BOARD OF GOVERNORS

Executive Committee Meeting

October 25, 2023 • 2:00 PM

L.A. Care Health Plan

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

AGENDA
Executive Committee Meeting
Board of Governors

DRAFT

Wednesday, October 25, 2023, 2:00 P.M.
L.A. Care Health Plan, 1055 West 7th Street, Conference Room 1017-18
Los Angeles, CA 90017

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

To listen to the meeting via videoconference please register by using the link below:
https://lacare.webex.com/lacare/j.php?MTID=m0dfa2ecbb948308a2522ce88932a853d

To listen to the meeting via teleconference please dial: +1-213-306-3065
Meeting Number: 2482 439 0217 Password: lacare

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

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

You can also send your public comments by voicemail, email or text. If we receive your comments by 2:00 P.M. on October 25, 2023, it will be provided to the members of the Executive Committee in writing at the beginning of the meeting. The chat message, text, voicemail, or email must indicate if you wish to be identified or remain anonymous, and must include the name of the item to which your comment relates.

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

Please note that there may be delay in the digital transmittal of emails, texts and voicemail. The Chair will announce when public comment period is over for each item. If your public comments are not received on time for the specific agenda item you want to address, your public comments will be read at the public comment section prior to the board going to closed session.
The purpose of public comment is an opportunity for members of the public to inform the governing body about their views. The Executive Committee appreciates hearing the input as it considers the business on the Agenda. All public comments submitted will be read for up to 3 minutes during the meeting. The process for public comment is evolving and may change at future meetings. We thank you for your patience.

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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 — Alvaro Ballesteros, MBA, *Chair*

1. Approve today's Agenda — *Chair*
2. Public Comment *(Please read instructions above.)* — *Chair*
3. Approve September 27, 2023 meeting minutes p.5 — *Chair*
4. Chairperson's Report — *Chair*
5. Chief Executive Officer Report — John Baackes, *Chief Executive Officer*
   - Government Affairs Update p.17 — Cherie Compartore, *Senior Directors, Government Affairs*

Committee Issues

6. Presentation on Community Health Investment Fund (CHIF) Priorities for FY 2023-24 p.47 — Shavonda Webber-Christimas, *Director, Community Benefits*
7. Housing & Homelessness Incentive Program Investment agreement with United Way of Greater Los Angeles (UWGLA) **(EXE 100)**p.56 — Karl Calhoun, *Director, Housing Initiatives*
8. Human Resources Policies HR 105 (Employee Benefit Plans), HR 109 (Jury Duty and Witness Subpoenas), and HR 709 (Language Proficiency Assessment) **(EXE A)** p.58 — Terry Brown, *Chief Human Resources Officer*
9. Approve the list of items that will be considered on a Consent Agenda for November 2, 2023 Board of Governors Meeting. — *Chair*
   - October 5, 2023 Board of Governors Meeting Minutes
   - Housing & Homelessness Incentive Program Investment agreement with United Way of Greater Los Angeles (UWGLA)
   - I Color Printing and Mailing Inc. Contract Amendment Premium Billing Unit with printing, storage, postage/mailing, reporting, and order fulfillment services through June 30, 2025
   - MCG (Milliman) Contract provide clinical care guidelines for the period of November 10, 2023 to October 31, 2028
   - Accounts & Finance Services Policy AFS-008 (Annual Investment Policy Review)
   - Ratify the elected Chair and Vice Chair of the Temporary Transitional Executive Community Advisory Committee (TTECAC)
10. Public Comment on Closed Session Items *(Please read instructions above.)* — *Chair*

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

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

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

13. CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION
Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act
MemorialCare Select Health Plan v. L.A. Care Health Plan
American Health Law Association, Case No. 7028, filed April 28, 2022

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

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

RECONVENE IN OPEN SESSION

ADJOURNMENT *Chair*

The next Executive Committee meeting is scheduled on Wednesday, November 15, 2023 at 2:00 p.m.
and may be conducted as a teleconference meeting.

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

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

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

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

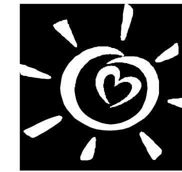
Any documents distributed to a majority of the Board Members regarding any agenda item for an open session after the agenda has been posted will be available for public inspection at 1055 W. 7th Street, Los Angeles, CA, in the reception area in the main lobby or at http://www.lacare.org/about-us/public-meetings/board-meetings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

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

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

Last Saved 10/20/2023 10:32 AM

BOARD OF GOVERNORS
Executive Committee
Meeting Minutes – September 27, 2023



1055 West 7th Street, 10th Floor, Los Angeles, CA 90017

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

* *Absent*
** *Via Teleconference*

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

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Alvaro Ballesteros, MBA, *Chairperson,* called to order the regular meetings of the L.A. Care Executive Committee and the L.A. Care Joint Powers Authority Executive Committee regular meetings at 2:01 p.m. The meetings were held simultaneously. He welcomed everyone to the meetings. • For those who provided public comment for this meeting by voice message or in writing, L.A. Care is glad that they provided input today. The Committee will hear their comments and the Committee also needs to finish the business on the Agenda today. • For people who have access to the internet, the meeting materials are available at the lacare.org website. If anyone needs information about how to locate the meeting materials, they can reach out to L.A. Care staff. • Information for public comment is on the Agenda available on the web site. Staff will read the comment received in writing from each person for up to three minutes. • Public comment will be heard before the Committee discusses an item. If the comment is not on a specific agenda item, it will be read at the general Public Comment. He provided information on how to submit a comment in-person, or using the “chat” feature.	

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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
APPROVE MEETING AGENDA	The motion for Housing & Homelessness Incentive Program Investment agreement The Agenda for today's meeting was approved as amended.	**Approved unanimously.** **4 AYES (Ballesteros, Booth, Raffoul, and Shapiro)**
PUBLIC COMMENT	There were no public comments.	
APPROVE MEETING MINUTES	Committee Member Booth proposed amendments to the August 23, 2023 meeting minutes. Strike on page 4: "Board Member Booth asked how this compares to other issues L.A. Care has had to enact regarding the importance for L.A. Care's patient care, reasonable cost, and the amount of work required in implementing the changes." Add on page 4: "Board member Booth noted there seemed to be a large number of additional tasks involved with the current contract amendment. She does not have a complete understanding of DHCS's requirements listed in the amendment, or the effort that will be required of LA Care to meet the requirements. She noted it would be helpful to know 1) what DHCS's goals were that prompted writing the new requirements, as well as 2) the value of the intended work product related to LA Care's Mission. The contract amendment seems to require a lot of work by health plans and she wonders if the value of the result is equivalent to the value of work needed to be completed to achieve the result. She hopes someone could explain to her whether, and how, the results might justify the effort required." The minutes of the August 23, 2023 meeting were approved as amended.	**Approved unanimously.** **4 AYES (Ballesteros, Booth, Raffoul, and Shapiro)**
CHAIRPERSON'S REPORT	There was no report from the Chairperson.	
CHIEF EXECUTIVE OFFICER REPORT	John Baackes, *Chief Executive Officer*, reported: • L.A. Care has received the third month of data for the resumption of Medi-Cal eligibility redetermination. The number of beneficiaries that have not completed the process are placed "on hold" for 90 days. If the redetermination process is completed within the 90-day period, benefits are reinstated. The redetermination results in Los Angeles County are a bit better than the statewide results. About 40% of Medi-Cal members are determined to be eligible through an ex parte process, where data from other programs is used to qualify beneficiaries for Medi-Cal for another year and beneficiaries are notified. The remaining 60% of beneficiaries are	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	sent information about completing the 20-page redetermination packet. It is estimated that only 4% will complete the packet and have their benefits reinstated. Across California, about 21% of those packets are not completed and those beneficiaries are placed on hold for 90 days. A 70% disenrollment rate is projected, and the numbers in Los Angeles County are consistent with that number. It was not anticipated that there would be a significant number of new enrollment applications for Medi-Cal in Los Angeles County and statewide. L.A. Care is checking to determine whether these are prior members re-enrolling with a new application instead of using the redetermination forms. In the first three months there does not seem to be a significant number of re-enrollments among the new enrollment applications received. In the first three months of the redetermination process, about 120,000 L.A. Care members were placed on hold and there were about 96,000 new members enrolled resulting in a small net loss in members. Certified Enrollers at L.A. Care's Community Resource Centers (CRC) are helping people successfully complete the redetermination packet. Half the appointments are with people applying for Medi-Cal for the first time. We are seeing many new members among people who previously have not been eligible. This is occurring statewide, although there seems to be a little higher rate of new enrollees in Los Angeles County. There is a great deal of uncertainty in the redetermination process and whether the current enrollment trend will continue. The results of resuming the redetermination will not be known until August of 2024. On January 1, 2024, two things will happen: 1. Kaiser Permanente will begin to operate under its own direct Medi-Cal contract with the State of California. The 287,000 Medi-Cal lives that are now counted as part of L.A. Care's enrollment will be transitioned to that Kaiser contract. Los Angeles County will effectively become a three-plan county, although that phrase has not been used yet. The interesting new development that has come out since the Board last met is that the state has announced the number of Medi-Cal beneficiaries will be expected for Kaiser default enrollment. Default enrollment affects about 40% of the people applying for Medi-Cal as they do not select a health plan as they enroll. California Department of Health Care Services (DHCS) has an algorithm based on quality for the default enrollment. L.A. Care currently receives 56% of that, and Health Net receives the remainder. If Kaiser is to receive a portion of the default enrollment, a question is how Kaiser's default assignment will be determined. If it were based on a quality score, Kaiser would likely have the highest quality scores, because they	

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	have the lowest acuity. DHCS has assigned a number for Medi-Cal enrollment for Kaiser in each county. In Los Angeles County, Kaiser will be required to enroll 946 members by default assignment. In Kern County, the default assignment to Kaiser is 50 members. That will have a negligible effect on L.A. Care's default assignment, and is another indication that Kaiser is being treated differently from the other health plans in the Medi-Cal managed care program in California. 2. Health Net will have to surrender 50% of its enrollment to Molina Health, its plan partner. Health Net and Molina have a long-standing plan partner relationship; Molina currently has about 80,000 of the 1.2 million Health Net members in Los Angeles County. The statewide health plan reprocurement process conducted in 2022 was canceled at the end of 2022. Through an agreement made behind closed doors, Health Net will be required to maintain a contract with Molina, and 50% of Health Net membership will transition to Molina. Sometime this fall 550,000 people enrolled with Health Net will receive a letter that as of January 1, 2024, their Medi-Cal benefits will transition to Molina. DHCS has not definitively told other plans how this will be done, but we assume that people will be transferred based on primary care physician. Molina has been signing up every provider they can in Los Angeles County so that it has a network that matches Health Net and beneficiaries can be moved without a disruption in care. One outcome is that Molina has no bargaining power because Molina needs those providers in its network. Providers are getting top dollar reimbursement, which may become precedent that other health plans will need to match in a year or two. L.A. Care is not losing significant enrollment in Medi-Cal due to the redetermination process. There are many redeterminations yet to be processed. L.A. Care will continue to monitor this process, as it has repercussions on enrollment numbers and L.A. Care's financial outlook. Chairperson Ballesteros asked about early enrollment through expansion of eligibility for Medi-Cal on January 1, 2024, and if any of the current new enrollment is related. Mr. Baackes responded that some beneficiaries are currently being enrolled in partial benefits and will switch to full benefits on January 1, 2024. It is estimated that there are 270,000 potentially eligible beneficiaries between the ages of 26 and 49 in Los Angeles County, and L.A. Care expects to enroll 70% of those. L.A. Care's budget estimate was 140,000 to be enrolled, and the actual enrollment could be higher than forecast in the budget. The estimate of 270,000 was provided by DHCS, based on the partial	

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	participation. In Los Angeles County, some beneficiaries are receiving care through *My Health LA*. A challenge for L.A. Care is that many of those beneficiaries are currently receiving services at Los Angeles County Department of Health Services (DHS) sites or at federally qualified health centers (FQHC) and will need to be enrolled with their current primary care provider or specialty care providers. In the summer of 2022, members ages 50 and older became eligible beneficiaries for Medi-Cal, and the process for matching those new beneficiaries with existing health care providers was quite a challenge. L.A. Care has put procedures in place to simplify enrollment and preserve continuity of care. Chairperson Ballesteros commented that it would be helpful for DHS to assist FQHCs in outreach and enrollment. Mr. Baackes noted that L.A. Care could assist in facilitating that process. Chairperson Ballesteros is advocating for support through Community Clinic Association of Los Angeles County (CCALAC) to make the extra effort for support through the transition. Mr. Baackes suggested that L.A. Care could convene a meeting with CCALAC, Health Net and county representatives in this regard. Sameer Amin, MD, *Chief Medical Officer,* added that he has brought this idea to DHS a number of times and they are open to it, and there is opportunity to work together on it. Board Member Booth suggested including independent practices. Mr. Baackes agreed, and suggested including the Los Angeles County Medical Association (LACMA). He noted that if beneficiaries in the cohort are currently receiving care, likely through DHS sites and FQHCs. There may be an issue in matching an enrollee to a primary care provider other than DHS sites or with FQHCs. L.A. Care has ended default enrollment in DHS sites because of capacity.	
• Department of Managed Health Care Enforcement Matter Report	The report is provided for the Board member's information concerning EM (*a copy of the report can be obtained by contacting Board Services)*. The Board has delegated authority to the CEO up to $250,000 under L.A. Care's policy to settle threatened litigation matters, including DMHC Enforcement Matters, without Board approval. The policy requires the CEO to report the settlement to the Executive Committee and/or to the Board, before or after settlement. The settlement amounts listed in the report are within the CEO's delegated authority.	
• Government Affairs Update	Cherie Compartore, *Senior Director, Government Affairs,* reported: • The federal fiscal year begins on October 1 annually. In years where the US Congress has not enacted a budget or a continuing resolution that continues current funding for federal programs, there is a shut down in federal programs. It is common in past years for continuing resolutions to be enacted while the US	

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	Congress negotiates the federal budget, and shut downs are very rare. A shut down did occur in 2018, lasting about one month. The US Senate will vote this week on a continuing resolution, that will extend current funding through November 17, 2023, but it is not expected to be passed through the House of Representatives. Some members of Congress have indicated that funding for Ukraine is not acceptable. It is hoped there will not be a shut down. It remains to be seen if the Speaker of the House of Representatives, Kevin McCarthy, will negotiate approval of a continuing resolution in the House. • The effects of a potential shut down on federal programs is not yet known because of the changing situation. The Medi-Cal program has full funding until at least the first quarter of the year. However, many staff at Centers for Medicare and Medicaid Services (CMS) would be furloughed in a federal shutdown, which could hinder progress on rates, renewals, etc. L.A. Care has confirmed with CMS that no problems are anticipated with the Covered California product line in a shut down. Medicare Advantage (Dual Special Needs Plans, or D-SNPs) are also expected to be paid at the first of every month even in a shutdown, as those payments come directly from the Treasury and payments are mandated. For the Supplemental Nutrition Assistance Program (SNAP), known as Cal Fresh in California, current funding is allocated through October 31, 2023. If there is a shutdown, states may need to supplement the funding in order to operate the program. If there is a shut down, it is hoped that, as in 2018-19, a bill currently proposed in US Congress would be approved to provide three months' federal funding for Cal Fresh. • The Women, Infants and Children (WIC) program could be negatively impacted by a shutdown, as there is no funding left in this program after October 1, 2023. Continued operation of WIC in a shut down after October 1, 2023 would require funding by states. • Federal funding for benefits under Supplemental Security Income, Veteran's programs and unemployment would continue. Afzal Shah, *Chief Financial Officer,* asked about the Managed Care Organization (MCO) tax and potential effects of a federal shutdown. Ms. Compartore noted that CMS staff would not be available to process approval of the MCO tax in a shut down, so the payment for the first quarter (including retroactive payments) would be in jeopardy. There is no information about where negotiations are between CMS and California representatives.	

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COMMITTEE ISSUES		
Scout Exchange Contract Amendment	Terry Brown, *Chief Human Resources Officer,* summarized a motion requesting approval to execute Amendment VI to the contract with Scout Exchange adding $15,000,000 to the maximum expense, to be expended in the 2023-24 fiscal year. Scout provides L.A. Care with software to assist in the management of contingent workers. Using Scout streamlines the contingent workforce management process, including timecards, staffing requests and vendor management. We request approval to extend the contract through September 30, 2024 with an additional $15,000,000 (for a total cost not to exceed $63,464,908). **<u>Motion EXE 100.1023</u>** **To authorize staff to increase the spend of the existing purchase order, by an additional amount of $15,000,000 not to exceed a total spend of $63,464,908 with Scout Exchange for contingent worker vendor management services rendered through the end of the contract term on September 30, 2024.**	**Approved unanimously.** **4 AYES (Ballesteros, Booth, Raffoul, and Shapiro)**
Amendments to L.A. Care Health Plan Retirement Benefit Plan	Mr. Brown noted that the Board delegated authority for approval of this motion at its last meeting following a presentation of the potential costs by L.A. Care's actuary. The required waiting period following that presentation has expired so the final approval is now in order. L.A. Care maintains the L.A. Care Health Plan Retirement Benefit Plan (the Plan), a qualified defined contribution money purchase pension plan, for the benefit of its eligible employees and their beneficiaries. The Plan was most recently restated effective January 1, 2020. Currently, the Plan requires eligible employees to complete one year of service in order to become eligible to participate in the additional employer non-elective contribution equal to 3.5% of compensation and the employer matching contribution equal to 100% of the participant's elective contributions to the Deferred Compensation Plan up to 4% of Compensation. In order to better attract qualified employees, staff proposed to amend the Plan to eliminate the one-year-of-service requirement for eligibility to participate in the additional employer non-elective contribution and employer matching contribution. This motion seeks final approval by the Executive Committee for the changes.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	<u>**Motion EXE A.0923**</u> **To approve the future costs of the elimination of the one-year-of-service requirement to participate in the additional employer non-elective contribution and employer matching contribution under the L.A. Care Health Plan Retirement Benefit Plan and authorize any necessary or appropriate actions to implement its decision, and to express a preference that if it decides to do so, then it consider the following actions:** **1. Approve the amendment of the L.A. Care Health Plan Retirement Plan to eliminate the one-year-of-service requirement for eligibility to participate in the additional employer non-elective contribution and employer matching contribution.** **2. Authorize and direct the Chief Executive Officer to execute the amendment to the Plan to eliminate that requirement and take all other actions necessary or appropriate to implement the foregoing resolutions.**	**Approved unanimously.** **4 AYES (Ballesteros, Booth, Raffoul, and Shapiro)**
Human Resources Policy HR 219 (Standards of Conduct)	Mr. Brown then presented a motion to revise HR 219. L.A. Care Health Plan (L.A. Care) requires order, focus, discipline and rigor to succeed as an organization, and professionalism, productivity, and cooperation are required from all employees. The standards of conduct outlined in HR-219 help achieve those requirements with minor corrections and by updating language pertaining to alcohol and substance use to include functions where employees are representing L.A. Care outside working hours. <u>**Motion EXE B.0923**</u> **To approve the Human Resources Policy & Procedure HR-219 Standard of Conducts, as presented.**	**Approved unanimously.** **4 AYES (Ballesteros, Booth, Raffoul, and Shapiro)**
Funding for Workforce Development **(EXE 101)**	Mr. Baackes introduced a motion which results from a presentation made during the September 7, 2023 Board Meeting. L.A. Care has made significant financial commitments to supporting safety net workforce needs. In May 2018, L.A. Care's Board of Governors approved an initial five-year $155 million commitment in Board Designated Funds for its Elevating the Safety Net Initiative, which covered a range of programs including medical school scholarships, provider loan repayment, provider recruitment grants to clinics and practices, and other workforce programs. In May 2022, the Board approved a five-year	

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	extension to continue investing the remaining $61 million in some of the programs under Elevating the Safety Net through FY 2026-27. Much good has come from our Elevating the Safety Net (ESN) investments, including 48 students receiving medical school scholarships, 152 new physicians hired, 173 physicians awarded loan repayment assistance, 44 new residents added, 54 Community Health Workers trained and employed, among other achievements. However, additional community and safety net needs continue to emerge. The new Medi-Cal contract that begins on January 1, 2024 requires health plans to dedicate a percentage of annual net income to community investments. L.A. Care has consistently exceeded the required percentage. However, in the spirit of the state requirement and to further L.A. Care's longstanding commitment to strengthening the safety net, this motion requests Board approval to add $50 million from unassigned reserves to the initial Board Designated Fund of $155 million for workforce development. This will assure continuity of funding through the five-year expansion commitment that the Board approved in May 2022 and will provide flexibility to address other safety net and community needs that arise in the interim. Board Member Raffoul asked about the potential settlement funds that may be received. Mr. Baackes reported that the funds that might be received from a settlement could provide additional funding for L.A. Care's community benefit programs. Board Member Booth asked if disbursements from this fund would require Board approval. Mr. Baackes responded that the Board has approved disbursements in the past in block amounts by category and individual vendor contract expenditures. Two examples would be the Board approval of $5 million to the Charles R. Drew University to start up the Medical School, and a similar amount to Keck Graduate Institute to start the Community Medicine Program. Member Booth asked if there were plans to fund interns and residency programs. Mr. Baackes responded that the residency program is under review. Wendy Schiffer, *Senior Director of Strategic Planning,* added that the ESN program was approved at a smaller expenditure, and programs were evaluated for effectiveness and impact. The residency portion of the original investment was not included in the second expenditure. She noted that staff could review the program for a new funding program. Mr. Baackes noted that L.A. Care is frequently asked to expand the funds allocated for provider recruitment, as the current funding for recruitment is limited to recruitment for primary care and psychiatry. The motion could allow	

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	expansion into other areas of practice. Member Booth indicated that she would like to see additional data on the results of the residency grants to determine the value that was added to the safety net provider network through the program. Mr. Baackes noted that grants to a provider site are made for a particular position over three years. If the person hired leaves the position, the provider is obligated to refill the position within the three-year period. L.A. Care added to the recruitment grant the potential for the person hired to receive a monthly allocation to reduce debt from medical school tuition up to $180,000 over three years, and if the person leaves during the three years, the allocation for medical school tuition ends. Mr. Baackes offered to provide a report to the Board on the recruitment program. Member Booth asked about the timing for a report on the L.A. Care Scholars, and Mr. Baackes indicated it would likely be eight years after the first group began medical school. Member Booth commented that reports on the locations of the Scholars for their residency will be helpful. Many residents end up settling in the community where they served their residency. Mr. Baackes has been impressed by the number of students that want to return to Los Angeles County to practice medicine, particularly those with family in Los Angeles County. Dr. Amin agreed it would be helpful and he offered to present a report at a future meeting. **<u>Motion EXE 101.1023</u>** **To authorize adding $50 million from unassigned reserves to the Board Designated Fund for workforce development to address emerging safety net and community needs through FY 2026-27.**	**Approved unanimously.** **4 AYES (Ballesteros, Booth, Raffoul, and Shapiro)**
Approve Consent Agenda	Approve the list of items that will be considered on a Consent Agenda for October 5, 2023 Board of Governors Meeting. • September 7, 2023 Board of Governors Retreat and Meeting Minutes • Scout Exchange Contract Amendment • Language Line Solutions Contract Extension • TierPoint Contract to provide Disaster Recovery • Cognizant/Trizetto Technology Solutions, Infosys Ltd. and Solugenix Corporation Contract Amendment for Information Technology Staff Augmentation • NICE Systems, INC. to provide an Engage Quality Monitoring Cloud Based platform with Real-Time Authentication Contract • EPlus Contract to provide Storage Service	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• NetCentric Technologies, Inc. Contract Amendment • Ntooitive Contract • Ratify the re-election of Tara Ficek, MPH as Chairperson and Maryjane Puffer, BSN, MPA as Vice Chairperson of the Children's Health Consultant Advisory Committee	**Approved unanimously.** **4 AYES (Ballesteros, Booth, Raffoul, and Shapiro)**
PUBLIC COMMENTS	There were no public comments.	
ADJOURN TO CLOSED SESSION	The Joint Powers Authority Executive Committee meeting adjourned at 2:54 pm. Augustavia J. Haydel, Esq., *General Counsel* announced the items to be discussed in closed session. She announced there is no report anticipated from the closed session. The meeting adjourned to closed session at 3:13 pm. CONTRACT RATES Pursuant to Welfare and Institutions Code Section 14087.38(m) • Plan Partner Rates • Provider Rates • DHCS Rates • Plan Partner Services Agreement REPORT INVOLVING TRADE SECRET Pursuant to Welfare and Institutions Code Section 14087.38(n) Discussion Concerning New Service, Program, Business Plan Estimated date of public disclosure: *June 2025* CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION Significant exposure to litigation pursuant to Section 54956.9(d)(2) of Ralph M. Brown Act: Four Potential Cases THREAT TO PUBLIC SERVICES OR FACILITIES Government Code Section 54957 Consultation with: Thomas Mapp, Chief Compliance Officer, Serge Herrera, Privacy Director and Gene Magerr, Chief Information Security Officer	

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 • Department of Managed Health Care Enforcement Matter Numbers: 18-799, 20-063, 21-428, 21-509, 21-680 • Department of Health Care Services, Office of Administrative Hearings and Appeals, In the matter of: L.A. Care Health Care Plan Appeal No. MCP22-0322-559-MF	
RECONVENE IN OPEN SESSION	The meeting reconvened in open session at 4:15 pm. No reportable actions were taken during the closed session.	
ADJOURNMENT	The meeting adjourned at 4:28 pm.	

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

APPROVED BY:

____
Alvaro Ballesteros, MBA, *Board Chairperson*
Date: ______________________________________

DRAFT

Final 2023 Legislative Matrix

Last Updated: October 16, 2023

Bills by Issue

2023 Legislation (33)

Bill Number	Status	Position
AB 102	Enacted	Monitor

Title
Budget Act of 2023.

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

Primary Sponsors
Phil Ting

Bill Number	Status	Position
AB 103	Enacted	Monitor

Title
Budget Acts of 2021 and 2022.

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

Primary Sponsors
Phil Ting

Bill Number	Status	Position
AB 112	**Enacted**	**Monitor**

Title
Distressed Hospital Loan Program.

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

Primary Sponsors
House Budget Committee

Bill Number
AB 118

Status
Enacted

Position
Monitor

Title
Budget Act of 2023: health.

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

Primary Sponsors
House Budget Committee

Bill Number
AB 119

Status
Enacted

Position
Monitor

Title
Medi-Cal: managed care organization provider tax.

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

Primary Sponsors
House Budget Committee

Bill Number	Status	Position
AB 120	**Enacted**	**Monitor**

Title
Human services.

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

Primary Sponsors
House Budget Committee

Bill Number
AB 129

Status
Enacted

Position
Monitor

Title
Housing.

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

Primary Sponsors
House Budget Committee

Bill Number	Status	Position
AB 254	**Enacted**	**Monitor**

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

Description
AB 254, Bauer-Kahan. Confidentiality of Medical Information Act: reproductive or sexual health application information. The Confidentiality of Medical Information Act (CMIA) prohibits a provider of health care, a health care service plan, a contractor, or a corporation and its subsidiaries and affiliates from intentionally sharing, selling, using for marketing, or otherwise using any medical information, as defined, for any purpose not necessary to provide health care services to a patient, except as provided. The CMIA makes a business that offers software or hardware to consumers, including a mobile application or other related device that is designed to maintain medical information in order to make the information available to an individual or a provider of health care at the request of the individual or a provider of health care, for purposes of allowing the individual to manage the individual's information or for the diagnosis, treatment, or management of a medical condition of the individual, a provider of health care subject to the requirements of the CMIA. Existing law makes a violation of these provisions that results in economic loss or personal injury to a patient punishable as a misdemeanor.This bill would revise the definition of "medical information" to include reproductive or sexual health application information, which the bill would define to mean information about a consumer's reproductive or sexual health collected by a reproductive or sexual health digital service, as specified. The bill would make a business that offers a reproductive or sexual health digital service to a consumer for the purpose of allowing the individual to manage the individual's information, or for the diagnosis, treatment, or management of a medical condition of the individual, a provider of health care subject to the requirements of the CMIA. Because the bill would expand the scope of a crime, it would impose a state-mandated local program.This bill would incorporate additional changes to Section 56.05 of the Civil Code proposed by AB 1697 to be operative only if this bill and AB 1697 are enacted and this bill is enacted last.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

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

Bill Number
AB 317

Status
Enacted

Position
Monitor

Title
Pharmacist service coverage.

Description
AB 317, Weber. Pharmacist service coverage. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care under authority of the Director of the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law authorizes health care service plans and certain disability insurers, that offer coverage for a service that is within the scope of practice of a duly licensed pharmacist, to pay or reimburse the cost of the service performed by a pharmacist for the plan or insurer if the pharmacist otherwise provides services for the plan or insurer.This bill would instead require a health care service plan and certain disability insurers that offer coverage for a service that is within the scope of practice of a duly licensed pharmacist to pay or reimburse the cost of services performed by a pharmacist at an in-network pharmacy or by a pharmacist at an out-of-network pharmacy if the health care service plan or insurer has an out-of-network pharmacy benefit. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Akilah Weber

Bill Number	Status	Position
AB 352	**Enacted**	**Monitor**

Title
Health information.

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

Primary Sponsors
Rebecca Bauer-Kahan

Bill Number
AB 425

Status
Enacted

Position
Monitor

Title
Medi-Cal: pharmacogenomic testing.

Description
AB 425, Alvarez. Medi-Cal: pharmacogenomic testing. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law sets forth a schedule of covered benefits under the Medi-Cal program.This bill would, commencing on July 1, 2024, add pharmacogenomic testing as a covered benefit under Medi-Cal, as specified. The bill would define pharmacogenomic testing as laboratory genetic testing that includes, but is not limited to, a panel test, to identify how a person’s genetics may impact the efficacy, toxicity, and safety of medications.The bill would condition implementation of this benefit coverage on receipt of any necessary federal approvals and the availability of federal financial participation. The bill would authorize the department to implement these provisions through all-county letters or similar instructions.The bill would also make related legislative findings.

Primary Sponsors
David Alvarez

Bill Number
AB 531

Status
Enacted

Position
Monitor

Title
The Behavioral Health Infrastructure Bond Act of 2023.

Description
AB 531, Irwin. The Behavioral Health Infrastructure Bond Act of 2023. Existing law establishes the Multifamily Housing Program administered by the Department of Housing and Community Development. Existing law requires assistance for projects under the program to be provided in the form of deferred payment loans to pay for eligible costs of specified types of development, as provided. Existing law requires that specified funds appropriated to provide housing for individuals and families who are experiencing homelessness or who are at risk of homelessness and who are inherently impacted by or at increased risk for medical diseases or conditions due to the COVID-19 pandemic or other communicable diseases be disbursed in accordance with the Multifamily Housing Program for specified uses.The California Environmental Quality Act (CEQA) requires a lead agency, as defined, to prepare, or cause to be prepared, and certify the completion of, an environmental impact report on a project that it proposes to carry out or approve that may have a significant effect on the environment or to adopt a negative declaration if it finds that the project will not have that effect. CEQA does not apply to the approval of ministerial projects. Existing law, until July 1, 2024, exempts from CEQA a project funded to provide housing for individuals and families who are experiencing homelessness, as described above, if certain requirements are satisfied, including if the project proponent obtains an enforceable commitment to use a skilled and trained workforce for any proposed rehabilitation, construction, or major alterations, as specified.This bill would provide that projects funded by the Behavioral Health Infrastructure Bond Act of 2024 that provide housing for individuals and families who are experiencing homelessness or who are at risk of homelessness and who are inherently impacted by or at increased risk for medical diseases or conditions due to the COVID-19 pandemic or other communicable diseases and are disbursed in accordance with the Multifamily Housing Program, or projects that are disbursed in accordance with the Behavioral Health Continuum Infrastructure Program, are a use by right and subject to the streamlined, ministerial review process. The bill would define use by right for these purposes to mean that the local government’s review of the project does not require a conditional use permit, planned unit development permit, or other discretionary local government review or approval that would constitute a project subject to the approval process in CEQA.Because the bill would revise the approval process of specified projects, the bill would impose a state-mandated local program.Existing law authorizes the State Department of Health ... (click bill link to see more).

Primary Sponsors
Jacqui Irwin, Susan Eggman, Richard Roth

Bill Number
AB 557

Status
Enacted

Position
Monitor

Title
Open meetings: local agencies: teleconferences.

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

Primary Sponsors
Gregg Hart

Bill Number
AB 614

Status
Enacted

Position
Monitor

Title
Medi-Cal.

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

Primary Sponsors
Jim Wood

Bill Number	Status	Position
AB 659	**Enacted**	**Monitor**

Title
Cancer Prevention Act.

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

Primary Sponsors
Cecilia Aguiar-Curry

Organizational Notes

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

Bill Number
AB 663

Status
Enacted

Position
Monitor

Title
Pharmacy: mobile units.

Description
AB 663, Haney. Pharmacy: mobile units. Existing law, the Pharmacy Law, requires the California State Board of Pharmacy within the Department of Consumer Affairs to license and regulate the practice of pharmacy, including pharmacists, pharmacy technicians, and pharmacies. Existing law authorizes a county, city and county, or special hospital authority, as defined, to operate a mobile unit as an extension of a pharmacy license held by the county, city and county, or special hospital authority to provide prescription medication within its jurisdiction to specified individuals, including those individuals without fixed addresses. Existing law authorizes a mobile unit to dispense prescription medication pursuant to a valid prescription if the county, city and county, or special hospital authority meets prescribed requirements for licensure, staffing, and operations, including a prohibition on carrying or dispensing controlled substances.Existing law, the California Uniform Controlled Substances Act, classifies certain controlled substances into Schedules I to V, inclusive.This bill would instead authorize a county, city and county, or special hospital authority to operate one or more mobile units as an extension of a pharmacy license held by the county, city and county, or special hospital authority, as described above. The bill would require the pharmacist-in-charge to determine the number of mobile units that are appropriate for a particular pharmacy license. The bill would additionally authorize a mobile unit to provide prescription medication within its jurisdiction to city-and-county-operated housing facilities.This bill would exempt from the above-described prohibition on carrying or dispensing controlled substances Schedule III, Schedule IV, or Schedule V controlled substances approved by the United States Food and Drug Administration for the treatment of opioid use disorder. The bill would require any controlled substance for the treatment of opioid use disorder carried or dispensed in accordance with that exemption to be carried in reasonable quantities based on prescription volume and stored securely in the mobile pharmacy unit.Existing law requires a city, city and county, or special hospital authority, at least 30 days before commencing operation of a mobile unit, to notify the board of its intention to operate a mobile unit. Existing law further requires that the board be given notice at least 30 days before discontinuing operation of a mobile unit.This bill would instead require a county, city and county, or special hospital authority to notify the board of its intention to operate a mobile unit as soon as possible, and no later than 5 business days after commencing operation of a mobile unit. The bill would a... (click bill link to see more).

Primary Sponsors
Matt Haney

Bill Number
AB 712

Status
Enacted

Position
Support

Title
CalFresh: hot and prepared foods.

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

Primary Sponsors
Wendy Carrillo

Organizational Notes

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

Bill Number	Status	Position
AB 716	**Enacted**	**Monitor**

Title
Ground medical transportation.

Description
AB 716, Boerner. Ground medical transportation. Existing law creates the Emergency Medical Services Authority to coordinate various state activities concerning emergency medical services. Existing law requires the authority to report specified information, including reporting ambulance patient offload time twice per year to the Commission on Emergency Medical Services.This bill would require the authority to annually report the allowable maximum rates for ground ambulance transportation services in each county, including trending the rates by county, as specified.Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires that health care service plan contracts and health insurance policies provide coverage for certain services and treatments, including medical transportation services, and requires a policy or contract to provide for the direct reimbursement of a covered medical transportation services provider if the provider has not received payment from another source.This bill would delete that direct reimbursement requirement and would require a health care service plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2024, to require an enrollee or insured who receives covered services from a noncontracting ground ambulance provider to pay no more than the same cost-sharing amount that the enrollee or insured would pay for the same covered services received from a contracting ground ambulance provider. The bill would prohibit a noncontracting ground ambulance provider from sending to collections a higher amount, would limit the amount an enrollee or insured owes a noncontracting ground ambulance provider to no more than the in-network cost-sharing amount, and would prohibit a ground ambulance provider from billing an uninsured or self-pay patient more than the established payment by Medi-Cal or Medicare fee-for-service amount, whichever is greater. The bill would require a plan or insurer to directly reimburse a noncontracting ground ambulance provider for ground ambulance services the difference between the in-network cost-sharing amount and an amount described, as specified, unless it reaches another agreement with the noncontracting ground ambulance provider. Because a willful violation of the bill’s requirements relative to a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local ... (click bill link to see more).

Primary Sponsors
Tasha Boerner Horvath

Organizational Notes

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

Bill Number
AB 816

Status
Enacted

Position
Monitor

Title
Minors: consent to medical care.

Description
AB 816, Haney. Minors: consent to medical care. Existing law authorizes a minor who is 12 years of age or older to consent to medical care and counseling relating to the diagnosis and treatment of a drug- or alcohol-related problem. Existing law exempts replacement narcotic abuse treatment, as specified, from these provisions.This bill would authorize a minor who is 16 years of age or older to consent to replacement narcotic abuse treatment that uses buprenorphine at a physician’s office, clinic, or health facility, by a licensed physician and surgeon or other health care provider, as specified, whether or not the minor also has the consent of their parent or guardian. The bill would authorize a minor 16 years of age or older to consent to any other medications for opioid use disorder from a licensed narcotic treatment program as replacement narcotic therapy without the consent of the minor’s parent or guardian only if, and to the extent, expressly permitted by federal law.

Primary Sponsors
Matt Haney

Bill Number
AB 904

Status
Enacted

Position
Monitor

Title
Health care coverage: doulas.

Description
AB 904, Calderon. Health care coverage: doulas. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act’s requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan or health insurer to develop a maternal mental health program designed to promote quality and cost-effective outcomes. Existing law encourages a plan or insurer to include coverage for doulas.This bill would require a health care service plan or health insurer, on or before January 1, 2025, to develop a maternal and infant health equity program that addresses racial health disparities in maternal and infant health outcomes through the use of doulas. Under the bill, a Medi-Cal managed care plan would satisfy that requirement by providing coverage of doula services so long as doula services are a Medi-Cal covered benefit. The bill would require the Department of Managed Health Care, in consultation with the Department of Insurance, to collect data and submit a report describing the doula coverage and the above-described programs to the Legislature by January 1, 2027. Because a willful violation of the provisions relative to health care service plans would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Lisa Calderon, Sabrina Cervantes

Bill Number
AB 948

Status
Enacted

Position
Monitor

Title
Prescription drugs.

Description
AB 948, Berman. Prescription drugs. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law prohibits the copayment, coinsurance, or any other form of cost sharing for a covered outpatient prescription drug for an individual prescription from exceeding $250 for a supply of up to 30 days, except as specified. Existing law requires a health care service plan contract or health insurance policy for a nongrandfathered individual or small group product that maintains a drug formulary grouped into tiers, and that includes a 4th tier, to define each tier of the drug formulary, as specified. Existing law defines Tier 4 to include, among others, drugs that are biologics. Existing law repeals these provisions on January 1, 2024.This bill would delete drugs that are biologics from the definition of Tier 4. The bill would require a health care service plan or a health insurer, if there is a generic equivalent to a brand name drug, to ensure that an enrollee or insured is subject to the lowest cost sharing that would be applied, whether or not both the generic equivalent and the brand name drug are on the formulary. The bill also would delete the January 1, 2024, repeal date of the above provisions, thus making them operative indefinitely. Because extension of the bill’s requirements relative to health care service plans would extend the existence of a crime, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Marc Berman, Scott Wiener

Bill Number
AB 952

Status
Enacted

Position
Monitor

Title

Dental coverage disclosures.

Description

AB 952, Wood. Dental coverage disclosures. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law imposes specified coverage and disclosure requirements on health care service plans and health insurers, including specialized plans and insurers, that cover dental services.This bill would require a health care service plan or health insurer that issues, sells, renews, or offers a contract covering dental services, including a specialized health care service plan or specialized health insurer covering dental services, to disclose whether an enrollee's or insured's dental coverage is "State Regulated" through a provider portal, if available, or otherwise upon request, on or after January 1, 2025. The bill would require a plan or insurer to include the statement "State Regulated," if the enrollee's or insured's dental coverage is subject to regulation by the appropriate department, on an electronic or physical identification card, or both if available, for contracts covering dental services issued on or after January 1, 2025. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors

Jim Wood

Bill Number
AB 988

Status
Enacted

Position
Monitor

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

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

Primary Sponsors
Devon Mathis, Buffy Wicks

Bill Number
AB 1241

Status
Enacted

Position
Monitor

Title
Medi-Cal: telehealth.

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

Primary Sponsors
Akilah Weber

Bill Number
SB 311

Status
Enacted

Position
Support

Title
Medi-Cal: Part A buy-in.

Description
SB 311, Eggman. Medi-Cal: Part A buy-in. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires the department, to the extent required by federal law, for Medi-Cal recipients who are qualified Medicare beneficiaries, to pay the Medicare premiums, deductibles, and coinsurance for certain elderly and disabled persons. Existing federal law authorizes states to pay for Medicare benefits for specified enrollees pursuant to either a buy-in agreement to directly enroll and pay premiums or a group payer arrangement to pay premiums.This bill would require the department to enter into a Medicare Part A buy-in agreement, as defined, for qualified Medicare beneficiaries with the federal Centers for Medicare and Medicaid Services by submitting a state plan amendment. Under the bill, the buy-in agreement would be effective on January 1, 2025, or the date the department communicates to the Department of Finance in writing that systems have been programmed for implementation of these provisions, whichever date is later.The bill would authorize the department to implement these provisions through all-county letters or similar instructions until regulations are adopted. Under the bill, these provisions would be implemented only to the extent that any necessary federal approvals are obtained and that federal financial participation is available and is not otherwise jeopardized.To the extent that the bill would increase duties for counties, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Primary Sponsors
Susan Eggman

Organizational Notes

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

Bill Number
SB 326

Status
Enacted

Position
Monitor

Title
The Behavioral Health Services Act.

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

Primary Sponsors
Susan Eggman

Bill Number	Status	Position
SB 348	**Enacted**	**Support**

Title
Pupil meals.

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

Primary Sponsors
Nancy Skinner

Organizational Notes

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

Bill Number	Status	Position
SB 496	**Enacted**	**Monitor**

Title
Biomarker testing.

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

Primary Sponsors
Monique Limon

Organizational Notes

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

Bill Number	Status	Position
SB 502	**Enacted**	**Monitor**

Title

Medi-Cal: children: mobile optometric office.

Description

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

Primary Sponsors

Ben Allen

Bill Number
SB 525

Status
Enacted

Position
Monitor

Title
Minimum wages: health care workers.

Description
SB 525, Durazo. Minimum wages: health care workers. Existing law generally requires the minimum wage for all industries to not be less than specified amounts to be increased until it is $15 per hour commencing January 1, 2022, for employers employing 26 or more employees, and commencing January 1, 2023, for employers employing 25 or fewer employees. Existing law makes a violation of minimum wage requirements a misdemeanor. This bill would establish 5 separate minimum wage schedules for covered health care employees, as defined, depending on the nature of the employer.This bill would require, for any covered health care facility employer, as defined, with 10,000 or more full-time equivalent employees (FTEE), as defined, any covered health care facility employer that is a part of an integrated health care delivery system or a health care system with 10,000 or more FTEEs, a covered health care facility employer that is a dialysis clinic or is a person that owns, controls, or operates a dialysis clinic, or a covered health facility owned, affiliated, or operated by a county with a population of more than 5,000,000 as of January 1, 2023, the minimum wage for covered health care employees to be $23 per hour from June 1, 2024, to May 31, 2025, inclusive, $24 per hour from June 1, 2025, to May 31, 2026, inclusive, and $25 per hour from June 1, 2026, and until as adjusted as specified.This bill would require, for any hospital that is a hospital with a high governmental payor mix, an independent hospital with an elevated governmental payor mix, a rural independent covered health care facility, or a covered health care facility that is owned, affiliated, or operated by a county with a population of less than 250,000 as of January 1, 2023, as those terms are defined, the minimum wage for covered health care employees to be $18 per hour from June 1, 2024, to May 31, 2033, inclusive, and $25 per hour from June 1, 2033, and until as adjusted as specified.This bill would require, for specified clinics that meet certain requirements, the minimum wage for covered health care employees to be $21 per hour from June 1, 2024, to May 31, 2026, inclusive, and $22 per hour from June 1, 2026, to May 31, 2027, inclusive, and $25 from June 1, 2027, and until as adjusted as specified.This bill would require, for all other covered health care facility employers, the minimum wage for covered health care employees to be $21 per hour from June 1, 2024, to May 31, 2026, inclusive, $23 per hour from June 1, 2026, to May 31, 2028, inclusive, and $25 per hour from June 1, 2028, and until as adjusted as specified. This bill would provide that a covered health care facility that is county owned, affiliated, or operated must implement the appropriate minimum... (click bill link to see more).

Primary Sponsors
Maria Durazo

Bill Number
SB 621

Status
Enacted

Position
Monitor

Title
Health care coverage: biosimilar drugs.

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

Primary Sponsors
Anna Caballero

Bill Number
SB 770

Status
Enacted

Position
Monitor

Title
Health care: unified health care financing.

Description
SB 770, Wiener. Health care: unified health care financing. Prior state law established the Healthy California for All Commission for the purpose of developing a plan towards the goal of achieving a health care delivery system in California that provides coverage and access through a unified health care financing system for all Californians, including, among other options, a single-payer financing system.This bill would direct the Secretary of the California Health and Human Services Agency to research, develop, and pursue discussions of a waiver framework in consultation with the federal government with the objective of a health care system that incorporates specified features and objectives, including, among others, a comprehensive package of medical, behavioral health, pharmaceutical, dental, and vision benefits, and the absence of cost sharing for essential services and treatments. The bill would further require the secretary to engage specified stakeholders to provide input on topics related to discussions with the federal government and key design issues, as specified. The bill would require the secretary, no later than January 1, 2025, to provide an interim report to specified committees of the Legislature and propose statutory language to the chairs of those committees authorizing the development and submission of applications to the federal government for waivers necessary to implement a unified health care financing system. The bill would require the secretary, no later than June 1, 2025, to complete drafting the waiver framework, make the draft available to the public on the agency’s internet website, and hold a 45-day public comment period thereafter. The bill would require the secretary, no later than November 1, 2025, to provide the Legislature and the Governor with a report that communicates the finalized waiver framework, as specified, and sets forth the specific elements to be included in a formal waiver application to establish a unified health care financing system, as specified. The bill would also include findings and declarations of the Legislature related to the implementation of a unified health care financing system.

Primary Sponsors
Scott Wiener, Mike McGuire

Organizational Notes

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

Bill Number
HR 3068

Status
In House

Position
Support

Title
Equal Health Care for All Act

Primary Sponsors
Adam Schiff

L.A. Care
HEALTH PLAN®

For All of L.A.

Community Benefits
2023-24 Community Health Investment Fund (CHIF) Grantmaking Priorities

Board of Governors Meeting
November 2, 2023
Shavonda Webber-Christmas, Director
Community Benefits Department

ELEVATING HEALTHCARE
IN LOS ANGELES COUNTY
SINCE 1997

L.A. Care

Community Health Investment Fund (CHIF)

Overview

- As of October 1, 2023, the CHIF Program has supported more than 979 projects for 190 unique community entities, and invested more than $138 million in organizations caring for under-resourced communities.

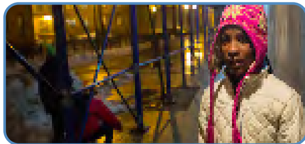
- CHIF awards improve clinic's workforce and infrastructure, access to care and improved health outcomes for members, and social determinants for under-resourced communities and to strengthen the safety net.

- Motion seeks Board approval to allocate the approved $10 million CHIF fund* across Community Benefits' Grantmaking Priorities for FY 2023-24

Grantmaking Priorities

Categories that CHIF initiative and ad hoc awards are allocated

Support the health care safety net to improve infrastructure and address disparities



Advance solutions for social determinants of health to reduce inequities

Close pervasive health disparities gaps

Empower and invest in health and social service organizations that address systemic racism

Grantmaking Priorities

Support the health care safety net to improve infrastructure and address disparities

- Supports projects that address the infrastructure needs of safety net providers, including technological, personnel, and care coordination methods that enable healthcare providers to resolve broad structural and racial inequities in the health care system, and to ensure quality and equitable care and client outcomes.

- Portfolio may be distributed through initiatives such as the Robert E. Tranquada, MD Safety Net Initiative, and community initiated ad hocs, including major healthcare investments.

- Budget - $4.45M

- Grants starting at $100K each

Grantmaking Priorities

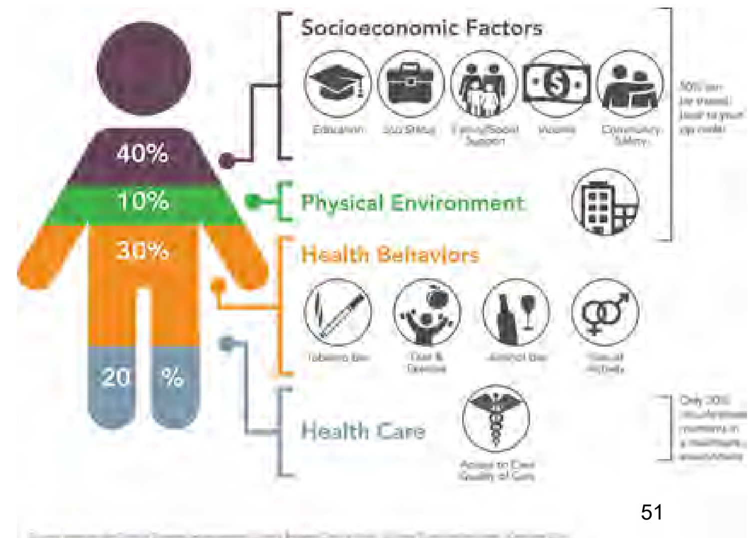
Advance solutions for social determinants of health to reduce inequities

- Supports community based strategies and policy efforts to reduce health inequities associated with social determinants and improve health and wellbeing for marginalized community members. Projects impacting food and housing security, economic empowerment, and education are prioritized.

- Portfolio may be distributed through initiatives such as Advancing Economic Mobility and community initiated ad hocs that improve social determinants.

- Budget - $2.8M

- Grants starting at $125K each



Grantmaking Priorities

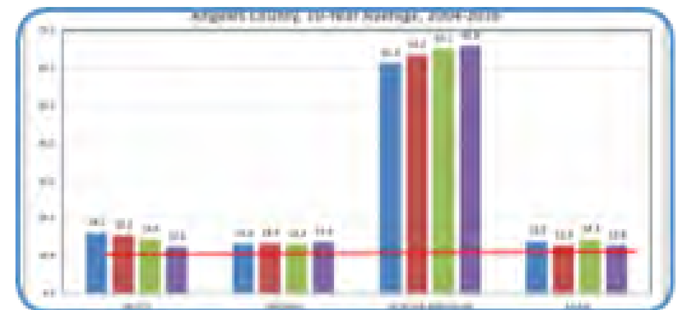
Close pervasive health disparities gaps

- Uplifts projects that directly address health disparities among under resourced populations due to race or ethnicity, sex, gender identity, age, ability, socioeconomic status, geographic location, and especially coexistent or intersectional characteristics.

- Portfolio may be distributed through initiatives such as GAAINS*, and community initiated ad hocs aligned with reducing health disparities, including data surveillance.

- Budget - $1.5M

- Grants starting at $125K each



*Generating African American Infant & Nurturers' Survival

Grantmaking Priorities

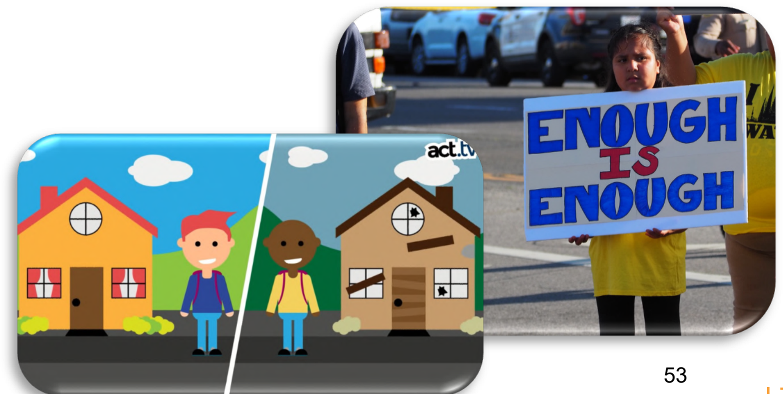
Empower and invest in health and social service organizations that address systemic racism.

- Supports trusted BIPOC-led and serving organizations that provide services to meet community health and social needs and address root causes of systemic injustices. Focuses on building infrastructure and capacity among agencies historically underfunded by philanthropy to resource community driven solutions to systemic racism.

- Portfolio may be organized around initiatives, such as the Equity & Resilience Initiative, and community initiated ad hocs aligned with eliminating systemic racism.

- Budget - $1.25M

- Grant average $125K each



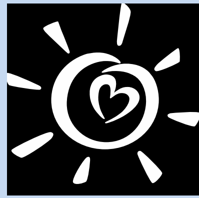
Grantmaking Priorities Motion

1. Approve the recommended approach for the Community Health Investment Fund (CHIF) FY 2023-24 allocation of $10 million in the following priority categories:

PRIORITIES PROJECTION SUMMARY		
PRIORITY/PORTFOLIO	ALLOCATION	AWARDS
Support the health care safety net to improve infrastructure and address disparities	$4,450,000	27
Advance solutions for social determinants of health to reduce inequities	$2,800,000	13
Close pervasive health disparities gaps	$1,500,000	12
Empower and invest in health and social service organizations that address systemic racism	$1,250,000	10
Total CHIF Allocation	$10,000,000	62

2. Delegate authority to the CEO to adjust CHIF priority category amounts noted above to align with evolving community needs and requests.

Thank You



Board of Governors
MOTION SUMMARY

Date: October 25, 2023 | **Motion No. EXE 100.1123**

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

Requesting Department: Safety Initiatives

Issue: Execute a Housing & Homelessness Incentive Program Investment agreement with United Way of Greater Los Angeles (UWGLA). UGWLA proposes to scale and stabilize the homeless services sector workforce, including those working in organizations offering Community Supports, by supporting a workforce leadership development table to pilot new initiatives, expanding the talent pipeline, collecting data, providing retention stipends, and increasing average tenure by strengthening the back office.

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

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

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

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

In order to align with HHIP goals and to help meet HHIP metrics and thus draw down funds, L.A. Care staff requests approval to execute a contract with United Way of Greater Los Angeles (UWGLA) from October 1, 2023 to October 1, 2025 of up to three million five hundred thousand dollars ($3,500,000.00). This investment will be jointly funded with Health Net, who will be providing $2 million for the initiative, and will leverage additional committed funds from the Hilton Foundation and Cedars-Sinai.

With this HHIP investment, UWGLA will implement two initiatives:

1. Reestablish and redefine a Work Force Development Leadership Team for the homeless services sector in LA. This team will come together to design, implement and evaluate a series of pilots to test recruitment and retention strategies that demonstrate potential to reduce vacancy rates across homeless service sector at scale. United Way will also evaluate pilots and conduct additional data collection on the state of the sector.

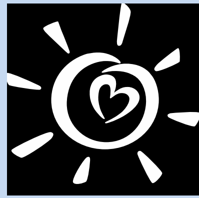
2. Provide funding to homeless services organizations for staff retention stipends and infrastructure improvements. This effort will increase the ability for agencies in Los Angeles County to recruit and retain employees into best-in-practice offices and improve the day-to-day experience of staff within these agencies.

L.A. Care selected UWGLA because of their experience and position to quickly build capacity and coordinate the required services for vulnerable communities throughout Los Angeles. United Way led a wide-ranging analysis of challenges facing homeless services in 2022, and has a history of launching multiple pilots to test innovations in the sector. L.A. Care did not conduct a request for proposal for this vendor because of their experience and required timing for making the HHIP investment in order to meet Department of Health Care Services (DHCS) goals within the current reporting period (January 1, 2023 – October 31, 2023) and earn future HHIP funding.

Member Impact: L.A Care members will benefit from this motion as it will help homeless services providers, including those in L.A. Care's network of Enhanced Care Management and Community Supports providers, to better recruit and retain staff to provide essential services.

Budget Impact: The cost was anticipated and included in the Investment Plan and approved budget for the Housing and Homeless Incentive Program and will use HHIP funds already received by L.A. Care. This investment is part of a larger $5 million effort between L.A. Care, Health Net, the Hilton Foundation and Cedars-Sinai.

Motion: **To authorize staff to execute an HHIP investment agreement in the amount of $3,500,000 with United Way of Greater Los Angeles to refine and reestablish the Workforce Development Leadership Team, launch priority pilot initiatives, provide stipends, and provide infrastructure funding to strengthen recruitment and retention of staff in agencies in Los Angeles County for the period of October 1, 2023 through October 1, 2025.**



Board of Governors
MOTION SUMMARY

Date: October 25, 2023

Motion No. EXE A.1023

Committee: Executive

Chairperson: Alvaro Ballesteros, MBA

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

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

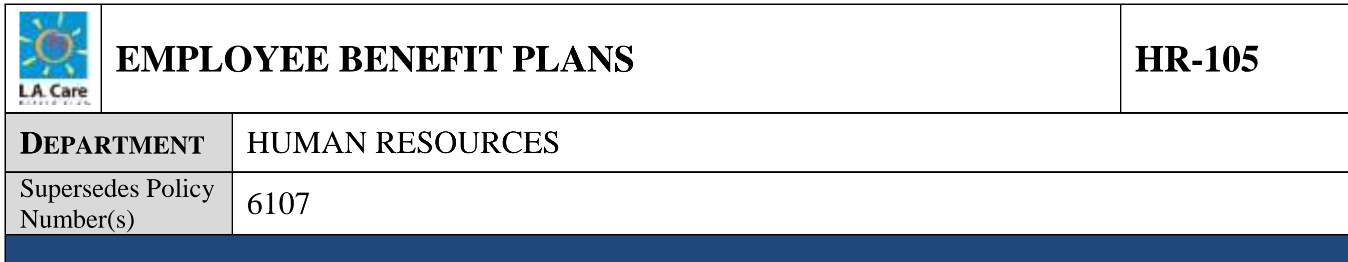
Background: The revised policies are written to comply with changes to Regulatory, Legislative and Judicial changes, and reflect changes in L.A. Care's practices.

Policy Number	Policy	Section	Description of Modification
HR-105	Employee Benefit Plans	Benefits	Revision – clarified definitions and specific processes; update Reporting and Monitoring sections using standard verbiage; removed age requirement under 3.2.7.1 as plan docs do not contain a min age requirement
HR-109	Jury Duty and Witness Subpoenas	Benefits	Updated definition of Eligible Employees
HR-709	Language Proficiency Assessment	Learning and Development	Policy Review

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

Budget Impact: None

Motion: **To approve revisions to Human Resources Policies HR 105 (Employee Benefit Plans), HR 109 (Jury Duty and Witness Subpoenas), and HR 709 (Language Proficiency Assessment), as presented.**



	EMPLOYEE BENEFIT PLANS	HR-105
DEPARTMENT	HUMAN RESOURCES	
Supersedes Policy Number(s)	6107	

DATES					
Effective Date	8/28/2006	Review Date	~~4/30/2019~~9/5/2023	Next Annual Review Date	~~4/30/2020~~9/5/2024
Legal Review Date	~~4/15/2019~~9/28/2023	Committee Review Date	4/22/2019		

LINES OF BUSINESS

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

DELEGATED ENTITIES / EXTERNAL APPLICABILITY

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

ACCOUNTABILITY MATRIX

ATTACHMENTS

ELECTRONICALLY APPROVED BY THE FOLLOWING

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

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

REFERENCES

HISTORY	
REVISION DATE	**DESCRIPTION OF REVISIONS**
12/1/2009	Revision
April 2014	Review
4/22/2019	Revision, Policy name changed to Employee Benefit Plan; Eligible Employees updated and defined; benefits offered by L.A. Care updated; procedure for benefit enrollment updated.
~~7/30/2020~~9/5/2023	Revision – clarified definitions and specific processes; update Reporting and Monitoring sections using standard verbiage; removed age requirement under 3.2.7.1 as plan docs do not contain a min age requirement

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

1.0 OVERVIEW:

1.1 The purpose of this policy is to identify existing health care and life insurance benefits L.A. Care Health Plan (L.A. Care) makes available to eligible employees and their eligible dependents.

2.0 DEFINITIONS:

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

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

~~2.1 All regular status employees regularly scheduled to work 60 hours or more per two-week pay period or 30 hours or more per week, are eligible to enroll in L.A. Care's sponsored medical, dental, vision, life insurance, and voluntary insurance plans. Temporary employees regularly scheduled 30 hours or more per week are eligible to enroll in L.A. Care's sponsored medical, dental, vision, and EAP benefits. Per diem and part-time employees scheduled less than 30 hours a week are eligible for L.A. Care's medical benefit if it is determined they worked the full-time equivalency during the look-back period.~~

2.2 Eligible Dependents - are defined as:

2.2.1 Employee's spouse;

2.2.2 Employee's domestic partner;

2.2.3 Children of employee or domestic partner up to age 26 without regard to student or marital status;

2.2.4 Children of employee or domestic partner who are disabled, if coverage is approved by the specific plan's Claims Administrator.

2.3 Look-Back Period - is the number of hours worked in the past 12 months to determine medical benefit eligibility as determined by the Affordable Care Act (ACA).

3.0 POLICY:

3.1 Health and welfare benefits are effective the first of the month following date of hire or eligible status change.

3.2 Benefit Programs Available

3.2.1 Medical Insurance

3.2.1.1 Eligible Employees and their Eligible Dependents may enroll in L.A. Care sponsored medical plans. Eligible Employees and their Eligible Dependents may elect to waive medical coverage by completing the employer's online survey attesting coverage elsewhere or enroll in just the medical plan and not select a dental or vision plan.

3.2.2 Dental Insurance

3.2.2.1 Eligible Employees and their Eligible Dependents, may enroll in L.A. Care sponsored dental plans. Eligible Employees and their Eligible Dependents may elect to enroll in just the dental plan and not select a medical or vision plan.

3.2.3 Vision Insurance

3.2.3.1 Eligible Employees and their Eligible Dependents, may enroll in L.A. Care sponsored vision plan. Eligible Employees and their Eligible Dependents may elect to enroll in just the vision plan and not select a medical or dental plan.

3.2.4 Flexible Spending and Health Savings Accounts ~~(Medical Care Spending and Dependent Care)~~

3.2.4.1 Eligible Employees may enroll in Flexible Spending and Health Savings Accounts. ~~in the Medical Flexible Spending Account if qualified.~~

3.2.5 Employee Assistance Program (EAP)

3.2.5.1 Eligible Eemployees are automatically enrolled in EAP.

~~3.2.5~~3.2.6 Life and Accidental Death and Dismemberment (AD&D); Short-Term Disability; Long-Term Disability Insurance

~~3.2.5.1~~3.2.6.1 Eligible[JG1] Employees ~~All regular status employees scheduled to work 30 hours or more per week~~ are automatically enrolled in L.A. Care sponsored Life insurance, Accidental Death and Dismemberment (AD&D) benefit, Short-Term and Long-Term Disability insurance coverage at no cost to the employee.

~~3.2.6~~3.2.7 Voluntary Insurance Plans

~~3.2.6.1~~3.2.7.1 Various optional insurance plans are available to Eligible Employees who qualify including Voluntary Whole and Term Life Insurance, Hospital Indemnity, Accident, Critical Illness, ~~Long-Term Care~~, Individual Short Term Disability, and Pet Insurance Coverage. Some of the voluntary plans are portable upon employee separation. An Eligible Employee may

apply for any of these voluntary insurance programs during the annual open enrollment period or when otherwise eligible, per plan programs' guidelines.

~~3.2.7~~3.2.8 457(b) Deferred Compensation Plan

~~3.2.7.1~~3.2.8.1 All employees ~~over the age of 21~~ are eligible to participate in the voluntary 457(b) deferred compensation plan from date of hire. Enrollments and changes begin the first of the following month. Employees may elect to contribute up to ~~Each year an~~ the annual maximum ~~pre-taxed contribution level will be identified~~as determined by the IRS.

~~3.2.8~~3.2.9 401(a) Retirement Benefit Plan

~~3.2.8.1~~3.2.9.1 All employees, excluding employees whose employment is covered by Social Security, are eligible to participate in mandatory pre-tax employee salary reduction contributions and employer nonelective contributions, each equal to 6.2% of compensation up to the Social Security wage base, upon date of hire. All employees, excluding employees who are scheduled to work fewer than 30 hours per week, temporary and per diem employees who are originally hired on or after January 1, 2013, or who are rehired on or after that date more than six months after termination, are, upon completion of one year of service, eligible to participate in employer matching contributions equal to 100% of their elective contributions to the 457(b) deferred compensation plan up to 4% of compensation and additional employer nonelective contributions equal to 3.5% of compensation. L.A. Care automatically withholds employee contributions from compensation and deposits employee and employer contributions into the plan for ~~E~~eligible ~~E~~employees. ~~Employees who elected to participate in the plan in lieu of Social Security also make contributions toward the plan.~~

~~3.2.8.2~~3.2.9.2 401(a) Management Supplemental Retirement Plan. This is a mandatory plan for management staff that begins once eligible earnings reach the current Social Security wage base maximum through the end of the calendar year, based on an irrevocable contribution election of a fixed percentage. L.A. Care automatically withholds employee contributions equal to the fixed percentage from each eligible employees' compensation in excess of the Social Security wage on a pre-tax basis and contributes them to the plan.

4.0 PROCEDURES:

4.1 Benefit Enrollment

4.1.1 Information regarding all health, welfare and retirement benefits offered by L.A. Care will be provided to the Eligible Employee prior to starting employment at L.A. Care.

4.1.2 Employees complete an online enrollment process to elect coverage. The effective date of health, dental, vision and life insurance, if elected, typically is the first of the month following employment or eligible status change.

4.1.3 Except for retirement benefits, the enrollment period expires 30 calendar days from the date of eligibility. If you fail to enroll within 30 days of when you first become eligible, for medical, you will be defaulted into the employer-selected ~~the Kaiser Permanente HMO~~ health plan for Employee Only coverage. For all other benefits, you will not be able to enroll until the next annual open enrollment period, or should you have a qualifying life event. An employee may enroll in the voluntary retirement plan~~s~~ at any time.

4.1.4 Once enrolled, the Eligible Employee will receive ~~his/her~~ their medical ID card(s) and all appropriate benefit materials typically within 10-15 business days from the completion of online enrollment. Dental and vision ID cards may be obtained on the carrier's website.

4.1.5 Employees enrolled in any of the voluntary insurance plans will receive information at their home address of record.

4.1.6 Employees waiving coverage must complete the online declination survey for medical and may receive opt-out credits for waiving medical and/or dental benefits, if eligible.

4.2 Enrollment Status Changes

4.2.1 Due to the structure of L.A. Care's group insurance plans, enrollment changes can only be made during the annual open enrollment period, unless a qualifying event such as marriage, divorce, birth of a child, death of a dependent, or significant prolonged increase or decrease in work hours occurs.

~~4.2.1~~

~~4.2.1.1~~4.2.2 If an employee elected deductions to be taken on a post-tax (after-tax) basis, ~~he/she~~ they may cancel coverage any time during the year, however, if ~~he/she~~ they wish~~es~~ to enroll at a later date, a qualifying event must take place or the employee must wait until the next annual open enrollment period.

~~4.2.1.2~~4.2.3 Voluntary insurance coverage may be canceled at any time throughout the year. To re-enroll, the employee will need to wait until the next open enrollment period.

~~4.2.1.3~~4.2.4 Coverage changes due to a life event must be requested within 30 calendar days of the qualifying event by contacting Human Resources. In

most instances tThe effective date is the first of the following month following date of the qualifying event.

4.3 Employee Contributions

4.3.1 Employee contributions for medical, dental or vision coverage are made on a pre-tax basis through bi-weekly payroll deductions or by personal check or money order, if an employee is on an approved leave of absence.

4.3.2 The Flexible Spending Account deductions are made on a pre-tax basis through bi-weekly payroll.

4.3.3 The Health Savings Account deductions are made on a federally pre-tax basis through bi-weekly payroll.

4.3.4 The 457(b) Plan contributions are made through bi-weekly payroll, and are made on a pre-tax basis through bi-weekly payroll, unless these contributions are for their Roth which are on an post-tax. basis.

4.3.5 Voluntary insurance contributions are made on a post-tax basis through bi-weekly payroll.

4.3.6 If an employee's contribution cannot be made through payroll deductions due to a leave of absence, the employee will be required to make the appropriate employee contributions to maintain coverage. If an employee does not make the necessary contributions for medical, dental, and voluntary term life coverage while on leave of absence, he/she they may make arrangements with Human Resources through future payroll deductions to avoid cancellation and gaps in coverage (for employer-sponsored benefits and term life coverages only). Employees should make payments of all other voluntary benefits to avoid carrier cancellation. within five days of notification, all insurance coverage will be canceled effective the last day of the month for which the last payment was received. The employee will be responsible for any charges incurred after the date of cancellation.

4.3.7 If an employee's coverage is canceled for nonpayment, the employee may not be eligible to enroll in benefits until the next annual open enrollment period.

4.4 Separation of Employment

4.4.1 Medical, dental, vision, and Employee Assistance Program ("EAP") insurance coverage will terminate at the end of the month of separation of employment. Eligibility to continue medical, dental, vision, Health Flexible Spending Account, and EAP will be offered as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA). Coverage continuation information will be forwarded to the employee's home address of record

within 21 calendar days after the COBRA Plan Administrator is notified of termination. Life and Accidental Death and Dismemberment, Short-Term Disability, Dependent Care Flexible Spending Account, Health Savings Account, Long Term Disability and Voluntary benefit coverage ends on the employee's separation date.

4.5 Employees on a Family and Medical Leave

4.5.1 Group insurance coverage will continue for employees enrolled under its group plans during an employee's authorized Family and Medical Leave for the period of the leave as required by specific Federal/State guidelines at the level and under the conditions which would have applied if the employee had continued working. The employee is responsible for ~~his/her~~ their portion of health premiums that would have been due if the employee were not on leave.

~~**4.5.2** If the employee's premium payment is more than 30 calendar days late, L.A. Care will provide advance written notice that coverage may terminate due to non-payment of premiums.~~

4.6 Summary Plan Documents governing the health & welfare plans are available through the Human Resources Department.

5.0 MONITORING:

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

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

6.0 REPORTING:

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

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

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

	JURY DUTY AND WITNESS SUBPOENAS	HR-109

DEPARTMENT	HUMAN RESOURCES
Supersedes Policy Number(s)	6111

DATES					
Effective Date	5/30/1996	Review Date	~~8/12/2019~~8/18/2023	Next Annual Review Date	8/18/2024~~8/12/2020~~
Legal Review Date	6/17/2019	Committee Review Date	N/A		

LINES OF BUSINESS

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

DELEGATED ENTITIES / EXTERNAL APPLICABILITY

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

ACCOUNTABILITY MATRIX

ATTACHMENTS

ELECTRONICALLY APPROVED BY THE FOLLOWING		
	OFFICER	DIRECTOR
NAME	Terry Brown	Sarah Viloria Diaz
DEPARTMENT	Human Resources	Human Resources
TITLE	Chief Human Resources Officer	Director, Human Resources Total Rewards

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

REFERENCES

HISTORY	
REVISION DATE	DESCRIPTION OF REVISIONS
2/24/2007	Revision
4/2014	Review
8/12/2019	Review
7/30/2020	Updated Reporting section to standard verbiage
8/18/2023	Updated definition of Eligible Employees

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

1.0 OVERVIEW:

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

2.0 DEFINITIONS:

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

2.1 **Benefit-Eligible Employee** – Employees in positions who are scheduled to work 60 hours or more per two-week pay period or 30 hours or more per week. Employees in positions classified as "regular" or "assignment with limited duration (ALD) who are scheduled to work 30 hours or more per week.

2.2 **Non-Benefit Eligible Employee** – Employees in positions classified as temporary, per diem, part time scheduled to work less than 30 hours per week.

2.1

3.0 POLICY:

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

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

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

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

3.5 Service on any County's criminal grand jury is covered, but service on a civil grand jury is not covered, because such service is entirely voluntary. An employee may serve on a County civil grand jury if the employee's supervisor approves an unpaid

leave of absence, but the employee does not receive his or her regular pay or jury duty leave.

3.6 Any Benefit--Eligible Employee is eligible for witness leave if the employee is subpoenaed to appear in court or hearing provided the court appearance is not as an expert witness or as a party to the case being heard. "A party to the case" is defined as being either the plaintiff, defendant, cross-complainant or cross-defendant in a civil matter, or the defendant in a criminal matter. Benefit-Eligible Employees will be allowed the time necessary to be absent from work and will receive full pay when subpoenaed.

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

4.0 PROCEDURES:

~~4.0~~

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

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

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

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

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

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

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

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

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

4.10 Employees required to appear in court as a witness must report the hours/days on witness leave in the automated time record system. Employees must provide a copy of the subpoena and report to Payroll any witness fees received before payment is authorized.

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

5.0 MONITORING:

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

6.0 REPORTING:

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

~~**6.1** Any suspected violations to this policy should be reported to any member of the management or Leadership Team, any of L.A Care's Human Resources Business Partners in the Employee Business Support Services unit or dial ext. 6947 (myhr) (confidential line), Compliance Department or Compliance Helpline at (800) 400-4889.~~

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

	LANGUAGE PROFICIENCY ASSESSMENT	HR-709

DEPARTMENT	HUMAN RESOURCES
Supersedes Policy Number(s)	

DATES					
Effective Date	1/31/2018	Review Date	~~4/1/2022~~8/14/2023	Next Annual Review Date	~~4/1/2023~~8/14/2024
Legal Review Date	~~2/14/2022~~10/16/2023	Committee Review Date	4/26/2022		

LINES OF BUSINESS

☐ Medicare D-SNP~~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		
Health Education, Cultural and Linguistic Services	CL-003		

ATTACHMENTS

Language Proficiency Passing Level Grid

ELECTRONICALLY APPROVED BY THE FOLLOWING		
	OFFICER	**DIRECTOR**
NAME	Terry Brown	Deborah Decker
DEPARTMENT	Human Resources	Talent Strategy & HR Technology
TITLE	Chief Human Resources Officer	Senior Manager, Learning Experience

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 212-04

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
10/16/2023	Annual Review

1.0 OVERVIEW:

1.1 L.A. Care Health Plan (L.A. Care) has established language proficiency requirements, both spoken and written.,

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, 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 under the supervision of a physician and who 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 not treat members or provide direct care.

2.9 **Sight Translation** - Oral rendition of text written in one language into another language. Sight translation 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 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&L~~S~~), and management of 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 thereafter.

4.2.1 The test will evaluate the candidates or employee's Oral and/or Written Language Proficiency including fluency, grammar, vocabulary, and comprehension oral/written Clinical and/or Non-Clinical Terminology related to both health care settings and member services.

4.3 The 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 hires start date with the authorized outside vendor.

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 Employees who have passed the assessment 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.

~~One time retesting can be given to the employee who failed the initial assessment within the six weeks from the initial testing to allow preparation to achieve the required test score.~~

4.4.3 Employees who do not pass the assessment must use the language assistance services offered through ~~Cultural & Linguistic Services~~C&L when it is necessary to communicate with LEP Members.

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 Human Resources. One-time retTesting 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 requiredBilingual in one of L.A. Care Health Plan's threshold languages is highly desirable", candidates that do not pass the assessment and are not hired because of the restrictive language requirements, the candidate may re-apply when another position becomes available ., and re-test to achieve the required test score. When the job description states "non-English language skill preferred[NY1]", candidates that do not pass the assessment can still be considered for the position. If hired, candidates are not allowed to use their non-English language for the role.

4.6 One time retesting can be given to the candidates who failed the initial assessment within the six weeks from the initial testing to allow preparation to achieve the required test score.

4.7 The 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 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.

4.8.34.8.2 Cultural competency review and feedback.

4.8.44.8.3 Cultural and Linguistic Services Glossary Committee.

4.8.54.8.4 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 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.

4.9.6 Slight Translation (conversion of one written language into another spoken language).

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.

5.15.2 Cultural & Linguistic ServicesC&L reviews the list of bilingual staff on a quarterly basisibasis to ensure compliance with applicable requirements.

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.[JT2][NR3][NY4]

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.