



L.A. Care
HEALTH PLAN[®]

For All of L.A.

EXECUTIVE COMMITTEE MEETING

Board of Governors

May 24, 2022 • 2:00 PM

L.A. Care Health Plan

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



**ELEVATING
HEALTHCARE**
IN LOS ANGELES COUNTY
SINCE 1997



AGENDA

Executive Committee Meeting Board of Governors

Tuesday, May 24, 2022, 2:00 P.M.

L.A. Care Health Plan, 1055 West 7th Street, 10th Floor, Los Angeles

DRAFT

Please recheck these directions for updates prior to the start of the meeting.

This meeting will be conducted in accordance with the provisions of the Ralph M. Brown Act, allowing members of the Board, members of the public and staff to participate via teleconference, because State and Local officials are recommending measures to promote social distancing. Accordingly, members of the public should join this meeting via teleconference as follows:

<https://lacare.webex.com/lacare/j.php?MTID=ma3ab09e9f58a84c113f6f493548afb00>

To join and LISTEN ONLY via teleconference please dial: (213) 306-3065

Access code: 2485 097 6306 Password: lacare

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

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

We continue to use different ways to submit public comment live and direct during the meeting.

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

Your comments can also be sent by voicemail, email or text. If we receive your comments by 2:00 pm on

May 24, 2022, it will be provided to the members of the Executive Committee at the beginning of the meeting. **The chat message, text, voicemail, or email must indicate if you wish to be identified or remain anonymous, and must also include the name of the item to which your comment relates.**

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

Once the meeting has started, public comment must be received before the agenda item is called by the meeting Chair and staff will read those comments for up to three minutes. Chat messages submitted will be read for up to three minutes during the public comment period for each item. If your public comment is not related to any of the agenda item topics, your public comment will be read in the general public comment agenda item.

These are extraordinary circumstances, and the process for public comment is evolving and may change at future meetings. We thank you for your patience.

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

DRAFT

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

All votes in a teleconferenced meeting shall be conducted by roll call.

If you are an individual with a disability and need a reasonable modification or accommodation pursuant to the Americans with Disabilities Act (ADA) please contact L.A. Care Board Services staff prior to the meeting for assistance by text to 213 628-6420 or by email to BoardServices@lacare.org.

WELCOME

Hector De La Torre, *Chair*

1. Approve today's meeting Agenda *Chair*
2. Public Comment (*please see instructions above*) *Chair*
3. Approve April 26, 2022 Meeting Minutes p.5 *Chair*
4. Chairperson's Report *Chair*
5. Chief Executive Officer Report

John Baackes
Chief Executive Officer

COMMITTEE ITEMS

6. Government Affairs Update p.14
Cherie Compartore
Senior Director, Government Affairs
7. Revised 2022 Board of Governors & Committee Meeting Schedule **(EXE 100)** p.128
Linda Merkens
Senior Manager, Board Services
8. Human Resources Policy HR-706 (Introductory Orientation and Mandatory Training) **(EXE A)** p.130
Terry Brown
Chief Human Resources Officer
9. Approve the list of items that will be considered on a Consent Agenda for June 2, 2022 Board of Governors Meeting. *Chair*
 - May 5, 2022 Board of Governors Meeting Minutes
 - Revised 2022 Board of Governors & Committee Meeting Schedule
 - Imagenet, LLC Contract Amendment
10. Public Comment on Closed Session Items (*Please read instructions above.*) *Chair*

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

Chair

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

DRAFT

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

ADJOURN

Chair

The next Executive Committee meeting is scheduled on **Tuesday, June 28, 2022 at 2:00 p.m.**
and may be conducted as a teleconference meeting.

Public comments will be read for up to three minutes.

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

If a teleconference location is listed at the top of this agenda, the public can participate in the meeting by calling the teleconference call in number provided. If teleconference arrangements are listed at the top of this Agenda, note that the arrangements may change prior to the meeting.

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

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

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

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

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

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

BOARD OF GOVERNORS
Executive Committee

Meeting Minutes – April 26, 2022

1055 West 7th Street, Los Angeles, CA 90017



L.A. Care
 HEALTH PLAN

Members

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

Management/Staff

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

State and local officials continue to impose or recommend measures to promote social distancing to reduce transmission of the COVID 19 virus. It is prudent to use caution in protecting the health of the public, L.A. Care’s employees and its members where adequate virtual means exist to permit the meeting to occur by teleconference/videoconference with the public being afforded the ability to comment in real time. The Board of Governors and all legislative bodies of the L.A. Care Health Plan, and the Board of Directors and all legislative bodies of the Joint Powers Authority will continue to meet virtually and the Boards will review that decision on an on-going basis as provided in the Brown Act. Members of the public had the opportunity to listen to the meeting via teleconference, and share their comments via voicemail, email, or text.

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Hector De La Torre, <i>Chairperson</i> , called to order the L.A. Care Executive Committee and the L.A. Care Joint Powers Authority Executive Committee meetings at 2:04 p.m. The meetings were held simultaneously. He welcomed everyone to the meetings. <ul style="list-style-type: none"> • For those who provided public comment for this meeting by voice message or in writing, we are really glad that you provided input today. The Committee will hear your comments and we also have to finish the business on our Agenda today. • If you have access to the internet, the materials for today’s meeting are available at the lacare.org website. If you need information about how to locate the meeting materials, please let us know. • Information for public comment is on the Agenda available on the web site. Staff will read the comment from each person for up to three minutes. 	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	<ul style="list-style-type: none"> The Chairperson will invite public comment before the Committee starts to discuss an item. If the comment is not on a specific agenda item, it will be read at the general Public Comment item 2 on today's agenda. <p>He provided information on how to comment live and directly using the "chat" feature.</p>	
APPROVE MEETING AGENDA	The Agenda for today's meeting was approved.	Approved unanimously by roll call. 4 AYES (Ballesteros, Booth, De La Torre, and Perez).
PUBLIC COMMENT	There were no public comments.	
APPROVE MEETING MINUTES	The minutes of the March 22, 2022 meeting were approved as submitted.	Approved unanimously by roll call. 4 AYES
CHAIRPERSON'S REPORT	Chairperson De La Torre noted two recent news items. The U.S. Department of Justice announced that it has determined that Kaiser Permanente has fraudulently billed over \$1 billion to Medicare and a legal process is underway. This will impact healthcare everywhere as Kaiser is a major healthcare organization. It was also announced that Centene Corporation, the parent company of Magellan, which began managing the Medi-Cal pharmacy benefits on January 1, 2022, is under investigation by the California Department of Health Care Services for improper actions. This will also impact healthcare in California, and will impact L.A. Care's members in Los Angeles County.	
CHIEF EXECUTIVE OFFICER REPORT	<p>John Baackes, <i>Chief Executive Officer</i>, reported:</p> <ul style="list-style-type: none"> Like all healthcare providers, L.A. Care is finding it difficult to recruit nurses for open positions in utilization management (UM) and care management (CM). L.A. Care has started a public campaign in social media, radio and television, to advertise the open positions. The campaign specifies the recruitment for UM and CM, in order to attract nurses who may be considering positions other than direct patient care. L.A. Care is offering sign up bonuses. There has been a slight improvement in the successful recruitment of four nurses in the past week. L.A. Care is also recruiting in the customer service area. It was previously reported that the expansion of Medi-Cal eligibility for undocumented adults ages 50 and up may result in additional enrollment of up to 	

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	<p>75,000 in May-July. L.A. Care is preparing for an increase in calls to the Member Services department.</p> <ul style="list-style-type: none"> • The public health emergency has been extended to July 15, and it is expected that it will not be extended further. The state and county agencies are preparing to resume the process of eligibility redetermination for Medi-Cal when the public health emergency is lifted. The eligibility redetermination process has been suspended since the beginning of the public health emergency in February 2020, so there is a huge backlog. It is expected that redetermination kits will start to be distributed to current beneficiaries in August 2022. L.A. Care is preparing call center staff to help beneficiaries with that process and will be conducting an extensive outreach campaign to remind Medi-Cal members to complete the redetermination process and avoid interruption of coverage for members. L.A. Care will work closely with its partners including advisory committee members, federally qualified health centers (FQHCs) and others to assist Medi-Cal beneficiaries with the redetermination process. Medi-Cal members that may lose coverage due to an increase in income over the last two years, may be eligible for premium subsidies offered through the L.A. Care Covered program, and could maintain continuity of care by moving to that program. • Mr. Baackes has previously reported in his CEO Reports and will continue to update Board members on the extraordinary transformational change in the new Medi-Cal contract which will begin in January 2024. The changes will increase the health plan oversight role over Plan Partners and delegated entities, with more reporting required on financial arrangements and performance. Additional contract terms will put more of an administrative burden on all health plans, and it will be a major effort to make the necessary changes. • Those contract changes are similar to the significant work that L.A. Care has put into implementing the new California Advancing and Improving Medi-Cal (CalAIM) provisions which began on January 1, 2022. Mr. Baackes will be reporting utilization metrics so Board Members can get a sense of the scale of the changes in utilization management through Enhanced Care Management (ECM) and Community Supports (CS) programs in CalAIM. The prior Health Homes and Whole Person Care programs were replaced by ECM and CS, which had 40 vendor contracts. The implementation of ECM and CS increased the number of vendors to 59 for ECM and 50 for CS. The increase in administrative effort to monitor those contracts is significant. In the first six months L.A. Care is working particularly closely with 	

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	<p>those contractors to help them become acclimated to the detailed reporting and billing requirements. Additional information will be provided at the upcoming Board Meeting.</p> <ul style="list-style-type: none"> • A request to renew the Elevating the Safety Net (ESN) program will be brought for Board consideration. It was five years since the request was made to set aside funds to use for this program. ESN has become a significant four-part program and has not used all the funding that was set aside. Sufficient funding remains to renew ESN for five years, with some modifications. • The work L.A. Care has done through the Equity Committee includes an Anti-racism and Cultural Humility training program, run by Dr. Jan Marie Garcia at the University of California, Davis. The two-day training began for Chief Officers at L.A. Care last fall. L.A. Care has a goal to train all Directors and above, which resumed in April, and will continue through the end of the fiscal year in September. 	
<p>Vision 2024 Progress Report</p>	<p>Mr. Baackes noted that the written Vision 2024 Progress Report is included in the meeting materials to inform Board Members of L.A. Care’s progress on the tactical elements in the plan. The four broad attributes have remained the same, but new tactics are developed each year to make progress toward achieving the attributes.</p> <p>Board Member Booth asked about the number of ECM and CS providers indicated in the Vision Report. Mr. Baackes indicated that in order to meet the demand for services, the number of vendors has increased. There are limitations for the services, including staffing at the service sites. The process of building capacity for ECM and CS was closely monitored by state representatives, as the desire was that health plans support community based organizations through these programs. Richard Seidman, MD, MPH, <i>Chief Medical Officer</i>, noted that the number of providers in the network is driven by the demand for services, and the number in the Vision 2024 document may not be current.</p> <p>Board Member Booth asked if the Generating African Infant and Nurturers Survival Initiative would be conducted as a study, because the problem is so great and it is important to develop good baseline data. As a medical study there could be important generalized information that could help people caring for African American moms and babies.</p> <p>Mr. Baackes responded that within L.A. Care’s Quality Department there is examination of disparities and this is a key area. He asked James Kyle, MD, <i>Chief of Equity & Quality Medical Director</i>, to comment on this program. Dr. Kyle noted that it is not an academic</p>	

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	<p>exercise. Regional data is available, and it is pretty discouraging. L.A. Care has a cross functional team that is actively looking for ways to improve the numbers. L.A. Care is in contact with the Charles R. Drew University Center for Excellence in Black Birthing and is exploring the work of Doulas and Mid-wives to help with the network of providers. When the initiative is launched and operating, additional data will be gathered to assess the progress made. This is seen as a long-term initiative to generate the highest impact. The African American maternal and infant mortality rates are between three and five times that of white mothers, irrespective of economics or education, and there is a great deal of work to be done in this area. In terms of disparities, this is one of the highest priority initiatives. Dr. Kyle has also asked staff to begin cataloging disparities and prioritize efforts to eliminate or improve them. He will report more specifically at future meetings. He indicated it was not the intention of this initiative to design a medical study in this area, although data is being collected. There is much study of this area already, but solutions so far have not had much effect. The data seems to indicate that structural racism underlies this issue. The disparities in outcome for maternal and infant health among a population of people, irrespective of education or health status, does not appear to have a biological cause but may indicate issues with access to care, lack of attention from providers, lack of early intervention, and other structural issues. It appears that it is about resources, the numbers of providers and retraining providers, advocating on behalf of patients and training patients to advocate on their own behalf. There are a number of strategies which L.A. Care will evaluate and use the best strategies in Los Angeles.</p> <p>Augustavia J. Haydel, Esq., <i>General Counsel</i>, noted that Wendy Schiffer, <i>Senior Director, Strategic Planning, Strategy, Regulatory and External Affairs</i>, submitted a “chat” comment in response to Board Member Booth’s question about the number of ECM and CS providers indicated in the Vision Report:</p> <p style="padding-left: 40px;">Board Member Booth, it is a timing issue. Vision 2024 Progress Report covers the January to March quarter.</p> <p>Dr. Seidman indicated that it is likely that seven providers were added in the second quarter. He stated that the network is larger than it was before and the total number of ECM providers is very close to what Mr. Baackes reported.</p> <p>Continuing the discussion about the Generating African Infant and Nurturers Survival Initiative, Ms. Schiffer noted that this was not structured as a research study. A request for proposal has been distributed through the Community Health Investment Fund. The review panel is working on selecting the grantees, who are all doing different programs so</p>	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	it does not necessarily lend itself to a research study but there will be an evaluation. More information will be provided at future meetings.	
Government Affairs Update	Mr. Baackes reported that the California State Legislature is still in session. L.A. Care is monitoring bills that have been introduced, particularly the bill that will approve the direct contract for Medi-Cal, exempting Kaiser from the competitive bidding process in which the other commercial health plans are currently engaged. A hearing was held at the Assembly Budget Committee where two health plan members of Local Health Plans of California (LHPC) testified, Jarrod B. McNaughton, Chief Executive Officer of Inland Empire Health Plan, and Stephanie Sonnenshine, Chief Executive Officer of Central California Alliance for Health. It would be naïve to think that the approval of this contract through the legislative initiative will be stopped, but health plans are seeking amendments to the bill to ensure that the impact of the contract will not have unintended consequences. The focus is on how the contract approval might negatively affect patients and safety net providers. LHPC has proposed five broad amendments to the bill, and some of those amendments are expected to be adopted although the bill is expected to be approved and Kaiser awarded a direct contract to provide managed care services to Medi-Cal beneficiaries. Staff will continue to report to the Board at future meetings.	
Annual Disclosure Commissions paid to brokers for employee health insurance programs	Terry Brown, <i>Chief Human Resources Officer</i> , reported that L.A. Care is required to provide this report to the Board annually. The brokerage commissions paid in 2020-21 were the same as those paid in the prior year and are in line with the accepted ranges. In fact, L.A. Care is paying 2.7% of the overall premium, where the median in the marketplace for organizations of its size in California is 3.7%.	
Approve Human Resources Policy HR-709 (Language Proficiency Assessment)	Mr. Brown noted that a change in the policy is that a proficiency passing level grids were added as appendices to the policy. A comment was received from a Board Member prior to this meeting regarding sign language. L.A. Care will verify if there is a requirement for sign language, and if there is no requirement, it will be removed from this policy. <u>Motion EXE A.0422</u> To approve the Human Resources Policy & Procedure HR-709 (Language Proficiency Assessment), as presented. Board Member Perez noted that at the last Executive Community Advisory Committee meeting she stated to Mr. Baackes that the Community Outreach & Engagement	Approved unanimously by roll call. 4 AYES

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	<p>(CO&E) is understaffed. Participation by CO&E staff members is demanded by consumer advisory committee members who would like to be involved in many different activities. She feels that it could be understaffing or collaboration with other departments to help with the activities suggested by the members. She encourages members to be more proactive and be involved in many activities. Unfortunately, during the pandemic there was no opportunity to meet in person and the Regional Community Advisory Committee (RCAC) members are just beginning to meet again virtually. She understands that there are concerns about funding. At the same time, there is a way to reset projects. She would like to see, during her time remaining on the Board, that if L.A. Care wants members involved, she suggests that there be internal coordination of that effort. She encouraged consideration of this idea to create a conversation about full engagement of CO&E in supporting members. She noted that CO&E staff has been great in reaching out to members by telephone and email, asking if members need anything. She recommended that the Community Resource Centers and Family Resource Centers reach out to RCAC members to inform them of the programs available, instead of referring RCAC members to the website to find the information.</p> <p>Mr. Brown responded that he will follow up with CO&E to make sure they have resources they need. Board Member Perez thanked Mr. Brown for being at L.A. Care events. She noted that the need she sees in the communities is apparent at the L.A. Care events. Even small support really helps. Families are struggling with the cost of rent, so any events that provide support for the community are really needed. She encouraged Board Members to participate in the community events.</p>	
Approve Consent Agenda	<p>Approve the list of items that will be considered on a Consent Agenda for May 5, 2022 Board of Governors Meeting.</p> <ul style="list-style-type: none"> • April 7, 2022 Board of Governors Meeting Minutes • Quarterly Investments Reports 	Approved unanimously by roll call. 4 AYES
PUBLIC COMMENTS		
ADJOURN TO CLOSED SESSION	<p>The Joint Powers Authority Executive Committee meeting was adjourned at 2:50 p.m.</p> <p>Ms. Haydel announced the items to be discussed in closed session. She announced there is no report anticipated from the closed session. The meeting adjourned to closed session at 2:51 p.m.</p>	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	<p>CONTRACT RATES Pursuant to Welfare and Institutions Code Section 14087.38(m)</p> <ul style="list-style-type: none"> • Plan Partner Rates • Provider Rates • DHCS Rates <p>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: <i>April 2024</i></p> <p>CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act Names of Five Cases:</p> <ul style="list-style-type: none"> • Methodist Hospital of Southern CA v. L.A. Care, Case No. 21STCV39978 • THC- Orange County, LLC DBA Kindred Hospital et al. v. L.A. Care, AHLA Case No. 6386 • THC- Orange County, LLC DBA Kindred Hospital et al. v. L.A. Care, Case No. 21STCV38231 • THC- Orange County, LLC DBA Kindred Hospital et al. v. L.A. Care, AHLA Case No. 6798 • USC Center for Health Financing, Policy, and Management, et al. v. Local Initiative Health Authority for Los Angeles County, Case No. 22STCP01429 <p>CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION Significant exposure to litigation pursuant to Section 54956.9(d)(2) of Ralph M. Brown Act: Three Potential Cases</p> <p>THREAT TO PUBLIC SERVICES OR FACILITIES Consultation with Tom MacDougall, <i>Chief Information & Technology Officer</i></p> <p>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</p> <p>PUBLIC EMPLOYEE PERFORMANCE EVALUATION Pursuant to Section 54957 of the Ralph M. Brown Act Title: Chief Executive Officer</p>	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	CONFERENCE WITH LABOR NEGOTIATOR Pursuant to Section 54957.6 of the Ralph M. Brown Act Agency Designated Representative: Hector De La Torre Unrepresented Employee: John Baackes	
RECONVENE IN OPEN SESSION	The meeting reconvened in open session at 4:14 p.m. No reportable actions were taken during the closed session.	
ADJOURNMENT	The meeting adjourned at 4:14 p.m.	

Respectfully submitted by:

Linda Merkens, *Senior Manager, Board Services*
 Malou Balones, *Board Specialist III, Board Services*
 Victor Rodriguez, *Board Specialist II, Board Services*

APPROVED BY:

 Hector De La Torre, *Chair*
 Date: _____



Legislative Matrix

Last Updated: May 16, 2022

Legislative Matrix as of 5/16/2022

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

If there are any questions, please contact Cherie Compartore of Government Affairs at ccompartore@lacare.org.

Bills by Issue

2022 Legislation (116)

Title

Medi-Cal: eligibility.

Description

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

Primary Sponsors

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

Organizational Notes

Last edited by Joanne Campbell at Apr 15, 2022, 8:24 PM

Support: L.A. Care, Local Health Plans of CA, California Medical Association, California Association of Health Plans

Title

Civil damages: medical malpractice.

Description

AB 35, Reyes. Civil damages: medical malpractice. Existing law, referred to as the Medical Injury Compensation Reform Act of 1975 (MICRA), prohibits an attorney from contracting for or collecting a contingency fee for representing any person seeking damages in connection with an action for injury or damage against a health care provider based upon alleged professional negligence in excess of specified limits. This bill would recast those provisions and base the amount of contingency fee that may be contracted for upon whether recovery is pursuant to settlement agreement and release of all claims executed before a civil complaint or demand for arbitration is filed, or pursuant to settlement, arbitration, or judgment after a civil complaint or demand for arbitration is filed, as specified. The bill would add and revise definitions for these purposes. Existing law provides that in any action against a health care provider based upon professional negligence, the injured plaintiff is entitled to recover noneconomic losses to compensate for pain, suffering, inconvenience, physical impairment, disfigurement, and other nonpecuniary damage. Existing law limits the amount of damages for noneconomic losses in an action for injury against a health care provider based on professional negligence to \$250,000. This bill would remove the \$250,000 limit on noneconomic damages and expand the recast provisions to include an action for injury against a health care institution, as defined. The bill would increase the applicable limitation based upon whether the action for injury involved wrongful death. The bill would specify that these limitations would increase by \$40,000 each January 1st for 10 years and beginning on January 1, 2034, the applicable limitations on noneconomic damages for personal injury and for wrongful death would be adjusted for inflation on January 1st of each year by 2%. Existing law specifies that in any action for injury or damages against a provider of health care services, a superior court shall, at the request of either party, enter a judgment ordering that money damages or its equivalent for future damages of the judgment creditor be paid in whole or in part by periodic payments rather than by a lump-sum payment if the award equals or exceeds \$50,000. This bill would increase the minimum amount of the judgment required to request periodic payments to \$250,000. Existing law makes statements, writings, or benevolent gestures expressing sympathy or a general sense of benevolence relating to the pain, suffering, or death of a person involved in an accident and made to that person, or to the family of that person, inadmissible as evidence of an admission of liability in a civil action. This bill would specify that sta... (click bill link to see more).

Primary Sponsors

Eloise Reyes, Tom Umberg, Marc Berman, Bob Hertzberg, John Laird, Mark Stone

Title

Health care coverage: insulin affordability.

Description

AB 97, as amended, Nazarian. Health care coverage: insulin affordability. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or disability insurance policy issued, amended, delivered, or renewed on or after January 1, 2000, that covers prescription benefits to include coverage for insulin, if it is determined to be medically necessary. This bill would prohibit a health care service plan contract or a health disability insurance policy, as specified, issued, amended, delivered, or renewed on or after January 1, 2022, from imposing a deductible on an insulin prescription drug, except as specified for a high deductible health plan, as defined. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors

Adrin Nazarian

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:06 PM
Oppose: CA. Assoc. of Health Plans

Title

Medi-Cal benefits: rapid Whole Genome Sequencing.

Description

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

Primary Sponsors

Brian Maienschein

Title

Local health department workforce assessment.

Description

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

Primary Sponsors

Freddie Rodriguez

Title

Behavioral health: older adults.

Description

AB 383, as amended, Salas. Behavioral health: older adults. Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the continuously appropriated Mental Health Services Fund to fund various county mental health programs, including the Adult and Older Adult Mental Health System of Care Act. Existing law authorizes the MHSA to be amended by a 2/3 vote of the Legislature if the amendments are consistent with, and further the purposes of, the MHSA, and also permits the Legislature to clarify procedures and terms of the MHSA by a majority vote. This bill would establish within the State Department of Health Care Services an Older Adult Behavioral Health Services Administrator to oversee behavioral health services for older adults. The bill would require that position to be funded with administrative funds from the Mental Health Services Fund. The bill would prescribe the functions of the administrator and its responsibilities, including, but not limited to, developing outcome and related indicators for older adults for the purpose of assessing the status of behavioral health services for older adults, monitoring the quality of programs for those adults, and guiding decisionmaking on how to improve those services. The bill would require the administrator to receive data from other state agencies and departments to implement these provisions, subject to existing state or federal confidentiality requirements. The bill would require the administrator to report to the entities that administer the MHSA on those outcome and related indicators by July 1, 2022, and would require the report to be posted on the department's internet website. The bill would also require the administrator to develop a strategy and standardized training for all county behavioral health personnel in order for the counties to assist the administrator in obtaining the data necessary to develop the outcome and related indicators. This bill would declare that it clarifies procedures and terms of the Mental Health Services Act.

Primary Sponsors

Rudy Salas

Title

Medi-Cal: eligibility.

Description

AB 470, as amended, Carrillo. Medi-Cal: eligibility. Existing law, the Medi-Cal Act, provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires Medi-Cal benefits to be provided to individuals eligible for services pursuant to prescribed standards, including a modified adjusted gross income (MAGI) eligibility standard. Existing law prohibits the use of an asset or resources test for individuals whose financial eligibility for Medi-Cal is determined based on the application of MAGI. Existing federal law authorizes a state to establish a non-MAGI standard for determining the eligibility of specified individuals, and existing law imposes the use of a resources test for establishing Medi-Cal eligibility for prescribed populations. This bill would prohibit the use of resources, including property or other assets, to determine eligibility under the Medi-Cal program to the extent permitted by federal law, and would require the department to seek federal authority to disregard all resources as authorized by the flexibilities provided pursuant to federal law. The bill would authorize the department to implement this prohibition by various means, including provider bulletins, without taking regulatory authority. By January 1, 2023, the bill would require the department to adopt, amend, or repeal regulations on the prohibition, and to update its notices and forms to delete any reference to limitations on resources or assets. Because counties are required to make Medi-Cal eligibility determinations, and this bill would expand Medi-Cal eligibility, the bill would impose a state-mandated local program. With respect to the prohibition on resources, the bill would make various conforming and technical changes to the Medi-Cal Act. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Primary Sponsors

Wendy Carrillo

Organizational Notes

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

Title

Program of All-Inclusive Care for the Elderly.

Description

AB 540, as amended, Petrie-Norris. Program of All-Inclusive Care for the Elderly. Existing federal law establishes the Program of All-Inclusive Care for the Elderly (PACE), which provides specified services for older individuals at a PACE center, defined, in part, as a facility that includes a primary care clinic, so that they may continue living in the community. Federal law authorizes states to implement the PACE program as a Medicaid state option. Existing state law establishes the California Program of All-Inclusive Care for the Elderly (PACE program) to provide community-based, risk-based, and capitated long-term care services as optional services under the state's Medi-Cal State Plan, as specified. Existing law authorizes the State Department of Health Care Services to enter into contracts with various entities for the purpose of implementing the PACE program and fully implementing the single-state agency responsibilities assumed by the department in those contracts, as specified. This bill would exempt a Medi-Cal beneficiary who is enrolled in a PACE organization with a contract with the department from mandatory or passive enrollment in a Medi-Cal managed care plan, and would require persons enrolled in a PACE plan to receive all Medicare and Medi-Cal services from the PACE program. The bill would require, in areas where a PACE plan is available, that the PACE plan be presented as a Medi-Cal managed care plan enrollment option in the same manner as other Medi-Cal managed care plan options. In areas of the state where a presentation on Medi-Cal managed care plan enrollment options is unavailable, the bill would require the department or its contracted vendor to provide outreach and enrollment materials on PACE. The bill would require the department to establish a system to identify Medi-Cal beneficiaries who appear to be eligible for PACE based on age, residence, and prior use of services, and, with respect to that system, would require the department to conduct specified outreach and referrals.

Primary Sponsors

Cottie Petrie-Norris

Title

Integrated School-Based Behavioral Health Partnership Program.

Description

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

Primary Sponsors

Sharon Quirk-Silva

Title

Pupil health: health and mental health services: School Health Demonstration Project.

Description

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

Primary Sponsors

Patrick O'Donnell, Rudy Salas, Jim Wood

Title

Health care practitioners: electronic prescriptions: nurse practitioner scope of practice: practice without standardized procedures.

Description

AB 852, as amended, Wood. Health care practitioners: electronic prescriptions: nurse practitioner scope of practice: practice without standardized procedures. (1) Existing law requires health care practitioners authorized to issue prescriptions to have the capability to issue electronic data transmission prescriptions and requires a pharmacy, pharmacist, or other practitioner authorized to dispense or furnish a prescription to have the capability to receive those electronic transmissions. Existing law requires those health care practitioners to issue a prescription as an electronic data transmission prescription, except under certain conditions, including that the electronic prescription is unavailable due to a temporary technological or electrical failure. Existing law requires a pharmacy that receives an electronic prescription from a prescribing health care practitioner who has issued a prescription but has not dispensed the medication to the patient to immediately transfer or forward the electronic prescription to an alternative pharmacy designated by the requester. This bill would prohibit a pharmacy, pharmacist, or other practitioner authorized to dispense or furnish a prescription from refusing to dispense or furnish an electronic prescription solely because the prescription was not submitted via, or is not compatible with, their proprietary software. The bill would permit a pharmacy, pharmacist, or other authorized practitioner to decline to dispense or furnish an electronic prescription submitted via software that fails to meet any one of specified criteria, including compliance with the federal Health Insurance Portability and Accountability Act of 1996. With respect to health care practitioners who are required to issue a prescription as an electronic data transmission prescription, the bill would make additional exceptions to that requirement, including for a prescriber who registers with the California State Board of Pharmacy and states that they satisfy one or more criteria, including that they issue 100 or fewer prescriptions per calendar year. The bill would make specified exceptions to the requirement for a pharmacy to immediately transfer an electronic prescription to an alternative pharmacy. (2) Existing law, the Nursing Practice Act, provides for the certification and regulation of nurse practitioners by the Board of Registered Nursing. Existing law authorizes a nurse practitioner who meets certain education, experience, and certification requirements to perform, in certain settings or organizations, specified functions without standardized procedures, including, among others, conducting an advanced assessment; ordering, performing, and interpreting diagnostic procedures, as specified; and presc... (click bill link to see more).

Primary Sponsors

Jim Wood

Title

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

Description

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

Primary Sponsors

Adam Gray, Rudy Salas, Melissa Hurtado

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:09 PM
Oppose Unless Amended: Local Health Plans of California

Title

Emergency ground medical transportation.

Description

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

Primary Sponsors

Tasha Boerner Horvath

Title

California Health Care Quality and Affordability Act.

Description

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

Primary Sponsors

Jim Wood

Organizational Notes

Last edited by Joanne Campbell at Apr 14, 2022, 3:49 PM

Support: Western Center on Law and Poverty

Title

Medi-Cal.

Description

AB 1132, as amended, Wood. Medi-Cal. (1) Existing law authorizes the board of supervisors in each county to designate an entity or entities to assist county jail inmates with applying for a health insurance affordability program, as defined, consistent with federal requirements. Commencing January 1, 2023, this bill would instead require the board of supervisors, in consultation with the county sheriff, to designate an entity or entities to assist both county jail inmates and juvenile inmates with the application process, and would make conforming changes to provisions relating to the coordination duties of jail administrators. By creating new duties for local officials, including boards of supervisors and jail administrators, the bill would impose a state-mandated local program. No sooner than January 1, 2023, the bill would require the department to develop and implement a mandatory process for county jails and county juvenile facilities to coordinate with Medi-Cal managed care plans and Medi-Cal behavioral health delivery systems to facilitate continued behavioral health treatment in the community for inmates, as specified, and would authorize the sharing of prescribed data with and among counties and other specified entities, as determined necessary by the department. (2) Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services, including mental health and substance use disorder services, either through a fee-for-service or managed care delivery system. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing federal law provides for the federal Medicare program, which is a public health insurance program for persons who are 65 years of age or older and specified persons with disabilities who are under 65 years of age. Under existing law, a demonstration project known as the Coordinated Care Initiative (CCI) enables beneficiaries who are dually eligible for the Medi-Cal program and the Medicare Program to receive a continuum of services that maximizes access to, and coordination of, benefits between these programs. Existing law, the Medi-Cal 2020 Demonstration Project Act, requires the department to implement specified components of a Medi-Cal demonstration project, including the Global Payment Program (GPP), the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program, and the Whole Person Care pilot program, consistent with the Special Terms and Conditions approved by the federal Centers for Medicare and Medicaid Services. Pursuant to existing law, the department has created a multiyear initiative, the California Advancing... (click bill link to see more).

Primary Sponsors

Jim Wood

Title

Health care coverage: claims payments.

Description

AB 1162, as amended, Villapudua. Health care coverage: claims payments. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan or health insurer to provide access to medically necessary health care services to its enrollees or insureds who have been displaced by a state of emergency. Existing law enumerates actions that a plan or insurer may be required to take to meet the needs of its enrollees or insureds during the state of emergency. Under existing law, the department may relax time limits for prior authorization during a state of emergency. Existing law requires a health care service plan or a health insurer to reimburse each complete claim, as specified, as soon as practical, but no later than 30 working days, or for a health maintenance organization, 45 working days, after receipt of the complete claim. Under existing law, within 30 working days, or 45 working days for a health maintenance organization, after receipt of the claim, a plan or insurer can contest or deny a claim, as specified. Existing law also authorizes the plan or insurer to request reasonable additional information about a contested claim within 30 working days, or for a health maintenance organization, 45 working days. Existing law allows the plan or insurer 30 working days, or a health maintenance organization 45 working days, after receipt of the additional information to reconsider the claim. Under existing law, once the plan or insurer has received all the information necessary to determine payer liability for the claim and has not reimbursed the claim deemed to be payable within 30 working days, or 45 working days for a health maintenance organization, interest will accrue as specified. Under existing law, for an unpaid claim for nonemergency services, the plan or insurer is required to pay interest, and a plan is required to automatically include the interest in its payment to the claimant on an uncontested claim that has not been paid within the prescribed period. Under existing law, if a plan fails to automatically include this interest owed, it is required to also pay the claimant a \$10 fee for failing to comply with this requirement. Under existing law, if a claim for emergency services is not contested by the plan or insurer, and the plan or insurer fails to pay the claim within the 30- or 45-day respective period, the plan or insurer is required to pay a fee or interest, as specified. This bill would require a health care ... (click bill link to see more).

Primary Sponsors

Carlos Villapudua

Organizational Notes

Last edited by Joanne Campbell at Apr 15, 2022, 8:28 PM

Oppose: California Association of Health Plans

Title

Medi-Cal: serious mental illness: drugs.

Description

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

Primary Sponsors

Jacqui Irwin

Title

Medi-Cal: Independent Medical Review System.

Description

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

Primary Sponsors

Marc Levine

Organizational Notes

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

Title

Mental Health Services Oversight and Accountability Commission.

Description

AB 1668, as amended, Patterson. Mental Health Services Oversight and Accountability Commission. Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the Mental Health Oversight and Accountability Commission to oversee the implementation of the MHSA. Existing law specifies the composition of the 16-member commission, including the Attorney General or their designee, the Superintendent of Public Instruction or their designee, specified members of the Legislature, and 12 members appointed by the Governor, as prescribed. Existing law authorizes the MHSA to be amended by a 2/3 vote of the Legislature if the amendments are consistent with, and further the purposes of, the MHSA, or by a majority vote to clarify procedures and terms. This bill would urge the Governor, in making appointments, to consider ensuring geographic representation among the 10 regions of California defined by the 2020 census.

Primary Sponsors

Jim Patterson

Title

Mental health services.

Description

AB 1859, as introduced, Levine. Mental health services. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, to include coverage for essential health benefits, which include mental health services. Existing law, the Lanterman-Petris-Short Act, sets forth procedures for the involuntary detention, for up to 72 hours for evaluation and treatment, of a person who, as a result of a mental health disorder, is a danger to others or to themselves or is gravely disabled. This bill would require a health care service plan or a health insurance policy issued, amended, or renewed on or after January 1, 2023, that includes coverage for mental health services to, among other things, approve the provision of mental health services for persons who are detained for 72-hour treatment and evaluation under the Lanterman-Petris-Short Act and to schedule an initial outpatient appointment for that person with a licensed mental health professional on a date that is within 48 hours of the person's release from detention. The bill would prohibit a noncontracting provider of covered mental health services from billing the previously described enrollee or insured more than the cost-sharing amount the enrollee or insured would pay to a contracting provider for those services. Because a willful violation of the bill's requirement by a health care service plan would be a crime, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors

Marc Levine

Organizational Notes

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

Title

California Health Benefit Exchange: affordability assistance.

Description

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

Primary Sponsors

Jim Wood

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:11 PM

Support if Amended: CA. Assoc. of Health Plans

Title

Prior authorization and step therapy.

Description

AB 1880, as amended, Arambula. Prior authorization and step therapy. Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law authorizes a health care service plan or health insurer to require step therapy if there is more than one drug that is appropriate for the treatment of a medical condition, as specified. Existing law requires a health care service plan or health insurer to expeditiously grant a step therapy exception request if the health care provider submits justification and supporting clinical documentation, as specified. Under existing law, if a health care service plan or other related entity fails to notify a prescribing provider of its coverage determination within a prescribed time period after receiving a prior authorization or step therapy exception request, the prior authorization or step therapy exception request is deemed approved for the duration of the prescription. Existing law excepts contracts entered into under specified medical assistance programs from these time limit requirements. Existing law permits a health care provider or prescribing provider to appeal a denial of a step therapy exception request for coverage of a nonformulary drug, a prior authorization request, or a step therapy exception request, consistent with the current utilization management processes of the health care service plan or health insurer. Existing law also permits an enrollee or insured, or the enrollee's or insured's designee or guardian, to appeal a denial of a step therapy exception request for coverage of a nonformulary drug, prior authorization request, or step therapy exception request by filing a grievance under a specified provision. This bill would require health care service plan's or health insurer's utilization management process to ensure that an appeal of a denial of an exception request is reviewed by a clinical peer of the health care provider or prescribing provider, as specified. The bill would define the term "clinical peer" for these purposes. The bill would require health care service plans and health insurers that require step therapy or prior authorization to maintain specified information, including, but not limited to, the number of exception requests for coverage of a nonformulary drug, step therapy exception requests, and prior authorization requests received by the plan or insurer, and, upon request, to provide the information in a deidentified format to the department or commissioner, as appropriate. Bec... (click bill link to see more).

Primary Sponsors

Joaquin Arambula

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:12 PM

Support: Arthritis Foundation (Co-Sponsor), the California Rheumatology Alliance (Co-Sponsor), and the Crohn's and Colitis Foundation (Co-Sponsor) Oppose: CA. Assoc. of Health Plans

Title

Medi-Cal: orthotic and prosthetic appliances.

Description

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

Primary Sponsors

Heath Flora

Title

Medi-Cal: income level for maintenance.

Description

AB 1900, as introduced, Arambula. Medi-Cal: income level for maintenance. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law, to the extent federal financial participation is available, requires the department to exercise its option under federal law to implement a program for individuals who are 65 years of age or older or are disabled, without a share of cost, if they meet certain financial eligibility criteria, including not exceeding 138% of the federal poverty level in their countable income or as specified. Under existing law, certain medically needy persons with higher incomes qualify for Medi-Cal with a share of cost, if they meet specified criteria. Under existing law, the share of cost for those persons is generally the total after deducting an amount for maintenance from the person's monthly income. Existing law requires the department to establish income levels for maintenance at the lowest levels that reasonably permit a medically needy person to meet their basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under applicable federal law. Under existing law, for a single individual, the amount of the income level for maintenance per month is based on a calculation of 80% of the highest amount that would

ordinarily be paid to a family of 2 persons, without any income or resources, under specified cash assistance provisions, multiplied by the federal financial participation rate, adjusted as specified. This bill, to the extent that any necessary federal authorization is obtained, would increase the above-described income level for maintenance per month to be equal to the income limit for Medi-Cal without a share of cost for individuals who are 65 years of age or older or are disabled, generally totaling 138% of the federal poverty level. The bill would require the department to seek any necessary federal authorization for maintaining that income level for maintenance and would make conforming changes to related provisions.

Primary Sponsors

Joaquin Arambula, Jim Wood

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:13 PM

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

Bill Number

AB 1917

Status

In Assembly

Position

Monitor

Title

Personal information: contact tracing.

Description

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

Primary Sponsors

Marc Levine

Title

Medi-Cal: violence preventive services.

Description

AB 1929, as amended, Gabriel. Medi-Cal: violence preventive services. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes a schedule of benefits under the Medi-Cal program, including various mental health services. Existing federal law authorizes, at the option of the state, preventive services, as defined, that are recommended by a physician or other licensed practitioner of the healing arts. This bill would require the department to establish a community violence prevention and recovery program, under which violence preventive services would be provided by qualified violence prevention professionals, as defined, as a covered benefit under the Medi-Cal program, in order to reduce the incidence of violent injury or reinjury, trauma, and related harms, and promote trauma recovery, stabilization, and improved health outcomes. Under the bill, the services would be available to a Medi-Cal beneficiary who (1) has been violently injured as a result of community violence, as defined, (2) for whom a licensed health care provider has determined that the beneficiary is at significant risk of experiencing violent injury as a result of community violence, or (3) has experienced chronic exposure to community violence. The bill would authorize the department to meet these requirements by ensuring that qualified violence prevention professionals are designated as community health workers. The bill would set forth training and certification and continuing education requirements for those professionals, as specified, and would require the department to approve one or more training and certification programs with certain curriculum components. The bill would require an entity that employs or contracts with a qualified violence prevention professional to take specified actions to ensure the professional's compliance with these requirements. The bill would require the department to post on its internet website the date upon which violence preventive services could be provided and billed. The bill would condition implementation of its provisions on receipt of any necessary federal approvals and the availability of federal financial participation.

Primary Sponsors

Jesse Gabriel, Mike Gipson

Title

Medi-Cal: comprehensive perinatal services.

Description

AB 1930, as amended, Arambula. Medi-Cal: comprehensive perinatal services. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including comprehensive perinatal services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, a pregnant individual or targeted low-income child who is eligible for, and is receiving, health care coverage under any of specified Medi-Cal programs is eligible for full-scope Medi-Cal benefits for the duration of the pregnancy and for a period of one year following the last day of the individual's pregnancy. This bill, during the one-year postpregnancy eligibility period, and as part of comprehensive perinatal services under Medi-Cal, would require the department to cover additional comprehensive perinatal assessments and individualized care plans and to provide additional visits and units of services in an amount, duration, and scope that are at least proportional to those available on July 27, 2021, during pregnancy and the initial 60-day postpregnancy period in effect on that date. The bill would require the department to collaborate with the State Department of Public Health and a broad stakeholder group to determine the specific number of additional comprehensive perinatal assessments, individualized care plans, visits, and units of services to be covered. The bill would require the department to seek any necessary federal approvals to cover preventive services that are recommended by a physician or other licensed practitioner and that are rendered by a nonlicensed perinatal health worker in a beneficiary's home or other community setting away from a medical site, as specified. The bill would also require the department to seek any necessary federal approvals to allow a nonlicensed perinatal health worker rendering those preventive services to be supervised by (1) an enrolled Medi-Cal provider that is a clinic, hospital, community-based organization (CBO), or licensed practitioner, or (2) a CBO that is not an enrolled Medi-Cal provider, so long as an enrolled Medi-Cal provider is available for Medi-Cal billing purposes. The bill would condition implementation of the provisions above on receipt of any necessary federal approvals and the availability of federal financial participation.

Primary Sponsors

Joaquin Arambula

Organizational Notes

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

Title

Local government: open and public meetings.

Description

AB 1944, as amended, Lee. Local government: open and public meetings. Existing law, the Ralph M. Brown Act, requires, with specified exceptions, that all meetings of a legislative body of a local agency, as those terms are defined, be open and public and that all persons be permitted to attend and participate. The act contains specified provisions regarding the timelines for posting an agenda and providing for the ability of the public to observe and provide comment. The act allows for meetings to occur via teleconferencing subject to certain requirements, particularly that the legislative body notice each teleconference location of each member that will be participating in the public meeting, that each teleconference location be accessible to the public, that members of the public be allowed to address the legislative body at each teleconference location, that the legislative body post an agenda at each teleconference location, and that at least a quorum of the legislative body participate from locations within the boundaries of the local agency's jurisdiction. The act provides an exemption to the jurisdictional requirement for health authorities, as defined. Existing law, until January 1, 2024, authorizes a local agency to use teleconferencing without complying with those specified teleconferencing requirements in specified circumstances when a declared state of emergency is in effect, or in other situations related to public health. This bill would require the agenda to identify any member of the legislative body that will participate in the meeting remotely. The bill would also require an updated agenda reflecting all of the members participating in the meeting remotely to be posted, if a member of the legislative body elects to participate in the meeting remotely after the agenda is posted. This bill would authorize, under specified circumstances and upon a determination by a majority vote of the legislative body, a member to be exempt from identifying the address of the member's teleconference location in the notice and agenda or having the location be accessible to the public, if the member elects to teleconference from a location that is not a public place. This bill would require all open and public meetings of a legislative body that elects to use teleconferencing to provide a video stream accessible to members of the public and an option for members of the public to address the body remotely during the public comment period through an audio-visual or call-in option. This bill would repeal these provisions on January 1, 2030. Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with fin... (click bill link to see more).

Primary Sponsors

Alex Lee, Cristina Garcia

Title

Telehealth: dental care.

Description

AB 1982, as amended, Santiago. Telehealth: dental care. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires contract between a health care service plan or health insurer and a health care provider to require the plan or insurer to reimburse the provider for the diagnosis, consultation, or treatment of an enrollee, subscriber, insured, or policyholder appropriately delivered through telehealth services on the same basis and to the same extent as the same service through in-person diagnosis, consultation, or treatment. Existing law requires a health care service plan or health insurer that offers a service via telehealth to meet specified conditions, including, that the health care service plan or health insurer disclose to the enrollee or insured the availability of receiving the service on an in-person basis or via telehealth. This bill would require a health care service plan or health insurer covering dental services that offers a service via telehealth through a third-party corporate telehealth provider to disclose to the enrollee or insured the impact of third-party telehealth visits on the patient's benefit limitations, including frequency limitations and the patient's annual maximum. The bill would also require those plans and insurers to submit specified information for each product type. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors

Miguel Santiago

Title

Medi-Cal: premiums, contributions, and copayments.

Description

AB 1995, as amended, Arambula. Medi-Cal: premiums, contributions, and copayments. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires that Medi-Cal benefits be provided to optional targeted low-income children, as defined, based on a certain income eligibility threshold. Existing law also establishes the

Medi-Cal Access Program, which provides health care services to a woman who is pregnant or in her postpartum period and whose household income is between certain thresholds, and to a child under 2 years of age who is delivered by a mother enrolled in the program, as specified. Existing law also establishes a program under which certain employed persons with disabilities are eligible for Medi-Cal benefits based on income and other criteria. Existing law requires the department to exercise the option, available to the state under federal law, to impose specified monthly premiums, based on income level, for the above-described children and employed persons with disabilities. Existing law requires the department to determine schedules for subscriber contribution amounts for persons enrolled in the Medi-Cal Access Program. This bill would eliminate the premiums and subscriber contributions for the above-described populations. The bill would make conforming changes to related provisions. Existing law creates the County Health Initiative Matching Fund in the State Treasury, administered by the department for the purpose of providing matching state funds and local funds received by the fund through intergovernmental transfers to a county agency, a local initiative, or a county organized health system in order to provide health insurance coverage to certain children and adults in low-income households who do not qualify for health care benefits through the Healthy Families Program or Medi-Cal. This bill would prohibit the department from imposing subscriber contributions for that program, to the extent allowable by federal law, as specified. Existing law requires Medi-Cal beneficiaries to make set copayments for specified services, including for nonemergency services received in an emergency department or emergency room. This bill would prohibit the department from imposing copayments on recipients of specified services, to the extent allowable by federal law.

Primary Sponsors

Joaquin Arambula

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:14 PM

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

Bill Number
AB 1999

Status
In Assembly

Position
Monitor

Title

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

Description

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

Primary Sponsors

Joaquin Arambula

Bill Number
AB 2007

Status
In Assembly

Position
Monitor

Title

Health care language assistance services.

Description

AB 2007, as introduced, Valladares. Health care language assistance services. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law requires the Department of Managed Health Care to adopt regulations establishing standards and requirements for health care service plans to provide enrollees with appropriate access to language assistance in obtaining health care services. Existing law requires the department to report biennially to, among others, the Legislature, regarding plan compliance with the standards. This bill would instead require the department to provide that report 3 times a year.

Primary Sponsors

Suzette Valladares

Title

Health care coverage: diagnostic imaging.

Description

AB 2024, as amended, Friedman. Health care coverage: diagnostic imaging. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract issued, amended, delivered, or renewed on or after January 1, 2000, or an individual or group policy of disability insurance or self-insured employee welfare benefit plan to provide coverage for mammography for screening or diagnostic purposes upon referral by specified professionals. This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2023, to provide coverage for screening mammography, medically necessary diagnostic or supplemental breast examinations, or testing for screening or diagnostic purposes upon referral by specified professionals. The bill would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2023, from imposing cost sharing for screening mammography, medically necessary or supplemental breast examinations, or testing, unless the contract or policy is a high deductible health plan and the deductible has not been satisfied for the year. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors

Laura Friedman

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:14 PM

Oppose: CA. Assoc. of Health Plans

Title

Health care coverage: treatment for infertility.

Description

AB 2029, as amended, Wicks. Health care coverage: treatment for infertility. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of disability insurers by the Department of Insurance. Existing law imposes various requirements and restrictions on health care service plans and disability insurers, including, among other things, a requirement that every group health care service plan contract or health insurance policy that is issued, amended, or renewed on or after January 1, 1990, offer coverage for the treatment of infertility, except in vitro fertilization. Existing law provides that any employer that is a religious organization, or a health care service plan or disability insurer that is a subsidiary of an entity whose owner or corporate member is a religious organization, is not required to offer coverage for forms of treatment of infertility in a manner inconsistent with the religious organization's religious and ethical principles, as specified. This bill would require a health care service plan contract or disability insurance policy that is issued, amended, or renewed on or after January 1, 2023, to provide coverage for the diagnosis and treatment of infertility and fertility services, as specified, up to a lifetime maximum benefit of \$75,000. The bill would except specialty health care service plan contracts and disability insurance policies from that requirement. The bill also would require a small group health care service plan contract or disability insurance policy, except a specialized contract or policy, that is issued, amended, or renewed on or after January 1, 2023, to offer coverage for the treatment of infertility, as specified. The bill would revise the definition of infertility, and would remove the exclusion of in vitro fertilization from coverage. The bill would also delete a requirement that a health care service plan contract and health insurance policy provide infertility treatment under agreed-upon terms that are communicated to all group contractholders and policyholders and prospective group contractholders and policyholders. With respect to a health care service plan, the bill would not apply to Medi-Cal managed care health care service plan contracts or any entity that enters into a contract with the State Department of Health Care Services for the delivery of health care services pursuant to specified provisions. The bill would prohibit a health care service plan or health insurer from placing different conditions or coverage limitations on fertility medications or services, ... (click bill link to see more).

Primary Sponsors

Buffy Wicks

Organizational Notes

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

Title

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

Description

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

Primary Sponsors

Lisa Calderon

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:15 PM

Support: L.A. Care, Local Health Plans of California, California Senior Legislature (sponsor), Support California Senior Legislature (sponsor), Alzheimer's Association State Policy Office, California Long-term Care Ombudsman Association, California Advocates for Nursing Home Reform, California Hospital Association, California PACE Association, Justice in Aging

Title

Health Care Consolidation and Contracting Fairness Act of 2022.

Description

AB 2080, as amended, Wood. Health Care Consolidation and Contracting Fairness Act of 2022. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law regulates contracts between health care service plans or health insurers and health care providers or health facilities, including requirements for reimbursement and the cost-sharing amount collected from an enrollee or insured. This bill, the Health Care Consolidation and Contracting Fairness Act of 2022, would prohibit a contract issued, amended, or renewed on or after January 1, 2023, between a health care service plan or health insurer and a health care provider or health facility from containing terms that, among other things, restrict the plan or insurer from steering an enrollee or insured to another provider or facility or require the plan or insurer to contract with other affiliated providers or facilities. The bill would authorize the appropriate regulating department to refer a plan's or insurer's contract to the Attorney General, and would authorize the Attorney General or state entity charged with reviewing health care market competition to review a health care practitioner's entrance into a contract that contains specified terms. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. Existing law requires a health care service plan that intends to merge with, consolidate with, or enter into an agreement resulting in its purchase, acquisition, or control by, an entity to give notice to, and secure prior approval from, the Director of the Department of Managed Health Care. Existing law authorizes the director to disapprove the transaction or agreement if the director finds it would substantially lessen competition in health care service plan products or create a monopoly in this state. This bill would additionally require a health care service plan that intends to acquire or obtain control of an entity, as specified, to give notice to, and secure prior approval from, the director. Because a willful violation of this provision would be a crime, the bill would impose a state-mandated local program. The bill would also authorize the director to disapprove a transaction or agreement if it would substantially lessen competition in the health system or among a particular category of health care providers, and would require the director to provide information related to competition to the Attorney General... (click bill link to see more).

Primary Sponsors

Jim Wood

Organizational Notes

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

Title

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

Description

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

Primary Sponsors

Mia Bonta

Title

Acute hospital care at home.

Description

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

Primary Sponsors

Akilah Weber

Title

Mobile stroke units.

Description

AB 2117, as amended, Gipson. Mobile stroke units. Existing law provides for the licensure and regulation of health facilities by the State Department of Public Health, and defines various types of health facilities for those purposes. This bill would define "mobile stroke unit" to mean a multijurisdictional mobile facility that serves as an emergency response critical care ambulance under the direction and approval of a local emergency medical services (EMS) agency, and as a diagnostic, evaluation, and treatment unit, providing radiographic imaging, laboratory testing, and medical treatment under the supervision of a physician in person or by telehealth, for patients with symptoms of a stroke, to the extent consistent with any federal definition of a mobile stroke unit, as specified.

Primary Sponsors

Mike Gipson

Organizational Notes

Last edited by Joanne Campbell at Apr 22, 2022, 2:34 PM

Oppose: (removed) California Association of Health Plans

Title

Health care coverage: dependent adults.

Description

AB 2127, as amended, Santiago. Health care coverage: dependent adults. Existing law establishes the Health Insurance Counseling and Advocacy Program (HICAP) in the California Department of Aging to provide Medicare beneficiaries and those imminently eligible for Medicare with counseling and advocacy regarding health care coverage options. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires an individual health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2023, that provides dependent coverage to make dependent coverage available to a qualified dependent parent or stepparent. Existing law requires a plan, an insurer, or the California Health Benefit Exchange to provide an applicant seeking to add a dependent parent or stepparent with written notice about HICAP at the time of solicitation and on the application. This bill would clarify that a health care service plan, a health insurer, or a solicitor is required to provide an individual with the name, address, and telephone number of the local HICAP program and the statewide HICAP telephone number at the time of solicitation and, for a plan or insurer, on the application. Because a violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. The bill would state the intent of the Legislature to ensure an individual is informed of and understands their specific rights and health care options before enrolling a Medicare-eligible or enrolled dependent parent or stepparent in individual health care coverage. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors

Miguel Santiago

Title

California Medical School Tuition for Medical Service Pilot Program.

Description

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

Primary Sponsors

Carlos Villapudua

Title

Reproductive health care.

Description

AB 2134, as amended, Akilah Weber. Reproductive health care. Existing law, the Reproductive Privacy Act, prohibits the state from denying or interfering with a person's right to choose or obtain an abortion prior to viability of the fetus, or when the abortion is necessary to protect the life or health of the person. The act defines "abortion" as a medical treatment intended to induce the termination of a pregnancy except for the purpose of producing a live birth. Existing law establishes the Department of Health Care Access and Information to oversee and administer various health programs. Existing law establishes the Medi-Cal program, under which qualified low-income individuals receive health care services. Existing law establishes a schedule of benefits under the Medi-Cal program and provides for various services, including comprehensive clinical family planning services that are rendered through the Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program. This bill would establish the California Reproductive Health Equity Program within the Department of Health Care Access and Information to ensure abortion and contraception services are affordable for and accessible to all patients and to provide financial support for safety net providers of these services. The bill would authorize a Medi-Cal enrolled provider to apply to the department for a grant, and a continuation award after the initial grant, to provide abortion and contraception at no cost to an individual with a household income at or below 400% of the federal poverty level who is uninsured or has health care coverage that does not include both abortion and contraception, and who is not eligible to receive both abortion and contraception at no cost through the Medi-Cal and Family PACT programs. The bill would establish the California Reproductive Health Equity Fund, a continuously appropriated fund, to provide this grant funding. The bill would require the department to conduct an annual evaluation of the program and report its findings to the Legislature. By creating a continuously appropriated fund, the bill would make an appropriation. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires group health care service plan contracts and disability insurance policies to cover contraceptive services and methods without cost sharing, as specified. Existing law authorizes a religious employer to request a contract or policy that does not include contracep... (click bill link to see more).

Primary Sponsors

Akilah Weber, Cristina Garcia, Anna Caballero

Title

Mental health: information sharing.

Description

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

Primary Sponsors

James Ramos

Title

Birthing Justice for California Families Pilot Project.

Description

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

Primary Sponsors

Buffy Wicks

Title

California Health Benefit Exchange: abortion services coverage reporting.

Description

AB 2205, as amended, Carrillo. California Health Benefit Exchange: abortion services coverage reporting. Existing federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. Existing state law creates the California Health Benefit Exchange (Exchange), also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. If a qualified health plan covers abortion services, PPACA requires the plan to deposit the premium amounts that equal the actuarial value of the coverage of those services into a separate account, as specified. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service plans and makes a willful violation of the act a crime. Existing law also requires the Department of Insurance to regulate health insurers. This bill would require, beginning July 1, 2023, a health care service plan or health insurer offering qualified health plans, as defined, to annually report the total amount of funds in the segregated account maintained pursuant to PPACA. The bill would require the annual report to include the ending balance of the account and the total dollar amount of claims paid during a reporting year. By expanding the scope of a crime, this bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors

Wendy Carrillo

Title

CalWORKs and CalFresh: work requirements.

Description

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

Primary Sponsors

Ash Kalra

Organizational Notes

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

Title

Children's psychiatric residential treatment facilities.

Description

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

Primary Sponsors

James Ramos

Title

Reproductive health care pilot program.

Description

AB 2320, as amended, Cristina Garcia. Reproductive health care pilot program. Existing law establishes the Department of Health Care Access and Information, and requires the department to administer various health professions development programs. This bill, until January 1, 2028, would require the department to establish and administer a pilot program to direct funds to primary care clinics that provide reproductive health care services in 5 counties. The bill would require a participating primary care clinic to implement at least one of a number of specified activities to improve health care delivery for marginalized patients, and to annually report to the department over 2 years regarding its efforts and progress with those activities. The bill would require the department to report to the Legislature on the program on or before June 1, 2026.

Primary Sponsors

Cristina Garcia

Title

Lead poisoning prevention: laboratory reporting.

Description

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

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

Primary Sponsors

Eloise Reyes

Organizational Notes

Last edited by Joanne Campbell at Apr 14, 2022, 3:50 PM

Support: Western Center on Law and Poverty

Bill Number
AB 2352

Status
In Assembly

Position
Monitor

Title

Prescription drug coverage.

Description

AB 2352, as amended, Nazarian. Prescription drug coverage. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or health insurance policy that provides coverage for outpatient prescription drugs to cover medically necessary prescription drugs and subjects those policies to certain limitations on cost sharing and the placement of drugs on formularies. Existing law limits the maximum amount an enrollee or insured may be required to pay at the point of sale for a covered prescription drug to the lesser of the applicable cost-sharing amount or the retail price, and requires that payment to apply to the applicable deductible. This bill would require a health care service plan or health insurer that provides prescription drug benefits and maintains one or more drug formularies to furnish specified information about a prescription drug upon request by an enrollee or insured, or their prescribing provider. The bill would require the plan or insurer to respond in real time to that request and ensure the information is current no later than one business day after a change is made. The bill would prohibit a health care service plan or health insurer from, among other things, restricting a prescribing provider from sharing the information furnished about the prescription drug or penalizing a provider for prescribing a lower cost drug. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors

Adrin Nazarian

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:16 PM
Oppose Unless Amended: CA. Assoc. of Health Plans

Bill Number
AB 2402

Status
In Assembly

Position
Support

Title

Medi-Cal: continuous eligibility.

Description

AB 2402, as amended, Blanca Rubio. Medi-Cal: continuous eligibility. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and

under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires the department, to the extent federal financial participation is available, to exercise a federal option to extend continuous eligibility to children 19 years of age and younger until the earlier of either the end of a 12-month period following the eligibility determination or the date the child exceeds 19 years of age. Under this bill, a child under 5 years of age would be continuously eligible for Medi-Cal, including without regard to income, until the child reaches 5 years of age. The bill would prohibit the redetermination of Medi-Cal eligibility before the child reaches 5 years of age, unless the department or county possesses facts indicating that the family has requested the child's voluntary disenrollment, the child is deceased, the child is no longer a state resident, or the child's original enrollment was based on a state or county error or on fraud, abuse, or perjury, as specified. The bill would condition implementation of these provisions on receipt of any necessary federal approvals and, except as specified, on the availability of federal financial participation. Existing law establishes the Medi-Cal Access Program, which provides health care services to a woman who is pregnant or in her postpartum period and whose household income is above 208% but does not exceed 317% of the federal poverty level, and to a child under 2 years of age who is delivered by a mother enrolled in the program, as specified. Existing law requires a subscriber to provide income information at the end of 12 months of coverage, and requires that the infant be disenrolled from the program if the annual household income exceeds 317% of the federal poverty level or if the infant is eligible for full-scope Medi-Cal with no share of cost. This bill would remove the requirement for providing income information at the end of the 12 months, and would instead require that the infant remain continuously eligible for the Medi-Cal program until they are 5 years of age, as specified, to the extent that any necessary federal approvals are obtained and federal financial participation is available. Existing law establishes the County Health Initiative Matching Fund, administered by the department, through which an applicant county, county agency, a local initiative, or a county organized health system that provides an intergovernmental transfer, as specified, is authorized to subm... (click bill link to see more).

Primary Sponsors

Blanca Rubio

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:17 PM

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

Title

Martin Luther King, Jr. Community Hospital.

Description

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

Primary Sponsors

Mike Gipson

Organizational Notes

Last edited by Joanne Campbell at Apr 14, 2022, 10:52 PM

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

Title

Open meetings: local agencies: teleconferences.

Description

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

Primary Sponsors

Blanca Rubio

Title

California Children's Services: reimbursement rates.

Description

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

Primary Sponsors

Akilah Weber

Title

Health care coverage: human papillomavirus.

Description

AB 2516, as amended, Aguiar-Curry. Health care coverage: human papillomavirus. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2002, to provide coverage for an annual cervical cancer screening test, including a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA). Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services and under which health care services are provided to low-income individuals pursuant to a schedule of benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law also establishes the Family Planning, Access, Care, and Treatment (Family PACT) Program, administered by the Office of Family Planning within the department, under which comprehensive clinical family planning services are provided to a person who has a family income at or below 200% of the federal poverty level, and who is eligible to receive these services. This bill would expand the coverage requirement for an annual cervical cancer screening test to disability insurance policies that provide coverage for hospital, medical, or surgical benefits and would require a health care service plan contract or disability insurance policy that provides coverage for hospital, medical, or surgical benefits issued, amended, or renewed on or after January 1, 2023, to provide coverage without cost sharing for the HPV vaccine for persons for whom the vaccine is FDA approved. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program. The bill would also expand comprehensive clinical family planning services under the Family PACT Program to include the HPV vaccine for persons for whom it is FDA approved. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors

Cecilia Aguiar-Curry

Organizational Notes

Last edited by Joanne Campbell at Apr 22, 2022, 2:29 PM

Oppose: California Association of Health Plans

Title

California Health Benefit Exchange: financial assistance.

Description

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

Primary Sponsors

Jim Wood

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:18 PM

Oppose Unless Amended: CA. Assoc. of Health Plans Support: CA Labor Fed. LA County Labor Fed. UNITE HERE Teamsters UFCW SEIU California Conference Board of the Amalgamated Transit Union California Conference of Machinists The Utility Workers Union of America The Engineers and Scientists of California

Title

Individual Shared Responsibility Penalty: waiver: health care service plans.

Description

AB 2564, as introduced, Bigelow. Individual Shared Responsibility Penalty: waiver: health care service plans. Existing law establishes the Minimum Essential Coverage Individual Mandate to require an individual who is a California resident to ensure that the individual, and any spouse or dependent of the individual, is enrolled in and maintains minimum essential medical coverage for each month, except as specified. Existing law imposes the Individual Shared Responsibility Penalty for the failure to maintain minimum essential coverage, as determined and collected by the Franchise Tax Board, in collaboration with the California Health Benefit Exchange, as specified. This bill would require the Franchise Tax Board to waive the Individual Shared Responsibility Penalty for an individual who either was enrolled in minimum essential coverage for at least 6 consecutive months during the taxable year, or had at least one verified meeting with a specified employee to discuss the individual's health care insurance purchasing options. The bill would require verification of a meeting with a specified employee under penalty of perjury, and would thereby impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors

Frank Bigelow

Title

Health care service plans: mental health and substance use disorders: provider credentials.

Description

AB 2581, as amended, Salas. Health care service plans: mental health and substance use disorders: provider credentials. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law requires a health care service plan contract issued, amended, or renewed on or after January 1, 2021, that provides hospital, medical, or surgical coverage to provide coverage for medically necessary treatment of mental health and substance use disorders, under the same terms and conditions applied to other medical conditions, as specified. For provider contracts issued, amended, or renewed on and after January 1, 2023, this bill would require a health care service plan that provides coverage for mental health and substance use disorders and credentials health care providers of those services for the health care service plan's networks, to assess and verify the qualifications of a health care provider within 60 days after receiving a completed provider credentialing application. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors

Rudy Salas

Title

Health care coverage: nonpharmacological pain management treatment.

Description

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

Primary Sponsors

Kevin McCarty

Title

Air ambulance services.

Description

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

Primary Sponsors

Tim Grayson

Title

Medi-Cal managed care: midwifery services.

Description

AB 2659, as amended, Patterson. Medi-Cal managed care: midwifery services. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services through various delivery systems, including managed care. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes certain time and distance and appointment time standards for specified Medi-Cal managed care covered services, including obstetrics and gynecology primary care, consistent with federal regulations relating to network adequacy standards, to ensure that those services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner, as specified. Existing law sets forth other network adequacy requirements for a Medi-Cal managed care plan with respect to its service area. Existing law authorizes the holder of a midwifery license or nurse-midwifery certificate to provide prenatal, intrapartum, and postpartum care, as specified. Under existing law, midwifery services and nurse-midwifery services are covered under the Medi-Cal program, subject to utilization controls and other conditions. This bill would require a Medi-Cal managed care plan to have within its provider network at least one licensed midwife (LM) and one certified-nurse midwife (CNM) within each county where the Medi-Cal managed care plan provides services to Medi-Cal beneficiaries. The bill would exempt a Medi-Cal managed care plan from that requirement for purposes of a given county if no LM or CNM is available in that county or if no LM or CNM in that county accepts Medi-Cal payments. If a Medi-Cal managed care plan is exempt from that requirement, the bill would require the Medi-Cal managed care plan to reevaluate its network adequacy for midwifery care in the county on an annual basis and to make a good faith effort to work with the appropriate professional midwifery organizations for LMs and CNMs, and their respective licensing and regulatory agencies, to assist in determining the availability of midwives in the county who accept Medi-Cal payments. The bill would also require a Medi-Cal managed care plan to have within its provider network at least one licensed alternative birth center speciality clinic within each county where the Medi-Cal managed care plan provides services to Medi-Cal beneficiaries provided that at least one qualified licensed alternative birth center speciality clinic is available in that county and is willing to contract with the Medi-Cal managed care plan. The bill would condition implementation of these provisions on receipt of any necessary federal approvals and ... (click bill link to see more).

Primary Sponsors

Jim Patterson

Title

Medi-Cal: Community Health Navigator Program.

Description

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

Primary Sponsors

Joaquin Arambula

Title

Medi-Cal: community health workers and promotores.

Description

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

Primary Sponsors

Cecilia Aguiar-Curry

Organizational Notes

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

Title

Medi-Cal: alternate health care service plan.

Description

AB 2724, as amended, Arambula. Medi-Cal: alternate health care service plan. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services through various delivery systems, including managed care pursuant to Medi-Cal managed care plan contracts. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. This bill would authorize the department to enter into one or more comprehensive risk contracts with an alternate health care service plan (AHCSP), as defined, to serve as a primary Medi-Cal managed care plan for specified eligible beneficiaries in geographic regions designated by the department. The bill would prohibit the AHCSP from denying enrollment to any of those eligible beneficiaries, unless the department or the Department of Managed Health Care has ordered the AHCSP to cease enrollment in a service area. The bill would require the contract with the AHCSP to include the same standards and requirements, except with respect to enrollment, as for other Medi-Cal managed care plans, as specified. The bill would require the Health Care Options Program, which is an entity overseen by the department for Medi-Cal managed care education and enrollment, to disenroll any member of an AHCSP if the member meets any one of the reasons for disenrollment enumerated in specified regulations. Under the bill, except when an AHCSP is already contracted with the department as a Medi-Cal managed care plan as of January 1, 2022, contracts entered into pursuant to these provisions would be effective no sooner than January 1, 2024, as specified. The bill would authorize the department to implement these provisions through plan letters or other similar instructions. The bill would condition implementation of these provisions on receipt of any necessary federal approvals and the availability of federal financial participation.

Primary Sponsors

Joaquin Arambula

Organizational Notes

Last edited by Cherie Compartore at Apr 13, 2022, 11:17 PM

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

Title

Medi-Cal: eligibility.

Description

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

Primary Sponsors

Jim Wood

Organizational Notes

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

Title

Mental health and substance use disorders: database of facilities.

Description

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

Primary Sponsors

Marie Waldron

Title

Long-Term Services and Supports Benefit Program.

Description

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

Primary Sponsors

Miguel Santiago

Title

COVID-19 testing capacity.

Description

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

Primary Sponsors

Jacqui Irwin

Title

Taxes to fund health care coverage and cost control.

Description

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

Primary Sponsors

Ash Kalra, Alex Lee

Title

Office of Racial Equity.

Description

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

Primary Sponsors

Richard Pan, Joaquin Arambula, David Chiu

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:21 PM

Support - L.A. Care, L.A. Board of Supervisors, Community Clinic Association of Las Angeles County, California Assoc. of Public Hospitals, County Welfare Directors Association

Title

Health care workforce development: California Medicine Scholars Program.

Description

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

Primary Sponsors

Melissa Hurtado

Title

Medi-Cal: eligibility.

Description

SB 56, as amended, Durazo. Medi-Cal: eligibility. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services (department), under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. The federal Medicaid program provisions prohibit payment to a state for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Existing law requires individuals under 19 years of age enrolled in restricted-scope Medi-Cal at the time the Director of Health Care Services makes a determination that systems have been programmed for implementation of these provisions to be enrolled in the full scope of Medi-Cal benefits, if otherwise eligible, and extends eligibility for full-scope Medi-Cal benefits to individuals under 25 years of age, and who are otherwise eligible for those benefits but for their immigration status. Existing law makes the effective date of enrollment for those individuals the same day that systems are operational to begin processing new applications pursuant to the director's determination, and requires the department to maximize federal financial participation for purposes of implementing the requirements. To the extent that federal financial participation is unavailable, existing law requires the department to implement those provisions using state funds appropriated for that purpose. Existing law provides that Medi-Cal benefits for individuals who are 65 years of age or older, and who do not have satisfactory immigration statuses or are unable to establish satisfactory immigration statuses, will be prioritized in the Budget Act for the upcoming fiscal year if the Department of Finance projects a positive ending balance in the Special Fund for Economic Uncertainties for the upcoming fiscal year and each of the ensuing 3 fiscal years that exceeds the cost of providing those individuals with full-scope Medi-Cal benefits. This bill would, subject to an appropriation by the Legislature, and effective July 1, 2022, extend eligibility for full-scope Medi-Cal benefits to individuals who are 60 years of age or older, and who are otherwise eligible for those benefits but for their immigration status. The bill would delete provisions delaying implementation until the director makes the determination described above. The bill would require the department to seek federal approvals to obtain federal financial participation to implement these requirements, and would require that state-only funds be used for those benefits if federal financial participation is una... (click bill link to see more).

Primary Sponsors

Maria Durazo, Joaquin Arambula

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:23 PM

Support: L.A. Care, Local Health Plans of California, CA. Assoc. of Health Plans, Community Clinic Association of Los Angeles County, County Welfare Directors Assoc, California Hospital Assoc.

Title

Health care coverage: abortion services: cost sharing.

Description

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

Primary Sponsors

Lena Gonzalez, Sydney Kamlager, Connie Leyva

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:25 PM

Oppose: CA. Assoc. of Health Plans

Title

Health care coverage.

Description

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

Primary Sponsors

Richard Pan

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:25 PM

Oppose: CA. Assoc. of Health Plans

Title

California Advancing and Innovating Medi-Cal.

Description

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

Primary Sponsors

Richard Pan

Title

Medi-Cal: California Community Transitions program.

Description

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

Primary Sponsors

Bill Dodd

Title

Medi-Cal specialty mental health services.

Description

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

Primary Sponsors

Monique Limon, Adam Gray, Anthony Portantino

Title

California Health Benefit Exchange.

Description

SB 455, as amended, Leyva. California Health Benefit Exchange. Existing federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. Existing state law creates the California Health Benefit Exchange, also known as Covered California, governed by an executive board, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Existing law specifies the powers of the board. Existing law authorizes the board to adopt necessary rules and regulations by emergency regulations until January 1, 2022, with the exception of regulations implementing prescribed provisions relating to criminal background history checks for persons with access to confidential, personal, or financial information. Existing law authorizes the Office of Administrative Law to approve more than 2 readoptions of emergency regulations until January 1, 2027. Existing law provides that these extensions apply to any regulation adopted before January 1, 2019. This bill would instead extend the authority of the board to adopt those necessary rules and regulations by emergency regulations to January 1, 2027, and would extend the authority of the Office of Administrative Law to approve more than 2 readoptions of emergency regulations until January 1, 2032. The bill would provide that these prescribed time extensions apply to any regulation adopted before January 1, 2022, as specified.

Primary Sponsors

Connie Leyva

Title

Health care coverage: insulin cost sharing.

Description

SB 473, as amended, Bates. Health care coverage: insulin cost sharing. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or health insurance policy issued, amended, delivered, or renewed on or after January 1, 2000, to include coverage for equipment, supplies, and, if the contract or policy covers prescription benefits, prescriptive medications for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes, as medically necessary. This bill would prohibit a health care service plan contract or a health insurance policy that is issued, amended, delivered, or renewed on or after January 1, 2023, from imposing cost sharing on a covered insulin prescription, except for a copayment not to exceed \$35 per month per each dosage form of insulin products. The bill would also prohibit a health care service plan contract that is issued, amended, delivered, or renewed on or after January 1, 2023, from imposing a deductible requirement on benefits related to managing and treating diabetes, as specified. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors

Pat Bates

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:28 PM

Oppose: CA. Assoc. of Health Plans

Title

Drug manufacturers: value-based arrangement.

Description

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

Primary Sponsors

Steve Bradford

Title

Health care coverage: contraceptives.

Description

SB 523, as amended, Leyva. Health care coverage: contraceptives.

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

Primary Sponsors

Connie Leyva

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:31 PM

Oppose: CA. Assoc. of Health Plans

Title

Deductibles: chronic disease management.

Description

SB 568, as amended, Pan. Deductibles: chronic disease management. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law, in accordance with the federal Patient Protection and Affordable Care Act, requires a health care service plan or health insurance issuer offering coverage in the individual or small group market to ensure that the coverage includes the essential health benefits package and defines this package to mean coverage that, among other requirements, includes preventive and wellness services and chronic disease management. Existing law, with respect to those individual or group health care service plan contracts and health insurance policies, prohibits the copayment, coinsurance, or any other form of cost sharing for a covered outpatient prescription drug for an individual prescription from exceeding \$250, as specified. Existing law requires a health care service plan contract that covers hospital, medical, or surgical expenses to include coverage for certain equipment and supplies for the management and treatment of various types of diabetes as medically necessary, even if those items are available without a prescription. This bill would prohibit a health care service plan contract or health insurance policy that is issued, amended, or renewed on or after January 1, 2023, from imposing a deductible requirement for a covered prescription drug or the above equipment and supplies used to treat a chronic disease, as defined. The bill would limit the amount paid for the benefit by an enrollee, subscriber, policyholder, or insured to no more than the amount of copayment or coinsurance specified in the health care service plan contract or disability insurance policy for a covered prescription drug or similar benefit that is not used to treat a chronic disease, as specified. This bill would prohibit a health care service plan contract or disability insurance policy that meets the definition of a "high deductible health plan" under specified federal law from imposing a deductible requirement with respect to any covered benefit for preventive care, in accordance with that law, and is not subject to the other deductible restrictions imposed by the bill. The bill would authorize the Insurance Commissioner to implement, interpret, or make specific its provisions by issuing guidance, without taking regulatory action, until regulations are adopted. Because a violation of the requirements of the bill by a health care service plan would be... (click bill link to see more).

Primary Sponsors

Richard Pan

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:33 PM

Oppose: CA. Assoc. of Health Plans

Title

Medi-Cal managed care: behavioral health services.

Description

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

Primary Sponsors

Richard Roth

Title

Health care: prescription drugs.

Description

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

Primary Sponsors

Richard Pan

Title

Prescription drug coverage.

Description

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

Primary Sponsors

Scott Wiener

Organizational Notes

Last edited by Cherie Compartore at Apr 11, 2022, 6:20 PM

Oppose: CA. Assoc. of Health Plans

Last edited by Joanne Campbell at Jan 20, 2022, 3:03 PM

Sponsored by Crohn's & Colitis Foundation

Title

Health care service plans: discipline: civil penalties.

Description

SB 858, as amended, Wiener. Health care service plans: discipline: civil penalties. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law authorizes the Director of the Department of Managed Health Care to take disciplinary measures, including the imposition of civil penalties, against a licensee when the director determines that the licensee has committed an act or omission constituting grounds for disciplinary action, as specified. Under existing law, a person who violates the act, or a rule or order adopted or issued under the act, is generally liable for a civil penalty not to exceed \$2,500 per violation. Existing law also includes various provisions that assess specific civil and administrative penalties for certain violations. Fines and penalties under the act are deposited into the Managed Care Administrative Fines and Penalties Fund, and used, upon appropriation by the Legislature, for designated purposes. This bill would increase the base amount of the civil penalty from \$2,500 per violation to not less than \$25,000 per violation, which would be adjusted annually commencing January 1, 2024, as specified. The bill would multiply the amounts of other specified civil and administrative penalties by 4, commencing January 1, 2023, and would also annually adjust those penalties, commencing January 1, 2024. The bill would authorize the director to impose a corrective action plan to require future compliance with the act, under certain circumstances. If a health care service plan fails to comply with the corrective action plan in a timely manner, the bill would require the department to monitor the health care service plan through medical surveys, financial examinations, or other means necessary to ensure timely compliance. The bill would require the director, when assessing administrative penalties against a health care service plan, to determine the appropriate amount of the penalty for each violation, based upon consideration of specified factors, such as the nature, scope, and gravity of the violation, whether the violation is an isolated incident, and the amount of the penalty necessary to deter similar violations in the future. The bill would require the director to provide a written explanation of the amount of the penalty, including the factors the director relied upon in assessing that amount.

Primary Sponsors

Scott Wiener

Organizational Notes

Last edited by Joanne Campbell at Apr 14, 2022, 3:53 PM

Oppose: CA. Assoc. of Health Plans Support: Western Center on Law and Poverty

Title

Minors: vaccine consent.

Description

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

Primary Sponsors

Scott Wiener, Richard Pan, Buffy Wicks

Title

Public health: immunizations.

Description

SB 871, as introduced, Pan. Public health: immunizations. Existing law prohibits the governing authority of a school or other institution from unconditionally admitting any person as a pupil of any public or private elementary or secondary school, childcare center, day nursery, nursery school, family day care home, or development center, unless prior to their admission to that institution they have been fully immunized against various diseases, including measles, mumps, pertussis, hepatitis B, and any other disease deemed appropriate by the State Department of Public Health, as specified. Existing law authorizes an exemption from those provisions for medical reasons. Under existing law, notwithstanding the above-described prohibition, full immunization against hepatitis B is not a condition by which the governing authority admits or advances a pupil to the 7th grade level of a public or private elementary or secondary school. This bill would remove the above-described exception relating to hepatitis B. The bill would additionally prohibit the governing authority of a school or other institution from unconditionally admitting any person as a pupil of any public or private elementary or secondary school, childcare center, day nursery, nursery school, family day care home, or development center, unless prior to their admission to that institution they have been fully immunized against COVID-19. To the extent that the bill would create new duties for school districts, the bill would impose a state-mandated local program. For purposes of the additional immunizations deemed appropriate by the department, and that would be mandated before a pupil's first admission to the institution, existing law requires that exemptions be allowed for both medical reasons and personal beliefs. This bill would repeal that provision, thereby removing the personal belief exemption from any additional immunization requirements deemed appropriate by the department. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Primary Sponsors

Richard Pan, Cecilia Aguiar-Curry, Josh Newman, Akilah Weber, Buffy Wicks, Scott Wiener

Title

Biomarker testing.

Description

SB 912, as amended, Limón. Biomarker testing. (1) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plan contract or health insurance policy issued, amended, delivered, or renewed on or after July 1, 2000, to provide coverage for all generally medically accepted cancer screening tests, and prohibits that contract or policy issued, amended, delivered, or renewed on or after July 1, 2022, from requiring prior authorization for biomarker testing for certain enrollees or insureds. Existing law applies the provisions relating to biomarker testing to Medi-Cal managed care plans, as prescribed. This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after July 1, 2023, to provide coverage for biomarker testing, including whole genome sequencing, for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's or insured's disease or condition if the test is supported by medical and scientific evidence, as prescribed. 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 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. This bill would apply these provisions relating to biomarker testing to the Medi-Cal program, including Medi-Cal managed care plans, as specified. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. (2) Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services pursuant to a schedule of benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law includes Rapid Whole Genome Sequencing as a covered benefit for any Medi-Cal beneficiary who is one year of age or younger and is receiving inpatient hospital services in an intensive care unit. Subject to the extent that federal financial participation is available and not otherwise jeopardized, and any necessary federal approvals have been obtained, this bill would expand the Medi-Cal schedule of benefits to includ... (click bill link to see more).

Primary Sponsors

Monique Limon

Organizational Notes

Last edited by Cherie Compartore at Apr 11, 2022, 6:21 PM

Oppose: CA. Assoc. of Health Plans

Title

Gender-affirming care.

Description

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

Primary Sponsors

Scott Wiener, Cristina Garcia

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:34 PM

Sponsor: California LGBTQ Health and Human Services Network, Equality California, National Health Law Program, and Western Center on Law & Poverty Oppose Unless Amended: CA. Assoc. of Health Plans

Title

Prescription drug pricing.

Description

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

Primary Sponsors

Richard Pan

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:35 PM

Sponsor: APLA Health, CA Health+ Advocates Oppose Unless Amended: CA. Assoc. of Health Plans, Association of Health Insurance Plans

Title

California Health Benefit Exchange: affordability assistance.

Description

SB 944, as introduced, Pan. California Health Benefit Exchange: affordability assistance. Existing federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. Existing state law creates the California Health Benefit Exchange (Exchange), also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Existing law requires the Exchange, in consultation with stakeholders and the Legislature, to develop options for providing cost-sharing reduction subsidies to reduce cost sharing for low- and middle-income Californians, and requires the Exchange to report the developed options on or before January 1, 2022. Existing law requires the options to include, among other things, options for all Covered California enrollees with income up to 400 percent of the federal poverty level to reduce cost sharing, including copays, deductibles, coinsurance, and maximum out-of-pocket costs. This bill would require the Exchange to implement those options for providing health care affordability assistance. The bill would require the affordability assistance to reduce cost-sharing, including copays, coinsurance, and maximum out-of-pocket costs, and to eliminate deductibles for all benefits. The bill would specify the actuarial value of cost sharing assistance based on the income level of an enrollee, and would require the Exchange to adopt standard benefit designs consistent with these specifications.

Primary Sponsors

Richard Pan

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:35 PM

Support if Amended: CA. Assoc. of Health Plans Support: Western Center on Law and Poverty

Title

Medication and Patient Safety Act of 2022.

Description

SB 958, as amended, Limón. Medication and Patient Safety Act of 2022. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or health insurance policy that provides coverage for outpatient prescription drugs to cover medically necessary prescription drugs. This bill would prohibit a health care service plan or health insurer, or its designee, from requiring a vendor to dispense an infused or injected medication directly to a patient with the intent that the patient will transport the medication to a health care provider for administration. The bill would authorize a plan or insurer, or its designee, to arrange for an infused or injected medication to be administered in an enrollee's or insured's home when the treating health care provider and patient determine home administration is in the best interest of the patient. The bill would prohibit a plan or insurer, or its designee, from requiring an infused or injected medication to be supplied by a vendor specified by the plan or insurer, or its designee, as a condition of coverage, unless specified criteria are met. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors

Monique Limon, Anthony Portantino

Organizational Notes

Last edited by Joanne Campbell at May 11, 2022, 8:03 PM

Oppose: CA. Assoc. of Health Plans, Local Health Plans of California (Unless Amended)

Title

Behavioral health.

Description

SB 964, as amended, Wiener. Behavioral health. (1) Existing law, the Donahoe Higher Education Act, sets forth the missions and functions of the 3 segments comprising the state's public postsecondary education system. These segments are the University of California, administered by the Regents of the University of California, the California State University, administered by the Trustees of the California State University, and the California Community Colleges, administered by the Board of Governors of the California Community Colleges. Provisions of the act apply to the University of California only to the extent that the regents act, by resolution, to make the provisions applicable. This bill would amend the act to require the California Community Colleges and the California State University, and to request the University of California, to develop 2 accelerated programs of study related to degrees in social work. The bill would require one program to offer a concurrent bachelor's and master's of social work program that would allow students to combine their last one or 2 years of undergraduate study in social work with their graduate study in social work in order to complete both programs at an accelerated rate. The bill would require the 2nd program to offer an accelerated academic program in which students with experience as peer support specialists, registered or certified alcohol or other drug counselors, community health workers, or psychiatric technicians could receive their associate's degree, as well as a bachelor's and master's degree in social work. The bill would require both programs to require a student to take a course on working with the severely mentally ill, with a focus on working in the public behavioral health system. (2) Existing law establishes the Department of Health Care Access and Information and authorizes the department, among other things, to award competitive grants to entities and individuals it deems qualified to expand the supply of behavioral health counselors, coaches, peer supports, and other allied health care providers serving children and youth. This bill would establish the Behavioral Health Workforce Preservation and Restoration Fund as a fund in the state treasury, to be administered by the department, for the purpose of stabilizing the current licensed, certified, or registered clinical behavioral health workforce. The bill would authorize moneys from the fund to be used, upon appropriation by the Legislature, to provide hiring or performance-based bonuses, salary augmentation, overtime pay, or hazard pay to licensed, certified, or registered professionals working in the behavioral health sector. The bill would also require the department to establish a stipend program, in ... (click bill link to see more).

Primary Sponsors

Scott Wiener, Anna Caballero, Henry Stern

Title

Federally qualified health centers and rural health clinics: visits.

Description

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

Primary Sponsors

Monique Limon, Rudy Salas

Organizational Notes

Last edited by Joanne Campbell at Apr 22, 2022, 5:47 PM

Support: Local Health Plans of California, California Health+ Advocates (co-sponsored), California Association of Marriage and Family Therapists (co-sponsored)

Title

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

Description

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

Primary Sponsors

Bob Hertzberg, Joaquin Arambula

Title

Health care coverage: diagnostic imaging.

Description

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

Primary Sponsors

Anthony Portantino, Cristina Garcia

Organizational Notes

Last edited by Cherie Compartore at Apr 11, 2022, 6:22 PM

Oppose: CA. Assoc. of Health Plans

Title

California Cancer Care Equity Act.

Description

SB 987, as amended, Portantino. California Cancer Care Equity Act. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services through various health care delivery systems, including managed care pursuant to Medi-Cal managed care plan contracts. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. This bill would require a Medi-Cal managed care plan to include in its contracted provider network at least one National Cancer Institute (NCI)-Designated Cancer Center, as specified, and ensure that any beneficiary diagnosed with a complex cancer diagnosis, as defined, is referred to an NCI-Designated Cancer Center within 15 business days of the diagnosis, unless the beneficiary selects a different cancer treatment provider. Existing law also requires a Medi-Cal managed care plan to give a beneficiary timely and adequate notice of an adverse benefit determination, as defined, in writing consistent with specified federal regulations that set forth, among other things, rules for standard and expedited decisions regarding authorization of services. This bill would require a Medi-Cal managed care plan to give a request for, or related to, treatment pursuant to a complex cancer diagnosis to receive an expedited authorization decision, as specified. This bill, to the extent necessary federal approvals are obtained and federal financial participation is available, would, among other things, also require Medi-Cal managed care plans to comply with additional requirements relating to contracting and eligible enrollees' access to services. The bill would require contracts between Medi-Cal managed care plans and primary care providers to require the diagnosing or treating provider who determines cancer stage or response to treatment to inform enrollees who receive a complex cancer diagnosis of the right to receive care through an NCI-Designated Cancer Center. The bill would require a Medi-Cal managed care plan to provide written and verbal notice to an enrollee of their right to access care through an NCI-Designated Cancer Center, as specified, and would require the department, in consultation with others, to develop a standard written notice and a process for verbally notifying enrollees of their right to access cancer treatment care through an NCI-Designated Cancer Center. The bill would, beginning January 1, 2023, require each applicable Medi-Cal managed care plan to reimburse an NCI-Designated Cancer Center provider furnishing services to a Medi-Cal beneficiary with a complex cancer diagnosis enrolled in that plan, and require each NCI-Designated Cancer Center... (click bill link to see more).

Primary Sponsors

Anthony Portantino

Organizational Notes

Last edited by Joanne Campbell at May 11, 2022, 8:04 PM

Oppose: CA. Assoc. of Health Plans, Local Health Plans of California Support: Western Center on Law and Poverty

Title

Health coverage: mental health and substance use disorders.

Description

SB 999, as amended, Cortese. Health coverage: mental health and substance use disorders. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service plans and makes a willful violation of the act a crime. Existing law also requires the Department of Insurance to regulate health insurers. Existing law requires a health care service plan or disability insurer, as specified, to base medical necessity determinations and the utilization review criteria the plan or insurer, and any entity acting on the plan's or insurer's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders, on current generally accepted standards of mental health and substance use disorder care. This bill would require a health care service plan and a disability insurer, and an entity acting on a plan's or insurer's behalf, to ensure compliance with specific requirements for utilization review, including that a health care service plan and a disability insurer, or an entity acting on the plan's or insurer's behalf, maintain telephone access during California business hours for a health care provider to request authorization for mental health and substance use disorder care and conduct peer-to-peer discussions regarding specific issues related to treatment. Because a willful violation of the requirements governing 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

Dave Cortese

Organizational Notes

Last edited by Cherie Compartore at Apr 11, 2022, 6:23 PM

Oppose: CA. Assoc. of Health Plans

Title

Enhanced Clinically Integrated Program for Federally Qualified Health Centers.

Description

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

Primary Sponsors

Bob Hertzberg, Wendy Carrillo, Ash Kalra

Title

Medi-Cal managed care plans: mental health benefits.

Description

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

Primary Sponsors

Lena Gonzalez

Organizational Notes

Last edited by Joanne Campbell at Apr 14, 2022, 3:55 PM

Support: CPEHN (Sponsor), API Equality-LA Bakersfield American Indian Health Project California Alliance of Child and Family Services Central Valley Immigrant Integration Collaborative Children Now Maternal and Child Health Access National Association of Social Workers, California Chapter Racial and Ethnic Mental Health Disparities Coalition, Western Center on Law and Poverty

Title

Health care coverage.

Description

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

Primary Sponsors

Richard Pan

Organizational Notes

Last edited by Joanne Campbell at Apr 14, 2022, 3:54 PM

Support: CPEN (Sponsor), Western Center on Law and Poverty

Title

CalWORKs: pregnancy and homeless assistance.

Description

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

Primary Sponsors

Nancy Skinner

Organizational Notes

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

Title

Medi-Cal: eyeglasses: Prison Industry Authority.

Description

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

Primary Sponsors

Scott Wilk

Title

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

Description

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

Primary Sponsors

Richard Pan

Title

Confidentiality of Medical Information Act: school-linked services coordinators.

Description

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

Primary Sponsors

Dave Cortese

Title

Medi-Cal: pharmacogenomic testing.

Description

SB 1191, as amended, Bates. Medi-Cal: pharmacogenomic testing. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law sets forth a schedule of covered benefits under the Medi-Cal program. This bill, to be known as the Utilizing Pharmacogenomics to Greatly Reduce Adverse Drug Events (UPGRADE) Act, would add pharmacogenomic testing as a covered benefit under Medi-Cal. The bill would define pharmacogenomic testing as laboratory genetic testing, by a laboratory with specified licensing, accreditation, and certification, to identify how a person's genetics may impact the efficacy, toxicity, and safety of medications. The bill would cover the benefit under Medi-Cal if a medication is being considered for use, or is already being administered, and is approved for use, in treating a Medi-Cal beneficiary's condition and is known to have a gene-drug or drug-drug-gene interaction that has been demonstrated to be clinically actionable, as specified, if the medication is ordered by an enrolled Medi-Cal clinician or pharmacist. The bill would authorize the department to implement the above-described provisions through all-county or plan letters, or similar instructions, until the department promulgates regulations.

Primary Sponsors

Pat Bates

Title

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

Description

SB 1207, as amended, Portantino. Health care coverage: maternal and pandemic-related mental health conditions. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of that act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plans and health insurers to provide specified mental health and substance use disorder coverage, and requires a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2021, that provides hospital, medical, or surgical coverage to provide coverage for medically necessary treatment of mental health and substance use disorders, under the same terms and conditions applied to other medical conditions, as specified. Existing law requires health care service plans and health insurers, by July 1, 2019, to develop, consistent with sound clinical principles and processes, a maternal mental health program designed to promote quality and cost-effective outcomes, as specified. This bill would make findings and declarations relating to the effect of the COVID-19 pandemic on mental health in California and the importance of outreach, education, and access to quality mental health treatment. The bill would extend the deadline for establishment of the maternal mental health program to July 1, 2023. The bill would revise the requirements of the program to include quality measures to encourage screening, diagnosis, treatment, and referral. The bill also would encourage health care service plans and health insurers to include coverage for doulas, incentivize training opportunities for contracting obstetric providers, and educate enrollees and insureds about the program. Because a violation of the bill by a health care service plan would be a crime, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors

Anthony Portantino

Organizational Notes

Last edited by Cherie Compartore at Apr 15, 2022, 5:38 PM

Oppose: CA. Assoc. of Health Plans

Title

Los Angeles County Abortion Access Safe Haven Pilot Program.

Description

SB 1245, as amended, Kamlager. Los Angeles County Abortion Access Safe Haven Pilot Program. Existing law, the Reproductive Privacy Act, provides that every individual possesses a fundamental right of privacy with respect to their personal reproductive decisions, including the fundamental right to choose to bear a child or to choose and to obtain an abortion. This bill would establish, subject to appropriation by the Legislature, the Los Angeles County Abortion Access Safe Haven Pilot Program for the purpose of expanding and improving access to reproductive and sexual health care, including abortion, in the County of Los Angeles. The bill would require any funds allocated for the Los Angeles County Abortion Access Safe Haven Pilot Program to be used by the County of Los Angeles to administer a pilot project to support innovative approaches and patient-centered collaborations to safeguard patient access to abortions, regardless of residency. The bill would authorize the funds to be used for implementing recommendations from the County of Los Angeles, including building secure infrastructure, among other things.

Primary Sponsors

Sydney Kamlager

Title

Behavioral Health Continuum Infrastructure Program.

Description

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

Primary Sponsors

Rosilicie Ochoa Bogh

Title

Coordinated specialty care for early psychosis: interventions and access to care.

Description

SB 1337, as amended, McGuire. Coordinated specialty care for early psychosis: interventions and access to care. Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plan contracts and health insurance policies that provide hospital, medical, or surgical coverage to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses, as defined, of a person of any age. This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on and after January 1, 2023, to provide coverage for coordinated specialty care (CSC) services for the treatment of early psychosis, composed of specified treatment modalities and affiliated activities including, but not limited to, case management, pharmacotherapy and medication management, psychotherapy, and outreach and recruitment activities. The bill would require those treatment modalities and affiliated activities to be billed and reimbursed as a bundle. The bill would require the CSC services provided to be consistent with specified provisions applicable to the treatment of mental health and substance use disorders. The bill would specify the membership of the CSC team. The bill would specify that these provisions do not apply to specified Medi-Cal managed care contracts entered into between the State Department of Health Care Services and a health care service plan for enrolled Medi-Cal beneficiaries. The bill would require the California Health and Human Services Agency, in consultation with the Mental Health Services Oversight and Accountability Commission, to commission a study to improve understanding, awareness, and accountability associated with psychosis, the duration of untreated psychosis, and its impacts. Among other components, the bill would require the study to document the annual prevalence rate for the onset of psychosis in California and the availability of coordinated specialty care services to Californians who experience a first episode of psychosis, and to recommend a state or county-based system, or both, to monitor outcomes associated with access to the most effective interventions and services in response to psychosis and those associated with the lack of access to effective interventions and services, as specified. The bill also would require the agency, in consultation with the commission, to develop and implement strategies to annually improve access to ef... (click bill link to see more).

Primary Sponsors

Mike McGuire

Organizational Notes

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

Title

Prescription drugs: cost sharing: pharmacy benefit managers.

Description

SB 1361, as amended, Kamlager. Prescription drugs: cost sharing: pharmacy benefit managers. (1) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care under authority of the Director of the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance under the authority of the Insurance Commissioner. Existing law limits the maximum amount an enrollee or insured may be required to pay at the point of sale for a covered prescription drug to the lesser of the applicable cost-sharing amount or the retail price. This bill, commencing no later than January 1, 2024, would require an enrollee's or insured's defined cost sharing for each prescription drug to be calculated at the point of sale based on a price that is reduced by an amount equal to 90% of all rebates received, or to be received, in connection with the dispensing or administration of the drug. The bill would require a health care service plan or health insurer to, among other things, pass through to each enrollee or insured at the point of sale a good faith estimate of the enrollee's or insured's decrease in cost sharing. The bill would require a health care service plan or health insurer to calculate an enrollee's or insured's defined cost sharing and provide that information to the dispensing pharmacy, as specified. The bill would require the department and the commissioner to submit an annual report on the impact of these provisions to the appropriate policy committees of the Legislature, as specified. The bill would make these provisions inoperative on January 1, 2026. (2) Existing law requires a health care service plan or health insurer that files certain rate information to report to the appropriate department specified cost information regarding covered prescription drugs, including generic drugs, brand name drugs, and specialty drugs, dispensed as provided. This bill, until January 1, 2025, would require a health care service plan or health insurer to report additional information on the above-described point of sale provision. (3) Existing law defines a "pharmacy benefit manager" as a person, business, or other entity that, pursuant to a contract with a health care service plan, either directly or indirectly provides one or more pharmacy benefit management services on behalf of the health care service plan, as specified. Existing law requires a pharmacy benefit manager under contract with a health care service plan, among other things, to register with the Department of Managed Health Care, disclose specified unifo... (click bill link to see more).

Primary Sponsors

Sydney Kamlager

Organizational Notes

Last edited by Joanne Campbell at Apr 22, 2022, 2:32 PM

Oppose: California Association of Health Plans

Title

Nursing: nurse practitioners.

Description

SB 1375, as introduced, Atkins. Nursing: nurse practitioners.

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

Primary Sponsors

Toni Atkins, Jim Wood

Title

Health information.

Description

SB 1419, as amended, Becker. Health information. (1) Existing law generally requires a health care professional at whose request a test is performed to provide or arrange for the provision of the results of a clinical laboratory test to the patient who is the subject of the test if so requested by the patient, in oral or written form. Existing law requires those results to be disclosed in plain language and in oral or written form, except the results may be disclosed in electronic form if requested by the patient and if deemed most appropriate by the health care professional who requested the test. Existing law requires a patient's consent to receive their laboratory results by internet posting or other electronic means and requires those results to be disclosed to the patient in a reasonable time period, but only after the results have been reviewed by a health care professional and if access to the results is restricted by use of a secure personal identification number when the results are disclosed to the patient. This bill would define "test" for these purposes to apply to both clinical laboratory tests and imaging scans, such as x-rays, magnetic resonance imaging, ultrasound, or other similar technologies. The bill would also make conforming changes. (2) Existing law establishes procedures for providing access to health care records or summaries of those records by patients and those persons having responsibility for decisions respecting the health care of others. Under existing law, any adult patient of a health care provider, any minor patient authorized by law to consent to medical treatment, and any patient's personal representative is entitled to inspect patient records upon presenting to the health care provider a request for those records and upon payment of reasonable costs, except as specified. A patient who is a minor is entitled to inspect patient records pertaining only to health care of a type for which the minor is lawfully authorized to consent. Existing law also prohibits the representative of a minor from inspecting the minor's patient records under certain circumstances, including with respect to which the minor has a right of inspection. This bill would additionally prohibit the representative of a minor from inspecting the minor's patient records when the records relate to certain services, including medical care related to the prevention or treatment of pregnancy, as specified. (3) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insu... (click bill link to see more).

Primary Sponsors

Josh Becker

Title

Health care coverage: enrollment periods.

Description

SB 1473, as amended, Pan. Health care coverage: enrollment periods. Existing federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. Existing state law creates the California Health Benefit Exchange (Exchange), also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan or health insurer to provide a special enrollment period for individual health benefit plans offered through the Exchange from December 16 of the preceding calendar year to January 31 of the benefit year, inclusive, for policy years beginning on or after January 1, 2020. Under existing law, February 1 of the benefit year is the effective coverage date for individual health benefit plans offered outside and through the Exchange that are selected from December 16 to January 31, inclusive. This bill would eliminate the above-described special enrollment period for individual health benefit plans offered through the Exchange for policy years on or after January 1, 2023, and would instead create an annual enrollment period from November 1 of the preceding calendar year to January 31 of the benefit year, inclusive. The bill would specify that the effective date of coverage for individual health benefit plans offered outside and through the Exchange would be no later than January 1 of the benefit year for plan selection made from November 1 to December 31 of the preceding calendar year, inclusive, and would be no later than February 1 of the benefit year for plan selection made from January 1 to January 31 of the benefit year, inclusive. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors

Richard Pan

Title

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

Description

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

Primary Sponsors

Richard Pan



L.A. Care
HEALTH PLAN

Board of Governors
MOTION SUMMARY

Date: May 24, 2022

Motion No. EXE 100.0622

Committee:

Chairperson: Hector De La Torre

Issue: Approval of revision to 2022 schedule of meetings for the Board of Governors and Committees.

Background: The schedule is revised to reflect new start time off Board of Governors meetings to 1 pm.

Member Impact: Public input is welcome at all Board and Committee meetings.

Budget Impact: None.

Motion: To approve the revised 2022 Board of Governors and Committees to reflect new start time of Board of Governors meetings to 1 pm, effective June 2, 2022.

2022 Regular Board and Committee Meeting schedule

BoG: Board of Governors, meets at **1:00** for approximately 3 hours, and meets all day in September for strategic discussion

C&Q: Compliance and Quality Committee, meets at 2:00 p.m. for approximately 2 hours

Exec: Executive Committee meets at 2:00 p.m. for approximately 90 minutes

F&B: Finance & Budget Committee meets at 1:00 p.m. for approximately 60 minutes

CHCAC: Children’s Health Consultant Advisory Committee meets at 8:30 a.m. for approximately 2 hours

ECAC: Executive Community Advisory Committee meets at 10:00 a.m. for approximately 2 hours

TAC: Technical Advisory Committee meeting schedule to be determined

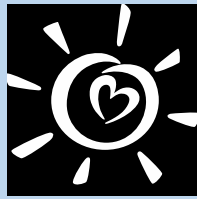
JPA and LACH: Joint Powers Authority and L.A. Care Community Health Plan meet concurrently with a BoG meeting

Meetings are usually held at 1055 West 7th Street, 1st Floor, Los Angeles, CA 90017

Except where *offsite* meetings are indicated below or if a different address is posted on the meeting agenda.

<u>January 2022</u> <i>No Board meeting</i> 1/12 – ECAC 1/20 – C&Q 1/18 – CHCAC 1/24 –F&B, Exec TBD – Audit, TAC	<u>February 2022</u> 2/3 – BoG 2/9 - ECAC 2/28 –F&B, Exec	<u>March 2022</u> 3/3 BoG (tentative) 3/9 – ECAC 3/15 – CHCAC 3/17 - C&Q 3/28 – F&B, Exec TBD – GOV
<u>April 2022</u> 4/7 – BoG 4/13 – ECAC 4/19 – C&Q 4/25 – F&B, Exec TBD - TAC	<u>May 2022</u> 5/5 – BoG 5/11 – ECAC 5/17 – CHCAC 5/19 – C&Q 5/23 – F&B, Exec	<u>June 2022</u> 6/2 – BoG (<i>offsite</i>)* 6/8 – ECAC 6/16 – C&Q 6/27 – F&B, Exec
<u>July 2022</u> <i>No BoG Committee Meetings</i> 7/28 – BOG 7/21 – C&Q	<u>August 2022</u> <i>No Board meeting</i> 8/10 - ECAC 8/16 – CHCAC 8/18 – C&Q 8/22 – F&B, Exec TBD – Audit, TAC	<u>September 2022</u> 9/1 – BoG (<i>offsite all day retreat</i>)* 9/14 - ECAC 9/15 – C&Q 9/19 - F&B, Exec* <i>*Due to religious holiday</i> 9/20 – CHCAC TBD –GOV
<u>October 2022</u> 10/6 BoG (tentative) 10/12 – ECAC 10/20 – C&Q 10/24 - F&B, Exec TBD - TAC	<u>November 2022</u> 11/3 – BoG 11/9 – ECAC 11/14 - F&B, Exec* <i>*Due to Thanksgiving holiday</i> 11/15 – CHCAC 11/17 – C&Q	<u>December 2022</u> 12/1 – BoG 12/14 – ECAC <i>No other meetings</i>

*Offsite locations are tentative



L.A. Care
HEALTH PLAN®

Board of Governors
MOTION SUMMARY

Date: May 24, 2022

Motion No. EXE A.0522

Committee: Executive

Chairperson: Hector De La Torre

Issue: Approve revisions to Human Resources Policy & Procedure HR-706 Introduction Orientation and Mandatory Training

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


Background: L.A. Care Policy HR-501 requires that the Executive Committee review substantial changes to the Human Resource policies. HR-706 was revised to include Diversity, Equity and Inclusion (DEI) as a required education. DEI education is being added to support NCQA Accreditation under the *2022 Standards and Guidelines for the Accreditation of Health Plans*, effective July 1, 2022.

Staff is proposing other minor annual revisions to HR-706 Introduction Orientation and Mandatory Training Policy.

Member Impact: None

Budget Impact: None

Motion: **To approve the Human Resources Policy & Procedure HR-706 (Introduction Orientation and Mandatory Training), as presented.**

	INTRODUCTORY ORIENTATION AND MANDATORY TRAINING		HR-706
	DEPARTMENT	HUMAN RESOURCES	
Supersedes Policy Number(s)	6209, 309		

DATES					
Effective Date	5/30/1996	Review Date	8/20/2020 4/20/22	Next Annual Review Date	2/27/2020 4/20/23
Legal Review Date	2/15/2019 2/11/2022	Committee Review Date	2/25/2019		

LINES OF BUSINESS			
<input type="checkbox"/> Cal MediConnect	<input type="checkbox"/> L.A. Care Covered	<input type="checkbox"/> L.A. Care Covered Direct	<input type="checkbox"/> MCLA
<input type="checkbox"/> PASC-SEIU Plan	<input checked="" type="checkbox"/> Internal Operations		

DELEGATED ENTITIES / EXTERNAL APPLICABILITY			
<input type="checkbox"/> PP – Mandated	<input type="checkbox"/> PP – Non-Mandated	<input type="checkbox"/> PPGs/IPA	<input type="checkbox"/> Hospitals
<input type="checkbox"/> Specialty Health Plans	<input type="checkbox"/> Directly Contracted Providers	<input type="checkbox"/> Ancillaries	<input type="checkbox"/> Other External Entities

ACCOUNTABILITY MATRIX			

ATTACHMENTS	

ELECTRONICALLY APPROVED BY THE FOLLOWING		
	OFFICER	DIRECTOR
NAME	Terry Brown	Frankie Edwards
DEPARTMENT	Human Resources	Talent Strategy and HR Technology Human Resources
TITLE	Chief Human Resources Officer	Senior Director, Talent Strategy and HR Technology Director, Learning and Development



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
2/8/2010	Revision
April 2014	Review
3/28/2018	Revision, Change policy number from HR-309 to HR-706 and title from New Hire Orientation and Mandatory Training to Introductory Orientation and Mandatory Training. Policy revised to differentiate employees from interns.
2/25/2019	Mandatory annual training added
8/20/2020	Review
<u>4/20/22</u>	<u>Addition of Diversity, Equity and Inclusion Education to Mandatory Training</u>

DEFINITIONS

Please visit the L.A. Care intranet for a comprehensive list of definitions used in policies:
<http://insidelac/ourtoolsandresources/departmentspoliciesandprocedures>



1.0 OVERVIEW:

1.1 It is L.A. Care Health Plan’s (L.A. Care) policy to provide general and department-specific Orientation to all newly hired employees, Temporary Employees, and newly onboarded Student Interns. This Orientation ensures that important department-specific information is reviewed by the employee or Student Intern on a timely basis. Individuals new to management roles are also required to review policies and procedures that assist in the effective management and development of their work force. Further, newly hired-all employees, Temporary Employees and newly onboarded Student Interns are required to complete mandatory annual compliance and Diversity Equity and Inclusion (DEI) training programs that meet the requirements established by fFederal, State orand local regulatory agencies.

2.0 DEFINITIONS:

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

2.1.1 Orientation – a program that allows newly hired employees, Temporary Employees, and newly-and onboarded Student Interns to become familiar with L.A. Care’s mission, vision, values, policies and procedures.

2.1.2 Contingent Worker - Consultants, Contractors, Clinical Residents (unpaid), and Temporary Employees through a third-party vendor not on L.A. Care payroll and ineligible for merit and incentive payouts.

2.1.3 Temporary Employee - Temporary Employees are those who have been hired by L.A. Care for a temporary assignment, are on L.A. Care Payroll, and are ineligible for merit and incentive payouts.

2.1.4 Student Intern - Student Interns are from a qualifying educational institution selected to participate in L.A. Care’s Internship Program who are brought in to gain experience in their field of study for a defined period of time, and are ineligible for merit and incentive payouts.

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3.0 POLICY:

3.1 All new or rehired full-time, part-time, per diem, temporary Employees and newly onboarded Student Interns must attend and complete a general Orientation program no later than 30 calendar days from date of hire or assignment or onboarding (as applicable). for employees or 30 calendar days from the date of onboarding for interns. Completion of the Orientation is attested by signature on the Orientation sign in sheet and tracked by Human Resources (HR), Learning Experience department (LX)and-Development department (L&D), in the Human Resources Information System (HRIS).



3.1.1 If an employee is rehired within 30 calendar days from termination with L.A. Care and had previously completed the introductory ~~o~~Orientation, that employee is not required to participate in the introductory Orientation program.

3.2 Department Directors must ensure that all employees, ~~and Student I~~nterns, ~~and Temporary Employees~~ attend and complete the respective Orientation program and that ~~managers-employees~~ complete the annual mandatory management training within the required time frames. Any changes to the content or deadlines for Orientation must be reviewed with ~~L&DLX~~ leadership in advance of the occurrence.

3.3 Compliance ~~and other~~ training programs are also mandatory and must be completed within 30 calendar days from the date of hire for employees, ~~Temporary Employees and Contingent Workers, and-or~~ ~~Temporary Employees and Contingent Workers, and-or~~ within 30 calendar days from the onboarding date for ~~Student I~~nterns and annually thereafter. These training programs include, but are not limited to, Code of Conduct; HIPAA Privacy and Information Security; ~~Diversity Equity and Inclusion (DEI);~~ and Fraud and Abuse Awareness. The Compliance ~~and Human Resources~~ department ~~is-are~~ accountable to track and ensure completion of these trainings by all employees and ~~Student I~~nterns.

4.0 PROCEDURES:

4.1 All new full-time, part-time, per diem, ~~T~~emporary ~~E~~mployees and ~~Student I~~nterns will be scheduled to participate in general Orientation by the HR and ~~L&DLX~~ department.

4.2 Access to L.A. Care Learning Management System (LMS) and Intranet pages will be provided during the onboarding process. Department Directors are responsible to ensure that their new hire or ~~Student I~~ntern has completed all required trainings by the assigned due date.

~~4.2.14.3 Orientation and all mandatory training programs must be completed within 30 calendar days from the date of hire for employees or within 30 calendar days from the onboarding date for interns and annually thereafter. These trainings include, but are not limited to, Code of Conduct, HIPAA Privacy and Information Security, and Fraud and Abuse Awareness. Failure to comply with mandatory compliance training may lead to disciplinary action, up to and including termination of employment for employees and end of internship program for Student Interns.~~

5.0 MONITORING:

5.1 Human Resources will conduct an annual review of the New Hire Orientation and Mandatory Training policy to ensure compliance.

6.0 REPORTING:



6.1 Any suspected violations to this policy should be reported to any department head, any member of the L.A. Care's Leadership Team, any member of the Human Resources department, Compliance Department or Compliance Helpline at (800) 400-4889.

~~7.0~~ ~~your Human Resources Business Partner.~~

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