



**L.A. Care**  
HEALTH PLAN

*For All of L.A.*

# EXECUTIVE COMMITTEE MEETING

## Board of Governors

May 26, 2020 • 2:00 PM

L.A. Care Health Plan

1055 W. 7<sup>th</sup> Street, Los Angeles, CA 90017



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



**AGENDA**  
**Executive Committee Meeting**  
**Board of Governors**

**DRAFT**

Tuesday, May 26, 2020, 2:00 P.M.  
L.A. Care Health Plan, 1055 West 7<sup>th</sup> Street, 10<sup>th</sup> Floor, Los Angeles

California Governor issued Executive Order No. N-29-20, which among other provisions amends the Ralph M. Brown Act and Executive Order No. 33-20, ordering all residents to stay in their homes, except for specific essential functions. Accordingly, members of the public should now listen to this meeting via teleconference as follows:

**Teleconference Call-In Information/Site**

Call (844) 907-7272 or (213) 438-5597  
Participant Access Code #73259739

Members of the Executive Committee or staff may also participate in this meeting via teleconference. *The public may listen to the Executive Committee’s meeting by teleconference. The public is encouraged to submit its public comments or comments on Agenda items in writing. You can e-mail public comments to [BoardServices@lacare.org](mailto:BoardServices@lacare.org), or send a text or voicemail to: 213 628-6420.*

**The text, voicemail, or email should indicate if you wish to be identified or remain anonymous, and should also include the name of the item to which your comment relates.**

Comments received by voicemail, email or text by 2:00 pm on May 26, 2020 will be provided to the members of the Board of Governors that serve on the Executive Committee. Public comments submitted shall be read for 3 minutes.

Once the meeting has started, voicemails, emails and texts for public comment should be submitted before the item is called by the meeting Chair. If you wish to submit public comment on an item, you must submit it at any time prior to the time the Chair announces the item and asks for public comment. The Chair will announce when public comment period is over.

**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](mailto: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 27, 2020 Meeting Minutes p.4 *Chair*
- 4. Chair’s Report *Chair*
- 5. Chief Executive Officer Report John Baackes  
*Chief Executive Officer*
  - COVID-19 Medicaid Relief Leadership Letter p.12
  - 2020-21 Governor’s May Budget Revise Summary p.17

**COMMITTEE ITEMS**

- 6. Government Affairs Update Cherie Compartore  
*Senior Director, Government Affairs*
  - Legislative Matrix p.23

**DRAFT**

7. Human Resources Policy (**EXE A**) p.67

Terry Brown  
*Chief Human Resources Officer*

8. Approve the list of items that will be considered on a Consent Agenda for June 4, 2020 Board of Governors Meeting
- Minutes of May 7, 2020 Board of Governors meeting
  - Edifecs Contract Amendment
  - Change Healthcare Contract Amendment
  - Cognizant Contract Amendment

*Chair*

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

*Chair*

9. CONTRACT RATES

Pursuant to Welfare and Institutions Code Section 14087.38(m)

- Plan Partner Rates
- Provider Rates
- DHCS Rates
- Plan Partner Services Agreement

10. 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 2022*

11. CONFERENCE WITH LABOR NEGOTIATOR

Pursuant to Section 54957.6 of the Ralph M. Brown Act

Agency Designated Representative: John Baackes  
Unrepresented Employee: All L.A. Care Employees

12. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION

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

**RECONVENE IN OPEN SESSION**

**ADJOURN**

*Chair*

**The next Executive Committee is scheduled on Monday, June 22, 2020 at 2:00 p.m.**

Public comments will be read for three minutes or less.

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

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

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

**NOTE: THE EXECUTIVE COMMITTEE CURRENTLY MEETS ON THE FOURTH MONDAY OF MOST MONTHS AT**

**2:00 P.M. POSTED AGENDA and MEETING MATERIALS ARE AVAILABLE FOR INSPECTION AT [www.lacare.org](http://www.lacare.org).**

Any documents distributed to a majority of the Board Members regarding any agenda item for an open session after the agenda has been posted will be available at [www.lacare.org](http://www.lacare.org).

AN AUDIO RECORDING OF THE MEETING MAY BE MADE TO ASSIST IN WRITING THE MINUTES AND IS RETAINED FOR 30 DAYS.

*Meetings are accessible to people with disabilities. Individuals who may require any accommodations (alternative formats – i.e., large print, audio, translation of meeting materials, interpretation, etc.) to participate in this meeting and wish to request an alternative format for the agenda, meeting notice, and meeting packet may contact L.A. Care's Board Services Department at (213) 694-1250. Notification at least one week before the meeting will enable us to make reasonable arrangements to ensure accessibility to the meetings and to the related materials.*

**BOARD OF GOVERNORS**  
**Executive Committee**

**Meeting Minutes – April 27, 2020**

1055 West 7<sup>th</sup> Street, Los Angeles, CA 90017



**L.A. Care**  
 HEALTH PLAN

**Members**

Hector De La Torre, *Chairperson*  
 Al Ballesteros, *Vice Chairperson*  
 Robert H. Curry, *Treasurer*  
 Layla Gonzalez, *Secretary*  
 Stephanie Booth, MD  
 Hilda Perez

*\*Absent*

**Management/Staff**

John Baackes, *Chief Executive Officer*  
 Terry Brown, *Chief Human Resources Officer*  
 Augustavia J. Haydel, Esq., *General Counsel*  
 Marie Montgomery, *Chief Financial Officer*  
 Richard Seidman, MD, MPH, *Chief Medical Officer*

**California Governor issued Executive Order No. N-29-20, which among other provisions amends the Ralph M. Brown Act and Executive Order No. 33-20, ordering all residents to stay in their homes, except for specific essential functions.**

**Members of the public can listen to this meeting via teleconference.**

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
<p><b>CALL TO ORDER</b></p>	<p>Hector De La Torre, <i>Chairperson</i>, called the meetings to order for L.A. Care Executive Committee and L.A. Care’s Joint Powers Authority Executive Committee at 2:25 p.m. The meetings were held simultaneously.</p> <p>He welcomed everyone to the meetings and invited the members of the Committees, staff and guests to introduce themselves.</p> <p>Chair De La Torre summarized the process for this teleconference meetings as reflected on the meeting agenda.</p> <ul style="list-style-type: none"> <li>• Public comments received by voicemail, email or text received by 2:00 p.m. today were provided in writing to the Executive Committee members. Public comments will be read for 3 minutes during the meeting.</li> <li>• Once the meeting has started, emails and texts for public comment should be submitted before the item is called by the meeting Chair. If you wish to submit public comment on an item, you must submit it at any time prior to the time the Chair starts consideration of the item. The Chair will ask for public comment and will announce the item. The Chair will announce when public comment period is over.</li> </ul>	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
<b>APPROVE MEETING AGENDA</b>	The Agenda for today’s meeting was approved.	<b>Approved unanimously by roll call. 5 AYES (Ballesteros, Booth, De La Torre, Gonzalez, and Perez)</b>
<b>PUBLIC COMMENTS</b>	There were no public comments.	
<b>APPROVE MEETING MINUTES</b>	The minutes of the March 24, 2020 meeting were approved, as submitted.	<b>Approved unanimously by roll call. 5 AYES</b>
<b>CHAIRPERSON’S REPORT</b>	Chairperson De La Torre thanked staff for their work and assistance to the Board for continuing L.A. Care’s operations. The Leadership Team is the backbone of this operation. He added that he is proud of L.A. Care for stepping up in assist the providers to assure access to care for and to assist L.A. Care members.	
<b>CHIEF EXECUTIVE OFFICER REPORT</b>	<p>John Baackes, <i>Chief Executive Officer</i>, reported: Recap of COVID crisis</p> <ul style="list-style-type: none"> <li>• Staff has been working from home since March 16. On the weekend preceding March 16, Information Technology (IT) staff put together equipment to distribute to employees setting up a home office. IT has maintained a command center, which keeps everyone functioning. All key business indicators are being met by L.A. Care staff. Employees are remarkably upbeat and many are grateful to work from home.</li> <li>• Post pandemic, L.A. Care employees will want to continue to work from home. Mr. Baackes has asked Human Resources to come up with work from home policy, and will continue to update this Committee.</li> <li>• He thanked IT and Facility department staff for their remarkable support during the transition to working from home.</li> <li>• L.A. Care’s main role is to provide access to care for members, and we will continue to support the providers who care for L.A. Care members.</li> <li>• L.A. Care will advance Pay for Performance (P4P) incentive payments to Federally Qualified Health Centers (FQHCs) and other providers equal to what they received last year. The payments were scheduled to be paid in January 2021. \$20 million was disbursed to providers last week. If a provider earns more incentive than we have paid, they get more in January 2021. If they earn less they keep the difference.</li> </ul>	

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	<ul style="list-style-type: none"> <li>• To help many members with social needs, L.A. Care has repurposed budgeted Community Health Investment Fund (CHIF) grants to direct \$6 million in grants to various agencies. Staff will present a motion at the May 7 Board of Governors meeting. Projects to be funded will include: <ul style="list-style-type: none"> <li>○ More recuperative care beds</li> <li>○ Tents and supplies for homeless</li> <li>○ Testing for congregate living</li> <li>○ Telehealth</li> <li>○ Eviction prevention</li> <li>○ Meal delivery</li> <li>○ Support for safety net clinics</li> <li>○ Advanced payments for CHIF grants</li> <li>○ For hospitals who have not seen CARES act funds.</li> <li>○ Advanced payment of claims to hospitals</li> <li>○ Accelerated \$50 million</li> </ul> </li> </ul> <p>Dino Kasdagly, <i>Chief Operating Officer</i>, added that a couple weeks ago, the timing for claims payments was 20 days for electronic and 25 days for paper. That has been reduced to 10 days and 15 days to support the providers. The reduction was accomplished by temporarily loosening quality assurance and payment integrity processes, which is not a best practice, but the goal was to get funds to providers quickly in the current emergency situation.</p> <p>Mr. Baackes asked Marie Montgomery, <i>Chief Financial Officer</i>, to report on Proposition 56 and other funds L.A. Care is responsible for distributing.</p> <p>Ms. Montgomery reported that in March L.A. Care sent out over \$550 million in hospital directed payment and quality assurance funds, and Cost Based Reimbursement Clinics (CBRC) funds to Los Angeles County Department of Health Services of about \$97 million. Staff is focused on distributing existing Proposition 56 and family planning funds that were received by L.A. Care in mid-April.</p> <p>Mr. Baackes noted that L.A. Care doing as much as possible so providers are not lacking funds and can continue to serve members. L.A. Care is also working with Community Clinics Association of Los Angeles County, Private Essential Access Community Hospitals and the Hospital Association of Southern California to coordinate aid for providers that need it most.</p>	

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	<ul style="list-style-type: none"> <li>• In California, the unprecedented high level of unemployment will likely lead to additional enrollment in Medi-Cal. L.A. Care is working with a model developed by Health Management Associates that predicts Medi-Cal will increase by more than 1 million, which could be an additional 230,000-460,000 gain in members for LA Care. This is significant, but will not be a permanent gain in members. The challenge will be not to inflate infrastructure, so that when enrollment returns to pre pandemic levels, L.A. Care is not left with too much overhead.</li> <li>• California Department of Health Care Services (DHCS) has announced that the current federal waiver, Cal AIM, is suspended for at least a year, and is instead asking that existing waivers be extended for Whole Person Care and Housing4Health programs.</li> <li>• Unfortunately, DHCS is pressing on with a proposed carve out of Prescription drugs from Medi-Cal benefits. L.A. Care and a coalition of health plans has submitted a letter asking that this proposal is delayed. A delay appears unlikely.</li> <li>• Cuts in the Medi-Cal program are likely due to lower federal payments which will likely lead to reductions in benefits, determining that categories of members are ineligible and lowering rates paid to providers of care.</li> <li>• L.A. Care has joined with 14 other plans in asking for federal support for the duration of the recession: <ul style="list-style-type: none"> <li>○ Seeking funds to maintain existing benefits through the Coronavirus Aid, Relief, and Economic Security (CARES) Act</li> <li>○ With increased enrollment, asking for additional funds to keep Medicaid (Medi-Cal) programs whole</li> <li>○ indefinitely suspend Medicaid Fiscal Accountability Proposed Rule (MFAR) regulations, which determine how hospitals receive directed payments</li> <li>○ Amended Medicaid regulations to allow presumptive eligibility</li> <li>○ Suspend public charge rules</li> </ul> </li> <li>• L.A. Care is also working with other health plans around the country on continued funding and benefits during the looming recession</li> <li>• This morning, the Supreme Court in unprecedented 8-1 decision, ruled in favor of insurance companies on the constitutional legality of the risk sharing payments due to plans through the Affordable Care Act. L.A. Care’s potential share is about \$23 million.</li> </ul>	

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	<p>Member Perez asked if there is a written report regarding this. Mr. Baackes responded that this will be covered in his written CEO report for the May 7 board meeting. He will provide copies of letters sent to U.S. Congress California legislative delegation.</p> <p>Member Ballesteros commended L.A. Care's support for community health centers and FQHCs, which he has announced at several local meetings, and clinics are very appreciative. Patient visits to facilities are down 20-50%, and this arrived at the right time to maintain cash flow amid the current level of operations. He expressed his and the clinics' appreciation to the Board and Mr. Baackes for the support.</p> <p>As of April 1, through a cooperative agreement with Heritage IPA, L.A. Care moved 41,000 members to a different IPA (away from Heritage) because of quality concerns. Additional 15,000 members will move with their primary care physicians (PCPs) in L.A. Care's direct network. There will be announcements in the next few months about increases in L.A. Care's directly contracted provider network.</p> <p>Member Booth commented that many of the doctor visits were postponed because of the stay at home order, and in keeping a health equity action plan in mind, this may be a good time to provide resources and training to assist providers with chronic disease management, such as diabetes and asthma care.</p> <p>Richard Seidman, <i>Chief Medical Officer</i>, responded that L.A. Care continues to provide information about telehealth, encouraging PCPs to use telehealth and on how to bill for those services. In-person visits are down but telehealth use is increasing.</p> <p>Member Ballesteros noted that many providers are providing services more than 50% of the time in telehealth and chronic disease management is ongoing, however, there are certain visits that cannot be done by telephone.</p>	
<p><b>2<sup>nd</sup> Quarter FY 2019-20 Vision 2021 Progress Report</b></p>	<p>Mr. Baackes referred to the report included in the meeting materials (<i>a copy of the report may be requested by contacting Board Services</i>).</p> <p>Member Booth commented that the improved report now clearly demonstrates how L.A. Care is a leader and role model for the community. Mr. Baackes thanked Member Booth for her comments and suggestions to improve the report.</p>	
<p><b>Government Affairs Update</b></p>	<p>Cherie Compartore, <i>Senior Director, Government Affairs</i>, reported that Governor Newsom announced on Friday that effective immediately, additional food services would be provided for seniors. The state in partnership with Federal Emergency Management</p>	

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	Agency (FEMA) will contract with independent restaurants to provide seniors with three meals daily. The cost of these services will be shared 75% by the state and 25% by local governments.	
<b>Revise 2020 Board &amp; Committee Meeting Schedule (EX)</b>	<p>Linda Merkens, <i>Senior Manager, Board Services</i>, presented a motion to revise the Board meeting schedule to hold the June 4, 2020 at L.A. Care Health Plan, 1055 W. 7<sup>th</sup> Street, Los Angeles, CA 90017. The meeting was originally scheduled to be held offsite, but because of the public health orders related to the COVID-19 pandemic, that meeting will now be rescheduled to be held at L.A. Care’s offices.</p> <p><b><u>Motion EXE 100.0520</u></b>  <b>To approve the revised 2020 Board of Governors meeting schedule as submitted.</b></p>	<p><b>Approved unanimously by roll call. 5 AYES</b></p> <p><b>The Committee approved including this motion on the Consent Agenda for the May 7 Board of Governors meeting</b></p>
<b>Annual Disclosure of Broker Fees</b>	<p>Terry Brown, <i>Chief Human Resources Officer</i>, referred Committee members to the report included in the meeting packet (<i>a copy of the report may be requested by contacting Board Services</i>). This is to comply with the requirements of AB 2589 in reporting insurance broker fees associated with the various benefits L.A. Care offers to its employees. It is the disclosure of the commission earned by Woodruff Sawyer, L.A. Care’s broker of record for the majority of various health and wellness insurers providing L.A. Care employee benefits for the last two fiscal years (2018-19 and 2019-20). Commission is paid to Woodruff Sawyer on a monthly or annual basis, and the amount is based on the number of participants in the benefit program. This disclosure also includes commissions paid to LTC Solutions, Inc., the writing agent for the Genworth policy.</p>	
<b>Authorization of Expenditures for existing programs under the Elevating the Safety Net (ESN) Initiative</b>	<p>Mr. Baackes summarized a motion requesting authorization to add In Home Support Services (IHSS) Home Care Integration Training Program to the existing L.A. Care program with California Long-Term Care Education Center (CLTCEC), to align the work L.A. Care is doing to equip our non-clinical professionals with the tools and skills to serve members and work with providers.</p> <p>Member Gonzalez noted that the CLTCEC graduations are going on now. Given the current resources available, they do not have the right personal protective equipment (PPE) to continue. She asked if L.A. Care will try to provide PPE to the graduates. Mr. Baackes asked Dr. Seidman to make a request to the Los Angeles County Medicaid group that meets weekly, to try to source the PPE. Dr. Seidman will work on the request</p>	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	<p>and will forward to the Office of Emergency Medical Services in Los Angeles County. He noted that everybody needs PPE, and medical practitioners are priority.</p> <p>Mr. Baackes reported that SoCal Transformation is a group looking for ideas about mitigating effects of the pandemic and pending recession. Mr. Baackes commented that he has proposed an idea to enhance local pandemic preparation that seeks resources from local businesses, to help the local economy.</p> <p>Dr. Seidman noted that there are good resources specific to IHSS workers for recommended practical everyday precautions.</p> <p>Member Booth added that she supports adding IHSS to the Elevating the Safety Net (ESN) program. She asked if payments would be made directly to doctors or to providers. Mr. Baackes responded that L.A. Care uses a vendor who administer direct payments to doctors for the ESN program.</p> <p><b><u>Motion EXE 101.0520</u></b>  <b>To delegate authority to the Chief Executive Officer to:</b></p> <ol style="list-style-type: none"> <li><b>1. Authorize expenditures of up to \$6 million to continue awarding providers in the Provider Loan Repayment Program, currently managed by Uncommon Good.</b></li> <li><b>2. Approve and authorize integrating the California Long-Term Care Education Center (CLTCEC) IHSS+ Home Care Integration Training Program under Elevating the Safety Net in the FY 2020-21.</b></li> </ol>	<p>Approved unanimously by roll call. 5 AYES</p>
<p><b>Approve the Consent Agenda for May 7, 2020 Board of Governors meeting</b></p>	<ul style="list-style-type: none"> <li>• Minutes of April 2, 2020 Board of Governors meeting</li> <li>• Revised 2020 Board of Governors Meeting Schedule</li> <li>• Quarterly Investment Report</li> <li>• WEX Health Contract Amendment</li> <li>• <del>Toney Health Care Consulting Contract Amendment</del></li> <li>• TransUnion Contract Amendment</li> <li>• SAP Contract Amendment</li> </ul>	<p>Approved unanimously by roll call. 6 AYES  <b>(Ballesteros, Booth, Curry, De La Torre, Gonzalez, and Perez)</b></p>
<p><b>PUBLIC COMMENTS</b></p>	<p>There were no public comments.</p>	

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<b>ADJOURN TO CLOSED SESSION</b>	<p>Augustavia J. Haydel, Esq., <i>General Counsel</i>, announced the items to be discussed in closed session. She announced there is no report anticipated from the closed session. The meeting adjourned to closed session at 3:29 p.m.</p> <p><b>CONTRACT RATES</b> Pursuant to Welfare and Institutions Code Section 14087.38(m)</p> <ul style="list-style-type: none"> <li>• Plan Partner Rates</li> <li>• Provider Rates</li> <li>• DHCS Rates</li> </ul> <p><b>CONFERENCE WITH REAL PROPERTY NEGOTIATORS</b> Pursuant to Section 54956.8 of the Ralph M. Brown Act Property: 11725 Rosecrans Ave., Norwalk, CA. 90650 Agency Negotiator: John Baackes Negotiating Parties: Hekmatravan Family Norwalk, LLC, and Levian Family Norwalk, LLC. Under Negotiation: Price and Terms of Payment</p> <p><b>REPORT INVOLVING TRADE SECRET</b> Pursuant to Welfare and Institutions Code Section 14087.38(n) Discussion Concerning New Service, Program, Business Plan Estimated date of public disclosure: <i>April 2022</i></p> <p><b>CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION</b> Significant exposure to litigation pursuant to Section 54956.9(d) (2) of Ralph M. Brown Act One Potential Case</p>	
<b>RECONVENE IN OPEN SESSION</b>	The meeting reconvened in open session at 4:16 pm. No reportable actions were taken during the closed session.	
<b>ADJOURNMENT</b>	The meeting adjourned at 4:17p.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: \_\_\_\_\_

May 11, 2020

The Honorable Mitch McConnell  
Senate Majority Leader  
U.S. Senate  
Washington, DC 20515

The Honorable Charles Schumer  
Senate Minority Leader  
U.S. Senate  
Washington, DC 20515

The Honorable Nancy Pelosi  
Speaker of the House  
U.S. House of Representatives  
Washington, DC 20515

The Honorable Kevin McCarthy  
House Minority Leader  
U.S. House of Representatives  
Washington, DC 20515

Dear Leaders:

Thank you for your leadership to help overcome the COVID-19 crisis. The magnitude of the crisis is extraordinary and sadly, more must be done. The undersigned 27 Managed Care Organizations represent over 16 million Medicaid beneficiaries across the country who rely on Medicaid for their health and well-being. We stand united in our commitment to work with you and to work together.

As a result of this national emergency, we know the impacts of the pandemic will result in a significant increase in Medicaid enrollment, further straining every state's budget over the next two years, if not longer.

Our experience during the financial crisis of 2008-2011, where over the two-and-a half-year period, the American Recovery and Reinvestment Act provided for \$98 Billion in direct fiscal relief, leads us to believe that the following steps, taken in concert will help Medicaid beneficiaries, Managed Care Organizations, and the safety net throughout the country.

**Stable Medicaid Funding**

*Increase the federal share of Medicaid spending and to commit to at least a two-year period of federal Medicaid funding for states.*

Because of COVID-19, states will experience large declines in revenue as the needs for services, including Medicaid, will significantly increase. As we learned from the last recession, state revenues dropped significantly while spending growth continued, resulting in large budget gaps. Not surprisingly, states are already estimating significant revenue declines and unemployment estimates that could easily exceed those experienced during the last recession.

Based on analysis of the provisions included in the 2009 American Recovery and Reinvestment Act (ARRA) to fund a temporary increase in the Federal share of Medicaid costs, as well as Medicaid enrollment trends, we calculated an inflation-adjusted, per-enrollee amount of funding currently needed. We then applied this to recent estimates from Health Management Associates (HMA) that predict a national increase in Medicaid enrollment from the current 71 million beneficiaries to 82 to 94 million beneficiaries as a result of growth in unemployment<sup>i</sup>. We found that between \$167.6 billion and \$192.1 billion in funding is needed to sustain the Medicaid program at the state level in the midst of the COVID-19 pandemic and the resulting recession.

The COVID-19 health crisis will increase demands on Medicaid. By picking up a larger share of the costs of Medicaid, the federal government can make sure that state budget decisions do not constrain the health response by the states and ensure that increased Medicaid costs do not force states to cut spending in other areas (e.g., education or public safety) in ways that could contribute to a further economic downturn or even cause a delay of economic recovery.

**Medicaid Fiscal Accountability Proposed Rule (MFAR)**

*The Medicaid Fiscal Accountability Proposed Rule must not be finalized during the COVID-19 crisis. In fact, due to the devastating financial impact on states that the Rule would have, we contend the proposed rule be suspended until more analysis is done by CMS to understand the policy and financial impacts the proposed rule would have on states and in particular, the Medicaid delivery system and beneficiaries.*

In November, 2019 CMS released the MFAR which would reduce the amount of funding provided to states as part of their Medicaid matching funds when the funding is generated through various supplemental means (e.g., provider taxes, intergovernmental transfers). Many states use supplemental funding mechanisms to provide the non-federal share of some of its Medicaid funding.

Moving forward without this information is dangerous to the efficiency and operation of any Medicaid program, and jeopardizes beneficiary services. Prior to the COVID-19 crisis, it was estimated that millions of patients could lose access to care in public health care systems alone, and project that many public health care systems could not be financially stable and thus would have to close.

For nearly all states, the reductions that would result from MFAR could unquestionably mean cuts in Medicaid program enrollment and covered services. The impact in some states could be catastrophic on state Medicaid funding and ultimately reduce access to critically needed health services for Medicaid beneficiaries.

### **Presumptive Eligibility**

*Extend Presumptive Eligibility (PE) to all applicants that appear to be Medicaid eligible (based on initial income screening by a qualified entity); expand the types of entities qualified to perform PE screening; allow qualified entities to utilize online/telephonic applications and online/telephonic signatures for PE applications; and disallow any maximum limitation amounts that would prohibit a person from applying for PE more than once in a twelve-month period.*

Presumptive Eligibility (PE) is a Medicaid policy option allowing states to authorize specific types of entities (e.g., federally qualified health centers, hospitals, and schools) to screen eligibility based on income and temporarily enroll them in Medicaid coverage while their full enrollment application is being considered. The goal of PE is to provide short-term coverage of health care services for those with limited incomes, who appear to be eligible for Medicaid, but not currently enrolled. This allows those individuals to receive much needed medical care, while they complete the full Medicaid application and allow counties to conduct the enrollment process. Because of the potential Medicaid application backlog, we believe counties may experience challenges with processing all of the applications in a timely manner. Thus, we are asking that the federal government allow PE for a period of 90 days while counties and the Medicaid applicants complete the enrollment process, and to allow for extensions if counties are experiencing delays in processing Medicaid applications.

Presumptive Eligibility is a powerful tool in ensuring that, as people lose individual or employer coverage during this pandemic and appear to be income-eligible, they are able to receive services via Medicaid without having to wait weeks or even months to complete the Medicaid enrollment process before receiving services.

### **Cease Implementation of the Public Charge Rule (Rule)**

*The Public Charge Rule should be fully suspended until the COVID-19 emergency has subsided.*

On February 23, 2020 the U.S. Supreme Court removed the remaining Public Charge injunctions, allowing the policy to go into full effect on February 24, 2020. As you know, the Public Charge rule makes immigrants who receive non-cash public benefits, such as Medicaid, food assistance, and housing assistance potentially ineligible for green cards and visas.

Not surprisingly, the Public Charge has created an environment of fear throughout immigrant communities who were already wary of accessing health care coverage, long before the Rule went into place. In December 2018, the Urban Institute conducted a survey on non-elderly adults in immigrant families and found that one in seven did not participate in non-cash government benefit programs because of their fear of harming their or their families green card application.

As an effective public health response, it is vital that the federal government fully suspend the Public Charge rule for the duration of the emergency, at a minimum.

The undersigned managed care plans are prepared to provide expertise, data and ideas as you consider various issues to be addressed in the next relief package. We stand ready to work with you to craft solutions that will ensure the solvency of the Medicaid program during and after this national emergency. These are trying and uncertain times for all Americans,

and more so for our most vulnerable. Taking the above steps will result in better health care outcomes for the members of our communities and for the nation as a whole.

Sincerely,



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John Baackes  
Chief Executive Officer  
L.A. Care Health Plan



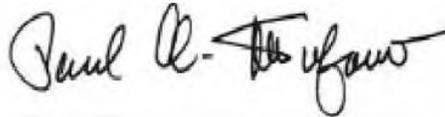
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Paul Markovich  
President & Chief Executive Officer  
Blue Shield of California



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Scott E. Coffin  
Chief Executive Officer  
Alameda Alliance for Health



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Paul A. Tufano  
Chairman & Chief Executive Officer  
AmeriHealth Caritas



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Bob Freeman  
Chief Executive Officer  
CenCal Health



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Stephanie Sonnenshine  
Chief Executive Officer  
Central California Alliance for Health



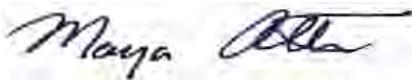
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Margaret Tatar  
Interim Chief Executive Officer  
Gold Coast Health Plan



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Brian Ternan  
President & Chief Executive Officer  
Health Net of California & California Health & Wellness



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Maya Altman  
Chief Executive Officer  
Health Plan of San Mateo



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Jarrod B. McNaughton  
Chief Executive Officer  
Inland Empire Health Plan



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Douglas A. Hayward  
Chief Executive Officer



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Gregory Hund  
CalViva Health

---

Elizabeth Gibboney  
Chief Executive Officer  
Partnership HealthPlan of California

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John F. Grgurina, Jr.  
Chief Executive Officer  
San Francisco Health Plan

---

Christine M. Tomcala  
Chief Executive Officer  
Santa Clara Family Health Plan

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Michelle Tetreault  
Interim Chief Executive Officer  
Health Plan of San Joaquin

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Norma Diaz  
Chief Executive Officer  
Community Health Group

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Sharron Mackey  
Chief Executive Officer  
Contra Costa Health Plan

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Erhardt Preitauer  
Chief Executive Officer  
CareSource

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Eric C. Hunter  
President & Chief Executive Officer  
CareOregon

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James Kiamos  
Chief Executive Officer  
CountyCare Health Plan, CCH

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Edward Kumian  
Chief Executive Officer  
Priority Partners

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Christopher D. Palmieri  
President & Chief Executive Officer  
Commonwealth Care Alliance

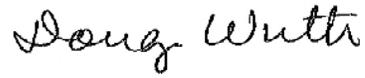
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John Lovelace  
Chief Executive Officer  
UPMC For You, Inc.



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Leanne Berge  
Chief Executive Officer  
Community Health Network of Washington  
Community Health Plan of Washington



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Doug Wirth  
President & Chief Executive Officer  
Amida Care



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Peter Marino  
President & CEO  
Neighborhood Health Plan of Rhode Island

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<sup>i</sup> <https://www.healthmanagement.com/wp-content/uploads/HMA-Estimates-of-COVID-Impact-on-Coverage-public-version-for-April-3-830-CT.pdf>



May 21, 2020

To: Executive Committee, Board of Governors  
From: Cherie Compartore, *Senior Director, Government Affairs Department*  
Subject: **2020-21 May Revise Summary**

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On May 14, Governor Newsome released his 2020-21 May Revise. The May Revise contains revisions to the proposed state budget that the Governor released in January 2020. The May Revise includes updated spending and revenue estimates, as well as updated priorities and proposals. The Legislature uses this revised spending proposal to review, offer revisions, and finally approve the budget by the constitutional deadline of June 15 and send it to the Governor for consideration.

This memo includes a summary of the May Revision for 2020-21, with a summary of the budget proposals that are pertinent to L.A. Care's strategic and operational interests. Budget summary information may be found at <http://www.ebudget.ca.gov> and [https://www.dhcs.ca.gov/Documents/Budget\\_Highlights/DHCS-FY-2020-21-MR-Highlights-051320.pdf](https://www.dhcs.ca.gov/Documents/Budget_Highlights/DHCS-FY-2020-21-MR-Highlights-051320.pdf).

### **State Budget Overview**

The May Revise reflects the harsh reality of the COVID-19 Recession. The 2020 unemployment rate is projected to be 18 percent, and personal income is projected to decline by 9 percent in 2020. This is in stark contrast to the Governor's Budget in January, which projected a \$5.6 billion surplus in 2020-21 and included significant new investments, particularly in health care and homelessness.

As required by the California Constitution, the May Revise presents a balanced budget by cancelling new initiatives proposed in the Governor's Budget, cancelling or reducing spending, drawing down reserves, borrowing from special funds, temporarily increasing revenues, and accounting for CARES Act funding. The respective dollars attributed to each of these strategies is included in the below table (Table 1) from the Budget Summary. The \$14 billion of "Triggers" in Table 1 are cuts proposed that will be "triggered off" if the federal government provides sufficient funding. It is unclear of the priority of the Trigger cuts if only partial federal government funding is provided.

**Table 1**

**May Revise Proposed Balance Solution (dollars in billions)**

Cancelled Expansions & Other Reduction	\$8.4
Reserves	\$8.8
Borrowing, Transfers, Deferrals	\$10.4
New Revenues	\$4.4
Federal Funds	\$8.3
Trigger Cuts	\$14.0
<b>Total</b>	<b>\$54.3</b>

**Medi-Cal Program Overview**

Below in Table 2 you will find a comparison of the May Revision with both the Governor’s Budget and the current year Budget. While the total budget has increased, because of cuts and other offsets detailed later in this memo, the General Fund obligation has decreased from the Governor’s Budget and only marginally increased from current budget year.

**Table 2**

**Medi-Cal Budget Comparison Table (dollars in billions)**

<b>Budget</b>	<b>Total Fund</b>	<b>General Fund</b>
May Revision	\$112.1	\$23.2
Governor’s Budget (January)	\$107.4	\$26.4
<b>Difference</b>	<b>\$4.7</b>	<b>(\$3.2)</b>
May Revision	\$112.1	\$23.2
2019-20 Budget	\$99.5	\$22.7
<b>Difference</b>	<b>\$12.6</b>	<b>\$0.5</b>

Table 3 below aggregates the savings amounts as a result of the withdrawn proposals, program and service cuts, and managed care capitation adjustments.

**Table 3**

**Medi-Cal Estimated Savings/Reductions in 2020-21**

<b>Savings Category</b>	<b>Dollar Amount (GF)</b>
Proposals Withdrawn from Gov.’s Budget	\$612.9 million
Managed Care Adjustments	\$273.6 million
Program and Service Cuts	\$1.47 billion
<b>Total</b>	<b>\$2.34 billion</b>

## Withdrawn Budget Proposals

Due to the significant financial impact of COVID-19 on the state's budget, the May Revise reflects the withdrawal of some previously proposed policies included in the Governor's January Budget proposal, including:

- Delay of CalAIM initiative. DHCS is working with CMS to extend current 1115 Waiver for one year. General Fund savings of \$347.5 million.
- Elimination of the Behavioral Health Quality Improvement Program. General Fund savings of \$45 million.
- Withdraw the Full-Scope Medi-Cal expansion to the undocumented over 65 years of age, including IHSS. General Fund savings of \$87 million.
- Eliminate the 2019 Budget Act expansion of Medi-Cal to Aged, Blind and Disabled individuals with incomes between 123% and 138% FPL. Eliminates implement of the Aged, Blind, And Disabled Medicare Part B Disregard. General Fund savings of \$67.7 million.
- Eliminates the Medical Interpreters Pilot Project. SB 165 (2019). General Fund savings of \$5 million.
- Eliminate the maternal postpartum mental health expansion for beneficiaries who receive pregnancy-related services, and are diagnosed with a mental health condition, to remain eligible for Medi-Cal postpartum care for up to 12 months after the last day of pregnancy. General Fund savings of \$34.3 million.
- Withdraw the supplemental payment pool for non-hospital 340B clinics. General Fund savings of \$26 million in 2020-21, \$52.5 million in 2021-22 onward.
- Eliminate the proposal to create a new state program to assist families with the cost of hearing aids and related services for children without health insurance coverage of hearing aids in households with incomes up to 600% FPL. (This did not apply to Medi-Cal children -Cal as hearing aids are a covered benefit and will remain so). General Fund savings of \$5 million.
- Eliminate the proposal to create an Office of Health Care Affordability which was charged with increasing price and quality transparency.

## Budget Proposals

### ➤ Medi-Cal Caseload Estimates

The budget assumes an increase of the Medi-Cal caseload. Medi-Cal projected enrollment estimated at 14.5 million beneficiaries in July 2020 (approximately 2 million above what caseload would have been absent the pandemic).

### ➤ Rate Reductions

- 1.5% Rate Reduction for the period of 07/01/19 – 12/31/20. General Fund savings of \$182 million. This rate reduction does not require CMS approval as DHCS can make a 1.5% adjustment (+/- 1.5%) on current rating period without obtaining federal approval.
  - Will impact Adult, Child, Optional Expansion, and SPD (non-full dual). The cut does not appear to impact supplemental rates such as maternity, behavioral health treatment, or CCI.
- Additional Managed Care Rate Changes: The May Revision also proposes various additional changes to the way that managed care capitation rates are determined. These changes include various acuity, efficiency, and cost containment adjustments. These adjustments would be effective for the managed care rate year starting 01/01/21, and would yield General Fund savings of \$91.6 million in 2020-21 and \$179 million in 2021-22.
  - Implement an inpatient maximum fee schedule equal to the APR-DRG payment levels via a direct payment. Applicable to all private hospitals and district municipal public hospitals. Would not apply to county hospitals and UC hospitals.

- Implement a Low Acuity NonEmergency (LANE) Services Efficiency Adjustment. The LANE efficiency adjustment focuses on identifying instances in which an emergency room visit could have been avoided had effective outreach, care coordination, and access to preventive care been available.
- Healthcare Common Procedure Coding System (HCPCS) Efficiency Adjustment.
- Implement a reduced Managed Care Underwriting Gain (UG) within the final certified capitation rates. The UG would be reduced from 2 percent to 1.5 percent, resulting in a 0.5 percent reduction.

➤ Elimination of Adult Optional Benefits (Trigger Cut)

- Reduction of dental (reduces to partial restoration levels in 2014)
- Audiology
- Speech therapy
- Optometry
- Podiatry
- Incontinence creams and washes
- Acupuncture services
- Nurse anesthetist services (this service was never previously cut as the other optional benefits have been in the past)
- Occupational therapy
- Physical therapy
- Diabetes prevention program

The above budget proposal does not apply children, beneficiaries in long-term care, beneficiaries receiving pregnancy related services, or those who receive services in an FQHC or RHC as required under federal law. This proposal may be “triggered off” if the feds government provides sufficient funding to restore. General Fund savings of \$54.7 million.

➤ Elimination of Community-Based Adult Services (CBAS) and Multipurpose Senior Services (MSSP) Programs (Trigger Cut)

- CBAS effective date: 01/01/21. General Fund savings of \$107 million in 2020-21; \$256 million in 2021-22.
- MSSP effective date: no sooner than 07/01/20 (General Fund savings of \$22 million in 2020-21; \$22 million in 2021-22).
- This proposal may be “triggered off” if the feds government provides sufficient funding to restore.

➤ Redirection of Proposition 56 Supplemental Payments and Programs (Trigger Cut)

Shifts \$1.2 billion in Prop 56 supplemental payments for physician, dental, family health services, developmental screenings and non-emergency medical transportation, value-based payments, and loan repayments for physicians and dentists. Funds will be re-directed to fund the costs associated with increased Medi-Cal enrollment.

Maintains \$67 million in Prop 56 funding to continue rate increases for home health providers, pediatric day health care facilities, pediatric subacute facilities, AIDS waiver supplemental payments, already awarded physician and dentist loan repayments, and trauma screenings.

This proposal may be “triggered off” if the feds government provides sufficient funding to restore.

- Martin Luther King Jr. Hospital (Trigger Cut)  
Eliminates the supplemental payment for MLK. General Fund savings of \$8.2 million in 20-21 and \$12.4 million ongoing. This proposal may be “triggered off” if the feds government provides sufficient funding to restore.
- Medi-Cal Estate Recovery Policy (Trigger Cut)  
Reinstates the Medi-Cal estate recovery policy in place before the 2016 Budget Act. General Fund savings of \$17 million. This proposal may be “triggered off” if the feds government provides sufficient funding to restore.
- IHSS (Trigger Cut)  
IHSS service hours will be cut by a 7 percent reduction in the number of hours provided to IHSS beneficiaries, effective 1/1/21. General Fund savings of \$205 million in 2020-21. This proposal may be “triggered off” if the feds government provides sufficient funding to restore.
- FQHC (Trigger Cut)  
Eliminates special carve outs for FQHCs. General Fund savings of \$50 million in 2020-21. This proposal may be “triggered off” if the feds government provides sufficient funding to restore.
- Hospital Presumptive Eligibility  
Expands HPE to include those individuals that are aged (65+), disabled and blind. Additionally, allows those to apply twice in a 12-month period (currently disallowed).
- Skilled Nursing Facilities  
Effective 03/01/20, the budget provides for a 10 percent rate increase for SNF’s and ICF-DDs during the pandemic. Will get the increase for full duals in CCI but will not receive the rate increase for the non-duals. General Fund Cost of \$72.4 million in 2019-20 and \$41.6 million in 2020-21.
- Covered California – State Subsidies  
Maintains expanded state-financed subsidies in Covered California, including the extension of subsidies to individuals between 400% and 600% FPL (up to \$75,000 for individuals and \$150,000 for a family of four).
- Covered California Adjustments
  - Lower-than-projected enrollment in state subsidies resulting in a General Fund cost of \$164.2 million 2019-20, and \$90.3 million General Fund costs in 2020-21.
  - Individual mandate penalty revenues resulting in an increase of General Fund savings of \$15 million in 2020-21.
- Pharmacy Carve-Out  
The May Revision continues to assume a 01/01/21 implementation date of the Medi-Cal pharmacy carve out.
- Homelessness  
Following are significant adjustments made to homelessness proposals:
  - Eliminate the *California Access to Housing and Services Fund*. Eliminates the fund to support the development of affordable housing, rental subsidies, and stabilized board and care facilities. General Fund savings of \$750 million.
  - Federal Funding Equivalent for Project Roomkey: The May Revision proposes \$750 million in federal funding to purchase hotels and motels secured through Project Roomkey. These units

will be owned and operated by local governments or non-profit providers. To date, the following funding has already been allocated for Project Roomkey:

- \$100 million to local governments and continuums of care.
- \$50 million allocated to DSS to secure hotel and motel rooms and trailers to house homeless populations.
- As of mid-May, there are 15,000 hotel and motel units secured of which 7,200 occupied, and 1,305 trailers have purchased and disbursed to local governments.

### **Medi-Cal Revenue Sources**

- **Enhanced FMAP**
  - General Fund savings of \$5.1 billion due to federal enhanced FMAP of 6.2%.
- **MCO Tax**
  - General Fund savings of \$1.7 billion due to MCO Tax revenue in 2020-21.
- **Drug Rebate Reserve**
  - General Fund savings \$181 million due to not restoring a drug rebate volatility reserve.

Government Affairs will continue to provide updates on the budget as more details emerge. If you have any questions, please contact Cherie Compartore, Senior Director of Government Affairs, at [ccompartore@lacare.org](mailto:ccompartore@lacare.org) or 916.216.7963.



# 2020 Legislative Matrix

Last Updated: May 18, 2020

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The following is a list of priority legislation currently tracked by Government Affairs that has been introduced during the 2020-2021 Legislative Session and is of interest to L.A. Care. If there are any questions, please contact Cherie Compartore, Senior Director of Government Affairs at [ccompartore@lacare.org](mailto:ccompartore@lacare.org) or extension 5481.

In response to COVID-19, the state legislature voted to recess in order to allow members and staff to observe social distancing until May, resulting in a compressed legislative calendar. Additionally, COVID-19 has reduced the state's 2020-2021 revenues and increased emergency spending; the budget will be "slimmed down" since the state's needs, resources and available time have changed. As a result, the Assembly and Senate leadership have directed their members to only carry bills that directly relate to COVID-19 and to drop all other bills that do not directly relate to the crisis and to run them next year. However, there has been no official direction from Senate and Assembly leadership on what bills will move through the process; and members have been justifying their bill packages even though some of the issues are only tangentially related to COVID-19. The legislative matrix includes the bills that could directly impact L.A. Care and have not been confirmed dropped by the author.

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## Direct Impact Bills

**Bill State: CA (54)**

**Title**  
Wellness programs.

**Introduction Date:** 2019-02-15

**Description**

AB 648, as amended, Nazarian. Wellness programs. (1) Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacted various health care coverage market reforms that took effect January 1, 2014. Among other things, PPACA sets forth various requirements related to wellness programs, which encompass programs of health promotion or disease prevention. 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 (department) and makes a willful violation of the act a crime. Existing law also provides for the regulation of various insurers by the Department of Insurance, headed by the Insurance Commissioner. This bill would prohibit health care service plans and insurers from sharing any personal information or data collected through a wellness program, except as specified, and would prohibit health care service plans or insurers from taking any adverse action, as defined, against an enrollee or member, or insured (individual), if the action of the health care service plans or insurers is in response to an individual's election to not participate in a wellness program. The bill would establish and impose upon health care service plans and insurers various requirements related to a wellness program, such as requiring a health care service plan or insurer to post a written explanation that is reasonably likely to be understood by an individual on its internet website concerning its policies and practices pertaining to wellness programs, as specified. The bill would require a health care service plan or insurer, for purposes of administering and operating a wellness program, to limit its collection, dissemination, retention, and use of any personal information of an individual to only information that is reasonably necessary to operate a wellness program, except as specified, and would extend various requirements, to the extent that they are applicable, to any entity that the health care service plan or insurer contracts with for purposes of administering or operating a wellness program on their behalf. The bill would authorize the commissioner to assess penalties on an insurer for any violation of these provisions, as specified. Because a willful violation of these requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program. (2) Existing law establishes the Division of Labor Standards Enforcement, headed by the Labor Commissioner, within the Department of Industrial Relations, for the purpose of enforcing labor laws, including those relating to employer retaliation. This bill would, among other things, prohibit... (click bill link to see more).

**Primary Sponsors**

Adrin Nazarian

**Organizational Notes**

Last edited by Joanne Campbell at Mar 26, 2019, 7:22 PM  
Organizational Sponsor: Consumer Reports California Association of Health Plans - Oppose

**Title** **Introduction Date:** 2019-02-19  
California Consumer Privacy Act of 2018.

**Description**

AB 713, as amended, Mullin. California Consumer Privacy Act of 2018. (1) Existing law, the California Consumer Privacy Act of 2018 (CCPA), grants a consumer various rights with regard to personal information relating to that consumer collected by a business, including the right to know the categories and the specific pieces of personal information that have been collected and to opt out of the sale of personal information. The act also grants a consumer the right to request a business to delete any personal information about the consumer collected by the business and requires a business to do so upon receipt of a verified request, except as specified. The act excepts certain categories of personal information and entities from its provisions, including medical information, as specified. This bill would except from the CCPA information that was deidentified in accordance with specified federal law, was derived from protected health information, individually identifiable health information, or identifiable private information, consistent with specified federal policy, as provided. The bill also would except from the CCPA a business associate of a covered entity, as defined, that is governed by federal privacy, security, and data breach notification rules if the business associate maintains, uses, and discloses patient information in accordance with specified requirements. This bill would additionally except personal information that is collected for, or used in, biomedical research subject to institutional review board standards and the ethics and privacy laws of an identified federal policy, specified clinical practice guidelines, or human subject protection requirements of the United States Food and Drug Administration (FDA). The bill would further except personal information of certain types that is collected for, or used in, research, as defined, and, as specified, personal information collected by a business for purposes of product registration and tracking regulated by the FDA, specified public health activities, or quality, safety, or effectiveness compliance regulated by the FDA. The bill would define terms for these purposes. (2) The CCPA requires a business to make certain disclosures to consumers, in a specified form, in its online privacy policy, if the business has an online privacy policy, and in any California-specific description of consumers' privacy rights, or, if the business does not maintain an online privacy policy or policies, on its internet website, and to update that information at least once every 12 months. This bill would require a business that sells or discloses information that was deidentified in accordance with specified federal law, was derived from protected health information, individua... (click bill link to see more).

**Primary Sponsors**

Kevin Mullin

**Title**

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

**Introduction Date:** 2019-02-20

**Description**

AB 890, as amended, Wood. Nurse practitioners: scope of practice: practice without standardized procedures. Existing law, the Nursing Practice Act, provides for the certification and regulation of nurse practitioners by the Board of Registered Nursing. Existing law authorizes the implementation of standardized procedures that authorize a nurse practitioner to perform certain acts that are in addition to other authorized practices, including certifying disability after performing a physical examination and collaboration with a physician and surgeon. A violation of the act is a misdemeanor. This bill, until January 1, 2026, would establish the Advanced Practice Registered Nursing Board within the Department of Consumer Affairs, which would consist of 9 members. The bill would require the board, by regulation, to define minimum standards for a nurse practitioner to transition to practice without the routine presence of a physician and surgeon. The bill would authorize a nurse practitioner who meets certain education, experience, and certification requirements to perform, in certain settings or organizations, specified functions without standardized procedures, including ordering, performing, and interpreting diagnostic procedures, certifying disability, and prescribing, administering, dispensing, and furnishing controlled substances. The bill would also authorize a nurse practitioner to perform those functions without standardized procedures outside of specified settings or organizations in accordance with specified conditions and requirements if the nurse practitioner holds an active certification issued by the board. The bill would require the board to issue that certification to a nurse practitioner who meets additional specified education and experience requirements. The bill would also require the board to request the department's Office of Professional Examination Services, or an equivalent organization, to perform an occupational analysis of nurse practitioners performing certain functions. The bill would require the board to take specified measures to identify and assess competencies. The bill would require the board to identify and develop a supplemental examination for licensees if needed based on the assessment, as provided. Existing law makes it unlawful for specified healing arts practitioners, including physicians and surgeons, psychologists, and acupuncturists, to refer a person for certain services, including laboratory, diagnostic nuclear medicine, and physical therapy, if the physician and surgeon or their immediate family has a financial interest with the person or in the entity that receives the referral. A violation of those provisions is a misdemeanor and subject to specified civil penalties a... (click bill link to see more).

**Primary Sponsors**

Jim Wood

**Title**  
Health care service plans: regulations: exemptions.

**Introduction Date:** 2019-02-21

**Description**

AB 1124, as amended, Maienschein. Health care service plans: regulations: exemptions. Existing federal law defines a voluntary employees' beneficiary association as an organization composed of a voluntary association of employees that provides for the payment of life, sick, accident, or similar benefits to members, their dependents, or designated beneficiaries. Existing federal law defines a welfare plan as any plan, fund, or program established or maintained by an employer or employee organization, or both, for the purpose of providing participants or their beneficiaries specified benefits, such as medical, surgical, or hospital care or benefits. Existing law further defines a multiemployer plan as a plan to which more than one employer is required to contribute, that is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer, and that meets other specified requirements. 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 the willful violation of the act a crime. Existing law exempts specified persons or plans from the requirements of the act and authorizes the Director of the Department of Managed Health Care (director) to exempt additional specified persons or plans if the director finds, among other things, that the exemption is in the public interest. Under existing law, upon the request of the Director of Health Care Services, the director must exempt a county-operated pilot program contracting with the State Department of Health Care Services, and may exempt a noncounty-operated pilot program, subject to any conditions the Director of Health Care Services deems appropriate. Existing law also exempts a health care service plan operated by a city, county, city and county, public entity, political subdivision, or public joint labor management trust that satisfies certain criteria, including that the plan requires providers to be reimbursed solely on a fee-for-service basis. This bill would authorize the director, no later than an unspecified date, to authorize 2 pilot programs, one in northern California and one in southern California, under which providers approved by the department may undertake risk-bearing arrangements with a voluntary employees' beneficiary association with enrollment of more than 100,000 lives, notwithstanding the fee-for-service requirement described above, or a trust fund that is a welfare plan and a multiemployer plan with enrollment of more than 25,000 lives, if certain criteria are met, including that each risk-bearing provider is registered with the department as a r... (click bill link to see more).

**Primary Sponsors**

Brian Maienschein

**Title**

Healing arts licensees: virginity examinations or tests.

**Introduction Date:** 2020-01-08

**Description**

AB 1909, as introduced, Gonzalez. Healing arts licensees: virginity examinations or tests. Existing law establishes the Department of Consumer Affairs in the Business, Consumer Services, and Housing Agency. The department is composed of boards for purposes of licensing and regulating various professions and vocations, including healing arts licensees. The boards are established for the purpose of ensuring that those private businesses and professions deemed to engage in activities that have potential impact upon the public health, safety, and welfare are adequately regulated in order to protect the people of California. Existing law makes certain acts by a healing arts licensee, including, but not limited to, sexual abuse, misconduct, or relations with a patient, unprofessional conduct and grounds for disciplinary action. This bill would prohibit a healing arts licensee, as defined, from performing an examination or test on a patient for the purpose of determining whether the patient is a virgin. The bill would also make a violation of its provisions unprofessional conduct and grounds for disciplinary action by the licensing board for the healing arts licensee.

**Primary Sponsors**

Lorena Gonzalez Fletcher

**Title** Introduction Date: 2020-01-16  
Prescription drugs: 340B discount drug purchasing program.

**Description**

AB 1938, as amended, Low. Prescription drugs: 340B discount drug purchasing program. 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 federal law requires the United States Secretary of Health and Human Services to enter into an agreement with each manufacturer of covered drugs that are not subject to a rebate under an agreement between the state Medicaid program and the manufacturer under which the amount required to be paid to the manufacturer for covered drugs purchased by a covered entity does not exceed an amount equal to the average manufacturer price for the drug under the federal Medicaid program in the preceding calendar quarter, reduced by the rebate received pursuant to the Medicaid agreement. This program is commonly referred to as the 340B Drug Pricing program or 340B program. Existing state law requires a covered entity to dispense only the above-described drugs to Medi-Cal beneficiaries, authorizes a covered entity that is unable to purchase the above-described drugs to dispense a drug purchased at regular drug wholesale rates to a Medi-Cal beneficiary if the covered entity maintains documentation of their inability to obtain the drugs, and requires a not-for-profit hospital that participates in the drug discount program established under federal law to enter into an agreement with the department that includes specified terms, including that the not-for-profit hospital continues its historic commitment to the provision of charity care. This bill would define a "designated entity" as a nonprofit organization, including any subsidiary of that organization, that individually or collectively with one or more of its subsidiaries meets specified requirements, including that the designated entity is a licensed managed care organization that has previously contracted with the department as a primary care case management organization, contracts with the federal Centers for Medicare and Medicaid Services to provide services in the Medicare Program as a Medicare special needs plan, and participates in the 340B program. The bill would prohibit a designated entity from using any revenue from a contract with the department, a contract with the federal Centers for Medicare and Medicaid Services, and from the 340B program on specified activity, such as funding litigation under the California Environmental Quality Act. The bill would require a designated entity, and any subsidiary of that entity, to annually report on its internet website specified information, including the amou... (click bill link to see more).

**Primary Sponsors**

Evan Low, Susan Eggman, Scott Wiener

**Title**

Family Planning, Access, Care, and Treatment (Family PACT) Program.

**Introduction Date:** 2020-01-21

**Description**

AB 1965, as introduced, Aguiar-Curry. Family Planning, Access, Care, and Treatment (Family PACT) Program. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care 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. Existing law provides that comprehensive clinical family planning services under the program includes preconception counseling, maternal and fetal health counseling, and general reproductive health care, among other things. This bill would expand comprehensive clinical family planning services under the program to include the human papillomavirus (HPV) vaccine for persons of reproductive age.

**Primary Sponsors**

Cecilia Aguiar-Curry

**Title**

Health care coverage: abortion services: cost sharing.

Introduction Date: 2020-01-22

**Description**

AB 1973, as amended, Kamlager. Health care coverage: abortion services: cost sharing. Existing law, the Reproductive Privacy Act, provides that the state may not deny or interfere 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 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 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, 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 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 of disability insurance that is issued, amended, renewed, or delivered on or after January 1, 2021, from imposing a deductible, coinsurance, copayment, or any other cost-sharing requirement on coverage for all abortion services, as specified, and additionally would prohibit cost sharing from being imposed on a Medi-Cal beneficiary for those services. The bill would apply the same benefits with respect to an enrollee's or insured's covered spouse and covered nonspouse dependents. The bill would not require an individual or group health care service plan contract or disability insurance policy to cover an experimental or investigational treatment. 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**

Sydney Kamlager

**Title**  
Eligibility.

**Introduction Date:** 2020-01-27

**Description**

AB 1994, as amended, Holden. Eligibility. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law provides for the suspension of Medi-Cal benefits to an inmate of a public institution, which ends on the date they are no longer an inmate of a public institution or one year from the date they become an inmate of a public institution, whichever is sooner. Existing law requires county welfare departments to notify the department within 10 days of receiving information that an individual who is receiving Medi-Cal is or will be an inmate of a public institution. Existing law generally requires a county to redetermine a Medi-Cal beneficiary's eligibility to receive Medi-Cal benefits every 12 months and whenever the county receives information about changes in a beneficiary's circumstances that may affect their eligibility for Medi-Cal benefits. Existing federal law, the SUPPORT for Patients and Communities Act, prohibits a state from terminating Medi-Cal eligibility for an eligible juvenile if they are an inmate of a public institution, authorizes the suspension of Medicaid benefits to that eligible juvenile, and requires a state to conduct a redetermination of Medicaid eligibility or process an application for medical assistance under the Medicaid program for an eligible juvenile who is an inmate of a public institution. This bill would instead require the suspension of Medi-Cal benefits to an inmate of a public institution to end on the date they are no longer an inmate of a public institution or 3 years from the date they become an inmate of a public institution, whichever is sooner. The bill would conform state law with those specified federal provisions, and would impose those responsibilities on county welfare departments. The bill would require the county welfare department to suspend Medi-Cal benefits to an eligible juvenile in conformity with the above-specified suspension standard. Because counties are required to make Medi-Cal eligibility determinations, and the bill would expand Medi-Cal determinations of eligibility for eligible juveniles of public institutions, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those... (click bill link to see more).

**Primary Sponsors**

Chris Holden

**Title**

Introduction Date: 2020-01-28

Medi-Cal: federally qualified health center: rural health clinic: telehealth.

**Description**

AB 2007, as introduced, Salas. Medi-Cal: federally qualified health center: rural health clinic: telehealth. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services, 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. FQHC and RHC services are reimbursed, to the extent that federal financial participation is obtained, to providers on a per-visit basis, and a "visit" is defined as a face-to-face encounter between a patient of an FQHC or RHC and specified health care professionals, including dental providers. Existing law prohibits a requirement of in-person contact between a health care provider and a Medi-Cal patient when the service may be provided by telehealth, and, for purposes of telehealth, prohibits the department from limiting the type of setting where Medi-Cal services are provided. Existing law authorizes, to the extent that federal financial participation is available, the use of health care services by store and forward under the Medi-Cal program, subject to billing and reimbursement policies developed by the department, and prohibits a requirement of in-person contact between a health care provider and a Medi-Cal patient when these services are provided by store and forward. This bill would provide that an FQHC or RHC "visit" includes an encounter between an FQHC or RHC patient and a health care provider using telehealth by synchronous real time or asynchronous store and forward. The bill would clarify, for purposes of an FQHC or RHC visit, that face-to-face contact between a health care provider and a patient is not required for an FQHC or RHC to bill for telehealth by synchronous real time or asynchronous store and forward if specified requirements are met, including that a billable provider in the Medi-Cal program, and who is employed by the FQHC or RHC, supervises or provides the services for that patient via telehealth by synchronous real time or asynchronous store and forward.

**Primary Sponsors**

Rudy Salas

**Organizational Notes**

Last edited by Cherie Compartore at Mar 10, 2020, 9:23 PM

Organization Sponsor: California Primary Care Association, Children's Partnership, Children Now, and CaliforniaHealth + Advocates, California Dental Assoc.

**Title**

Mental illness and substance use disorder: restorative care program: pilot projects.

**Introduction Date:** 2020-01-30

**Description**

AB 2025, as amended, Gipson. Mental illness and substance use disorder: restorative care program: pilot projects. Existing law, the Bronzan-McCorquodale Act, governs the organization and financing of community mental health services for persons with mental disorders in every county through locally administered and locally controlled community mental health programs. Existing law authorizes the State Department of Health Care Services, in its discretion, to permit new programs to be developed and implemented without complying with licensure requirements established pursuant to existing state law, except for requirements relating to fire and life safety of persons with mental illness. This bill would also include within that exception requirements relating to fire and life safety of persons with alcohol or substance use disorder. The bill would, subject to the above licensing provisions, authorize the County of Los Angeles to establish a pilot project for up to 6 years to develop a restorative care program for community-based care and treatment that addresses the interrelated and complex needs of individuals suffering from mental illness and substance use disorder, along with other medical comorbidities, and homelessness. The bill would require the department, in conjunction with the Los Angeles County Director of Mental Health, to report to the Legislature within 2 years of the commencement of the operation of the initial facility regarding the progress and cost-effectiveness demonstrated by the pilot project. Under the bill, authorization for the pilot projects would be repealed as of January 1, 2026. This bill would declare that it is to take effect immediately as an urgency statute.

**Primary Sponsors**

Mike Gipson

**Title** Introduction Date: 2020-01-30  
Medi-Cal: medically necessary services.

**Description**

AB 2032, as amended, Wood. Medi-Cal: medically necessary 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 medically necessary health care services, including specified mental health and substance use disorder services, pursuant to a schedule of benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, for individuals 21 years of age and older, a service is “medically necessary” if it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. Existing law provides that for individuals under 21 years of age, “medically necessary” or “medical necessity” standards are governed by the definition in federal law. This bill would provide that the above-specified medical necessity standards do not preclude coverage for, and reimbursement of, a clinically appropriate and covered mental health or substance use disorder assessment, screening, or treatment service before a provider renders a diagnosis.

**Primary Sponsors**

Jim Wood

**Title**

Specialty mental health services and substance use disorder treatment.

Introduction Date: 2020-02-03

**Description**

AB 2055, as amended, Wood. Specialty mental health services and substance use disorder treatment. (1) 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 behavioral health services, which encompass specialty mental health services and substance use disorder treatment that are provided under the Medi-Cal Specialty Mental Health Services Program, the Drug Medi-Cal Treatment Program, and the Drug Medi-Cal organized delivery system, respectively. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions, and specialty mental health services and substance use disorder treatment are funded through certified public expenditures. Existing law requires the department to implement managed mental health care for purposes of delivering specialty mental health services to Medi-Cal beneficiaries through contracts with county mental health plans. 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 Medi-Cal Healthier California for All initiative, for purposes of building upon the outcomes of various Medi-Cal pilots and demonstration projects, including the Medi-Cal 2020 demonstration project. This bill would require the department to establish, implement, and administer the Behavioral Health Quality Improvement Program to assist county mental health plans and counties that administer the Drug Medi-Cal Treatment Program or the Drug Medi-Cal organized delivery system for purposes of preparing those entities for implementation of the behavioral health components included in the Medi-Cal Healthier California for All initiative, and would establish in the State Treasury the Behavioral Health Quality Improvement Account to fund those efforts. The bill would require the department to determine the methodology and distribution of funds appropriated to those entities. The bill would authorize the department to implement these provisions by various means, including provider bulletin, without taking regulatory action, and to enter into contracts that would be exempt from specified provisions of state contracting requirements. The bill would condition the implementation of these provisions to the extent that the department determines that federal fin... (click bill link to see more).

**Primary Sponsors**

Jim Wood

**Title**

Medi-Cal: pharmacy benefits.

**Introduction Date:** 2020-02-05

**Description**

AB 2100, as amended, Wood. Medi-Cal: pharmacy benefits.

(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 Knox-Keene Health Care Service Plan Act provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Under this act, a health care service plan is required to provide an external, independent review process, which meets prescribed standards, to examine the plan's coverage decisions on experimental or investigational therapies for an enrollee who meets specified criteria, including that the enrollee was denied coverage by the plan for a drug, device, procedure, or other therapy recommended or requested. Existing law 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. By executive order, the Governor directed the department to transition pharmacy services for Medi-Cal managed care to a fee-for-service benefit by January 1, 2021. Existing law requires the department to convene an advisory group to receive feedback on the changes, modifications, and operational timeframes on the implementation of pharmacy benefits offered in the Medi-Cal program, and to provide regular updates on the pharmacy transition, including a description of changes in the division of responsibilities between the department and managed care plans relating to the transition of the outpatient pharmacy benefit to fee-for-service. This bill would require the department to establish the Independent Prescription Drug Medical Review System (IPDMRS), commencing on January 1, 2021, 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 grievance involving a disputed health care service is eligible for review under the IPDMRS, and would define "disputed health care service" as any outpatient prescription drug eligible for coverage and payment by the Medi-Cal program ... (click bill link to see more).

**Primary Sponsors**

Jim Wood

**Organizational Notes**

Last edited by Cherie Compartore at Mar 3, 2020, 7:07 PM

Organization Sponsor: CA Pharmacists Association, Western Center on Law & Poverty

**Title**

Health care service plans and health insurers: reporting requirements.

**Introduction Date:** 2020-02-06

**Description**

AB 2118, as amended, Kalra. Health care service plans and health insurers: reporting requirements. 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 offering a contract or policy in the individual, small, and large group markets to file specified information, including total earned premiums and total incurred claims for each contract or policy form, with the appropriate department at least 120 days before implementing a rate change. Existing law requires a large group market health care service plan or insurer to report additional information relating to cost sharing and specified aggregate rate information. Existing law requires the Department of Managed Health Care and the Department of Insurance to conduct an annual public meeting regarding large group rates. This bill would expand reporting requirements for health care service plans and health insurers, for products in the individual and small group markets to include, for rates effective during the 12-month period ending January 1 of the following year, specified information on premiums, cost sharing, benefits, enrollment, and trend factors as reported in all rate filings for the health care service plan or insurer, including both price and utilization. The bill would require each department, beginning in 2022, to annually present the information required by the bill at the meeting regarding large group rates and at a public meeting of the board of Covered California, as specified. 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**

Ash Kalra

**Organizational Notes**

Last edited by Joanne Campbell at May 18, 2020, 9:16 PM  
Organization Sponsor: Health Access CAHP: Opposed Unless Amended

**Title**  
Health care coverage: step therapy.

**Introduction Date:** 2020-02-10

**Description**

AB 2144, as amended, Arambula. Health care coverage: step therapy. Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law authorizes a health insurer to require step therapy if there is more than one drug that is appropriate for the treatment of a medical condition, and authorizes a health care service plan to utilize step therapy consistent with Knox-Keene. Under existing law, if a health care service plan, health insurer, or contracted physician group fails to respond to a completed prior authorization request from a prescribing provider within a specified timeframe, the prior authorization request is deemed to have been granted. This bill would clarify that a health care service plan may require step therapy if there is more than one drug that is appropriate for the treatment of a medical condition. The bill would require a health care service plan or health insurer to expeditiously grant a step therapy exception if specified criteria are met. The bill would authorize an enrollee or insured or their designee, guardian, primary care physician, or health care provider to file an appeal of a prior authorization or the denial of a step therapy exception request, and would require a health care service plan or health insurer to designate a clinical peer to review those appeals. The bill would require a health care service plan, health insurer, or utilization review organization to annually report specified information about their step therapy exception requests and prior authorization requests to the Department of Managed Health Care or the Department of Insurance, as appropriate. The bill would require a prior authorization request or step therapy exception request to be deemed to have been granted if a health care service plan, health insurer, or contracted physician group fails to send an approval or denial within a specified timeframe. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

**Primary Sponsors**

Joaquin Arambula

**Organizational Notes**

Last edited by Cherie Compartore at Mar 3, 2020, 7:11 PM  
Organization Note: Arthritis Foundation, CA Rheumatology Alliance

**Title**

Health care coverage: independent dispute resolution process.

**Introduction Date:** 2020-02-10

**Description**

AB 2157, as introduced, Wood. Health care coverage: independent dispute resolution process. Existing law provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and provides for the regulation of health insurers by the Department of Insurance. Existing law requires each department to establish an independent dispute resolution process to resolve a claim dispute between a health care service plan or health insurer, as appropriate, and a noncontracting individual health professional, and sets forth requirements and guidelines for that process, including contracting with an independent organization for the purpose of conducting the review process. Existing law requires each department to establish uniform written procedures for the submission, receipt, processing, and resolution of these disputes, as specified. Existing law requires the independent organization, in deciding the dispute, to base its decision regarding the appropriate reimbursement on all relevant information. This bill would require the procedures established by each department to include a process for each party to submit into evidence information that will be kept confidential from the other party, in order to preserve the confidentiality of the source contract. The bill would specifically require the independent organization to conduct a de novo review of the claim dispute, based solely on the information and documents timely submitted into evidence by the parties. The bill would require the independent organization to assign reviewers to each case based on their relevant education, background, and medical claims payment and clinical experience.

**Primary Sponsors**

Jim Wood

**Title**  
Health care coverage.

**Introduction Date:** 2020-02-10

**Description**

AB 2158, as introduced, Wood. Health care coverage. Existing federal law, the Patient Protection and Affordable Care Act (PPACA), enacts various health care market reforms. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a group or individual health care policy issued, amended, renewed, or delivered on or after September 23, 2010, to comply with the requirements of the PPACA, and any rules or regulations issued under the PPACA, that require a group health plan and health insurance issuer offering group or individual health insurance coverage to, at a minimum, provide coverage for specified preventive services, and prohibits the plan or health insurance issuer from imposing any cost-sharing requirements for those preventive services. Existing law requires a health insurer to comply with those provisions to the extent required by federal law. This bill would delete the requirement that a health insurer comply with the requirement to cover preventive health services without cost sharing to the extent required by federal law, and would instead require a group or individual health insurance policy to, at a minimum, provide coverage for specified preventive services without any cost-sharing requirements for those preventive services, thereby indefinitely extending those requirements.

**Primary Sponsors**

Jim Wood

**Title**  
Health care coverage.

**Introduction Date:** 2020-02-10

**Description**

AB 2159, as introduced, Wood. Health care coverage. The federal Patient Protection and Affordable Care Act (PPACA) enacts various health care market reforms. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health insurer that issues, sells, renews, or offers plan contracts for health care coverage in the state to comply with the requirements of the PPACA, and any rules or regulations issued under the PPACA, that generally prohibit a health insurer offering group or individual coverage from imposing lifetime or annual limits on the dollar value of benefits for an insured. Existing law requires an insurer to comply with those provisions to the extent required by federal law. This bill would delete the requirement that a health insurer comply with the prohibition on lifetime or annual limits to the extent required by federal law, and would instead prohibit an individual or group health insurance policy from establishing lifetime or annual limits on the dollar value of benefits for an insured, thereby indefinitely extending the prohibitions on lifetime or annual limits.

**Primary Sponsors**

Jim Wood

**Title**  
Eligibility: redetermination.

**Introduction Date:** 2020-02-11

**Description**

AB 2170, as introduced, Blanca Rubio. Eligibility: redetermination. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law provides for the suspension of Medi-Cal benefits to an inmate of a public institution, and requires county welfare departments to notify the department within 10 days of receiving information that an individual who is receiving Medi-Cal is or will be an inmate of a public institution. Existing law generally requires a county to redetermine a Medi-Cal beneficiary's eligibility to receive Medi-Cal benefits every 12 months and whenever the county receives information about changes in a beneficiary's circumstances that may affect their eligibility for Medi-Cal benefits. This bill would require a county welfare department to conduct a redetermination of eligibility for the Medi-Cal program for any juvenile who is either detained at a juvenile detention center or an inmate of a public institution, and would provide that Medi-Cal eligibility be restored upon their release from that facility if they meet eligibility requirements. Because counties are required to make Medi-Cal eligibility determinations, and the bill would expand Medi-Cal determinations of eligibility for eligible juveniles in public institutions, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

**Primary Sponsors**

Blanca Rubio

**Title**  
Insulin cost-sharing cap.

**Introduction Date:** 2020-02-12

**Description**

AB 2203, as amended, Nazarian. Insulin cost-sharing cap. 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 requires every health care service plan contract that covers hospital, medical, or surgical expenses to include coverage for specified equipment and supplies for the management and treatment of diabetes. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health insurance policy issued, amended, delivered, or renewed on or after January 1, 2000, to include coverage for specified equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes as medically necessary, even if the items are available without a prescription. Existing law requires a health insurance policy issued, amended, delivered, or renewed on or after January 1, 2000, that covers prescription benefits to include coverage for specified diabetes management prescription items, including insulin and glucagon. 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, 2021, from imposing cost sharing on a covered insulin prescription, except for a copayment not to exceed \$50 per 30-day supply of insulin, and no more than \$100 total per month, regardless of the amount or type of insulin. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

**Primary Sponsors**

Adrin Nazarian

**Organizational Notes**

Last edited by Joanne Campbell at May 18, 2020, 9:15 PM  
Organization Sponsor: American Diabetes Association CAHP: Opposed

**Title** Introduction Date: 2020-02-12  
Transgender Wellness and Equity Fund.

**Description**

AB 2218, as amended, Santiago. Transgender Wellness and Equity Fund. 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. This bill would establish the Transgender Wellness and Equity Fund, under the administration of the office, for grants to transgender-led (Trans-led) organizations and hospitals, health care clinics, and other medical providers that provide gender-conforming health care services and have an established partnership with a Trans-led organization, to create, or fund existing, programs focused on coordinating trans-inclusive health care, as defined, for people that identify as transgender, gender nonconforming, or intersex. The bill would appropriate \$15,000,000 from the General Fund to the Transgender Wellness and Equity Fund, established pursuant to this bill, for these purposes.

**Primary Sponsors**

Miguel Santiago, Scott Wiener

**Title**

Medi-Cal: Blood lead screening tests.

**Introduction Date:** 2020-02-14

**Description**

AB 2276, as amended, Reyes. Medi-Cal: Blood lead screening tests. 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 authorizes the department to enter contracts with managed care plans to provide Medi-Cal services, and imposes requirements on the Medi-Cal managed care plans, including network adequacy standards. Under existing law, Medi-Cal covers early and periodic screening, diagnostic, and treatment for individuals under 21 years of age, consistent with federal law. This bill would require the department to ensure that a Medi-Cal beneficiary who is a child receives blood lead screening tests at specified ages consistent with state regulatory standards, and would require a contract between the department and a Medi-Cal managed care plan to ensure that the Medi-Cal managed care plan and its contracting health care providers who are responsible for performing a periodic health assessment of a child meet specified standard of care requirements relating to blood lead testing. The bill would require the department to report its progress toward blood lead screening tests for Medi-Cal beneficiaries who are children, as specified, annually on its internet website. The bill would require each Medi-Cal managed care plan to establish a monitoring system related to blood lead screening tests, to require its contracting health care providers who are responsible for performing a periodic health assessment of a child to test each child pursuant to specified standards of care for lead testing, to inform a child's parent, parents, guardian, or other person charged with their support and maintenance with specified information, including the risks and effects of lead exposure, and to notify a child's health care provider when that child has missed a required blood lead screening test. The bill would provide that it is the goal of the state that children at risk of lead exposure receive blood lead screening tests.

**Primary Sponsors**

Eloise Reyes, Cristina Garcia, Bill Quirk, Rudy Salas, Connie Leyva

**Title**

Medi-Cal: Blood lead screening tests.

**Introduction Date:** 2020-02-14

**Description**

AB 2277, as amended, Salas. Medi-Cal: Blood lead screening tests. 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 authorizes the department to enter contracts with managed care plans to provide Medi-Cal services. Under existing law, Medi-Cal covers early and periodic screening, diagnosis, and treatment for individuals under 21 years of age, consistent with federal law. This bill would require any contract between the department and a Medi-Cal managed care plan to impose requirements on the Medi-Cal managed care plan to identify every enrollee who does not have a record of completing those tests at 12 and 24 months of age, and to remind the contracting health care provider who is responsible for performing a periodic health assessment of a child of the need to perform those tests. The bill would require the department to develop and implement procedures, and take enforcement action, as prescribed, to ensure that a Medi-Cal managed care plan performs those duties. If a Medi-Cal managed care plan enrollee who is a child misses a required blood lead screening test at 12 and 24 months of age, the bill would require the Medi-Cal managed care plan to notify specified individuals responsible for that child, including the parent or guardian, about those missed blood lead screening tests, and would require that notification to be included as part of an annual notification on preventive services.

**Primary Sponsors**

Rudy Salas, Cristina Garcia, Bill Quirk, Eloise Reyes, Connie Leyva

**Title**  
Lead screening.

**Introduction Date:** 2020-02-14

**Description**

AB 2278, as amended, Quirk. Lead screening. Existing law requires the State Department of Public Health to maintain an electronic database to support electronic laboratory reporting of blood lead tests, management of lead-exposed children, and assessment of sources of lead exposures. Existing law requires a laboratory that performs a blood lead analysis on human blood drawn in California to report specified information, including the test results and the name, birth date, and address of the person tested, to the department for each analysis on every person tested. Existing law authorizes the department to share the information reported by a laboratory with, among other entities, 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 also would additionally require a laboratory that performs a blood lead analysis to report to the department, among other things, the Medi-Cal identification number and medical plan identification number, if available, for each analysis on every person tested.

**Primary Sponsors**

Bill Quirk, Cristina Garcia, Tim Grayson, Eloise Reyes, Rudy Salas, Connie Leyva

**Title**  
Information privacy: digital health feedback systems.

**Introduction Date:** 2020-02-14

**Description**

AB 2280, as introduced, Chau. Information privacy: digital health feedback systems. Existing law, the Confidentiality of Medical Information Act, generally prohibits a provider of health care, a health care service plan, or a contractor from disclosing medical information regarding a patient of the provider of health care or an enrollee or subscriber of a health care service plan without first obtaining an authorization, except as otherwise specified. Existing law defines "medical information" for purposes of these provisions to mean certain individually identifiable health information in possession of or derived from a provider of health care, among others. Existing law makes a violation of these provisions that results in economic loss or personal injury to a patient punishable as a misdemeanor. This bill would define "personal health record information" for purposes of the act to mean individually identifiable information, in electronic or physical form, about an individual's mental or physical condition that is collected by an FDA-approved commercial internet website, online service, or product that is used by an individual at the direction of a provider of health care with the primary purpose of collecting the individual's individually identifiable personal health record information through a direct measurement of an individual's mental or physical condition or through user input regarding an individual's mental or physical condition. The bill would provide that a business that offers personal health record software or hardware to a consumer, in order to make information available to an individual or provider of health care at the request of the individual or provider of health care, for purposes of allowing the individual to manage their information, or for the diagnosis, treatment, or management of a medical condition of the individual, shall be deemed to be a provider of health care subject to the requirements of the Confidentiality of Medical Information Act. Because the bill would expand the definition of a crime, it 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**

Ed Chau

**Title**  
Schedule II controlled substances: partial fill.

**Introduction Date:** 2020-02-14

**Description**

AB 2288, as introduced, Low. Schedule II controlled substances: partial fill. Existing law, the Pharmacy Law, provides for the licensing and regulation of pharmacists by the California State Board of Pharmacy in the Department of Consumer Affairs. The law specifies the functions pharmacists are authorized to perform, including to administer, orally or topically, drugs and biologicals pursuant to a prescriber's order, and to administer immunizations pursuant to a protocol with a prescriber. Existing law authorizes a pharmacist to dispense a Schedule II controlled substance as a partial fill if requested by the patient or prescriber. A violation of the Pharmacy Law is a crime. This bill would require a pharmacist to offer, to a patient, to dispense a Schedule II controlled substance containing an opioid as a partial fill if the prescription is for greater than 7 days. By expanding the scope of a crime, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

**Primary Sponsors**

Evan Low

**Title** Introduction Date: 2020-02-18  
Health care coverage: financial assistance.

**Description**

AB 2347, as amended, Wood. Health care coverage: 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. Until January 1, 2023, existing law requires the Exchange to administer a program of financial assistance, and authorizes the program to provide assistance, including premium assistance subsidies, to program participants with household incomes at or below 600% of the federal poverty level. This bill, contingent upon an appropriation by the Legislature, would reduce premiums to zero for program participants with household incomes at or below 138% of the federal poverty level, and would scale the premium assistance subsidy amount for program participants with household incomes of 139% to 600%, inclusive, of the federal poverty level pursuant to the program design adopted by the board of the Exchange.

**Primary Sponsors**

Jim Wood

**Organizational Notes**

Last edited by Cherie Compartore at Feb 20, 2020, 9:50 PM  
Organization Sponsor: Health Access

**Title**  
Pharmacy benefit management.

**Introduction Date:** 2020-02-18

**Description**

AB 2348, as amended, Wood. Pharmacy benefit management. Existing law provides for the regulation of health care service plans by the Department of Managed Health Care. A willful violation of those provisions is a crime. Existing law requires health care service plans that cover prescription drug benefits and contract with pharmacy providers and pharmacy benefit managers to meet specified requirements, including requiring pharmacy benefit managers with whom they contract to register with the department and exercise good faith and fair dealing, among other requirements. Existing law provides for the registration and regulation of pharmacy benefit managers, as defined, that contract with health care service plans to manage their prescription drug coverage. Under existing law, a pharmacy benefit manager is required to submit specified information to the department to apply to register with the department. This bill would require a pharmacy benefit manager to, beginning October 1, 2021, annually report specified information to the department regarding the covered drugs dispensed at a pharmacy and specified information about the pharmacy benefit manager's revenue, expenses, health care service plan contracts, the scope of services provided to the health care service plan, and the number of enrollees that the pharmacy benefit manager serves. The bill would require the department to compile this reported information and make the report publicly available, as specified, but would exempt records other than the report from public disclosure. The bill would include in the requirements that health care service plans are required to impose on a pharmacy benefit manager with which they contract, the requirement that the pharmacy benefit manager comply with these reporting requirements. Because a willful violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason. 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.

**Primary Sponsors**

Jim Wood

**Title** Introduction Date: 2020-02-18  
Telehealth: mental health.

**Description**

AB 2360, as amended, Maienschein. Telehealth: mental health. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of that act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plan contracts and health insurance policies that provide hospital, medical, or surgical coverage to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses, as defined, of a person of any age. Existing law also requires health care service plans and health insurers, by July 1, 2019, to develop maternal mental health programs, as specified. This bill would require health care service plans and health insurers, by January 1, 2021, to establish a telehealth consultation program that provides providers who treat children and pregnant and postpartum persons with access to a psychiatrist, as specified, in order to more quickly diagnose and treat children and pregnant and postpartum persons suffering from mental illness. The bill would require the consultation to be done by telephone or telehealth video, and would authorize the consultation to include guidance on providing triage services and referrals to evidence based treatment options, including psychotherapy. The bill would require health care service plans and insurers to communicate information relating to the telehealth program at least twice a year in writing. The bill would require health care service plans and health insurers to maintain records and data pertaining to the utilization of the program and the availability of psychiatrists in order to facilitate ongoing changes and improvements, as necessary. The bill would exempt certain specialized health care service plans and health insurers from these provisions. Because a willful violation of the bill's requirement by a health care service plan would be a crime, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

**Primary Sponsors**

Brian Maienschein

**Organizational Notes**

Last edited by Joanne Campbell at May 18, 2020, 9:15 PM  
Organization Sponsor: 2020 Mom CAHP: Opposed

**Title**  
Lead testing.

**Introduction Date:** 2020-02-19

**Description**

AB 2422, as introduced, Grayson. Lead testing. 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 United States Centers for Disease Control and Prevention 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 the standard of care for a child who is determined to be "at risk" for lead poisoning to include the screening of that child. Existing regulations require every health care provider who performs a periodic health assessment of a child to order a child who receives services from a publicly funded program for low-income children to be screened for lead poisoning. 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 department for each analysis on every person tested. 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, so long as the entity receiving the information otherwise maintains the confidentiality of the information, as specified. Existing law requires the State Department of Public Health to implement and administer a program to meet the requirements of the federal Residential Lead-Based Paint Hazard Reduction Act of 1992. Among other things, the program requires the department to establish certification requirements for persons conducting lead-related construction work, abatement, or lead hazard evaluation. Existing regulations require specified information relating to hazard evaluations for public and residential buildings to be provided to the department. This bill would add to the information that a laboratory is required to provide the Medi-Cal identification number, or other equivalent medical identification number of the person tested. The bill would require, if the person tested is a minor, that the laboratory include the person's contact information and a unique identifier, in a form to be determined by the department, as specified. This bill would require the department to develop and maintain on its internet website a public registry of lead-contaminated locations reported to the department pursuant to the provisions relating to lead hazards in buildings. The bill would require the department to ensure that personally identifiable information is not disclosed to the public. (click bill link to see more).

**Primary Sponsors**

Tim Grayson

**Title**  
Emergency ground medical transportation.

**Introduction Date:** 2020-02-20

**Description**

AB 2625, 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, 2021, 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**  
Medi-Cal: presumptive eligibility.

**Introduction Date:** 2020-02-20

**Description**

AB 2729, as introduced, Bauer-Kahan. Medi-Cal: presumptive eligibility. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing federal law, as a condition of receiving federal Medicaid funds, requires states to provide health care services to specified individuals. Existing federal law authorizes states to provide presumptive eligibility to pregnant women or children, and existing state law requires the department to provide presumptive eligibility to pregnant women and children, as specified. Under existing law, a minor may consent to pregnancy prevention or treatment services without parental consent. Under existing law, an individual under 21 years of age who qualifies for presumptive eligibility is required to go to a county welfare department office to obtain approval for presumptive eligibility. This bill would expand the presumptive eligibility for pregnant women to all pregnant people, renaming the program "Presumptive Eligibility for Pregnant People" (PE4PP). The bill would make a presumptively eligible pregnant person eligible for coverage of all medical care, services, prescriptions, and supplies available under the Medi-Cal program, except for inpatient services and institutional long-term care. The bill would also require the department to ensure that a pregnant person receiving coverage under PE4PP who applies for full-scope Medi-Cal benefits within 60 days receives coverage under PE4PP until their full-scope Medi-Cal application is approved or denied, as specified. The bill would allow a pregnant individual under 26 years of age who can consent to services without parental approval to receive presumptive eligibility by a qualified hospital. The bill would also make conforming changes. Because counties are required to make eligibility determinations, and this bill would expand Medicaid eligibility, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

**Primary Sponsors**  
Rebecca Bauer-Kahan

**Title**  
Timely access to health care.

**Introduction Date:** 2020-02-20

**Description**

AB 2775, as introduced, Ting. Timely access to health 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. 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, and existing regulations set forth these timely access standards for specified health care appointments. This bill would declare the intent of the Legislature to ensure that patients receive timely access to health care services, including nonemergency followup appointments with mental health care providers within 10 business days.

**Primary Sponsors**

Phil Ting

**Organizational Notes**

Last edited by Cherie Compartore at Mar 3, 2020, 7:41 PM  
Organization Sponsor: National Union of Healthcare Workers

**Title**  
Health Care Payments Data Program.

**Introduction Date:** 2020-02-20

**Description**

AB 2830, as amended, Wood. Health Care Payments Data Program. Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene), 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 provides for the regulation of health insurers by the Department of Insurance. Existing law, the Information Practices Act of 1977, regulates the collection and disclosure of personal information regarding individuals by state agencies, except as specified. Under existing law, a person who willfully requests or obtains a record containing personal information from an agency under false pretenses or a person who intentionally discloses medical, psychiatric, or psychological information held by an agency is guilty of a misdemeanor. Existing law states the intent of the Legislature to establish the Health Care Cost Transparency Database to collect information on the cost of health care, and requires the Office of Statewide Health Planning and Development to convene a review committee to advise the office on the establishment and implementation of the database. Existing law requires, subject to appropriation, the office to establish, implement, and administer the database by July 1, 2023. Existing law requires certain health care entities, including a health care service plan, to provide specified information to the office for collection in the database. This bill would delete those provisions relative to the Health Care Cost Transparency Database and would instead require the office to establish the Health Care Payments Data Program to implement and administer the Health Care Payments Data System, which would include health care data submitted by health care service plans, health insurers, a city or county that offers self-insured or multiemployer-insured plans, and other specified mandatory submitters. The bill would require the Department of Managed Health care and the Department of Insurance to take appropriate action to bring a plan or insurer into compliance if the office notifies the appropriate department of a plan or insurer's failure to submit required data, and would specify that the failure of a health care service plan to submit required data is a violation of Knox-Keene. Because a willful violation of these provisions by a health care service plan would be a crime, and because a city or county that offers self-insured or multiemployer-insured plans would be required to submit health care data to the office, the bill would impose a state-mandated local program. This bill would require the office to use the above-described data to produce publicly available information, including data products, summaries... (click bill link to see more).

**Primary Sponsors**

Jim Wood

**Organizational Notes**

Last edited by Joanne Campbell at May 18, 2020, 9:17 PM  
CAHP: Opposed Unless Amended

**Title**

Medi-Cal: substance use disorder services: reimbursement rates.

**Introduction Date:** 2020-02-21

**Description**

AB 2871, as introduced, Fong. Medi-Cal: substance use disorder services: reimbursement rates. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services, including specialty mental health services and substance use disorder services that are delivered through the Medi-Cal Specialty Mental Health Services Program, the Drug Medi-Cal Treatment Program (Drug Medi-Cal), and the Drug Medi-Cal organized delivery system (DMC-ODS). The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under Drug Medi-Cal, the department is authorized to enter into contracts with counties for various drug treatment services to Medi-Cal recipients, or is required to directly arrange for these services if a county elects not to do so. Existing law specifies the method of determining the maximum allowable reimbursement rates for Drug Medi-Cal and group outpatient drug free services. Existing law requires the department to implement the Medi-Cal 2020 demonstration project, including the DMC-ODS that provides alcohol and drug use services to eligible persons and authorizes the department to enter into a DMC-ODS contract with a county for the provision of those services within a county service area. This bill would require the department, in establishing reimbursement rates for services under Drug Medi-Cal and capitated rates for a Medi-Cal managed care plan contract that covers substance use disorder services to ensure that those rates are equal to the reimbursement rates for similar services provided under the Medi-Cal Specialty Mental Health Services Program. The bill would also require the department to require its managed care contractors that cover substance use disorder services to set reimbursement rates for those services at equal rates to similar services provided under the Medi-Cal Specialty Mental Health Services Program.

**Primary Sponsors**

Vince Fong

**Title**  
Pharmacies: automatic refills.

**Introduction Date:** 2020-02-21

**Description**

AB 2983, as amended, Holden. Pharmacies: automatic refills. Existing law, the Pharmacy Law, provides for the licensure and regulation of pharmacists and pharmacies by the California State Board of Pharmacy, and makes a willful violation of those provisions a misdemeanor. Existing law prohibits a prescription for any dangerous drug or dangerous device to be refilled except upon authorization of the prescriber. This bill would prohibit a pharmacy from automatically contacting a prescriber to authorize a prescription for any dangerous drug or device to be refilled for more than a 7-day supply unless the prescriber or patient has expressly authorized the pharmacy to automatically contact the prescriber to refill that prescription. The bill would require a pharmacy to obtain separate written authorization for each prescription and would prohibit a pharmacy from requesting more than the number of refills authorized in the original prescription. The bill would require the pharmacy to retain a record of the authorization for at least 3 years. The bill would exempt certain pharmacies owned or operated by a nonprofit health care service plan, as specified. Because the bill would expand the scope of a crime, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

**Primary Sponsors**

Chris Holden

**Title**  
Prescription drug cost sharing.

**Introduction Date:** 2020-02-21

**Description**

AB 2984, as amended, Daly. Prescription drug cost sharing. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law limits the maximum amount an enrollee or insured may be required to pay at the point of sale for a covered prescription drug to the lesser of the applicable cost-sharing amount or the retail price. This bill would require an enrollee's or insured's defined cost sharing for each prescription drug to be calculated at the point of sale based on a price that is reduced by an amount equal to 90% of all rebates received, or to be received, in connection with the dispensing or administration of the drug. The bill would prohibit a health care service plan, health insurer, or a plan's or insurer's agents from publishing or otherwise revealing information regarding the actual amount of rebates the health care service plan or health insurer receives on a product-specific, manufacturer-specific, or pharmacy-specific basis. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

**Primary Sponsors**

Tom Daly

**Title**  
Medically supportive food.

**Introduction Date:** 2020-02-21

**Description**

AB 3118, as amended, Bonta. Medically supportive food. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services, including enteral nutrition products, pursuant to a schedule of benefits, and subject to utilization controls, such as prior authorization. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law, until January 1, 2021, or as otherwise specified, requires the department to establish a 3-year pilot program in specified counties, including the Counties of Alameda and Sonoma, to provide medically tailored meals, as defined, to Medi-Cal participants with specified health conditions, such as cancer and renal disease. This bill would require the department to establish, no earlier than January 1, 2021, a pilot program for a 3-year period in the County of Alameda to provide medically supportive food, such as healthy food vouchers or renewable food prescriptions, as a covered benefit for a Medi-Cal beneficiary who has a specified chronic health condition, including diabetes or heart disease, when utilizing evidence-based practices that demonstrate the prevention, reduction, or reversal of those specified diseases. The bill would authorize the department, in consultation with stakeholders, to establish utilization controls, including the limitation on the number of services, and to enter into contracts for purposes of implementing the pilot program. The bill would require the department to evaluate the pilot program upon its conclusion, to report to the Legislature on those findings, and to implement these provisions by various means, including provider bulletins, without taking regulatory action. The bill would condition the implementation of these provisions to the extent permitted by federal law, the availability of federal financial participation, and the department securing federal approval, and would repeal these provisions on January 1, 2026. This bill would make legislative findings and declarations as to the necessity of a special statute for the County of Alameda.

**Primary Sponsors**

Rob Bonta

**Title**  
Medi-Cal: antipsychotic drugs.

**Introduction Date:** 2020-02-21

**Description**

AB 3285, as introduced, Irwin. Medi-Cal: antipsychotic 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. Existing law provides for the provision of prescription drugs as a Medi-Cal benefit, subject to the list of contract drugs and utilization controls. Existing law limits prescribed drugs under the Medi-Cal program to 6 drugs per month, unless prior authorization is obtained, and except under specified circumstances. This bill would prohibit requiring prior authorization for an antipsychotic drug to treat the serious mental illness of a Medi-Cal enrollee for 365 days after the initial prescription has been dispensed, and would require automatic approval of an antipsychotic drug to treat the serious mental illness of a Medi-Cal enrollee if the department verifies a paid claim that documents a diagnosis of a serious mental illness within 365 days before the date of that prescription. The bill would exclude an antipsychotic drug to treat serious mental illness from the Medi-Cal program's limit of 6 drugs per month. The bill would require the department to allow a pharmacist to dispense a 90-day supply or early refill of a prescribed antipsychotic drug if specified criteria are met.

**Primary Sponsors**

Jacqui Irwin

**Title** Homelessness: California Access to Housing and Services Act. **Introduction Date:** 2020-02-21

**Description**

AB 3300, as amended, Santiago. Homelessness: California Access to Housing and Services Act. Existing law establishes the Homeless Housing, Assistance, and Prevention program for the purpose of providing jurisdictions with one-time grant funds to support regional coordination and expand or develop local capacity to address their immediate homelessness challenges informed by a best-practices framework focused on moving homeless individuals and families into permanent housing and supporting the efforts of those individuals and families to maintain their permanent housing. Upon appropriation, existing law requires the Business, Consumer Services, and Housing Agency to distribute \$650,000,000 among continuums of care, cities, and counties pursuant to the program. By executive order, the Governor required the Department of Finance to establish the California Access to Housing and Services Fund, administered by the State Department of Social Services, to provide funding for additional affordable housing units, providing rental and operating subsidies, and stabilizing board and care homes. This bill, the California Access to Housing and Services Act, would establish the California Access to Housing and Services Fund in the State Treasury and continuously appropriate moneys in the fund solely for the purpose of implementing and administering the bill's provisions. The bill, for the 2020–21 fiscal year and each fiscal year thereafter, would require the Controller to transfer \$2,000,000,000 from the General Fund to the fund and require the Department of Housing and Community Development and the State Department of Social Services to jointly administer the fund pursuant to a memorandum of understanding, as provided. The bill would require the departments, in collaboration with the California Health and Human Services Agency and after deduction for administrative costs and certain allocations to the Governor's Office to End Homelessness, if the bill establishing that office is enacted, to allocate 55% of the moneys in the fund to counties and continuums of care that apply jointly, 45% to large cities, and 5% to developers operating in unincorporated areas and cities that are not eligible for an allocation. The bill would define various terms for these purposes. The bill would require that recipients and subrecipients ensure that any expenditure of moneys allocated to them serve the eligible population, as defined, unless otherwise expressly provided in the bill. The bill would require eligible recipients to apply for allocations and require the departments to evaluate those applications based on specified criteria and make annual allocations, as provided. The bill would require recipients to contractually obligate 100% of the ... (click bill link to see more).

**Primary Sponsors**

Miguel Santiago, Richard Bloom, Rob Bonta, Mike Gipson, Sharon Quirk-Silva, Buffy Wicks, Wendy Carrillo, Todd Gloria, Ash Kalra, Adrin Nazarian

**Title**

Medi-Cal: federally qualified health centers and rural health clinics.

**Introduction Date:** 2020-02-21

**Description**

AB 3344, as introduced, Gloria. Medi-Cal: federally qualified health centers and rural health clinics. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law provides that federally qualified health center (FQHC) services and rural health clinic (RHC) services, as defined, are covered benefits under the Medi-Cal program, to be reimbursed, to the extent that federal financial participation is obtained, to providers on a per-visit basis. This bill would make technical, nonsubstantive changes to those provisions.

**Primary Sponsors**

Todd Gloria

**Title** Introduction Date: 2019-01-08  
Health care coverage: financial assistance.

**Description**

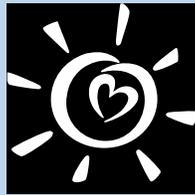
SB 65, as amended, Pan. Health care coverage: financial assistance. Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various healthcare coverage market reforms. Among other things, the PPACA requires each state to establish an American Health Benefit Exchange that facilitates the purchase of qualified health plans by qualified individuals and qualified small employers and requires that state entity to meet certain other requirements. Existing law creates the California Health Benefit Exchange (the Exchange), also known as Covered California, for the purpose of facilitating the enrollment of qualified individuals and qualified small employers in qualified health plans as required under the PPACA. Until January 1, 2023, existing law requires the Exchange, among other duties, to administer an individual market assistance program to provide assistance, including premium assistance subsidies, to program participants with household incomes at or below 600% of the federal poverty level. This bill would reduce premiums to zero for program participants with household incomes at or below 138% of the federal poverty level, and would specify the premium assistance subsidy amount for program participants with household incomes of 139% to 600%, inclusive, of the federal poverty level. The bill would require the financial assistance administered by the Exchange to include cost-sharing reduction assistance to reduce the copays, deductibles, coinsurance, out-of-pocket maximums, and other cost sharing of a program participant with a household income of 200% to 400%, inclusive, of the federal poverty level.

**Primary Sponsors**

Richard Pan

**Organizational Notes**

Last edited by Cherie Compartore at Mar 20, 2020, 8:44 PM  
Organization Sponsor: Health Access Support - California Association of Health Plans



**L.A. Care**  
HEALTH PLAN®

**Board of Governors**  
**MOTION SUMMARY**

**Date:** May 26, 2020

**Motion No.** EXE A.0520

**Committee:** Executive

**Chairperson:** Hector De La Torre

**Issue:** Approve revisions to Human Resources Policy & Procedure HR-114 (Paid-Time-Off) mainly relating to unforeseeable emergency paid time off (PTO) cash-out available to L.A. Care employees.

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

**Background:** L.A. Care Health Plan provides Paid Time Off (PTO) to eligible employees for their use for any reason they choose such as vacations, sick time, non-company holidays, and personal needs.

On April 2, 2020, the Board approved motion EXE 102.0420 to provide the use of emergency PTO for certain COVID-19 related circumstances to mitigate potentially severe financial impact on employees who would suffer a loss of income if they were unable to work and to incorporate the paid sick leave requirements under the Families First Coronavirus Response Act.

Recognizing that employees may experience an unforeseen and severe financial hardship resulting from other circumstances, Staff is proposing additional revisions to HR-114, as noted in the attached document, to provide financial relief through the payment of accrued, unused PTO in the event of an *unforeseeable emergency* resulting from:

- an illness or accident of the employee, the employee's spouse, the employee's dependent or other family member of the employee;
- loss of the employee's property due to casualty (including the need to rebuild a home following damage to a home not otherwise covered by homeowner's insurance, such as damage as a result of a natural disaster);
- other similar extraordinary and unforeseeable circumstances arising as a direct result of events beyond the control of the employee, such as a major disaster or state of emergency declared by the President, a public health emergency declared by the Secretary of the U.S. Department of Health and Human Services, a state of emergency declared by the Governor of the State of California, or a local emergency declared by the Mayor of the City of Los Angeles or by the Board of Supervisors of the County of Los Angeles;
- the imminent foreclosure or eviction from the employee's home;
- the need to pay for medical expenses, including non-refundable deductibles, as well as the cost of prescription drug medication;
- the need to pay for the funeral expenses of a spouse, eligible dependent or other family member of the employee.

Neither the purchase of a home nor the payment of college tuition nor paying off credit card debt qualify as an unforeseeable emergency under the policy. Under the policy, PTO cash-out for

## **Board of Governors**

### **MOTION SUMMARY**

unforeseeable emergency would require leaving a balance of 80 accrued hours.

Additionally, the revisions clarify that the emergency PTO that is provided for qualifying COVID-19 events, is not eligible for any PTO cash-out or L.A. Care's friends helping friends program. Finally, the revisions to the policy remove Section 4.1.6 relating to the use of PTO by trainees, which is no longer applicable.

**Member Impact:** None

**Budget Impact:** Minimal. Payment of accrued, unused PTO is a budgeted.

**Motion:** To approve the Human Resources Policy & Procedure HR-114, as presented.

	<b>PAID TIME OFF</b>	<b>HR-114</b>
<b>DEPARTMENT</b>	HUMAN RESOURCES	
Supersedes Policy Number(s)	9115	

DATES					
Effective Date	4/1/1996	Review Date	04/14/2020	Next Annual Review Date	04/14/2021
Legal Review Date	3/18/2020	Committee Review Date	04/02/2020		

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	Sarah Vioria Diaz
DEPARTMENT	Human Resources	Human Resources
TITLE	Chief Human Resources Officer	Director, Human Resources Total Rewards

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

REFERENCES	

HISTORY	
REVISION DATE	DESCRIPTION OF REVISIONS
1/6/2014	Review
9/21/2017	Revision
3/23/2020	Revision, Friends Helping Friends (PTO donation) section updated; Emergency PTO for COVID-19 added
<u>5/26/2020</u>	<u>Revisions, Section 4.1.5, 4.2.1, 4.4.5, Unforeseen Emergency PTO-Cash Out added</u>

DEFINITIONS	
Please visit the L.A. Care intranet for a comprehensive list of definitions used in policies: <a href="http://inside.lac/ourtoolsandresources/departmentsandprocedures">http://inside.lac/ourtoolsandresources/departmentsandprocedures</a>	



## 1.0 OVERVIEW:

**1.1** L.A. Care Health Plan (L.A. Care) provides Paid Time Off (PTO) benefits to eligible employees for vacations, illness and personal needs. PTO is also provided to employees for periodic rest and relaxation away from the job. Additional compensation is not provided in lieu of actual time off.

## 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 Family Member** - biological, adopted, or foster child, stepchild, legal ward or a child to whom the employee stands in loco parentis; an employee’s biological, adoptive, or foster parent, stepparent, or legal guardian of an employee or the employee’s spouse or registered domestic partner, or a person who stood in loco parentis when the employee was a minor child; spouse; registered domestic partner; grandparent; grandchild; and sibling as defined in California Labor Code §§245.5 and 246.5, or for any individual related by blood or affinity whose close association with the employee is the equivalent of a family relationship, pursuant to the City of Los Angeles Sick Leave Ordinance No. 184320, Municipal Code Chap. XVIII, Art. 7, Section 187.04.

**2.2 Length of Service** - calculated from the original hire date, adjusted for Leave of Absences (LOAs), reinstatement, or change of employment status.

**2.3 Medical Emergency** - a serious illness or other medical condition (e.g., heart attack, surgery, automobile accident injuries, cancer, or other life threatening disease) of the PTO Recipient or his or her Family Member that is likely to (a) require the PTO Recipient's absence from work for a prolonged period, and (b) result in a substantial loss of income to the PTO Recipient because he or she will have exhausted all accrued unused PTO. A Medical Emergency or the death of a Family Member will be considered likely to result in a PTO Recipient's absence from work for a prolonged period and a substantial loss of income only if the PTO Recipient is absent or expected to be absent from work without PTO for a period of at least one day for a full-time employee. This minimum required number of hours of absence will be prorated for a part-time employee.

**2.4 PTO Benefits** - benefit provided for employees to use for any reason they choose such as vacations, sick time, non-company holidays LOA as mandated by law or L.A. Care policy, doctor’s appointments, etc.

**2.42.5 Unforeseeable Emergency** - a severe financial hardship of the employee resulting from an illness or accident of the employee, the employee’s spouse, the employee’s dependent (as defined in Internal Revenue Code section 152, and, without regard to Internal Revenue Code sections 152(b)(1), (b)(2), and (d)(1)(B)), or other Family



Member of the employee; loss of the employee's property due to casualty (including the need to rebuild a home following damage to a home not otherwise covered by homeowner's insurance, such as a damage that is the result of a natural disaster); or other similar extraordinary and unforeseeable circumstances arising as a direct result of events beyond the control of the employee, such as a major disaster or state of emergency declared by the President under section 401 or 501 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act, a public health emergency declared by the Secretary of the U.S. Department of Health and Human Services under section 319 of the Public Health Service Act, a state of emergency declared by the Governor of the State of California under California Government Code section 8625, or a local emergency declared by the Mayor of the City of Los Angeles or by the Board of Supervisors of the County of Los Angeles. For example, the imminent foreclosure or eviction from the employee's home may constitute an Unforeseeable Emergency. In addition, the need to pay for medical expenses, including non-refundable deductibles, as well as for the cost of prescription drug medication, may constitute an Unforeseeable Emergency. Finally, the need to pay for the funeral expenses of a spouse, dependent (as defined in Internal Revenue Code section 152, and, without regard to Internal Revenue Code sections 152(b)(1), (b)(2), and (d)(1)(B)) or other Family Member of the employee may also constitute an Unforeseeable Emergency. Neither the purchase of a home nor the payment of college tuition nor paying off credit card debt is an Unforeseeable Emergency.

### **3.0 POLICY:**

- 3.1** All eligible employees, regularly scheduled to work at least 30 hours per week, are eligible to earn pro-rated PTO. The rate earned varies with the employee's Length of Service, Fair Labor Standards Act (FLSA) status and hours worked during each pay period.
- 3.2** The PTO Benefit is designed to provide income for eligible employees while off work and may not be used to compensate for tardiness.
- 3.3** In the event of an emergency declared by the federal government of the United States, the State of California, the cities in or County of Los Angeles, L.A. Care will, in accordance with Section 4.4, provide up to 80 hours of emergency PTO in recognition of the effects of such declared emergency on the workforce and the community related to the novel coronavirus known as COVID-19, or as that term may change under the circumstances ("COVID-19"). This emergency PTO is intended to satisfy the applicable emergency paid sick leave requirements set forth in Division E of the Families First Coronavirus Response Act (P.L. 116-127) ("FFCRA"). Accordingly, this emergency PTO is in lieu of, not in addition to, the FFCRA-required emergency paid sick leave. In offering the emergency PTO under this Subsection 3.3 and Section 4.4 below, L.A. Care finds that there is significant public purpose in providing this emergency PTO under the circumstance as it will support federal, state and local efforts to mitigate the spread of COVID-19 within the community, abide by the applicable directives



from federal, state or local authority(ies) in an effort to mitigate the impact of the spread of COVID-19 and related impact on the health care system, and help mitigate the financial impact on affected employees who are unable to work remotely.

#### **4.0 PROCEDURES:**

##### **4.1 Paid Time Off (PTO)**

**4.1.1** The maximum number of PTO hours that eligible employees are able to maintain in their PTO bank is 520 hours. An employee who reached the maximum level of 520 hours will not earn additional PTO until enough PTO hours have been used to reduce the accumulated hours below the maximum level, at which time the accrual will begin again.

**4.1.2** Employees are required to use their accrued PTO hours for any and all time off except for specific LOAs including bereavement leave, jury duty and witness subpoenas.

**4.1.3** Pre-approved time off that is entered in L.A. Care's timekeeping system (automated timekeeping system) will be deducted automatically from the employee's PTO bank as soon as the time is taken. Time off that is not pre-approved and/or not entered in automated timekeeping system will be deducted on the next pay period after the time is noted in automated timekeeping system.

**4.1.4** Employees may use PTO only up to the number of unused accrued hours in their PTO bank. Employees are not allowed to have a negative balance in their PTO bank.

~~**4.1.5** PTO begins to accrue with the first pay period following employment. PTO continues to accrue every pay period in which the employee remains eligible.~~

~~**4.1.6** 4.1.5 Employees classified as trainees are eligible to accrue PTO beginning the first pay period following employment but cannot use the accrued PTO until the completion of three months of employment.~~

~~**4.1.7** 4.1.6 PTO is considered to be vested when earned and must be used when the employee is off work, except as it relates to certain LOAs including bereavement leave, jury duty and witness subpoenas. Employees must obtain prior approval from their supervisor with as much advance notice as possible. PTO approval is not automatic and will be scheduled according to the staffing needs of L.A. Care and workload of individual departments.~~

~~**4.1.8** 4.1.7 Unless otherwise specified, an increase in PTO accrual will be in effect the pay period in which the Length of Service of an exempt or non-~~



exempt employee reaches the 49<sup>th</sup> month (four years and one month). The second increase in PTO accrual for a non-exempt employee will be in effect the pay period in which the Length of Service of the employee reaches the 109<sup>th</sup> month (nine years and one month).

**4.1.194.1.8** PTO will be integrated with State Disability Insurance (SDI), Workers Compensation (WC), Paid Family Leave (PFL), or Short Term Disability (STD) benefits when eligible. This means L.A. Care will pay from PTO Benefits to complete the employee’s lost wages for the period covered. Employees will accrue PTO based on the hours paid while off work until they have used all accrued PTO and enter a non-paid employee status.

**4.1.104.1.9** PTO is paid at the employee’s base rate in effect at the time the PTO hours are used.

**4.1.114.1.10** An employee who transfers from a PTO eligible status to a non-eligible status will be paid at the time of transfer for all hours of accrued unused PTO at the rate of pay in effect before the transfer.

**4.1.124.1.11** All requests (exempt and non-exempt employees) for PTO must be done through the automated time record system and forwarded to their immediate supervisor for approval. The immediate supervisor then determines if the time will be approved or not.

**4.1.134.1.12** Employees must inform their supervisor in a timely manner if they did not use their previously approved PTO. Employees must complete a Time Exception Report for adjustments after the time card has been approved and locked in the automated time record system.

**4.1.144.1.13** All accrued unused PTO hours at the time of separation from employment are paid at the rate of pay in effect on the date of separation.

**4.1.154.1.14** Employees may earn PTO according to the following schedule:

<b>FLSA Status</b>	<b>Length of Service</b>	<b>PTO Accrual Pay Period (PP)</b>	<b>PTO Accrual Per Year</b>
Non-Exempt (Hourly)	0 through 48 months	up to 5.23 hours	up to 17 days
	49 months through 108 months	up to 6.78 hours	up to 22 days
	109 months and over	up to 8.31 hours	up to 27 days
Exempt (Salaried)	0 through 48 months	up to 6.78 hours	up to 22 days
	49 months and over	up to 8.31 hours	up to 27 days

Senior Directors



and Above                      0 months and over                      up to 8.31 hours                      up to 27 days

## 4.2 PTO Cash-Out

**4.2.1** Requests—Except as provided in Section 4.2.2, requests for PTO cash-out must be made in December for payout the following calendar year in December in accordance with this Section 4.2.1.

**4.2.1.1** The employee must have a minimum of 80 PTO hours at the time the request is made.

**4.2.1.1.1** PTO cash-out request must be made in increments of eight hours.

**4.2.1.2** The requested PTO cash-out hours cannot exceed the amount of PTO earned during the payout year.

**4.2.1.3** Requests can only be made once per year.

**4.2.1.4** Cash-out elections will be processed, less mandated taxes and withholdings, the last pay date of December.

**4.2.1.5** Cash-out elections must be irrevocable and made only with respect to PTO that has not yet been earned and that will be earned during the calendar year in which the PTO is cashed out, and the employee can neither increase nor decrease the elected number of PTO hours for which payment will be made.

**4.2.1.6** Any PTO taken by the employee will be subtracted first from any unused PTO carried over from the calendar year in which the election is made, and second from any PTO hours earned in the year that was not cashed out.

**4.2.1.7** If the employee terminates employment before December of the calendar year in which the PTO is cashed out, no cash payment will be made under this section. Instead, the rules for payment of accrued and unused PTO upon separation of employment will apply.

**4.2.2** In the event of an Unforeseeable Emergency that cannot be satisfied from other resources, an employee may apply to the Human Resources Department for a PTO cash-out in accordance with the rules in this Section 4.2.2.

**4.2.2.1** The net payment resulting from any PTO cash-out granted in accordance with this Section 4.2.2 will be limited to the amount that is reasonably necessary to satisfy the emergency need,



including any amounts that may be necessary to pay any federal, state, or local income taxes or penalties reasonably anticipated as a result of the cash-out.

4.2.2.2 No PTO cash-out will be paid under this Section 4.2.2 to the extent that such an emergency is or may be relieved through reimbursement or compensation from insurance or otherwise, by liquidation of the employee's assets, to the extent liquidation of such assets would not itself cause severe financial hardship.

4.2.2.3 To obtain a PTO cash-out under this Section 4.2.2, an employee must submit to the Human Resources Department a written, certified statement on the Unforeseeable Emergency PTO Cash-Out Request Form provided by L.A. Care and available supporting documentation to demonstrate the financial need, the amount of the financial need, and that the financial need was due to extraordinary and unforeseeable circumstances arising as a direct result of events beyond the employee's control and cannot be satisfied from other available resources. The form, including the certified statement and all supporting documentation, must be approved by the Human Resources Department before any PTO cash-out will be paid under this Section 4.2.2.

4.2.2.4 The Chief Human Resources Officer (CHRO) or designee will, in his or her sole discretion, determine based on the recommendation of the designated staff member of the Human Resources Department whether an unforeseeable emergency exists and the extent of the financial need, and approve or deny the request for unforeseeable emergency PTO cash-out based on that determination. The Human Resources Department will notify the employee in writing of the CHRO's determination as soon as administratively practical, but in no event more than 30 days, after its receipt of the completed request form. If approved, the PTO cash-out will be paid as soon as administratively practical following approval.

4.2.2.5 The PTO cash-out cannot exceed the amount of the employee's accrued PTO, and an employee must have a minimum of at least 80 hours of accrued PTO remaining in ~~the his or her~~ employee's PTO bank after the requested PTO cash-out.

~~4.2.1.74.2.2.6~~ 4.2.2.6 All PTO cash-outs will be subject to income and FICA taxes, and all required tax withholdings will be applied to the cash-out.

### 4.3 Friends Helping Friends – PTO-Sharing Program



**4.3.1** The Friends Helping Friends – Under the rules set forth in this section, this PTO-Sharing Program permits an employee (PTO Contributor) to transfer accrued PTO hours from employee’s PTO bank directly to the PTO bank of another employee (PTO Recipient) who experiences a Medical Emergency or the death of a Family Member that will likely require a prolonged absence from work, including intermittent absences that are related to the same Medical Emergency, and who will suffer a substantial loss of income because employee will, apart from this PTO-Sharing Program, have exhausted all of the PTO hours available in employee’s accrued unused PTO bank.

**4.3.1.1** An employee who wishes to become a PTO Recipient or employee’s personal representative must submit the Friends Helping Friends Sharing of PTO application form provided by L.A. Care to Employee Benefit Administrator or the Human Resources Total Rewards Coordinator in the Human Resources Department for consideration. The completed application form must include: (1) the potential PTO Recipient's name and position title; (2) the number of additional PTO hours employee reasonably needs to deal with the Medical Emergency or death of a Family Member; (3) the reasons the transferred leave is needed, including a brief description of the nature, severity, and anticipated duration of the Medical Emergency; (4) a written statement from a health care provider or government agency certifying the nature, severity and anticipated duration of the Medical Emergency; and (5) any other documentation or information about the Medical Emergency or death that Human Resources may require.

**4.3.1.1.1** All employees are prohibited from soliciting donated hours on their own behalf. If staff is found to have solicited PTO hours, the donated hours from solicited staff may be revoked.

**4.3.1.1.2** Human Resources will determine, at its sole discretion, the amount of PTO (if any) that may be transferred to any applicant to be a PTO Recipient. Such determination will be made on the basis of the applicant’s need. A PTO contributor may donate a maximum of 40 PTO hours in a rolling calendar year.

**4.3.1.1.3** The contributor must have a minimum of 80 PTO hours at the time of donation.

**4.3.1.2** Human Resources will notify the PTO Recipient in writing of its decision regarding the application as soon as practical, but in no



event more than 30 days after its receipt of the application. If the application is disapproved, in whole or in part, Human Resources will include the reason for its disapproval in the notice.

**4.3.1.3** After the PTO Recipient's application has been approved and the PTO Recipient has exhausted all of the PTO hours in his or her accrued unused PTO bank, the PTO Recipient is eligible to receive transfers of PTO hours not to exceed the number of PTO hours requested (to be paid at his or her normal rate of compensation) from the PTO Contributor(s).

**4.3.1.3.1** PTO hours transferred from the PTO Contributor will be credited to the PTO Recipient's PTO bank for use in accordance with this PTO-Sharing Program.

**4.3.1.3.2** No PTO will be transferred to the PTO Recipient's PTO bank if the applicant to be a PTO Recipient cannot accumulate or receive additional leave under L.A. Care's existing policies, programs or plans.

**4.3.1.4** An employee who wishes to become a PTO Contributor by transferring PTO hours from employee's PTO bank directly to the PTO bank of the PTO Recipient must submit a completed Friends Helping Friends Sharing of PTO form provided by L.A. Care to Employee Benefit Administrator or the Human Resources Total Rewards Coordinator in the Human Resources Department for consideration. PTO-Sharing is subject to the following rules:

**4.3.1.4.1** PTO-Sharing will be strictly voluntary; the identity of the PTO Contributors will be held in absolute confidence unless they want their identity revealed.

**4.3.1.4.2** PTO hours transferred by the PTO Contributor will be subtracted from the PTO Contributor's PTO bank hour for hour.

**4.3.1.4.3** The PTO transfer request is irrevocable by the PTO Contributor. The contributor agrees that contributor will not be entitled to use the PTO that contributor requests to transfer on the completed Friends Helping Friends Sharing of PTO form submitted to Employee Benefit Administrator or the Human Resources Total Rewards Coordinator in the Human



Resources Department for any purpose, including but not limited to PTO and PTO cash-out.

**4.3.1.4.4** Human Resources has the sole discretion to determine to accept or reject any PTO transfer request.

**4.3.1.4.5** No leave will be transferred to the PTO Recipient's PTO bank unless and until Human Resources makes a reasonable determination that the PTO Recipient will need the PTO for the Medical Emergency or death of a Family Member.

**4.3.1.4.6** Transfers of PTO to the PTO Recipient's PTO bank will be made on a first-in, first-out basis.

**4.3.1.4.7** If the PTO Contributor terminates employment with L.A. Care before all PTO that contributor requested be transferred in accordance with the PTO transfer request form has been transferred to the PTO Recipient's PTO bank, L.A. Care will treat the PTO that has not yet been transferred as credited to the PTO Contributor's PTO bank. That PTO will be cashed out on the PTO Contributor's termination with L.A. Care in accordance with governing law.

**4.3.1.5** The PTO Recipient may use the additional PTO only for the absence related to the Medical Emergency or Family Member's death for which the PTO Recipient was approved.

**4.3.1.5.1** The PTO Recipient may not transfer PTO received to another PTO Recipient.

**4.3.1.5.2** The PTO Recipient may not cash out any PTO hours transferred from the PTO Contributor's PTO bank to the PTO Recipient's PTO bank under the PTO-Sharing Program.

**4.3.1.5.3** A PTO Recipient's use of any PTO transferred under this PTO-Sharing Program is subject to all existing L.A. Care policies and procedures relating to the use of any other PTO, including prior approval before this PTO may be used.

**4.3.1.5.4** Any PTO transferred under this PTO-Sharing Program and credited to the PTO Recipient's PTO bank is not vested and is conditioned on the use of



the PTO transferred in accordance with the terms and conditions of this PTO-Sharing Program and as otherwise may be specified by L.A. Care at any time and from time to time to achieve the purposes of this PTO-Sharing Program.

- 4.3.1.5.5** If for any reason the PTO Recipient does not use PTO transferred to his or her PTO bank under this PTO-Sharing Program to deal with a Medical Emergency or death of a Family Member in accordance with this PTO-Sharing Program, then any PTO transferred to employee's PTO bank under this PTO-Sharing Program will be removed from employee's PTO bank and returned to the PTO Contributor's PTO Bank if the PTO Contributor is still employed by L.A. Care.
- 4.3.1.5.6** If the PTO Recipient terminates employment with L.A. Care before using all PTO transferred under this PTO-Sharing Program, the unused PTO will be removed from the PTO Recipient's PTO bank and returned to the PTO Contributor's PTO Bank if the PTO Contributor is still employed by L.A. Care. In that case, the PTO Recipient will not be paid the cash value of the PTO on termination.
- 4.3.1.6** L.A. Care will administer the PTO-Sharing Program in a uniform and nondiscriminatory manner. L.A. Care has the sole and absolute discretion to administer and interpret the PTO-Sharing Program as necessary or appropriate to carry out its purposes. Accordingly, all determinations made by L.A. Care with respect to the PTO-Sharing Program will be given the maximum deference allowed by law.
- 4.3.1.7** L.A. Care reserves the right to amend or terminate this PTO-Sharing Program at any time and for any reason. If L.A. Care terminates the PTO-Sharing Program, any PTO hours that have not been transferred from any PTO Contributor's PTO bank to any PTO Recipient's PTO bank at termination will not be transferred and will remain in the PTO Contributor's PTO bank.
- 4.3.1.8** Whether or not the PTO-Sharing Program is terminated, L.A. Care reserves the right to cease transferring PTO hours to any PTO Recipient at any time and for any reason. In that case, all PTO hours that have not yet been transferred will not be transferred.



**4.3.1.9** In accordance with IRS Revenue Ruling 90-29, L.A. Care will treat the income attributable solely to the PTO hours transferred from the PTO Contributor's PTO bank to the PTO Recipient's PTO bank under the PTO-Sharing Program, as described herein, as wages of the PTO Recipient, not the PTO Contributor, for purposes of withholding and reporting federal and state income and employment taxes (e.g., Social Security and Medicare taxes under the Federal Insurance Contributions Act). However, L.A. Care does not guarantee or warrant to any individual that the intended tax consequences of the PTO-Sharing Program will prevail or be accepted by the Internal Revenue Service or by any court.

#### **4.4 Emergency PTO For COVID-19**

- 4.4.1** Notwithstanding the above, L.A. Care shall provide up to 80 hours of emergency PTO in recognition of the effects of COVID-19 on the workforce and the community in accordance with this section. This emergency PTO is to be used in conjunction with, and offset by, any other applicable federal and/or state approved benefits to the extent permitted by law. In addition, this emergency PTO is intended to satisfy the emergency paid sick leave requirements set forth in Division E of the FFCRA and, therefore, is in lieu of, not in addition to, the FFCRA-required emergency paid sick leave.
- 4.4.2** This emergency PTO is available for use immediately by each L.A. Care employee, regardless of how long the employee has been employed or how many hours a week the employee has worked.
- 4.4.3** Each employee may use this emergency PTO first, before the employee uses other accrued PTO or, if applicable, sick time pursuant to HR-125 Sick Leave for Per Diem, Part-Time, and Non-Regular Employees policy.
- 4.4.4** The emergency PTO is available during the duration of the emergency declared by the federal government of the United States, the State of California, cities in or County of Los Angeles, whichever ends later; provided, however, that the emergency PTO is available during a period that begins no later than April 1, 2020, and ends no earlier than December 31, 2020.
- 4.4.5** Any unused emergency PTO will expire and will not carry over from one year to the next and will not to be paid out at the end of an employee's employment, to the extent permitted by applicable laws. [This emergency PTO is not eligible for PTO cash-out or PTO Sharing Program pursuant to sections 4.2 and 4.3 above.](#)



- 4.4.6** L.A. Care shall provide up to 80 hours of emergency PTO to each employee to the extent the employee is unable to work (or telework) due to a need for leave because:
- 4.4.6.1** The employee is subject to a federal, state or local quarantine or isolation order related to COVID-19.
  - 4.4.6.2** The employee has been advised by a healthcare provider to self-quarantine due to concerns relating to COVID-19.
  - 4.4.6.3** The employee is experiencing the symptoms of COVID-19 and seeking a medical diagnosis.
  - 4.4.6.4** The employee is caring for a Family Member who is:
    - 4.4.6.5**
      - 4.4.6.5.1** Advised by a healthcare provider to self-quarantine due to concerns related to COVID-19; or
      - 4.4.6.5.2** Subject to a federal, state, or local quarantine or isolation order related to COVID-19.
  - 4.4.6.6** The employee is caring for the employee's child if the child's school or place of care has been closed or the child's childcare provider is unavailable due to COVID-19 precautions.
  - 4.4.6.7** The employee is experiencing any other substantially similar condition specified by the Department of Health and Human Services in consultation with the IRS and the Department of Labor, or other COVID-19-driven circumstance approved by the Chief of Human Resources Officer or Chief Medical Officer.
- 4.4.7** An employee who qualifies for emergency PTO as described in this section must submit a request for emergency PTO in the prescribed manner to the Leave of Absence Department in Human Resources or designee, which request must be approved before emergency PTO will be granted.
- 4.4.8** L.A. Care shall calculate the emergency PTO based on the number of hours the employee would otherwise normally be scheduled to work and a rate of pay that is no less than the employee's regular rate of pay (as determined under section 7(e) of the Fair Labor Standards Act of 1938 (29 U.S.C. 207(e)) ("FLSA"), the minimum wage rate in effect under section 6(a)(1) of the FLSA, or the minimum wage rate in effect for the employee in the applicable state or locality, whichever is greater.

## **5.0 MONITORING:**



**5.1** Human Resources will conduct annual review of the PTO policy to ensure compliance.

**6.0** **REPORTING:**

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

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