EXECUTIVE COMMITTEE MEETING
Board of Governors

March 22, 2022 • 2:00 PM
L.A. Care Health Plan
1055 W. 7th Street, Los Angeles, CA 90017
AGENDA
Executive Committee Meeting
Board of Governors
Tuesday, March 22, 2022, 2:00 P.M.
L.A. Care Health Plan, 1055 West 7th Street, 10th Floor, Los Angeles

Please recheck these directions for updates prior to the start of the meeting. This meeting will be conducted in accordance with the provisions of the Ralph M. Brown Act, allowing members of the Board, members of the public and staff to participate via teleconference, because State and Local officials are recommending measures to promote social distancing. Accordingly, members of the public should join this meeting via teleconference as follows:
https://lacare.webex.com/lacare/j.php?MTID=me198337b440101202eb5b01bf8a0ccc4

To join and LISTEN ONLY via teleconference please dial: (213) 306-3065
Access code: 249 626 42877 Password: lacare

Members of the Executive Committee or staff may participate in this meeting via teleconference. The public is encouraged to submit public comments or comments on Agenda items in writing by e-mail to BoardServices@lacare.org, or by sending a text or voicemail to (213) 628-6420.

Attendees who log on to lacare.webex using the URL above will be able to use “chat” during the meeting for public comment. You must be logged into Webex to use the “chat” feature. The log in information is at the top of the meeting Agenda.

We continue to use different ways to submit public comment live and direct during the meeting.
1. The “chat” will be available during the public comment periods before each item.
2. To use the “chat” during public comment periods, look at the bottom right of your screen for the icon that has the word, “chat” on it.
3. Click on the chat icon. It will open two small windows.
4. Select “Everyone” in the To: window,
5. The chat message, 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.
6. Type your public comment in the box that says “Enter chat message here”.
7. When you hit the enter key, your message is sent and everyone can see it.
8. L.A. Care staff will read the chat messages for up to three minutes during public comment so people who are on the phone can hear the comment.

Your comments can also be sent by voicemail, email or text. If we receive your comments by 2:00 pm on February 22, 2022, it will be provided to the members of the Executive Committee at the beginning of the meeting. The chat message, text, voicemail, or email must indicate if you wish to be identified or remain anonymous, and must also include the name of the item to which your comment relates.

Public comments submitted will be read for up to three minutes during the meeting.

Once the meeting has started, public comment must be received before the agenda item is called by the meeting Chair and staff will read those comments for up to three minutes. Chat messages submitted will be read for up to three minutes during the public comment period for each item. 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.
These are extraordinary circumstances, and the process for public comment is evolving and may change at future meetings. We thank you for your patience.

There may be some delay in the digital transmittal of emails, texts and voicemail. The Chair will announce when public comment period is over for each item. If your public comments are not received in 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. 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 Chair
2. Public Comment (please see instructions above) Chair
3. Approve February 22, 2022 Meeting Minutes p.5 Chair
4. Chairperson’s Report Chair
5. Chief Executive Officer Report John Baackes Chief Executive Officer

COMMITTEE ITEMS
Cherie Compartore Senior Director, Government Affairs
6. Government Affairs Update p.13 Chair
John Baackes Cynthia Carmona Senior Director, Safety Net Initiatives
7. Elevating the Safety Net Initiatives Update p.122 Chair

8. Approve the list of items that will be considered on a Consent Agenda for April 7, 2022 Board of Governors Meeting.
   • March 3, 2022 Board of Governors Meeting Minutes
   • TransUnion Contract for encounter collection and processing services
   • Change Health Resources Contract Amendment
   • Invent Health Contract Amendment
   • Interpreting Services International, LLC Contract (ISI)

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

ADJOURN TO CLOSED SESSION (Est. time: 90 mins.)
Chair

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

11. 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: March 2024

12. CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION
   Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act
   Butler v. L.A. Care, Case No. 18STCV08155

13. CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION
   Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act

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

15. CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION
   Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act
   Department of Managed Health Care Enforcement Matter Numbers: 18-799, 20-063, 21-428, 21-509, 21-680

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

17. CONFERENCE WITH LABOR NEGOTIATOR
   Pursuant to Section 54957.6 of the Ralph M. Brown Act
   Agency Designated Representative: Hector De La Torre
   Unrepresented Employee: John Baackes

RECONVENE IN OPEN SESSION

ADJOURN

The next Executive Committee meeting is scheduled on Tuesday, April 26, 2022 at 2:00 p.m.
and may be conducted as a teleconference meeting.

Public comments will be read for up to three minutes.

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 participate in 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.

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

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

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

Any documents distributed to a majority of the Board Members regarding any agenda item for an open session after the agenda has been posted will be available for public inspection at http://www.lacare.org/about-us/public-meetings/board-meetings and can be requested by email to BoardServices@lacare.org.

An audio recording of the meeting is made to assist in writing the minutes and is retained for 30 days.

Meetings are accessible to people with disabilities. Individuals who may require any accommodations (alternative formats - i.e., large print, audio, translation of meeting materials, interpretation, etc.) to participate in this meeting and wish to request an alternative format for the agenda, meeting notice, and meeting packet may contact L.A. Care’s Board Services Department at (213) 628 6420. Notification at least one week before the meeting will enable us to make reasonable arrangements to ensure accessibility to the meetings and to the related materials.
State and local officials continue to impose or recommend measures to promote social distancing to reduce transmission of the COVID-19 virus. It is prudent to use caution in protecting the health of the public, L.A. Care’s employees and its members where adequate virtual means exist to permit the meeting to occur by teleconference/videoconference with the public being afforded the ability to comment in real time. The Board of Governors and all legislative bodies of the L.A. Care Health Plan, and the Board of Directors and all legislative bodies of the Joint Powers Authority will continue to meet virtually and the Boards will review that decision on an on-going basis as provided in the Brown Act. Members of the public had the opportunity to listen to the meeting via teleconference, and share their comments via voicemail, email, or text.

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<td>CALL TO ORDER</td>
<td>Hector De La Torre, <em>Chairperson</em>, called to order the L.A. Care Executive Committee and the L.A. Care Joint Powers Authority Executive Committee meetings at 2:16 p.m. The meetings were held simultaneously. He welcomed everyone to the meetings. Chairperson De La Torre acknowledged that February is Black History Month. He noted that it is very important to think about the impacts on our African American population including L.A. Care members, staff, stakeholders, provider network, and the great contributions that have been made and the work that still needs to be done going forward. • 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.</td>
<td><strong>ACTION TAKEN</strong></td>
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|                      | • 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 an 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.  
He provided information on how to comment live and direct using the “chat” feature. | Approved unanimously by roll call. 4 AYES (Ballesteros, Booth, De La Torre and Shapiro). |
| APPROVE MEETING AGENDA | The Agenda for today’s meeting was approved.  
(Member Perez joined the meeting.) | Approved unanimously by roll call. 4 AYES (Ballesteros, Booth, De La Torre and Shapiro). |
| PUBLIC COMMENT | There were no public comments. | |
| APPROVE MEETING MINUTES | The minutes of the January 25, February 11, and February 15, 2022 meetings were approved as submitted. | Approved unanimously by roll call. 5 AYES (Ballesteros, Booth, De La Torre, Perez and Shapiro). |
| CHAIRPERSON’S REPORT | Chairperson De La Torre announced that the Los Angeles County Board of Supervisors has appointed a new Board Member for the seat representing disproportionate share hospitals, John Raffoul. Mr. Raffoul is President of Adventist White Memorial, and his first board meeting will be March 3, 2022. | |
| CHIEF EXECUTIVE OFFICER REPORT | John Baackes, Chief Executive Officer, reported  
• L.A. Care continues its efforts to increase the COVID 19 vaccination rate among enrollees. As of this date, 67.5% of L.A. Care members 12 years and older have received a vaccine. This is still 20 percentage points behind the rate for all residents in Los Angeles County. California uses the 12+ age metric for the state-wide incentive program, which has provided resources that L.A. Care has used to increase the vaccination rate. The state-wide incentive program began on September 1, 2021 and will end on March 2, 2022.  L.A. Care will continue to offer an incentive program | |
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<td>after March 2. L.A. Care’s latest addition to efforts to increase the vaccination rate involves primary care providers, as a trusted source of information, reaching out to unvaccinated L.A. Care members to listen to the members and encourage them to get a vaccine. L.A. Care offers a financial incentive to the primary care provider for each person that is vaccinated. Mr. Baackes, and everyone at L.A. Care, believes that it is really important to keep up the effort to increase the vaccination rate among members. Members who are not vaccinated may be subject to continued variations of the COVID 19 virus, and may also be putting themselves at risk for other things that could develop. It is probably the most important thing we can do to improve the health status for L.A. Care members.</td>
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<td>• L.A. Care’s enrollment continues to increase, and is over 2.5 million in January 2022, and is even higher in February, 2022. There are several sources of the increase:</td>
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<td>o 19,000 additional members in L.A. Care Covered,</td>
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<td>o Implementation of the new California Advancing and Innovating Medi-Cal (CalAIM) program has increased Medi-Cal enrollment by moving categories of members from fee for service to managed care,</td>
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<td>o Re-determination of eligibility for Medi-Cal has not resumed, which has allowed Medi-Cal members to continue to receive benefits. It is expected the redetermination will resume in April, 2022, although there is an effort across California to have the date extended to avoid a large backlog. Counties will have to process all Medi-Cal members within one year, and</td>
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<td>o In May, 2022, another large influx of members is expected as eligible undocumented residents ages 50 years and older will be able to enroll in Medi-Cal. The Governor’s proposed budget includes a provision to allow eligible undocumented residents ages 27-49 years old to enroll in Medi-Cal beginning in 2023.</td>
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<th>Government Affairs Update</th>
<th>Public Comment</th>
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<td>Received via text February 22, 2022, at 9:25 am, from Carolyn Rogers Navarro</td>
<td>Public comment 2-22-2022 executive meeting Government Affairs Update LA Care gaslights enrollees, they even go as far as to censor online comments and reviews, on Yelp where multiple reviews I’ve written have been flagged by I know who and removed, only to add credence and standing to my current review (thank you)! LA Care lists on Yelp they pay people in foreign countries to censor reviews, they list John Baackes, an insurance salesman owns LA</td>
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### Agenda Item/Presenter

**Care! Why is LA Care so defensive?**
LA Care hugs enrollees while their contractors are stabbing them in the back, LA Care knows perfectly well their contractors don’t do their jobs, LA Care is too stingy and corrupt to get rid of these contractors who live in lavish homes, living off the disabled and getting a free lunch because these contractors save them money while enrollees, especially special needs people are being exploited and abused.

Mr. Baackes stop publicaly listing on Yelp online that you are the owner of LA Care, you just a guy being used to make LA Care look like a decent company when it’s not!

Mr. Baackes stated, for the benefit of the public as well as the person submitting the comment, L.A. Care’s Facebook account is managed internally by one staff member who is a Los Angeles County resident. Facebook automatically hides comments if foul language is used, and deletes comments flagged by users as vaccination disinformation for example, and after a review. He noted that he was not aware that Yelp lists him as the owner of L.A. Care. We will ask Yelp to change that. He stated that L.A. Care has no means to delete reviews on Yelp. The platform itself does delete reviews if guidelines are not met. He reassured those listening that L.A. Care cannot delete Yelp reviews, Yelp operates on its own. L.A. Care will ask Yelp to change the ownership listing, as L.A. Care is a public entity, so there would be no single owner. He emphasized that L.A. Care manages the Facebook account and does not have employees or contractors in other countries managing the Facebook account.

Cherie Compartore, Senior Director, Government Affairs, reported that:

- California Legislative session is on the second year, and the deadline to introduce bills was February 18.
- Many of the bills are repeat bills from last year, while other bills are taking on new issues. There are some themes for 2022 such as, healthcare access and affordability, reproductive health, behavioral health continues to be a very strong subject, prescription drug coverage, and the usual mandate bills.
- Staff is reviewing all the bills related to health care of significance to L.A. Care, and there will be a new matrix of proposed legislation in the packet for next week’s Board Meeting. The list will be lengthy, as it is very early in the legislative process and includes bills for which there is not yet a great deal of information. As has been done in prior years, staff will highlight the most relevant legislation at the meetings.
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<td>• California Budget subcommittee hearings have started and will continue for the next several weeks and then will taper off as policy bills start being heard.</td>
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<td>• The real work will begin on the budget when the Governor releases his revisions in May. June 15 is the deadline for the legislature to approve a budget to be sent to the Governor for his consideration.</td>
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<td>• The former federal administration issued a rule that severely harmed many Medicaid beneficiaries through public charge requirements. The Department of Homeland Security announced on February 17 a draft rule that will return to the previous rules. This is good news as beneficiaries can be reassured that accepting enrollment will not be counted as a “public charge” in immigration proceedings, and it will encourage more eligible people to enroll. Staff is reviewing the 300-page draft rule and will draft public comment in support of removing the imposition of public charge and any concerns that may be in the rule.</td>
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<td>• California Department of Health Care Services (DHCS) announced that the Cal Medi-Connect program scheduled to be implemented on January 1, 2022, was delayed to July 1, 2022, and is now scheduled to be implemented on January 1, 2023. L.A. Care is engaged with Los Angeles County and other stakeholders in continuing conversations in preparation for the benefit.</td>
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Chairperson De La Torre noted that as described by the Legislative Counsel, a “spot bill”, upon introduction, is merely a placeholder for future language, with a title or description of the intended legislation. Some of these bills are amended with substantive language and some just expire. Early in the legislative term the legislator proposing the bill may have an idea that is not fully developed, so it is proposed as a placeholder.

Approve Consent Agenda

Approve the list of items that will be considered on a Consent Agenda for March 3, 2022 Board of Governors Meeting.
- February 3, 2022 Board of Governors Meeting Minutes
- Contract Amendment with Infosys, Cognizant, HCL, and Solugenix for Information Technology Staff Augmentation

Approved unanimously by roll call. 5 AYES

PUBLIC COMMENTS

Public Comment
Received via text February 22, 2022, at 2:32 pm, from sender not self-identified
Via text received 2:32 pm, sender not self-identified

*General comment, why does LA Care list foreign countries on Facebook as moderating pg, people’s comments are deleted ?*
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| Via text received 2:35 pm  
*See screenshot I took just now showing foreign countries, I’ve saw someone complain her comments were being deleted. You stopped letting people review you.* |

![Screenshot](image1.png)

| Via text received 2:36 pm  
*It says Mexico and “3 others” why is that Screenshot is from your Facebook pg!* |

| Via text received 2:38 pm  
*Add to general comment. I observed you may actually be breaking the law as a public entity censoring public comments. Who removes them, I’ve seen them removed?!* |

Chairperson De La Torre referred to Mr. Baackes’ previous comments. In terms of government censorship, he noted that Facebook and Yelp are private companies that provide a service. Those companies are not run by L.A. Care, but are websites run by private companies that have their own set of rules and protocols for how they conduct their business. If it was the L.A. Care website, one could think there was something unusual going on. L.A. Care has no control over Facebook, Instagram, Twitter, Yelp or any other apps. L.A. Care participates in those services as a means of communicating with the general public. Mr. Baackes clarified that L.A. Care has only one employee who runs the social media pages and that employee is here in Los Angeles County and not in other countries. Chairperson De La Torre noted that further public comments received
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<td>after the public comment period ended can be submitted for the Board Meeting on March 3, 2022.</td>
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<td>ADJOURN TO CLOSED SESSION</td>
<td>The Joint Powers Authority Executive Committee meeting was adjourned at 2:42 p.m. Augustavia J. Haydel, General Counsel, announced the items to be discussed in closed session. She announced there is no report anticipated from the closed session. The meeting adjourned to closed session at 2:42 p.m.</td>
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**CONTRACT RATES**

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

**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: February 2024

**CONFERENCE WITH REAL PROPERTY NEGOTIATORS**

Section 54956.8 of the Ralph M. Brown Act
Property address: 2426 N. Broadway, Los Angeles, CA. 90031
Agency Negotiator: John Baackes, Chief Executive Officer
Negotiating Parties: Daniel Roberts
Landlord: 2426 N. Broadway, Inc.
Under Negotiation: Price and Terms of Payment

**CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION**

Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act

**CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION**

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

**PUBLIC EMPLOYEE PERFORMANCE EVALUATION**

Pursuant to Section 54957 of the Ralph M. Brown Act
Title: Chief Executive Officer
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<td>CONFERENCE WITH LABOR NEGOTIATOR</td>
<td>Pursuant to Section 54957.6 of the Ralph M. Brown Act</td>
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<td>Agency Designated Representative: Hector De La Torre</td>
<td>Unrepresented Employee: John Baackes</td>
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<td>RECONVENE IN OPEN SESSION</td>
<td>The meeting reconvened in open session at 4:35 p.m. No reportable actions were taken during the closed session.</td>
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<td>ADJOURNMENT</td>
<td>The meeting adjourned at 4:37 p.m.</td>
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Respectfully submitted by:
Linda Merkens, Senior Manager, Board Services
Malou Balones, Board Specialist III, Board Services
Victor Rodriguez, Board Specialist II, Board Services

APPROVED BY:
Hector De La Torre, Chair

Date: ________________________

Below are public comment that were received after public comment period ended.

Via text received 2:40 pm
*General comment, why does it say Mexico on your pg*

Via text received 2:41 pm
*why is Baackes listed as owner of LA Care*
Legislative Matrix as of 3/14/2022

The following is a list of the legislation currently tracked by Government Affairs that has been introduced during the 2021-2022 Legislative Session and is of interest to L.A. Care. This matrix includes the priority bills, that could have a direct impact on L.A. Care's operations and also bills of interest, which could have an indirect impact or are of significance to L.A. Care's strategic interests.

If there are any questions, please contact Cherie Compartore, Senior Director of Government Affairs at ccompartore@lacare.org or (916) 216.7963.

Bills by Issue

2022 Legislation (117)
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, David Chiu, Mike Gipson, Lorena Gonzalez, Eloise Reyes, Miguel Santiago, Bonta

Organizational Notes
Last edited by Cherie Compartore at Aug 16, 2021, 3:30 PM
Support: L.A. Care, LHPC, CMA, CAHP, CCLAC, CAPH
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’... (click bill link to see more).

Primary Sponsors
Cecilia Aguiar-Curry, Robert Rivas

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 (Sponsor) Association (CPCA) (Sponsor) California Medical Association (CMA) (Sponsor) Essential Access Health (EAH) (Sponsor) Planned Parenthood Affiliates of California (PPAC) (Sponsor)
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, except as specified for a high deductible health plan, as defined. 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

Organizational Notes
Last edited by Cherie Compartore at Apr 26, 2021, 3:11 PM
Oppose: CAHP
Medi-Cal benefits: rapid Whole Genome Sequencing.

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.

Primary Sponsors
Brian Maienschein
Local health department workforce assessment.

AB 240, as amended, Rodriguez. Local health department workforce assessment. Existing law establishes the State Department of Public Health to implement various programs throughout the state relating to public health, including licensing and regulating health facilities, control of infectious diseases, and implementing programs relating to chronic health issues. Existing law authorizes the department to implement the required programs through, or with the assistance of, local health departments. Existing law requires the department, after consultation with and approval by the California Conference of Local Health Officers, to establish standards of education and experience for professional and technical personnel employed in local health departments and for the organization and operation of the local health departments. This bill would require the department to contract with an appropriate and qualified entity to conduct an evaluation of the adequacy of the local health department infrastructure and to make recommendations for future staffing, workforce needs, and resources, in order to accurately and adequately fund local public health. The bill would exempt the department from specific provisions relating to public contracting with regard to this requirement. The bill would require the department to report the findings and recommendations of the evaluation to the appropriate policy and fiscal committees of the Legislature on or before July 1, 2024. The bill would also require the department to convene an advisory group, composed of representatives from public, private, and tribal entities, as specified, to provide input on the selection of the entity that would conduct the evaluation. The bill would further require the advisory group to provide technical assistance and subject matter expertise to the selected entity. The bill would make its provisions contingent on sufficient funding and repeal its provisions on January 1, 2026.

Primary Sponsors
Freddie Rodriguez
Behavioral health: older adults.

Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the continuously appropriated Mental Health Services Fund to fund various county mental health programs, including the Adult and Older Adult Mental Health System of Care Act. Existing law authorizes the MHSA to be amended by a 2/3 vote of the Legislature if the amendments are consistent with, and further the purposes of, the MHSA, and also permits the Legislature to clarify procedures and terms of the MHSA by a majority vote. This bill would establish within the State Department of Health Care Services an Older Adult Behavioral Health Services Administrator to oversee behavioral health services for older adults. The bill would require that position to be funded with administrative funds from the Mental Health Services Fund. The bill would prescribe the functions of the administrator and its responsibilities, including, but not limited to, developing outcome and related indicators for older adults for the purpose of assessing the status of behavioral health services for older adults, monitoring the quality of programs for those adults, and guiding decisionmaking on how to improve those services. The bill would require the administrator to receive data from other state agencies and departments to implement these provisions, subject to existing state or federal confidentiality requirements. The bill would require the administrator to report to the entities that administer the MHSA on those outcome and related indicators by July 1, 2022, and would require the report to be posted on the department's internet website. The bill would also require the administrator to develop a strategy and standardized training for all county behavioral health personnel in order for the counties to assist the administrator in obtaining the data necessary to develop the outcome and related indicators. This bill would declare that it clarifies procedures and terms of the Mental Health Services Act.

Primary Sponsors
Rudy Salas
Title
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
Health insurance.

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 regulation provisions, as prescribed.

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

Description
AB 510, as introduced, Wood. Out-of-network health care benefits. 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
Title
Program of All-Inclusive Care for the Elderly.

Description
AB 540, as amended, 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 Medi-Cal 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, and would require persons enrolled in a PACE plan to receive all Medicare and Medi-Cal services from the PACE program. The bill would require, in areas where a PACE plan is available, that the PACE plan be presented as a Medi-Cal managed care plan enrollment option in the same manner as other Medi-Cal managed care plan options. In areas of the state where a presentation on Medi-Cal managed care plan enrollment options is unavailable, the bill would require the department or its contracted vendor to provide outreach and enrollment materials on PACE. The bill would require the department to establish a system to identify Medi-Cal beneficiaries who appear to be eligible for PACE based on age, residence, and prior use of services, and, with respect to that system, would require the department to conduct specified outreach and referrals.

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

Description
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. This bill would authorize the Integrated School-Based Behavioral Health Partnership Program, which the bill would establish, 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 services, and would specify the types of services, including prevention, intervention, and brief initial intervention services, as specified, that may be provided pursuant to the partnership program. The bill would require the local educational agency and county behavioral health agency to develop a process related to servi... (click bill link to see more).

Primary Sponsors
Sharon Quirk-Silva
Title
Pupil health: health and mental health services: School Health Demonstration Project.

Description
AB 586, as amended, O'Donnell. Pupil health: health and mental health services: School Health Demonstration Project. Existing law requires a school of a school district or county office of education and a charter school to notify pupils and parents or guardians of pupils no less than twice during the school year on how to initiate access to available pupil mental health services on campus or in the community, as provided. Existing law authorizes a county to use funds from the Mental Health Services Act, enacted by the voters at the November 2, 2004, statewide general election as Proposition 63, to provide a grant to a school district or county office of education, or to a charter school, within the county, for purposes of funding specified activities relating to pupil mental health. This bill would establish, within the State Department of Education, the School Health Demonstration Project, a pilot project, to be administered by the department, in consultation with the State Department of Health Care Services, to expand comprehensive health and mental health services to public school pupils by providing training and support services to selected local educational agencies to secure ongoing Medi-Cal funding for those health and mental health services, as provided. The bill would, subject to an appropriation, require a local educational agency selected to serve as a pilot project participant to receive $500,000 each year of the 2-year pilot project, to be used for contracting with one of 3 technical assistance teams selected by the Superintendent of Public Instruction. The bill would authorize the funds to also be used by the local educational agency for staffing, professional development, outreach, and data analysis and reporting, related to the project. The bill would require the State Department of Education, in consultation with the State Department of Health Care Services, participating local educational agencies, and the technical assistance teams, to prepare and submit a report to the Legislature that includes specified information related to the results of the pilot project.

Primary Sponsors
Patrick O'Donnell, Rudy Salas, 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
Prescription drug coverage.

Description
AB 752, as amended, Nazarian. Prescription drug coverage. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or health insurance policy that provides coverage for outpatient prescription drugs to cover medically necessary prescription drugs and subjects those policies to certain limitations on cost sharing and the placement of drugs on formularies. 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, and requires that payment to apply to any applicable deductible. This bill would require a health care service plan or health insurer to furnish specified information about a prescription drug upon request by an enrollee or insured or their health care provider. The bill would require a health care service plan or health insurer to, among other things, respond in real time to a request for the above-described information. The bill would prohibit a health care service plan or health insurer from, among other things, restricting a health care provider from sharing the information furnished about the prescription drug or penalizing a provider for prescribing a lower cost 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

Organizational Notes
Last edited by Joanne Campbell at Apr 12, 2021, 6:44 PM
Support: California Chronic Care Coalition (Sponsor) Oppose: CAHP
AB 852, as amended, Wood. Nurse practitioners: scope of practice: practice without standardized procedures. (1) Existing law, the Nursing Practice Act, provides for the certification and regulation of nurse practitioners by the Board of Registered Nursing. Existing law authorizes a nurse practitioner who meets certain education, experience, and certification requirements to perform, in certain settings or organizations, specified functions without standardized procedures, including, but not limited to, conducting an advanced assessment; ordering, performing, and interpreting diagnostic procedures, as specified; and prescribing, administering, dispensing, and furnishing controlled substances. Existing law, beginning January 1, 2023, authorizes a nurse practitioner to perform the functions described above without standardized procedures outside of the specified settings or organizations, in accordance with certain conditions and requirements, if the nurse practitioner holds an active certification issued by the board. Existing law requires those nurse practitioners to obtain physician consultation as specified in the individual protocols and under certain circumstances, including acute decompensation of patient situation. Existing law also requires those nurse practitioners to establish a referral plan for complex medical cases and emergencies to a physician and surgeon or other appropriate healing arts provider that addresses various circumstances and conditions, including a patient that has acute decomposition or rare condition. This bill would refer to practice protocols, as defined, instead of individual protocols and would delete the requirement to obtain physician consultation in the case of acute decompensation of patient situation. The bill would revise the requirement to establish a referral plan, as described above, by requiring it to address the situation of a patient who is acutely decompensating in a manner that is not consistent with the progression of the disease and corresponding treatment plan. This bill would include references and incorporate nurse practitioners who function pursuant to the above-described provisions without standardized procedures into various provisions of law regulating healing arts licensees. (2) Existing law exempts from discovery as evidence the proceedings and records of specified organized committees of health care professionals and review committees having the responsibility of evaluation and improvement of the quality of care. This bill would extend this exemption, for purposes of civil proceedings only, to the proceedings and records of nurse practitioner organized committees and review committees, as specified.

Primary Sponsors
Jim Wood
Title
PACE program: risk mitigation program.

Description
AB 874, as amended, Quirk-Silva. PACE program: risk mitigation program. Existing law, known commonly as the Property Assessed Clean Energy (PACE) program, authorizes a public agency, by making specified findings, to authorize public agency officials and property owners to enter into voluntary contractual assessments to finance the installation of distributed generation renewable energy sources or energy or water efficiency improvements that are permanently fixed to real property. Existing law also requires the California Alternative Energy and Advanced Transportation Financing Authority to develop and administer a PACE risk mitigation program for PACE financing to increase its acceptance in the marketplace and protect against the risk of default and foreclosure. This bill would require the authority, upon an appropriation by the Legislature for purposes of the bill, to develop and administer the PACE risk mitigation program to address residential PACE-related mortgage and tax delinquencies in order to avoid default or foreclosure by awarding a grant, in an amount equal to at least one annual PACE assessment but not more than 4 annual PACE assessments, to an eligible property owner, as defined. The bill would require the authority to award the grants on a first-come, first-served basis.

Primary Sponsors
Sharon Quirk-Silva

Title
Proposition 56 Medi-Cal Physicians and Dentists Loan Repayment Act Program.

Description
AB 882, as amended, Gray. Proposition 56 Medi-Cal Physicians and Dentists Loan Repayment Act Program. 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, the California Healthcare, Research and Prevention Tobacco Tax Act of 2016, an initiative measure approved as Proposition 56 at the November 8, 2016, statewide general election, increases taxes imposed on distributors of cigarettes and tobacco products and requires all revenues to be deposited into the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 Fund, a continuously appropriated fund. Proposition 56 requires the Controller to transfer 82% of those revenues to the Healthcare Treatment Fund, to be used by the department to increase funding for the Medi-Cal program and other specified health care programs and services in a way that, among other things, ensures timely access, limits geographic shortages of services, and ensures quality care. The act authorizes
the Legislature to amend the provision relating to the allocation of revenues in the Healthcare Treatment Fund to further the purposes of the act with a 2/3 vote of the membership of each house of the Legislature. Existing law, until January 1, 2026, establishes the Proposition 56 Medi-Cal Physicians and Dentists Loan Repayment Act Program, which requires the department to develop and administer the program to provide loan assistance payments to qualifying, recent graduate physicians and dentists who serve beneficiaries of the Medi-Cal program and other specified health care programs using moneys from the Healthcare Treatment Fund. Existing law requires this program to be funded using moneys appropriated to the department for this purpose in the Budget Act of 2018, and requires the department to administer 2 separate payment pools for participating physicians and dentists, respectively, consistent with the allocations provided for in the Budget Act of 2018. For purposes of that program, and by January 1, 2022, this bill would require the department to exclusively provide loan assistance payments to Medi-Cal physicians and dentists who maintain a patient caseload composed of a minimum of 30% Medi-Cal beneficiaries and who meet one or more of specified requirements relating to practicing in areas, or serving populations, with provider shortages. The bill would make this provision inapplicable to an individual who enters into, and maintains compliance with, an Awardee Agreement to receive loan assistance payments before January 1, 2022. The b... (click bill link to see more).

Primary Sponsors
Adam Gray, Rudy Salas, Melissa Hurtado

Organizational Notes
Last edited by Cherie Compartore at May 17, 2021, 3:54 PM
Oppose Unless Amended: LHPC
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
Telephone medical advice services.

Description
AB 1102, as introduced, Low. Telephone medical advice services. Existing law requires a telephone medical advice service, as defined, to be responsible for, among other requirements, ensuring that all health care professionals who provide medical advice services are appropriately licensed, certified, or registered, as specified. Existing law requires the respective healing arts licensing board to be responsible for enforcing specified provisions related to telephone medical advice services. Existing law requires a telephone medical advice service to ensure that all health care professionals who provide telephone medical advice services from an out-of-state location are licensed, registered, or certified in the state within which they are providing the telephone medical advice services and are operating consistent with the laws governing their respective scopes of practice. Existing law further requires a telephone medical advice service to comply with all directions and requests for information made by the respective healing arts licensing boards. This bill would specify that a telephone medical advice service is required to ensure that all health care professionals who provide telephone medical advice services from an out-of-state location are operating consistent with the laws governing their respective licenses. The bill would specify that a telephone medical advice service is required to comply with all directions and requests for information made by the respective healing arts licensing boards.

Primary Sponsors
Evan Low
Emergency ground medical transportation.

AB 1107, as introduced, Boerner Horvath. Emergency ground medical transportation. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires that health care service plan contracts and health insurance policies provide coverage for certain services and treatments, including emergency medical transportation services. This bill would require a health care service plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2022, that offers coverage for emergency ground medical transportation services to include those services as in-network services and would require the plan or insurer to pay those services at the contracted rate pursuant to the plan contract or policy. Because a willful violation of the bill's requirements relative to a health care service plan would be a crime, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Tasha Boerner Horvath
Title
California Health Care Quality and Affordability Act.

Description
AB 1130, as amended, Wood. California Health Care Quality and Affordability Act. Existing law generally requires the State Department of Public Health to license, inspect, and regulate health facilities, including hospitals. Existing law requires health facilities to meet specified cost and disclosure requirements, including maintaining an understandable written policy regarding discount payments and charity. Existing law establishes the Department of Health Care Access and Information (HCAI) to oversee various aspects of the health care market, including oversight of hospital facilities and community benefit plans. Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Violation of the Knox-Keene Act is a misdemeanor. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires each department to develop and adopt regulations to ensure that enrollees and insureds have access to needed health care services in a timely manner. Existing law requires that health care service plans and health insurers submit rates to their regulating entity for review. This bill would establish, within HCAI, the Office of Health Care Affordability to analyze the health care market for cost trends and drivers of spending, develop data-informed policies for lowering health care costs for consumers and purchasers, set and enforce cost targets, and create a state strategy for controlling the cost of health care and ensuring affordability for consumers and purchasers. The bill would also establish the Health Care Affordability Board, composed of 8 members, appointed as prescribed. The bill would require the board to establish a statewide health care cost target, as defined, for the 2025 calendar year, and specific targets for each health care sector, including fully integrated delivery system sector and geographic region, and for an individual health care entity, as appropriate, for the 2028 calendar year. The bill, commencing in 2026, would require the office to take progressive actions against health care entities for failing to meet the cost targets, including performance improvement plans and escalating administrative penalties. The bill would establish the Health Care Affordability Fund for the purpose of receiving and, upon appropriation by the Legislature, expending revenues collected pursuant to the provisions of the bill. The bill would require the office to set standards for various health care metrics, including health care quality and equity, alternative payment models, primary care and behavioral health investment... (click bill link to see more).

Primary Sponsors
Jim Wood
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 co... (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.
MEDI-CAL

AB 1132, as amended, Wood. Medi-Cal. (1) Existing law authorizes the board of supervisors in each county to designate an entity or entities to assist county jail inmates with applying for a health insurance affordability program, as defined, consistent with federal requirements. Commencing January 1, 2023, this bill would instead require the board of supervisors, in consultation with the county sheriff, to designate an entity or entities to assist both county jail inmates and juvenile inmates with the application process, and would make conforming changes to provisions relating to the coordination duties of jail administrators. By creating new duties for local officials, including boards of supervisors and jail administrators, the bill would impose a state-mandated local program. No sooner than January 1, 2023, the bill would require the department to develop and implement a mandatory process for county jails and county juvenile facilities to coordinate with Medi-Cal managed care plans and Medi-Cal behavioral health delivery systems to facilitate continued behavioral health treatment in the community for inmates, as specified, and would authorize the sharing of prescribed data with and among counties and other specified entities, as determined necessary by the department.

(2) Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services, including mental health and substance use disorder 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. Existing law, the Medi-Cal 2020 Demonstration Project Act, requires the department to implement specified components of a Medi-Cal demonstration project, including the Global Payment Program (GPP), the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program, and the Whole Person Care pilot program, consistent with the Special Terms and Conditions approved by the federal Centers for Medicare and Medicaid Services. Pursuant to existing law, the department has created a multiyear initiative, the California Advancing... (click bill link to see more).

Primary Sponsors
Jim Wood
Title
Health care coverage: claims payments.

Description
AB 1162, as amended, 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 ...

Primary Sponsors
Carlos Villapudua

Organizational Notes
Last edited by Cherie Compartore at Apr 26, 2021, 3:09 PM
Oppose: CAHP
Title
Medi-Cal: serious mental illness: drugs.

Description
AB 1178, as amended, Irwin. Medi-Cal: serious mental illness: drugs. Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services and under which health care services are provided to qualified low-income persons pursuant to a schedule of benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, the provision of prescription drugs is a Medi-Cal benefit, subject to the list of contract drugs and utilization controls. After a determination of cost benefit, existing law requires the Director of Health Care Services to modify or eliminate the requirement of prior authorization as a control for treatment, supplies, or equipment that costs less than $100, except for prescribed drugs. This bill would delete the prior authorization requirement for any drug prescribed for the treatment of a serious mental illness, as defined, for a period of 180 days after the initial prescription has been dispensed for a person over 18 years of age who is not under the transition jurisdiction of the juvenile court. The bill would require the department to automatically approve a prescription for a drug for the treatment of a serious mental illness if that drug was previously dispensed to the patient, as specified, and certain conditions are met, including that the patient is not under the transition jurisdiction of the juvenile court. The bill would require the department to authorize a pharmacist to dispense a 90-day supply of a drug prescribed for the treatment of a serious mental illness if that prescription drug is included in the Medi-Cal list of contract drugs and the prescription otherwise conforms to applicable formulary requirements, including that the patient has filled at least a 30-day supply for the same prescription in the previous 90 days, and to dispense an early refill prescribed for the treatment of a serious mental illness if that prescription drug is included in the Medi-Cal list of contract drugs and the prescription otherwise conforms to prescribed standards, such as limiting the number of refills to no more than 3 in a calendar year.

Primary Sponsors
Jacqui Irwin
Title
Medi-Cal: Independent Medical Review System.

Description
AB 1355, as amended, Levine. Medi-Cal: Independent Medical Review System. (1) Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services and under which health care services are provided to qualified low-income persons pursuant to a schedule of benefits, which includes pharmacy benefits, through various health care delivery systems, including fee-for-service and managed care. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law authorizes the department to enter into various types of contracts for the provision of services to beneficiaries, including contracts with a managed care plan. Existing law generally requires Medi-Cal managed care plan contractors to be licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975. The act provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. The act requires the Department of Managed Health Care to establish the Independent Medical Review System, which generally serves to address grievances involving disputed health care services based on whether the service is medically necessary. This bill would require the State Department of Health Care Services to establish the Independent Medical Review System (IMRS) for the Medi-Cal program, commencing on January 1, 2023, which generally models the above-described requirements of the Knox-Keene Health Care Service Plan Act. The bill would provide that any Medi-Cal beneficiary appeal involving a disputed health care service is eligible for review under the IMRS if certain requirements are met, and would define “disputed health care service” as any service covered under the Medi-Cal program that has been denied, modified, or delayed by a decision of the department, or by one of its contractors, including, but not limited to, a Medi-Cal managed care plan, that makes a final decision, in whole or in part, due to a finding that the service is not medically necessary. The bill would require information on the IMRS to be displayed in or on specified material, including the “myMedi-Cal: How to Get the Health Care You Need” publication and the department’s internet website. The bill would specify that Medi-Cal managed care plans licensed pursuant to the Knox-Keene Health Care Service Plan Act and enrollees of those plans would instead follow the review system established pursuant to that act. The bill would authorize a beneficiary to apply to the department for an Independent Medical Review (IMR) of a decision involving a disputed health care service within 6 months of receipt of the notice of adverse action, and would prohibit a requirement that the beneficiary pay any app... (click bill link to see more).

Primary Sponsors
Marc Levine
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<th>Title</th>
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<td>Description</td>
<td>AB 1668, as introduced, Patterson. Mental Health Services Oversight and Accountability Commission. Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the Mental Health Oversight and Accountability Commission to oversee the implementation of the MHSA. Existing law specifies the composition of the 16-member commission, including the Attorney General or their designee, the Superintendent of Public Instruction or their designee, specified members of the Legislature, and 12 members appointed by the Governor, as prescribed. Existing law authorizes the MHSA to be amended by a 2/3 vote of the Legislature if the amendments are consistent with, and further the purposes of, the MHSA, or by a majority vote to clarify procedures and terms. This bill would require the 16 members of the commission to include at least one member from each of the 10 regions of California defined by the 2020 census and, if a member of the commission who is the only representative of a region is removed or leaves the commission, would require the Governor to ensure that the region is represented in the next regularly scheduled round of appointments.</td>
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<td>Primary Sponsors</td>
<td>Jim Patterson</td>
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| 40 |
Title
Mental health services.

Description
AB 1859, as introduced, Levine. Mental health services. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, to include coverage for essential health benefits, which include mental health services. Existing law, the Lanterman-Petris-Short Act, sets forth procedures for the involuntary detention, for up to 72 hours for evaluation and treatment, of a person who, as a result of a mental health disorder, is a danger to others or to themselves or is gravely disabled. This bill would require a health care service plan or a health insurance policy issued, amended, or renewed on or after January 1, 2023, that includes coverage for mental health services to, among other things, approve the provision of mental health services for persons who are detained for 72-hour treatment and evaluation under the Lanterman-Petris-Short Act and to schedule an initial outpatient appointment for that person with a licensed mental health professional on a date that is within 48 hours of the person's release from detention. The bill would prohibit a noncontracting provider of covered mental health services from billing the previously described enrollee or insured more than the cost-sharing amount the enrollee or insured would pay to a contracting provider for those services. 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
Marc Levine
Title
California Health Benefit Exchange: affordability assistance.

Description
AB 1878, as introduced, Wood. California Health Benefit Exchange: affordability assistance. Existing federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. Existing state law creates the California Health Benefit Exchange (Exchange), also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Existing law requires the Exchange, in consultation with stakeholders and the Legislature, to develop options for providing cost-sharing reduction subsidies to reduce cost sharing for low- and middle-income Californians, and requires the Exchange to report the developed options on or before January 1, 2022. Existing law requires the options to include, among other things, options for all Covered California enrollees with income up to 400 percent of the federal poverty level to reduce cost sharing, including copays, deductibles, coinsurance, and maximum out-of-pocket costs. This bill would require the Exchange to implement those options for providing health care affordability assistance. The bill would require the affordability assistance to reduce cost sharing, including copays, coinsurance, and maximum out-of-pocket costs, and to eliminate deductibles for all benefits. The bill would specify the actuarial value of cost-sharing assistance based on the income level of an enrollee, and would require the Exchange to adopt standard benefit designs consistent with these specifications.

Primary Sponsors
Jim Wood
Title
Prior authorization and step therapy.

Description
AB 1880, as introduced, Arambula. Prior authorization and 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 care service plan or health insurer to require step therapy if there is more than one drug that is appropriate for the treatment of a medical condition, as specified. Existing law requires a health care service plan or health insurer to expeditiously grant a step therapy exception request if the health care provider submits justification and supporting clinical documentation, as specified. Under existing law, if a health care service plan or other related entity fails to notify a prescribing provider of its coverage determination within a prescribed time period after receiving a prior authorization or step therapy exception request, the prior authorization or step therapy exception request is deemed approved for the duration of the prescription. Existing law excepts contracts entered into under specified medical assistance programs from these time limit requirements. This bill would delete that exception. Existing law permits a health care provider or prescribing provider to appeal a denial of a step therapy exception request for coverage of a nonformulary drug, a prior authorization request, or a step therapy exception request, consistent with the current utilization management processes of the health care service plan or health insurer. Existing law also permits an enrollee or insured, or the enrollee's or insured's designee or guardian, to appeal a denial of a step therapy exception request for coverage of a nonformulary drug, prior authorization request, or step therapy exception request by filing a grievance under a specified provision. This bill would require health care service plan's or health insurer's utilization management process to ensure that an appeal of an exception request denial is reviewed by a clinical peer of the health care provider or prescribing provider, as specified. The bill would require the appropriate department to consult a clinical peer as an independent expert in reviews of an enrollee's or insured's grievance, as specified. The bill would define the term “clinical peer” for these purposes. The bill would require health care service plans and health insurers that require step therapy or prior authorization to maintain specified information, including, but not limited to, the number of step therapy exception requests and prior authorization requests received by th... (click bill link to see more).

Primary Sponsors
Joaquin Arambula
Medi-Cal: orthotic and prosthetic devices.

Description
AB 1892, as introduced, Flora. Medi-Cal: orthotic and prosthetic devices. 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 establish a list of covered services and maximum allowable reimbursement rates for prosthetic and orthotic appliances and durable medical equipment and publish the list in provider manuals. Existing law prohibits reimbursement for prosthetic and orthotic appliances from exceeding 80% of the lowest maximum allowance for California established by the federal medicare program. This bill would instead require reimbursement for these appliances to be set at 80% of the lowest maximum allowance for California established by the federal medicare program and would require that reimbursement to be adjusted annually.

Primary Sponsors
Heath Flora
Title
Medi-Cal: income level for maintenance.

Description
AB 1900, as introduced, Arambula. Medi-Cal: income level for maintenance. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law, to the extent federal financial participation is available, requires the department to exercise its option under federal law to implement a program for individuals who are 65 years of age or older or are disabled, without a share of cost, if they meet certain financial eligibility criteria, including not exceeding 138% of the federal poverty level in their countable income or as specified. Under existing law, certain medically needy persons with higher incomes qualify for Medi-Cal with a share of cost, if they meet specified criteria. Under existing law, the share of cost for those persons is generally the total after deducting an amount for maintenance from the person's monthly income. Existing law requires the department to establish income levels for maintenance 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. Under existing law, for a single individual, the amount of the income level for maintenance per month is based on a calculation of 80% of the highest amount that would ordinarily be paid to a family of 2 persons, without any income or resources, under specified cash assistance provisions, multiplied by the federal financial participation rate, adjusted as specified. This bill, to the extent that any necessary federal authorization is obtained, would increase the above-described income level for maintenance per month to be equal to the income limit for Medi-Cal without a share of cost for individuals who are 65 years of age or older or are disabled, generally totaling 138% of the federal poverty level. The bill would require the department to seek any necessary federal authorization for maintaining that income level for maintenance and would make conforming changes to related provisions.

Primary Sponsors
Joaquin Arambula, Jim Wood
Title
Personal information: contact tracing.

Description
AB 1917, as amended, Levine. Personal information: contact tracing. Existing law, the Information Practices Act of 1977, prescribes a set of requirements, prohibitions, and remedies applicable to public agencies, as defined, with regard to their collection, storage, and disclosure of personal information. Existing law, the California Consumer Privacy Act of 2018 (CCPA), grants a consumer various rights with respect to personal information, as defined, that is collected or sold by a business, as defined, including the right to direct a business that sells personal information about the consumer to third parties not to sell the consumer's personal information. This bill would, with certain exceptions, prohibit a correctional officer or an officer, deputy, employee, or agent of a law enforcement agency, as defined, from conducting contact tracing, as defined. The bill would authorize a person to bring a civil action to obtain injunctive relief for a violation of these provisions.

Primary Sponsors
Marc Levine
Title
Medi-Cal: violence preventive services.

Description
AB 1929, as introduced, Gabriel. Medi-Cal: violence preventive services. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes a schedule of benefits under the Medi-Cal program, including various mental health services. Existing federal law authorizes, at the option of the state, preventive services, as defined, that are recommended by a physician or other licensed practitioner of the healing arts. This bill would require the department to establish, no later than January 1, 2024, a violence intervention pilot program at a minimum of 9 sites, including at least one site in 9 specified counties, and would require the department to consult with identified stakeholders, such as professionals in the community violence intervention field, for purposes of establishing the pilot program. The bill would require the department to provide violence preventive services that are rendered by a qualified violence prevention professional to a Medi-Cal beneficiary who meets identified criteria, including that the beneficiary has received medical treatment for a violent injury. The bill would require the department to approve one or more training and certification programs for violence prevention professionals, and would require an entity that employs or contracts with a qualified violence prevention professional to maintain specified documentation on, and to ensure compliance by, that professional. The bill would require the department to seek any federal approvals necessary to implement these requirements, and would condition the department's implementation of these provisions to the extent that federal financial participation is available and not otherwise jeopardized, and any necessary federal approvals have been obtained. The bill would make its provisions inoperative 5 calendar years following the date upon which violence preventive services are able to be provided and billed pursuant to the bill, as specified. The bill would require the department to issue, at least one calendar year prior to the inoperative date, a report to the Legislature on the implementation of the violence intervention pilot program, and the demonstrated impact of violence preventive services.

Primary Sponsors
Jesse Gabriel, Mike Gipson
Medi-Cal: comprehensive perinatal services.

Description
AB 1930, as introduced, Arambula. Medi-Cal: comprehensive perinatal services. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including comprehensive perinatal services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, a pregnant individual or targeted low-income child who is eligible for, and is receiving, health care coverage under any of specified Medi-Cal programs is eligible for full-scope Medi-Cal benefits for the duration of the pregnancy and for a period of one year following the last day of the individual’s pregnancy. This bill, during the one-year postpregnancy eligibility period, and as part of comprehensive perinatal services under Medi-Cal, would require the department to cover additional comprehensive perinatal assessments and individualized care plans and to provide additional visits and units of services in an amount, duration, and scope that are at least proportional to those available on July 27, 2021, during pregnancy and the initial 60-day postpregnancy period in effect on that date. The bill would require the department to collaborate with the State Department of Public Health and a broad stakeholder group to determine the specific number of additional comprehensive perinatal assessments, individualized care plans, visits, and units of services to be covered. The bill would also require the department to seek any necessary federal approvals to (1) cover preventive services that are recommended by a physician or other licensed practitioner and that are rendered by a nonlicensed perinatal health worker in a beneficiary’s home or other community setting away from a medical site, as specified, and (2) allow a nonlicensed perinatal health worker rendering those preventive services to be supervised by an enrolled Medi-Cal provider that is a clinic, hospital, community-based organization, or licensed practitioner. The bill would condition implementation of the provisions above on receipt of any necessary federal approvals and the availability of federal financial participation.

Primary Sponsors
Joaquin Arambula
Medi-Cal: out-of-pocket pregnancy costs.

AB 1937, as introduced, Patterson. Medi-Cal: out-of-pocket pregnancy costs. 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, an individual is eligible for Medi-Cal benefits, as though the individual was pregnant, for all pregnancy-related and postpartum services for a one-year period beginning on the last day of pregnancy. Existing law also establishes the Medi-Cal Access Program, which provides health care services to a person who is pregnant or in their postpartum period and whose household income is between specific thresholds and to a child under 2 years of age who is delivered by a mother enrolled in the program, as specified. This bill would require the department, on or before January 1, 2024, to establish a health expense account program for pregnant Medi-Cal beneficiaries and pregnant subscribers of the Medi-Cal Access Program. The bill would make a Medi-Cal beneficiary who is pregnant or a pregnant subscriber of the Medi-Cal Access Program eligible for reimbursement for “out-of-pocket pregnancy related costs,” as defined, in an amount not to exceed $1,000. The bill would require the person to submit the request for reimbursement within 3 months of the end of the pregnancy in order to be reimbursed. The bill would require the department to seek to maximize federal financial participation in implementing the program. The bill would require the department, to the extent federal financial participation is unavailable, to implement the program only with state funds.

Primary Sponsors
Jim Patterson

Introduction Date: 2022-02-10
Title
Telehealth: dental care.

Description
AB 1982, as introduced, Santiago. Telehealth: dental care. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, 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 contract 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 or health insurer that offers a service via telehealth to meet specified conditions, including, that the health care service plan or health insurer disclose to the enrollee or insured the availability of receiving the service on an in-person basis or via telehealth, from, among others, the primary care provider or from another contracting individual health professional. Existing law defines "contracting individual health professional" for those purposes and excludes a licensed dentist from that definition. This bill would remove the exclusion for dentists from the definition of "contracting individual health professional" and would instead require a health care service plan or health insurer offering telehealth, for dental plans, to disclose to the enrollee or insured the impact of third-party telehealth visits on the patient's benefit limitations, including frequency limitations and the patient's annual maximum. 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
Miguel Santiago
Medi-Cal: premiums, contributions, and copayments.

Description
AB 1995, as amended, Arambula. Medi-Cal: premiums, contributions, and copayments. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires that Medi-Cal benefits be provided to optional targeted low-income children, as defined, based on a certain income eligibility threshold. Existing law also establishes the Medi-Cal Access Program, which provides health care services to a woman who is pregnant or in her postpartum period and whose household income is between certain thresholds, and to a child under 2 years of age who is delivered by a mother enrolled in the program, as specified. Existing law also establishes a program under which certain employed persons with disabilities are eligible for Medi-Cal benefits based on income and other criteria. Existing law requires the department to exercise the option, available to the state under federal law, to impose specified monthly premiums, based on income level, for the above-described children and employed persons with disabilities. Existing law requires the department to determine schedules for subscriber contribution amounts for persons enrolled in the Medi-Cal Access Program. This bill would eliminate the premiums and subscriber contributions for the above-described populations. The bill would make conforming changes to related provisions. Existing law requires Medi-Cal beneficiaries to make set copayments for specified services, including for nonemergency services received in an emergency department or emergency room. This bill would, as of July 1, 2022, prohibit the department from imposing copayments on recipients of specified services, to the extent allowable by federal law.

Primary Sponsors
Joaquin Arambula
Health care coverage: diagnostic imaging.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract issued, amended, delivered, or renewed on or after January 1, 2000, or an individual or group policy of disability insurance or self-insured employee welfare benefit plan to provide coverage for mammography for screening or diagnostic purposes upon referral by specified professionals. This bill would require a health care service plan contract issued, amended, or renewed on or after January 1, 2023, to provide coverage for medically necessary diagnostic or supplemental breast examinations, as defined, without a referral by specified professionals. The bill would require the cost-sharing imposed for a diagnostic or supplemental breast examination to be the same as the cost-sharing imposed for mammography under a health care service plan contract issued, amended, or renewed on or after January 1, 2023. 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
Laura Friedman
Title
Health care coverage: treatment for infertility.

Description
AB 2029, as introduced, Wicks. Health care coverage: treatment for infertility. 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 imposes various requirements and restrictions on health care service plans and health insurers, including, among other things, a requirement that every group health care service plan contract or health insurance policy that is issued, amended, or renewed on or after January 1, 1990, offer coverage for the treatment of infertility, except in vitro fertilization. Existing law provides that any employer that is a religious organization, or a health care service plan or health insurer that is a subsidiary of an entity whose owner or corporate member is a religious organization, shall not be required to offer coverage for forms of treatment of infertility in a manner inconsistent with the religious organization's religious and ethical principles, as specified. This bill would require a health care service plan contract or health insurance policy that is issued, amended, or renewed on or after January 1, 2023, to provide coverage for the diagnosis and treatment of infertility and fertility services. The bill would revise the definition of infertility, and would remove the exclusion of in vitro fertilization from coverage. The bill would delete the exemption for religiously affiliated employers, health care service plans, and health insurance policies, from the requirements relating to coverage for the treatment of infertility, thereby imposing these requirements on these employers, plans, and policies. The bill would also delete a requirement that a health care service plan contract and health insurance policy provide infertility treatment under agreed-upon terms that are communicated to all group contractholders and prospective group contractholders. With respect to a health care service plan, the bill would not apply to Medi-Cal managed care health care service plan contracts or any entity that enters into a contract with the State Department of Health Care Services for the delivery of health care services pursuant to specified provisions. The bill would prohibit a health care service plan that is a health maintenance organization from placing different conditions or coverage limitations on fertility medications or services, or the diagnosis and treatment of infertility and fertility services, than would apply to other conditions, as specified. Because the violation of these provisions by a health care service plan woul... (click bill link to see more).

Primary Sponsors
Buffy Wicks
Title
Medi-Cal: monthly maintenance amount: personal and incidental needs.

Description
AB 2077, 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 $50, and would specify that the cost of this benefit would be supplemented by federal funds, to the extent they are available.

Primary Sponsors
Lisa Calderon
Title
Health Care Consolidation and Contracting Fairness Act of 2022.

Description
AB 2080, as introduced, Wood. Health Care Consolidation and Contracting Fairness Act of 2022. 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 regulates contracts between health care service plans or health insurers and health care providers or health facilities, including requirements for reimbursement and the cost-sharing amount collected from an enrollee or insured. This bill, the Health Care Consolidation and Contracting Fairness Act of 2022, would prohibit a contract issued, amended, or renewed on or after January 1, 2023, between a health care service plan or health insurer and a health care provider or health facility from containing terms that, among other things, restrict the plan or insurer from steering an enrollee or insured to another provider or facility or require the plan or insurer to contract with other affiliated providers or facilities. The bill would authorize the appropriate regulating department to refer a plan's or insurer's contract to the Attorney General, and would authorize the Attorney General or state entity charged with reviewing health care market competition to review a health care practitioner's entrance into a contract that contains specified terms. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. Existing law requires a health care service plan that intends to merge with, consolidate with, or enter into an agreement resulting in its purchase, acquisition, or control by, an entity to give notice to, and secure prior approval from, the Director of the Department of Managed Health Care. Existing law authorizes the director to disapprove the transaction or agreement if the director finds it would substantially lessen competition in health care service plan products or create a monopoly in this state. This bill would additionally require a health care service plan that intends to acquire or obtain control of an entity, as specified, to give notice to, and secure prior approval from, the director. Because a willful violation of this provision would be a crime, the bill would impose a state-mandated local program. The bill would also authorize the director to disapprove a transaction or agreement if it would substantially lessen competition in the health system or among a particular category of health care providers, and would require the director to provide information related to competition to the Attorney General... (click bill link to see more).

Primary Sponsors
Jim Wood
### AB 2127

**Title**
Medical information: confidentiality.

**Description**
AB 2127, as introduced, Santiago. Medical information: confidentiality. Existing law, on and after July 1, 2022, requires a health insurer, to the extent permitted by federal law, to take specified steps to protect the confidentiality of an insured's medical information. In this regard, existing law prohibits a health insurer from requiring a protected individual, as defined, to obtain the policyholder's, the primary subscriber's, or other enrollee's authorization to receive sensitive services or to submit a claim for sensitive services if the protected individual has the right to consent to care. This bill would make technical, nonsubstantive changes to those provisions governing the confidentiality of medical information.

**Primary Sponsors**
Miguel Santiago

### AB 2134

**Title**
The California Abortion and Reproductive Equity (CARE) Act.

**Description**
AB 2134, as introduced, Akilah Weber. The California Abortion and Reproductive Equity (CARE) Act. Existing law, the Reproductive Privacy Act, provides that every individual possesses a fundamental right of privacy with respect to their personal reproductive decisions. Existing law prohibits the state from denying or interfering with a pregnant person's right to choose or obtain an abortion before the fetus is viable or when necessary to protect the pregnant person's life or health. Existing law also sets forth various reproductive health provisions within the jurisdiction of the State Department of Public Health, the State Department of Health Care Services, and other agencies, relating to family planning services, pregnancy, childbirth, and other factors of maternal health. Under existing law, a health insurance policy issued, amended, renewed, or delivered on or after January 1, 2017, excluding specialized health insurance policies, is prohibited from requiring an insured to receive a referral before receiving coverage or services for reproductive and sexual health care, including, among other things, the diagnosis and treatment of sexually transmitted diseases and the prevention or treatment of pregnancy for a minor. This bill would express the intent of the Legislature to enact the California Abortion and Reproductive Equity Act because cost should not be a barrier to reproductive health services.

**Primary Sponsors**
Akilah Weber
**Title**
Doula services.

**Description**
AB 2199, as introduced, Wicks. Doula services. Existing law provides for various services relating to maternal health, including community-based perinatal health care. This bill would state the intent of the Legislature to enact legislation relating to doula access and maternal health programs.

**Primary Sponsors**
Buffy Wicks

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**Title**
California Health Benefit Exchange: data collection and transparency.

**Description**
AB 2205, as introduced, Carrillo. California Health Benefit Exchange: data collection and transparency. Existing federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. Existing state law creates the California Health Benefit Exchange (Exchange), also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Existing law prescribes the duties of the board of the Exchange, including requiring a health plan seeking certification as a qualified health plan to submit specified data to the board. Existing law requires the board, if it requires or has previously required a qualified health plan to report on cost reduction efforts, quality improvements, or disparity reductions, to make public plan-specific data on cost reduction efforts, quality improvements, and disparity reductions, as specified. This bill would state the Legislature’s intent to enact legislation requiring greater transparency and data collection from qualified health plans offered through the Exchange.

**Primary Sponsors**
Wendy Carrillo
Title
Reproductive health.

Description
AB 2223, as introduced, Wicks. Reproductive health. Existing law, the Reproductive Privacy Act, provides that every individual possesses a fundamental right of privacy with respect to their personal reproductive decisions. This bill would state the intent of the Legislature to enact legislation that would relate to reproductive health.

Primary Sponsors
Buffy Wicks

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Title
Mental health services: planning, research, and evaluation.

Description
AB 2291, as introduced, Muratsuchi. Mental health services: planning, research, and evaluation. Existing law requires the State Department of Health Care Services to perform various functions with regard to the statewide delivery of mental health services, including, among other things, implementing a system of required performance reporting by local mental health programs. This bill would make technical, nonsubstantive changes to those provisions.

Primary Sponsors
Al Muratsuchi
Title
Nutrition Assistance: “Food as Medicine.”

Description
AB 2304, as introduced, Mia Bonta. Nutrition Assistance: “Food as Medicine.” Existing law provides for the California Health and Human Services Agency, which includes the State Department of Health Care Services, the State Department of Public Health, and the State Department of Social Services. Existing law establishes various programs and services under those departments, including the Medi-Cal program, under which qualified low-income individuals receive health care services, such as enteral nutrition products, the California Special Supplemental Nutrition Program for Women, Infants, and Children, which is administered by the State Department of Public Health and counties and under which nutrition and other assistance are provided to eligible individuals who have been determined to be at nutritional risk, and the CalFresh program, under which supplemental nutrition assistance benefits allocated to the state by the federal government are distributed to eligible individuals by each county. This bill would declare the intent of the Legislature to enact the Wilma Chan Food as Medicine Act of 2022.

Primary Sponsors
Mia Bonta
Title
Children's psychiatric residential treatment facilities.

Description
AB 2317, as introduced, Ramos. Children's psychiatric residential treatment facilities. Existing law, the California Community Care Facilities Act, provides for the licensing and regulation of community care facilities, including a children's crisis residential program, by the State Department of Social Services, and defines a children's crisis residential program to mean a facility licensed as a short-term residential therapeutic program and approved by the State Department of Health Care Services, or a county mental health plan, to operate a children's crisis residential mental health program to serve children experiencing mental health crises as an alternative to psychiatric hospitalization. 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 specified mental health and substance use disorder services. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions. Existing federal Medicaid regulations provide for inpatient psychiatric services for individuals under 21 years of age in psychiatric facilities, as prescribed. The bill would require the State Department of Health Care Services to license and establish regulations for psychiatric residential treatment facilities, which the bill would define as a licensed residential facility operated by a public agency or private organization that provides psychiatric services, as prescribed under the Medicaid regulations, to individuals under 21 years of age, in an inpatient setting. The bill would require the department's regulations and certifications to be consistent with applicable Medicaid regulations governing psychiatric residential treatment facilities, in order to maximize federal financial participation, as specified. The bill would include inpatient psychiatric services to individuals under 21 years of age provided in a licensed children's crisis psychiatric residential treatment facility as mental health services provided under the Medi-Cal program.

Primary Sponsors
James Ramos
<table>
<thead>
<tr>
<th><strong>Title</strong></th>
<th>Reproductive health care pilot program.</th>
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<tr>
<td><strong>Description</strong></td>
<td>AB 2320, as introduced, Cristina Garcia. Reproductive health care pilot program. Existing law establishes the State Department of Health Care Services, and requires the department to administer various health programs. Existing law authorizes the department to award funding and grants for specified health programs and studies, including maternal and child health grants. This bill, until January 1, 2028, would require the department to establish and administer a pilot program to direct funds to community health clinics that provide reproductive health care services in 5 counties. The bill would require a participating health clinic to undertake specified activities to improve health care delivery for marginalized patients, and to annually report to the department over 2 years regarding its efforts and progress with those activities. The bill would require the department to report to the Legislature on the program on or before June 1, 2026.</td>
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<tr>
<td><strong>Primary Sponsors</strong></td>
<td>Cristina Garcia</td>
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</tbody>
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**Introduction Date:** 2022-02-16

**Bill Number:** AB 2320

**Status:** In Assembly

**Position:** Monitor
Title
Prescription drug coverage.

Description
AB 2352, as introduced, Nazarian. Prescription drug coverage.
Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or health insurance policy that provides coverage for outpatient prescription drugs to cover medically necessary prescription drugs and subjects those policies to certain limitations on cost sharing and the placement of drugs on formularies. 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, and requires that payment to apply to the applicable deductible. This bill would require a health care service plan or health insurer that provides prescription drug benefits and maintains one or more drug formularies to furnish specified information about a prescription drug upon request by an enrollee or insured, or their health care provider. The bill would require the plan or insurer to respond in real time to that request and ensure the information is current no later than one business day after a change is made. The bill would prohibit a health care service plan or health insurer from, among other things, restricting a health care provider from sharing the information furnished about the prescription drug or penalizing a provider for prescribing a lower cost 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
AB 2402, as introduced, Blanca Rubio. Medi-Cal: continuous eligibility. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires the department, to the extent federal financial participation is available, to exercise a federal option to extend continuous eligibility to children 19 years of age and younger until the earlier of either the end of a 12-month period following the eligibility determination or the date the child exceeds 19 years of age. Under this bill, a child under 5 years of age would be continuously eligible for Medi-Cal, including without regard to income and without an annual review of eligibility, until the child reaches 5 years of age, to the extent that any necessary federal approvals are obtained and federal financial participation is available. The bill would also apply this continuous eligibility to children who are without satisfactory immigration status but who are eligible for Medi-Cal, as specified. Existing law establishes the Medi-Cal Access Program, which provides health care services to a woman who is pregnant or in her postpartum period and whose household income is above 208% but does not exceed 317% of the federal poverty level, and to a child under 2 years of age who is delivered by a mother enrolled in the program, as specified. Existing law requires a subscriber to provide income information at the end of 12 months of coverage, and requires that the infant be disenrolled from the program if the annual household income exceeds 317% of the federal poverty level or if the infant is eligible for full-scope Medi-Cal with no share of cost. This bill would, if the annual household income exceeds 317% of the federal poverty level, instead require that the infant remain continuously eligible for the program until they are 5 years of age, to the extent that any necessary federal approvals are obtained and federal financial participation is available. Existing law establishes the County Health Initiative Matching Fund, administered by the department, through which an applicant county, county agency, a local initiative, or a county organized health system that provides an intergovernmental transfer, as specified, is authorized to submit a proposal to the department for funding for the purpose of providing comprehensive health insurance coverage to certain children. For purposes of eligibility, existing law requires the child to meet specified citizenship and immigration status requirements, that their family income be at or below 317% of the federal poverty level... (click bill link to see more).
Title
Open meetings: local agencies: teleconferences.

Description
AB 2449, as introduced, Blanca Rubio. Open meetings: local agencies: teleconferences. Existing law, the Ralph M. Brown Act, requires, with specified exceptions, that all meetings of a legislative body of a local agency, as those terms are defined, be open and public and that all persons be permitted to attend and participate. The act contains specified provisions regarding the timelines for posting an agenda and providing for the ability of the public to observe and provide comment. The act allows for meetings to occur via teleconferencing subject to certain requirements, particularly that the legislative body notice each teleconference location of each member that will be participating in the public meeting, that each teleconference location be accessible to the public, that members of the public be allowed to address the legislative body at each teleconference location, that the legislative body post an agenda at each teleconference location, and that at least a quorum of the legislative body participate from locations within the boundaries of the local agency's jurisdiction. The act provides an exemption to the jurisdictional requirement for health authorities, as defined. Existing law, until January 1, 2024, authorizes a local agency to use teleconferencing without complying with those specified teleconferencing requirements in specified circumstances when a declared state of emergency is in effect, or in other situations related to public health. This bill would authorize a local agency to use teleconferencing without complying with those specified teleconferencing requirements if at least a quorum of the members of the legislative body participates in person from a singular location clearly identified on the agenda that is open to the public and situated within the local agency's jurisdiction. The bill would impose prescribed requirements for this exception relating to notice, agendas, the means and manner of access, and procedures for disruptions. The bill would require the legislative body to implement a procedure for receiving and swiftly resolving requests for reasonable accommodation for individuals with disabilities, consistent with federal law. Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest. This bill would make legislative findings to that effect. The California Constitution requires 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 ame... (click bill link to see more).

Primary Sponsors
Blanca Rubio
Title
California Children's Services: reimbursement rates.

Description
AB 2458, as introduced, Akilah Weber. California Children's Services: reimbursement rates. Existing law establishes the California Children's Services (CCS) Program, administered by the State Department of Health Care Services and a designated agency of each county, to provide medically necessary services for persons under 21 years of age who have any of specified medical conditions and who meet certain financial eligibility requirements. Existing law establishes the Medi-Cal program, which is administered by the department and under which qualified low-income individuals receive health care services. Existing law requires that provider rates of payment for services rendered in the CCS Program be identical to the rates of payment for the same service performed by the same provider type pursuant to the Medi-Cal program. Notwithstanding that requirement, existing law authorizes the reimbursement of services provided under the CCS Program at rates greater than the Medi-Cal rate that would otherwise be applicable if those rates are adopted by the Director of Health Care Services in regulations. Existing law establishes a Whole Child Model program for Medi-Cal eligible CCS children and youth enrolled in a Medi-Cal managed care plan served by a county organized health system or Regional Health Authority in specified counties. Existing law requires the department to pay a participating managed care plan a certain rate, and requires the plan to pay physician and surgeon provider services at rates that are equal to or exceed the applicable CCS fee-for-service rates, except as specified. Physician services provided under the CCS Program are currently reimbursed at rates that are 39.7% greater than the applicable Medi-Cal rates. This bill would make legislative findings relating to the need for an increase in the reimbursement rates for physician services provided under the CCS Program. Under the bill, subject to an appropriation, and commencing January 1, 2023, those reimbursement rates would be increased by adding at least 25% to the above-described augmentation percentage relative to the applicable Medi-Cal rates. The bill would make the rate increase applicable only if the services are provided by a physician in a practice in which at least 30% of the practice's pediatric patients are Medi-Cal beneficiaries. The bill would, no later than January 1, 2026, and every 3 years thereafter, require the department to complete a review of those reimbursement rates, including whether the department recommends an increase in the rates, as specified. The bill would require that the reviews contain data disaggregated by rural or urban area, ZIP Code, and satellite clinic providing CCS services. The bill would require the department to submit rep... (click bill link to see more).

Primary Sponsors
Akilah Weber
Title
Health care coverage: human papillomavirus.

Description
AB 2516, as introduced, Aguiar-Curry. Health care coverage: human papillomavirus. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2002, to provide coverage for an annual cervical cancer screening test, including a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA). Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services and under which health care services are provided to low-income individuals pursuant to a schedule of benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law also establishes the Family Planning, Access, Care, and Treatment (Family PACT) Program, administered by the Office of Family Planning within the department, under which comprehensive clinical family planning services are provided to a person who has a family income at or below 200% of the federal poverty level, and who is eligible to receive these services. This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2023, to provide coverage without cost sharing for the HPV vaccine for persons for whom the vaccine is FDA approved. 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 bill would also expand comprehensive clinical family planning services under the Family PACT Program to include the HPV vaccine for persons for whom it is FDA approved. 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
Cecilia Aguiar-Curry
Title
California Health Benefit Exchange: financial assistance.

Description
AB 2530, as introduced, Wood. California Health Benefit Exchange: financial assistance. Existing federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. Existing state law creates the California Health Benefit Exchange (Exchange), also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Under existing regulations, an individual may enroll in a plan through the Exchange in a special enrollment period that is triggered if the individual loses other coverage due to termination of employment or reduction in the number of hours of employment. Existing law requires the Exchange, until January 1, 2023, to administer a program to provide health care coverage financial assistance to California residents with household incomes at or below 600% of the federal poverty level. This bill, upon appropriation by the Legislature, would require the Exchange to administer a program of financial assistance to help Californians obtain and maintain health benefits through the Exchange if they lose employer-provided health care coverage as a result of a labor dispute. Under the bill, an individual who has lost minimum essential coverage from an employer or joint labor management trust fund as a result of a strike, lockout, or other labor dispute would receive the same premium assistance and cost-sharing reductions as an individual with a household income of 133% of the federal poverty level, and would also not pay a deductible for any covered benefit.

Primary Sponsors
Jim Wood
Title
Individual Shared Responsibility Penalty: waiver: health care service plans.

Description
AB 2564, as introduced, Bigelow. Individual Shared Responsibility Penalty: waiver: health care service plans. Existing law establishes the Minimum Essential Coverage Individual Mandate to require an individual who is a California resident to ensure that the individual, and any spouse or dependent of the individual, is enrolled in and maintains minimum essential medical coverage for each month, except as specified. Existing law imposes the Individual Shared Responsibility Penalty for the failure to maintain minimum essential coverage, as determined and collected by the Franchise Tax Board, in collaboration with the California Health Benefit Exchange, as specified. This bill would require the Franchise Tax Board to waive the Individual Shared Responsibility Penalty for an individual who either was enrolled in minimum essential coverage for at least 6 consecutive months during the taxable year, or had at least one verified meeting with a specified employee to discuss the individual's health care insurance purchasing options. The bill would require verification of a meeting with a specified employee under penalty of perjury, and would thereby 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
Frank Bigelow
Title
Health care service plans: mental health and substance use disorders: provider credentials.

Description
AB 2581, as introduced, Salas. Health care service plans: mental health and substance use disorders: provider credentials. 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 contract issued, amended, or renewed on or after January 1, 2021, that provides hospital, medical, or surgical coverage to provide coverage for medically necessary treatment of mental health and substance use disorders, under the same terms and conditions applied to other medical conditions, as specified. For provider contracts issued, amended, or renewed on and after January 1, 2023, this bill would require a health care service plan that provides coverage for mental health and substance use disorders and credentials health care providers of those services for the health care service plan's networks, to assess and verify the qualifications of a health care provider within 45 days after receiving a completed provider credentialing application. The bill would authorize an applicant to make a written request for a temporary credential if the health care service plan has not approved or denied the completed application within 45 days of receipt, and would require the health care service plan to issue the temporary credential, unless the applicant has reported a history of malpractice, substance abuse or mental health issues, or disciplinary action on their application. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Rudy Salas
### AB 2585

**Title**
Health care coverage: nonpharmacological pain management treatment.

**Description**
AB 2585, as introduced, McCarty. Health care coverage: nonpharmacological pain management treatment. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. These provisions require specified services and drugs to be covered by various health care services plans and health insurers. This bill would permit an individual or group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2023, that covers hospital, medical, or surgical expenses to provide coverage for nonpharmacological pain management treatment, as defined. Because a willful violation of these provisions by a health care service plan is a crime, this bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

**Primary Sponsors**
Kevin McCarty

**Introduction Date:** 2022-02-18

### AB 2648

**Title**
Prescription drugs.

**Description**
AB 2648, as introduced, Grayson. Prescription drugs. Existing law, the California Affordable Drug Manufacturing Act of 2020, requires the California Health and Human Services Agency to enter into partnerships resulting in the production or distribution of generic prescription drugs in order to, among other purposes, address shortages in the market and increase patient access to affordable drugs. This bill would make a technical, nonsubstantive change to one of the provisions of that act.

**Primary Sponsors**
Tim Grayson

**Introduction Date:** 2022-02-18
Title
Medi-Cal managed care: midwifery services.

Description
AB 2659, as introduced, Patterson. Medi-Cal managed care: midwifery services. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services through various delivery systems, including managed care. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes certain time and distance and appointment time standards for specified Medi-Cal managed care covered services, including obstetrics and gynecology primary care, consistent with federal regulations relating to network adequacy standards, to ensure that those services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner, as specified. Existing law sets forth other network adequacy requirements for a Medi-Cal managed care plan with respect to its service area. Existing law authorizes the holder of a midwifery license or nurse-midwifery certificate to provide prenatal, intrapartum, and postpartum care, as specified. Under existing law, midwifery services and nurse-midwifery services are covered under the Medi-Cal program, subject to utilization controls and other conditions. This bill would require a Medi-Cal managed care plan to have within its provider network at least one licensed midwife (LM) or certified-nurse midwife (CNM) within each county where the Medi-Cal managed care plan provides services to Medi-Cal beneficiaries. The bill would exempt a Medi-Cal managed care plan from that requirement for purposes of a given county if no LM or CNM is available in that county or if no LM or CNM in that county accepts Medi-Cal payments. The bill would condition implementation of these provisions on receipt of any necessary federal approvals and the availability of federal financial participation.

Primary Sponsors
Jim Patterson

Introduction Date: 2022-02-18
Title
Medi-Cal: Community Health Navigator Program.

Description
AB 2680, as introduced, Arambula. Medi-Cal: Community Health Navigator Program. 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 that counties administer public social services, including Medi-Cal. Existing law also authorizes a county to collaborate with a community-based organization to maintain up-to-date contact information in order to assist with timely submission of annual reaffirmation forms, among others. This bill would require the department to create the Community Health Navigator Program to make direct grants to qualified community-based organizations, as defined, to conduct targeted outreach, enrollment, retention, and access activities for Medi-Cal-eligible individuals and families. The bill would specify the basis for issuing a grant, including specified factors in the applicant's service area. The bill would require the department to contract with a private foundation to administer the grant application and allocation process. The bill would require the department to contract with specified providers to furnish training and technical assistance to grant recipients. The bill would also require the department to coordinate and partner with Covered California and counties that elect to participate, on an approach for outreach, enrollment, retention, and access activities for marketing to eligible individuals, including development of a joint application tracker system to allow specified persons and entities to track application and referrals between commercial and Medi-Cal enrollment progress and facilitation of quarterly meetings on enrollment and access barriers and solutions, among other requirements.

Primary Sponsors
Joaquin Arambula
Title
Medi-Cal: community health workers and promotores.

Description
AB 2697, as introduced, Aguiar-Curry. Medi-Cal: community health workers and promotores. 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. This bill would state the intent of the Legislature to enact legislation to establish standards and requirements for qualification, payment and reimbursement, supervision, and scope of eligible services, and to create an advisory structure for a community health worker and promotores benefit in the Medi-Cal program. The bill would further state the intent of the Legislature to enact legislation to establish processes aimed at ensuring, among others, community health workers and promotores have the supportive structures in place to adequately serve community needs, as specified. The bill would make related findings and declarations.

Primary Sponsors
Cecilia Aguiar-Curry
Title
Emergency ground medical transportation.

Description
AB 2709, as introduced, Boerner Horvath. Emergency ground medical transportation. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires that health care service plan contracts and health insurance policies provide coverage for certain services and treatments, including emergency medical transportation services. This bill would require a health care service plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2023, to require an enrollee or insured who receives covered services from a noncontracting ground ambulance provider to pay no more than the same cost-sharing amount that the enrollee or insured would pay for the same covered services received from a contracting ground ambulance provider, and would prohibit the noncontracting ground ambulance provider from billing or sending to collections a higher amount. The bill would require the plan or insurer to reimburse a noncontracting ground ambulance provider the greater of the average contracted rate or 125% of the Medicare reimbursement rate for those services, as specified. Because a willful violation of the bill's requirements relative to a health care service plan would be a crime, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Tasha Boerner Horvath
Medi-Cal: eligibility.

AB 2727, as amended, Wood. Medi-Cal: eligibility. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law prohibits the use of an assets or resources test for individuals whose financial eligibility for Medi-Cal is determined based on the application of a modified adjusted gross income (MAGI) standard, as specified. Existing law prohibits the use of resources, including property or other assets, to determine Medi-Cal eligibility for applicants or beneficiaries whose eligibility is not determined using the MAGI-based financial methods, and requires the department to seek federal authority to disregard all resources as authorized by the flexibilities provided under federal law. Existing law conditions implementation of that provision on the Director of Health Care Services determining that systems have been programmed for those disregards and their communicating that determination in writing to the Department of Finance, no sooner than January 1, 2024. Existing law also conditions implementation of that provision on receipt of any necessary federal approvals and the availability of federal financial participation. Existing law states the intent of the Legislature to provide, to the extent practicable, through the Medi-Cal program, for health care for those aged and other persons, including family persons who lack sufficient annual income to meet the costs of health care, and whose other assets are so limited that their application toward the costs of that care would jeopardize the person or family’s future minimum self-maintenance and security. This bill would, commencing on January 1, 2024, remove from that statement of legislative intent the above-described assets as an eligibility criterion. The bill would also make other changes to that statement.

Primary Sponsors
Jim Wood
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<thead>
<tr>
<th>Bill Number</th>
<th>Status</th>
<th>Position</th>
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<tbody>
<tr>
<td>AB 2768</td>
<td>In Assembly</td>
<td>Monitor</td>
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<tr>
<td>AB 2783</td>
<td>In Assembly</td>
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<td>AB 2833</td>
<td>In Assembly</td>
<td>Monitor</td>
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### Mental Health

**Title**
Mental health.

**Description**
AB 2768, as introduced, Waldron. Mental health. Existing law establishes a system of mental health programs, largely administered through the counties, to provide mental health services in the state. This bill would state the intent of the Legislature to enact legislation that would make changes to the provision of mental health services in the state.

**Primary Sponsors**
Marie Waldron

Introduction Date: 2022-02-18

### Health Care Coverage

**Title**
Health care coverage.

**Description**
AB 2783, as introduced, Waldron. Health care coverage. Existing law provides for the regulation of health care service plans by the Department of Managed Health Care and the regulation of health insurers by the Department of Insurance. This bill would state the intent of the Legislature to enact legislation relating to health care coverage.

**Primary Sponsors**
Marie Waldron

Introduction Date: 2022-02-18

### Essential Health Benefits

**Title**
Essential health benefits.

**Description**
AB 2833, as introduced, Irwin. Essential health benefits. 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. The act requires an individual or small group health care service plan contract issued, amended, or renewed on or after January 1, 2017, to, at a minimum, cover essential health benefits, and defines “essential health benefits” to include health benefits covered by other particular benchmark plans, including a certain plan offered during the first quarter of 2014. A willful violation of the act is a crime. This bill would make technical, nonsubstantive changes to those provisions.

**Primary Sponsors**
Jacqui Irwin

Introduction Date: 2022-02-18
Title
Prescription drug cost sharing.

Description
AB 2942, as introduced, Daly. Prescription drug cost sharing.
(1) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care under authority of the Director of the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance under the authority of the Insurance Commissioner. Existing law limits the maximum amount an enrollee or insured may be required to pay at the point of sale for a covered prescription drug to the lesser of the applicable cost-sharing amount or the retail price. This bill would require an enrollee's or insured's defined cost sharing for each prescription drug to be calculated at the point of sale based on a price that is reduced by an amount equal to 90% of all rebates received, or to be received, in connection with the dispensing or administration of the drug. The bill would require a health care service plan or health insurer to, among other things, pass through to each enrollee or insured at the point of sale a good faith estimate of their decrease in cost sharing. The bill would require a health care service plan or health insurer to calculate an enrollee's or insured's defined cost sharing and provide that information to the dispensing pharmacy, as specified. The bill would require a health care service plan or health insurer to disclose information, as specified, sufficient to show compliance with these provisions to the director or commissioner. 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. The bill would make a violation of its provisions not a crime under the act. The bill would authorize the director or commissioner to assess a civil penalty for each violation of these provisions, as specified. The bill would make those provisions inoperative on January 1, 2025. The bill would require the department and the commissioner, on or before March 1 each year, to provide a report on the impact of those provisions on drug prices and health care premium rates, as specified. The bill would repeal those provisions January 1, 2026.
(2) Existing law requires a health care service plan or health insurer that files certain rate information to report to the appropriate department specified cost information regarding covered prescription drugs, including generic drugs, brand name drugs, and specialty drugs, dispense... (click bill link to see more).

Primary Sponsors
Tom Daly
Title
Taxes to fund health care coverage and cost control.

Description
ACA 11, as introduced, Kalra. Taxes to fund health care coverage and cost control. Existing law imposes various taxes, including personal income and excise taxes. The California Constitution requires a 2/3 vote of both houses of the Legislature for the passage of any change in statute that results in any taxpayer paying a higher tax. The California Constitution generally prohibits the total annual appropriations subject to limitation of the state and each local government from exceeding the appropriations limit of the entity of government for the prior fiscal year, adjusted for the change in the cost of living and the change in population, and prescribes procedures for making adjustments to the appropriations limit. This measure would impose an excise tax, payroll taxes, and a State Personal Income CalCare Tax at specified rates to fund comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of every resident of the state, as well as reserves deemed necessary to ensure payment, to be established in statute. The measure would authorize the Legislature, upon an economic analysis determining insufficient amounts to fund these purposes, to increase any or all of these tax rates by a statute passed by majority vote of both houses of the Legislature. This measure would establish the CalCare Trust Fund in the State Treasury and would deposit these tax revenues in the fund for the purpose of funding this health care coverage, cost control system, and reserves, and would authorize the Legislature to appropriate these funds by a statute passed by a majority vote of the membership of both houses. The measure would exclude appropriations of revenues from the CalCare Trust Fund from the limitation on appropriations and from consideration for purposes of educational funding mandated by the California Constitution. This measure would prohibit the above-described provisions from becoming operative until the later operative date of a statute that establishes comprehensive universal single-payer health care coverage, a health care cost control system, and necessary reserves, and a statute that establishes the administration, collection, and enforcement of the excise tax, payroll taxes, and a State Personal Income CalCare Tax imposed by the measure.

Primary Sponsors
Ash Kalra, Alex Lee
Title
Office of Racial Equity.

Description
SB 17, as amended, Pan. Office of Racial Equity. Existing law establishes an Office of Health Equity in the State Department of Public Health for purposes of aligning state resources, decisionmaking, and programs to accomplish certain goals related to health equity and protecting vulnerable communities. Existing law requires the office to develop department-wide plans to close the gaps in health status and access to care among the state's diverse racial and ethnic communities, women, persons with disabilities, and the lesbian, gay, bisexual, transgender, queer, and questioning communities, as specified. Existing law requires the office to work with the Health in All Policies Task Force to assist state agencies and departments in developing policies, systems, programs, and environmental change strategies that have population health impacts by, among other things, prioritizing building cross-sectoral partnerships within and across departments and agencies to change policies and practices to advance health equity. Existing law establishes the Task Force to Study and Develop Reparation Proposals for African Americans, with a Special Consideration for African Americans Who are Descendants of Persons Enslaved in the United States to, among other things, identify, compile, and synthesize the relevant corpus of evidentiary documentation of the institution of slavery that existed within the United States and the colonies. Existing law requires the task force to submit a written report of its findings and recommendations to the Legislature. This bill, until January 1, 2029, would establish in state government an Office of Racial Equity, an independent public entity not affiliated with an agency or department, governed by a Racial Equity Advisory and Accountability Council. The bill would authorize the council to hire an executive director to organize, administer, and manage the operations of the office. The bill would task the office with coordinating, analyzing, developing, evaluating, and recommending strategies for advancing racial equity across state agencies, departments, and the office of the Governor. The bill would require the office, in consultation with state agencies, departments, and public stakeholders, as appropriate, to develop a statewide Racial Equity Framework that includes a strategic plan with policy and inclusive practice recommendations, guidelines, goals, and benchmarks to reduce racial inequities, promote racial equity, and address individual, institutional, and structural racism. The bill would require the office to develop the statewide Racial Equity Framework in collaboration with a Chief Equity Officer, who would be appointed and serve at the pleasure of the Governor and who would report to the Secret... (click bill link to see more).

Primary Sponsors
Richard Pan, Joaquin Arambula, David Chiu

Organizational Notes
Last edited by Cherie Compartore at Aug 16, 2021, 3:56 PM
Support - L.A. Care, L.A. Board of Supervisors, CCLAC, CAPH, CWDA
Title
Health care workforce development: California Medicine Scholars Program.

Description
SB 40, as amended, Hurtado. Health care workforce development: California Medicine Scholars Program. Existing law establishes various programs to facilitate the expansion of the health care workforce in rural and underserved communities, including, but not limited to, the Health Professions Career Opportunity Program, the California Registered Nurse Education Program, and the Steven M. Thompson Medical School Scholarship Program. This bill, contingent upon an appropriation by the Legislature, as specified, would create the California Medicine Scholars Program, a 5-year pilot program commencing January 1, 2023, and would require the Office of Statewide Health Planning and Development to establish and facilitate the pilot program. The bill would require the pilot program to establish a regional pipeline program for community college students to pursue premedical training and enter medical school, in an effort to address the shortage of primary care physicians in California and the widening disparities in access to care in vulnerable and underserved communities, including building a comprehensive statewide approach to increasing the number and representation of minority primary care physicians in the state. The bill would require the office to contract with a managing agency for the pilot program, as specified. The bill would require the pilot program to consist of 4 Regional Hubs of Health Care Opportunity (RHHO) to achieve its objectives, and would require each RHHO to include, at a minimum, 3 community colleges, one public or nonprofit, as defined, 4-year undergraduate institution, one public or nonprofit, as defined, medical school, and 3 local community organizations. The bill would require the managing agency to appoint an objective selection committee, with specified membership, to evaluate prospective RHHO applications and select RHHOs that meet certain requirements to participate in the pilot program. The bill would require each selected RHHO to enter into memoranda of understanding between the partnering entities setting forth participation requirements, and to perform other specified duties, including establishing an advisory board to oversee and guide the programmatic direction of the RHHO and developing partnership agreements with one or more campus-based learning communities, groups, or entities to assist with outreach, recruitment, and support of students. The bill would require the selection process to be completed by June 30, 2022. This bill would require each RHHO to recruit and select 50 California Medicine Scholars each calendar year from 2023 to 2026, inclusive, in accordance with specified criteria, and to provide, by December 31, 2023, and by that date of each year thereafter, up to and including 2026, ... (click bill link to see more).

Primary Sponsors
Melissa Hurtado
Medi-Cal: eligibility.

Description
SB 56, as amended, Durazo. Medi-Cal: eligibility. Existing law provides for 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. 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, and extends eligibility for full-scope Medi-Cal benefits to individuals 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, and requires the department to maximize federal financial participation for purposes of implementing the requirements. To the extent that federal financial participation is unavailable, existing law requires the department to implement those provisions using state funds appropriated for that purpose. 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, will 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 with full-scope Medi-Cal benefits. This bill would, subject to an appropriation by the Legislature, and effective July 1, 2022, extend eligibility for full-scope Medi-Cal benefits to individuals who are 60 years of age or older, and who are otherwise eligible for those benefits but for their immigration status. The bill would delete provisions delaying implementation until the director makes the determination described above. The bill would require the department to seek federal approvals to obtain federal financial participation to implement these requirements, and would require that state-only funds be used for those benefits if federal financial participation is unavailable... (click bill link to see more).

Primary Sponsors
Maria Durazo, Joaquin Arambula

Organizational Notes
Last edited by Cherie Compartore at Aug 16, 2021, 4:00 PM
Support: L.A. Care, LHPC, CAHP, CCLAC, CWDA, CHA
Title

Description
SB 114, Committee on Budget and Fiscal Review. Employment: COVID-19: supplemental paid sick leave. (1) Existing law, the Healthy Workplaces, Healthy Families Act of 2014, entitles an employee who works in California for the same employer for 30 or more days within a year from the commencement of employment to paid sick days. Under existing law, an employee accrues paid sick days at a rate of not less than one hour per every 30 hours worked, subject to certain use, accrual, and yearly carryover limitations. Existing law requires the Labor Commissioner to enforce the act and provides for procedures, including investigation and hearing, and for remedies and penalties. Existing law, until December 31, 2020, provided for COVID-19 food sector supplemental paid sick leave for food sector workers and required a hiring entity to provide COVID-19 food sector supplemental paid sick leave, as described, to each food sector worker unable to work due to specified reasons relating to COVID-19. Existing law also established, until December 31, 2020, COVID-19 supplemental paid sick leave for covered workers, including certain persons employed by private businesses of 500 or more employees or persons employed as certain types of health care providers or emergency responders by public or private entities. Existing law, until September 30, 2021, provided for COVID-19 supplemental paid sick leave for covered employees, in-home supportive service providers, and waiver personal care service providers who were unable to work due to certain reasons related to COVID-19, including that the employee or provider was advised by a health care provider to self-quarantine due to concerns related to COVID-19. Existing law entitled a covered employee or provider to 80 hours of COVID-19 supplemental paid sick leave, as specified, and set the compensation for that leave. This bill, beginning January 1, 2022, until September 30, 2022, would provide for COVID-19 supplemental paid sick leave for covered employees who are unable to work or telework due to certain reasons related to COVID-19, including that the employee is attending a COVID-19 vaccine or vaccine booster appointment for themselves or a family member, or is experiencing symptoms, or caring for a family member experiencing symptoms, related to a COVID-19 vaccine or vaccine booster. The bill would entitle a covered employee to 40 hours of COVID-19 supplemental paid sick leave if that employee works full time or was scheduled to work, on average, at least 40 hours per week for the employer in the 2 weeks preceding the date the covered employee took COVID-19 supplemental paid sick leave. The bill would provide a different calculation for supplemental paid sick leave for a covered employee who is a firefighter ... (click bill link to see more).

Primary Sponsors
Senate Committee on Budget and Fiscal Review
Title
Health care coverage: abortion services: cost sharing.

Description
SB 245, as amended, Gonzalez. Health care coverage: abortion services: cost sharing. Existing law, the Reproductive Privacy Act, prohibits the state from denying or interfering with a person's right to choose or obtain an abortion prior to viability of the fetus, or when the abortion is necessary to protect the life or health of the person. The act defines "abortion" as a medical treatment intended to induce the termination of a pregnancy except for the purpose of producing a live birth. Existing law also 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 through, among other things, managed care plans licensed under the act that contract with the State Department of Health Care Services. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service plans and makes a willful violation of the act a crime. Existing law also requires the Department of Insurance to regulate health insurers. Existing law requires group and individual health care service plan contracts and disability insurance policies to cover contraceptives, without cost sharing, as specified. This bill would prohibit a health care service plan or an individual or group policy or certificate of health insurance or student blanket disability insurance that is issued, amended, renewed, or delivered on or after January 1, 2023, from imposing a deductible, coinsurance, copayment, or any other cost-sharing requirement on coverage for all abortion and abortion-related services, as specified. The bill would prohibit a health care service plan and an insurer subject to these requirements from imposing utilization management or utilization review on the coverage for outpatient abortion services. The bill would require that for a contract, certificate, or policy that is a high deductible health plan, the cost-sharing prohibition would apply once the enrollee's or insured's deductible has been satisfied for the benefit year. The bill would not require an individual or group contract or policy to cover an experimental or investigational treatment. The bill's requirements would also apply to Medi-Cal managed care plans and their providers, independent practice associations, preferred provider groups, and all delegated entities that provide physician services, utilization management, or utilization review. The bill would require the Department of Managed Health Care and the Department of Insurance to adopt related regulations on or before January 1, 2026. Because a violation of the bill by a health care service plan would be a crime, the bill would imp... (click bill link to see more).

Primary Sponsors
Lena Gonzalez, Sydney Kamlager, Connie Leyva

Organizational Notes
Last edited by Joanne Campbell at Apr 5, 2021, 5:26 PM
CAHP - Oppose
Title
Health care coverage.

Description
SB 250, as amended, Pan. Health care coverage. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan or health insurer to establish criteria or guidelines that meet specified requirements to be used to determine whether or not to authorize, modify, or deny health care services. This bill would authorize the Department of Managed Health Care and the Insurance Commissioner, as appropriate, to review a plan's or insurer's clinical criteria, guidelines, and utilization management policies to ensure compliance with existing law. If the criteria and guidelines are not in compliance with existing law, the bill would require the Director of the Department of Managed Health Care or the commissioner to issue a corrective action and send the matter to enforcement, if necessary. The bill would require each department, on or before July 1, 2022, to develop a methodology for a plan or insurer to report the number of prospective utilization review requests it denied in the preceding 12 months, as specified. This bill would require a health care service plan contract or health insurance contract issued, amended, or renewed on or after January 1, 2022, to reimburse a contracting individual health professional, as defined, the in-network cost-sharing amount for services provided to an enrollee or insured at a contracting health facility, as defined. The bill would also require a plan or insurer and its delegated entities, on or before January 1, 2023, and annually thereafter, to report, among other things, its average number of denied prospective utilization review requests, as specified. The bill would require, on and after January 1, 2023, a plan or insurer to examine an individual health professional's record of prospective utilization review requests during the preceding 12 months and grant the individual health professional "deemed approved" status for 2 years, meaning an exemption from the prospective utilization review process, if specified criteria are met. The bill would authorize a plan or insurer to request an audit of an individual health professional's records after the initial 2 years of an individual health professional's deemed approved status and every 2 years thereafter, and would specify the audit criteria by which an individual health professional would keep or lose that status. The bill would authorize the commissioner to adopt regulations to implement these provisions, as specified. Because a willful... (click bill link to see more).

Primary Sponsors
Richard Pan

Organizational Notes
Last edited by Joanne Campbell at Mar 5, 2021, 4:57 PM
CAHP - Oppose
Title
California Advancing and Innovating Medi-Cal.

Description
SB 256, as amended, Pan. California Advancing and Innovating 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. The Medi-Cal program is, in part, governed by, and funded pursuant to, federal Medicaid program provisions. Under existing law, health care services are provided under the Medi-Cal program pursuant to a schedule of benefits, and those benefits are provided to beneficiaries through various health care delivery systems, including fee-for-service and managed care. 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 Medi-Cal managed care plan contractors, and requires the department to pay capitations rates to health plans participating in the Medi-Cal managed care program using actuarial methods. Existing law authorizes the department to establish, and requires the department to utilize, health-plan- and county-specific rates for specified Medi-Cal managed care plan contracts, and requires those developed rates to include identified information, such as health-plan-specific encounter and claims data. Existing law, the Medi-Cal 2020 Demonstration Project Act, requires the department to implement specified components of a Medi-Cal demonstration project, including the Global Payment Program, the Whole Person Care pilot program, and the Dental Transformation Initiative, consistent with the Special Terms and Conditions approved by the federal Centers for Medicare and Medicaid Services. Pursuant to existing law, the department has created a multiyear initiative, the California Advancing and Innovating Medi-Cal (CalAIM) initiative, for purposes of building upon the outcomes of various Medi-Cal pilots and demonstration projects, including the Medi-Cal 2020 demonstration project. 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. This bill would establish the CalAIM initiative, and would require the implementation of CalAIM to support stated goals of identifying and managing the risk and needs of Medi-Cal beneficiaries, transitioning and transforming the Medi-Cal program to a more consistent and seamless system, and improving quality outcomes. The bill would require the department to seek federal approval for the CalAIM initiative, and would condition its implementation on receipt of any necessary federal approvals and... (click bill link to see more).

Primary Sponsors
Richard Pan
Title
Medi-Cal: California Community Transitions program.

Description
SB 281, as amended, Dodd. Medi-Cal: California Community Transitions program. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing federal law establishes the Money Follows the Person Rebalancing Demonstration, which is designed to achieve various objectives with respect to institutional and home- and community-based long-term care services provided under state Medicaid programs. Under the Money Follows the Person Rebalancing Demonstration, an eligible individual is required to meet prescribed qualifications, including that they have resided in an inpatient facility for at least 90 consecutive days. Existing law requires the department to provide services consistent with the Money Follows the Person Rebalancing Demonstration for transitioning eligible individuals out of an inpatient facility who have not resided in the facility for at least 90 days, and to cease providing those services on January 1, 2024. Existing law repeals these provisions on January 1, 2025. This bill would instead require the department to provide those services for individuals who have not resided in the facility for at least 60 days, and would make conforming changes. The bill would extend the provision of those services to January 1, 2029, and would extend the repeal date of those provisions to January 1, 2030. This bill would require the department to implement and administer the California Community Transitions program to provide services for qualified beneficiaries who have resided in the facility for 60 days or longer. The bill would require a lead organization to provide services under the program. The bill would require program services to include prescribed services, such as transition coordination services. The bill would authorize a Medi-Cal beneficiary to participate in this program if the Medi-Cal beneficiary meets certain requirements, and would require eligible Medi-Cal beneficiaries to continue to receive program services once they have transitioned into a qualified residence. The bill would require the department to use federal funds, which are made available through the Money Follows the Person Rebalancing Demonstration, to implement this program, and to administer the program in a manner that attempts to maximize federal financial participation if that program is not reauthorized or if there are insufficient funds. This bill would declare that it is to take effect immediately as an urgency statute.

Primary Sponsors
Bill Dodd
Title
Medi-Cal specialty mental health services.

Description
SB 293, as amended, Limón. Medi-Cal specialty mental health 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 specialty mental health services, and Early and Periodic Screening, Diagnostic, and Treatment services for an individual under 21 years of age. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, one of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care health plans, including mental health plans that provide specialty mental health services. Existing law requires the department to ensure that Medi-Cal managed care contracts include a process for screening, referral, and coordination with mental health plans of specialty mental health services, to convene a steering committee to provide advice on the transition and continuing development of the Medi-Cal mental health managed care systems, and to ensure that the mental health plans comply with various standards, including maintaining a system of outreach to enable Medi-Cal beneficiaries and providers to participate in and access Medi-Cal specialty mental health services under the mental health plans. With respect to specialty mental health services provided under the Early and Periodic Screening, Diagnostic, and Treatment Program, on or after January 1, 2022, this bill would require the department to develop standard forms, including intake and assessment forms, relating to medical necessity criteria, mandatory screening and transition of care tools, and documentation requirements pursuant to specified terms and conditions, and, for purposes of implementing these provisions, would require the department to consult with representatives of identified organizations, including the County Behavioral Health Directors Association of California. The bill would authorize the department to develop and maintain a list of department-approved nonstandard forms, and would require the department to conduct, on or before July 1, 2023, regional trainings for county mental health plan personnel and their provider networks on proper completion of the standard forms. The bill would require each county mental health plan contractor to distribute the training material and standard forms to their provider networks, and to commence, by July 1, 2023, exclusively using the standard forms, unless they use department-approved nonstandard forms.

Primary Sponsors
Monique Limon, Adam Gray, Anthony Portantino
Title
Medi-Cal: federally qualified health centers and rural health clinics.

Description
SB 316, as introduced, Eggman. Medi-Cal: federally qualified health centers and rural health clinics. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services, including federally qualified health center (FQHC) services and rural health clinic (RHC) services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law provides that FQHC and RHC services are to be reimbursed, to the extent that federal financial participation is obtained, to providers on a per-visit basis. “Visit” is defined as a face-to-face encounter between a patient of an FQHC or RHC and specified health care professionals, including a physician and marriage and family therapist. Under existing law, “physician,” for these purposes, includes, but is not limited to, a physician and surgeon, an osteopath, and a podiatrist. This bill would authorize reimbursement for a maximum of 2 visits taking place on the same day at a single location if after the first visit the patient suffers illness or injury requiring additional diagnosis or treatment, or if the patient has a medical visit and a mental health visit or a dental visit, as defined. The bill would authorize an FQHC or RHC that currently includes the cost of a medical visit and a mental health visit that take place on the same day at a single location as a single visit for purposes of establishing the FQHC’s or RHC’s rate to apply for an adjustment to its per-visit rate, and after the department has approved that rate adjustment, to bill a medical visit and a mental health visit that take place on the same day at a single location as separate visits, in accordance with the bill. This bill would also include a licensed acupuncturist within those health professionals covered under the definition of a “visit.” The bill would require the department, by July 1, 2022, to submit a state plan amendment to the federal Centers for Medicare and Medicaid Services to reflect certain changes described in the bill, and to seek necessary federal approvals. The bill would also make conforming and technical changes.

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

Organizational Notes
Last edited by Cherie Compartore at Aug 16, 2021, 4:08 PM
Support: L.A. Care, CAHP, LHPC, CCLAC, CWDA, CMA
Title
Health information technology.

Description
SB 371, as amended, Caballero. Health information technology.
Existing law establishes the California Health and Human Services Agency (CHHSA), which includes departments charged with the administration of health, social, and other human services. Existing law authorizes CHHSA to apply for federal health information technology and exchange funding. If CHHSA applies for and receives that funding through the federal American Recovery and Reinvestment Act of 2009, existing law requires those funds to be deposited in the California Health Information Technology and Exchange Fund for use, upon appropriation by the Legislature, for purposes related to health information technology and exchange. This bill would require any federal funds CHHSA receives for health information technology and exchange to be deposited in the California Health Information Technology and Exchange Fund. The bill would authorize CHHSA to use the fund to provide grants to health care providers to implement or expand health information technology and to contract for direct data exchange technical assistance for safety net providers. The bill would require a health information organization to be connected to the California Trusted Exchange Network and to a qualified national network. The bill would also require a health care provider, health system, health care service plan, or health insurer that engages in health information exchange to comply with specified federal standards. This bill would create the position of Deputy Secretary for Health Information Technology within CHHSA to serve as a single point of contact for health information technology programs that interact with the state government and to coordinate with specified federal agencies. The bill would require the deputy secretary to establish and appoint specified members to the California Health Information Technology Advisory Committee, which would provide information and advice to CHHSA on health information technology issues. On or before July 1, 2022, the bill would require the deputy secretary, in consultation with the advisory committee, to develop a plan to use federal funding to promote data exchange. The bill would also require the deputy secretary, in consultation with the advisory committee, to annually submit a report to the Legislature and the Secretary of California Health and Human Services. 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 make incentive payments to Medi-Cal providers for the implementation an... (click bill link to see more).

Primary Sponsors
Anna Caballero

Organizational Notes
Last edited by Cherie Compartore at Mar 31, 2021, 4:06 PM
Support: California Medical Association (Sponsor), California Hospital Association, California Dental Association, Kaiser Permanente, Sutter Health
**Title**
California Health Benefit Exchange.

**Description**
Existing federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. Existing state law creates the California Health Benefit Exchange, also known as Covered California, governed by an executive board, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Existing law specifies the powers of the board. Existing law authorizes the board to adopt necessary rules and regulations by emergency regulations until January 1, 2022, with the exception of regulations implementing prescribed provisions relating to criminal background history checks for persons with access to confidential, personal, or financial information. Existing law authorizes the Office of Administrative Law to approve more than 2 readoptions of emergency regulations until January 1, 2027. Existing law provides that these extensions apply to any regulation adopted before January 1, 2019. This bill would instead extend the authority of the board to adopt those necessary rules and regulations by emergency regulations to January 1, 2027, and would extend the authority of the Office of Administrative Law to approve more than 2 readoptions of emergency regulations until January 1, 2032. The bill would provide that these prescribed time extensions apply to any regulation adopted before January 1, 2022, as specified.

**Primary Sponsors**
Connie Leyva

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<td>SB 455</td>
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<td>Monitor</td>
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Title
Health care coverage: insulin cost sharing.

Description
SB 473, as amended, Bates. Health care coverage: insulin 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'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 health insurance policy issued, amended, delivered, or renewed on or after January 1, 2000, to include coverage for equipment, supplies, and, if the contract or policy covers prescription benefits, prescriptive medications for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes, as medically necessary. This bill would prohibit a health care service plan contract or a health insurance policy that is issued, amended, delivered, or renewed on or after January 1, 2023, from imposing cost sharing on a covered insulin prescription, except for a copayment not to exceed $35 per month per each dosage form of insulin products. The bill would also prohibit a health care service plan contract that is issued, amended, delivered, or renewed on or after January 1, 2023, from imposing a deductible requirement on benefits related to managing and treating diabetes, as specified. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Pat Bates

Organizational Notes
Last edited by Cherie Compartore at Apr 26, 2021, 3:13 PM
Oppose: CAHP
Title
Drug manufacturers: value-based arrangement.

Description
SB 521, as amended, Bradford. Drug manufacturers: value-based arrangement. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services, including prescription drugs that are subject to the Medi-Cal List of Contract Drugs, pursuant to a schedule of benefits. The Medi-Cal program is, in part, governed by, and funded pursuant to, federal Medicaid program provisions. Existing law provides that the department is the purchaser of prescribed drugs under the Medi-Cal program for the purpose of enabling the department to obtain from manufacturers of prescribed drugs the most favorable price for those drugs furnished by those manufacturers, based upon the large quantity of the drugs purchased under the Medi-Cal program, and to enable the department to obtain from the manufacturers discounts, rebates, or refunds based on the quantities purchased under the Medi-Cal program. Existing law requires the department to contract with manufacturers of single-source drugs on a negotiated basis, and with manufacturers of multisource drugs on a bid or negotiated basis. This bill would authorize the department to enter into a value-based arrangement, including a rebate, discount, or price reduction, with drug manufacturers based on outcome data or other metrics, as determined by the department and the drug manufacturers, pursuant to those contracts. The bill would require the department to report to the Legislature, on or before July 1, 2022, on how value-based arrangements may be implemented in the Medi-Cal program.

Primary Sponsors
Steve Bradford
Title
Health care coverage: contraceptives.

Description
SB 523, as amended, Leyva. Health care coverage: contraceptives.
(1) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law establishes health care coverage requirements for contraceptives, including, but not limited to, requiring a health care service plan, including a Medi-Cal managed care plan, or a health insurance policy issued, amended, renewed, or delivered on or after January 1, 2017, to cover up to a 12-month supply of federal Food and Drug Administration approved, self-administered hormonal contraceptives when dispensed at one time for an enrollee or insured by a provider or pharmacist, or at a location licensed or authorized to dispense drugs or supplies. This bill, the Contraceptive Equity Act of 2021, would make various changes to expand coverage of contraceptives by a health care service plan contract or health insurance policy issued, amended, renewed, or delivered on and after January 1, 2022, including requiring a health care service plan or health insurer to provide point-of-sale coverage for over-the-counter FDA-approved contraceptive drugs, devices, and products at in-network pharmacies without cost sharing or medical management restrictions. The bill would require health care service plans and insurance policies offered by public or private institutions of higher learning that directly provide health care services only to its students, faculty, staff, administration, and their respective dependents, approved on or after January 1, 2023, to comply with these contraceptive coverage requirements. The bill would also require coverage for clinical services related to the provision or use of contraception, as specified. The bill would revise provisions applicable when a covered, therapeutic equivalent of a drug, device, or product is deemed medically inadvisable by deferring to the attending provider, as specified. This bill would also prohibit a health care service plan contract or disability insurance policy issued, amended, renewed, or delivered on or after January 1, 2022, with certain exceptions, from imposing a deductible, coinsurance, copayment, or any other cost-sharing requirement on vasectomy services and procedures, as specified, under conditions similar to those applicable to other contraceptive coverage. This bill would require a health benefit plan or contract with the Board of Public Relations of the Public Employees’ Retirement System to provide coverage for contraceptives and vasectomies consistent with th... (click bill link to see more).

Primary Sponsors
Connie Leyva

Organizational Notes
Last edited by Cherie Compartore at Apr 26, 2021, 3:14 PM
Oppose: CAHP
Title
Health care coverage: pervasive developmental disorders or autism.

Description
SB 562, as amended, Portantino. Health care coverage: pervasive developmental disorders or autism. Existing law, the Lanterman Developmental Disabilities Services Act, requires the State Department of Developmental Services to contract with regional centers to provide services and supports to individuals with developmental disabilities and their families. Existing law defines developmental disability for these purposes to include, among other things, autism. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or a health insurance policy to provide coverage for behavioral health treatment for pervasive developmental disorder or autism, and defines “behavioral health treatment” to mean specified services and treatment programs, including treatment provided pursuant to a treatment plan that is prescribed by a qualified autism service provider and administered either by a qualified autism service provider or by a qualified autism service professional or qualified autism service paraprofessional who is supervised as specified. Existing law defines a “qualified autism service provider” to refer to a person who is certified or licensed and a “qualified autism service professional” to refer to a person who meets specified educational, training, and other requirements and is supervised and employed by a qualified autism service provider. Existing law defines a “qualified autism service paraprofessional” to mean an unlicensed and uncertified individual who meets specified educational, training, and other criteria, is supervised by a qualified autism service provider or a qualified autism service professional, and is employed by the qualified autism service provider. Existing law also requires a qualified autism service provider to design, in connection with the treatment plan, an intervention plan that describes, among other information, the parent participation needed to achieve the plan’s goals and objectives, as specified. This bill would revise the definition of behavioral health treatment to require the services and treatment programs provided to be based on behavioral, developmental, relationship-based, or other evidence-based models. The bill also would expand the definition of a “qualified autism service professional” to include behavioral service providers who meet specified educational and professional or work experience qualifications, and to expressly include licensed occupational therapy a... (click bill link to see more).

Primary Sponsors
Anthony Portantino

Organizational Notes
Last edited by Joanne Campbell at Sep 1, 2021, 5:31 PM
Oppose: CAHP, DMHC
Title
Deductibles: chronic disease management.

Description
SB 568, as amended, Pan. Deductibles: chronic disease management. 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, in accordance with the federal Patient Protection and Affordable Care Act, requires a health care service plan or health insurance issuer offering coverage in the individual or small group market to ensure that the coverage includes the essential health benefits package and defines this package to mean coverage that, among other requirements, includes preventive and wellness services and chronic disease management. Existing law, with respect to those individual or group health care service plan contracts and health insurance policies, prohibits the copayment, coinsurance, or any other form of cost sharing for a covered outpatient prescription drug for an individual prescription from exceeding $250, as specified. Existing law requires a health care service plan contract that covers hospital, medical, or surgical expenses to include coverage for certain equipment and supplies for the management and treatment of various types of diabetes as medically necessary, even if those items are available without a prescription. This bill would prohibit a health care service plan contract or health insurance policy that is issued, amended, or renewed on or after January 1, 2023, from imposing a deductible requirement for a covered prescription drug or the above equipment and supplies used to treat a chronic disease, as defined. The bill would limit the amount paid for the benefit by an enrollee, subscriber, policyholder, or insured to no more than the amount of copayment or coinsurance specified in the health care service plan contract or disability insurance policy for a covered prescription drug or similar benefit that is not used to treat a chronic disease, as specified. This bill would prohibit a health care service plan contract or disability insurance policy that meets the definition of a “high deductible health plan” under specified federal law from imposing a deductible requirement with respect to any covered benefit for preventive care, in accordance with that law, and is not subject to the other deductible restrictions imposed by the bill. The bill would authorize the Insurance Commissioner to implement, interpret, or make specific its provisions by issuing guidance, without taking regulatory action, until regulations are adopted. Because a violation of the requirements of the bill by a health care service plan would be...

Primary Sponsors
Richard Pan

Organizational Notes
Last edited by Cherie Compartore at Apr 26, 2021, 3:13 PM
Oppose: CAHP
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### SB 773

**Title**
Medi-Cal managed care: behavioral health services.

**Description**
SB 773, as amended, Roth. Medi-Cal managed care: behavioral health services. Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which health care services, such as behavioral health treatment services, are provided to qualified, low-income persons by various health care delivery systems, including managed care. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law imposes requirements on Medi-Cal managed care plans, including standards on network adequacy, alternative access, and minimum loss ratios. This bill would, commencing with the January 1, 2022, rating period, and through December 31, 2024, require the department to make incentive payments to qualifying Medi-Cal managed care plans that meet predefined goals and metrics associated with targeted interventions, rendered by school-affiliated behavioral health providers, that increase access to preventive, early intervention, and behavioral health services for children enrolled in kindergarten and grades 1 to 12, inclusive, at those schools. The bill would require the department to consult with certain stakeholders on the development of interventions, goals, and metrics, to determine the amount of incentive payments, and to seek any necessary federal approvals. The bill would condition the issuance of incentive payments on compliance with specified federal requirements and the availability of federal financial participation. Alternatively, if federal approval is not obtained, the bill would authorize the department to make incentive payments on a state-only funding basis, but only to the extent the department determines that federal financial participation for the Medi-Cal program is not otherwise jeopardized.

**Primary Sponsors**
Richard Roth

### SB 838

**Title**
Health care: insulin manufacturing.

**Description**
SB 838, as introduced, Pan. Health care: insulin manufacturing. Existing law requires the California Health and Human Services Agency to enter into partnerships to increase patient access to affordable drugs, including partnerships to produce or distribute generic prescription drugs and at least one form of insulin, if a viable pathway for manufacturing a more affordable form of insulin exists at a price that results in savings. This bill would eliminate that viability requirement.

**Primary Sponsors**
Richard Pan
Title
Prescription drug coverage.

Description
SB 853, as amended, Wiener. Prescription drug coverage. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or health insurer to use utilization review, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Existing law prohibits a health care service plan contract that covers prescription drug benefits or a specified health insurance policy from limiting or excluding coverage for a drug on the basis that the drug is prescribed for a use that is different from the use for which it was approved by the federal Food and Drug Administration if specified conditions are met. This bill would expand the above-described prohibitions to prohibit limiting or excluding coverage of a drug prescribed for a medical condition if that drug has been previously approved for coverage if an enrollee continues to be prescribed that drug, as specified. This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2023, that covers prescription drug benefits to provide coverage for a drug, dose of a drug, or dosage form during utilization review and any appeals if that drug has been previously approved for a medical condition of the enrollee or insured and has been prescribed by a health care provider. The bill would prohibit a plan or insurer from seeking reimbursement for that coverage if the final utilization review decision is to deny coverage for the prescription drug, dose, or dosage form. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Scott Wiener

Organizational Notes
Last edited by Joanne Campbell at Jan 20, 2022, 3:03 PM
Sponsored by Crohn's & Colitis Foundation
Title
Health care service plans: discipline: civil penalties.

Description
SB 858, as introduced, Wiener. Health care service plans: discipline: civil penalties. 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 authorizes the Director of the Department of Managed Health Care to take disciplinary measures, including the imposition of civil penalties, against a licensee when the director determines that the licensee has committed an act or omission constituting grounds for disciplinary action, as specified. Under existing law, a person who violates the act, or a rule or order adopted or issued under the act, is generally liable for a civil penalty not to exceed $2,500 per violation. Existing law also includes various provisions that assess specific civil and administrative penalties for certain violations. Fines and penalties under the act are deposited into the Managed Care Administrative Fines and Penalties Fund, and used, upon appropriation by the Legislature, for designated purposes. This bill would increase the maximum base amount of the civil penalty from $2,500 per violation to $25,000 per violation, which would be adjusted annually commencing January 1, 2024, as specified. The bill would multiply the amounts of other specified civil and administrative penalties by 4, commencing January 1, 2023, and would also annually adjust those penalties, commencing January 1, 2024. The bill would authorize the director to impose a corrective action plan to require future compliance with the act, under certain circumstances. If a health care service plan fails to comply with the corrective action plan in a timely manner, the bill would require the department to monitor the health care service plan through medical surveys, financial examinations, or other means necessary to ensure timely compliance. The bill would require the director, when assessing administrative penalties against a health care service plan, to determine the appropriate amount of the penalty for each violation, based upon consideration of specified factors, such as the nature, scope, and gravity of the violation, whether the violation is an isolated incident, and the amount of the penalty necessary to deter similar violations in the future. The bill would require the director to provide a written explanation of the amount of the penalty, including the factors the director relied upon in assessing that amount.

Primary Sponsors
Scott Wiener
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<td>SB 866</td>
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**Title**  
Minors: vaccine consent.

**Description**  
SB 866, as amended, Wiener. Minors: vaccine consent. Existing law prescribes various circumstances under which a minor may consent to their medical care and treatment without the consent of a parent or guardian. These circumstances include, among others, authorizing a minor 12 years of age or older who may have come into contact with an infectious, contagious, or communicable disease to consent to medical care related to the diagnosis or treatment of the disease, if the disease or condition is one that is required by law or regulation to be reported to the local health officer, or is a related sexually transmitted disease, as may be determined by the State Public Health Officer. This bill would additionally authorize a minor 12 years of age or older to consent to vaccines that meet specified federal agency criteria. The bill would authorize a vaccine provider, as defined, to administer a vaccine pursuant to the bill, but would not authorize the vaccine provider to provide any service that is otherwise outside the vaccine provider’s scope of practice.

**Primary Sponsors**  
Scott Wiener, Richard Pan, Buffy Wicks
Title
Public health: immunizations.

Description
SB 871, as introduced, Pan. Public health: immunizations. Existing law prohibits the governing authority of a school or other institution from unconditionally admitting any person as a pupil of any public or private elementary or secondary school, childcare center, day nursery, nursery school, family day care home, or development center, unless prior to their admission to that institution they have been fully immunized against various diseases, including measles, mumps, pertussis, hepatitis B, and any other disease deemed appropriate by the State Department of Public Health, as specified. Existing law authorizes an exemption from those provisions for medical reasons. Under existing law, notwithstanding the above-described prohibition, full immunization against hepatitis B is not a condition by which the governing authority admits or advances a pupil to the 7th grade level of a public or private elementary or secondary school. This bill would remove the above-described exception relating to hepatitis B. The bill would additionally prohibit the governing authority of a school or other institution from unconditionally admitting any person as a pupil of any public or private elementary or secondary school, childcare center, day nursery, nursery school, family day care home, or development center, unless prior to their admission to that institution they have been fully immunized against COVID-19. To the extent that the bill would create new duties for school districts, the bill would impose a state-mandated local program. For purposes of the additional immunizations deemed appropriate by the department, that would be mandated before a pupil's first admission to the institution, existing law requires that exemptions be allowed for both medical reasons and personal beliefs. This bill would repeal that provision, thereby removing the personal belief exemption from any additional immunization requirements deemed appropriate by the department. 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
Richard Pan, Cecilia Aguiar-Curry, Josh Newman, Akilah Weber, Buffy Wicks, Scott Wiener
Biomarker testing.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plan contract or health insurance policy issued, amended, delivered, or renewed on or after July 1, 2000, to provide coverage for all generally medically accepted cancer screening tests, and prohibits that contract or policy issued, amended, delivered, or renewed on or after July 1, 2022, from requiring prior authorization for biomarker testing for certain enrollees or insureds. Existing law applies the provisions relating to biomarker testing to Medi-Cal managed care plans, as prescribed. This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after July 1, 2023, to provide coverage for biomarker testing, including whole genome sequencing, for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee’s or insured’s disease or condition if the test is supported by medical and scientific evidence, as prescribed. This bill would apply these provisions relating to biomarker testing to the Medi-Cal program, including Medi-Cal managed care plans, as specified. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services pursuant to a schedule of benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law includes Rapid Whole Genome Sequencing as a covered benefit for any Medi-Cal beneficiary who is one year of age or younger and is receiving inpatient hospital services in an intensive care unit. Subject to the extent that federal financial participation is available and not otherwise jeopardized, and any necessary federal approvals have been obtained, this bill would expand the Medi-Cal schedule of benefits to include biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a Medi-Cal beneficiary’s disease or condition if the test is supported by medical and scientific evidence, as prescribed. The bill would authorize the department to implement this provision by various means without taking regulatory action. 

Primary Sponsors
Monique Limon
Gender-affirming care.

Description
SB 923, as amended, Wiener. Gender-affirming care. (1) Existing law establishes the Transgender Wellness and Equity Fund, administered by the Office of Health Equity within the State Department of Public Health, for the purpose of grant funding focused on coordinating trans-inclusive health care for individuals who identify as transgender, gender nonconforming, or intersex (TGI). Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services through various health care delivery systems, including managed care. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes the California Program of All-Inclusive Care for the Elderly (PACE program) to provide community-based, long-term care services for older individuals under the Medi-Cal State Plan. Under existing law, certain entities that exclusively serve PACE participants are exempt from licensure by the State Department of Public Health and are subject to oversight and regulation as PACE organizations by the State Department of Health Care Services. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. This bill would require a Medi-Cal managed care plan, a PACE organization, a health care service plan, or a health insurer, as specified, to require its staff and contracted providers to complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care, as defined, for individuals who identify as TGI. The bill would specify the required components of the training and would make use of any training curricula subject to approval by the respective departments. The bill would require an individual to complete a refresher course if a complaint has been filed, and a decision has been made in favor of the complainant, against that individual for not providing trans-inclusive health care, or on a more frequent basis if deemed necessary. The bill would require the respective departments to develop and implement procedures, and would authorize them to impose sanctions, to ensure compliance with the above-described provisions. The bill would also require the plan, organization, or insurer to annually and publicly report certain information relating to compliance, monitoring, and any related complaints or grievances. Because a violation of these new requirements by a health care service p... (click bill link to see more).

Primary Sponsors
Scott Wiener, Cristina Garcia

Organizational Notes
Last edited by Joanne Campbell at Feb 4, 2022, 8:06 PM
Sponsor: California LGTBQ Health and Human Services Network, Equality California, National Health Law Program, and Western Center on Law & Poverty
Title
Prescription drug pricing.

Description
SB 939, as introduced, Pan. Prescription drug pricing. Existing federal law requires the United States Secretary of Health and Human Services to enter into an agreement with each manufacturer of covered outpatient drugs to ensure the amount a covered entity is required to pay for those drugs does not exceed the average manufacturer price of the drug under the federal Medicaid program. Existing state law requires a covered entity to dispense only drugs subject to these federal pricing requirements to Medi-Cal beneficiaries. Existing law defines a "covered entity" to include a federally qualified health center and entities receiving specified grants and federal funding. This bill would prohibit a pharmacy benefit manager from discriminating against a covered entity or its pharmacy in connection with dispensing a drug subject to federal pricing requirements or preventing a covered entity from retaining the benefit of discounted pricing for those drugs. The bill would prohibit a drug manufacturer that is subject to federal pricing requirements from imposing preconditions, limitations, delays, or other barriers to the purchase of covered drugs.

Primary Sponsors
Richard Pan

Organizational Notes
Last edited by Joanne Campbell at Mar 11, 2022, 7:01 PM
Sponsor: APLA Health, CA Health+ Advocates
Title
California Health Benefit Exchange: affordability assistance.

Description
SB 944, as introduced, Pan. California Health Benefit Exchange: affordability assistance. Existing federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. Existing state law creates the California Health Benefit Exchange (Exchange), also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA.

Existing law requires the Exchange, in consultation with stakeholders and the Legislature, to develop options for providing cost-sharing reduction subsidies to reduce cost sharing for low- and middle-income Californians, and requires the Exchange to report the developed options on or before January 1, 2022. Existing law requires the options to include, among other things, options for all Covered California enrollees with income up to 400 percent of the federal poverty level to reduce cost sharing, including copays, deductibles, coinsurance, and maximum out-of-pocket costs. This bill would require the Exchange to implement those options for providing health care affordability assistance. The bill would require the affordability assistance to reduce cost-sharing, including copays, coinsurance, and maximum out-of-pocket costs, and to eliminate deductibles for all benefits. The bill would specify the actuarial value of cost sharing assistance based on the income level of an enrollee, and would require the Exchange to adopt standard benefit designs consistent with these specifications.

Primary Sponsors
Richard Pan
Title

Description
SB 958, as introduced, Limón. Medication and Patient Safety Act of 2022. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or health insurance policy that provides coverage for outpatient prescription drugs to cover medically necessary prescription drugs. This bill would prohibit a health care service plan or health insurer, or its designee, from arranging for or requiring a vendor to dispense an infused or injected medication directly to a patient with the intent that the patient will transport the medication to a health care provider for administration. The bill would authorize a plan or insurer, or its designee, to cover an infused or injected medication to be administered in an enrollee's or insured's home if the treating health care provider determines it is safe and appropriate, and to cover an infused or injected medication supplied by a vendor specified by the plan or insurer, or its designee, if specified criteria are met. 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
Monique Limon, Anthony Portantino
Behavioral health.

Description
SB 964, as introduced, Wiener. Behavioral health. (1) Existing law establishes the Board of Behavioral Sciences in the Department of Consumer Affairs for the purpose of licensing and regulating marriage and family therapists, licensed educational psychologists, clinical social workers, and licensed professional clinical counselors. This bill would require the board, on or before January 1, 2024, to conduct an analysis and provide recommendations to the Legislature regarding specified topics relating to behavioral health professionals, including the scope of practice laws for behavioral health workers, license requirements and clinical training requirements for behavioral health professionals, and requirements for renewing the license of a behavioral health professional who has an expired license. (2) Existing law, the Donahoe Higher Education Act, sets forth the missions and functions of the 3 segments comprising the state's public postsecondary education system. These segments are the University of California, administered by the Regents of the University of California, the California State University, administered by the Trustees of the California State University, and the California Community Colleges, administered by the Board of Governors of the California Community Colleges. Provisions of the act apply to the University of California only to the extent that the regents act, by resolution, to make the provisions applicable. This bill would amend the act to require the California Community Colleges, the California State University, and, if made applicable by the regents by appropriate resolution, the University of California, to develop 2 accelerated programs of study related to degrees in social work. The bill would require one program to offer a concurrent bachelor's and master's of social work program that will allow students to combine their last one or 2 years of undergraduate study in social work with their graduate study in social work in order to complete both programs at an accelerated rate. The bill would require the second program to offer an accelerated academic program in which students with experience as peer support specialists, community health workers, or psychiatric technicians could receive their associate's degree, as well as a bachelor's and master's degree in social work. The bill would require both programs to require a student to take a course on working with the severely mentally ill, with a focus on working in the public behavioral health system. (3) Existing law establishes the Department of Health Care Access and Information and authorizes the department, among other things, to award competitive grants to entities and individuals it deems qualified to expand the supply of behavioral health ... (click bill link to see more).

Primary Sponsors
Scott Wiener, Anna Caballero, Henry Stern
Title
Federally qualified health centers and rural health clinics: visits.

Description
SB 966, as introduced, Limón. Federally qualified health centers and rural health clinics: visits. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including federally qualified health center (FQHC) services and rural health clinic (RHC) services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, to the extent that federal financial participation is available, FQHC and RHC services are reimbursed on a per-visit basis, as specified. “Visit” is defined as a face-to-face encounter between an FQHC or RHC patient and any of specified health care professionals, including a physician, a licensed clinical social worker, or a marriage and family therapist. This bill would also include, within the definition of a visit, a face-to-face encounter between an FQHC or RHC patient and an associate clinical social worker or associate marriage and family therapist when supervised by a licensed behavioral health practitioner as required by the Board of Behavioral Sciences, as specified. The bill would make this provision operative 60 days after the termination of the national emergency declared on March 13, 2020. If an FQHC or RHC that currently includes the cost of the services of a dental hygienist in alternative practice, or a marriage and family therapist for the purposes of establishing its FQHC or RHC rate chooses to bill these services as a separate visit, existing law requires the FQHC or RHC to apply for an adjustment to its per-visit rate, and, after the rate adjustment has been approved by the department, to bill these services as a separate visit. Under existing law, multiple encounters with dental professionals or marriage and family therapists that take place on the same day constitute a single visit. Existing law requires the department to develop the appropriate forms to determine which FQHC’s or RHC’s rates are to be adjusted and to facilitate the calculation of the adjusted rates. This bill would require that the forms for calculation of the adjusted rates be the same or substantially similar for each provider described above. Existing law requires an FQHC or RHC that does not provide dental hygienist, dental hygienist in alternative practice, or marriage and family therapist services, and later elects to add these services and bill these services as a separate visit, to process the addition of these services as a change in scope of service, as specified. This bill would remove marriage and family therapist services from that requirement.

Primary Sponsors
Monique Limon, Rudy Salas
Title
Health care coverage: tax returns: information sharing authorization and outreach.

Description
SB 967, as introduced, Hertzberg. Health care coverage: tax returns: information sharing authorization and outreach. Existing federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans. Existing state law creates the California Health Benefit Exchange (Exchange), also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Existing law requires every California resident, their spouse, and their dependents to be enrolled in and maintain minimum essential coverage for each month, except as specified, and requires the Exchange to administer a financial assistance program to help low-income and middle-income Californians access affordable health care coverage through the Exchange until January 1, 2023. Existing law requires the Franchise Tax Board to provide specified information to the Exchange regarding individuals who do not maintain minimum essential coverage, and requires the Exchange to annually conduct outreach and enrollment efforts with those individuals. Existing law requires the Franchise Tax Board (board) to disclose to the Exchange individual income tax return information, as described, for purposes of conducting this outreach and enrollment effort to those individuals. This bill would require the Exchange to annually conduct outreach and enrollment efforts to individuals who indicate on their individual income tax returns that they are interested in no-cost or low-cost health care coverage. The bill would require the board to include, on and after January 1, 2023, a checkbox for a taxpayer to indicate on their individual income tax return that they are interested in no-cost or low-cost health care coverage and authorize the board to share information from their tax return with the Exchange for purposes of conducting outreach and enrollment efforts to these taxpayers.

Primary Sponsors
Bob Hertzberg, Joaquin Arambula
Title
Health care coverage: diagnostic imaging.

Description
SB 974, as introduced, Portantino. Health care coverage: diagnostic imaging. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract issued, amended, delivered, or renewed on or after January 1, 2000, or an individual or group policy of disability insurance or self-insured employee welfare benefit plan to provide coverage for mammography for screening or diagnostic purposes upon referral by specified professionals. Under existing law, mammography performed pursuant to those requirements or that meets the current recommendations of the United States Preventive Services Task Force is provided to an enrollee or an insured without cost sharing. This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2023, to provide coverage without imposing cost sharing for medically necessary diagnostic breast imaging, including diagnostic breast imaging following an abnormal mammography result. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Anthony Portantino
Medi-Cal: time and distance standards.

Description
SB 987, as introduced, Portantino. Medi-Cal: time and distance standards. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services through various health care delivery systems, including managed care pursuant to Medi-Cal managed care plan contracts. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes certain time and distance and appointment time standards for specified Medi-Cal managed care covered services, consistent with federal regulations relating to network adequacy standards, to ensure that those services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner, as specified. Existing law repeals these provisions on January 1, 2023. This bill would extend the repeal date for those provisions until January 1, 2028.

Primary Sponsors
Anthony Portantino
Title
Health coverage: substance use disorders.

Description
SB 999, as introduced, Cortese. Health coverage: substance use disorders. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service plans and makes a willful violation of the act a crime. Existing law also requires the Department of Insurance to regulate health insurers. Existing law requires a health care service plan or disability insurer, as specified, to base medical necessity determinations and the utilization review criteria the plan or insurer, and any entity acting on the plan's or insurer's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders, on current generally accepted standards of mental health and substance use disorder care. Existing law defines “generally accepted standards of mental health and substance use disorder care” for these purposes to mean standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties, including as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment, as specified. This bill would make that definition apply only to “generally accepted standards of mental health care” and would remove the reference to addiction medicine and counseling. The bill would define “generally accepted standards of substance use disorder care” to mean the patient placement criteria established by the American Society of Addiction Medicine. The bill would prohibit a health care service plan or disability insurer, or any entity acting on the plan's or insurer's behalf, from using any criteria in addition to the generally accepted standards of substance use disorder care to make a medical necessity determination, or for the utilization review criteria, for health care services and benefits for the diagnosis, prevention, and treatment of substance use disorders. This bill would require the utilization review process and utilization review criteria for mental health and substance use disorder care used by a health care service plan or a disability insurer, or an entity acting on the plan's or insurer's behalf, to be accredited by an independent, nonprofit organization on or before July 1, 2023, and would require the health care service plan or the insurer, or the entity acting on its behalf, to maintain an active accreditation while providing utilization review services. The bill would require the Director of the Department of Managed Health Care and the Insurance Commissioner, as applicable, to adopt rules to govern the selection of an independent, nonprofit... (click bill link to see more).

Primary Sponsors
Dave Cortese
Title
Medi-Cal managed care plans: mental health benefits.

Description
SB 1019, as introduced, Gonzalez. Medi-Cal managed care plans: mental health benefits. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services through various 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 requires a Medi-Cal managed care plan to provide mental health benefits covered in the state plan, excluding those benefits provided by county mental health plans under the Specialty Mental Health Services Waiver. This bill would require a Medi-Cal managed care plan to conduct annual outreach and education to its enrollees regarding the mental health benefits that are covered by the plan, and to also develop annual outreach and education to inform primary care physicians regarding those mental health benefits. The bill would require that the outreach and education efforts be informed by stakeholder engagement and the plan’s Population Needs Assessment, as specified, and that the efforts meet cultural and linguistic appropriateness standards and incorporate best practices in stigma reduction. The bill would require the department to review and approve annual outreach and education efforts, and to consult with stakeholders to develop the standards for the review and approval. The bill would require the department to annually assess enrollee experience with mental health benefits covered by Medi-Cal managed care plans. The bill would require the department, by January 1, 2024, to develop survey tools and methodologies relating to the assessment of consumer experience, including best practice methods for data collection and reporting, as specified. The bill would require the department to publish annual reports on its internet website on consumer experience with mental health benefits covered by Medi-Cal managed care plans. The bill would require the reports to include plan-by-plan data, provide granularity for subpopulations, address inequities based on key demographic factors, and provide recommendations.

Primary Sponsors
Lena Gonzalez
Title
Health care coverage.

Description
SB 1033, as introduced, Pan. Health care coverage. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance, which is under the control of the Insurance Commissioner. Existing law requires the Department of Managed Health Care and the commissioner to develop and adopt regulations establishing standards and requirements to provide enrollees and insureds with appropriate access to language assistance in obtaining health care services and covered benefits. Existing law requires the Department of Managed Health Care and commissioner, in developing the regulations, to require health care service plans and health insurers to assess the linguistic needs of the enrollee and insured population, and to provide for translation and interpretation for medical services, as indicated. Existing law requires the regulations to include, among other things, requirements for conducting assessments of the enrollees and insured groups, and requires health care service plans and health insurers to update the needs assessment, demographic profile, and language translation requirements every 3 years. This bill would require the Department of Managed Health Care and the commissioner to revise these regulations, no later than July 1, 2023, and to require health care service plans and health insurers to assess the cultural, linguistic, and health-related social needs of the enrollees and insured groups for the purpose of identifying and addressing health disparities, improving health care quality and outcomes, and addressing population health. The bill would also require the department and commissioner to require plans and insurers to obtain accreditation, as described, establish standardized categories for the collection and reporting of self-reported demographic and health-related social needs, as outlined, and establish a program to provide technical assistance and other support to plans and providers. The bill would require plans and insurers to update the assessments every year. 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
Richard Pan
Title

Description
SB 1089, as introduced, Wilk. Medi-Cal: eyeglasses: Prison Industry Authority within the Department of Corrections and Rehabilitation and authorizes it to operate industrial, agricultural, and service enterprises that will provide products and services needed by the state, or any political subdivision of the state, or by the federal government, or any department, agency, or corporation of the federal government, or for any other public use. Existing law requires state agencies to purchase these products and services at the prices fixed by the authority. Existing law also requires state agencies to make maximum utilization of these products and consult with the staff of the authority to develop new products and adapt existing products to meet their needs. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including certain optometric services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. This bill, for purposes of Medi-Cal reimbursement for covered optometric services, would authorize an optometrist to purchase eyeglasses from a private entity, as an alternative to a purchase of eyeglasses from the Prison Industry Authority. The bill would condition implementation of this provision on receipt of any necessary federal approvals and the availability of federal financial participation. The bill, notwithstanding the above-described requirements, would authorize an optometrist participating in the Medi-Cal program to purchase eyeglasses from the authority or private entities, based on the optometrist’s needs and assessment of quality and value.

Primary Sponsors
Scott Wilk
Title
Medi-Cal: CalAIM Access Report for Multiple Lines of Business.

Description
SB 1180, as introduced, Pan. Medi-Cal: CalAIM Access Report for Multiple Lines of Business. 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 requires the department to seek federal approval for and create a multiyear initiative, the California Advancing and Innovating Medi-Cal (CalAIM) initiative, to build upon the outcomes of various Medi-Cal pilots and demonstration projects, including the Medi-Cal 2020 Demonstration Project Act. Existing law requires that the CalAIM initiative be implemented only to the extent that federal approvals are obtained and federal financial participation is not jeopardized. Federal approval of CalAIM is subject to Special Terms and Conditions that require a Medi-Cal Managed Care Plan Access Report for Multiple Lines of Business to be sent to the Centers for Medicare and Medicaid Services. This bill would require that report also be sent to specified committees in the Senate and Assembly.

Primary Sponsors
Richard Pan
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<td>SB 1191</td>
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**Title**
Confidentiality of Medical Information Act: school-linked services coordinators.

**Description**
SB 1184, as amended, Cortese. Confidentiality of Medical Information Act: school-linked services coordinators. Existing law, the Confidentiality of Medical Information Act, prohibits a provider of health care, a health care service plan, or contractor from disclosing medical information, as defined, regarding a patient of the provider of health care or an enrollee or subscriber of the health care service plan without first obtaining an authorization, except as prescribed. The act authorizes a provider of health care or a health care service plan to disclose medical information in certain circumstances, including by authorizing disclosure to providers of health care, health care service plans, contractors, or other health care professionals or facilities for purposes of diagnosis or treatment of the patient. This bill would additionally authorize a provider of health care or a health care service plan to disclose medical information to a school-linked services coordinator, as prescribed. The bill would define the term "school-linked services coordinator" as any of certain individuals or entities, including a licensed educational psychologist, located on a school campus or under contract by a county behavioral health provider agency for the treatment and health care operations and referrals of students and their families.

**Primary Sponsors**
Dave Cortese

**Title**
Drug Medi-Cal Treatment Program.

**Description**
SB 1191, as introduced, Bates. Drug Medi-Cal Treatment Program. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care benefits, including substance use disorder services. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions. Existing law also provides for the Drug Medi-Cal Treatment Program (Drug Medi-Cal). Existing law authorizes the department to enter into a Drug Medi-Cal contract with each county to provide alcohol and drug use services within the county service area. Existing law authorizes a county that has multiple contracts with the department for providing multiple alcohol and drug use services to enter into a single contract with the department. This bill would make technical, nonsubstantive changes to those provisions.

**Primary Sponsors**
Pat Bates
Title
Health care coverage: mental health services.

Description
SB 1207, as introduced, Portantino. Health care coverage: mental health services. 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 plans and health insurers to provide specified mental health and substance use disorder coverage and to develop, consistent with sound clinical principles and processes, a maternal mental health program, as specified. This bill would declare the intent of the Legislature to enact legislation to require health care service plans and health insurers to expand coverage for maternal mental health services and to provide coverage that includes targeted services for individuals with mental health conditions caused or exacerbated by the COVID-19 pandemic.

Primary Sponsors
Anthony Portantino

Title
Abortion care access pilot program.

Description
SB 1245, as introduced, Kamlager. Abortion care access pilot program. Existing law, the Reproductive Privacy Act, provides that every individual possesses a fundamental right of privacy with respect to their personal reproductive decisions, including the fundamental right to choose to bear a child or to choose and to obtain an abortion. This bill would express the intent of the Legislature to create and fund a pilot program in the County of Los Angeles to ensure equitable access to abortion care.

Primary Sponsors
Sydney Kamlager
Nursing: nurse practitioners.

(1) Existing law, the Nursing Practice Act, provides for the licensure and regulation of registered nurses, including nurse practitioners and certified nurse-midwives, by the Board of Registered Nursing. Existing law makes a violation of this act a crime. In order to perform an abortion by aspiration techniques under the act, a person with a license or certificate to practice as a nurse practitioner or a certified nurse-midwife is required to complete board-recognized training. This bill would revise that provision to specify that it applies to a person with a license or certificate to practice as a nurse practitioner practicing pursuant to a standardized procedure, and to a qualified nurse practitioner functioning pursuant to certain advanced practice provisions. By expanding the application of a crime, the bill would impose a state-mandated local program. Existing law requires a person with a license or certificate to practice as a nurse practitioner or a certified nurse midwife, in order to perform an abortion by aspiration techniques, to adhere to standardized procedures that specify, among other conditions, the extent of supervision by a physician and surgeon with relevant training and expertise. This bill would revise the above-described requirement, with respect to a nurse practitioner, to apply to practice as a nurse practitioner practicing pursuant to standardized procedures and would specify that it does not apply to a qualified nurse practitioner functioning pursuant to certain advanced practice registered nurse practitioner provisions. The bill would also delete a provision authorizing a nurse practitioner or certified nurse-midwife who has completed training and achieved clinical competency to perform abortions by aspiration techniques. Existing law defines specified terms for purposes of provisions governing advanced practice registered nurses. Existing law defines “transition to practice” under these provisions to mean additional clinical experience and mentorship provided to prepare a nurse practitioner to independently practice. Existing law requires the board, by regulation, to define minimum standards for transition to practice and further specifies that clinical experience may include experience obtained before January 1, 2021, if the experience meets the requirements established by the board. This bill would delete the above-described requirement for the board to define, by regulation, minimum standards for transition to practice. The bill would require a nurse practitioner who has been practicing a minimum of 3 full-time equivalent years or 4,600 hours as of January 1, 2023, to satisfy the transition to practice requirement. The bill would...

Primary Sponsors
Toni Atkins, Jim Wood
Title
Pharmacy: remote services.

Description
SB 1379, as introduced, Ochoa Bogh. Pharmacy: remote services. The Controlled Substances Act regulates, among other matters, the dispensing by prescription of controlled substances, which are classified into schedules, and the Pharmacy Law regulates, among other matters, the dispensing by prescription of dangerous drugs and dangerous devices, which also include controlled substances. Existing law authorizes a prescriber, a prescriber's authorized agent, or a pharmacist to electronically enter a prescription or order from outside of a pharmacy or hospital, as specified, except for prescriptions for controlled substances classified in Schedules II, III, IV, or V. Under existing law, a violation of these provisions is a crime. This bill would extend the authority to remotely enter a prescription or order to include prescriptions for controlled substances classified in Schedules II, III, IV, or V. The bill would also authorize a pharmacist to perform various services remotely, as specified, on behalf of a pharmacy located in California and under the written authorization of a pharmacist-in-charge. The bill would condition this authority on specified actions by the pharmacy for which the pharmacist performs those services, including obtaining the consent of the pharmacist, developing and training the pharmacist on policies and procedures for the performance of those services, and taking specified steps to ensure the security of the information processed and the integrity of the pharmacy's system. Because violation of these provisions would be a crime, this bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Rosilicie Ochoa Bogh
Title
Health care coverage: enrollment periods.

Description
SB 1473, as amended, Pan. Health care coverage: enrollment periods. Existing federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. Existing state law creates the California Health Benefit Exchange (Exchange), also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. 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 a special enrollment period for individual health benefit plans offered through the Exchange from December 16 of the preceding calendar year to January 31 of the benefit year, inclusive, for policy years beginning on or after January 1, 2020. Under existing law, February 1 of the benefit year is the effective coverage date for individual health benefit plans offered outside and through the Exchange that are selected from December 16 to January 31, inclusive. This bill would eliminate the above-described special enrollment period for individual health benefit plans offered through the Exchange for policy years on or after January 1, 2023, and would instead create an annual enrollment period from November 1 of the preceding calendar year to January 31 of the benefit year, inclusive. The bill would specify that the effective date of coverage for individual health benefit plans offered outside and through the Exchange would be no later than January 1 of the benefit year for plan selection made from November 1 to December 31 of the preceding calendar year, inclusive, and would be no later than February 1 of the benefit year for plan selection made from January 1 to January 31 of the benefit year, inclusive. 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
Richard Pan
COVID-19 testing in schools: COVID-19 testing plans.

SB 1479, as introduced, Pan. COVID-19 testing in schools: COVID-19 testing plans. Existing law appropriates funds to the State Department of Public Health for various programs related to the safe reopening of schools during the COVID-19 pandemic, including funds to support COVID-19 testing in schools allocated from the federal American Rescue Plan Act of 2021 and funds from the General Fund for the Safe Schools For All Team to coordinate technical assistance, community engagement, increased transparency, and enforcement by the appropriate entity for public school health and safety during the COVID-19 pandemic. Existing law authorizes certain school apportionments to be used for any purpose consistent with providing in-person instruction for any pupil participating in in-person instruction, including, but not limited to, COVID-19 testing, as provided. Existing law prescribes public health reporting requirements related to COVID-19 for local educational agencies, including the development of a COVID-19 safety plan, as provided. This bill would, contingent on an appropriation, require the department to continue administering specified school district, county office of education, and charter school COVID-19 testing programs that are currently federally funded, and would require appropriated funds to be used for testing programs for teachers, staff, and pupils to help schools reopen and keep schools operating safely for in-person learning. The bill would also require those funds to be used to expand the department's contagious, infectious, or communicable disease testing and other public health mitigation efforts to include prekindergarten, onsite after school programs, and childcare centers. This bill would require each school district, county office of education, and charter school to create a COVID-19 testing plan and designate one staff member to report information on its COVID-19 testing program to the department. The bill would require that all COVID-19 testing data be in a format that facilitates a simple process by which parents and local educational agencies may report data to the department. By imposing new obligations on local educational agencies, the bill would impose a state-mandated local program. The bill would also authorize each school within a school district to name a staff member to lead its COVID-19 testing program. The bill would require the department to determine which COVID-19 tests are appropriate for the testing program. The bill would make the implementation of all of its provisions contingent upon an appropriation by the Legislature. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish ... (click bill link to see more).

Primary Sponsors
Richard Pan
Elevating the Safety Net (ESN) initiative – www.lacare.org/elevateproviders

DATE: March 22, 2022

TO: L.A. Care Executive Committee and Board Members

FROM: ESN workgroup – Safety Net Initiatives, Strategic Planning and Communications

SUBJECT: ESN initiative – Impact Summary and Future Funding Recommendations

Since the launch of the ESN initiative in 2018, with a Board of Governors approved investment of up to $155 million to address various gaps in our local workforce, L.A. Care has invested nearly $93.6 million across ten programs. With over $61.4 million available for future investments, L.A. Care will prioritize funding for four of the ten current programs over the next five years - starting FY 2022-23 through FY 2026-27.

The four programs listed below have demonstrated an impact on member access to care and increase in the number of and diversity among program participants or beneficiaries. Through our data collection and analysis, we have also identified opportunities for improving the eligibility criteria and funding priorities for each of the four programs.

1. Provider Loan Repayment Program – $26 million invested through the end of FY 2021-22 and will commit up to $4 million annually starting FY 2022-23 through FY 2026-27.
2. Provider Recruitment Program – $22.5 million invested through the end of FY 2021-22 and will commit to $4 million annually starting FY 2022-23 through FY 2026-27.
3. Medical School Scholarship Program – $14.4 million invested through the end of FY 2021-22 and will commit up to $3.5 million annually starting FY 2022-23 through FY 2026-27.
4. In-Home Support Services Training Program – $5.8 million invested through the end of FY 2021-22 and will commit up to $1 million annually starting FY 2023-24 through FY 2026-27.

The remaining six programs listed below have also demonstrated a strong impact in addressing various gaps in the workforce pipeline. Grantees and contractors for the programs below will leverage alternative local, state and federal funding streams to sustain the programs beyond L.A. Care’s investments.

5. National Medical Fellowship – $600,000 invested through FY 2022-23.
6. Community Health Worker Training – $657,000 invested through FY 2021-22.
8. Keck Graduate Institute, Master of Science in Community Medicine – $5 million investment through FY 2023-24.

We highly encourage you to review the accompanying slides, which include more detail on the impact, demographic data collected and recommendations for continued funding. For any questions related to this memo or accompanying presentation, please contact Cynthia Carmona, Senior Director, Safety Net initiatives at ccarmona@lacare.org. We thank you for continuing to support of our ESN initiative and we look forward to offering more updates on the impact of each of the programs.

Sincerely,

Cynthia Carmona and ESN workgroup
Elevating the Safety Net (ESN) Initiative

Impact Summary and Funding Recommendations

Presented by: Safety Net Initiatives, Strategic Planning, Community Benefits, and Communications (ESN Workgroup)

Date: Tuesday, March 22, 2022
Executive Committee Meeting

Date: Thursday, April 7, 2022
Board of Governors Meeting
Summary of funding commitment

Opportunity to extend funding for an additional five years across four programs

$155 million
Board Designated Fund
Initial 3 programs

$93.6 million*
spent
Expanded to 10 programs

$61.4 million**
available
Prioritize 4 of the 10 programs

Initial 5 years

5-year extension

FY 2017-18
FY 2021-22
FY 2022-23
FY 2026-27

* $93,599,981.52 projected expenditures by end of FY 2021-22
**$61,400,018.48 projected available starting FY 2022-23 and recommending four of the ten programs for continuity funding
**Elevating the Safety Net (ESN) Investments**

Over $61.4 million available for future investments to address ongoing workforce needs

### Investments by Program

<table>
<thead>
<tr>
<th>Program</th>
<th>Total Investment During First 5 Years*</th>
<th>Projected Annual Investment for 5 Additional Years**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Loan Repayment Program</td>
<td>$26M</td>
<td>$4M</td>
</tr>
<tr>
<td>Provider Recruitment Program</td>
<td>$22.5M</td>
<td>$4M</td>
</tr>
<tr>
<td>Medical School Scholarship Program</td>
<td>$14.4M</td>
<td>$3.5M</td>
</tr>
<tr>
<td>Residency Support Program</td>
<td>$12.9M</td>
<td></td>
</tr>
<tr>
<td>In-Home Support Services Training Program</td>
<td>$5.8M</td>
<td>$1M</td>
</tr>
<tr>
<td>CDU - New Medical Education Program</td>
<td>$5M</td>
<td></td>
</tr>
<tr>
<td>KGI - Master of Science in Community Medicine</td>
<td>$5M</td>
<td></td>
</tr>
<tr>
<td>Health Career Connection Internship Program</td>
<td>$800K</td>
<td></td>
</tr>
<tr>
<td>CHW Training Program</td>
<td>$657K</td>
<td></td>
</tr>
<tr>
<td>National Medical Fellowship</td>
<td>$600K</td>
<td></td>
</tr>
</tbody>
</table>

*Includes investments from FY 2017-18 through closing of FY 2021-22 totaling approximately $93,599,981.52

**Provides estimated annual investments with flexibility to incorporate new programs based on future workforce needs

**Projected maximum annual investments starting in FY 2022-23**
## Elevating the Safety Net initiative (ESN)

### Programs Recommended for 5 years of Additional ESN Funding

<table>
<thead>
<tr>
<th>Program</th>
<th>Benefit to L.A. Care Members and Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provider Recruitment Program (PRP)</strong></td>
<td>• Physicians hired alleviate workloads and improve access to care*</td>
</tr>
<tr>
<td></td>
<td>• PRP funded grantees experienced a 44.6% increase in MCLA membership compared to 38.2% among non-PRP funded clinics/entities.</td>
</tr>
<tr>
<td></td>
<td>• 87% physician retention rate through Cycle 10 (134 of 154 physician slots are currently filled)</td>
</tr>
<tr>
<td><strong>Provider Loan Repayment Program</strong></td>
<td>• 89% (96 of 108) of physicians retained and on track to complete 3 years of service</td>
</tr>
<tr>
<td></td>
<td>• 73% (70 of 96) of physicians deliver at least 32 hours of direct patient care/week</td>
</tr>
<tr>
<td></td>
<td>• 73% (70 of 96) of physicians report at least $200k in education debt</td>
</tr>
<tr>
<td><strong>Medical School Scholarships</strong></td>
<td>• 87.4% of students identify as Hispanic/Latinx or Black/African American</td>
</tr>
<tr>
<td></td>
<td>•Eliminates between $337k and $390k in school debt per student</td>
</tr>
<tr>
<td><strong>In-Home Support Services Training Program</strong></td>
<td>• Efficient training and placement – 300 to 400 providers/quarter</td>
</tr>
<tr>
<td></td>
<td>• Reduces ER and inpatient visits among members receiving care from trained providers**</td>
</tr>
</tbody>
</table>

*Based on report summaries submitted by PRP funded grantees.

**Utilization data was reported by L.A. Care’s Population Health Management on February 5, 2020 summarizing the decrease of ER and inpatient visit rate.
## Elevating the Safety Net (ESN) initiative

<table>
<thead>
<tr>
<th>Programs with Funding Alternative to ESN</th>
<th>ESN Funding Commitment by Fiscal Year*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Program</strong></td>
<td><strong>2019-20</strong></td>
</tr>
<tr>
<td>Institutions and organizations are pursuing alternative local, state and federal funding.</td>
<td></td>
</tr>
<tr>
<td>Residency Support Program</td>
<td></td>
</tr>
<tr>
<td>CHW Training Program</td>
<td></td>
</tr>
</tbody>
</table>
  *Reviewing state funding and reimbursement*
| Health Career Connection Internship Program | | | | | | | | | |
| National Medical Fellowship             | | | | | | | | | |
  *L.A. Care’s Community Benefits may offer annual ad-hoc grants moving forward*
| Keck Graduate Institute – Master of Science in Community Medicine | | | | | | | | | |
| CDU – New Medical Education Program     | | | | | | | | | |

*Based on the grant or service contract terms agreed upon by both Parties (L.A. Care and funding recipient(s)). Orange cells represent the 5-year extension period to continue investing the remaining ~$61.4 million.**
Data Limitations

**Definition:** ESN program participants include physicians, students, in-home support service providers, fellows, residents, CHWs and interns.

- **Population Sizes:** Data sets for ESN program participants are significantly smaller (where \( n < 4,200 \)) when compared to MCLA members (where \( n > 1,200,000 \)) as of January 2022.

<table>
<thead>
<tr>
<th>Program or Group</th>
<th>n*</th>
</tr>
</thead>
<tbody>
<tr>
<td>L.A. Care Medi-Cal (MCLA) Members – reference population</td>
<td>1,278,571</td>
</tr>
<tr>
<td>Provider Recruitment Program (PRP)</td>
<td>134</td>
</tr>
<tr>
<td>Provider Loan Repayment Program (PLRP)</td>
<td>96</td>
</tr>
<tr>
<td>Medical School Scholarship Program (Scholars)</td>
<td>32</td>
</tr>
<tr>
<td>In-Home Support Services (IHSS) Training Program</td>
<td>4,182</td>
</tr>
</tbody>
</table>

*Data as of January 2022

- **Limited Representation:** Data for ESN program participants does not represent the entire workforce category (i.e. all physicians or CHWs in L.A. County or L.A. Care’s provider network).

- **Limited Data Collection:** For data categories presented, not all programs collected the same data in the same format. Comparisons among ESN program participants and MCLA populations vary across programs, based on availability of data.

- **Exclusive Representation:** ESN program participants represented in each of the data categories are exclusive. Exception where 29 physicians awarded in the Provider Loan Repayment Program and Provider Recruitment Program are represented in both programs.
## Race and Ethnicity*

<table>
<thead>
<tr>
<th>Group</th>
<th>MCLA</th>
<th>IHSS</th>
<th>Scholars</th>
<th>PRP</th>
<th>PLRP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic or Latinx</td>
<td>39.7%</td>
<td>53.9%</td>
<td>53%</td>
<td>14.2%</td>
<td>20.8%</td>
</tr>
<tr>
<td>White or Caucasian</td>
<td>30.4%</td>
<td>7.1%</td>
<td>6.3%</td>
<td>29.1%</td>
<td>28.1%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>12.5%</td>
<td>9.2%</td>
<td>34.4%</td>
<td>7.5%</td>
<td>9.4%</td>
</tr>
<tr>
<td>Asian</td>
<td>10.6%</td>
<td>14.3%</td>
<td>6.3%</td>
<td>31%</td>
<td>15.6%</td>
</tr>
<tr>
<td>Native Hawaiian or Pacific Islander</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0%</td>
<td>0%</td>
<td>11.5%</td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td>0.2%</td>
<td>0.3%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

*Data: As of January 2022
Groups including Declined or Unknown, Not Reported and Other were omitted due to low representation among participants
## ESN Program Participants Compared to MCLA Members

### GENDER

<table>
<thead>
<tr>
<th></th>
<th>Female*</th>
<th>Male*</th>
</tr>
</thead>
<tbody>
<tr>
<td>IHSS Providers</td>
<td>88%**</td>
<td>10%**</td>
</tr>
<tr>
<td>Scholars</td>
<td>53%</td>
<td>47%</td>
</tr>
<tr>
<td>PLRP Physicians</td>
<td>65%</td>
<td>35%</td>
</tr>
<tr>
<td>MCLA Members</td>
<td>52%</td>
<td>48%</td>
</tr>
</tbody>
</table>

*Data: As of January 2022
**2% of IHSS Providers Declined to State their gender.
Data for Provider Recruitment Physicians (PRP) physicians is not available
## ESN Program Participants Compared to MCLA Members

### LANGUAGES

<table>
<thead>
<tr>
<th></th>
<th>English*</th>
<th>Spanish*</th>
</tr>
</thead>
<tbody>
<tr>
<td>IHSS Providers</td>
<td>28%</td>
<td>46%</td>
</tr>
<tr>
<td>Scholars</td>
<td>100%</td>
<td>53%</td>
</tr>
<tr>
<td>PLRP Physicians</td>
<td>100%</td>
<td>43%</td>
</tr>
<tr>
<td>MCLA Members</td>
<td>63.1%</td>
<td>26.9%</td>
</tr>
</tbody>
</table>

*Data: As of January 2022. Only listing the two major languages spoken by 90% of MCLA members. Other languages accounted for the remaining 10% of languages spoken by MCLA members.

Data for Provider Recruitment Program (PRP) physicians is not available.
## ESN Program Participants by Regional Community Advisory Council (RCAC)

<table>
<thead>
<tr>
<th>RCAC</th>
<th>MCLA Members</th>
<th>PRP</th>
<th>PLRP*</th>
</tr>
</thead>
<tbody>
<tr>
<td>RCAC 1 - Antelope Valley</td>
<td>5.5%</td>
<td>6%</td>
<td>4.2%</td>
</tr>
<tr>
<td>RCAC 2 - Van Nuys, Pacoima, West Hills, North Hills, Arleta, Sepulveda</td>
<td>17.3%</td>
<td>12.7%</td>
<td>13.5%</td>
</tr>
<tr>
<td>RCAC 3 - Alhambra, Pasadena, Foothill</td>
<td>5.9%</td>
<td>3%</td>
<td>6.3%</td>
</tr>
<tr>
<td>RCAC 4 - Hollywood, Wilshire, Central L.A., Glendale</td>
<td>13.2%</td>
<td>19.4%</td>
<td>31.3%</td>
</tr>
<tr>
<td>RCAC 5 - Culver City, Venice, Santa Monica, Malibu, Westchester</td>
<td>3.6%</td>
<td>5.2%</td>
<td>2.1%</td>
</tr>
<tr>
<td><strong>RCAC 6 - Compton, Inglewood, Watts, Gardena, Hawthorne</strong></td>
<td><strong>21.3%</strong></td>
<td><strong>23.1%</strong></td>
<td><strong>12.5%</strong></td>
</tr>
<tr>
<td>RCAC 7 - Huntington Park, Bellflower, Norwalk, Cudahy</td>
<td>7.4%</td>
<td>4.5%</td>
<td>10.4%</td>
</tr>
<tr>
<td>RCAC 8 - Carson, Torrance, San Pedro, Wilmington</td>
<td>3.9%</td>
<td>5.2%</td>
<td>2.1%</td>
</tr>
<tr>
<td>RCAC 9 - Long Beach</td>
<td>4.1%</td>
<td>7.5%</td>
<td>7.3%</td>
</tr>
<tr>
<td>RCAC 10 - East Los Angeles, Whittier, Highland Park</td>
<td>7.9%</td>
<td>4.5%</td>
<td>6.3%</td>
</tr>
<tr>
<td>RCAC 11 - Pomona, El Monte</td>
<td>9.3%</td>
<td>9%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Unidentified</td>
<td>0.6%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Legend**
- Green: Low priority
- Yellow: Moderate priority
- Red: High priority

*Provider Recruitment Program (PRP)  Provider Loan Repayment Program (PLRP)*

Data: As of January 2022. 29 physicians overlap between the PRP and PLRP

*RCAC listed as primary site or site where physician is delivering the majority of patient care per week
Provider Loan Repayment Program (PLRP) and Provider Recruitment Program (PRP)

**Primary Care Specialty***

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Provider Recruitment Program</th>
<th>Provider Loan Repayment Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Medicine</td>
<td>42%</td>
<td>46%</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>32%</td>
<td>32%</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>16%</td>
<td>18%</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>1%</td>
<td>6%</td>
</tr>
<tr>
<td>Obstetrics/Gynecology</td>
<td>2%</td>
<td>5%</td>
</tr>
</tbody>
</table>

**Employer Type***

<table>
<thead>
<tr>
<th>Employer Type</th>
<th>Provider Recruitment Program</th>
<th>Provider Loan Repayment Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>FQHC, including community clinics</td>
<td>92%</td>
<td>54%</td>
</tr>
<tr>
<td>County DHS</td>
<td>24%</td>
<td></td>
</tr>
<tr>
<td>Medical Group</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td>County DMH</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td>Private Practice</td>
<td>8%</td>
<td></td>
</tr>
</tbody>
</table>

*Data: As of January 2022
**Provider Recruitment Program**

**Physician Residency Location Prior to Hire**

- Other
- L.A. County-Based Provider (Non Medi-Cal)
- Out-of-State Provider
- Completed Residency (in L.A. County)
- Completed Residency (In-State)
- State-Based Provider
- Completed Residency (Out-of-State)

---

**Medical School Scholarship Program**

**Scholar Birthplace/Hometown***

- From L.A. County
- Outside of L.A. County, but in CA
- Outside of CA, but in U.S.
- Outside of U.S.

---

*All students reported CA residency and were raised in CA. Regions outside of the U.S. where L.A. Care Scholars report their birthplace include Mexico, Nigeria, Lebanon, and Vietnam.

---

Data: As of January 2022 where n=32

---

*Provider Recruitment Program (PRP) n=134*
## Future Recommendations

### Provider Recruitment Program

<table>
<thead>
<tr>
<th><strong>Annual Investment</strong></th>
<th>Up to $4M annually (from FY 2022-23 through FY 2026-27)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Flexible grantmaking</strong></td>
<td>Continue the grantmaking process launched in FY 2021-22 of two Scheduled Cycles and Rolling Deadline Grants, while also restricting all PRP grants to filling newly created physician positions only.</td>
</tr>
<tr>
<td><strong>Prioritize funding</strong></td>
<td>Consider prioritizing funding for clinics/entities with small to midsized annual operating budgets.</td>
</tr>
<tr>
<td><strong>Private practices</strong></td>
<td>Increase the number/percentage of PRP physicians employed with independent private practices.</td>
</tr>
</tbody>
</table>

### Provider Loan Repayment Program

<table>
<thead>
<tr>
<th><strong>Annual Investment</strong></th>
<th>Up to $4M annually to award new physicians and offer award extensions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prioritize gaps in representation</strong></td>
<td>RCAC, Employer Type, Specialties and other categories by adjusting priorities throughout the year.</td>
</tr>
<tr>
<td><strong>Conduct Targeted Outreach</strong></td>
<td>Promote among associations and residency programs to encourage applications from underrepresented groups in medicine.</td>
</tr>
</tbody>
</table>
Future Recommendations (continued)

### In-Home Support Services (IHSS) Training

<table>
<thead>
<tr>
<th>Annual Investment</th>
<th>Up to $1M annually to train 300-400 new workers per quarter starting in the summer of 2023</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review anticipated cost increase</td>
<td>Review budget since Center for Caregiver Advancement (CCA) anticipates an 8% increase in training costs starting in 2023.</td>
</tr>
<tr>
<td>Monitor State funding</td>
<td>SB172 funds caregiver training for IHSS workers across the state, includes a stipend post-training, as well as pays workers their hourly wage for each hour of class attended.</td>
</tr>
</tbody>
</table>

### Medical School Scholarship Program

<table>
<thead>
<tr>
<th>Annual Investment</th>
<th>Up to $3.5M annually to support 8 students. Account for 2-3% annual tuition increase.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility Requirements</td>
<td>Prioritize awards for local (L.A. County raised) students Highly encourage that students pursue primary care specialties – Family Medicine, Internal Medicine, Obstetrics and Gynecology, Pediatrics and Psychiatry</td>
</tr>
</tbody>
</table>
## Elevating the Safety Net

### Recommended Future Funding

Projections for future funding - *Starting FY 2022-23 through FY 2026-27 (5 years)*

<table>
<thead>
<tr>
<th>Program and Projected Investment Yield</th>
<th>Proposed Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provider Loan Repayment Program</strong></td>
<td>Up to $4M / Yr</td>
</tr>
<tr>
<td>Combination of new awards and award extensions (<em>will vary</em>)</td>
<td></td>
</tr>
<tr>
<td><strong>Provider Recruitment Program</strong></td>
<td>Up to $4M / Yr</td>
</tr>
<tr>
<td>Multiple cycle-based and ad-hoc grants per fiscal year (<em>will vary</em>)</td>
<td></td>
</tr>
<tr>
<td><strong>Medical School Scholarship Program</strong></td>
<td>Up to $3.5M / Yr</td>
</tr>
<tr>
<td>8 scholars (4 at CDU and 4 at UCLA annually)</td>
<td></td>
</tr>
<tr>
<td><strong>In-Home Support Services Training</strong></td>
<td>Up to $1M / Yr</td>
</tr>
<tr>
<td>300-400 Providers per quarter (<em>will vary</em>). Current contract expires in May 2023</td>
<td></td>
</tr>
<tr>
<td><strong>Other programs to address future workforce needs</strong> (<em>flexible</em>)</td>
<td>TBD</td>
</tr>
<tr>
<td><strong>Total Remaining for Future Funding</strong></td>
<td>$61.4M</td>
</tr>
</tbody>
</table>