage.</td>
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<td>The Biden Administration has removed public charge provisions from government sponsored health coverage programs. This is good news for hundreds of thousands of legal immigrants in Los Angeles who might have been penalized for accessing programs like Medi-Cal, in which they would be entitled to enroll. This should bring greater security for those who may not have been comfortable enrolling previously.</td>
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<td>Member Perez asked about the COVID-19 vaccine events. Mr. Baackes clarified that the schedule had been revised, and the correct schedule will be distributed to Committee members. Dr. Seidman added that getting confirmation of an adequate supply of vaccine to plan the events has been a challenge, as the supply is not yet sufficient to meet the demand for vaccines. The supply is expected to stabilize and to increase as we approach the month of April. L.A. Care has provided information about the vaccine events to the Los Angeles County Department of Public Health (DPH). DPH officials are excited and supportive, and have made a commitment to have 16,000 doses of the Johnson &amp; Johnson vaccine.</td>
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<td>Mr. Oaxaca announced that the first vaccine clinic will be held from 9 am to 5 pm on April 7, 2021 at Los Angeles City College. A full list of the vaccination schedule will be available. Direct telephone outreach will be conducted to all ECAC and RCAC members to pre-screen for eligibility to receive the vaccine. Those that are eligible will be connected with the appointment scheduling team.</td>
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<td>Member Gonzalez asked how the subsidies for L.A. Care Covered will be applied. Mr. Baackes reported that the revised subsidy will be effective April 1, 2021, and is not retroactive. Chairperson De La Torre noted that the increased subsidy may help some</td>
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### Government Affairs Update

Cherie Compartore, Senior Director, Government Affairs, reported:

- Last week the U.S. House of Representatives passed a bill that would provide a path to citizenship for “Dreamers”. The vote was largely along party lines, with nine Republicans voting for the bill. She reminded the Committee members that L.A. Care has supported a pathway to citizenship for Deferred Action for Childhood Arrivals (DACA) program participants. The bill will now be moved to the U.S. Senate for consideration. The Senate would need ten Republicans to vote for the bill to pass, which may not be possible. Legislation to provide a path to citizenship for Dreamers has been considered for about 30 years. L.A. Care continues to encourage passage of the bill, working with a national trade association, distributing a media statement, and speaking with legislators. There are approximately 700,000 Dreamers in California who would be impacted by passage of this legislation.

- Department of Homeland Security has announced that it will no longer consider receiving benefits through Medicaid, with exceptions, public housing, Cal-Fresh or Supplemental Nutrition Assistance Program (SNAP), as part of the public charge determination. The previous federal Administration had determined that those...
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<td>benefits would be counted against anybody applying for a “Green Card” in the United States, and it has now been rolled back to the same policy that was in place in 2009. The public charge will still apply to those that receive long term care coverage for Medicaid, as was in effect in 2009. It is believed that application of the public charge by the previous federal administration stopped people from applying or accessing those benefits for which they were eligible, out of fear of not being able to get a “Green Card”.</td>
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<td>Mr. Baackes added that L.A. Care is following developments in the prescription drug “carve out” proposed in California. There has been no clarity and the program is still in limbo, as the state determines what to do about a potential conflict of interest on the part of Magellan, the pharmacy benefit management firm that was selected. Health plans in California are asking for information about the implementation of the pharmacy benefit carve out.</td>
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<td>L.A. Care also continues to work with Department of Health Care Services (DHCS) representatives on details for the California Advancing and Innovating Medi-Cal (CalAIM) program, which becomes effective in January, 2022. L.A. Care is interested in determining the benefits to be offered through the Enhanced Care Management and In-Lieu-of Services segments of CalAIM. These two new programs offer great benefits for members and will take considerable coordination to implement. The Board will be updated on CalAIM at future meetings.</td>
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<td>Member Booth asked about a letter from Centers for Medicare and Medicaid Services (CMS) referencing the 1115 Waiver requests and the pharmacy carve out program. Mr. Baackes noted that the letter extends the 1115 Waiver until December 2021, that would have expired in December 2020. The extension means that Health Homes and Whole Person Care programs have continued to be funded through 2021. CMS has not directly opined on California’s proposed pharmacy carve out. California officials have not provided any clarity on the timeline for implementing the proposed pharmacy carve out. Member Ballesteros asked about the timeframe for notifying beneficiaries about the proposed pharmacy carve out. Mr. Baackes responded that there are notification requirements, and some notices were sent out for the original implementation date of January 1, 2021, before the DHCS sent notice to health plans that the program would be delayed. Health plans have recommended to DHCS that the proposed pharmacy benefit carve out should not occur until at least January 2022, or not at all, because starting this while the COVID 19 vaccination effort is underway could be enormously confusing.</td>
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### AGENDA ITEM/PRESENTER

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<td>The plans have also been quite clear that Magellan should not be retained as the PBM for the pharmacy carve out. Mr. Ballesteros stated that federally qualified health centers (FQHCs) have also recommended that the proposed pharmacy benefit carve out should not occur.</td>
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<td>Member Gonzalez asked if the proposed bill AB 13, Automated Decision Systems, would affect Medi-Cal members. Ms. Compartore noted that this is a consumer privacy bill, and she does not believe it would have a direct impact other than requiring that L.A. Care update its policies and procedures relating to beneficiaries who do not select a primary care provider upon enrollment.</td>
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<td>Chairperson De La Torre noted that bills under consideration by California’s State Legislature are just beginning the committee hearing process this month. It is likely that more detail will be known about the proposed legislation in May 2021. In the meantime, many of the bills will be withdrawn or not considered further.</td>
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**Revised Communications Policy COMM 006 (Sponsorships)**

Mr. Oaxaca summarized a motion to approve revisions to the Communication policy, COMM-006. The bulk of the revisions are to align the content of the policy with the most current policy template, which includes the addition of a policy summary (section 3.0), section 5.0- Monitoring and section 6.0- Reporting. An edit in section 4.2 to the internal administrative approval process is also included, to reflect recent updates to the electronic review and approval process. The approval process section was also updated so that Francisco Oaxaca, Chief of Communications and Community Relations, may approve updates to the policy on Compliance 360. He thanked Member Booth for sending her concerns and questions, which are addressed in the policy presented for consideration.

**Motion EXE 100.0421**

To approve revisions to Communications Policy COMM-006 (Sponsorships) as submitted.

Approved unanimously by roll call. 6 AYES

**Approve the Consent Agenda for April 1, 2021 Board of Governors meeting**

Approve the list of items that will be considered on a Consent Agenda for April 1, 2021 Board of Governors Meeting.

- Minutes of March 4, 2021 Board of Governors Meeting
- Revised Communications Policy COMM 006

Approved unanimously by roll call. 6 AYES

**PUBLIC COMMENTS**

There were no public comments for the closed session items.
<table>
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<tr>
<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 3:19 p.m.</td>
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<tr>
<td>CONTRACT RATES</td>
<td>Pursuant to Welfare and Institutions Code Section 14087.38(m)</td>
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<td>• Plan Partner Rates</td>
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<td>Pursuant to Welfare and Institutions Code Section 14087.38(n)</td>
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<td>Discussion Concerning New Service, Program, Business Plan</td>
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<td></td>
<td>Estimated date of public disclosure: March 2023</td>
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<td>CONFERENCE 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>Two Potential Cases</td>
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<tr>
<td>CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION</td>
<td>Initiation of litigation pursuant to Section 54956.9(d)(4) of Ralph M. Brown Act:</td>
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<td>One Potential Case</td>
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<tr>
<td>CONFERENCE WITH LABOR NEGOTIATOR</td>
<td>Section 54957.6 of the Ralph M. Brown Act</td>
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<td>Agency Designated Representative: Hector De La Torre</td>
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<td>Unrepresented Employee: John Baackes</td>
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<tr>
<td>RECONVENE IN OPEN SESSION</td>
<td>The meeting reconvened in open session at 3:29 pm. No reportable actions were taken during the closed session.</td>
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<td>ADJOURNMENT</td>
<td>The meeting adjourned at 3:31 p.m.</td>
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April 19, 2021

TO: Board of Governors

FROM : John Baackes, CEO

SUBJECT: 2nd Quarter FY 2020-21 Vision 2021 Progress Report

This report summarizes the progress made on the activities outlined in Vision 2021, L.A. Care’s Strategic Plan. This is the second quarterly report for the 2020-21 fiscal year, which represents the third and final year of our three-year plan. We continued to make steady progress this quarter while remaining adaptable and responsive to the ongoing COVID-19 pandemic.

L.A. Care’s notable second quarter activities include:

- L.A. Care’s Direct Network activated an additional 200 specialists, continuing county-wide network adequacy improvements.
- L.A. Care Community Link added functionality to allow the upload of documents to its secure servers. When enabled, this technology will allow L.A. Care to share documentation needed to complete referrals to address social determinants of health.
- Continued to focus on our multi-year, multi-faceted systems improvement projects (for customer service, financial management, provider data management, care management, and encounter management).
- Diversity, Equity and Inclusion training began with the L.A. Care Quality Improvement (QI) staff; an outside vendor will begin training of the entire staff next quarter.
- Full construction was in progress for Norwalk, El Monte, and Wilmington Community Resource Center (CRC) sites.
### 1 High Performing Enterprise

A high functioning health plan with clear lines of accountability, processes, and people that drive efficiency and excellence.

**Goal 1.1**
Achieve operational excellence through improved plan functionality.

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<tr>
<th>Key Activities</th>
<th>Status</th>
<th>Update</th>
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<tr>
<td>Enhance the systems, tools, and processes to improve customer service through the Voice of the Customer (VOICE) initiative.</td>
<td>💚</td>
<td>VOICE began Q2 deployment of system enhancements designed to better capture and maintain a member's contact consent (TCPA), including the option to opt-out of Automatic Health Care Coverage Enrollment (SB260). VOICE is also working towards rebranding the voice of L.A. Care with a persona that better resonates with our local community. Expected delivery of this is end of fiscal year 2021. The program has also reinforced our telecommunications infrastructure to ensure members never experience call failures and can reach our agents 24/7. In February, we completed an upgrade to the Quality Assurance (QA) infrastructure that now provides more robust data, allowing our QA unit to identify areas of improvement and coaching opportunities. This will continue to keep us aligned with our commitment to providing optimal customer service. Additional system enhancements are underway within the Customer Solutions Center to promote efficiency and improved user experience. Work continues on the development of the member data lake and the automation of PCP assignment/changes with the goal of capturing an array of member preferences, reduce transaction times, and improve transactional accuracy. These are scheduled to deploy late Q4.</td>
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<td>Improve business functions related to financial management with the Enterprise Resource Platform (ERP).</td>
<td>💚</td>
<td>During Q2, the project team continued to develop test cases for testing business scenarios from all integration points including SAP, QNXT, Payspan, BofA, claims, supplemental files, shared risk, payment recovery and capitation. The SAP development activities were substantially completed and integration was in progress. Due to delays in getting quality data samples to Payspan and other factors, the project</td>
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**Color Indicator Legend**
- Green – On target, no issues
- Yellow – Some issues, probable risks, concerns
- Red – Major issues, high risk
- Blue – Complete
## Key Activities

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| **team agreed to extend the claims implementation with the vendor by four weeks. In order to reduce the possibility of separate go-live dates and the business utilizing multiple systems for end-to-end processing, the project team, along with management, agreed to a new go-live date for all functionally of 5/1/2021. The teams continue to focus on testing and preparation of the new go-live.**  

Phase 1 of the ERP program officially closed out in February 2021. |
| **Modernize provider data management through continued operations of the Total Provider Management (TPM) initiative.**  

As a result of the integrated provider data strategy, L.A. Care has executed the SPF ingestion of a single PPG, Angeles IPA, as stated in the Q1 update. Following the ingestion of the file into our core data system, MPD, both IT and the Provider Network Management (PNM) teams began to audit the ingestion to identify if there were any anomalies. To date, the teams have identified several concerns with the ingestion which include items that were in scope and out of scope for the DQYE implementation. As a part of our refined integrated provider data strategy, the decision has been made to place a hold on SPF ingestions and focus efforts on six major items:  
1. Remediation of the data loaded into MPD incorrectly  
2. Development of an enhanced disposition report to identify the flow of all data from the SPF into downstream systems, a view required to perform a comprehensive audit of the ingestion  
3. Development of an orphan provider report to identify those providers who are active in our internal systems but not included in the group’s SPF, indicating the providers may need to be terminated and members moved, where applicable  
4. Implementation of the Symphony utility to immediately begin cleansing the provider data in our systems for all L.A. Care providers  
5. Developing a Target State for provider data and the associated roadmap to achieve that Target State  
6. Moving the PNOR database technology to the IT infrastructure for ongoing management |
| **Improve coordination of care for members with the Care Catalyst initiative, and the Population Health Management System (SyntraNet/Thrasys).**  

Workflows, desktop procedures, and other training materials were developed and disseminated. Hands-on SyntraNet training was completed for the Utilization Management (UM) staff. Continued collaboration with IT, Behavioral Health, MLTSS, and other key stakeholders to prepare for system launch in Q3. |
## Key Activities Status Update

### Implement strategies to improve encounters and risk adjustment processes.
- Project specifications have been reviewed and defined by each work stream. We have confirmed the commitment of needed IT resources to complete the project on schedule for Sept 2021.

### Implement improvements for diversity and inclusion within the L.A. Care workforce, as recommended by the L.A. Care Team Equity Council.
- Diversity, Equity and Inclusion training began with L.A. Care Quality Improvement (QI) staff in March with Dr. Jann Murray-Garcia and Dr. Victoria Ngo. An outside vendor will begin training of the entire staff next quarter.

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### Goal 1.2
**Maximize the growth potential of our product lines.**

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<td>Implement a product governance process to ensure enterprise-wide alignment for products, programs, and service offerings across all lines of business.</td>
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<td>Product leadership continues to lead cross-functional teams to ensure a consistent approach to cross-cutting issues such as growth and retention across all products. The Chief Product Officer serves on key leadership committees to represent the needs of the products and to ensure alignment across the organization.</td>
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<td>Create a tailored approach to member enrollment and retention, based on unique needs of the product.</td>
<td></td>
<td>The Marketing team is currently finalizing the Member Journey map for the L.A. Care Covered (LACC) line of business. Work will continue with the Medicare and Medi-Cal product teams to further map member touchpoints for these lines of business. Due to a larger than expected volume of touchpoints discovered during the initial process, we anticipate that this project will not be completed until Q4. We are also in the midst of revising our LACC marketing and sales strategy to accommodate the subsidy changes resulting from the recently enacted American Rescue Plan.</td>
</tr>
<tr>
<td>Leverage our ability to offer member choice and provide value-added programs for all product lines.</td>
<td></td>
<td>L.A. Care is looking to build upon the increased usage of telehealth benefits among our membership during the COVID-19 pandemic by exploring expanded virtual care options beyond our current telehealth offering. We are also planning for 2022 Covered California open enrollment, with the goal of offering members a balance of competitive price and provider choice.</td>
</tr>
</tbody>
</table>

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### Color Indicator Legend
- **Green** – On target, no issues
- **Yellow** – Some issues, probable risks, concerns
- **Red** – Major issues, high risk
- **Blue** – Complete
## Key Activities Status Update

<table>
<thead>
<tr>
<th>Key Activities</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Plan and prepare for the implementation of a Dual Eligible Special Needs Program to serve our dually eligible Medi-Cal and Medicare population.</td>
<td>![Green]</td>
<td>The D-SNP Business Case process is nearing completion. The requirements review process has been completed and architecture assessment and modeling is underway in preparation for estimation and the subsequent portfolio analysis and disposition processes. Workgroups are underway for critical activities such as network, stars, and communications. Monthly DHCS CMC to D-SNP Enrollment Transition Workgroups are also in flight. There have been limited state/CMS regulatory decisions thus far. Agencies are collecting stakeholder feedback on critical issues.</td>
</tr>
</tbody>
</table>

### 2 High Quality Network

**A network that aligns reimbursement with member risk and provider performance to support high quality, cost efficient care.**

#### Goal 2.1

**Maintain a robust provider network that supports access to high-quality, cost efficient care.**

<table>
<thead>
<tr>
<th>Key Activities</th>
<th>Status</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Engage in a provider network strategy that meets distinct business and competitive needs of all products and ensures that members receive high-value care.</td>
<td>![Green]</td>
<td>Focus remains on supporting our network of contracted physicians as they continue to care for our members during the COVID-19 pandemic. In addition, overall network adequacy average has increased 2.5% since January 2021.</td>
</tr>
<tr>
<td>Optimize oversight of delegated functions.</td>
<td>![Green]</td>
<td>Work on the Delegated Entity Manual continued this quarter and it is scheduled to be finalized and published in April 2021.</td>
</tr>
</tbody>
</table>

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Quarterly Progress Report
January – March 2021

**Goal 2.2**
**Build foundational capabilities to support expansion of the L.A. Care Direct Network.**

<table>
<thead>
<tr>
<th>Key Activities</th>
<th>Status</th>
<th>Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement initiatives to promote diversity and equal opportunity among vendors, providers, and purchased services, as recommended by the Vendor and Provider Equity Council.</td>
<td>🟢</td>
<td>We are seeking to identify the racial/ethnic background of our provider network in order to foster more concordance between members and providers. Since the information is voluntary our data is incomplete.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key Activities</th>
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</thead>
<tbody>
<tr>
<td>Strategically develop, expand, and address gaps in the Direct Network to meet all member needs.</td>
<td>🟢</td>
<td>L.A. Care continues to improve the network adequacy of its specialty network access county-wide with an additional 200 specialists activated during Q2. The PNM team implemented targeted provider recruitment data reporting and tools to monitor network adequacy, tracking and trending of contracting efforts, and monitoring specialty access of the current network. At this time, PCP recruitment efforts are on pause due to the Utilization Management function pending approval from DMHC.</td>
</tr>
<tr>
<td>Improve the operations of all L.A. Care functions necessary to support and scale up the Direct Network.</td>
<td>🟢</td>
<td>The Direct Network Administration Steering Committee continues to prioritize work related to operational enhancements and is working cross-functionally with the Direct Network workgroup to implement those enhancements. As a result of this prioritization process, efforts are focused on supporting overall provider data management, which includes the management of Direct Network provider data.</td>
</tr>
</tbody>
</table>
## Goal 2.3
Providers receive the individualized information and resources they need to provide high-quality care with low administrative burden.

<table>
<thead>
<tr>
<th>Key Activities</th>
<th>Status</th>
<th>Update</th>
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<tbody>
<tr>
<td>Provide practices with actionable data, education, and resources to support ongoing efforts to improve quality and NCQA status.</td>
<td></td>
<td>The final Measure Year (MY) 2019/ Report Year (RY) 2020 L.A. Care Covered (LACC) and Cal MediConnect (CMC) Value Initiative for IPA Performance (VIIP) Reports were released to IPAs representing the prior year performance results. The LACC VIIP reports accompanied incentive payments for the first time while CMC VIIP reports are scheduled for incentive payments beginning MY20/RY21. Feedback for the final IPA Action Plan results were provided to IPAs from L.A. Care subject matter experts. Provider Opportunity Reports showing gaps in care were distributed to the network for HEDIS. Utilization Management Reports and Quarterly Encounter Reports were also shared in this time period to give additional actionable data for monitoring. The 2020 CG-CAHPS member experience survey completed fielding with new results scheduled for distribution in May. QI-IPA meetings also launched this quarter with a focus on higher volume IPAs to discuss various QI topics, mainly member experience, offer support and strategize for improvement in the coming year. We continue training webinars on multiple quality topics in coordination with the CME program. Our provider engagement efforts continue with multiple interactions with office staff helping optimize services and coding and a redesign of our web accessible materials. This quarter the L.A. Care Provider Continuing Education (PCE) Program offered several webinars to L.A. Care Providers and other healthcare professionals. Webinar topics included Youth Substance Use Disorder (SUD) and Mental Health Treatments, Adverse Childhood Experiences (ACEs), and Medicaid Assisted Treatment (MAT) for Alcohol and Opioid Use Disorders. Webinars had an average of 137 participants, with an average of 35% being L.A. Care Providers. In addition, L.A. Care and Health Net collaborated to offer a two-part Implicit Bias Webinar Series featuring presenter Dr. Bryant Marks, Sr.. The virtual series was hosted by Health Net and L.A. Care served as the accredited CME/CE provider. The Virtual Provider Recognition Awards were held on February 25th, airing live on YouTube with a total of 329 viewers. During the 30-minute event, the 10 winners were presented with their awards and honored with their own custom segments as well as...</td>
</tr>
<tr>
<td>Celebrate top providers and improved performance.</td>
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### Key Activities

**Offer access to loan repayment and recruitment assistance for new physicians (Elevating the Safety Net).**

- **Provider Recruitment Program (PRP)** – We continue to grow the PRP program, with 169 grants awarded and 127 providers hired.
- **Provider Loan Repayment Program (PLRP)** – Sixty-six providers have been awarded under this program.

**Support practice transformation and use of electronic resources such as Electronic Health Records (EHRs), Health Information Technology (HIE), and virtual care.**

- As a CMS Network of Quality Improvement and Innovation Contractor (NQIIC), L.A. Care continues to review projects to bid on as they are released.
- L.A. Care and First 5 LA kicked off their partnership to help practices improve child development.
- eManagement is implemented with 95 providers serving 75,000 MCLA members.
- Transform L.A. virtually coaches 13 engaged Direct Network practices with 71 providers, 3,500 Direct Network members, and 31,600 L.A. Care members.
- HIT and Health Services are working on the second part of the virtual care strategy for L.A. Care which includes advocacy and quarterly market updates.
- L.A. Care HIT serves as a LANES channel partner to support CalHOP enrollment and HIE milestone achievement in the Direct Network.

### Status

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### Update

Words of congratulation from various L.A. Care leaders. Awardees also shared stories of how they helped their communities during the COVID-19 pandemic.

In addition to the awards ceremony, winners were also recognized in their own communities by having billboards dedicated to them for an entire month in celebration of their accomplishments.
3 Member-Centric Care

Member-centric services and care, tailored to the needs of our varied populations.

Goal 3.1
Understand our member needs so we can better manage their care and plan for the future.

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<tr>
<td>Use all available data sources, including the Optum Impact Symmetry Suite (Member360), to assess and improve the population health of our membership.</td>
<td>![Green]</td>
<td>L.A. Care continues to socialize the use of the Optum Impact Symmetry Suite across the Health Services department. L.A. Care has completed drafting the annual Population Health Assessment (NCQA), and Population Needs Assessment (DHCS). To assess social determinants of health (SDOH), a combination of data from the Symmetry Suite and the Area Deprivation Index was used. We are also working with Optum to explore the use of the Centers for Disease Control and Prevention’s Social Vulnerability Index (SVI) as another measure of SDOH. We’re also in the process of investigating the use of other risk scores included in the Symmetry Suite. The Advanced Analytic Lab (AAL) is evaluating how well the Symmetry risk scores perform in our population and if we can start using those for clinical decision making. We have also been working to incorporate DHCS COVID-19 data sources into our data lake. These data sources include COVID-19 vaccinations paid by fee-for-service Medi-Cal, as well as data from the California Immunization Registry (CAIR). While we work to get these data into the data lake we have begun to share the data with our plan partners and independent physician associations (IPAs).</td>
</tr>
</tbody>
</table>
| Incorporate assessment of social needs into the day-to-day work of staff who interact directly with members. | ![Yellow] | Community Link  
L.A. Care Community Link added functionality to allow the upload of documents to its secure servers. We are working with the Privacy Team to enable document sharing with Community Based Organizations while safeguarding the Protected Health Information of our members. When enabled, this technology will allow L.A. Care to share photo IDs or other documentation needed to complete referrals to address social determinants of health.  
Care Management  
The Care Management team was trained specifically on supporting members through the COVID-19 pandemic, including many of the social needs that have been exacerbated during this challenging period. As a result of these additional trainings, they...
## Key Activities Status Update

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<td>have been able to assess members and provide them with information on resources such as rent relief, utility reduction, caregiver respite, and transportation. Community Health Workers (CHWs) serve as community messengers for critical public health and social service information. During Q2, they informed our highest risk members about where to access food and meal delivery resources, COVID-19 testing, health services, food pantries, diaper banks, and hardship funds. CHWs continued to support our highest need members with telehealth accompaniment and helped navigate technology-challenged members through the new telehealth landscape.</td>
<td></td>
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</tr>
<tr>
<td>Improve coordination of care for members with the Care Catalyst initiative, and the Population Health Management System (SyntraNet/Thrasys).</td>
<td>Green</td>
<td>Workflows, desktop procedures, and other training materials were developed and disseminated. Hands-on SyntraNet training was completed for the Utilization Management (UM) staff. Continued collaboration with IT, Behavioral Health, MLTSS, and other key stakeholders to prepare for system launch in Q3.</td>
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### Goal 3.2
**Address members’ unmet health and social needs by making care accessible in the right way, at the right place, at the right time.**

<table>
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<tr>
<td>Increase access to virtual care by implementing the initial steps of L.A. Care’s Virtual Care Strategy.</td>
<td>Green</td>
<td>This quarter, specialist providers were selected and an engagement and onboarding plan was created. In addition, an asynchronous curbside communication system between PCPs and specialists (eConsult) was selected.</td>
</tr>
<tr>
<td>Expand care management at Community Resource Centers/Family Resource Centers.</td>
<td>Green</td>
<td>While in-person interventions were still not conducted this quarter due to the ongoing COVID-19 pandemic, Community Health Workers (CHWs) continued to enhance their roles in supporting members through care management. Misinformation and lack of understanding around vaccines can have devastating consequences in historically under-served and under-resourced communities. Our CHWs provided reliable COVID-19 vaccine education that has lowered hesitation and increased participation in the community. In Q2, our CHWs outreached and engaged over 300 of our highest risk members to help them with vaccine education and navigation.</td>
</tr>
</tbody>
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Quarterly Progress Report
January – March 2021

Key Activities | Status | Update
--- | --- | ---
When the Community Resource Centers open again, the CHWs and the rest of the Care Management team are committed to continuing the expansion of community-based care management activities.

Implement strengthened or expanded activities to promote equity among members, as recommended by the Member Health Equity Council.

The Consumer Equity Council has met twice now, with the last meeting focusing on training around Disparities and Equity. Metrics are still in development.

4 Health Leader

Recognized leader in improving health for low income and vulnerable communities.

Goal 4.1
Be a local, state, and national leader to advance health and social services for low income and vulnerable communities.

Key Activities | Status | Update
--- | --- | ---
Advocate for policies that improve access to care and quality of life for low income communities.

Public Charge
On March 9, 2021 the Department of Homeland Security announced it would no longer consider a person’s receipt of Medicaid (except for long-term institutionalization), public housing, or Supplemental Nutrition Assistance Program (SNAP, formerly known as food stamps) benefits as part of the Public Charge inadmissibility determination. This action sets aside a policy introduced by the previous administration that would count receipt of Medicaid benefits against anyone applying for permanent legal residence in the United States. Public Charge is a decades-old “test” used by immigration officials to decide whether a person can enter the United States on a visa or become a permanent legal resident (i.e., green card holder). Those considered “likely to become primarily dependent on the government for subsistence” could be denied either.

L.A. Care was very engaged on many advocacy levels (media, elected officials, community based advocacy organizations, administrators, etc.) in actively opposing the
### Quarterl Progress Report
**January – March 2021**

<table>
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<tr>
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<tbody>
<tr>
<td>Trump Administration’s Public Charge policy, arguing that the rule stopped</td>
<td>Green</td>
<td>The state released a revised CalAIM (California Advancing and Innovating Medi-Cal) proposal on January 8, 2021 and has fully restarted implementation efforts with a proposed target start date of January 1, 2022. In response, L.A. Care has restarted and ramped up our internal readiness efforts. We also continue to support waiver design discussions and advocate on behalf of our members through conversations with the state, workgroup meetings, public comment periods, and similar engagement opportunities.</td>
</tr>
<tr>
<td>people from accessing needed Medicaid benefits out of fear that it would</td>
<td></td>
<td></td>
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<tr>
<td>threaten their chances of getting their green card.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medi-Cal Pharmacy Carve Out</td>
<td>Red</td>
<td></td>
</tr>
<tr>
<td>The California Department of Health Care Services recently announced an “indefinite hold” on the implementation of the Medi-Cal pharmacy carve-out. The carve-out was supposed to go into effect on 1/1/2021. The Department of Managed Care recently announced it would be conducting a review of Centene’s acquisition of Magellan Health, the vendor selected to operate as the state’s pharmacy benefit administrator. Under the authority of state law, DMHC will conduct a state level anti-trust review. It is unknown when that review will be completed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In addition, based on the uncertainty around whether Magellan can serve as the state’s pharmacy benefit administrator and the resulting competition and healthcare privacy concerns, L.A. Care sent a letter to the state communicating that it will temporarily refrain from submitting additional healthcare data to Magellan. L.A. Care also cited its concerns about providing confidential proprietary network data to a competitor (Health Net/Centene, who now owns Magellan as a result of the acquisition) and whether L.A. Care would be in compliance with applicable privacy laws if it continued to transmit enrollee data to Magellan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demonstrate the value of a public option.</td>
<td>Green</td>
<td>L.A. Care continues to advocate the value of a public option in the healthcare system and serve as a model of how a public plan can successfully compete on a state exchange. State and federal activities related to a public option continue to be monitored.</td>
</tr>
<tr>
<td>Contribute to and participate in the State’s Medi-Cal Waiver design efforts</td>
<td>Yellow</td>
<td></td>
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<tr>
<td>to ensure waiver programs support and meet member needs.</td>
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### Key Activities
Identify and prioritize actions, programs, and interventions to promote equity and social justice internally and externally, as recommended by the Equity Council Steering Committee.

### Status
Green – On target, no issues

### Update
A statement on Anti-Asian hate crimes was completed and released. We are sponsoring various anti-hate initiatives led by the LA Human Rights Commission.

Diversity, Equity, and Inclusion training for staff is now under way.

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### Goal 4.2
Implement initiatives that improve the health and wellbeing of those served by safety net providers.

<table>
<thead>
<tr>
<th>Key Activities</th>
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</table>
• **Residency Support Program (RSP)** – Fifteen new residents and three new core faculty are receiving funding support across five teaching institutions, including AltaMed, CDU, UCLA, Adventist Health White Memorial, and Children’s Hospital of Los Angeles.  
• **Medical School Scholarships** – Twenty-four medical students have been awarded under this program.  
• **Provider Recruitment Program (PRP)** – We continue to grow the PRP program, with 169 grants awarded and 127 providers hired.  
• **Provider Loan Repayment Program (PLRP)** – Sixty-six providers have been awarded under this program.  
• **Elevating Community Health** – Fifty-four CHWs have participated in the training program. The first and second cohorts of the CHW training program completed six continuing education (CE) sessions while our third cohort will complete training activities in April 2021. The Center for Caregiver Advancement (CCA, formerly the California Long-Term Care Education Center) is currently in Trimester 12. As of this quarter, the program has had 3,498 graduates.  
• **National Medical Fellowship (NMF)** – Twenty-eight fellows have participated in the annual summer program since 2017. L.A. Care is preparing to fund a summer 2021 cohort in the NMF’s Primary Care Leadership Program (PCLP), an immersive summer program that places medical and mid-level clinical students in Los Angeles County safety net clinics, including Federally Qualified Health Centers (FQHCs). |
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Expand the number, size, and scope of our Community Resource Centers to a total of 14 sites across 11 Regional Community Advisory Committee regions in partnership with Blue Shield of California Promise Health Plan.</td>
<td></td>
<td>All existing CRCs continued to be closed due to the winter COVID-19 surge. Virtual programming continues. Plans for 16 COVID-19 vaccine clinic events in each CRC are being developed. A tentative re-opening date of May 1 for all centers was set and will be evaluated at the beginning of Q3. Full construction is in progress for Norwalk, El Monte, and Wilmington sites. Leases for these sites and a new Inglewood site have been fully executed.</td>
</tr>
<tr>
<td>Continue to optimize the Health Homes Community-Based Care Management Entity network and improve operations, pending clear direction from the State on Medi-Cal waiver design efforts.</td>
<td></td>
<td>Health Homes activities this quarter focused on continued quality improvement with the deployment of CB-CME progress reports. Capacity building activities to further performance improvement included the launch of assessment and care planning coaching, continued housing navigation coaching, and ongoing bi-weekly webinars. Following the release of DHCS' CalAIM proposal in January, L.A. Care launched planning activities to build the new programs and incorporate the transition of the Health Homes Program and Whole Person Care.</td>
</tr>
</tbody>
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L.A. Care Priority Matrix

Last Updated: April 19, 2021

Title
The following is a list of the priority legislation currently tracked by Government Affairs that has been introduced during the 2021 Legislative Session and is of interest to L.A. Care. These top priority bills, if passed, could have a direct impact on L.A. Care. If there are any questions, please contact Cherie Compartore, Senior Director of Government Affairs at ccompartore@lacare.org or 916.216.7963.

Please note, Government Affairs also has a list of all the bills that may not have a direct impact, but do have the possibility to be amended in the future to do so. Some of the bills included are spot bills, legislative place holders, in code sections that could have a policy impact on L.A. Care. If you would like a copy of this list please contact Cherie Compartore.

Bills by Issue
2021 Legislation (87)

<table>
<thead>
<tr>
<th>Bill Number</th>
<th>Last Action</th>
<th>Status</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>AB 4</td>
<td>From Committee Do Pass And Re Refer To Com On Appr Ayes 11 Noes 3 April 13 Re Referred To Com On Appr 2021 04 14</td>
<td>In Assembly</td>
<td>Support</td>
</tr>
</tbody>
</table>

Title
Medi-Cal: eligibility.

Description
AB 4, as introduced, Arambula. Medi-Cal: 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. The federal Medicaid program provisions prohibit payment to a state for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Existing law requires individuals under 19 years of age enrolled in restricted-scope Medi-Cal at the time the Director of Health Care Services makes a determination that systems have been programmed for implementation of these provisions to be enrolled in the full scope of Medi-Cal benefits, if otherwise eligible, pursuant to an eligibility and enrollment plan, and extends eligibility for full scope Medi-Cal benefits to individuals who are under 25 years of age, and who are otherwise eligible for those benefits but for their immigration status. Existing law makes the effective date of enrollment for those individuals the same day that systems are operational to begin processing new applications pursuant to the director's determination. Existing law requires an individual eligible for Medi-Cal under these provisions to enroll in a Medi-Cal managed care health plan. Existing law provides that Medi-Cal benefits for individuals who are 65 years of age or older, and who do not have satisfactory immigration statuses or are unable to establish satisfactory immigration statuses, as specified, are to be prioritized in the Budget Act for the upcoming fiscal year if the
Department of Finance projects a positive ending balance in the Special Fund for Economic Uncertainties for the upcoming fiscal year and each of the ensuing 3 fiscal years that exceeds the cost of providing those individuals full scope Medi-Cal benefits. Effective January 1, 2022, this bill would instead extend eligibility for full scope Medi-Cal benefits to anyone regardless of age, and who is otherwise eligible for those benefits but for their immigration status, pursuant to an eligibility and enrollment plan. The bill would delete the above-specified provisions regarding individuals who are under 25 years of age or 65 years of age or older and delaying implementation until the director makes the determination described above. The bill would require the eligibility and enrollment plan to ensure that an individual maintains continuity of care with respect to their primary care provider, as prescribed, would provide that an individual is not limited in their ability to select a different health c... (click bill link to see more).

Primary Sponsors
Joaquin Arambula, Rob Bonta, David Chiu, Mike Gipson, Lorena Gonzalez, Eloise Reyes, Miguel Santiago

Organizational Notes
Last edited by Joanne Campbell at Apr 8, 2021, 4:18 PM
Support: L.A. Care, LHPC

Title
Communications: broadband services: California Advanced Services Fund.

Description
AB 14, as introduced, Aguiar-Curry. Communications: broadband services: California Advanced Services Fund. (1) Existing law establishes the State Department of Education in state government, and vests the department with specified powers and duties relating to the state's public school system. This bill would authorize local educational agencies to report to the department their pupils' estimated needs for computing devices and internet connectivity adequate for at-home learning. The bill would require the department, in consultation with the Public Utilities Commission, to compile that information and to annually post that compiled information on the department's internet website. (2) Existing law expressly authorizes a county service area to acquire, construct, improve, maintain, and operate broadband internet access services, and requires a county service area that does so to take certain actions regarding the accessing of content on the internet by end users of that service. This bill would similarly authorize the board of supervisors of a county to acquire, construct, improve, maintain, or operate broadband internet access service, and any other communications service necessary to obtain federal or state support for the acquisition, construction, improvement, maintenance, or operation of broadband internet access service, and would require a board that does so to take certain actions regarding the accessing of content on the internet by end users of that service. (3) Existing law establishes the
Governor’s Office of Business and Economic Development, known as “GO-Biz,” within the Governor’s office to serve the Governor as the lead entity for economic strategy and the marketing of California on issues relating to business development, private sector investment, and economic growth. This bill would require the office, on or before June 30, 2022, to develop recommendations and a model for streamlined local land use approval and construction permit processes for projects related to broadband infrastructure deployment and connectivity and to adopt, and post on its internet website, the recommendations and model, as specified.(4) Under existing law, the Public Utilities Commission has regulatory authority over public utilities, including telephone corporations. Existing law requires the commission to develop, implement, and administer the California Advanced Services Fund (CASF) program to encourage deployment of high-quality advanced communications services to all Californians that will promote economic growth, job creation, and the substantial social benefits of advanced information and communications technologies. Existing law requires the commission, in approving CASF infrastructure projects, to give preference to proj... (click bill link to see more).

Primary Sponsors

Title
Telehealth.

Description
AB 32, as amended, Aguiar-Curry. 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. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, Medi-Cal services may be provided pursuant to contracts with various types of managed care health plans, including through a county organized health system. Under existing law, in-person contact between a health care provider and a patient is not required under the Medi-Cal program for services appropriately provided through telehealth. Existing law provides that neither face-to-face contact nor a patient's physical presence on the premises of an enrolled community clinic is required for services provided by the clinic to a Medi-Cal beneficiary during or immediately following a proclamation declaring a state of emergency. Existing law defines “immediately following” for this purpose to mean up to 90 days following the termination of the proclaimed state of emergency, unless there are extraordinary circumstances. 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. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a contract issued, amended, or renewed on or
after January 1, 2021, between a health care service plan or health insurer and a health care provider to require the plan or insurer to reimburse the provider for the diagnosis, consultation, or treatment of an enrollee, subscriber, insured, or policyholder appropriately delivered through telehealth services on the same basis and to the same extent as the same service through in-person diagnosis, consultation, or treatment. Existing law requires a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2021, to specify that coverage is provided for health care services appropriately delivered through telehealth on the same basis and to the same extent as in-person diagnosis, consultation, or treatment. Existing law exempts Medi-Cal managed care plans that contract with the State Department of Health Care Services under the Medi-Cal program from these provisions, and generally exempts county organized health systems that provide services under the Medi-Cal program from Knox-Keene. This bill would delete the above-described references to contracts issued, amended, or renewed on or after January 1, 2021, would require these provisions to apply to the plan or insurer's co...

Primary Sponsors
Robert Rivas, Aguiar-Curry

Organizational Notes
Last edited by Joanne Campbell at Mar 12, 2021, 10:12 PM
Support: California Association of Public Hospitals and Health Systems (CAPH) (Sponsor) California Health+ Advocates/California Primary Care Association (CPCA) (Sponsor) California Medical Association (CMA) (Sponsor) Essential Access Health (EAH) (Sponsor) Planned Parenthood Affiliates of California (PPAC) (Sponsor)
Title
Broadband for All Act of 2022.

Description
AB 34, as amended, Muratsuchi. Broadband for All Act of 2022. Existing law requires the Department of Technology to improve the governance and implementation of information technology by standardizing reporting relationships, roles, and responsibilities for setting information technology priorities. Existing law requires the Public Utilities Commission to develop, implement, and administer the California Advanced Services Fund program to encourage deployment of high-quality advanced communications services to all Californians. Existing law provides that the goal of the program is to, no later than December 31, 2022, approve funding for infrastructure projects that will provide broadband access to no less than 98% of California households, as provided. This bill would enact the Broadband for All Act of 2022, which, if approved by the voters, would authorize the issuance of bonds in the amount of $10,000,000,000 pursuant to the State General Obligation Bond Law to support the 2022 Broadband for All Program that would be administered by the department for purposes of providing financial assistance for projects to deploy broadband infrastructure and broadband internet access services. The bill would provide for the submission of the bond act to the voters at the November 8, 2022, statewide general election.

Primary Sponsors
Al Muratsuchi, Eduardo Garcia, Miguel Santiago, Steve Glazer, Devon Mathis, Carlos Villapudua

Title
Homelessness funding: Bring California Home Act.

Description
AB 71, as amended, Luz Rivas. Homelessness funding: Bring California Home Act. (1) The Personal Income Tax Law, in conformity with federal income tax law, generally defines gross income as income from whatever source derived, except as specifically excluded, and provides various exclusions from gross income. Existing federal law, for purposes of determining a taxpayer’s gross income for federal income taxation, requires that a person who is a United States shareholder of any controlled foreign corporation to include in their gross income the global intangible low-taxed income for that taxable year, as provided. This bill, for taxable years beginning on or after January 1, 2022, would include a taxpayer’s global intangible low-taxed income in their gross income for purposes of the Personal Income Tax Law, in modified conformity with the above-described federal provisions. The bill would exempt any regulation, standard, criterion, procedure, determination, rule, notice, or guideline established or issued by the Franchise Tax Board to implement its provisions from
the rulemaking provisions of the Administrative Procedure Act. The Corporation Tax Law, when the income of a taxpayer subject to tax under that law is derived from or attributable to sources both within and without the state, generally requires that the tax be measured by the net income derived from or attributable to sources within this state, as provided. Notwithstanding this requirement, the Corporation Tax Law authorizes a qualified taxpayer, as defined, to elect to determine its income derived from or attributable to sources within this state pursuant to a water's-edge election, as provided. For taxable years beginning on or after January 1, 2003, existing law requires that a water's-edge election be made on an original, timely filed return for the year of the election, as provided, and provides for the continued effect or termination of that election. This bill, beginning January 1, 2022, would require that a taxpayer that makes a water's-edge election under these provisions take into account 50% of the global intangible low-taxed income and 40% of the repatriation income of its affiliated corporations, as those terms are defined. The bill would allow a taxpayer, for calendar year 2022 only, the opportunity to revoke a water's-edge election if the taxpayer includes global intangible low-taxed income pursuant to these provisions. The bill would prohibit the total of all business credits, as defined, and all credits allowed under specified provisions of the Corporation Tax Law, with specified exceptions, from reducing the additional tax liability added by this bill's provisions by more than $5,000,000, as provided. The bill would exempt any regulation, standa... (click bill link to see more).

**Primary Sponsors**
Luz Rivas, Richard Bloom, David Chiu, Buffy Wicks, Ash Kalra

**Organizational Notes**
Last edited by Joanne Campbell at Apr 8, 2021, 4:15 PM
Support: L.A. Care, United Way of Greater Los Angeles, HOPICS, CSH, Housing California, All Home, Los Angeles Homeless Service Authority, Brilliant Corners, NPH, Steinburg Institute, The City and County of San Francisco, City of Los Angeles, County of Los Angeles, ECS, National Alliance to End Homelessness
Title
Substance use disorder treatment services.

Description
AB 77, as amended, Petrie-Norris. Substance use disorder treatment services. Existing law requires the State Department of Health Care Services to license and regulate alcoholism or drug abuse recovery or treatment facilities serving adults. Existing law authorizes the department to certify qualified alcoholism or drug abuse recovery or treatment programs, as prescribed. Under existing law, the department regulates the quality of these programs, taking into consideration the significance of community-based programs to alcohol and other drug abuse recovery and the need to encourage opportunities for low-income and special needs populations to receive alcohol and other drug abuse recovery or treatment services. This bill, commencing January 1, 2026, would require any substance use disorder treatment program to be licensed by the department, except as specified. The bill would require the department, in administering these provisions, to issue licenses for a period of 2 years for substance use disorder treatment programs that meet the requirements in these provisions. The bill would require the department to issue a license to a substance use disorder program once various requirements have been met, including an onsite review. The bill would authorize the department to renew a license, as provided. The bill would prohibit providing substance use disorder treatment services to individuals without a license. The bill would require a substance use disorder program licensed pursuant to these provisions to adopt written policies and procedures, as specified. The bill would require a person or entity applying for a license to submit, among other things, a licensure fee to the department. The bill would require various quality parameters of licensed substance use disorder treatment programs, including, among others, that patients admitted for treatment meet specified medical necessity criteria. The bill would require the department to conduct a site visit if a program is alleged to be in violation of those quality parameters and to provide written notice to the program, as specified. The bill would authorize a licensed substance use disorder treatment program to treat persons 12 to 17 years of age, inclusive, provided certain additional requirements are met, including that assessments include documentation of the person’s unique abilities and strengths in the patient treatment plan. The bill would require certain minimum requirements for substance use disorder program administrators and staff who provide services pursuant to these provisions and would grant the department sole authority to establish qualifications that exceed those requirements. The bill would require the department to conduct onsite visits to ensure compliance... (click bill link to see more).

Primary Sponsors
Cottie Petrie-Norris, Henry Stern
Pandemic response practices.

AB 93, as amended, Eduardo Garcia. Pandemic response practices. Existing law establishes the California Health and Human Services Agency, under the direction of the Secretary of California Health and Human Services, which includes, among other departments, the State Department of Public Health and the State Department of Health Care Services. Existing law establishes various programs for the prevention and control of communicable diseases, including programs that provide for the testing for, notifications of exposure to, and tracking by the state of, communicable diseases. This bill would require the Legislative Analyst's Office to conduct a comprehensive review and analysis of issues related to the state's response to the COVID-19 pandemic, including, among others, whether local public health departments were sufficiently staffed and funded to handle specified pandemic-related responsibilities, and what specific measures of accountability the state applied to monitor and confirm that local public health departments were following state directives related to any dedicated COVID-19 funds allocated to counties. The bill would require the office to report to the Joint Legislative Audit Committee and the health committees of the Legislature by June 30, 2022. The bill would require the state to include community health centers as a part of its organizational pandemic response structure, and would require community health centers, including federally qualified health centers, to serve as points of contact at the local and regional level, in the same manner as local health departments. The bill would require the state to establish a supply chain of medical supplies and equipment necessary to address the level of need established by the COVID-19 pandemic. The bill would authorize the state to provide economic incentives to help relocate manufacturers of medical supplies, as required to address a pandemic or public health crisis. The bill would require the State Department of Public Health and the State Department of Health Care Services to develop a statewide, comprehensive plan to provide an outreach and education campaign for implementation during a viral pandemic or health care emergency. The bill would require the campaign to focus on those communities in each county with the highest rates of health disparities. The bill would require the education and outreach campaign materials to be culturally sensitive to populations that experienced a high rate of health disparities that contributed to greater susceptibility to COVID-19. The bill would establish initial priority tiers of priority populations for rapid testing and vaccination during a pandemic. Tier I would include health care workers and first responders and Tier II... (click bill link to see more).

Primary Sponsors
Eduardo Garcia, Robert Rivas
Title
Health care coverage: insulin affordability.

Description
AB 97, as amended, Nazarian. Health care coverage: insulin affordability. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or disability insurance policy issued, amended, delivered, or renewed on or after January 1, 2000, that covers prescription benefits to include coverage for insulin, if it is determined to be medically necessary. This bill would prohibit a health care service plan contract or a health disability insurance policy, as specified, issued, amended, delivered, or renewed on or after January 1, 2022, from imposing a deductible on an insulin prescription drug. 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
Adrin Nazarian
Medi-Cal eligibility.

Description
AB 112, as amended, Holden. Medi-Cal 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 federal law 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. Under existing state law, the suspension of Medi-Cal benefits to an inmate of a public institution who is a juvenile, as defined in federal law, ends when the individual is no longer an eligible juvenile pursuant to federal law or one year from the date the individual becomes an inmate of a public institution, whichever is later. This bill would instead require the suspension of Medi-Cal benefits to an inmate of a public institution who is not a juvenile 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 also require the suspension of Medi-Cal benefits to an inmate of a public institution who is a juvenile on the date that the individual is no longer an inmate of a public institution or 3 years after the date the individual is no longer an eligible juvenile under federal law, whichever is sooner.

Primary Sponsors
Chris Holden

Organizational Notes
Last edited by Joanne Campbell at Apr 8, 2021, 4:14 PM
Support - L.A. Care
### Title
Medi-Cal benefits: rapid Whole Genome Sequencing.

### Description
AB 114, as amended, Maienschein. Medi-Cal benefits: rapid Whole Genome Sequencing. 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 pursuant to a schedule of benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. The Budget Act of 2018 appropriates $2,000,000 for the Whole Genome Sequencing Pilot Project, and requires the department to provide a grant to a state nonprofit organization for the execution of a one-time pilot project to investigate the potential clinical and programmatic value of utilizing clinical Whole Genome Sequencing in the Medi-Cal program. This bill would expand the Medi-Cal schedule of benefits to include rapid Whole Genome Sequencing, as specified, for any Medi-Cal beneficiary who is one year of age or younger and is receiving inpatient hospital services in an intensive care unit. The bill would authorize the department to implement this provision by various means without taking regulatory action. Existing law requires the department to develop and implement a Medi-Cal inpatient hospital reimbursement methodology based on diagnosis-related groups, subject to federal approval, that reflects the costs and staffing levels associated with quality of care for patients in general acute care hospitals, as specified. Under existing law, the diagnosis-related group-based payments apply to all claims, except claims for psychiatric inpatient days, rehabilitation inpatient days, managed care inpatient days, and swing bed stays for long-term care services, as specified. Existing law authorizes the department to exclude or include other claims and services as may be determined during the development of the payment methodology. This bill would make diagnosis-related group-based payments also inapplicable to claims for the above-described rapid Whole Genome Sequencing. The bill would specify that rapid Whole Genome Sequencing would be reimbursed in addition to, and separate from, a diagnosis-related group-based payment for any other qualifying claim for other services provided to the same individual.

### Primary Sponsors
Brian Maienschein
### AB 214
**Title**

**Description**
AB 214, as introduced, Ting. Budget Act of 2021. This bill would make appropriations for the support of state government for the 2021-22 fiscal year. This bill would declare that it is to take effect immediately as a Budget Bill.

**Primary Sponsors**
Phil Ting

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### AB 221
**Title**
Emergency food assistance.

**Description**
AB 221, as amended, Santiago. Emergency food assistance. Existing law establishes and requires the State Department of Social Services to administer the CalFood Program to provide food and funding to food banks whose primary function is to facilitate the distribution of food to low-income households, as specified. Upon the appropriation of funds by the Legislature for this purpose, or a determination by the Governor that specified funds available to the Governor may be used for this purpose, this bill would require the department to provide a food assistance benefit statewide to low-income California residents and to contract with specified entities, including a Feeding America partner state organization, to issue this benefit in the form of a one-time use, prepaid card preloaded with $600 for use at retailers that sell groceries. The bill would provide that a person is eligible for this benefit if they are an adult who self-attests to eligibility for at least one of 3 prescribed benefits, including the Federal Emergency Food Assistance Program, and that this benefit is a disaster benefit rather than a public social service. The bill would authorize the contractor to subcontract with local nonprofit organizations to issue the food assistance benefit, and would require any subcontracting nonprofit to comply with specified requirements, including maintaining records. The bill would establish various administrative requirements related to the benefit. The bill would require the department, in consultation with a workgroup, to conduct a study to provide recommendations and solutions to a permanent food assistance program for low-income California residents experiencing food insecurity, to complete that study by January 1, 2023, and to submit a copy of that study to the Legislature. This bill would declare that it is to take effect immediately as an urgency statute.

**Primary Sponsors**
Miguel Santiago, David Chiu, Mike Gipson, Robert Rivas, Susan Rubio

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Title
Medi-Cal: reimbursement rates.

Description
AB 265, as introduced, Petrie-Norris. Medi-Cal: 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 clinical laboratory or laboratory services. The Medi-Cal program is, in part, governed by, and funded pursuant to, federal Medicaid program provisions. Existing law requires the department to develop, subject to federal approval, reimbursement rates for clinical or laboratory services according to specified standards, such as requiring that reimbursement to providers for those services not exceed the lowest of enumerated criteria, including 80% of the lowest maximum allowance established by the federal Medicare Program for the same or similar services. This bill would delete provisions relating to the above-specified 80% standard and would make conforming changes.

Primary Sponsors
Cottie Petrie-Norris
### Description
AB 278, as introduced, Flora. Medi-Cal: podiatric services. 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 podiatric services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law does not require prior authorization for podiatric services provided on an outpatient or inpatient basis, but podiatric services are subject to the same Medi-Cal billing and services policies as required for a physician and surgeon, including a maximum numerical service limitation in any one calendar month. Existing law requires a health care provider applying for enrollment as a Medi-Cal services provider or a current Medi-Cal services provider applying for continuing enrollment, or a current Medi-Cal services provider applying for enrollment at a new location or a change in location, to submit a complete application package. Under existing law, a licensed physician and surgeon practicing as an individual physician practice or a licensed dentist practicing as an individual dentist practice, who is in good standing and enrolled as a Medi-Cal services provider, and who is changing the location of that individual practice within the same county, is eligible to instead file a change of location form in lieu of submitting a complete application package. This bill would make conforming changes to the provisions that govern applying to be a provider in the Medi-Cal program, or for a change of location by an existing provider, to include a doctor of podiatric medicine licensed by the California Board of Podiatric Medicine.

### Primary Sponsors
Heath Flora
Title
Local government: open and public meetings.

Description
AB 339, as amended, Lee. Local government: open and public meetings. Existing law, the Ralph M. Brown Act, requires, with specified exceptions, that all meetings of a legislative body of a local agency, as those terms are defined, be open and public and that all persons be permitted to attend and participate. Under existing law, a member of the legislative body who attends a meeting where action is taken in violation of this provision, with the intent to deprive the public of information that the member knows the public is entitled to, is guilty of a crime. This bill would require all meetings to include an opportunity for members of the public to attend via a telephonic option and an internet-based service option. The bill would require all meetings to include an in-person public comment opportunity, except in specified circumstances during a declared state or local emergency. The bill would require all meetings to provide the public with an opportunity to comment on proposed legislation in person and remotely via a telephonic and an internet-based service option, as provided, and would specify requirements for public comment registration. The bill would also require the legislative bodies of the local agency to provide interpretation services as requested, and have a system to process requests for interpretation services and publicize that system online. This bill would require legislative bodies of local agencies to make available instructions on joining the meeting to all non-English-speaking persons upon request, and publish the instructions in the 2 most spoken languages other than English within the local agency’s jurisdiction. By imposing new duties on local governments and expanding the application of a crime with respect to meetings, 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 specified reasons. The California Constitution requires local agencies, for the purpose of ensuring public access to the meetings of public bodies and the writings of public officials and agencies, to comply with a statutory enactment that amends or enacts laws relating to public records or open meetings and contains findings demonstrating that the enactment furthers the constitutional requirements relating to this purpose. This bill would make legislative findings to that effect.

Primary Sponsors
Alex Lee, Cristina Garcia
Title
Health care coverage: step therapy.

Description
AB 347, as amended, Arambula. 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 that provides coverage for prescription drugs may require step therapy, as defined, 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 the health care provider submits justification and supporting clinical documentation, if needed, that 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 ... (click bill link to see more).

Primary Sponsors
Joaquin Arambula

Organizational Notes
Last edited by Cherie Compartore at Mar 29, 2021, 3:38 PM
Oppose Unless Amended: CAHP
Title
Food prescriptions.

Description
AB 368, as amended, Bonta. Food prescriptions. 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 requires the department to establish a Medically Tailored Meals Pilot Program to operate for a period of 4 years from the date the program is established, or until funding is no longer available, whichever date is earlier, in specified counties, including the Counties of Alameda and Sonoma, to provide medically tailored meal intervention services to Medi-Cal participants with specified health conditions, such as diabetes and renal disease. This bill would require the department to establish, no earlier than January 1, 2022, a pilot program for a 2-year period in 3 counties, including the County of Alameda, to provide food prescriptions to eligible Medi-Cal beneficiaries, including individuals who have a specified chronic health condition, such as Type 2 diabetes and hypertension, when utilizing evidence-based practices that demonstrate the prevention, treatment, 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 a Medi-Cal managed care plan or their contractor that participates in the pilot program to establish procedures for referring and enrolling eligible Medi-Cal beneficiaries in 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 repeal these provisions on January 1, 2027. This bill would make legislative findings and declarations as to the necessity of a special statute for specified counties, including the County of Alameda.

Primary Sponsors
Rob Bonta
Medi-Cal services: persons experiencing homelessness.

Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires the department to provide presumptive Medi-Cal eligibility to pregnant women and children. Existing law authorizes a qualified hospital to make presumptive eligibility determinations if it complies with specified requirements. Existing law authorizes the department, on a regional pilot project basis, to issue an identification card to a person who is eligible for Medi-Cal program benefits, but does not possess a valid California driver's license or identification card issued by the Department of Motor Vehicles. Existing law requires the department, in consultation with the board governing the California Health Benefit Exchange, to develop a single paper, electronic, and telephone application for insurance affordability programs, including Medi-Cal. This bill would require the department to implement a program of presumptive eligibility for persons experiencing homelessness, under which a person would receive full-scope Medi-Cal benefits without a share of cost. The bill would require the department to authorize an enrolled Medi-Cal provider to issue a temporary Medi-Cal benefits identification card to a person experiencing homelessness, and would prohibit the department from requiring a person experiencing homelessness to present a valid California driver's license or identification card issued by the Department of Motor Vehicles to receive Medi-Cal services if the provider verifies the person's eligibility. The bill would require the insurance affordability program's paper application to include a check box, and electronic application to include a pull-down menu, for an applicant to indicate if they are experiencing homelessness at the time of application. This bill would authorize an enrolled Medi-Cal provider to make a presumptive eligibility determination for a person experiencing homelessness. The bill would authorize an enrolled Medi-Cal provider to bill the Medi-Cal program for Medi-Cal services provided off the premises to a person experiencing homelessness, as specified. The bill would require a Medi-Cal managed care plan to allow a beneficiary to seek those services and allow a provider to provide those services, but would authorize a Medi-Cal managed care plan to establish reasonable requirements governing utilization protocols and network participation. If a county determines a person experiencing homelessness is eligible for Medi-Cal services, the provider would be responsible for providing those services.

Primary Sponsors
Sydney Kamlager
Title
Whole Child Model program.

Description
AB 382, as introduced, Kamlager. Whole Child Model program. Under existing law, the State Department of Health Care Services administers various health programs, including the California Children's Services (CCS) program, which is a statewide program providing medically necessary services required by physically handicapped children whose parents are unable to pay for those services, and the Medi-Cal program, under which qualified low-income individuals receive health care services under specified health care delivery systems, such as managed care. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law authorizes the department to establish a Whole Child Model (WCM) program, under which managed care plans served by a county organized health system or Regional Health Authority in designated counties provide CCS services to Medi-Cal eligible CCS children and youth. Existing law requires the department to establish a statewide WCM program stakeholder advisory group that includes specified persons, such as CCS case managers, to consult with that advisory group on the implementation of the WCM, and to consider the advisory group's recommendations on prescribed matters. Existing law terminates the advisory group on December 31, 2021. This bill would instead terminate the advisory group on December 31, 2023.

Primary Sponsors
Sydney Kamlager, Richard Pan
Title
Optometry: scope of practice.

Description
AB 407, as introduced, Salas. Optometry: scope of practice. Existing law, the Optometry Practice Act, establishes the California State Board of Optometry in the Department of Consumer Affairs for the licensure and regulation of the practice of optometry. Existing law provides that the practice of optometry includes various functions relating to the visual system and the treatment and management of certain disorders and dysfunctions of the visual system, as well as the provision of rehabilitative optometric services, and doing certain things, including, but not limited to, the examination of the human eye or eyes. Existing law further authorizes an optometrist who is certified to use therapeutic pharmaceutical agents, as specified, to diagnose and treat certain conditions including, among others, hypotrichosis and blepharitis. This bill additionally would authorize an optometrist who is certified to use therapeutic pharmaceutical agents to diagnose and treat acquired blepharoptosis. The bill would further authorize such an optometrist to use and prescribe, including for rational off-label purposes, therapeutic pharmaceutical agents for the treatment of acquired blepharoptosis in diagnosing and treating the above-described list of conditions.

Primary Sponsors
Rudy Salas, Evan Low
Title
Health care provider emergency payments.

Description
AB 454, as amended, Rodriguez. Health care provider emergency payments. 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 authorizes a health care service plan or health insurer to contract with a provider for alternative rates of payment and authorizes a plan or insurer to seek reimbursement from a provider who has been overpaid for services. This bill would authorize the Director of the Department of Managed Health Care or the Insurance Commissioner to require a health care service plan or health insurer to provide specified payments and support to a provider during and at least 60 days after the end of a declared state of emergency or other circumstance, as specified. The bill would require that, when determining the appropriate amount and type of support to be provided by the health care service plan or health insurer, the director or commissioner take specified factors into consideration, including whether the plan or insurer’s providers have received support from the Federal Emergency Management Agency. Because a willful violation of the bill’s requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Freddie Rodriguez

Organizational Notes
Last edited by Cherie Compartore at Mar 10, 2021, 9:41 PM
Oppose: CAHP, LHPC
Medi-Cal: eligibility.

Description
AB 470, as amended, Carrillo. Medi-Cal: eligibility. Existing law, the Medi-Cal Act, 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 requires Medi-Cal benefits to be provided to individuals eligible for services pursuant to prescribed standards, including a modified adjusted gross income (MAGI) eligibility standard. Existing law prohibits the use of an asset or resources test for individuals whose financial eligibility for Medi-Cal is determined based on the application of MAGI. Existing federal law authorizes a state to establish a non-MAGI standard for determining the eligibility of specified individuals, and existing law imposes the use of a resources test for establishing Medi-Cal eligibility for prescribed populations. This bill would prohibit the use of resources, including property or other assets, to determine eligibility under the Medi-Cal program to the extent permitted by federal law, and would require the department to seek federal authority to disregard all resources as authorized by the flexibilities provided pursuant to federal law. The bill would authorize the department to implement this prohibition by various means, including provider bulletins, without taking regulatory authority. By January 1, 2023, the bill would require the department to adopt, amend, or repeal regulations on the prohibition, and to update its notices and forms to delete any reference to limitations on resources or assets. Because counties are required to make Medi-Cal eligibility determinations, and this bill would expand Medi-Cal eligibility, the bill would impose a state-mandated local program. With respect to the prohibition on resources, the bill would make various conforming and technical changes to the Medi-Cal Act. 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
Wendy Carrillo

Organizational Notes
Last edited by Joanne Campbell at Apr 8, 2021, 4:17 PM
Support - L.A. Care, LHPC
Title
Health insurance.

Description
AB 493, as introduced, Wood. Health insurance. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing federal law, the Patient Protection and Affordable Care Act (PPACA), enacts various health care market reforms. Existing law requires an individual or small group health insurance policy issued, amended, or renewed on or after January 1, 2017, to cover essential health benefits as prescribed, and provides that these provisions shall be implemented only to the extent essential health benefits are required pursuant to PPACA. This bill would delete the provision that conditions the implementation of that provision only to the extent essential health benefits are required pursuant to PPACA, and would make technical, nonsubstantive changes to that provision. Existing law prohibits a nongrandfathered health benefit plan for individual coverage from imposing a preexisting condition provision or waived condition provision upon a person, and makes this provision inoperative if prescribed federal law on minimum essential coverage is repealed or amended. This bill would delete the conditional operation of that provision. Among other things, PPACA requires each health insurance issuer that offers health insurance coverage in the individual or group market in a state to accept every employer and individual in the state that applies for coverage, and prohibits discriminatory premium rates, as specified. PPACA also requires applicable individuals to maintain minimum essential coverage, and imposes a shared responsibility penalty on an applicable individual who does not maintain minimum essential coverage. This provision is referred to as the individual mandate. Existing law requires a carrier to fairly and affirmatively offer, market, and sell all of the carrier's health benefit plans that are sold to, offered through, or sponsored by, small employers or associations that include small employers for plan years on or after January 1, 2014, to all small employers in each geographic region in which the carrier makes coverage available or provides benefits. Existing law provides that the premium rate for a small employer health benefit plan issued, amended, or renewed on or after January 1, 2014, shall vary with respect to the particular coverage involved only by age, geographic region, and whether the contract covers an individual or family, as specified. Under existing law, these provisions would become inoperative 12 months after the repeal of the federal coverage guarantee and premium rate regulation provisions, as prescribed. This bill would delete the conditional operation of the above-described provisions based on the continued operation of the federal coverage guarantee and premium rate r... (click bill link to see more).

Primary Sponsors
Jim Wood
Title
Out-of-network health care benefits.

Description
Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. If an enrollee or insured receives services under a health care service plan contract or health insurance policy issued, amended, or renewed on or after July 1, 2017, that includes coverage for out-of-network benefits, existing law authorizes a noncontracting individual health professional to bill or collect the out-of-network cost-sharing amount directly from the enrollee or insured if specified criteria are met, including that the enrollee or insured consents in writing to receive services from the noncontracting individual health professional at least 24 hours in advance of care. Existing law requires the consent to advise the enrollee or insured that they may seek care from a contracted provider for lower out-of-pocket costs and to be provided in the language spoken by the enrollee or insured, as specified. This bill would instead authorize a noncontracting individual health professional, excluding specified professionals, to bill or collect the out-of-network cost-sharing amount directly from the enrollee or insured receiving services under a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2022, if the enrollee consents in writing or electronically at least 72 hours in advance of care. The bill would require the consent to include a list of contracted providers at the facility who are able to provide the services and to be provided in the 15 most commonly used languages in the facility’s geographic region.

Primary Sponsors
Jim Wood
Medi-Cal: unrecovered payments: interest rate.

AB 521, as amended, Mathis. Medi-Cal: unrecovered payments: interest rate. 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 requires the Director of Health Care Services to establish administrative appeal processes to review grievances or complaints arising from the findings of an audit or examination. Under existing law, if recovery of a disallowed payment has been made by the department, a provider who prevails in an appeal of that payment is entitled to interest at the rate equal to the monthly average received on investments in the Surplus Money Investment Fund, or simple interest at the rate of 7% per annum, whichever is higher. Under existing law, with exceptions, interest at that same rate is assessed against any unrecovered overpayment due to the department. In the case of an assessment against any unrecovered overpayment due to the department, this bill would authorize the director to waive any or all of the interest or penalties owed by a provider, after taking into account specified factors, including the importance of the provider to the health care safety net in the community and the impact of the repayment amounts on the fiscal solvency of the provider.

Primary Sponsors
Devon Mathis
Program of All-Inclusive Care for the Elderly.

Description
AB 523, as amended, Nazarian. Program of All-Inclusive Care for the Elderly. Existing federal law establishes the Program of All-Inclusive Care for the Elderly (PACE), which provides specified services for older individuals at a PACE center, as defined, in part, as a facility that includes a primary care clinic, so that they may continue living in the community. Federal law authorizes states to implement the PACE program as a Medicaid state option. Existing state law establishes the California Program of All-Inclusive Care for the Elderly (PACE program), to provide community-based, risk-based, and capitated long-term care services as optional services under the state's Medi-Cal State Plan, and authorizes the State Department of Health Care Services to implement the PACE program by various means, including letters, or other similar instructions, without taking regulatory action. Under this authority, the department implemented various guidance on the PACE program in response to the state of emergency caused by the 2019 novel coronavirus (COVID-19). Existing law authorizes the department to enter into contracts with various entities to implement the PACE program and fully implement the single state agency responsibilities assumed by the department pursuant to those contracts, as specified. This bill would require the department to make permanent the specified PACE program flexibilities instituted, on or before January 1, 2021, in response to the state of emergency caused by COVID-19 by means of all-facility letters or other similar instructions taken without regulatory action. The bill would require the department to work with the federal Centers for Medicare and Medicaid Services to determine how to extend PACE program flexibilities approved during the COVID-19 emergency.

Primary Sponsors
Adrin Nazarian
Title
Program of All-Inclusive Care for the Elderly.

Description
AB 540, as introduced, Petrie-Norris. Program of All-inclusive Care for the Elderly. Existing federal law establishes the Program of All-Inclusive Care for the Elderly (PACE), which provides specified services for older individuals at a PACE center, defined, in part, as a facility that includes a primary care clinic, so that they may continue living in the community. Federal law authorizes states to implement the PACE program as a Medicaid state option. Existing state law establishes the California Program of All-Inclusive Care for the Elderly (PACE program) to provide community-based, risk-based, and capitated long-term care services as optional services under the state's Medi-Cal State Plan, as specified. Existing law authorizes the State Department of Health Care Services to enter into contracts with various entities for the purpose of implementing the PACE program and fully implementing the single-state agency responsibilities assumed by the department in those contracts, as specified. This bill would exempt a beneficiary who is enrolled in a PACE organization with a contract with the department from mandatory or passive enrollment in a Medi-Cal managed care plan. The bill would require, in areas where a PACE plan is available, that the PACE plan be presented as an enrollment option in the same manner as other managed care plan options, as specified. The bill would require the department to establish an auto-referral system to refer to PACE organizations beneficiaries who appear to be eligible for PACE, based on various criteria, including residence, as specified. The bill would also require, among other things, in areas where a PACE plan is available, that PACE be identified and presented as a Medicare plan option, as specified.

Primary Sponsors
Cottie Petrie-Norris
Integrated School-Based Behavioral Health Partnership Program.

AB 552, as amended, Quirk-Silva. Integrated School-Based Behavioral Health Partnership Program. Existing law requires the governing board of any school district to give diligent care to the health and physical development of pupils and authorizes the governing board of a school district to employ properly certified persons for the work. The School-based Early Mental Health Intervention and Prevention Services for Children Act of 1991 authorizes the Director of Health Care Services, in consultation with the Superintendent of Public Instruction, to award matching grants to local educational agencies to pay the state share of the costs of providing school-based early mental health intervention and prevention services to eligible pupils at schoolsites of eligible pupils, subject to the availability of funding each year. Existing law establishes the Mental Health Student Services Act as a mental health partnership competitive grant program for the purpose of establishing mental health partnerships between a county's mental health or behavioral health departments and school districts, charter schools, and the county office of education within the county, as provided. This bill would establish the Integrated School-Based Behavioral Health Partnership Program to provide prevention and early intervention for, and access to, behavioral health services for pupils. The bill would authorize a county behavioral health agency and the governing board or governing body of a local educational agency to agree to collaborate on conducting a needs assessment on the need for school-based mental health and substance use disorder services, and implement an integrated school-based behavioral health partnership program, to develop a memorandum of understanding outlining the requirements for the partnership program, and to enter into a contract for mental health or substance use disorder services. As part of a partnership program, the bill would require a county behavioral health agency to provide, through its own staff or through its network of contracted community-based organizations, one or more behavioral health professionals that meet specified contract, licensing, and supervision requirements, and who have a valid, current satisfactory background check, to serve pupils with serious emotional disturbances or substance use disorders, or who are at risk of developing a serious behavioral health condition. The bill would require a local educational agency to provide school-based locations, including space at schools, appropriate for the delivery of behavioral health services, and would additionally authorize these services to be provided through telehealth or through appropriate referral. The bill would establish processes for delivering se... (click bill link to see more).

Primary Sponsors
Sharon Quirk-Silva
Title
School-based health programs.

Description
AB 563, as amended, Berman. School-based health programs. 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 by, and funded pursuant to, federal Medicaid program provisions. Existing law establishes the Administrative Claiming process under which the department is authorized to contract with local governmental agencies and local educational consortia for the purpose of obtaining federal matching funds to assist with the performance of administrative activities relating to the Medi-Cal program that are provided by a local governmental agency or local educational agency (LEA). Existing law also provides that specified services provided by LEAs are covered Medi-Cal benefits and are reimbursable on a fee-for-service basis under the LEA Medi-Cal billing option. Existing law requires the department to engage in specified activities relating to the LEA Medi-Cal billing option, such as amending the Medicaid state plan to ensure that schools are reimbursed for all eligible services and examining methodologies for increasing school participation in the LEA Medi-Cal billing option. Existing law requires that these activities be funded and staffed by proportionately reducing federal Medicaid payments allocable to LEAs for the provision of benefits funded by federal Medicaid program payments under the LEA Medi-Cal billing option in an amount not to exceed $1,500,000 annually. This bill would require the State Department of Education to, no later than July 1, 2022, establish an Office of School-Based Health Programs for the purpose of administering current health-related programs under the purview of the State Department of Education and advising it on issues related to the delivery of school-based Medi-Cal services in the state. The bill would require the office to, among other things, provide technical assistance, outreach, and informational materials to LEAs on allowable services and on the submission of claims. The bill would authorize the office to form advisory groups, as specified, and, to the extent necessary, would require the State Department of Health Care Services to make available to the office any information on other school-based dental, health, and mental health programs, and school-based health centers, that may receive Medi-Cal funding. The bill would require the office to be supported through an interagency agreement with the State Department of Health Care Services, and would authorize the office to receive additional funds from grants and other sources. The bill would increase the annual funding limit for the activities of the State D... (click bill link to see more).

Primary Sponsors
Marc Berman, Patrick O'Donnell, James Ramos
Title
Medi-Cal: pharmacy benefits.

Description
AB 671, as amended, Wood. Medi-Cal: pharmacy benefits. 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 contract with a vendor for the purposes of surveying drug price information, collecting data from providers, wholesalers, or drug manufacturers, and calculating a proposed actual acquisition cost. Existing law authorizes the department to establish a list of maximum allowable ingredient cost for generically equivalent drugs, and to establish the actual acquisition cost based on 3 specified factors, including the volume weighted actual acquisition cost adjusted by the department to verify that the actual acquisition cost represents the average purchase price paid by retail pharmacies in California, or the proposed actual acquisition cost as calculated by a vendor, as specified. Existing law requires the department to establish a fee schedule for the list of pharmacist services. Existing law specifies the pharmacist services that may be provided to a Medi-Cal beneficiary. This bill would require the department to provide a disease management or similar payment to a pharmacy that the department has contracted with to dispense a specialty drug to Medi-Cal beneficiaries in an amount necessary to ensure beneficiary access, as determined by the department based on the results of the survey completed during the 2020 calendar year.

Primary Sponsors
Jim Wood
Title
Health care service plans: reimbursement.

Description
AB 685, as amended, Maienschein. Health care service plans: reimbursement. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law requires a health care service plan to reimburse complete claims, or portions thereof, within specified timeframes. Existing law establishes the process and for a health care service plan to contest or deny a claim for reimbursement. Existing law requires every insurer issuing group or individual policies of health insurance that cover hospital, medical, or surgical expenses to reimburse claims within specified timeframes and establishes the process for an insurer to contest or deny a claim for reimbursement. This bill would require health service plans and insurers to obtain an independent board-certified emergency physician review of the medical decisionmaking related to a service before denying benefits, reimbursing for a lesser procedure, reducing reimbursement based on the absence of a medical emergency, or making a determination that medical necessity was not present for claims billed by a licensed physician and surgeon for emergency medical services, as specified. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Brian Maienschein
Title
Observation services.

Description
AB 822, as amended, Rodriguez. Observation services. 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 individuals receive health care services, such as mental health and substance use disorder services, which are delivered through various delivery systems, including fee-for-service and managed care. Under existing law, mental health plans provide specialty mental health services, and Medi-Cal managed health care plans and the fee-for-service Medi-Cal program provide nonspecialty mental health services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. To the extent funds are made available in the annual Budget Act, this bill would expand mental health services to include observation services, as defined, for emergency psychiatric treatment when provided in an observation unit, as defined, subject to utilization controls. The bill would provide that observation services are not specialty mental health services, and would require a Medi-Cal managed health care plan or the fee-for-service Medi-Cal program to reimburse the provider for rendering those services. The bill would authorize the department to implement these provisions by various means, including provider bulletin, without taking regulatory action, and 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.

Primary Sponsors
Freddie Rodriguez

Organizational Notes
Last edited by Cherie Compartore at Apr 5, 2021, 5:54 PM
Oppose Unless Amended: LHPC
Title
Medi-Cal: monthly maintenance amount: personal and incidental needs.

Description
AB 848, as introduced, Calderon. Medi-Cal: monthly maintenance amount: personal and incidental needs. 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 provisions. Qualified individuals under the Medi-Cal program include medically needy persons and medically needy family persons who meet the required eligibility criteria, including applicable income requirements. Existing law requires the department to establish income levels for maintenance need at the lowest levels that reasonably permit a medically needy person to meet their basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under applicable federal law. In calculating the income of a medically needy person in a medical institution or nursing facility, or a person receiving institutional or noninstitutional services from a Program of All-Inclusive Care for the Elderly organization, the required monthly maintenance amount includes an amount providing for personal and incidental needs in the amount of not less than $35 per month while a patient. Existing law authorizes the department to increase, by regulation, this amount as necessitated by increasing costs of personal and incidental needs. This bill would increase the monthly maintenance amount for personal and incidental needs from $35 to $80, and would require the department to annually adjust that amount by the same percentage as the Consumer Price Index.

Primary Sponsors
Lisa Calderon
Title
Medi-Cal: demonstration project.

Description
AB 875, as amended, Wood. Medi-Cal: demonstration project.
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, either through a fee-for-service or managed care delivery system. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes the Global Payment Program (GPP), under which designated public hospitals, and any successor or differently named hospital, are eligible to receive global payments that are calculated using a value-based point methodology based on the health care that they provide to the uninsured. This bill would allow those designated hospitals, if restructured or reorganized, to continue to participate in the GPP.

Primary Sponsors
Jim Wood
Title
Prescription drug cost sharing.

Description
AB 933, as introduced, 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
Title
Telehealth: mental health.

Description
AB 935, as introduced, 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. This bill would require health care service plans and health insurers, by July 1, 2022, to provide access to a telehealth consultation program that meets specified criteria and provides providers who treat children and pregnant and certain postpartum persons with access to a mental health consultation program, as specified. The bill would require the consultation by a mental health clinician with expertise appropriate for pregnant, postpartum, and pediatric patients to be conducted by telephone or telehealth video, and to include guidance on the range of evidence-based treatment options, screening tools, and referrals. 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 monitor data pertaining to the utilization of the program to facilitate ongoing quality improvements, as necessary, and to provide a description of the program to the appropriate department. 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 Mar 24, 2021, 5:51 PM
Oppose Unless Amended - LHPC
Title
Medi-Cal: application for enrollment: prescription drugs.

Description
AB 1050, as introduced, Gray. Medi-Cal: application for enrollment: prescription drugs. (1) 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 requires the department to create and implement a simplified application package for children, families, and adults applying for Medi-Cal benefits. Existing federal law, the Telephone Consumer Protection Act, among other provisions, prohibits any person within the United States, or any person outside the United States if the recipient is within the United States, from making any call to any telephone number assigned to a paging service, cellular telephone service, specialized mobile radio service, or other radio common carrier service, or any service for which the called party is charged for the call, without the prior express consent of the called party, using any automatic telephone dialing system or an artificial or prerecorded voice. Under existing case law, a text message is considered a call for purposes of those provisions. This bill would require the application for enrollment to include a statement that if the applicant is approved for Medi-Cal benefits, the applicant agrees that the department, county welfare department, and a managed care organization or health care provider to which the applicant is assigned may communicate with them regarding their care or benefits through all standard forms of communication, including, but not limited to, Free to End User text messaging.

(2) Existing federal law, known as the 340B discount drug purchasing program, generally requires pharmaceutical manufacturers participating in Medicaid to give discounts on pharmaceutical drugs to covered entities, as defined, serving the Medicaid population. This program is commonly referred to as the 340B program. Under existing law, the Medi-Cal program requires a covered entity to dispense only drugs purchased through the 340B program to a Medi-Cal beneficiary. Existing law, if a covered entity is unable to purchase a drug for a Medi-Cal beneficiary through the 340B program, authorizes the covered entity to dispense a drug purchased at a regular drug wholesale rate, and limits the amount the covered entity may charge the Medi-Cal program for reimbursement of the purchase of the drug. This bill would provide that those reimbursement requirements do not apply to federally qualified health centers (FQHCs) or rural health clinics (RHC) that are subject to federal minimum payment provisions, which calculate payment for services of the FQHCs and RHCs according ...

(click bill link to see more).

Primary Sponsors
Adam Gray
Title
Medi-Cal: specialty mental health services: foster youth.

Description
AB 1051, as amended, Bennett. Medi-Cal: specialty mental health services: foster youth. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services (department), under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, specialty mental health services include federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services provided to eligible Medi-Cal beneficiaries under 21 years of age. Existing law requires each local mental health plan to establish a procedure to ensure access to outpatient specialty mental health services, as required by the EPSDT program standards, for youth in foster care who have been placed outside their county of adjudication, as described. Existing law requires the department to issue policy guidance concerning the conditions for, and exceptions to, presumptive transfer of responsibility for providing or arranging for specialty mental health services to a foster youth from the county of original jurisdiction to the county in which the foster youth resides, as prescribed. This bill would make those provisions for presumptive transfer inapplicable to a foster youth or probation-involved youth placed in a community treatment facility, group home, or a short-term residential therapeutic program (STRTP) outside of their county of original jurisdiction, as specified. The bill would prohibit the presumptive transfer of foster youth placed in a group home, community treatment facility, or a STRTP unless an exception is invoked, as requested by one of specified individuals or entities pursuant to certain criteria. The bill would make the county probation agency or the child welfare services agency responsible for determining whether invoking the exception is appropriate. Upon the approval of an exception by the county probation agency or the child welfare services agency, the bill would require presumptive transfer to immediately occur, and would require the mental health plan in the county in which the foster youth resides to assume responsibility for the authorization and provision of specialty mental health services and payments for those services. The bill would impose various notification requirements on the county placing agency and county mental health plans, and would require documentation of the invoked exception to be included in the foster youth’s case plan. The bill would authorize a requester who disagrees with the county agency’s determination to request judicial review, as specified. The bill would impose procedural requirements for mental health assessments of the affected foster youth. ... (click bill link to see more).

Primary Sponsors
Steve Bennett
Title
Pharmacy practice: vaccines: independent initiation and administration.

Description
AB 1064, as amended, Fong. Pharmacy practice: vaccines: independent initiation and administration. Existing law, the Pharmacy Law, establishes the California State Board of Pharmacy within the Department of Consumer Affairs and sets forth its powers and duties relating to the licensing and regulation of pharmacists. A violation of the Pharmacy Law is a crime. Existing law authorizes a pharmacist to administer immunizations pursuant to a protocol with the prescriber. Existing law provides additional authority for the pharmacist to independently initiate and administer any COVID-19 vaccines approved or authorized by the federal Food and Drug Administration, or vaccines listed on the routine immunization schedules recommended by the federal Advisory Committee on Immunization Practices (ACIP), in compliance with individual ACIP vaccine recommendations, and published by the federal Centers for Disease Control and Prevention for persons 3 years of age and older. This bill would recast this provision to instead authorize a pharmacist to independently initiate and administer any vaccine approved or authorized by the United States Food and Drug Administration for persons 3 years of age and older.

Primary Sponsors
Vince Fong

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Title
Health information network.

Description
AB 1131, as amended, Wood. Health information network. Existing law makes legislative findings and declarations on health information technology, including that there is a need to promote secure electronic health data exchange among specified individuals, such as health care providers and consumers of health care, and that specified federal law provides unprecedented opportunity for California to develop a statewide health information technology infrastructure to improve the state’s health care system. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law 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. This bill would
establish the statewide health information network (statewide HIN) governing board, an independent public entity not affiliated with an agency or department with specified membership, to provide the data infrastructure needed to meet California's health care access, equity, affordability, public health, and quality goals, as specified. The bill would require the governing board to issue a request for proposals to select an operating entity with specified minimum capabilities to support the electronic exchange of health information between, and aggregate and integrate data from multiple sources within, the State of California, among other responsibilities. The bill would require the statewide HIN to take specified actions with respect to reporting on, and auditing the security and finances of, the health information network. The bill would require the statewide HIN to convene a health technology advisory committee with specified membership to advise the statewide HIN and set agendas, hold public meetings with stakeholders, and solicit external input on behalf of the statewide HIN. The bill would also require a health care entity, including a hospital, health system, skilled nursing facility, laboratory, physician practice, health care service plan, health insurer, and the State Department of Health Care Services, to submit specified data to the operating entity. The bill would authorize the statewide HIN to add additional health care entities or data to the list of entities required to submit data to the statewide HIN by adopting a subsequent regulation. The bill would also require a health care service plan, health insurer, and a health care provider to col...
(click bill link to see more).

Primary Sponsors
Jim Wood

Organizational Notes
Last edited by Cherie Compartore at Apr 6, 2021, 3:46 PM
Support: Anthem Blue Cross, Blue Shield, Inland Empire Health plan, Manifest Medex, SEIU.
Title
Medi-Cal.

Description
AB 1132, as amended, Wood. Medi-Cal. 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, either through a fee-for-service or managed care delivery system. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing federal law provides for the federal Medicare program, which is a public health insurance program for persons who are 65 years of age or older and specified persons with disabilities who are under 65 years of age. Under existing law, a demonstration project known as the Coordinated Care Initiative (CCI) enables beneficiaries who are dually eligible for the Medi-Cal program and the Medicare Program to receive a continuum of services that maximizes access to, and coordination of, benefits between these programs. This bill would make specified portions of the CCI operative only through December 31, 2022, as specified, and would repeal its provisions on January 1, 2025.

Primary Sponsors
Jim Wood
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. Under existing law, these health care services are provided through various 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 Medi-Cal managed care plan. Existing law imposes various requirements on managed care plan contractors, including network adequacy standards relating to time and distance, and requires the department to ensure that specified benefits, such as mental health, are provided by the contractors in compliance with prescribed federal law. Existing federal law authorizes specified managed care entities that participate in a state's Medicaid program to cover, for enrollees, services or settings that are in lieu of services and settings otherwise covered under a state plan. Existing law requires the department to establish a Medically Tailored Meals Pilot Program to operate for a period of 4 years from the date the program is established, or until funding is no longer available, whichever date is earlier, in specified counties to provide medically tailored meal intervention services to Medi-Cal participants with prescribed health conditions, such as diabetes and renal disease. Effective for contract periods commencing on or after January 1, 2022, this bill would authorize Medi-Cal managed care plans to provide medically tailored meals to enrollees. The bill would authorize the department to implement this provision by various means, including plan or provider bulletins, and would require the department to seek federal approvals. The bill would condition the implementation of this provision on the department obtaining federal approval and the availability of federal financial participation.

Primary Sponsors
Blanca Rubio
Health care coverage: claims payments.

AB 1162, as introduced, Villapudua. Health care coverage: claims payments. 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 to provide access to medically necessary health care services to its enrollees or insureds who have been displaced by a state of emergency. Existing law enumerates actions that a plan or insurer may be required to take to meet the needs of its enrollees or insureds during the state of emergency. Under existing law, the department may relax time limits for prior authorization during a state of emergency. Existing law requires a health care service plan or a health insurer to reimburse each complete claim, as specified, as soon as practical, but no later than 30 working days, or for a health maintenance organization, 45 working days, after receipt of the complete claim. Under existing law, within 30 working days, or 45 working days for a health maintenance organization, after receipt of the claim, a plan or insurer can contest or deny a claim, as specified. Existing law also authorizes the plan or insurer to request reasonable additional information about a contested claim within 30 working days, or for a health maintenance organization, 45 working days. Existing law allows the plan or insurer 30 working days, or a health maintenance organization 45 working days, after receipt of the additional information to reconsider the claim. Under existing law, once the plan or insurer has received all the information necessary to determine payer liability for the claim and has not reimbursed the claim deemed to be payable within 30 working days, or 45 working days for a health maintenance organization, interest will accrue as specified. Under existing law, for an unpaid claim for nonemergency services, the plan or insurer is required to pay interest, and a plan is required to automatically include the interest in its payment to the claimant on an uncontested claim that has not been paid within the prescribed period. Under existing law, if a plan fails to automatically include this interest owed, it is required to also pay the claimant a $10 fee for failing to comply with this requirement. Under existing law, if a claim for emergency services is not contested by the plan or insurer, and the plan or insurer fails to pay the claim within the 30- or 45-day respective period, the plan or insurer is required to pay a fee or interest, as specified. This bill would require a health care s...

Primary Sponsors
Carlos Villapudua
Title
Medi-Cal eligibility.

Description
AB 1214, as amended, Waldron. Medi-Cal 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 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 make an individual incarcerated in the state prison or a county jail eligible for the Medi-Cal program for 30 days prior to the date they are released from the correctional facility if they have a chronic physical or behavioral health condition, a mental illness, or a substance use disorder. The bill would require the department to seek any waivers or state plan amendments necessary to implement its provisions, and would require the department to send an annual report to the Legislature on the implementation of these provisions, as specified. Because counties are required to make Medi-Cal eligibility determinations, 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
Marie Waldron
Board of Governors
MOTION SUMMARY

Date: April 26, 2021

Committee: Executive

Chairperson: Hector De La Torre

Motion No. EXE 100.0521

Issue: Approval of revisions to Legal Services Policy & Procedure No. LS-007 (Legal Hold of Records, Documents; Preservation of Evidence) pertaining to the placement of legal hold on documents and preservation of records, which expand the definition of covered individuals, ensure consistent use of defined terms, and comply with format of new template.

Background:
Legal Services Policy & Procedure No. LS-007 (the “Policy”) has been in effect since 2011. The Policy requires L.A. Care employees to preserve documents and records when the Legal Services Department issues a Legal Hold in response to a pending or potential legal action, government investigation, a subpoena, or as otherwise required by law.

The Legal Services Department has recently undertaken a review of the Policy and determined that it should be expanded to cover not only full-time and temporary employees and consultants, but also non-employees such as members of the Board of Governors, interns, volunteers, and agents of L.A. Care.

In addition, the Policy was revised for clarity and for consistent use of certain defined terms, as well as to comply with the standardized format for all L.A. Care policies and procedures.

A copy of the revised Policy showing the proposed revisions is attached hereto.

Member Impact: No member impact.

Budget Impact: No budget impact.

Motion: To approve the revisions to the attached Legal Services Policy & Procedure No. LS-007 (Legal Hold of Records, Documents; Preservation of Evidence) and delegate authority to General Counsel or designee to make any non-substantive or technical changes.
# Legal Hold of Records, Documents; Preservation of Evidence

**Department:** LEGAL SERVICES

**Supersedes Policy Number(s):**

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## Dates

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<th>10/12/2011</th>
<th>Review Date</th>
<th><em><strong>/</strong></em>/2018</th>
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<td>Committee Review Date</td>
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## Lines of Business

- [ ] Cal MediConnect
- [ ] L.A. Care Covered
- [ ] L.A. Care Covered Direct
- [ ] MCLA
- [ ] PASC-SEIU Plan
- [ ] Internal Operations

---

## Delegated Entities / External Applicability

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

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## Accountability Matrix

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## Attachments

- [ ] None

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## Electronically Approved By The Following

<table>
<thead>
<tr>
<th>Officer</th>
<th>Director</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME</td>
<td>DIRECTOR</td>
</tr>
<tr>
<td>Augustavia J. Haydel</td>
<td>Ellin Davtyan</td>
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<tr>
<td>DEPARTMENT</td>
<td>Legal Services</td>
</tr>
<tr>
<td>TITLE</td>
<td>Associate General Counsel</td>
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AUTHORITIES

- California Code of Civil Procedure Title 4, Civil Discovery Act.

REFERENCES


HISTORY

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<tr>
<td>###/##/2021</td>
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DEFINITIONS

Please visit the L.A. Care intranet for a comprehensive list of definitions used in policies: http://insidelac/ourtoolsandresources/departmentpoliciesandprocedures
1.0 OVERVIEW:

1.1 L.A. Care Health Plan (“L.A. Care”) shall comply with the legal duty to place a Legal Hold on Records, preserve Records, in whatever form they were generated and maintained, and not destroy Records relevant to an audit, investigation, official legal matter, or lawsuit or litigation when such occurs or is reasonably certain to occur, consistent with applicable laws and this policy.

2.0 DEFINITIONS:

Whenever a word or term appears capitalized in this Policy and Procedure, the reader should refer to the “Definitions” below.

2.1 Covered Individual[s]: For purposes of this Policy and Procedure, the term “Covered Individual[s]” includes full-time employees, members of the Board of Governors, temporary employees (whether through L.A. Care or a contracted temporary agency), interns, volunteers, per diem employees, consultants, and agents of L.A. Care.

2.2 General Counsel: For purpose of this Policy and Procedure the term “General Counsel” includes the General Legal Services Unit of the Legal Services Department, or any other designee of the General Counsel or authorized Legal Services Department staff.

2.12.3 Legal Hold: Legal Hold is a process to preserve and cease the destruction of and to “hold” Records and documents related to or reasonably believed to be relevant to an actual or reasonably certain to occur audit, investigation, legal matter, lawsuit or litigation. Legal Holds are, when appropriate or required by law.

2.22.4 Record[s]: For the purposes of this Policy and Procedure, the term “Record[s]” shall mean all recorded, retrievable information and documents, regardless of physical, computerized, or electronic form or medium, including but not limited to, all documents, letters, memoranda, opinions, reports, books, paper, drawings, e-mails, business records, contracts, medical records and research records, charts, photographs, x-rays, audio recordings, microfilm, magnetic tape, electronic media, electronic data, and other information created or received in connection with L.A. Care’s operations and activities, or related to its legal or regulatory obligations. Only one copy of any Record is required to be held.

3.0 POLICY:

3.1 Legal Hold Required. In the event of an imminent, actual, or pending lawsuit or litigation, government investigation or audit, or independent audit (“Matter[s]”), or when a Matter is reasonably certain to occur, Records applicable or related to such Matter, or those Records that L.A. Care should know are applicable or relevant to such Matter, shall not be destroyed and must be preserved until the conclusion of such Matter, as determined by the Legal Department-General Counsel. All
destruction of applicable or relevant Records undercovered by this policy and procedure must immediately cease upon notice of an imminent or pending lawsuit, litigation, investigation or audit.

3.1.1 Notwithstanding anything to the contrary in any L.A. Care Records Retention and Destruction Schedule or Policy and Procedure, applicable and relevant Records subject to Legal Hold may not be disposed of until the lawsuit or litigation, or government investigation or audit has been concluded or the Legal Department General Counsel confirms that the Records have no bearing on or relevance to the Matter. The General Counsel shall determine when such Records may again be destroyed in accordance with any Records Retention and Destruction Schedule or Policy and Procedure. The General Counsel shall notify L.A. Care staff when it may resume compliance with any Records Retention and Destruction Schedule or Policy and Procedure related to Records subject to Legal Hold.

3.1.2 The General Counsel shall, when required by law or is otherwise deemed appropriate and prudent, will take appropriate steps to issue a Legal Hold to ensure that applicable and related Records are identified and protected upon the occurrence of any of the following and shall institute a Legal Hold: (i) upon receipt of service of process commencing a civil lawsuit, administrative action, other legal process or litigation; (ii) upon receipt of subpoena, court order or search warrant requiring the production of Records; (iii) upon learning of a relevant government inquiry or audit; (iv) upon notification of or request for voluntary cooperation with governmental authorities, (v) upon notice of an impending legal or other action, including the presentation of a claim pursuant to the Government Claims Act or (vi) upon a reasonable certainty that any of the above may occur. The General Counsel shall have and retain the discretion to determine whether, in any given instance, a Legal Hold is required.

4.0 PROCEDURES:

3.24.1 Notice to Employees Covered Individuals and Third Parties. Upon determining that a Legal Hold is necessary, the General Counsel shall promptly issue a notice to employees Covered Individuals with sufficient information and instructions to commence a Legal Hold (“Legal Hold Notice”). L.A. Care Managers, Directors and Officers are responsible to ensure that their staffs comply with any Legal Hold and Legal Hold Notice. The Legal Hold Notice may also need to be issued to L.A. Care’s vendors, consultants or other outside entities, including but not limited to outside vendors.

\[\text{Any reference herein to “General Counsel” includes a designee of the General Counsel or the Legal Department staff.}\]
legal counsel ("Third Parties") if the General Counsel has reason to be believe that a Third Party is in the possession of Records subject to Legal Hold.

3.3 Legal Hold Monitoring and Tracking. The Legal Department shall track and record all Legal Hold Notices issued and Records subject to Legal Hold. Employees and Third Parties shall, at the General Counsel’s request in a format required by the Legal Services Department, provide the Legal Department with an itemized list of Records retained subject to the Legal Hold.

3.3.1 As necessary, the General Counsel shall issue periodic reminders of and updates to the Legal Hold Notice. The General Counsel shall document its reasons for implementing a Legal Hold for a particular matter. The General Counsel shall monitor compliance with the Legal Hold and this Policy and Procedure.

3.4 Any questions or uncertainty regarding whether a Record is in one of the categories set forth in this Policy and Procedure, or is otherwise subject to Legal Hold, should be immediately addressed with the Legal Department. General Counsel. The General Counsel’s approval shall be obtained prior to destruction of a Record subject to Legal Hold. Employees Covered Individuals shall not selectively discard Records that would otherwise normally be retained for a longer period of time pursuant to a Records retention and destruction schedule or that are subject to Legal Hold because the employee Covered Individual believes that the Records might be harmful to any employee Covered Individual, himself/herself or to L.A Care.

3.5 L.A. Care’s obligation to preserve Records potentially relevant to a matter subject to this Policy and Procedure and Legal Hold supersedes any existing L.A. Care document destruction schedule or policy. The Legal Hold applies and preservation must occur even if the information subject to the Legal Hold may ultimately be withheld as privileged or determined to be unreasonably burdensome to produce.

3.6 Employees (for purposes of this Policy and Procedure) "Employees" includes full-time, temporary and consultants. Covered Individuals shall maintain all Records subject to Legal Hold, in accordance with any directions of the Legal Department. Employees If the Legal Hold Notice includes instructions limiting the release of the Records subject thereto, Covered Individuals shall not release any such Records subject to Legal Hold to any outside entity or party unless and until at the direction of the they are permitted or directed to do so by the General Counsel.

3.7 Information pertaining to unauthorized destruction, removal or falsification of Records should be reported to the Legal Department or L.A. Care management directly or through L.A. Care’s Compliance Helpline at (800) 400-4889.

5.0 MONITORING:

5.1 The General Counsel shall track and record all Legal Hold Notices issued and Records subject to Legal Hold. Employees and Third Parties shall, at the General
Counsel’s request in a format required by the Legal Services Department, provide the Legal Services Department with an itemized list of Records retained subject to the Legal Hold.
Date: April 26, 2021  
Motion No. EXE 101.0521  
Committee: Executive  
Chairperson: Hector De La Torre  

**Issue:** Provide funding support for the development of a new independent medical education program (IMEP) at the Charles R. Drew University of Medicine and Science – College of Medicine.  

☑️ New Contract  □ Amendment  □ Sole Source  □ RFP/RFQ was conducted in N/A

**Background:** L.A. Care has been approached by the Charles R. Drew University of Medicine and Science (CDU) regarding funding support for a new four-year medical degree program aimed at addressing the physician workforce shortage in South Los Angeles. The new independent medical education program (IMEP) will admit 60 medical students annually starting in the summer of 2023. This program will complement, and not replace, the current CDU forty-year partnership with the University of California, Los Angeles (UCLA), which successfully trains 24-28 medical students per year in the CDU/UCLA Medical Education Program.  

As of April 15, 2021, CDU has raised $11,975,00.00, from institutions such as the Kaiser Foundation Hospitals and the California Endowment, towards the 5-year, $75 million comprehensive campaign. To further support the fund raising efforts, CDU has been working with CA legislature and Congress to seek appropriations or an earmark for the IMEP as well as inclusion in a higher education bond measure; has hired a major gift officer to secure major gifts to the university; and has planned meetings with several foundations to confirm additional funding support.  

CDU is seeking a one-time $5 million grant from L.A. Care to support the following key developments:  
- Enhance the current Simulation Center to offer medical training activities for students and faculty;  
- Establish a center for faculty development to focus on the recruitment, retention and development of faculty;  
- Establish a service learning program for medical students to offer certifications as emergency medical technicians, community health workers and patient navigators; and  
- Develop a community health pre-matriculation training experience focused on professionalism and wellness activities for medical students.  

The IMEP builds on L.A. Care’s current funding support for CDU under our Elevating the Safety Net (ESN) initiative - Medical School Scholarship Program and Residency Support Program.  

L.A. Care considers this program well-aligned with our ESN guiding principles of increasing health access, promoting equity and cultural competence, as well as building a premier health care workforce. L.A. Care’s ESN programs seek to increase access for our members in Los Angeles County and improve equity and cultural competence among our provider network.  

For this reason, we recommend supporting this endeavor through a one-time $5 million grant to CDU.
MOTION SUMMARY

**Member Impact:** This initiative aligns with L.A. Care’s organizational goal 2.2: develop and implement strategies to promote quality performance in the provider network. The initiative also aligns with organizational goal 4.3: mobilize our community resources to ensure that we are responsive and accountable to the needs of our members and constituents. Goal 4.5 is also addressed: foster innovative approaches to improving the health status of our members and the quality of care provided by the safety net.

**Budget Impact:** This expenditure will be funded by the Board Designated Funds which is already set aside for the workforce development initiative.

**Motion:** Authorize an expenditure in the amount of $5 million for the Charles R. Drew University of Medicine and Science (CDU) to support the development of an independent medical education program (IMEP) in South Los Angeles for the period of July 1, 2021 through December 31, 2027.
March 26, 2021

TO: Executive Committee
FROM: Terry Brown, Chief Human Resources Officer
SUBJECT: AB 2589 – Annual Disclosure of Broker Fees

To comply with the requirements of AB 2589 in reporting insurance broker fees associated with the various health and welfare benefits L.A. Care offers to its employees, identified below is the disclosure of the commission earned by Woodruff Sawyer, our broker of record for the majority of our various health and wellness insurers providing L.A. Care employee benefits for the last two fiscal years (2019-2020 and 2020-2021). Commission is paid to Woodruff Sawyer on a monthly or annual basis, and the amount is based on the number of participants in the benefit program. This disclosure also includes commissions paid to LTC Solutions, Inc., the writing agent for the Genworth policy.

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<tr>
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<td>Varies by plan 70%-90% 1st year 2.5%-10% years 2+</td>
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<td>Line of Coverage</td>
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<td>The rest of the residual target premium held from year 1 (total of 95% of target over 2 years) 1% years 3-10</td>
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In addition to insurance placement, additional services provided by Woodruff Sawyer for the commission payment include:

- Woodruff Sawyer core consulting services
- Wellness consulting services & platform up to $80k beginning 7/1/2017
- FSA/COBRA administration
- Assistance with development and updates to employee communications
- Self-funding actuarial reports, including reserve calculations & COBRA rates
- Compliance consulting
- ThinkHR and Zywave online & telephonic support for Human Resources
- Dependent Specialists, Inc. – dependent eligibility verification services
- Employee Call Center

Our external consultant, Pearl Meyer, has reviewed the commission structures and found them to be reasonably positioned in the range of costs paid by similarly-sized organizations in the state of California.
MEMO

Date: March 26, 2021

To: Terry Brown, Chief Human Resources Officer, L.A. Care

From: Steven T. Sullivan, Managing Director

RE: Reasonableness of L.A. Care Employee Benefit Broker Commissions

The broker costs (commissions and fees) levels paid by L.A. Care, as a percent of plan premiums for employee health insurance coverage during the 2020/2021 plan year are reasonably positioned in the range of costs paid by similar-sized organizations in the state of California. In general, there is an inverse relationship between organization size (# covered employees) and broker costs as a percent of plan premium. Larger organizations (such as L.A. Care) pay larger premiums, while the actual broker costs remain relatively constant. Broker costs as a percent of premium therefore are typically less for larger employers than for smaller employers with less insured employees.

Observations

L.A. Care, with as many as 1,900 covered employees enrolled in health insurance plans, paid broker costs of 1.90% of plan premiums across its lines of employee health insurance coverage for the 2019/2020 plan year. 500 California employers with a median (50th percentile) employee count of 1,740 paid a median broker cost (as a percent of premium) of 2.83%.

Based on the fact that L.A. Care has a smaller employee (enrollee) count for a number of its benefit coverages (Blue Shield with 205 enrollees, Pet Insurance with 94 enrollees), Pearl Meyer also evaluated a larger group of employers with smaller employee counts. 1,317 California employers with a median employee count of 772 paid a median broker cost (as a percent of premium) of 3.78%.

Generally across the U.S. marketplace, health insurance broker costs are 3% to 4% of plan premiums for fully-insured plans. The California market observations in the current analysis are all based on data reflecting fully-insured plans. Market data reflecting broker costs as a percent of plan premium for self-funded health insurance plans is not as reliable. Brokers can increase other payments in order to decrease their costs as a percent of premium.
Methodology

Pearl Meyer gathered data for the state of California for all employers that filed Form 5500s in 2018, 2019 and 2020. Plan data reflects all benefit plans with at least 100 participants. The following summarizes our approach to analyzing the data:

1) Eliminated all incomplete records
2) Eliminated all records prior to 2018
3) Eliminated all records for self-funded plans
4) The previous three steps resulted in a database of 5,185 employers
5) Eliminated all records below the 75th percentile based on employee count (reduced the database to the top quartile of employer size), resulting in 1,197 employers
6) Calculated 25th, 50th, 75th percentiles and average broker costs as a percent of plan premium
7) Eliminated all but the 500 largest employers based on employee count
8) Calculated 25th, 50th, 75th percentiles and average broker costs as a percent of plan premium