EXECUTIVE COMMITTEE MEETING

Board of Governors

April 26, 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, April 26, 2022, 2:00 P.M.
L.A. Care Health Plan, 1055 West 7th Street, 10th Floor, Los Angeles

DRAFT

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=mb8bb218d02d4bb4d3ad073fceaff872c

To join and LISTEN ONLY via teleconference please dial: (213) 306-3065
Access code: 2498 076 8186 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 April 26, 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.

DRAFT

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 March 22, 2022 Meeting Minutes p.5 — *Chair*
4. Chairperson's Report — *Chair*
5. Chief Executive Officer Report — John Baackes, *Chief Executive Officer*
   - Vision 2024 Progress Report p.16

COMMITTEE ITEMS

6. Government Affairs Update p.34 — Cherie Compartore, *Senior Director, Government Affairs*
7. Annual Disclosure Commissions paid to brokers for employee health insurance programs p.167 — Terry Brown, *Chief Human Resources Officer*
8. Approve Human Resources Policy HR-709 (Language Proficiency Assessment) **(EXE A)** p.169 — Terry Brown
9. Approve the list of items that will be considered on a Consent Agenda for May 5, 2022 Board of Governors Meeting. — *Chair*
   - April 7, 2022 Board of Governors Meeting Minutes
   - Quarterly Investments Reports
10. Public Comment on Closed Session Items *(Please read instructions above.)* — *Chair*

Chair

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

11. CONTRACT RATES
    Pursuant to Welfare and Institutions Code Section 14087.38(m)
    - Plan Partner Rates
    - Provider Rates
    - DHCS Rates
12. REPORT INVOLVING TRADE SECRET
    Pursuant to Welfare and Institutions Code Section 14087.38(n)
    Discussion Concerning New Service, Program, Business Plan
    Estimated date of public disclosure: *April 2024*

DRAFT

13. CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION
Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act
Names of Five Cases:
    - Methodist Hospital of Southern CA v. L.A. Care, Case No. 21STCV39978
    - THC- Orange County, LLC DBA Kindred Hospital et al. v. L.A. Care, AHLA Case No. 6386
    - THC- Orange County, LLC DBA Kindred Hospital et al. v. L.A. Care, Case No. 21STCV38231
    - THC- Orange County, LLC DBA Kindred Hospital et al. v. L.A. Care, AHLA Case No. 6798
    - USC Center for Health Financing, Policy, and Management, et al. v. Local Initiative Health Authority for Los Angeles County, Case No. 22STCP01429

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

15. THREAT TO PUBLIC SERVICES OR FACILITIES
Consultation with Tom MacDougall, *Chief Information & Technology Officer*

16. 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

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

18. 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 *Chair*

The next Executive Committee meeting is scheduled on Tuesday, May 24, 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 SUBMITTING 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.

BOARD OF GOVERNORS
Executive Committee
Meeting Minutes – March 22, 2022
1055 West 7th Street, Los Angeles, CA 90017

Members
Hector De La Torre, *Chairperson*
Al Ballesteros, *Vice Chairperson*
Ilan Shapiro MD, MBA, FAAP, FACHE, *Treasurer*
Stephanie Booth, MD, *Secretary*
Hilda Perez

Management/Staff
John Baackes, *Chief Executive Officer*
Terry Brown, *Chief of Human Resources*
Augustavia Haydel, *General Counsel*
James Kyle, MD, *Chief of Equity & Quality Medical Director*
Tom MacDougall, *Chief Technology & Information Officer*
Thomas Mapp, *Chief Compliance Officer*
Marie Montgomery, *Chief Financial Officer*
Noah Paley, *Chief of Staff*
Acacia Reed, *Chief Operating Officer*
Richard Seidman, MD, MPH, *Chief Medical Officer*

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.

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Hector De La Torre, *Chairperson,* called to order the L.A. Care Executive Committee and the L.A. Care Joint Powers Authority Executive Committee meetings at 2:12 p.m. The meetings were held simultaneously. He welcomed everyone to the meetings. • For those who provided public comment for this meeting by voice message or in writing, we are really glad that you provided input today. The Committee will hear your comments and we also have to finish the business on our Agenda today. • If you have access to the internet, the materials for today's meeting are available at the lacare.org website. If you need information about how to locate the meeting materials, please let us know. • Information for public comment is on the Agenda available on the web site. Staff will read the comment from each person for up to three minutes.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• 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 directly using the "chat" feature.	
APPROVE MEETING AGENDA	The Agenda for today's meeting was approved.	**Approved unanimously by roll call. 5 AYES (Ballesteros, Booth, De La Torre, Perez, and Shapiro).**
PUBLIC COMMENT	There were no public comments.	
APPROVE MEETING MINUTES	The minutes of the February 22, 2022 meeting were approved as submitted.	**Approved unanimously by roll call. 5 AYES (Ballesteros, Booth, De La Torre, Perez and Shapiro).**
CHAIRPERSON'S REPORT	There was no report from the Chairperson.	
CHIEF EXECUTIVE OFFICER REPORT	John Baackes, *Chief Executive Officer,* reported • On January 1, 2024, L.A. Care will have a new contract for Medi-Cal with the California Department of Health Care Services (DHCS). The contract has been available for review. The timing is motivated by the re-procurement process for commercial plans in Medi-Cal. L.A. Care is reviewing the contract terms, which appear to present new reporting requirements in the oversight of plan partners and delegated entities (which includes nearly all the medical groups with which L.A. Care contracts). L.A. Care's goal is to determine the true administrative costs of the contracted entities. Payments to the Plan Partners and delegated entities are considered to be medical expense, although those payments include some administrative expense. This is likely to be a huge adjustment burden for health plans. Reports on the provisions will be provided to the Board at future meetings. L.A. Care will work with DHCS to adjust the provisions as needed. • L.A. Care enrollment remains higher than forecast. In May, undocumented seniors (estimated 123,000 people in Los Angeles County) will become eligible to enroll in	

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	Medi-Cal. L.A. Care estimated in the budget that 60,000 new members may be added. It was assumed in the budget estimate that the public health emergency would be over and Medi-Cal eligibility redetermination would have resumed, resulting in erosion of up to 5%. The public health emergency has recently been extended to July 15. This means that the effect of the redetermination will be a smaller impact on enrollment in Fiscal Year 2022. • L.A. Care has experienced difficulty in recruiting employees. Earlier this year, to attract candidates, changes were made in L.A. Care's minimum salary, raising it to $20.00 and announced that a return to the office for employees would not take place until September, 2024. L.A. Care's senior management is currently in the office three days a week, to participate in in-person meetings. These changes seemed to increase hiring, and with new enrollment expected later this year, L.A. Care will offer enhancements to further improve recruitment.	
Government Affairs Update	Cherie Compartore, *Senior Director, Government Affairs*, reported that: • The California Legislative Analyst's Office (LAO) is a non-partisan department which provides the legislature with fiscal and policy analysis. LAO released a report that the cost of a proposed single payer health care system would be $500-$550 billion per year, which does not include necessary startup costs. Although the bill was not approved by California's legislature and will likely not be brought up again this year, a proposal will probably be brought forward in future years. • Recently the California legislature considered a resolution to end the Governor's state of emergency powers, which was considered in committee and was not approved. Governor Newsom's emergency powers, enacted in March 2020, will continue. The Committee will reconsider the resolution at a later date. • Funding that was being considered by Congress to provide additional COVID relief, also contained provisions to assist Ukraine. The proposal would retrieve previously enacted funding which remained unused in some states, and would redistribute those funds to other states. Speaker Pelosi thought that there was sufficient support from Democrats, but that was not the case. There appears to be some finger-pointing between the Speaker's office and the White House over this issue. The vote planned for this legislation does not seem to be moving forward.	

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Elevating the Safety Net Initiatives Update	Cynthia Carmona, *Senior Director, Safety Net Initiatives*, presented an Impact Summary and Funding Recommendations for Elevating the Safety Net (ESN) (*a copy of her presentation is available by contacting Board Services).* The initiative has reached the fifth year of investment. The initial commitment was $155 million in Board Designated funds, starting with three programs. The initiative expanded to 10 programs, with $93.6 million expended so far. Although approval was for five years of investments from the Board of Governors, because the fund is a Board Designated fund, we don't have a time limit on when we should spend the remaining funds. Of the initial commitment, $61.4 million remains unspent. Staff proposes to prioritize the most effective programs at a future Board Meeting for approval of a five-year extension of the initiative, including: Program — Benefit to L.A. Care Members and Participants **Provider Recruitment Program (PRP)** • Physicians hired alleviate workloads and improve access to care • PRP funded grantees experienced a 44.6% increase in MCLA membership compared to 38.2% among non-PRP funded clinics/entities. • 87% physician retention rate through Cycle 10 (134 of 154 physician slots are currently filled) **Provider Loan Repayment Program** • 89% of physicians retained and on track to complete 3 years of service • 73% of physicians deliver at least 32 hours of direct patient care/week • 73% of physicians report at least $200k in education debt **Medical School Scholarships** • 87.4% of students identify as Hispanic/Latinx or Black/African American • Eliminates between $337k and $390k in school debt per student	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	In-Home Support Services Training Program • Efficient training and placement – 300 to 400 providers/quarter • Reduces ER and inpatient visits among members receiving care from trained providers**	
	Ms. Carmona noted statistics regarding the race and ethnicity of participants in the ESN Workforce Initiative programs compared with the members of L.A. Care, and she noted: • Scholarships and IHHS provider training are supporting underrepresented groups in medicine • Assumption: Not enough physicians identifying as Black or African American and Hispanic or Latinx are applying or represented in our PRP and PLRP. May be due to upstream factors affecting medical school admissions. • 14% of IHSS providers did not self-report in this category • 17.9% and 14.6% of physicians in PRP and PLPR, respectively, identified as other Race or Ethnicity	
	Future Recommendations **Provider Recruitment Program** **Annual Investment**: Extend PRP grant making for five additional years (of up to $4 million per year) from FY 2022-23 through FY 2026-27. **Flexible grant making**: Continue the grant making 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. **Prioritize funding**: Consider prioritizing funding for clinics/entities with small to midsized annual operating budgets. **Private practices**: Increase the number/ percentage of PRP physicians employed with independent private practices. **Provider Loan Repayment Program**	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Annual Investment — Up to $4M annually to award new physicians and offer award extensions **Prioritize gaps in representation** — RCAC, Employer Type, Specialties and other categories by adjusting priorities throughout the year. **Conduct Targeted Outreach** — Promote among associations and residency programs to encourage applications from underrepresented groups in medicine. **Medical School Scholarship Program** **Annual Investment** — Up to $3.5M annually to support 8 students. Account for 2-3% annual tuition increase. **Eligibility Requirements** — 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 **In-Home Support Services (IHSS) Training** **Annual Investment** — Up to $1M annually to train 300-400 new workers per quarter starting in the summer of 2023 **Review anticipated cost increase** — Review budget since Center for Caregiver Advancement (CCA) anticipates an 8% increase in training costs starting in 2023. **Monitor State funding** — 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. **Program and Projected Investment Yield** — **Proposed Funding** **Provider Loan Repayment Program** Combination of new awards and award extensions (*will vary*) — Up to $4M / Yr.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Provider Recruitment Program Multiple cycle-based and ad-hoc grants per fiscal year (*will vary*) — Up to $4M / Yr. **Medical School Scholarship Program** 8 scholars (4 at CDU and 4 at UCLA annually) — Up to $3.5M / Yr. **In-Home Support Services Training** 300-400 Providers per quarter (*will vary*). Current contract expires in May 2023 — Up to $1M / Yr. ***Other programs to address future workforce needs*** *(flexible)* — *TBD* Total Remaining for Future Funding — $61.4M Board Member Booth asked for additional information that would help her understand if the program is helping to increase the workforce for safety net providers to serve L.A. Care's members. Mr. Baackes indicated that the proposal will be brought to the Board at the May 2022 meeting, and staff will provide additional data. He noted that he and Dr. Seidman will attend the upcoming graduations for the first group of L.A. Care Scholars in May. Board Member Perez asked about the In-Home Supportive Services (IHSS) future funding and if additional medical schools could be added to the scholarship program. Ms. Carmona noted that current funding for the IHSS program is approved through 2023. The proposal will include continued funding of the same program beyond 2023. Mr. Baackes noted that L.A. Care has trained 4,400 home caregivers through this program. Mr. Baackes also noted that the IHSS training program was not included in the ESN program. Since the IHSS training is workforce development it was moved under ESN. Mr. Baackes reported that the mission of Charles Drew Medical School is to educate minority students and to encourage them to work in the local community, which fits well with the ESN Initiative. The Geffen School of Medicine at UCLA was also selected for ESN because it has the goal of recruiting minority students. L.A. Care felt these two schools uniquely align with the long-range goal of building a pipeline to produce physicians who reflect the Medi-Cal membership at L.A. Care.	

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	Richard Seidman, MD, MPH, *Chief Medical Officer,* added that UCLA is a public institution and was chosen alongside Drew because of the alignment with the ESN goals. Other private local universities have endowments and other funds to assist students with tuition and costs. Board Member Perez asked how L.A. Care ensure that students remain in Los Angeles County to serve Medi-Cal members. Mr. Baackes responded that L.A. Care is getting information but it takes time. Medical School is four years and residency is three more years. Mr. Baackes is confident that the data will show that the L.A. Care Scholars will remain in Los Angeles County. Board Member Perez remains focused on serving L.A. Care members, and on the medical services and resources that the communities receive. Mr. Baackes noted that the reason for starting the ESN Workforce Initiative was to increase number of racially diverse physicians in Los Angeles County to serve Medi-Cal members. It takes seven years to go through medical school and residency. L.A. Care's investment in ESN is a small risk, and he expressed his gratitude to the Board of Governors for supporting this program. Board Member Perez noted that she sees that the ESN program changes the lives of these students and hopefully will improve the health and happiness of L.A. Care members and the community. Mr. Baackes related that at the last luncheon for L.A. Care Scholars in 2019, an L.A. Care Scholar from the Long Beach area announced that the scholarship had changed her life, because she would not be burdened with medical school debt and she will be able to pursue her dream of working in the community she came from, which is why she went to medical school in the first place. Mr. Baackes noted that by relieving these students from debt, they won't have to work in a high-paying position just to pay off loans incurred during medical school, and they can instead choose to work where they wish. Board Member Booth noted that it would be interesting to look at the tuition cost at other schools. Chairperson De La Torre asked about programs for Doctor of Osteopathic Medicine. Dr. Seidman noted that there is additional training for this degree after medical school. Ms. Carmona will provide data to Board Member Booth on emergency room visits for the IHSS training participants.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Mr. Baackes commended Ms. Carmona for not only leading the ESN program, but also leading the implementation of the CalAIM program at L.A. Care. Information about the Enhanced Care Management program will be provided at future Board meetings, as this program is expected to grow substantially, and it will be important to understand the program and the funding for these services.	
Approve Consent Agenda	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)	**Approved unanimously by roll call. 5 AYES (Ballesteros, Booth, De La Torre, Perez and Shapiro).**
PUBLIC COMMENTS	Received via email on March 22 at 2:41 pm, from Andria McFerson *Hello Chairperson De La Torre, I felt I needed to discuss the process of which the budget is determined. If you have staff members who can be effective and recognize good ethics and follow through with addressing the needs of the people they are here for then the budget could go towards meaningful public participation that would help save lives. But, due to the fact that you do have some staff members who believe that either systematic racism or negative treatment to those stakeholders who speak up is like a job requirement and is almost a popularity contest to hurt the ones they should help serve then I feel that some money needs to go towards staff empathy training. I get harassed during every ECAC meeting. Why? Is it my skin color or perhaps, maybe the positive impact that I have made and been advocating for I have no idea? Staff should not virtually mute a chair who has the floor and in turn keep their jobs let alone, get a raise, bonus or promotion for those actions. There was a motion that I placed on the floor and only 10 out of 13 chairs where able to vote yet staff member Idalia Del La Torre told us that 6 yay's only 2 nay's and 2 obstensions was enough to vote 👉{✓NAY}, so the motion was thrown out. Please let us know what our rights are and if that was the proper procedure. But, if not then why is this happening and more importantly why is it allowed to continue after so much harassment is reported? We are told not to tell personal stories but yet personal harassment is being done to us publicly on a*	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	regular basis so why is this allowed to happen we have every right to voice our strife because it's publicly being shown after so many years at ECAC meetings on a regular basis. Anytime you have been called by a chair to speak yet staff members purposely mute you MANY TIMES that is a form of cyberbullying and this needs to be reported but yet my past complaints are not even followed through by LA Care so I am reluctant to fo so. I hear from no one after I submit my complaints. This has to stop and the whole Robert's Rule of Order process needs to be respected during a meeting along with the people that are affected by it. Please instruct your staff to help and not hinder the stakeholder committee meetings and uphold the rules and ethics relative to a proper meeting and please evaluate the budget that affects proper work performance with your staff so that we could feel we are here for a credible and lifesaving cause. Please let us know if we need a focus group for budget related topics to broaden our own standards and outreach. Thanks, Andria McFerson Chairperson De La Torre asked Augustavia J. Haydel, *General Counsel,* to look into the issue about the vote and how it was conducted.	
ADJOURN TO CLOSED SESSION	The Joint Powers Authority Executive Committee meeting was adjourned at 3:15 p.m. Ms. Haydel announced the items to be discussed in closed session. She announced there is no report anticipated from the closed session. The meeting adjourned to closed session at 3:16 p.m. 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: March *2024* 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	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act L.A. Care v. Purdue Pharma L.P. et al.; Case No: 1:19-op-45212-DAP (N.D. Ohio) CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION Significant exposure to litigation pursuant to Section 54956.9(d)(2) of Ralph M. Brown Act: Four Potential Cases CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION 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 PUBLIC EMPLOYEE PERFORMANCE EVALUATION Pursuant to Section 54957 of the Ralph M. Brown Act Title: Chief Executive Officer CONFERENCE WITH LABOR NEGOTIATOR Pursuant to Section 54957.6 of the Ralph M. Brown Act Agency Designated Representative: Hector De La Torre Unrepresented Employee: John Baackes	
RECONVENE IN OPEN SESSION	The meeting reconvened in open session at 4:35 p.m. No reportable actions were taken during the closed session.	
ADJOURNMENT	The meeting adjourned at 4:37 p.m.	

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: _____

April 18, 2022

TO: Board of Governors

FROM : John Baackes, CEO

SUBJECT: 2nd Quarter FY 2021/22 Vision 2024 Progress Report

This report summarizes the progress made on the activities outlined in Vision 2024, L.A. Care's strategic plan. This is the second quarterly report for the 2021/22 fiscal year, which represents the first year of our three-year plan.

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

- CalAIM components such as L.A. Care's Enhanced Care Management (ECM) program and Community Supports launched successfully in January.
- The first Generating African American Infant and Nurturer's Survival (GAAINS) CHIF grant initiative was released.
- Member health reminders launched for cancer screenings and wellness visits, including a new pilot program that includes text messaging.
- L.A. Care's Quality Improvement team paid out the inaugural Direct Network (DN) Pay-for-Performance (P4P) program.

High Performing Plan

Achieve operational excellence by improving health plan functionality.

Build out information technology systems that support improved health plan functionality.	
Tactics	**Update**
Improve customer service through the Voice of the Customer (VOICE) initiative, our customer service information technology system.	Voice of the Customer (VOICE) continues to work on the Call Flow project, which includes features such as courtesy call back and post-call surveys. The project is currently in the development phase and is scheduled to be deployed by end of FY 21-22. The development will help improve overall customer experience and shorten handle times. Work is being continued on the enhanced provider assignment/change tool, with an anticipated deployment for Q3 FY 21-22. Improvements in the IVR (Interactive Voice Response) Call Flows have an anticipated deployment of Q4 FY 21-22.
Improve efficiency and effectiveness of financial management functions with the implementation of the additional phases of the SAP system, our Enterprise Resource Platform (ERP).	The Enterprise Resource Planning implementation for two SAP key projects: • 80% of configuration is completed for the FI-GL (General Ledger), Controlling, Fixed Asset, Project, and Accounts Payable modules in SAP. This implementation will replace Solomon, our old accounting system. Interface connections are being configured between our Payroll system, Concur Travel and Expense, and SAP Billing and Disbursements, which will eliminate manual intervention between the systems. • SAP Revenue Automation configuration is under way and will replace the manual process performed by the Medical Payment System and Services department. The target date for SAP ERP and Revenue Automation project is June 1, 2022.
Complete the implementation of SyntraNet to support operational improvements across the enterprise, with a particular emphasis on appeals and grievances.	Additional improvements have been made to the Utilization Management (UM) module of SyntraNet to improve efficiency and compliance. Work was initiated to address changes needed for new requirements for translating member notices. A number of additional foundational enhancements have been bundled, with the first of three phases to go live in Q3.

Build out information technology systems that support improved health plan functionality.	
Tactics	**Update**
Modernize provider data management by defining and creating a roadmap for achieving our target state for our provider data ecosystem.	The Provider Roadmap initiative is a multi-year program focused on improving L.A. Care's provider data quality and management, including enhancements to data intake, standardization, validation, storage, and reporting processes. As part of this initiative, L.A. Care is in the process of sourcing a provider data management platform that will: • establish a centralized provider data repository that will enable multiple disparate systems to be discontinued; • delineate all network affiliations, hierarchies, and subnetworks in order to facilitate the identification and management of all providers available to a member within a closed sub-network; • integrate contracting and credentialing workflows and task performance; • support the use of the standardized provider file (SPF) to receive provider data directly from our PPG partners; • leverage validated provider data available through a partnership with the Symphony Provider Directory Utility; and • employ the newly established data governance framework to ensure better data quality.
Refine and implement our three-year technology roadmap and ensure that the reference architecture serves as a blueprint that evolves with L.A. Care's needs.	The Technology Roadmap continues to evolve and is being refined as we move forward. Successful delivery of the first phase of CalAIM along with the additional foundational development made on the SyntraNet platform has allowed us to continue delivery on the components of design contained in the reference architecture. This further advances our goal for the exploitation of more modern technology services.
Develop real-time interoperability capabilities to share data with providers and members.	The first phase is complete with public facing provider directory API's (Application Program Interfaces) which allow any system or software application to search and download L.A. Care's complete Provider Directory. This allows search engines such as Google and others to access our Provider Directory and present results to their users. Additional work is underway to launch a data connection API for members to access all of their health information maintained by L.A. Care. Coming in June 2022, the data connection API will enable third party applications (typically on smart phones) to access member data, but only with member consent.

Support and sustain a diverse and skilled workforce and plan for future needs.	
Tactics	**Update**
Conduct succession planning, particularly at the leadership level.	We are working with members of Senior Leadership to develop strategies to ensure succession within the organization.
Maintain a diverse and inclusive workforce, validated by data analysis, to model L.A. Care's commitment to Diversity, Equity, and Inclusion.	L.A. Care continues to monitor and enhance its diversity dashboard, including monitoring ethnicity/race and gender by employee category (i.e. staff, supervisory, management, Director, Sr. Director, Officer).
Support a culture of accountability that encourages transparency.	L.A. Care is developing remote educational classes for management focused on ensuring proper performance assessment/management in the remote environment.
Improve managed care and Management Services Organization (MSO) acumen among staff.	We are assessing the knowledge gaps for staff and will develop a plan to target our training more specifically to address these needs.
Promote retention of staff in an evolving work environment.	L.A. Care has completed our Employee Engagement Survey and we are currently working on action plans. We actively support employees through our Employee Recognition Program and Employee Resource Groups. We established a Return to Office strategy, focused on remote work until 2024 to promote employee retention, that was shared with staff in January.

Ensure long-term financial sustainability.	
Tactics	**Update**
Implement recommendations from the administrative expense benchmarking study and update the administrative expense target in the revised forecasts.	L.A. Care continues to assess the findings from the benchmarking study and will implement appropriate changes to optimize staffing to meet business demands in the next forecast and FY 22-23 budget.

Ensure long-term financial sustainability.	
Tactics	**Update**
Develop risk arrangements for Enhanced Care Management (ECM) and the Dual Eligible Special Needs Plan (D-SNP).	Network Enhanced Care Management (ECM) & Community Supports (CS) updates for July 2022 effective date: • Seven projected providers for ECM • Still assessing number of providers for Community Supports. Providers currently going through certification. • LA County Contracts: o Department of Public Health will not be ready for a July start and will be pushed to the Fall.

Mature L.A. Care's family of product lines, taking an "all products" approach whenever possible.	
Tactics	**Update**
Launch a D-SNP to serve the dually-eligible Medicare and Medi-Cal population and transition members from Cal MediConnect (CMC) to the D-SNP.	• L.A. Care received and responded to CMS's Medicare Advantage Part C and D Applications Deficiency Notices. • Monthly Department of Health Care Services Cal MediConnect to D-SNP Enrollment Transition Workgroups continue. • Operational processes to support Exclusively Aligned Enrollment (EAE) continue to be developed by the state in partnership with stakeholders. • L.A. Care D-SNP implementation work streams continue, led by the Enterprise Portfolio Management Office.
Increase membership across all products by implementing member recruitment and retention strategies.	**Marketing** • **L.A. Care Covered (LACC):** Open Enrollment campaign concluded in March. We are still currently in the market with a "lights on effort" that will lead into our Special Enrollment Period (SEP) campaign launch in April. • **CMC:** Campaign will launch at the end of this month, with a bold growth intent, until October 1st. • **D-SNP:** Marketing plan for D-SNP launch to be finalized by April 15, highlighting all Marketing and Sales efforts.

Mature L.A. Care's family of product lines, taking an "all products" approach whenever possible.	
Tactics	**Update**
	• **L.A. Care Brand Research:** Annual research/focus groups for our brand were concluded for FY 21-22. Presentation of results currently being drafted to share with leadership in April. **Spring Campaigns** • **Medi-Cal:** Campaign underway for redetermination and set to launch expansion campaign in April. • **CMC:** Campaign set to launch by end of April. • **LACC:** SEP campaign launching in April. • **L.A. Care:** HR Recruitment campaign launching in second week of April. Community Resource Centers (CRCs) campaign set to launch in June. **Sales** • **Execution of Sales organization re-alignment** is underway in support of: o D-SNP (Duals Special Needs Plan) launch, o continued Commercial (Covered CA) growth, and o expanded Medi-Cal grass roots community marketing and redetermination support. • **Critical technology projects:** Continue including overall CRM (customer relationship management) systems integration, broker portal enhancements, and electronic enrollment application capabilities • **Sales paradigm shift:** Being driven by Medicare product shift from Cal MediConnect to D-SNP, including expansion of the broker channel through a significant increase in direct general agency contracts and selling through brokers.
Engage in a provider network strategy that meets distinct business and competitive needs of all products and ensures that members receive high-value care.	We continue to focus on building, growing, and adding valued providers to our Direct Network through focused recruitment efforts. Membership continues to grow and has increased 5.3% to nearly 31,650 members from the previous quarter. The team has been utilizing Quest Analytics software to leverage market data to ensure we are meeting network adequacy for members in all areas. Additionally, we continue to work closely with our regulators to ensure we are meeting the time and distance standards across all lines of business for all our members to access high-value care within the appropriate distance or time.

Mature L.A. Care's family of product lines, taking an "all products" approach whenever possible.	
Tactics	**Update**
	We continue to evaluate opportunities to transition PPG shared risk business to dual risk where it aligns with our capitated hospital partners, as appropriate. We currently have two provider groups in process of transition from shared risk to dual risk.

High Quality Network

Support a robust provider network that offers access to high-quality, cost-efficient care.

Mature and grow our Direct Network.	
Tactics	**Update**
Insource delegation functions that are currently outsourced, as appropriate and cost effective.	OptumHealth (Optum) continues to perform select Utilization Management (UM) and Care Management (CM) services for the L.A. Care Direct Network (DN) members. To ensure a transition that is seamless for L.A. Care's members and providers, L.A. Care is continuing work on a comprehensive readiness plan to in-source these services, by taking a holistic approach to ensure that the plan will be able to meet or exceed all compliance and quality standards to serve the DN members, and partner with DN providers.
Improve the operations of all L.A. Care functions necessary to support and scale up the Direct Network.	Continued efforts for operational improvements, with the support of the Direct Network Administration Steering Committee, include improving the overall Provider Experience. Improvements in progress include adoption of tools such as Therefore to enhance the provider load process, the availability of additional downloadable provider portal reporting, and the ability to access training opportunities through the Learning Management System, available through recorded trainings and instructor led. Additionally, we are closely evaluating the provider satisfaction results from 2021 to prepare for opportunities where necessary.
Strategically address gaps in the Direct Network to meet all member needs countywide.	L.A. Care continues to improve network adequacy by utilizing targeted provider recruitment data, analytics, and dashboards to make strategic network decisions. Quest Analytics software is utilized along with Tableau dashboards to help identify recruitment opportunities, mitigate access gaps, and identify market providers in rural areas. The team successfully added 55 in-demand specialty sites into the Direct Network in areas of dense member populations within

Mature and grow our Direct Network.	
Tactics	**Update**
	rural zip codes. The focus now remains on the continued expansion of specialty offices, in order to ensure we meet the needs of our growing membership countywide.
Increase access to virtual care by implementing L.A. Care's Virtual Specialty Care Program (VSCP).	• As of March 31, 2022, the Virtual Specialty Care project team has trained four high volume Direct Network practices and we are in the process of recruiting and training more. • We are still working with Children's Hospital Los Angeles (CHLA) to bring them onboard as our preferred pediatric virtual specialist.

Improve our quality across products and providers.	
Tactics	**Update**
Achieve quality scores for the Direct Network that are commensurate with the median IPA network scores.	L.A. Care's Quality Improvement team paid out the inaugural Direct Network (DN) Pay-for-Performance (P4P) program in March 2022. A total of $300,000 was distributed to 58 providers. The Direct Network received a performance report as part of the Medi-Cal Value Initiative for IPA Performance (VIIP) program, but not a payment. A provider was recognized as the Top Performing Direct Network practitioner during the annual Provider Recognition Awards. The Measurement Year 2022 Direct Network P4P Program Description was developed and approved.
Exceed the DHCS Minimum Performance Level for all measures for Medi-Cal, achieve a four-star quality rating for L.A. Care Covered, and build the infrastructure to achieve a four-star quality rating for our D-SNP.	To address our multi-year plan to improve quality, L.A. Care is launching initiatives that address members, providers, the community, and L.A. Care staff needs. • Member Experience trainings are scheduled to launch next quarter for select L.A. Care staff and L.A. Care providers. • Member health reminders launched for cancer screenings and wellness visits, including a new pilot program that includes text messaging. These will continue throughout the year, targeting different age groups and conditions. • Social media ads encouraging checkups and screenings launched this quarter and will also continue throughout the year. • L.A Care has been meeting with different medical groups to discuss and collaborate on quality improvement activities.

Improve our quality across products and providers.	
Tactics	**Update**
	• New pilot programs are being developed with the goal of providing more tools for high risk members to monitor and manage their health at home. These include items such as blood pressure monitors, at-home test kits, and meal deliveries. • Quality Improvement teams continue to work with IT to obtain and ingest more data more efficiently through Clinical Data Integration processes. • Stars Improvements continue with a new core team, Stars Steering and Stars workgroups, multiple consultant reviews, and more focus on closing gaps through appropriate staffing and resources. ** Of the 15 Measurement Year (MY) 2021/Reporting Year (RY) 2022 Managed Care Accountability Set (MCAS) Minimum Performance Level measures, 10 are above the 50th percentile and two more are expected by the end of RY2022.*
Improve clinical data integration and data governance, starting with race, ethnicity, language, sexual orientation, and gender identity data, in order to achieve the NCQA Health Equity Distinction.	The programs to further define and integrate race and ethnicity data elements and provide governance were launched in February as planned. We will complete a schedule for analysis of the language, sexual orientation, and gender identity elements, as well as the planning for governance and integration of the elements.
Improve clinical performance for children's care.	A social media campaign focused on adolescent immunizations launched during Preteen Vaccine Week. A text messaging campaign targeting the parents/guardians of children without a current well care visit also launched. These text messages provided reminders for well care visits, vaccines, and helpful health tips.

Invest in providers and practices serving our members and the L.A. County safety net.	
Tactics	**Update**
Assist our providers in adopting and using Health Information Technology (HIT) resources.	The 15 Transform L.A. practices are reporting 10 clinical quality measures from their electronic health record system. A new effort to ensure Primary Care Providers receive discharge notifications electronically is in progress.
Provide practice coaching to support patient-centered care.	Transform L.A. has maintained the number of Direct Network practices at 15 (31 sites) with 91 providers, 28% of Direct Network members, and 18% of L.A. Care's total members. Five practices are reporting improvement in Controlling High Blood Pressure and two practices are reporting improvements in Diabetes A1c Poor Control. The Help Me Grow initiative continues to progress. The program has two enrolled practices in their three-year pilot to increase developmental milestone screenings in L.A. Care members aged 0-5 years old. Early childhood development classes for the community and L.A. Care members have been launched at the CRCs. The first CME event "Childhood Health Conference" has been finalized and is scheduled for May 19, 2022.
Implement innovative programs to train, recruit, and retain highly qualified providers through the Elevating the Safety Net initiative.	• **Health Career Internship Program:** After hosting 35 interns in the summer of 2021, Health Career Connection (HCC) has confirmed various organizations to host the second cohort of 31 interns in the summer of 2022. Interviews and intern placement will occur April through May to launch internship activities in June. • **Residency Support Program (RSP):** L.A. Care is finalizing grant agreements with the institutions awarded under cycle 3 funding—AltaMed, Charles R. Drew University of Medicine and Science (CDU), UCLA, and White Memorial. The approved funds will support salaries and benefits for 25 residents across the four institutions starting in academic year 2022-23 through 2024-25. • **Medical School Scholarships:** CDU and UCLA are reviewing student applications to confirm the fifth cohort of eight L.A. Care Scholars as early as May 2022. Students from the first four cohorts are on track to complete their four-year medical education and training. • **Provider Loan Repayment Program (PLRP):** We have 86 active physician awards. Starting in May 2022, we anticipate between 30-60 additional awards for physicians who commit to practicing in our safety for at least three years.

Invest in providers and practices serving our members and the L.A. County safety net.	
Tactics	**Update**
	• **Provider Recruitment Program (PRP):** We continue to grow the PRP program, with 142 providers hired totaling more than $19.2 million in investment. There are currently 19 vacancies. • **Elevating Community Health:** For the Community Health Worker (CHW) program, the third cohort of CHWs completed the remaining continuing education sessions covering Emotional Intelligence and Self-Care and Boundaries and Professionalism. In the Center for Caregiver Advancement's (CCA) IHSS training program, 4,428 IHSS workers have graduated since the beginning of the program. (Note: the reporting process for the IHSS training program has been updated for accuracy, so the graduation count may vary from previous reports). • **National Medical Fellowship (NMF):** L.A. Care is reviewing the opportunity to fund a fifth cohort of seven fellows starting in June 2022. • **Keck Graduate Institute (KGI) Master of Science in Community Medicine (MSCM):** KGI is reviewing student applications to award twenty-three new scholarships as part of L.A. Care's $5 million investment in the graduate program. Twenty-two students who received a scholarship in 2021 are on track to complete their first year of graduate education in the MSCM program. • **CDU New Medical Education Program:** With L.A. Care's $5 million investment, CDU is making progress towards establishing the New Medical Education Program in preparation for welcoming the first class of 60 medical students in 2023.
Utilize the Community Health Investment Fund (CHIF) to leverage opportunities for providers to increase quality and access to care.	During the second quarter, the Community Benefits department released three CHIF grant Initiatives and two invitations for CHIF Ad Hoc applications. The Oral Health Initiative XIII for $1.5 million was released in January and is designed to support the hiring and retention of dental staff at community-based clinics. Recommended OHI XIII grants are in the process of being approved. The first Generating African American Infant and Nurturer's Survival (GAAINS) Initiative for $1.5 million was released in February and is designed to reduce and eventually eradicate the racial disparity in infant and maternal mortality. The grant review committee will be held in late April. The Robert E. Tranquada, MD Safety Net Initiative XIII for $2.25 million was released in March and is designed to support the hiring and retention of non-licensed personnel who work on-site at community-based clinics. The grant review committee

Invest in providers and practices serving our members and the L.A. County safety net.	
Tactics	**Update**
	will be held in early June. All these CHIF Initiatives and Ad Hoc grants focus on low-income individuals, including L.A. Care Health Plan members.

Member Centric Care

Provide services and care that meet the broad health and social needs of our members.

Operate all components of California Advancing and Innovating Medi-Cal (CalAIM) as they are launched.	
Tactics	**Update**
Maximize care for L.A. Care members, within funding constraints, through successful implementation of Enhanced Care Management (ECM) and Community Supports (CS) for specified populations of focus.	**Enhanced Care Management (ECM):** L.A. Care's ECM program launched successfully in January 2022, with a provider network of 44 ECM providers. More than 18,000 members were grandfathered into ECM from Health Homes and Whole Person Care, and several thousand additional members were identified as newly ECM-eligible by meeting the criteria for one or more ECM Populations of Focus. L.A. Care continues to partner with the other Los Angeles managed care plans and Los Angeles County entities to develop and streamline ECM operations. In Q2, we initiated work to optimize internal processes and technology; this work will continue into Q3 and support the expansion of ECM to include additional providers and future Populations of Focus. **Community Supports (CS):** L.A. Care grandfathered more than 7,000 members from Whole Person Care (WPC) and the Health Homes Program (HHP) to appropriate Community Supports (CS), Homeless and Housing Support Services (HHSS), and/or Recuperative Care on January 1, 2022. L.A. Care met with providers to go over program expectations, answer questions, and provide support in launch of the various CS programs. L.A. Care hosted various internal and external training sessions on each of the specific Community Supports that launched in January 2022 to ensure appropriate support and coordination.

Operate all components of California Advancing and Innovating Medi-Cal (CalAIM) as they are launched.	
Tactics	**Update**
	L.A. Care is working on program development, provider certification, and IT business requirements for the upcoming CS July 2022 services—Housing Deposits, Personal Care and Homemaker Services, Sobering Centers, and Respite Services.
Ensure CalAIM Population Health Management (PHM) requirements are met.	The member assessment workgroup is actively meeting and creating an inventory of all member facing assessments across all lines of business. Next, a comparison analysis will be done to identify duplications and future state coordination. We are identifying IT and non-IT requirements needed to meet all PHM program requirements. We are also identifying gaps in PHM program requirements. We will be working on closing those gaps with a cross-functional team.
Monitor and establish infrastructure for longer-term CalAIM initiatives.	• CalAIM Core Planning Team continues to meet on a bi-weekly basis. • Phase I of the Mandatory Managed Care Enrollment transition brought approximately 20,000 new members to L.A. Care and Plan Partners. • The member assessment workgroup kicked off in February and meets bi-weekly to ensure readiness for the Population Health Management (PHM) initiative. • Internal readiness activities continue for Community Supports (CS) that are going live July 2022, and the Long Term Care carve-in slated for January 2023, which is actively being managed by MLTSS (Managed Long-Term Services and Supports) and PNM (Provider Network Management).

Establish and implement a strategy for a high-touch care management approach.	
Tactics	**Update**
Maximize use of care managers and community health workers within our care management model.	Now that Enhanced Care Management (ECM) and Community Supports (CS) have gone live, our Care Managers and Community Health Workers have been working with new and existing members enrolled in Care Management to ensure enrollees are being connected with the services and supports that they need to regain optimal health. Part of this effort has gone toward ensuring that there is effective and widespread Community Supports utilization to connect all appropriate Medi-Cal eligible members to Medically Tailored Meals (MTM), Homeless & Housing Support Services (HHSS), and/or Recuperative Care. Additionally, we have coordinated processes to ensure that members receive the best kind of care

Establish and implement a strategy for a high-touch care management approach.	
Tactics	**Update**
	management to meet their unique needs, whether that be through our internal care management team or through ECM. This includes, when necessary, facilitating a warm handoff of members from care management to ECM or vice versa to support continuity of care coordination needs.
Increase use of field-based care management in the community.	As the COVID-19 positivity rate decreases and L.A. County begins to loosen restrictions, efforts have been underway to prepare our community health workers for redeployment into the community. Through planning and preparation efforts in Q2, the community health workers are ready to safely redeploy into members' homes, Community Resource Centers, and elsewhere in the community to provide high-touch support to members enrolled in High Risk and Complex care management in the beginning of Q3. The re-deployment of community health workers into the community is an important step toward achieving the field-based care management model that was underway pre-pandemic.
Expand upon our progress with palliative care and add other end-of-life services.	Palliative care provides an additional layer of support to members with serious illness. Our program is expanding and we have been able to enroll more members for these home-based supportive services. We are reaching out to community partners and increasing our reach to long-term care facilities, as well as working with local providers to enroll members during transitions of care.

Ensure that the services we provide to members promote equity and are free of implicit and explicit bias.	
Tactics	**Update**
Leverage external partnerships, grantmaking, and sponsorships to implement programs that address the root causes of inequity, including racism and poverty.	The Member Health Equity Council continues working on established goals and metrics for FY 21-22. The Consumer Health Equity Council, comprised of L.A. Care health plan members, met in March 2022 to discuss L.A. Care transportation services. The Health Equity team is meeting with community partners and finalizing documents for a Health Equity focused Community Health Investment Fund (CHIF) grant. This is planned to launch by the end of the fiscal year.

Ensure that the services we provide to members promote equity and are free of implicit and explicit bias.	
Tactics	**Update**
Identify and reduce health disparities among our members by implementing targeted quality improvement programs.	L.A. Care focused on disparities in diabetes, hypertension, and prenatal care: • The Diabetes Disparities Performance Improvement Project launched in November at a clinic in Antelope Valley. The health educator reached 14 out of 33 eligible members. All eligible members received educational materials. • The Diabetes Quality Improvement Project focuses on Black/African American Covered California members. This project will provide medically tailored meals to eligible members along with the option for nutrition counseling with a registered dietitian. • The QI intervention to improve blood pressure began early December and outreached six providers with information on how to capture blood pressure readings via telehealth. The six providers have 870 members with hypertension. The next round of intervention includes the delivery of 200 blood pressure cuffs to three providers with a large volume of members with high blood pressure as part of a pilot program. Other efforts to address hypertension include Case Management, Pharmacy, and soon, health promoters in Community Resource Centers. • L.A. Care plans to launch a targeted text messaging campaign to address disparities among Black/African American pregnant individuals seeking prenatal care by providing education about the importance of timely prenatal care and a connection to L.A. Care for assistance with appointment scheduling. • The Community Health Investment Fund (CHIF) launched its Close the Health Disparities Gap priority with a new initiative, Generating African American Infant and Nurturers Survival Initiative I (GAAINS I). Projects will reduce structural barriers that impede medical treatment and social supports, and produce positive outcomes at the individual, community/clinic, and/or systems level. Grantees will be announced by mid-June. • L.A. Care continues to work to address disparities in COVID-19 vaccination rates. The state's program officially concluded at the end of February.
Implement initiatives to promote diversity among providers, vendors, and purchased services.	L.A. Care engaged the LA Chamber of Commerce in a plan to sponsor tuition for up to 10 Small Business Training slots which will start in June/July 2023. The purpose of the training is to train and coach small businesses on how to prepare for RFPs, build proposals, and sustain performance in order to win more business as well as keep current business. We are currently developing a process and criteria for selecting 10 small businesses from a pool of small

Ensure that the services we provide to members promote equity and are free of implicit and explicit bias.	
Tactics	**Update**
	business vendors collected from the L.A. Care website and L.A. Care active vendor database by May/June 2023.
Offer providers Diversity, Equity, and Inclusion resources to promote bias-free care.	The L.A. Care Provider & Vendor Equity Council continues work on initiatives aimed at increasing provider access to Diversity, Equity, and Inclusion resources.

Health Leader

Serve as a national leader in promoting equitable healthcare to our members and the community and act as a catalyst for community change.

Drive improvements to the Affordable Care Act by serving as a model of a successful public option.	
Tactics	**Update**
Play a leading role in advocating for a public option at the state and national levels.	As the largest public plan in the country, L.A. Care continues to advocate for policies that would benefit Medi-Cal and the safety net. This quarter's advocacy emphasized the need to increase Medi-Cal reimbursement and the inherent inequity of lower reimbursement rates for services to low income populations.
Provide expertise and assistance to other public plans interested in participating in state exchanges.	L.A. Care continues to provide high level guidance to another plan considering joining the state exchange.

Optimize members' use of Community Resource Centers and expand our member and community offerings.	
Tactics	**Update**
Increase the number of Community Resource Centers to 14, in partnership with Blue Shield of California Promise Health Plan, and increase number of annual visits to 50,000 across all centers by Q4 2022 and 60,000 by Q4 2023.	Inglewood CRC reopened in its new location and the new El Monte and Norwalk CRCs opened to the public. Construction continues on the Long Beach CRC and lease negotiations continue for sites in South L.A., Lincoln Heights, and Panorama City.
Partner with community-based organizations to offer a range of services onsite.	Partnership formation continued to be delayed due to reduced CRC operations. With the planned resumption of in-person classes in Q3, onsite partners will be invited to the CRCs at that time.

Drive change to advance health and social services for our members and the community.	
Tactics	**Update**
Identify and prioritize actions, interventions, and programs to promote equity and social justice.	The Equity Council Steering Committee continues to meet on a bi-weekly basis to discuss and strategize around equity for members, staff, providers, and vendors. L.A. Care hosted a series of live and pre-recorded events in February for Black History Month. Events included "Revolutionizing Access to Care in the Black Community" and "Housing and Homelessness in the Black Community: Looking at the Numbers." Cultural Humility and Anti-Racism trainings are planned for Senior Directors and above in Q3.
Support regional Health Information Exchanges (HIE).	L.A. Care is committed to strengthening the regional Health Information Exchanges (HIE) by directly engaging with them on strategic and regulatory requirements. This is accomplished by delivering a network priority list specific to each HIE that would help them achieve the maximum market penetration and improve community access to member data. The regional HIE networks are making steady progress in onboarding new clinical partners. L.A Care's Leadership and the HIE Steering Committee are closely collaborating with the HIEs to address participant onboarding and are taking additional measures to strengthen the contract language for the hospitals around HIE participation. In addition, L.A Care has revised the Health Information Ecosystem (HIEc) Strategy to build a sustainable HIE infrastructure and laid out

Drive change to advance health and social services for our members and the community.	
Tactics	**Update**
	recommendations to further improve the regional HIE networks. L.A. Care is in the process of establishing a digital exchange with the HIEs using the latest Fast Healthcare Interoperability Resources (FHIR) format, in compliance with federal and state regulatory requirements. L.A. Care maintains close communication with the exchanges through bi-weekly operations meetings and we use this regular cadence to: • optimize the workflows to support clinical pharmacy initiatives, case management, utilization management, HEDIS measures, and behavioral health; and • develop and coordinate community based care workflows with the clinical partners such as Federally Qualified Health Centers, Independent Practice Associations, and Managed Services Organizations, to benefit at-risk populations and improve patient outcomes.
Create a deliberate and tailored strategy to address homelessness among our members.	As of end of March, Homeless and Housing Support Services (HHSS) had over 8,000 members enrolled. L.A. Care has been focused on improving HHSS program operations by working with IT and UpHealth teams to develop reporting specifications for HHSS operations, including DHCS regulatory reporting due May 2022. We continue to engage and meet with HHSS providers to offer assistance on various items such as referral processes to ensure program compliance and improvement.

Legislative Matrix

Last Updated: April 15, 2022

Legislative Matrix as of 4/15/2022

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 (136)

Bill Number	Status	Position
AB 4	In Senate	Support

Title
Medi-Cal: eligibility.

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

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

Organizational Notes

Last edited by Joanne Campbell at Apr 15, 2022, 8:24 PM
Support: L.A. Care, Local Health Plans of CA, California Medical Association, California Association of Health Plans

Bill Number	Status	Position
AB 32	In Senate	Monitor

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)

Bill Number	Status	Position
AB 97	**In Senate**	**Monitor**

Title
Health care coverage: insulin affordability.

Description
AB 97, as amended, Nazarian. Health care coverage: insulin affordability. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or disability insurance policy issued, amended, delivered, or renewed on or after January 1, 2000, that covers prescription benefits to include coverage for insulin, if it is determined to be medically necessary.This bill would prohibit a health care service plan contract or a health disability insurance policy, as specified, issued, amended, delivered, or renewed on or after January 1, 2022, from imposing a deductible on an insulin prescription drug, 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 15, 2022, 5:06 PM
Oppose: CA. Assoc. of Health Plans

Bill Number	Status	Position
AB 114	**In Senate**	**Monitor**

Title
Medi-Cal benefits: rapid Whole Genome Sequencing.

Description
AB 114, as amended, Maienschein. Medi-Cal benefits: rapid Whole Genome Sequencing. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services pursuant to a schedule of benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. The Budget Act of 2018 appropriates $2,000,000 for the Whole Genome Sequencing Pilot Project, and requires the department to provide a grant to a state nonprofit organization for the execution of a one-time pilot project to investigate the potential clinical and programmatic value of utilizing clinical Whole Genome Sequencing in the Medi-Cal program.This bill would expand the Medi-Cal schedule of benefits to include rapid Whole Genome Sequencing, as specified, for any Medi-Cal beneficiary who is one year of age or younger and is receiving inpatient hospital services in an intensive care unit. The bill would authorize the department to implement this provision by various means without taking regulatory action.

Primary Sponsors
Brian Maienschein

Bill Number	Status	Position
AB 240	In Senate	Monitor

Title
Local health department workforce assessment.

Description
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

Bill Number	Status	Position
AB 383	In Senate	Monitor

Title
Behavioral health: older adults.

Description
AB 383, as amended, Salas. 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

Bill Number	Status	Position
AB 470	In Senate	Support

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 Cherie Compartore at Apr 15, 2022, 5:07 PM
Support - L.A. Care, Local Health Plans of California

Bill Number	Status	Position
AB 493	In Senate	Monitor

Title
Health insurance.

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

Primary Sponsors
Jim Wood

Bill Number	Status	Position
AB 510	In Assembly	Monitor

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

Bill Number	Status	Position
AB 540	**In Senate**	**Monitor**

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

Bill Number	Status	Position
AB 552	In Senate	Monitor

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

Bill Number	Status	Position
AB 586	In Senate	Monitor

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

Bill Number	Status	Position
AB 685	In Assembly	Monitor

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

Bill Number	Status	Position
AB 752	In Assembly	Monitor

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 Cherie Compartore at Apr 15, 2022, 5:08 PM
Support: California Chronic Care Coalition (Sponsor) Oppose: CA. Assoc. of Health Plans

Bill Number	Status	Position
AB 852	In Senate	Monitor

Title
Nurse practitioners: scope of practice: practice without standardized procedures.

Description
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

Bill Number	Status	Position
AB 882	In Assembly	Monitor

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 Apr 15, 2022, 5:09 PM
Oppose Unless Amended: Local Health Plans of California

Bill Number	Status	Position
AB 1051	**In Senate**	**Monitor**

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

Bill Number	Status	Position
AB 1102	In Senate	Monitor

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 Department of Consumer Affairs.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

Bill Number	Status	Position
AB 1107	In Assembly	Monitor

Title
Emergency ground medical transportation.

Description
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

Bill Number	Status	Position
AB 1130	**In Senate**	**Monitor**

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

Organizational Notes

Last edited by Joanne Campbell at Apr 14, 2022, 3:49 PM
Support: Western Center on Law and Poverty

Bill Number	Status	Position
AB 1131	**In Assembly**	**Monitor**

Title
Health information network.

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

Primary Sponsors
Jim Wood

Organizational Notes

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

Bill Number	Status	Position
AB 1132	In Senate	Monitor

Title
Medi-Cal.

Description
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

Bill Number	Status	Position
AB 1162	In Assembly	Monitor

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 ... (click bill link to see more).

Primary Sponsors
Carlos Villapudua

Organizational Notes

Last edited by Joanne Campbell at Apr 15, 2022, 8:28 PM
Oppose: California Association of Health Plans

Bill Number	Status	Position
AB 1178	In Assembly	Monitor

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

Bill Number	Status	Position
AB 1355	In Senate	Monitor

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

Organizational Notes

Last edited by Joanne Campbell at Apr 14, 2022, 3:45 PM
Support: Western Center on Law and Poverty (Sponsor)

Bill Number	Status	Position
AB 1668	In Assembly	Monitor

Title
Mental Health Services Oversight and Accountability Commission.

Description
AB 1668, as amended, 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 urge the Governor, in making appointments, to consider ensuring geographic representation among the 10 regions of California defined by the 2020 census.

Primary Sponsors
Jim Patterson

Bill Number	Status	Position
AB 1823	In Assembly	Monitor

Title
Student health insurance.

Description
AB 1823, as amended, Bryan. Student health insurance. Existing law provides for the regulation of disability insurers by the Department of Insurance. Under existing law, disability insurance includes health insurance and blanket disability insurance that covers hospital, medical, or surgical benefits. Existing law requires, among other things, a health insurer to offer, market, and sell all of its health benefit plans to all individuals and dependents in each service area in which the insurer provides health care services, and requires all individual health benefit plans to be renewable, as specified. Existing law also requires a health insurer to establish specified enrollment periods and to provide specified levels of insurance coverage. Under existing law, a health insurer is required to consider the claims experience of all insureds and enrollees as a single risk pool for rating purposes in the individual market.This bill, for policy years beginning on or after January 1, 2023, would require student health insurance coverage, as defined, to be considered individual health insurance coverage. The bill would define student health insurance coverage as a blanket disability policy provided to students enrolled in an institution of higher education and to their dependents, that covers hospital, medical, or surgical benefits. The bill would exempt student health insurance coverage from certain requirements otherwise applicable to health insurers and health benefit plans, including the establishment of enrollment periods, guaranteed availability and renewability, specified coverage level requirements, and single risk pool rating requirements.

Primary Sponsors
Isaac Bryan

Bill Number	Status	Position
AB 1859	In Assembly	Monitor

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

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:10 PM
Oppose: CA. Assoc. of Health Plans

Bill Number	Status	Position
AB 1878	In Assembly	Monitor

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

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:11 PM
Support if Amended: CA. Assoc. of Health Plans

Bill Number	Status	Position
AB 1880	**In Assembly**	**Monitor**

Title
Prior authorization and step therapy.

Description
AB 1880, as amended, 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.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 a denial of an exception request is reviewed by a clinical peer of the health care provider or prescribing provider, 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 exception requests for coverage of a nonformulary drug, step therapy exception requests, and prior authorization requests received by the plan or insurer, and, upon request, to provide the information in a deidentified format to the department or commissioner, as appropriate... (click bill link to see more).

Primary Sponsors
Joaquin Arambula

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:12 PM
Support: Arthritis Foundation (Co-Sponsor), the California Rheumatology Alliance (Co-Sponsor), and the Crohn's and Colitis Foundation(Co-Sponsor) Oppose: CA. Assoc. of Health Plans

Bill Number
AB 1892

Status
In Assembly

Position
Monitor

Title
Medi-Cal: orthotic and prosthetic appliances.

Description
AB 1892, as amended, Flora. Medi-Cal: orthotic and prosthetic appliances. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires the department to establish a list of covered services and maximum allowable reimbursement rates for prosthetic and orthotic appliances and requires that the list be published 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 for the same or similar services.This bill would instead require reimbursement for these appliances to be set at least at 80% of the lowest maximum allowance for California established by the federal Medicare Program, and would require that reimbursement to be adjusted annually, as specified.

Primary Sponsors
Heath Flora

Bill Number
AB 1900

Status
In Assembly

Position
Support

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

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:13 PM
Support: L.A. Care, Local Health Plans of California , Bet Tzedek (co-sponsor), California Advocates for Nursing Home Reform (co-sponsor), Disability Rights California (co-sponsor), Justice in Aging (co-sponsor), Senior and Disability Action SF (co-sponsor), Western Center on Law & Poverty (co-sponsor), AARP, Alameda County Homeless Action Center, Asian Law Alliance, Bay Area Legal Aid, California Association of Health Facilities, California Council of The Blind, California Dental Association, California Health Advocates, California Pan-Ethnic Health Network, California Physicians Alliance, California PACE Association, Coalition of California Welfare Rights Organizations, County Behavioral Health Directors Association, Desert AIDS Project, Friends Committee on Legislation of California, Health Access California, Legal Aid Society of San Mateo County, Marin Center for Independent Living, Maternal and Child Health Access, Meals on Wheels Orange County, National Association of Social Workers, California Chapter, National Health Law Program, National Multiple Sclerosis Society, Public Law Center, Senior Advocates of The Desert Senior Services Coalition of Alameda County, Urban Counties of California, AARP, Bay Area Legal Aid, California Council of The Blind, California Physicians Alliance, California PACE Association, Coalition of California Welfare Rights Organizations, County Behavioral Health Directors Association, Friends Committee on Legislation of California, Health Access California, Justice in Aging, Marin Center for Independent Living, Maternal and Child Health Access, Meals on Wheels Orange County, National Multiple Sclerosis Society, Public Law Center, Senior Advocates of The Desert

Bill Number	Status	Position
AB 1917	**In Assembly**	**Monitor**

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

Bill Number	Status	Position
AB 1929	In Assembly	Monitor

Title
Medi-Cal: violence preventive services.

Description
AB 1929, as amended, 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 a community violence prevention and recovery program, under which violence preventive services would be provided by qualified violence prevention professionals, as defined, as a covered benefit under the Medi-Cal program, in order to reduce the incidence of violent injury or reinjury, trauma, and related harms, and promote trauma recovery, stabilization, and improved health outcomes. Under the bill, the services would be available to a Medi-Cal beneficiary who (1) has been violently injured as a result of community violence, as defined, (2) for whom a licensed health care provider has determined that the beneficiary is at significant risk of experiencing violent injury as a result of community violence, or (3) has experienced chronic exposure to community violence. The bill would authorize the department to meet these requirements by ensuring that qualified violence prevention professionals are designated as community health workers.The bill would set forth training and certification and continuing education requirements for those professionals, as specified, and would require the department to approve one or more training and certification programs with certain curriculum components. The bill would require an entity that employs or contracts with a qualified violence prevention professional to take specified actions to ensure the professional's compliance with these requirements.The bill would require the department to post on its internet website the date upon which violence preventive services could be provided and billed. The bill would condition implementation of its provisions on receipt of any necessary federal approvals and the availability of federal financial participation.

Primary Sponsors
Jesse Gabriel, Mike Gipson

Bill Number	Status	Position
AB 1930	In Assembly	Monitor

Title
Medi-Cal: comprehensive perinatal services.

Description
AB 1930, as amended, 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 require the department to seek any necessary federal approvals to 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. The bill would also require the department to seek any necessary federal approvals to allow a nonlicensed perinatal health worker rendering those preventive services to be supervised by (1) an enrolled Medi-Cal provider that is a clinic, hospital, community-based organization (CBO), or licensed practitioner, or (2) a CBO that is not an enrolled Medi-Cal provider, so long as an enrolled Medi-Cal provider is available for Medi-Cal billing purposes.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

Organizational Notes

Last edited by Joanne Campbell at Apr 14, 2022, 3:50 PM
Support: Western Center on Law and Poverty

Bill Number	Status	Position
AB 1937	In Assembly	Monitor

Title
Medi-Cal: out-of-pocket pregnancy costs.

Description
AB 1937, as amended, 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 July 1, 2023, 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 specified, in an amount not to exceed $1,250. 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. The bill would require the department to contract out for purposes of implementing the health expense account program, as specified. The bill would authorize the department to implement the above-described provisions through all-county or plan letters, or similar instructions, and would require regulatory action no later than January 1, 2026.

Primary Sponsors
Jim Patterson

Bill Number	Status	Position
AB 1944	In Assembly	Monitor

Title
Local government: open and public meetings.

Description
AB 1944, as introduced, Lee. Local government: open and public meetings. Existing law, the Ralph M. Brown Act, requires, with specified exceptions, that all meetings of a legislative body of a local agency, as those terms are defined, be open and public and that all persons be permitted to attend and participate. 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 specify that if a member of a legislative body elects to teleconference from a location that is not public, the address does not need to be identified in the notice and agenda or be accessible to the public when the legislative body has elected to allow members to participate via teleconferencing.This bill would require all open and public meetings of a legislative body that elects to use teleconferencing to provide a video stream accessible to members of the public and an option for members of the public to address the body remotely during the public comment period through an audio-visual or call-in option.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 amends or enacts laws relating to public records or open meetings and contains findings demonstrating t... (click bill link to see more).

Primary Sponsors
Alex Lee, Cristina Garcia

Bill Number
AB 1982

Status
In Assembly

Position
Monitor

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

Bill Number
AB 1995

Status
In Assembly

Position
Support

Title
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 creates the County Health Initiative Matching Fund in the State Treasury, administered by the department for the purpose of providing matching state funds and local funds received by the fund through intergovernmental transfers to a county agency, a local initiative, or a county organized health system in order to provide health insurance coverage to certain children and adults in low-income households who do not qualify for health care benefits through the Healthy Families Program or Medi-Cal.This bill would prohibit the department from imposing subscriber contributions for that program, to the extent allowable by federal law, as specified.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 prohibit the department from imposing copayments on recipients of specified services, to the extent allowable by federal law.

Primary Sponsors
Joaquin Arambula

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:14 PM
Support: L.A. Care, Local Health Plans of California, Western Center on Law and Poverty (Sponsor), Children Now (co-sponsor), American Academy of Pediatrics, California, American College of Obstetricians and Gynecologists District IX, Bay Area Legal Aid, California Coverage & Health Initiatives, California Dental Association, California Pan-Ethnic Health Network, California School-Based Health Alliance, California Advocates for Nursing Home Reform, Central California Asthma Collaborative, Children Now, Children's Specialty Care Coalition, Community Health Councils, County Behavioral Health Directors Association, County Health Executives Association of California, Desert AIDS Project, Disability Rights Education and Defense Fund, Friends Committee on Legislation of California, Grace Institute - End Child Poverty in California, Health Access California, Justice in Aging, Latino Coalition for a Healthy California, Legal Aid Society of San Mateo County, National Association of Social Workers, California Chapter, National Health Law Program, Nurse-Family Partnership, Shields for Families, The Los Angeles Trust for Children's Health, The Primary School, Youth Leadership Institute

Bill Number	Status	Position
AB 1999	In Assembly	Monitor

Title
Medi-Cal: behavioral health: individuals with vision loss.

Description
AB 1999, as amended, Arambula. Medi-Cal: behavioral health: individuals with vision loss. 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 behavioral health services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.This bill would require the department to establish a pilot project to provide behavioral health services to Medi-Cal beneficiaries who are blind or have low vision, as a covered benefit under the Medi-Cal program. The bill would require that the pilot project be implemented in at least 6 counties that have agreed to participate, with at least one of those counties being in northern California, one in central California, and one in southern California, as specified. The bill would require the participating counties to conduct outreach, as specified, and report certain information to the department and the Legislature no later than December 31, 2025. The bill would make related legislative findings.The bill would condition implementation of the pilot project on an appropriation by the Legislature, receipt of any necessary federal approvals, and the availability of federal financial participation.

Primary Sponsors
Joaquin Arambula

Bill Number	Status	Position
AB 2007	In Assembly	Monitor

Title
Health care language assistance services.

Description
AB 2007, as introduced, Valladares. Health care language assistance 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 requires the Department of Managed Health Care to adopt regulations establishing standards and requirements for health care service plans to provide enrollees with appropriate access to language assistance in obtaining health care services. Existing law requires the department to report biennially to, among others, the Legislature, regarding plan compliance with the standards.This bill would instead require the department to provide that report 3 times a year.

Primary Sponsors
Suzette Valladares

Bill Number	Status	Position
AB 2024	In Assembly	Monitor

Title
Health care coverage: diagnostic imaging.

Description
AB 2024, as amended, Friedman. 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 or health insurance policy issued, amended, or renewed on or after January 1, 2023, to provide coverage for screening mammography, medically necessary diagnostic or supplemental breast examinations, or testing for screening or diagnostic purposes upon referral by specified professionals. The bill would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2023, from imposing cost sharing for screening mammography, medically necessary or supplemental breast examinations, or testing.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

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:14 PM
Oppose: CA. Assoc. of Health Plans

Bill Number	Status	Position
AB 2029	In Assembly	Monitor

Title
Health care coverage: treatment for infertility.

Description
AB 2029, as amended, 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 health care service plans and health insurers 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 or health insurer from placing different conditions or coverage limitations on fertility medications or services, or the diagnosis and treatment of infertility and fertility services, than would apply to other conditions, as specified. Because the violation of these provisions by a health care service plan would be a crime, the bill would impose a stat... (click bill link to see more).

Primary Sponsors
Buffy Wicks

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:15 PM
Oppose: CA. Assoc. of Health Plans

Bill Number	Status	Position
AB 2077	In Assembly	Support

Title
Medi-Cal: monthly maintenance amount: personal and incidental needs.

Description
AB 2077, as amended, Calderon. Medi-Cal: monthly maintenance amount: personal and incidental needs. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions. Qualified individuals under the Medi-Cal program include medically needy persons and medically needy family persons who meet the required eligibility criteria, including applicable income requirements.Existing law requires the department to establish income levels for maintenance need at the lowest levels that reasonably permit a medically needy person to meet their basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under applicable federal law. In calculating the income of a medically needy person in a medical institution or nursing facility, or a person receiving institutional or noninstitutional services from a Program of All-Inclusive Care for the Elderly organization, the required monthly maintenance amount includes an amount providing for personal and incidental needs in the amount of not less than $35 per month while a patient. Existing law authorizes the department to increase, by regulation, this amount as necessitated by increasing costs of personal and incidental needs.This bill would increase the monthly maintenance amount for personal and incidental needs from $35 to $80.

Primary Sponsors
Lisa Calderon

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:15 PM
Support: L.A. Care, Local Health Plans of California, California Senior Legislature (sponsor), Support California Senior Legislature (sponsor), Alzheimer's Association State Policy Office, California Long-term Care Ombudsman Association, California Advocates for Nursing Home Reform, California Hospital Association, California PACE Association, Justice in Aging

Bill Number	Status	Position
AB 2080	In Assembly	Monitor

Title
Health Care Consolidation and Contracting Fairness Act of 2022.

Description
AB 2080, as amended, 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.Ex... (click bill link to see more).

Primary Sponsors
Jim Wood

Organizational Notes

Last edited by Cherie Compartore at Apr 11, 2022, 6:18 PM
California Assoc. of Health Plans - Oppose Unless Amended

Bill Number	Status	Position
AB 2091	In Assembly	Monitor

Title
Disclosure of information: reproductive health and foreign penal civil actions.

Description
AB 2091, as amended, Mia Bonta. Disclosure of information: reproductive health and foreign penal civil actions. (1) Existing law provides that every individual possesses a fundamental right of privacy with respect to their personal reproductive decisions. Existing law prohibits the state from denying or interfering with a person's right to choose or obtain an abortion prior to viability of the fetus, or when the abortion is necessary to protect the life or health of the person. Existing law requires a health insurer to take specified steps to protect the confidentiality of an insured's medical information, and prohibits an insurer from disclosing medical information related to sensitive health care services to the policyholder or any insureds other than the protected individual receiving care. Existing law generally prohibits a provider of health care, a health care service plan, or a contractor from disclosing medical information regarding a patient, enrollee, or subscriber without first obtaining an authorization, unless a specified exception applies, including that the disclosure is in response to a subpoena. Existing law authorizes a California court or attorney to issue a subpoena if a foreign subpoena has been sought in this state.This bill would prohibit compelling a person to identify or provide information that would identify an individual who has sought or obtained an abortion in a state, county, city, or other local criminal, administrative, legislative, or other proceeding if the information is being requested based on another state's laws that interfere with a person's right to choose or obtain an abortion or a foreign penal civil action, as defined. The bill would authorize the Insurance Commissioner to assess a civil penalty, as specified, against an insurer that has disclosed an insured's confidential medical information. The bill would prohibit a provider of health care, a health care service plan, or a contractor from releasing medical information related to an individual seeking or obtaining an abortion in response to a subpoena or a request if that subpoena or request is based on either another state's laws that interfere with a person's rights to choose or obtain an abortion or a foreign penal civil action. The bill would prohibit issuance of a subpoena if the submitted foreign subpoena relates to a foreign penal civil action.(2) Existing law sets forth the health care access rights of an incarcerated pregnant person and an incarcerated person who is identified as possibly pregnant or capable of becoming pregnant. Existing law prohibits the imposition of conditions or restrictions on an incarcerated person's ability to obtain an abortion.This bill would prohibit prison staff from disclosi... (click bill link to see more).

Primary Sponsors
Mia Bonta

Bill Number	Status	Position
AB 2092	In Assembly	Monitor

Title
Acute hospital care at home.

Description
AB 2092, as amended, Akilah Weber. Acute hospital care at home. Existing law provides for the licensure and regulation of various types of health facilities, including general acute care hospitals, by the State Department of Public Health. Existing law generally makes a violation of these provisions a misdemeanor.The federal Centers for Medicare and Medicaid Services (CMS) provides for a waiver program authorizing a hospital to establish an Acute Hospital Care at Home (AHCaH) program, as specified, if the hospital meets certain conditions, including receiving approval from CMS after submitting a waiver request.This bill would authorize a general acute care hospital to provide AHCaH services if the hospital (1) meets the requirements established by CMS for AHCaH services, as specified, (2) has received approval from CMS to operate an AHCaH program, and (3) has notified the department of the establishment of an AHCaH program, including certain information about the program. The bill would define AHCaH services as services provided by a general acute care hospital to qualified patients in their homes by using methods that include telehealth, remote monitoring, and regular in-person visits by nurses and other medical staff.Under the bill, patients cared for in a general acute care hospital's AHCaH program would be considered inpatients of the hospital, with hospital services being subject to oversight by the department. Under the bill, a violation of its provisions would not constitute the above-described misdemeanor.

Primary Sponsors
Akilah Weber

Bill Number	Status	Position
AB 2117	In Assembly	Monitor

Title
Mobile stroke units: health care coverage.

Description
AB 2117, as introduced, Gipson. Mobile stroke units: health care coverage. Existing law provides for the licensure and regulation of health facilities by the State Department of Public Health, and defines various types of health facilities for those purposes.This bill would define “mobile stroke unit” to mean a multijurisdictional mobile facility that serves as an emergency response critical care ambulance under the direction and approval of a local emergency medical services (EMS) agency, and as a diagnostic, evaluation, and treatment unit, providing radiographic imaging, laboratory testing, and medical treatment under the supervision of a physician in person or by telehealth, for patients with symptoms of a stroke, to the extent consistent with any federal definition of a mobile stroke unit, as specified.Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of that act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. 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 imposes certain requirements relating to coverage for emergency and ambulance services on health care service plan contracts, health insurance policies, and the Medi-Cal program.This bill would require a health care service plan contract or a health insurance policy that is issued, amended, or renewed on or after January 1, 2023, and that provides coverage for emergency health care services to include coverage for services performed by a mobile stroke unit, as defined above. Because a willful violation of this requirement by a health care service plan would be a crime, the bill would impose a state-mandated local program.The bill would also require Medi-Cal coverage for services performed by a mobile stroke unit, subject to receipt of any necessary federal approvals and the availability of federal financial participation.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Mike Gipson

Bill Number	Status	Position
AB 2123	In Assembly	Monitor

Title
Bringing Health Care into Communities Act of 2023.

Description
AB 2123, as amended, Villapudua. Bringing Health Care into Communities Act of 2023. Existing law establishes various programs, including the Family Homelessness Challenge Grants and Technical Assistance Program, with the goal of providing housing. Existing law charges various agencies with the administration of these programs, including the Department of Housing and Community Development and the California Housing Finance Agency. Existing law also 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 and the California Registered Nurse Education Program.This bill, the Bringing Health Care into Communities Act of 2023, would establish the Bringing Health Care into Communities Program to be administered by the agency to provide housing grants to specified health professionals to be used for mortgage payments for a permanent residence in a health professional shortage area, as specified. Under the bill, a health professional would be eligible for a grant for up to 5 years. The bill would make its provisions operative upon appropriation by the Legislature.

Primary Sponsors
Carlos Villapudua

Bill Number	Status	Position
AB 2127	In Assembly	Monitor

Title
Health care coverage: dependent adults.

Description
AB 2127, as amended, Santiago. Health care coverage: dependent adults. Existing law establishes the Health Insurance Counseling and Advocacy Program (HICAP) in the California Department of Aging to provide Medicare beneficiaries and those imminently eligible for Medicare with counseling and advocacy regarding health care coverage options. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires an individual health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2023, that provides dependent coverage to make dependent coverage available to a qualified dependent parent or stepparent. Existing law requires a plan, an insurer, or the California Health Benefit Exchange to provide an applicant seeking to add a dependent parent or stepparent with written notice about HICAP at the time of solicitation and on the application.This bill would clarify that a health care service plan, a health insurer, or a solicitor is required to provide an individual with the name, address, and telephone number of the local HICAP program and the statewide HICAP telephone number at the time of solicitation and, for a plan or insurer, on the application. Because a violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. The bill would state the intent of the Legislature to ensure an individual is informed of and understands their specific rights and health care options before enrolling a Medicare-eligible or enrolled dependent parent or stepparent in individual health care coverage.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

Bill Number	Status	Position
AB 2132	In Assembly	Monitor

Title
California Medical School Tuition for Medical Service Pilot Program.

Description
AB 2132, as amended, Villapudua. California Medical School Tuition for Medical Service Pilot Program. Existing law establishes the Student Aid Commission as the primary state agency for the administration of state-authorized student financial aid programs available to students attending all segments of postsecondary education. Existing law expresses the intent of the Legislature to review, during the annual budget process, the distribution of University of California medical school graduates with regard to placement in areas, and service to populations, underserved by the medical profession, as specified.This bill would establish the California Medical School Tuition for Medical Service Pilot Program under the administration of the Student Aid Commission. The bill would provide financial aid to certain students to support their undergraduate, medical school, and graduate medical educations. The bill would require these students to commit to practicing for a specified period of time in primary care or a high-needs specialty in California in medically underserved populations and areas. The bill would require the commission to begin implementing the pilot program during the 2023–24 academic year, including by developing program eligibility, outreach, and monitoring criteria. The bill would, among other things, require the commission to develop eligibility criteria, including by prioritizing students who are underrepresented in medicine based on race, ethnicity, and language.The bill would establish the Medical School Tuition for Medical Service Pilot Program Scholarship Fund in the State Treasury. The bill would authorize the commission to enter into certain contracts related to the pilot program with nonprofit entities headquartered in California, as specified. The bill would, regarding certain aspects of the pilot program, prohibit an exercise of discretion by the commission and its contractors from being subject to judicial review, except as specified. The bill would make its provisions operative only upon the appropriation of funds for purposes of the pilot program by the Legislature in the annual Budget Act or in another statute.

Primary Sponsors
Carlos Villapudua

Bill Number	Status	Position
AB 2134	In Assembly	Monitor

Title
Reproductive health care.

Description
AB 2134, as amended, Akilah Weber. Reproductive health care. 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 establishes the Department of Health Care Access and Information to oversee and administer various health programs. Existing law establishes the Medi-Cal program, under which qualified low-income individuals receive health care services. Existing law establishes a schedule of benefits under the Medi-Cal program and provides for various services, including comprehensive clinical family planning services that are rendered through the Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program.This bill would establish the California Reproductive Health Equity Program within the Department of Health Care Access and Information to ensure abortion and contraception services are affordable for and accessible to all patients and to provide financial support for safety net providers of these services. The bill would authorize a Medi-Cal enrolled provider to apply to the department for a grant, and a continuation award after the initial grant, to provide abortion and contraception at no cost to an individual with a household income at or below 400% of the federal poverty level who is uninsured or has health care coverage that does not include both abortion and contraception, and who is not eligible to receive both abortion and contraception at no cost through the Medi-Cal and Family PACT programs. The bill would establish the California Reproductive Health Equity Fund, a continuously appropriated fund, to provide this grant funding. The bill would require the department to conduct an annual evaluation of the program and report its findings to the Legislature.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 group health care service plan contracts and disability insurance policies to cover contraceptive services and methods without cost sharing, as specified. Existing law authorizes a religious employer to request a contract or policy that does not include contraception coverage for its employees. Existing law requires public and private employers to p... (click bill link to see more).

Primary Sponsors
Akilah Weber, Cristina Garcia, Anna Caballero

Bill Number	Status	Position
AB 2144	In Assembly	Monitor

Title
Mental health: information sharing.

Description
AB 2144, as introduced, Ramos. Mental health: information sharing. Existing law, the Children's Civil Commitment and Mental Health Treatment Act of 1988, authorizes a minor, if they are a danger to self or others, or they are gravely disabled, as a result of a mental health disorder, and authorization for voluntary treatment is not available, upon probable cause, to be taken into custody and placed in a facility designated by the county and approved by the State Department of Health Care Services as a facility for 72-hour treatment and evaluation of minors.Existing law, the Lanterman-Petris-Short Act, also authorizes the involuntary commitment and treatment of persons with specified mental health disorders. Under the act, if a person, as a result of a mental health disorder, is a danger to self or others, or is gravely disabled, the person may, upon probable cause, be taken into custody and placed in a facility designated by the county and approved by the State Department of Health Care Services for up to 72 hours for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment.Existing law prohibits a person detained pursuant to the Lanterman-Petris-Short Act because the person is a danger to self or others, from owning, possessing, controlling, receiving, or purchasing, or attempting to own, possess, control, receive, or purchase, any firearm. In order for the Department of Justice to determine the eligibility of the person to own, possess, control, receive, or purchase a firearm, existing law requires each designated facility, within 24 hours of admitting an individual subject to that prohibition, to submit a report to the Department of Justice that contains specified information, including the identity of the person.This bill would require the Department of Justice to provide to the State Department of Health Care Services, in a secure format, a copy of reports submitted pursuant to those provisions.The bill would also require a designated facility to submit a quarterly report to the State Department of Health Care Services that identifies people admitted to the facility pursuant to the Lanterman-Petris-Short Act because the person is gravely disabled and minors admitted pursuant to the Children's Civil Commitment and Mental Health Treatment Act of 1988 who are younger than 13 years of age. The bill would require the designated facility to include in the report the same information required to be reported to the Department of Justice for individuals who are subject to the above-described firearms restrictions.The bill would require the State Department of Health Care Services to annually submit a publicly accessible report to the Legislature of deidentified and aggregated data received p... (click bill link to see more).

Primary Sponsors
James Ramos

Bill Number	Status	Position
AB 2199	In Assembly	Monitor

Title
Birthing Justice for California Families Pilot Project.

Description
AB 2199, as amended, Wicks. Birthing Justice for California Families Pilot Project. 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. Existing law requires the department to convene a workgroup to examine the implementation of the Medi-Cal doula benefit, as specified. Existing law also requires the department, no later than July 1, 2024, to publish a report that addresses the number of Medi-Cal recipients utilizing doula services and identifies barriers that impede access to doula services, among other things. This bill would establish the Birthing Justice for California Families Pilot Project, which would include a 3-year grant program to provide grants to specified entities, including community-based doula groups, to provide full-spectrum doula care to members of communities with high rates of negative birth outcomes who are not eligible for Medi-Cal and incarcerated people. The bill would require the State Department of Public Health to take specified actions with regard to awarding grants, including awarding grants to selected entities on or before January 1, 2024. The bill would require a grant recipient to use grants funds to pay for the costs associated with providing full-spectrum doula care to eligible individuals and establishing, managing, or expanding doula services. The bill would require a grant recipient, in setting the payment rate for a doula being paid with grant funds, to comply with specified parameters, including that the payment rate not be less than the Medi-Cal reimbursement rate for doulas or the median rate paid for doula care in existing local pilot projects providing doula care in California, whichever is higher. The bill would require the department to utilize a portion of the funds allocated for administrative purposes to arrange for or provide, at no cost to the participants, training on the core competencies for doulas to people who want to become doulas, and community-based doulas in need of additional training to maintain competence, and who are from communities experiencing the highest burden of birth disparities in the state. The bill would require the department, on or before January 1, 2027, to submit a report to the appropriate policy and fiscal committees of the Legislature on the expenditure of funds and relevant outcome data for the pilot project. The bill would repeal these provisions on January 1, 2028.

Primary Sponsors
Buffy Wicks

Bill Number	Status	Position
AB 2205	In Assembly	Monitor

Title
California Health Benefit Exchange: abortion services coverage reporting.

Description
AB 2205, as amended, Carrillo. California Health Benefit Exchange: abortion services coverage reporting. 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. If a qualified health plan covers abortion services, PPACA requires the plan to deposit the premium amounts that equal the actuarial value of the coverage of those services into a separate account, as specified.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.This bill would require, beginning July 1, 2023, a health care service plan or health insurer offering qualified health plans, as defined, to annually report the total amount of funds in the segregated account maintained pursuant to PPACA. The bill would require the annual report to include the ending balance of the account and the total dollar amount of claims paid during a reporting year. By expanding the scope of 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
Wendy Carrillo

Bill Number	Status	Position
AB 2291	In Assembly	Monitor

Title
Mental health services: involuntary treatment.

Description
AB 2291, as amended, Muratsuchi. Mental health services: involuntary treatment. Existing law, the Lanterman-Petris-Short Act, provides for the involuntary commitment and treatment of persons with specified mental disorders for the protection of the persons committed. Under the act, when a person, as a result of a mental health disorder, is a danger to others, or to themselves, or gravely disabled, the person may, upon probable cause, be taken into custody and placed in a facility designated by the county and approved by the State Department of Health Care Services for up to 72 hours for evaluation and treatment. If certain conditions are met after the 72-hour detention, the act authorizes the certification of the person for a 14-day maximum period of intensive treatment, and then a 30-day maximum period of intensive treatment after the 14-day period. Existing law requires the professional person in charge of the facility providing the 72-hour evaluation and treatment or the intensive treatment to notify the county behavioral health director when the person is released and certain conditions apply.This bill would, for each person admitted for evaluation and treatment, require the facility providing the 72-hour evaluation and treatment to keep with the person's medical record contact information for an individual designated by the patient as their medical emergency contact, and would require that facility to develop a continuity of care plan for the person, which the facility shall make available to certain individuals and facilities, as specified. The bill would require, before the release of a person from the 72-hour detention or the intensive treatment, the professional person in charge of the facility providing the treatment to provide the county behavioral health director with the medical emergency contact information, the continuity of care plan, and the possible release date of the person, and would require the county behavioral health director to contact the person's medical emergency contact and provide that individual with the person's continuity of care plan. The bill would also require a county to offer a person who is released from involuntary detention after receiving 72-hour evaluation and treatment or intensive treatment, and who is homeless, a local crisis bed or recuperative care upon their release from the designated facility providing the involuntary treatment. By imposing new duties on county officials, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that, if t... (click bill link to see more).

Primary Sponsors
Al Muratsuchi

Bill Number	Status	Position
AB 2300	In Assembly	Monitor

Title
CalWORKs and CalFresh: work requirements.

Description
AB 2300, as amended, Kalra. CalWORKs and CalFresh: work requirements. (1) Existing law provides for the California Work Opportunity and Responsibility to Kids (CalWORKs) program, under which each county provides cash assistance and other benefits to qualified low-income families and individuals. Existing law generally requires a recipient of CalWORKs benefits to participate in welfare-to-work activities as a condition of eligibility for aid. Existing law exempts certain persons from the welfare-to-work activities, including an individual whose presence in the home is required because of the illness or incapacity of another member of the household and whose caretaking responsibilities impair the recipient's ability to be regularly employed or to participate in welfare-to-work activities. Under this bill, a parent, including both a birthing and nonbirthing parent, would qualify for that exemption for 12 weeks following the birth of a child. Under the bill, an adoptive or foster parent would also qualify for the exemption for 12 weeks following the adoption or foster placement of each child.Existing law prohibits sanctions from being applied for a failure or refusal to comply with program requirements if, among other reasons, the employment, offer of employment, activity, or other training for employment discriminates on specified bases or involves conditions that are in violation of applicable health and safety standards, or the employment or offer of employment exceeds the daily or weekly hours of work customary to the occupation.This bill would additionally prohibit sanctions from being applied for a failure or refusal to comply with program requirements if the recipient provides documentation that the anticipated hours would be so unpredictable for that specific recipient that they would not allow the recipient to anticipate compliance with program requirements related to the job, or if the recipient provides documentation that the scheduled hours exhibit a pattern of unpredictability for that specific recipient so that the recipient cannot anticipate compliance with program requirements related to the job. The bill would also prohibit sanctions from being applied if the recipient states that the employment or offer of employment fails to comply with the Healthy Workplaces, Healthy Families Act of 2014, that the recipient experienced sexual harassment or other abusive conduct at the workplace, or that the recipient's rights under specified laws were violated. The bill would require the county human services agency, when an applicant or recipient reports refusing any offer of employment, reducing hours, voluntarily quitting any employment, or being discharged from any employment, to provide the applicant or recip... (click bill link to see more).

Primary Sponsors
Ash Kalra

Organizational Notes

Last edited by Joanne Campbell at Apr 14, 2022, 3:48 PM
Support: Western Center on Law and Poverty (Sponsor)

Bill Number	Status	Position
AB 2304	In Assembly	Monitor

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

Bill Number	Status	Position
AB 2317	In Assembly	Monitor

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

Bill Number	Status	Position
AB 2320	In Assembly	Monitor

Title
Reproductive health care pilot program.

Description
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.

Primary Sponsors
Cristina Garcia

Bill Number	Status	Position
AB 2326	In Assembly	Monitor

Title
Lead poisoning prevention: laboratory reporting.

Description
AB 2326, as introduced, Reyes. Lead poisoning prevention: laboratory reporting. Existing law, the Childhood Lead Poisoning Prevention Act of 1991, requires the State Department of Public Health to adopt regulations establishing a standard of care at least as stringent as the most recent federal Centers for Disease Control and Prevention (CDC) screening guidelines, whereby all children are evaluated for risk of lead poisoning by health care providers during each child's periodic health assessment. Existing law requires a laboratory that performs a blood lead analysis on a specimen of human blood drawn in California to report specified information to the State Department of Public Health for each analysis on every person tested and requires other specified information to be reported when the laboratory has that information. Existing law authorizes the department to fine a laboratory that knowingly fails to meet the reporting requirements.This bill would require the laboratory to report additional information, including the National Provider Identifier (NPI) of the health care provider that ordered the analysis, the Clinical Laboratory Improvement Amendments (CLIA) number and the NPI of the laboratory, and the person's race, ethnicity, and pregnancy status. The bill would require a laboratory to request all of the required information from the health care provider who obtained the blood sample or ordered the test, but would waive the laboratory's reporting requirement when the health care provider cannot, or will not, provide the requested information.Existing law requires the laboratory to report within 3

working days if the result of the blood lead analysis is a blood lead level equal to or greater than 10 micrograms of lead per deciliter of blood and within 30 working days if the blood lead level is lower that threshold.This bill would make the threshold for reporting within 3 working days the most recent CDC reference level for an elevated blood lead level.Existing law requires that all information reported be confidential, except that the department is authorized to share the information for the purpose of surveillance, case management, investigation, environmental assessment, environmental remediation, or abatement with the local health department, environmental health agency, or building department, and with the State Department of Health Care Services for the purpose of determining whether children enrolled in Medi-Cal are being screened for lead poisoning and receiving appropriate related services.This bill would authorize the department to share the information for purposes of care coordination as well. The bill would authorize the department to share the information with health care providers and with the person to... (click bill link to see more).

Primary Sponsors
Eloise Reyes

Organizational Notes

Last edited by Joanne Campbell at Apr 14, 2022, 3:50 PM
Support: Western Center on Law and Poverty

Bill Number	Status	Position
AB 2352	In Assembly	Monitor

Title
Prescription drug coverage.

Description
AB 2352, 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 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 prescribing 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 prescribing 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 Cherie Compartore at Apr 15, 2022, 5:16 PM
Oppose Unless Amended: CA. Assoc. of Health Plans

Bill Number	Status	Position
AB 2402	In Assembly	Support

Title
Medi-Cal: continuous eligibility.

Description
AB 2402, as amended, 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, until the child reaches 5 years of age. The bill would prohibit the redetermination of Medi-Cal eligibility before the child reaches 5 years of age, unless the department or county possesses facts indicating that the family has requested the child's voluntary disenrollment, the child is deceased, the child is no longer a state resident, or the child's original enrollment was based on a state or county error or on fraud, abuse, or perjury, as specified. The bill would condition implementation of these provisions on receipt of any necessary federal approvals and, except as specified, on the availability of federal financial participation.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 remove the requirement for providing income information at the end of the 12 months, and would instead require that the infant remain continuously eligible for the Medi-Cal program until they are 5 years of age, as specified, 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 subm... (click bill link to see more).

Primary Sponsors
Blanca Rubio

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:17 PM
Support: L.A. Care, Local Health Plans of California, Western Center on Law and Poverty, The Children's Partnership (cosponsor), First 5 Center for Children's Policy (cosponsor), First 5 Association of California (cosponsor), Children Now (cosponsor), March of Dimes (cosponsor), Maternal and Child Health Access (cosponsor), National Health Law Program (cosponsor), Access Reproductive Justice, California Alliance of Child and Family Services, California Catholic Conference, California Pan-Ethnic Health Network, California Rural Legal Assistance Foundation, INC., CaliforniaHealth+ Advocates, Children's Specialty Care Coalition, Community Clinic Association of Los Angeles County, Community Health Initiative of Orange County, County Behavioral Health Directors Association, Friends Committee on Legislation of California, Health Access California, National Association of Social Workers, California Chapter, National Health Law Program, Nurse - Family Partnership, United Ways of California

Bill Number	Status	Position
AB 2426	In Assembly	Support

Title
Martin Luther King, Jr. Community Hospital.

Description
AB 2426, as amended, Gipson. Martin Luther King, Jr. Community Hospital. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law provides that Medi-Cal funding be made available to a new hospital, now known as the Martin Luther King, Jr. Community Hospital, to serve the population of South Los Angeles.This bill would require the department, in consultation with the hospital, to create a directed payment program in Medi-Cal managed care for outpatient hospital services to provide that total Medi-Cal managed care reimbursement received for services is approximately equal to the hospital's costs for those services, as specified. The bill would establish funding provisions if those minimum reimbursements required under the program would result in payments above the level of compensation the hospital would have otherwise received, and if a nonfederal share is necessary with respect to the additional compensation. The bill would require that the hospital's projected costs be based on specified principles. The bill would also require the department, in consultation with the hospital, to develop an alternative mechanism for ensuring inpatient services payment levels from Medi-Cal managed care plans, as specified. The bill would authorize the department to develop value-based quality directed payment, for use in payments to the hospital. The bill would authorize the department to implement those provisions by means of, among other things, all-facility letters. The bill would require the department to obtain federal approvals or waivers as necessary to implement those provisions, to obtain federal matching funds to the maximum extent permitted by federal law, and would condition the implementation of those provisions on obtaining federal approval.This bill would make related findings and declarations.This bill would make legislative findings and declarations as to the necessity of a special statute for the County of Los Angeles.

Primary Sponsors
Mike Gipson

Organizational Notes

Last edited by Joanne Campbell at Apr 14, 2022, 10:52 PM
Support: L.A. Care, Martin Luther King, Jr. Community Hospital (sponsor), Black Beauty and Wellness Foundation, Black Business Association, Boys & Girls Club Metro Los Angeles, Brotherhood Crusade, Cal State Dominguez Hills, California Black Women's Health Project, Charles R. Drew University of Medicine and Science, Community Coalition, Congress for Racial Equality - California, Forgiving for Living, Inc., Forgotten Children Inc., Girls Club of Los Angeles, Impact Enterprises Global, Inc., Inner City Youth Orchestra of Los Angeles, International Association of Chiefs of Police, Kappa Alpha Psi Western Region Province, Los Angeles Metropolitan Churches, Los Angeles Sentinel, Los Angeles Urban League, National Action Network – Los Angeles Chapter, National Association for the Advancement of Colored People – Los Angeles, National Coalition of 100 Black Women, Parents of Watts, Positive Results Corporation, Sanctuary of Hope, Southern Christin Leadership Conference of Southern California, Southside Coalition of Community Health Centers, St. Anne's Family Services, The Baptist Ministers Conference, The Latin Link, UNITE HERE Local 11, United Voices of Literacy, Watts Labor Community Action Committee, Willowbrook Inclusion Network

Bill Number	Status	Position
AB 2449	In Assembly	Monitor

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

Bill Number	Status	Position
AB 2458	In Assembly	Monitor

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

Bill Number	Status	Position
AB 2516	In Assembly	Monitor

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

Bill Number	Status	Position
AB 2530	In Assembly	Monitor

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

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:18 PM
Oppose Unless Amended: CA. Assoc. of Health Plans Support: CA Labor Fed. LA County Labor Fed. UNITE HERE Teamsters UFCW SEIU California Conference Board of the Amalgamated Transit Union California Conference of Machinists The Utility Workers Union of America The Engineers and Scientists of California

Bill Number	Status	Position
AB 2539	In Assembly	Monitor

Title
Public health: COVID-19 vaccination: proof of status.

Description
AB 2539, as introduced, Choi. Public health: COVID-19 vaccination: proof of status. Existing federal law, the Federal Food, Drug, and Cosmetic Act, authorizes the United States Secretary of Health and Human Services to approve new drugs and products, including vaccines, for introduction into interstate commerce, and authorizes the secretary to authorize vaccines for use in an emergency upon declaring a public health emergency. On February 4, 2020, the secretary determined that there is a public health emergency and declared circumstances exist justifying the authorization of emergency use of drugs and biological products. The secretary subsequently authorized the emergency use of 3 vaccines for the prevention of COVID-19, and on August 23, 2021, the secretary approved a vaccine for the prevention of COVID-19.The California Emergency Services Act authorizes the Governor to declare a state of emergency during conditions of disaster or extreme peril to persons or property, including epidemics. On March 4, 2020, the Governor declared a state of emergency relating to the COVID-19 pandemic. Pursuant to this authority, the Governor issued several executive orders requiring individuals in specified employment, health care, school, or other settings to provide proof of COVID-19 vaccination status, unless specified exceptions are met.This bill would require a public or private entity that requires a member of the public to provide documentation regarding the individual's vaccination status for any COVID-19 vaccine as a condition of receipt of any service or entrance to any place to accept a written medical record or government-issued digital medical record in satisfaction of the condition, as specified.

Primary Sponsors
Steve Choi

Bill Number	Status	Position
AB 2564	In Assembly	Monitor

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

Bill Number	Status	Position
AB 2581	In Assembly	Monitor

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

Bill Number	Status	Position
AB 2585	In Assembly	Monitor

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

Bill Number	Status	Position
AB 2648	In Assembly	Monitor

Title
Air ambulance services.

Description
AB 2648, as amended, Grayson. Air ambulance services. Existing law imposes a penalty of $4 until December 1, 2022, upon every conviction for a violation of the Vehicle Code or a local ordinance adopted pursuant to the Vehicle Code, other than a parking offense. Existing law requires the court that imposed the fine to transfer the revenues collected to the Treasurer for deposit into the Emergency Medical Air Transportation and Children's Coverage Fund. Existing law requires the assessed penalty to continue to be collected, administered, and distributed until exhausted or until December 31, 2023, whichever occurs first. Under existing law, moneys remaining unexpended and unencumbered in the fund on December 31, 2023, are to be transferred to the General Fund. These provisions remain operative until July 1, 2024, and are repealed effective January 1, 2025.This bill would change the date on which moneys remaining unexpended and unencumbered in the fund are to be transferred to the General Fund to June 30, 2024. The bill would make the above-described provisions inoperative on July 1, 2025, and would repeal them as of January 1, 2026.

Primary Sponsors
Tim Grayson

Bill Number	Status	Position
AB 2659	In Assembly	Monitor

Title
Medi-Cal managed care: midwifery services.

Description
AB 2659, as amended, 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) and one 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. If a Medi-Cal managed care plan is exempt from that requirement, the bill would require the Medi-Cal managed care plan to reevaluate its network adequacy for midwifery care in the county on an annual basis and to make a good faith effort to work with the appropriate professional midwifery organizations for LMs and CNMs, and their respective licensing and regulatory agencies, to assist in determining the availability of midwives in the county who accept Medi-Cal payments. The bill would also require a Medi-Cal managed care plan to have within its provider network at least one licensed alternative birth center speciality clinic within each county where the Medi-Cal managed care plan provides services to Medi-Cal beneficiaries provided that at least one qualified licensed alternative birth center speciality clinic is available in that county and is willing to contract with the Medi-Cal managed care plan. The bill would condition implementation of these provisions on receipt of any necessary federal approvals and ... (click bill link to see more).

Primary Sponsors
Jim Patterson

Bill Number	Status	Position
AB 2680	In Assembly	Monitor

Title
Medi-Cal: Community Health Navigator Program.

Description
AB 2680, as amended, 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

Bill Number	Status	Position
AB 2697	In Assembly	Monitor

Title
Medi-Cal: community health workers and promotores.

Description
AB 2697, as amended, Aguiar-Curry. Medi-Cal: community health workers and promotores. 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.This bill would require the department to implement a community health workers (CHW) and promotores benefit under the Medi-Cal program, subject to receipt of any necessary federal approvals and the availability of federal financial participation. Under the bill, CHW and promotores services would be preventive services, as defined under federal law, and would be designed for certain target populations based on health conditions and need for services, for Medi-Cal beneficiaries in the managed care or fee-for-service delivery system.The bill would require CHW and promotores, as defined, to provide health education and navigation, as specified. Under the bill, provision of the services would be subject to referral by a physician or other licensed practitioner of the healing arts within their scope of practice under state law. The bill would require the department, in collaboration with CHW and promotores stakeholders, to implement and evaluate the benefit, including the development of detailed policy guidance, letters, manuals, and other documents.If the benefit is implemented, the bill would require a Medi-Cal managed care plan to develop an annual outreach and education plan for enrollees and another for providers, including notices and materials containing specified information about the CHW and promotores benefit. The bill would require these outreach and education efforts to, among other things, meet cultural and linguistic appropriateness standards and be subject to review and approval by the department, as specified. The bill would also require a Medi-Cal managed care plan to conduct an annual assessment of CHW and promotores capacity and enrollee need, and to share the assessments with the department, including specified data.The bill would require the department to annually review the outreach and education plans and assessments, and to annually publish an analysis of the CHW and promotores benefit on its internet website, including specified data.

Primary Sponsors
Cecilia Aguiar-Curry

Organizational Notes

Last edited by Joanne Campbell at Apr 14, 2022, 3:51 PM
Support: Western Center on Law and Poverty

Bill Number	Status	Position
AB 2709	In Assembly	Monitor

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

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:19 PM
Oppose: CA. Assoc. of Health Plans

Bill Number	Status	Position
AB 2724	In Assembly	Oppose

Title
Medi-Cal: alternate health care service plan.

Description
AB 2724, as amended, Arambula. Medi-Cal: alternate health care service plan. 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 pursuant to Medi-Cal managed care plan contracts. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.This bill would authorize the department to enter into one or more comprehensive risk contracts with an alternate health care service plan (AHCSP), as defined, to serve as a primary Medi-Cal managed care plan for specified eligible beneficiaries in geographic regions designated by the department. The bill would require the Health Care Options Program, which is an entity overseen by the department for Medi-Cal managed care education and enrollment, to disenroll any member of an AHCSP if the member meets any one of the reasons for disenrollment enumerated in specified regulations.Under the bill, except where an AHCSP is already contracted with the department as a Medi-Cal managed care plan as of January 1, 2022, contracts entered into pursuant to these provisions would be effective no sooner than January 1, 2024, as specified.The bill would authorize the department to implement these provisions through plan letters or other similar instructions. The bill would condition implementation of these provisions on receipt of any necessary federal approvals and the availability of federal financial participation.

Primary Sponsors
Joaquin Arambula

Organizational Notes

Last edited by Cherie Compartore at Apr 13, 2022, 11:17 PM
Oppose: L.A. Care, Local Health Plans of California, California State Association of Counties, Central Coast Alliance for Health (Public Plan), Inland Empire Health Plan (Public Plan), Santa Clara Family Health Plan (Public Plan), Humboldt County, Mariposa County, Mendocino County, Plumas County, Colusa County, Monterey County, Santa Barbara County, San Mateo County, Ventura County, Sonoma County, San Luis Obispo County, Santa Cruz County, Yolo County, Santa Clara County, Santa Cruz Community Health Clinic, Salud Para La Gente Clinic, California Partnership for Health, Santa Barbara Neighborhood Clinics, Newman Medical Clinic, Big Sur Health Center Oppose Unless Amended: CalOptima (Public Plan) Letter of Concern: CPCA/CA Health+ Advocates, Health Care LA IPA

Bill Number	Status	Position
AB 2727	In Assembly	Support

Title
Medi-Cal: eligibility.

Description
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 refer to residents of the state and make other changes to that statement.

Primary Sponsors
Jim Wood

Organizational Notes

Last edited by Joanne Campbell at Apr 14, 2022, 3:52 PM
Support: L.A. Care, Western Center on Law and Poverty

Bill Number	Status	Position
AB 2768	In Assembly	Monitor

Title
Mental health and substance use disorders: database of facilities.

Description
AB 2768, as amended, Waldron. Mental health and substance use disorders: database of facilities. Existing law establishes a system of mental health programs, largely administered through the counties, to provide mental health and substance use disorder services in the state. Existing law regulates the facilities that provide these services, including acute psychiatric hospitals, residential substance abuse treatment facilities, and outpatient programs.This bill would require the California Health and Human Services Agency, either on its own or through the Behavioral Health Task Force established by the Governor, to create an ad hoc committee to study how to develop, in real time, an internet-based database to collect, aggregate, and display information about beds in inpatient psychiatric facilities, crisis stabilization units, residential community mental health facilities, and residential alcoholism or substance abuse treatment facilities in order to facilitate the identification and designation of facilities for the temporary treatment of individuals in mental health or substance use disorder crisis.

Primary Sponsors
Marie Waldron

Bill Number	Status	Position
AB 2783	In Assembly	Monitor

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

Bill Number	Status	Position
AB 2813	In Assembly	Monitor

Title
Long-Term Services and Supports Benefit Program.

Description
AB 2813, as introduced, Santiago. Long-Term Services and Supports Benefit Program. Existing law, the Mello-Granlund Older Californians Act, establishes the California Department of Aging in the California Health and Human Services Agency, and sets forth its mission to provide leadership to the area agencies on aging in developing systems of home- and community-based services that maintain individuals in their own homes or least restrictive homelike environments. Existing law establishes an Aging and Disability Resource Connection (ADRC) program, administered by the department, to provide information to consumers and their families on available long-term services and supports (LTSS) programs and to assist older adults, caregivers, and persons with disabilities in accessing LTSS programs at the local level. Existing law requires the ADRC program to provide services within the geographic area served and provide information to the public about the services provided by the program. Existing law makes the operation of these provisions contingent upon the appropriation of funds for that purpose.This bill would require the department, upon appropriation, in conjunction with an unspecified board operating under the auspices of the State Treasurer, to establish and administer a Long-Term Services and Supports Benefits Program with the purpose of providing supportive care to aging Californians and those with physical disabilities. The bill would establish the Long-Term Services and Supports Benefit Program Fund and would require the department and the board to administer the program using proceeds from the fund. The bill would require an individual to have paid into the fund for an unspecified number of years to be eligible to receive benefits pursuant to the program. The bill would authorize the maximum amount of benefit available to an eligible individual to exceed the amount the individual contributed into the fund. The bill would authorize eligible individuals to use the benefits pursuant to the program for specified services, including in-home support services support for an individual in need of assistance for at least 2 activities of daily living. The bill would require the department to ensure that all vendors and providers of services pursuant to the program have not taken any actions to actively discourage their employees' membership in labor organizations or collective bargaining.The bill would make related findings and declarations.

Primary Sponsors
Miguel Santiago

Bill Number	Status	Position
AB 2833	In Assembly	Monitor

Title
COVID-19 testing capacity.

Description
AB 2833, as amended, Irwin. COVID-19 testing capacity. Existing law requires the State Department of Public Health to examine the causes of communicable diseases occurring, or likely to occur, in the state and sets forth the department's duties for disease inspection and reporting, including through state and local public health laboratories. Existing law requires the department and the Office of Emergency Services to establish a personal protective equipment (PPE) stockpile, upon appropriation and as necessary, with PPE-related guidelines established for a pandemic or other health emergency.Existing law sets forth various provisions specific to COVID-19 testing, including, among others, provisions relating to health care coverage for testing and certain programs or requirements for the workplace or educational setting.This bill would require the department to make plans to ensure that the laboratory infrastructure in the state is sufficient and prepared for COVID-19 testing capacity to be scaled, within a period of 2 calendar weeks, to 500,000 tests per day, and for results of at least 90% of those COVID-19 tests to be returned to the individuals tested and to the department within 24 hours of collection of the testing samples.The bill would authorize the department to make plans to use the laboratory infrastructure for public health applications other than COVID-19 testing, as the department deems reasonable and appropriate based on the circumstances, including, but not limited to, testing for other specified infections, so long as that testing is otherwise authorized under law and the laboratory infrastructure continues to meet the above-described COVID-19 testing conditions.

Primary Sponsors
Jacqui Irwin

Bill Number	Status	Position
AB 2942	In Assembly	Monitor

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, dispens... (click bill link to see more).

Primary Sponsors
Tom Daly

Bill Number	Status	Position
ACA 11	In Assembly	Monitor

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

Bill Number	Status	Position
SB 17	In Assembly	Support

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 Apr 15, 2022, 5:21 PM
Support - L.A. Care, L.A. Board of Supervisors, Community Clinic Association of Las Angeles County, California Assoc. of Public Hospitals, County Welfare Directors Association

Bill Number	Status	Position
SB 40	In Assembly	Monitor

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

Bill Number	Status	Position
SB 56	In Assembly	Support

Title
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 una... (click bill link to see more).

Primary Sponsors
Maria Durazo, Joaquin Arambula

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:23 PM
Support: L.A. Care, Local Health Plans of California, CA. Assoc. of Health Plans, Community Clinic Association of Los Angeles County, County Welfare Directors Assoc, California Hospital Assoc.

Bill Number	Status	Position
SB 245	Enacted	Monitor

Title
Health care coverage: abortion services: cost sharing.

Description
SB 245, 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 impose a state-... (click bill link to see more).

Primary Sponsors
Lena Gonzalez, Sydney Kamlager, Connie Leyva

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:25 PM
Oppose: CA. Assoc. of Health Plans

Bill Number	Status	Position
SB 250	In Assembly	Monitor

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 Cherie Compartore at Apr 15, 2022, 5:25 PM
Oppose: CA. Assoc. of Health Plans

Bill Number	Status	Position
SB 256	In Assembly	Monitor

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

Bill Number	Status	Position
SB 281	In Assembly	Monitor

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

Bill Number	Status	Position
SB 293	In Assembly	Monitor

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

Bill Number	Status	Position
SB 316	In Assembly	Support

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 Apr 15, 2022, 5:27 PM
Support: L.A. Care, CA. Assoc. of Health Plans, Local Health Plans of California, Community Clinic Association of Los Angeles, County Welfare Directors Assoc. California Medical Assoc.

Bill Number	Status	Position
SB 371	In Assembly	Monitor

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

Bill Number	Status	Position
SB 455	In Assembly	Monitor

Title
California Health Benefit Exchange.

Description
SB 455, as amended, Leyva. California Health Benefit Exchange. 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

Bill Number	Status	Position
SB 473	In Assembly	Monitor

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 15, 2022, 5:28 PM
Oppose: CA. Assoc. of Health Plans

Bill Number	Status	Position
SB 521	In Assembly	Monitor

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

Bill Number	Status	Position
SB 523	In Assembly	Monitor

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 15, 2022, 5:31 PM
Oppose: CA. Assoc. of Health Plans

Bill Number	Status	Position

Bill Number	Status	Position
SB 562	In Assembly	Monitor

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 Cherie Compartore at Apr 15, 2022, 5:32 PM
Oppose: CA. Assoc. of Health Plans, Dept. of Managed Health Care

Bill Number	Status	Position
SB 568	In Assembly	Monitor

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... (click bill link to see more).

Primary Sponsors
Richard Pan

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:33 PM
Oppose: CA. Assoc. of Health Plans

Bill Number	Status	Position
SB 773	In Assembly	Monitor

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

Bill Number	Status	Position
SB 838	In Senate	Monitor

Title
Health care: prescription drugs.

Description
SB 838, as amended, Pan. Health care: prescription drugs. Existing law, the California Affordable Drug Manufacturing Act of 2020, requires the California Health and Human Services Agency (CHHSA) to enter into partnerships, in consultation with other state departments as necessary to, among other things, increase patient access to affordable drugs. Existing law requires CHHSA to enter into such partnerships to produce or distribute 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. Existing law exempts all nonpublic information and documents obtained under this program from disclosure under the California Public Records Act in order to protect proprietary, confidential information regarding manufacturer or distribution costs and drug pricing, utilization, and rebates.For purposes of implementing the California Affordable Drug Manufacturing Act of 2020, this bill would permit, until December 31, 2032, CHHSA and its departments to enter into exclusive or nonexclusive contracts on a bid or negotiated basis and would exempt these contracts from review or approval by the Department of General Services, as specified. The bill would eliminate the viability requirement for the manufacturing of insulin pursuant to these provisions and would require any partnership, among other things, to guarantee priority access to insulin supply for the state. The bill would additionally exempt all nonpublic information and documents prepared under the California Affordable Drug Manufacture Act of 2020 from disclosure under the California Public Records Act.This bill would require, upon appropriation by the Legislature, the development of a California-based manufacturing facility for generic drugs with the intent of creating high-skill, high-paying jobs within the state.Existing law, subject to appropriation by the Legislature, requires CHHSA to submit a report to the Legislature on or before July 1, 2023, that, among other things, assesses the feasibility and advantages of directly manufacturing generic prescription drugs and selling generic prescription drugs at a fair price. This provision is operative until January 1, 2025. Existing law also requires CHHSA to report to the Legislature on or before July 1, 2022, a description of the status of the drugs targeted for manufacture and an analysis of how CHHSA's activities have impacted competition, access, and costs for those drugs. Under existing law, this provision is operative until January 1, 2026.This bill would instead require CHHSA to submit the report assessing the feasibility of directly manufacturing generic prescription drugs on or before December 31, 2023. The bill would extend the de... (click bill link to see more).

Primary Sponsors
Richard Pan

Bill Number	Status	Position
SB 853	In Senate	Monitor

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. Existing law also prohibits a health care service plan that covers prescription drug benefits from limiting or excluding coverage for a drug that was previously approved for coverage if an enrollee continues to be prescribed that drug, as specified.This bill would expand the above-described prohibitions to prohibit limiting or excluding coverage of a dose of a drug or dosage form. The 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 Cherie Compartore at Apr 11, 2022, 6:20 PM
Oppose: CA. Assoc. of Health Plans

Last edited by Joanne Campbell at Jan 20, 2022, 3:03 PM
Sponsored by Crohn’s & Colitis Foundation

Bill Number	Status	Position
SB 858	In Senate	Monitor

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

Organizational Notes

Last edited by Joanne Campbell at Apr 14, 2022, 3:53 PM
Oppose: CA. Assoc. of Health Plans Support: Western Center on Law and Poverty

Bill Number	Status	Position
SB 866	In Senate	Monitor

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

Bill Number	Status	Position
SB 871	In Senate	Monitor

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, and 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

Bill Number	Status	Position
SB 912	In Senate	Monitor

Title
Biomarker testing.

Description
SB 912, as introduced, Limón. Biomarker testing. (1) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plan contract or health insurance policy issued, amended, delivered, or renewed on or after July 1, 2000, to provide coverage for all generally medically accepted cancer screening tests, and prohibits that contract or policy issued, amended, delivered, or renewed on or after July 1, 2022, from requiring prior authorization for biomarker testing for certain enrollees or insureds. Existing law applies the provisions relating to biomarker testing to Medi-Cal managed care plans, as prescribed.This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after July 1, 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.(2) Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services pursuant to a schedule of benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law includes Rapid Whole Genome Sequencing as a covered benefit for any Medi-Cal beneficiary who is one year of age or younger and is receiving inpatient hospital services in an intensive care unit.Subject to the extent that federal financial participation is available and not otherwise jeopardized, and any necessary federal approvals have been obtained, this bill 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.(3) The California Constitu... (click bill link to see more).

Primary Sponsors
Monique Limon

Organizational Notes

Last edited by Cherie Compartore at Apr 11, 2022, 6:21 PM
Oppose: CA. Assoc. of Health Plans

Bill Number	Status	Position
SB 923	In Senate	Monitor

Title
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 Cherie Compartore at Apr 15, 2022, 5:34 PM
Sponsor: California LGTBQ Health and Human Services Network, Equality California, National Health Law Program, and Western Center on Law & Poverty Oppose Unless Amended: CA. Assoc. of Health Plans

Bill Number	Status	Position
SB 939	**In Senate**	**Monitor**

Title
Prescription drug pricing.

Description
SB 939, as amended, 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 that are not required under federal law or regulations.

Primary Sponsors
Richard Pan

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:35 PM
Sponsor: APLA Health, CA Health+ Advocates Oppose Unless Amended: CA. Assoc. of Health Plans, Association of Health Insurance Plans

Bill Number	Status	Position
SB 944	In Senate	Monitor

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

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:35 PM
Support if Amended: CA. Assoc. of Health Plans Support: Western Center on Law and Poverty

Bill Number	Status	Position
SB 958	In Senate	Monitor

Title
Medication and Patient Safety Act of 2022.

Description
SB 958, as amended, 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 prohibit a plan or insurer, or its designee, from requiring an infused or injected medication to be administered in an enrollee's or insured's home as a condition of coverage, unless the treating health care provider determines home administration is safe and appropriate. The bill would prohibit a plan or insurer, or its designee, from requiring an infused or injected medication to be supplied by a vendor specified by the plan or insurer, or its designee, as a condition of coverage, unless 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

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:36 PM
Oppose: CA. Assoc. of Health Plans

Bill Number	Status	Position
SB 964	In Senate	Monitor

Title
Behavioral health.

Description
SB 964, as amended, Wiener. Behavioral health. (1) 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.(2) 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 counselors, coaches, peer supports, and other allied health care providers serving children and youth.This bill would establish the Behavioral Health Workforce Preservation and Restoration Fund as a fund in the state treasury, to be administered by the department, for the purpose of stabilizing the current licensed clinical behavioral health workforce. The bill would authorize moneys from the fund to be used, upon appropriation by the Legislature, to provide hiring or performance-based bonuses, salary augmentation, overtime pay, or hazard pay to licensed professionals working in the behavioral health sector. The bill would also require the department to establish a stipend program, in addition to and separate from the fund, for students pursuing a ... (click bill link to see more).

Primary Sponsors
Scott Wiener, Anna Caballero, Henry Stern

Bill Number	Status	Position
SB 966	In Senate	Monitor

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

Organizational Notes

Last edited by Joanne Campbell at Mar 28, 2022, 5:01 PM
Support: California Health+ Advocates (co-sponsored), California Association of Marriage and Family Therapists (co-sponsored)

Bill Number	Status	Position
SB 967	In Senate	Monitor

Title
Health care coverage: tax returns: information sharing authorization and outreach.

Description
SB 967, as amended, 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

Bill Number	Status	Position
SB 974	In Senate	Monitor

Title
Health care coverage: diagnostic imaging.

Description
SB 974, as amended, 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, an individual or group policy of disability insurance that provides hospital, medical, or surgical coverage, or a self-insured employee welfare benefit plan issued, amended, or renewed on or after January 1, 2023, to provide coverage without imposing cost sharing for screening mammography and medically necessary diagnostic breast imaging, including diagnostic breast imaging following an abnormal mammography result and for an enrollee or insured indicated to have a risk factor associated with breast cancer.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, Cristina Garcia

Organizational Notes

Last edited by Cherie Compartore at Apr 11, 2022, 6:22 PM
Oppose: CA. Assoc. of Health Plans

Bill Number	Status	Position
SB 987	In Senate	Monitor

Title
California Cancer Care Equity Act.

Description
SB 987, as amended, Portantino. California Cancer Care Equity Act. 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.This bill would require a Medi-Cal managed care plan to include in its contracted provider network at least one National Cancer Institute (NCI) Designated Cancer Center, as specified, and ensure that any beneficiary diagnosed with a complex cancer diagnosis, as defined, is referred to an NCI-Designated Cancer Center within 15 business days of the diagnosis, unless the beneficiary selects a different cancer treatment provider.Existing law also requires a Medi-Cal managed care plan to give a beneficiary timely and adequate notice of an adverse benefit determination, as defined, in writing consistent with specified federal regulations that set forth, among other things, rules for standard and expedited decisions regarding authorization of services.This bill would require a Medi-Cal managed care plan to give a request for, or related to, treatment pursuant to a complex cancer diagnosis to receive an expedited authorization decision, as specified.This bill, to the extent necessary federal approvals are obtained and federal financial participation is available, would, among other things, also require Medi-Cal managed care plans to comply with additional requirements, including ensuring that access to an NCI-Designated Cancer Center occurs only at the primary Medi-Cal managed care plan level. The bill would require contracts between Medi-Cal managed care plans and primary care providers to require primary care physicians to inform enrollees who receive a complex cancer diagnosis of the enrollee's health status, medical care, or treatment options, as specified. The bill would require a Medi-Cal managed care plan to provide written and verbal notice to an enrollee of their right to access care through an NCI-Designated Cancer center, and would require the department, in consultation with others, to develop a standard written notice and a process for verbally notifying enrollees of their right to access cancer treatment care through an NCI-Designated Cancer Center. The bill would authorize the department to implement, interpret, or make specific the provisions by means of all-county letters or similar guidance.

Primary Sponsors
Anthony Portantino

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:37 PM
Oppose: CA. Assoc. of Health Plans Support: Western Center on Law and Poverty

Bill Number	Status	Position
SB 999	In Senate	Monitor

Title
Health coverage: mental health and substance use disorders.

Description
SB 999, as amended, Cortese. Health coverage: mental health and 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.This bill would require the Director of Managed Health Care and the Insurance Commissioner to adopt rules mandating specific requirements for utilization review, including requiring the health care service plan or the disability insurer, as applicable, or an entity acting on the plan's or insurer's behalf, to maintain telephone access during California business hours for a health care provider to request authorization for mental health and substance use disorder care and conduct peer-to-peer discussions regarding specific issues related to treatment.Under the bill, if a health care service plan or a disability insurer, or an entity acting on the plan's or insurer's behalf, does not respond to a request for coverage or an appeal of a denial of coverage within the timeframe required for urgent care or nonurgent care treatment, coverage for the requested services would be deemed approved.Existing law requires every health care service plan and disability insurer to conduct interrater reliability testing to ensure consistency in utilization review decisionmaking covering how medical necessity decisions are made. Existing law prohibits a contract between a health care service plan or a disability insurer, and a physician, physician group, or other licensed health care practitioner from containing any incentive plan that includes specific payment made directly to a physician, physician group, or other licensed health care practitioner as an inducement to deny, reduce, limit, or delay specific, medically necessary, and appropriate services, as specified.Under this bill, an individual or health care provider who has an interrater reliability pass rate of less than 70% and is compensated more than 25% of the usual and customary rate paid to a health care provider in the plan or provider network would be deemed to violate the prohibition against incentive plans.... (click bill link to see more).

Primary Sponsors
Dave Cortese

Organizational Notes

Last edited by Cherie Compartore at Apr 11, 2022, 6:23 PM
Oppose: CA. Assoc. of Health Plans

Bill Number	Status	Position
SB 1014	In Senate	Monitor

Title
Enhanced Clinically Integrated Program for Federally Qualified Health Centers.

Description
SB 1014, as amended, Hertzberg. Enhanced Clinically Integrated Program for Federally Qualified Health Centers. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, federally qualified health center (FQHC) services are covered benefits under the Medi-Cal program, to be reimbursed on a per-visit basis, as specified, to the extent that federal financial participation is obtained.Existing federal law authorizes a state plan to provide for payment in any fiscal year to an FQHC for specified services in an amount that is determined under an alternative payment methodology (APM) if it is agreed to by the state and the FQHC and results in a payment to the FQHC of an amount that is at least equal to the amount otherwise required to be paid to the FQHC. Existing state law requires the department to authorize an APM pilot project for FQHCs that agree to participate, for implementation with respect to a county for a period of up to 3 years.This bill would require the department to authorize a new supplemental payment program for FQHCs pursuant to federal law, or as specified, to be named the Enhanced Clinically Integrated Program (ECIP). Under the bill, the nonfederal share of ECIP funding would be subject to an appropriation. The bill would require the department to request at least this amount to fund the program on an ongoing basis in future fiscal years.Under the bill, participation in ECIP would be optional for FQHCs, supplemental funding under ECIP would be provided in addition to all other funding received by FQHCs, as specified, and participation in ECIP would result in total payments to participating FQHCs that are greater than the prospective payment system (PPS) rate otherwise required to be paid to the FQHC. The bill would, subject to an appropriation, require the department, no later than July 1, 2023, to make funding available for the purpose of direct compensation of health center workers.The bill would require ECIP to improve quality and access to care by allocating funds, if appropriated, to FQHCs that meet certain standards relating to wage thresholds and participation in bona fide labor-management cooperation committees, as specified. The bill would set forth various requirements for funding allocations to, and uses by, participating FQHCs.The bill would require the department to establish a statewide 15-member board, as specified, with the responsibility of developing eligibility criteria, an application process, a fund distribution process, reporting r... (click bill link to see more).

Primary Sponsors
Bob Hertzberg, Wendy Carrillo, Ash Kalra

Bill Number	Status	Position
SB 1019	In Senate	Monitor

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

Organizational Notes

Last edited by Joanne Campbell at Apr 14, 2022, 3:55 PM
Support: CPEHN (Sponsor), API Equality-LA Bakersfield American Indian Health Project California Alliance of Child and Family Services Central Valley Immigrant Integration Collaborative Children Now Maternal and Child Health Access National Association of Social Workers, California Chapter Racial and Ethnic Mental Health Disparities Coalition, Western Center on Law and Poverty

Bill Number	Status	Position
SB 1033	In Senate	Monitor

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

Organizational Notes

Last edited by Joanne Campbell at Apr 14, 2022, 3:54 PM
Support: CPEN (Sponsor), Western Center on Law and Poverty

SB 1083	In Senate	Monitor

Title
CalWORKs: pregnancy and homeless assistance.

Description
SB 1083, as introduced, Skinner. CalWORKs: pregnancy and homeless assistance. Existing law provides for the California Work Opportunity and Responsibility to Kids (CalWORKs) program, under which each county provides cash assistance and other benefits to qualified low-income families and individuals. Existing law requires $47 per month to be paid to a pregnant person qualified for CalWORKs aid to meet special needs resulting from pregnancy, and requires county human services agencies to refer all these recipients of aid to a local provider of the California Special Supplemental Nutrition Program for Women, Infants, and Children.This bill would, among other things, also require county human services agencies to refer those recipients to perinatal home visiting services administered by county public health departments.Existing law provides for homeless assistance to a homeless family seeking shelter when the family is eligible for CalWORKs aid, and provides that a family is considered homeless for these purposes when, among other things, the family has received a notice to pay rent or quit. Existing law limits eligibility for temporary shelter assistance and permanent housing assistance to 16 cumulative calendar days of temporary assistance and one payment of permanent assistance every 12 months, except as specified.This bill would also make the homeless assistance available to a family that is in danger of becoming homeless, and would additionally provide that a family is considered homeless if they receive any notice that may lead to an eviction. The bill would require homeless assistance to be granted immediately after the family's application is submitted. This bill would increase the maximum days of benefits in a 12-month period to 40 cumulative calendar days, and would exclude from the those limits an eligible family that includes a pregnant person. This bill would also authorize a county human services agency to provide additional days of temporary shelter assistance, for an indeterminate period, if the pregnant person or family would be without any shelter if the assistance were ended, and would require a family receiving homeless assistance to remain eligible for that assistance following termination of their participation in the CalWORKs program due to reporting income that makes the family ineligible for aid, as specified.By imposing duties on counties that administer CalWORKs, the bill would impose a state-mandated local program.Existing law continuously appropriates moneys from the General Fund to defray a portion of county costs under the CalWORKs program.This bill would instead provide that the continuous appropriation would not be made for purposes of implementing these provisions.The California Constitution... (click bill link to see more).

Primary Sponsors
Nancy Skinner

Organizational Notes

Last edited by Joanne Campbell at Apr 14, 2022, 3:46 PM
Support: Western Center on Law and Poverty (Sponsor)

Bill Number	Status	Position
SB 1089	In Senate	Monitor

Title
Medi-Cal: eyeglasses: Prison Industry Authority.

Description
SB 1089, as amended, Wilk. Medi-Cal: eyeglasses: Prison Industry Authority. Existing law establishes the 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 a provider to obtain 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 the availability of federal financial participation.The bill, notwithstanding the above-described requirements, would authorize a provider participating in the Medi-Cal program to obtain eyeglasses from the authority or private entities, based on the optometrist's needs and assessment of quality and value.

Primary Sponsors
Scott Wilk

Bill Number	Status	Position
SB 1180	In Senate	Monitor

Title
Medi-Cal: time and distance standards for managed care services.

Description
SB 1180, as amended, Pan. Medi-Cal: time and distance standards for managed care services. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services, either through a fee-for-service or managed care delivery system. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Existing law establishes, until January 1, 2023, 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.This bill would extend the operation of those standards to January 1, 2026, and would require the department to seek input from stakeholders, as specified, prior to January 1, 2025, to determine what changes are needed to these provisions.

Primary Sponsors
Richard Pan

Bill Number	Status	Position
SB 1184	In Senate	Monitor

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 an individual that holds a services credential with a specialization in pupil personnel services, as specified, 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

Bill Number	Status	Position
SB 1191	In Senate	Monitor

Title
Medi-Cal: pharmacogenomic testing.

Description
SB 1191, as amended, Bates. Medi-Cal: pharmacogenomic testing. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law sets forth a schedule of covered benefits under the Medi-Cal program.This bill, to be known as the Utilizing Pharmacogenomics to Greatly Reduce Adverse Drug Events (UPGRADE) Act, would add pharmacogenomic testing as a covered benefit under Medi-Cal. The bill would define pharmacogenomic testing as laboratory genetic panel testing, by a laboratory with specified licensing and accreditation, to identify how a person's genetics may impact the efficacy, toxicity, and safety of medications. The bill would cover the benefit under Medi-Cal if a medication is being considered for use, or is already being administered, and is approved for use, in treating a Medi-Cal beneficiary's condition and is known to have a gene-drug or drug-drug-gene interaction that has been demonstrated to be clinically actionable, as specified, if the medication is ordered by an enrolled Medi-Cal clinician or pharmacist.The bill would authorize the department to implement the above-described provisions through all-county or plan letters, or similar instructions, without taking any further regulatory action.The bill, subject to implementation of the provisions above, and in collaboration with certain stakeholders, would require the Department of Health Care Access and Information to assess the impact of Medi-Cal coverage of pharmacogenomic testing and to annually prepare and publish a report on its internet website. The bill would require the annual reports to include an assessment of health economics and health outcomes of the benefit coverage, as specified.

Primary Sponsors
Pat Bates

Bill Number	Status	Position
SB 1207	In Senate	Monitor

Title
Health care coverage: maternal and pandemic-related mental health conditions.

Description
SB 1207, as amended, Portantino. Health care coverage: maternal and pandemic-related mental health conditions. 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 requires a health care service plan contract or health insurance policy 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. Existing law requires health care service plans and health insurers, by July 1, 2019, to develop, consistent with sound clinical principles and processes, a maternal mental health program designed to promote quality and cost-effective outcomes, as specified. This bill would make findings and declarations relating to the effect of the COVID-19 pandemic on mental health in California and the importance of outreach, education, and access to quality mental health treatment. The bill would extend the deadline for establishment of the maternal mental health program to July 1, 2023. The bill would revise the requirements of the program to include quality measures to encourage screening, diagnosis, treatment, and referral. The bill also would encourage health care service plans and health insurers to include coverage for doulas, incentivize training opportunities for contracting obstetric providers, and educate enrollees and insureds about the program. Because a violation of the bill by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Anthony Portantino

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:38 PM
Oppose: CA. Assoc. of Health Plans

Bill Number	Status	Position
SB 1245	**In Senate**	**Monitor**

Title
Los Angeles County Abortion Access Safe Haven Pilot Program.

Description
SB 1245, as amended, Kamlager. Los Angeles County Abortion Access Safe Haven 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 establish, subject to appropriation by the Legislature, the Los Angeles County Abortion Access Safe Haven Pilot Program for the purpose of expanding and improving access to reproductive and sexual health care, including abortion, in the County of Los Angeles. The bill would require any funds allocated for the Los Angeles County Abortion Access Safe Haven Pilot Program to be used by the County of Los Angeles to administer a pilot project to support innovative approaches and patient-centered collaborations to safeguard patient access to abortions, regardless of residency. The bill would authorize the funds to be used for implementing recommendations from the County of Los Angeles, including building secure infrastructure, among other things.

Primary Sponsors
Sydney Kamlager

Bill Number	Status	Position
SB 1298	**In Senate**	**Monitor**

Title
Behavioral Health Continuum Infrastructure Program.

Description
SB 1298, as introduced, Ochoa Bogh. Behavioral Health Continuum Infrastructure Program. Existing law authorizes the State Department of Health Care Services to, subject to an appropriation, establish a Behavioral Health Continuum Infrastructure Program. Existing law authorizes the department, pursuant to this program, to award competitive grants to qualified entities to construct, acquire, and rehabilitate real estate assets or to invest in needed mobile crisis infrastructure to expand the community continuum of behavioral health treatment resources to build or expand the capacity of various treatment and rehabilitation options for persons with behavioral health disorders, as specified.This bill would authorize the department, in awarding the above-described grants, to give preference to qualified entities that are, among other things, intending to place their projects in any recently closed hospitals or skilled nursing facilities, as specified. The bill would continuously appropriate, without regard to fiscal year, $1,000,000,000 to the department for purposes of implementing the Behavioral Health Continuum Infrastructure Program.

Primary Sponsors
Rosilicie Ochoa Bogh

Bill Number	Status	Position
SB 1337	In Senate	Monitor

Title
Coordinated specialty care for first-episode psychosis.

Description
SB 1337, as introduced, McGuire. Coordinated specialty care for first-episode psychosis. 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 requires health care service plan contracts and health insurance policies that provide hospital, medical, or surgical coverage to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses, as defined, of a person of any age.This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on and after January 1, 2023, to provide coverage for coordinated specialty care (CSC) services for the treatment of first-episode psychosis, which is described by the bill as a team-based service delivery method composed of specified treatment modalities and affiliated activities including, but not limited to, case management, pharmacotherapy and medication management, psychotherapy, and outreach and recruitment activities. The bill would require the CSC services provided to be consistent with the Coordinated Specialty Care for First Episode Psychosis Manual II: Implementation, developed by the National Institute of Mental Health. The bill would specify the membership of the CSC team and applicable training and supervision requirements. The bill would require the health care service plan or health insurer to use specified billing procedures for the services provided by the CSC team.The bill would require the Department of Managed Health Care and the Department of Insurance, as appropriate, in collaboration with the State Department of Health Care Services, to create a working group to establish guidelines, including, but not limited to, inclusion and exclusion criteria for individuals eligible to receive CSC services, and caseload and geographic boundary parameters for the treatment team. The bill would provide that its requirements would not apply to a nongrandfathered individual health care service plan contract or health insurance policy, or group health care service plan contract or health insurance policy covering 50 or fewer employees, if the appropriate department determines that compliance with any or all of those requirements would require the state to assume the cost and provide payments to enrollees or insureds to defray the cost of providing services described in the bill, pursuant to specified federal law.Because a violation of the bill’s requirements by a health care service plan would be a crime, the bill wo... (click bill link to see more).

Primary Sponsors
Mike McGuire

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:39 PM
Oppose: CA. Assoc. of Health Plans

Bill Number	Status	Position
SB 1361	In Senate	Monitor

Title
Importation of prescription drugs.

Description
SB 1361, as introduced, Kamlager. Importation of prescription drugs. 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 requires CHHSA to enter into partnerships to increase patient access to affordable drugs and to produce or distribute generic prescription drugs and at least one form of insulin, as specified.This bill would create the Affordable Prescription Drug Importation Program in CHHSA, under which the state would be a licensed wholesaler that imports prescription drugs, as specified, for the exclusive purpose of dispensing those drugs to program participants. The bill would require CHHSA to seek federal approval for the importation program on or before June 1, 2023, and would require CHHSA to contract with at least one contracted importer to provide services under the importation program within 6 months of receiving federal approval. The bill would require a contracted importer to, among other things, establish a wholesale prescription drug importation list that identifies the prescription drugs that have the highest potential for cost savings to the state and identify and contract with eligible Canadian suppliers who have agreed to export prescription drugs on that list.This bill would authorize a contracted importer to import a prescription drug from a Canadian supplier if specified requirements are met. The bill would authorize CHHSA to expand the importation program to authorize a manufacturer, wholesale distributor, or pharmacy in a foreign country other than Canada to export prescription drugs to California if specified requirements are met, including a change in federal law. If the importation program is expanded, the bill would authorize a contracted importer to import prescription drugs from a manufacturer, wholesale distributor, or pharmacy in a foreign country other than Canada.

Primary Sponsors
Sydney Kamlager

Bill Number	Status	Position
SB 1375	In Senate	Monitor

Title
Nursing: nurse practitioners.

Description
SB 1375, as introduced, Atkins. 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... (click bill link to see more).

Primary Sponsors
Toni Atkins, Jim Wood

Bill Number	Status	Position
SB 1379	In Senate	Monitor

Title
Pharmacy: remote services.

Description
SB 1379, as amended, 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 working for a hospital pharmacy to perform various services remotely, as specified, on behalf of a hospital 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 hospital 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 hospital 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

Bill Number	Status	Position
SB 1419	In Senate	Monitor

Title
Health information.

Description
SB 1419, as amended, Becker. Health information. (1) Existing law generally requires a health care professional at whose request a test is performed to provide or arrange for the provision of the results of a clinical laboratory test to the patient who is the subject of the test if so requested by the patient, in oral or written form. Existing law requires those results to be disclosed in plain language and in oral or written form, except the results may be disclosed in electronic form if requested by the patient and if deemed most appropriate by the health care professional who requested the test. Existing law requires a patient's consent to receive their laboratory results by internet posting or other electronic means and requires those results to be disclosed to the patient in a reasonable time period, but only after the results have been reviewed by a health care professional and if access to the results is restricted by use of a secure personal identification number when the results are disclosed to the patient.This bill would define "test" for these purposes to apply to both clinical laboratory tests and imaging scans, such as x-rays, magnetic resonance imaging, ultrasound, or other similar technologies. The bill would also make conforming changes.(2) Existing law establishes procedures for providing access to health care records or summaries of those records by patients and those persons having responsibility for decisions respecting the health care of others. Under existing law, any adult patient of a health care provider, any minor patient authorized by law to consent to medical treatment, and any patient's personal representative is entitled to inspect patient records upon presenting to the health care provider a request for those records and upon payment of reasonable costs, except as specified. A patient who is a minor is entitled to inspect patient records pertaining only to health care of a type for which the minor is lawfully authorized to consent. Existing law also prohibits the representative of a minor from inspecting the minor's patient records under certain circumstances. This bill would additionally prohibit the representative of a minor from inspecting the minor's patient records that relate to sensitive medical services, as defined. (3) 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 federal regulations require the implementation of specified application programming interfaces (API) for the access to and exchange of he... (click bill link to see more).

Primary Sponsors
Josh Becker

Bill Number	Status	Position
SB 1473	In Senate	Monitor

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

Bill Number	Status	Position
SB 1479	In Senate	Monitor

Title
COVID-19 testing in schools: COVID-19 testing plans.

Description
SB 1479, as amended, 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 require the department to coordinate specified school district, county office of education, and charter school COVID-19 testing programs that are currently federally funded or organized under the California COVID-19 Testing Task Force. The bill would require the department to provide supportive services, including technical assistance, vendor support, guidance, monitoring, and testing education, related to 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 the department to expand its 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 that is consistent with guidance from the department and to designate one staff member to report information on its COVID-19 testing program to the department. The bill would require each school within a school district to designate one staff member to report information on its COVID-19 testing program to the school district, and would authorize each school within a school district to name a staff member to lead its COVID-19 testing program. 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 require the department to determine which CO... (click bill link to see more).

Primary Sponsors
Richard Pan

DATE: April 11, 2022

TO: Executive Committee

FROM: Terry Brown, *Chief Human Resources Officer*

SUBJECT: AB 2589 – Annual Disclosure of Broker Fees

To comply with the requirements of AB 2589 in reporting insurance broker fees associated with the various health and welfare benefits L.A. Care offers to its employees, identified below is the disclosure of the commission earned by Woodruff Sawyer, our broker of record for the majority of our various health and wellness insurers providing L.A. Care employee benefits for the last two fiscal years (2020-2021 and 2021-2022). Commission is paid to Woodruff Sawyer on a monthly or annual basis, and the amount is based on the number of participants in the benefit program.

Line of Coverage	Carrier	Broker	2020/2021 Base Commission	2021/2022 Base Commission
Medical HMO	Kaiser	Woodruff Sawyer	1.5%	1.5%
Medical HMO and PPO	Blue Shield	Woodruff Sawyer	2%	2%
Dental HMO and PPO	Cigna Dental	Woodruff Sawyer	10% HMO $2.25 pepm	10% HMO $2.25 pepm
Vision	EyeMed	Woodruff Sawyer	$0.86 pepm	$0.86 pepm
EAP	Anthem Blue Cross	Woodruff Sawyer	0%	0%
Life, Long and Short-Term Disability	Unum	Woodruff Sawyer	10%	10%
Voluntary Benefits	Unum	Woodruff Sawyer	Varies by plan 70%-90% 1st year 2.5%-10% years 2+	Varies by plan 70%-90% 1st year 2.5%-10% years 2+
Business Travel Accident	Gerber	Woodruff Sawyer	0%	0%
Pet Insurance	Nationwide	Woodruff Sawyer	10% new and 5% renewal	10% new and 5% renewal

Line of Coverage	Carrier	Broker	2020/2021 Base Commission	2021/2022 Base Commission
Executive Disability	Unum	Woodruff Sawyer	50% 1st year 5% years 2-5 2.5% years 6-10 2% years 11+	50% 1st year 5% years 2-5 2.5% years 6-10 2% years 11+
Executive Term Life (CEO only eff. 2/1/2021)	Banner/Dye & Eskin	Woodruff Sawyer	25% 1st year 4% years 2-5 2% years 6-10 .5% years 11+	25% 1st year 4% years 2-5 2% years 6-10 .5% years 11+
Executive Term Life	Protective/Dye & Eskin (eff. 2/1/2021)	Woodruff Sawyer	For Year 1 Ages 18-59: 40% Ages 60-62: 38 Ages 63-64: 36 Ages 65-69: 34 Ages 70+: 32 Years 2-10: 4% Years 11+: 1%	For Year 1 Ages 18-59: 40% Ages 60-62: 38 Ages 63-64: 36 Ages 65-69: 34 Ages 70+: 32 Years 2-10: 4% Years 11+: 1%
Universal Life (CEO)	John Hancock	Woodruff Sawyer	The rest of the residual target premium held from year 1 (total of 95% of target over 2 years) 1% years 3-10	The rest of the residual target premium held from year 1 (total of 95% of target over 2 years) 1% years 3-10

In addition to insurance placement, additional services provided by Woodruff Sawyer for the commission payment include:

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

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

L.A. Care HEALTH PLAN

Board of Governors
MOTION SUMMARY

Date: April 26, 2022 **Motion No. EXE A.0422**

Committee: Executive **Chairperson:** Hector De La Torre

Issue: Approve revisions to Human Resources Policy & Procedure HR-709 Language Proficiency Assessment

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

Background: L.A. Care Health Plan (L.A. Care) has established language proficiency requirements, both spoken and written for employees whose position description requires them to communicate directly with Limited English Proficient Members or those employees who have to use their language in a permitted manner to meet the needs of L.A. Care.

All Clinical and Non-Clinical Bilingual Staff must be assessed and qualified in order to use their non-English language skills. Those who are not assessed and/or do not meet the language proficiency requirements are not allowed to use their non-English skills in their position.

Staff is proposing minor annual revisions to HR-709 Language Proficiency Assessment including the addition of a Language proficiency passing level grid, as noted in the attached document.

Member Impact: None

Budget Impact: None

Motion: **To approve the Human Resources Policy & Procedure HR-709 (Language Proficiency Assessment), as presented.**

	LANGUAGE PROFICIENCY ASSESSMENT	HR-709
DEPARTMENT	HUMAN RESOURCES	
Supersedes Policy Number(s)		

DATES					
Effective Date	1/31/2018	Review Date	1/31/2018	Next Annual Review Date	1/31/2019
Legal Review Date	1/10/2018	Committee Review Date	1/24/2018		

LINES OF BUSINESS

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

DELEGATED ENTITIES / EXTERNAL APPLICABILITY

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

ACCOUNTABILITY MATRIX

Enter department here	Enter policy §§ here		

ATTACHMENTS

Language Proficiency Passing Level Grid

ELECTRONICALLY APPROVED BY THE FOLLOWING		
	OFFICER	**DIRECTOR**
NAME	Terry Brown	Deborah Decker~~Jackie Tham~~
DEPARTMENT	Human Resources	Talent Strategy & HR Technology~~Human Resources~~
TITLE	Chief Human Resources Officer	Senior Manager, Learning Experience~~Senior Director Center for Organizational Excellence~~

AUTHORITIES
➢ HR-501, "Executive Committee of the Board: HR Roles and Responsibilities" ➢ California Welfare & Institutions Code, §14087.9605 ➢ Department of Health Care Services (DHCS) Agreement No. 04-36069 A08, Exhibit A, Attachment 9, provision 13.B ➢ Cal MediConnect (CMC) Contract §2.9.7.3 ➢ ~~—~~DHCS All Plan Letter 22-04 ➢

REFERENCES
➢ Enter all references, including policies and procedures, here.

HISTORY	
REVISION DATE	**DESCRIPTION OF REVISIONS**
1/31/2018	New P&P
4/19/2022	Revision and adding Language Proficiency Passing Level Grid

1.0 OVERVIEW:

1.1 L.A. Care Health Plan (L.A. Care) has established language proficiency requirements, both spoken and written., ~~which consist of formal testing process through a qualified vendor.~~

2.0 DEFINITIONS:

2.1 **Limited English Proficient (LEP) Members** - Members who cannot speak, read, write, or understand the English language at a level that permits them to interact effectively with health care providers and social services agencies.

2.2 **Clinical Terminology** ~~–~~ (also known as medical terminology)~~:~~ Includes terms for health care, plan services and benefits, ~~and~~ member services, body parts and associated components, body processes and physiology, common disease names, conditions and symptoms, clinical processes and procedures, and treatment plans.

2.3 **Non-clinical Terminology** ~~–~~ (also known as health care terminology)~~:~~ Includes terms for health care, plan services and benefits, and member services.

2.4 **Oral Language Proficiency** - An ability to understand and converse verbally in a non-English language in a professional manner including correct usage of vocabulary and grammar, accurate pronunciation, comprehension of spoken language related to non-clinical or clinical terminology and phraseology, and concepts relevant to health care delivery systems.

2.5 **Written Language Proficiency** - An ability to understand, read, and write a non-English language in a professional manner including correct usage of vocabulary and grammar, punctuations, spelling and comprehension of written language related to non-clinical or clinical terminology, and knowledge and experience with the culture of the intended audience.

2.6 **Qualified Bilingual Staff** - Staff who has been assessed for their non-English language proficiency and met the required threshold for the position.

2.7 **Clinical Staff** - Staff who work~~s~~ under the supervision of a physician and who ~~is~~are allowed by law, regulation, and L.A. Care's policy to perform or assist in the performance of a specified professional service.

2.8 **Non-Clinical Staff** - Staff who do~~es~~ not treat members or provide direct care.

2.9 **Sight Translation** - Oral rendition of text written in one language into another language. Sight translation ~~requires~~ is the ability to comprehend written text in one language (reading skills) and the ability to produce an oral or signed rendition in another language (speaking or speech production skills).

3.0 POLICY:

3.1 L.A. Care identifies, assesses, and tracks all bilingual employees whose position description requires them to communicate directly with ~~Limited English Proficient (~~LEP~~)~~ Members or who are asked to utilize their language skills in a permitted manner to meet the needs of L.A. Care.

3.2 All Clinical and Non-Clinical Bilingual Staff must be assessed and qualified in order to use their non-English language skills. Those who are not assessed and/or do not meet the language proficiency requirements are not allowed to use their non-English skills in their position.

4.0 PROCEDURES:

4.1 All staff in Clinical and Non-Clinical positions are identified for testing based on either specific job requirements (job descriptions stating "language skills' 'required' or 'preferred") or the needs of L.A. Care.

4.1.1 For bilingual staff identified for testing based on the needs of L.A. Care rather than their specific job requirements, special approval must be granted by the employee's direct supervisor, or the Manager or Director of Cultural and Linguistic Services (C&LS), and management of ~~Learning and Development department (L&D).~~the Human Resources department.

4.2 The language proficiency test is performed by a qualified outside vendor to all eligible candidates or employees upon hire, transfer, or special approval, and at L.A. Care's discretion based on business needs ~~every three years~~ thereafter.

4.2.1 The test will evaluate the candidate~~'~~s or employee's Oral and/or Written Language Proficiency including fluency, grammar, vocabulary, and comprehension oral/written Clinical and/or Non-C~~c~~linical Terminology ~~used at point of contact~~ related to both health care settings and member services.

4.3 The ~~L&D~~Human Resources department will coordinate the testing and re-testing process for new hire candidates and employees that may include making an appointment prior to the new hire~~'~~s start date with the authorized outside vendor.

~~4.3~~4.3.1 When a candidate or an employee takes the assessment off-site (remote work), they must sign the attestation prior to the assessment to confirm the they are the individual who will complete the assessment without any assistance from any sources, including but not limited to other persons, internet, translation tools, or dictionaries

4.4 The evaluation scale for the assessment portion is based on the U.S. Government's Interagency Language Roundtable (ILR) scale, administered by the authorized outside vendor.

4.4.1 Employees must complete the formal testing process with a passing score as defined by L.A. Care.

4.4.2 ~~Those~~ Employees who have passed the assessment ~~test~~ are allowed to use their non-English language skills in their position according to their job descriptions or based on the needs of L.A. Care.

4.4.3 ~~Those~~ Employees who d~~oid~~ not pass the ~~test~~ assessment must use the language assistance services offered through Cultural & Linguistic Services.

4.5 If the required test score is not achieved, the candidate or employee may re-test one (1) time to achieve the required test score, at the discretion of the hiring manager,

Manager or Director of C&LS, and Management of ~~L&D~~Human Resources. Testing should occur within six weeks of the initial testing. Human Resources in its discretion, may grant an exception for an additional retake of the test.

4.6 When the job description states "non-English language skill required", ~~C~~candidates that do not pass the ~~test~~ assessment and are not hired because of the restrictive language requirements, the candidate may re-apply when another position ~~is~~ becomes available, and re-test ~~one time~~ to achieve the required test score. When the job description states "non-English language skill preferred", candidates that do not pass the assessment can still be considered for the position.

4.7 The ~~L&D~~Human Resources department will monitor Oral and Written Language Proficiency of bilingual staff, and maintain a list of their capabilities. This will be made available to department managers upon request.

4.8 Qualified Bilingual Staff ~~is~~ are permitted to use their assessed language skills for:

4.8.1 Direct communication in the non-English language with LEP Members.

4.8.2 Sight Translation.

4.8.3 Cultural competency review and feedback.

4.8.4 Cultural and Linguistic Services Glossary Committee.

4.8.5 Any other activities based on the needs of L.A. Care that are approved by the employee's direct supervisor, the Manager or Director of ~~Cultural and Linguistic Services~~C&L, and Human Resources.

4.9 The following activities are prohibited for all staff, including Qualified Bilingual Non-clinical and Clinical Staff:

4.9.1 Interpreting (conversion of one spoken language into another).

4.9.2 Translation (conversion of one written language into another).

4.9.3 Editing and proofreading of translated documents.

4.9.4 Linguistic review of translated documents.

4.9.5 Large print conversion of translated documents.

~~**4.9.5**~~**4.9.6** Slight Translation

5.0 MONITORING:

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

6.0 REPORTING:

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

6.2 Human Resources provides C&L Services Unit with the Qualified Bilingual Staff list on a quarterly basis.

~~**1.1**~~

~~**2.0**~~**7.0** L.A. Care reserves the right to modify, rescind, delete, or add to this policy at any time, with or without notice.

Activity	Staff Type	Assessment(s)	Passing Level
Oral communication in the non-English language with LEP Members	Non-Clinical Staff	Speaking and Listening (General)	Level 9
	Clinical Staff	Speaking and Listening (General)	Level 9
		QBS	• Objective: 70% • Subjective: 3
Written communication in the non-English language with LEP Members	Non-Clinical Staff	Reading (General)	Level 11
		Writing (General)	Level 12
	Clinical Staff	Reading (General)	Level 11
		Writing (General)	Level 12
Cultural Competency Review and Feedback		Reading (General)	Level 11
		Writing (General)	Level 12
C&L Services Glossary Committee		Reading (General)	Level 11
		Writing (General)	Level 12

Assessment	Passing Level	Description of Passing Level
Speaking and Listening General	Level 9	A person at a level 9 can successfully handle in-depth conversations in the target language, on a broad range of subjects and at a normal rate of speech. Candidate has difficulty understanding some slang or idioms or some advanced grammatical structures, but can figure out what is said by the context of the discussion. When speaking, a person at a level 9 can express himself/herself over a broad range of topics at a normal speed. Candidate may have a noticeable accent and will make grammatical errors, for example with advanced tenses, but the errors will not cause misunderstanding to a native speaker.
	Level 10	A person at a level 10 can handle all of the tasks that a level 9 can, with the addition of demonstrating skills such as selling and persuasion. Candidate can successfully handle in-depth client questions, and does not require as much contextual support for understanding of slang and idioms. A person at this level is able to select vocabulary that conveys a finer shade of meaning with more precision than a level 9 and can better support his/her opinions. Errors in speech are few, are limited to advanced grammatical situations and do not affect understanding.
QBS (Medical Terminologies and Diagnosis & Instructions sections only)	Objective 70%	Communicate the meaning or concept in understandable, coherent, fluent Target language using significant words, phrases, and clauses in medical profession/patient encounters
	Subjective 3	* Pronunciation: Has acceptable pronunciation and use of rhythm, stress, and intonation that does not interfere with meaning * Grammar: Generally accurate use of gender, number, sentence structure, and subject-verb agreement. Grammar errors distract but do not affect meaning. * Conduit Role: Some changes, additions, and/or omissions that do not affect transfer between intended/original meaning and the message conveyed. Able to function according to the required context. * Conveying the Meaning: Accuracy is acceptable. Can convey nuances in the language, although sometimes language usage is awkward but does not affect meaning. * Fluidity in Language Transition: Acceptable control/flow. Requests for clarification and/or repetition do not affect fluidity. Hesitation and pauses also do not affect fluidity.
Reading	Level 11	The candidate has a wide range of comprehension and can understand advanced text materials with a near-native degree of precision.
Writing	Level 12	The candidate's writing structure is equivalent to that of a well-educated writer. The candidate is able to express opinions and explain procedures in a way that demonstrates an ability to write formal and informal styles. Any mistakes in grammar, spelling, punctuation, and/or vocabulary are very minor mistakes that a native speaker would make.