L.A. Care
HEALTH PLAN®

BOARD OF GOVERNORS

Executive Committee Meeting

August 28, 2024 • 2:00 PM

Lobby Conference Room 100

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

L.A. Care offices have moved to 1200 W. 7th Street, Los Angeles, CA 90017. Public meetings will continue to be held in the Board Room at 1055 W. 7th Street until early 2025.

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AGENDA
Executive Committee Meeting
Board of Governors

Wednesday, August 28, 2024, 2:00 P.M.
1055 West 7th Street, Conference Room 100, 1st Floor
Los Angeles, CA 90017

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

To listen to the meeting via videoconference please register by using the link below:
https://lacare.webex.com/lacare/j.php?MTID=m4e549313fadb3668fc1af7dc31ed85be

To listen to the meeting via teleconference please dial: +1-213-306-3065
Meeting Number: 2480 837 0540 Password: lacare

For those not attending the meeting in person, public comments on Agenda items can be submitted prior to the start of the meeting in writing by e-mail to BoardServices@lacare.org, or by sending a text or voicemail to (213) 628-6420. Due to time constraints, we are not able to transcribe and read public comment received by voice mail during the meeting. Public comment submitted by voice messages after the start of the meeting will be included in writing at the end of the meeting minutes.

The purpose of public comment is an opportunity for members of the public to inform the governing body about their views. The Committee appreciates hearing the input as it considers the business on the Agenda. All public comments submitted will be read for up to 3 minutes during the meeting. The process for public comment is evolving and may change at future meetings. We thank you for your patience.

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

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

Welcome		Alvaro Ballesteros, MBA *Chair*
1.	Approve today's Agenda	*Chair*
2.	Public Comment *(Please read instructions above.)*	*Chair*
3.	Approve the June 26, 2024 Meeting Minutes p.5	*Chair*
4.	Chairperson's Report	*Chair*
5.	Chief Executive Officer Report	John Baackes *Chief Executive Officer*

- Government Affairs Update p.21 — Cherie Compartore, *Senior Directors, Government Affairs*
    - Consideration of Support of Managed Care Organization (MCO) Tax Ballot Measure

Committee Issues

6. 2025 Board and Committee Meeting Schedule **(EXE 100)** p.116 — Linda Merkens, *Senior Manager, Board Services*

7. Pacifica Hospital of the Valley Grant **(EXE 101)** p.118 — John Baackes, Wendy Schiffer, *Senior Director, Strategic Planning*

8. Human Resources Policy HR- 628 (Use of Sign on and Retention Bonuses) **(EXE A)** p.120 — Terry Brown, *Chief Human Resources Officer*

9. Approve the list of items that will be considered on a Consent Agenda for September 5, 2024 Board of Governors Meeting. — *Chair*
    - June 6, 2024 meeting minutes
    - Ratify L.A. Care Chief Executive Officer's, John Baackes, execution of Amendment A04 to L.A. Care's Exclusively Aligned Enrollment (EAE) D-SNP Contract Number 22-20236 with the Department of Health Care Services (DHCS)
    - 2025 Board and Committee Meeting Schedule
    - Pacifica Hospital of the Valley Grant
    - Infosys Contract to provide Information Technology (IT) testing services.
    - Children's Health Consultant Advisory Committee (CHCAC) Membership
    - Children's Health Consultant Advisory Committee (CHCAC) Revised Charter

10. Public Comment on Closed Session Items *(Please read instructions above.)* — *Chair*

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

11. REPORT INVOLVING TRADE SECRET
    Pursuant to Welfare and Institutions Code Section 14087.38(n)
    Discussion Concerning New Service, Program, Technology, Business Plan
    Estimated date of public disclosure: *August 2026*

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

13. THREAT TO PUBLIC SERVICES OR FACILITIES
    Government Code Section 54957
    Consultation with: Tom MacDougall, *Chief Information & Technology Officer*, and Gene Magerr, *Chief Information Security Officer*

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

15. CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION
Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act
L.A. Care Health Plan's Notice of Contract Dispute under Contract No. 04-36069
Department of Health Care Services (Case No. Unavailable)

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

17. PUBLIC EMPLOYEE PERFORMANCE EVALUATION, PUBLIC EMPLOYMENT and CONFERENCE WITH LABOR NEGOTIATOR
Sections 54957 and 54957.6 of the Ralph M. Brown Act
Title: Chief Executive Officer
Agency Designated Representative: Alvaro Ballesteros, MBA
Unrepresented Employee: John Baackes

RECONVENE IN OPEN SESSION

ADJOURNMENT *Chair*

The next Executive Committee meeting is scheduled on
<u>Wednesday, September 25, 2024 at 2:00 p.m.</u>
and may be conducted as a teleconference meeting.

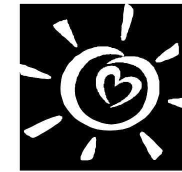
The order of items appearing on the agenda may change during the meeting.

THE PUBLIC MAY SUBMIT COMMENTS TO THE EXECUTIVE COMMITTEE BEFORE DISCUSSION OF EACH ITEM LISTED ON THE AGENDA BY SUBMITTING THE COMMENT IN WRITING BY TEXT MESSAGE TO 213 628 6420, OR IN WRITING BY EMAIL TO BoardServices@lacare.org. Please follow additional instructions on the first page of this Agenda.
ACTION MAY NOT BE TAKEN ON ANY MATTER RAISED DURING THE PUBLIC COMMENT PERIODS UNTIL THE MATTER IS SPECIFICALLY LISTED ON A FUTURE AGENDA, according to California Govt Code Section 54954.2 (a)(3) and Section 54954.3.

NOTE: THE EXECUTIVE COMMITTEE CURRENTLY MEETS ON THE FOURTH TUESDAY OF MOST MONTHS AT 2:00 P.M. AGENDA and PRINTED MEETING MATERIALS ARE AVAILABLE FOR INSPECTION AT http://www.lacare.org/about-us/public-meetings/board-meetings and by email request to BoardServices@lacare.org
Any documents distributed to a majority of the Board Members regarding any agenda item for an open session after the agenda has been posted will be available for public inspection at 1055 W. 7th Street, Los Angeles, CA, in the reception area in the main lobby or at http://www.lacare.org/about-us/public-meetings/board-meetings and can be requested by email to BoardServices@lacare.org.
An audio recording of the meeting is made to assist in writing the minutes and is retained for 30 days.

Meetings are accessible to people with disabilities. Individuals who may require any accommodations (alternative formats – i.e., large print, audio, translation of meeting materials, interpretation, etc.) to participate in this meeting and wish to request an alternative format for the agenda, meeting notice, and meeting packet may contact L.A. Care's Board Services Department at (213) 628 6420. Notification <u>at least one week before the meeting</u> 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 – June 26, 2024
1055 West 7th Street, 1st Floor, Los Angeles, CA 90017



L.A. Care
HEALTH PLAN

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

Management/Staff
John Baackes, *Chief Executive Officer**
Sameer Amin, MD, *Chief Medical Officer*
Augustavia J. Haydel, Esq., *General Counsel*
Todd Gower, *Interim Chief Compliance Officer*
Linda Greenfeld, *Chief Products Officer*
Darren Lee, *Deputy Chief of Human Resources*
Alex Li, MD, *Chief Health Equity Officer*
Noah Paley, *Chief of Staff*
Acacia Reed, *Chief Operating Officer*
Afzal Shah, *Chief Financial Officer*

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Alvaro Ballesteros, *Chairperson,* called to order the regular meetings of the L.A. Care Executive Committee and the L.A. Care Joint Powers Authority Executive Committee regular meetings at 2:25 p.m. The meetings were held simultaneously. He welcomed everyone to the meetings. He provided information on how to submit public comments.	
APPROVE MEETING AGENDA	The Agenda for today's meeting was approved.	**Approved unanimously. 3 AYES (Ballesteros, Booth and Shapiro)**
PUBLIC COMMENT	*Public Comment* *Elizabeth Cooper came here on a very, very serious matter. The members of the Executive Committee will discuss some very serious issues. She will speak on each item because she is very concerned about the issue. She appreciates the members of the Board who will make some tough decisions. She is here to give her point of view. She appreciates the time they spend but what she is concerned, she hopes they involve the Department of Managed Care and Department of Health Services. She wanted to give her comments before this important decision. She appreciates the comments that were made. She reserves the right to communicate with the Department of Managed Care and the Department of Health and Human Services. She knows the Board members are doing a fantastic job. But she's deeply concerned since she wasn't able, due to family issues, to come in and comment. She didn't get the agenda today so that's why she's in a rush. She would respectfully like to speak on all items on the Agenda for which she has requested.*	

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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
APPROVE MEETING MINUTES	The minutes of the May 22, 2024 meeting were approved.	**Approved unanimously.** **3 AYES**
CHAIRPERSON'S REPORT	*The Chairperson noted that public comment after this item will be limited to two minutes.* *<u>Public Comment</u>* *Elizabeth Cooper commented that she appreciates the courtesy, but this is a very serious matter and it affects members of L.A. Care. She's concerned regarding decisions the Committee will make today. Since she didn't have the agenda in a timely manner, she wasn't able to give her comments. She has to look at each agenda item. Because she reads the agenda and she wants to give public comment. It's very important her as a member of L.A. Care to give her public comments. The chairperson's report is important. The CEO report is going to be very important to her. She comes here to give her point of view because it's so important, health care is not something that she takes lightly. She will listen and give her comment. She thinks Mr. Baackes has done a beautiful job, but she has to respectfully have public comment. When those motions come up and that, because she didn't have time to read this. They didn't get from their ECAC members, as members of the RCAC, they didn't get much comment from the Chairs and it would have been possible if they had spoken to them. So she thanks the Chair for that public comment.* There was no report from the Chairperson.	
CHIEF EXECUTIVE OFFICER REPORT	*<u>Public Comment</u>* *Elizabeth Cooper commented on Mr. Baackes' report, she thinks he does the best he can but she has a point of view on a more serious note. She appreciates the ECAC and all what they have done, but she thinks they have not, in her opinion, addressed the issues if this motion goes through. They have not communicated with the members. They think of them as unimportant, but they are the ones who keep the engine going. They do not communicate with them. And if this motion goes through, she hopes this helps make sure that the Chairs communicate with the members, and they don't look at them as someone not important. All of these issues could have been discussed more freely if they had been more communication with the members, some don't even talk to the members, and that's why she's here. They are here to represent the people in their district.*	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	John Baackes, *Chief Executive Officer,* reported: The California Budget impacts a subject of great importance to L.A. Care, the managed care organization (MCO) tax. The Legislature reached an agreement on a Budget that includes a feature that the proceeds from the MCO tax, earmarked for about $2.6 billion this year, were swept by the Governor into the General Fund to help plug the budget deficit. This will have a negative impact for L.A. Care and all of the Medi-Cal providers. The Governor and the Legislature agreed that payments that would have gone to Medi-Cal in 2025 are pushed out to 2026. That's a meaningless gesture since the current Legislature cannot approve a budget provision for a future fiscal year. That has to be approved by the subsequent Legislature, so they will have to do it all over again next year. The MCO tax on managed care health plans like L.A. Care and our competitors, has been around for years. The money collected by the tax draws down a matching amount of dollars from the federal government. In the first nine years through 2021, the proceeds of that tax went to the general fund. None of the money went to Medi Cal. The tax was allowed to expire in 2023 because California had a one hundred billion dollar surplus. The health plan and provider community formed the Los Angeles Safety Net Coalition to try to get an increase in Medi-Cal funding to deal with financial impacts of COVID, the increased cost of nursing, and so forth. The Los Angeles County coalition, which consisted of hospitals, doctors, clinics, labor unions, and L.A. Care's competitor health plans, came up with the idea to have the tax reinstated with the proceeds earmarked specifically to increase MediCal reimbursement to providers. Surprisingly, the Coalition was able to get the Governor and Legislature to agree to implement it in last year's State Budget. The tax went into effect last July. It was supposed to be a three-year tax that would generate $19 billion in federal funding, with $8 billion going into the General Fund and $11 billion into Medi-Cal to increase payments to providers. By the Governor's action this year that funding is gone. It was assumed that when the tax was adopted last year that a ballot initiative was needed, which, if approved by the voters, would make the proceeds of the tax go to where it was originally intended. Sufficient signatures have been collected and the initiative has been certified by the Secretary of State. A ballot initiative number will be issued by July 3, and it will appear on the November ballot in California. If approved, it only takes a simple majority, the tax proceeds would begin to flow to increase Medi-Cal provider reimbursement and it will create another budget hole for the state next year to deal with. The coalition remains strong, everybody wants to proceed with this as planned. Local organizations have been part of the Coalition and it's really remarkable to have the various groups agree on the same thing. This is the number one issue right now.	

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• Government Affairs Update	Cherie Compartore, *Senior Director, Government Affairs*, reported: With regard to the California Budget, a directed payment program was approved for children's hospitals that brings in new funding of $230 million annually. The Governor issued a press release on another type of payment program for children's hospitals that may be in addition to that funding. Additional funding for the Equity and Practice Transformation payments for providers was removed from the Budget, leaving approximately $113 million believed for this year's program. Government Affairs staff is seeking information on next steps for that program. L.A. Care has 46 enrolled practices in that program. The Legislature and Governor agreed to funding for the: • Medi-Cal acupuncture benefit for adults, • benefits for In Home Supportive Services workers for undocumented seniors, • backup provider services for IHSS. Beneficiaries are eligible for approximately 80 hours per year, • Medi-Cal Continuous Eligibility program for children ages from birth through four years of age. Those are the main budget items. An updated State Budget review will be included in the next board meeting packet. Ms. Compartore reported that the main budget bill and the health budget trailer bill have been approved by the Governor and the Legislature, but there will be many budget trailer bills occurring through the summer and will be reported at a future Board meeting.	
COMMITTEE ISSUES		
Ratify L.A. Care Chief Executive Officer's, John Baackes, execution of Amendment A04 to L.A. Care's Exclusively Aligned Enrollment (EAE) D-SNP Contract Number 22-20236 with the Department of	***Public Comment*** *Elizabeth Cooper commented that a few years back when she was a member of the RCAC, they got the RCAC involved, and all these motions that she listens to, it is very important what she was saying and what Mr. Baackes said. Chairperson, she does pay attention to what is said and what the legislation is. But what she's concerned about is that she doesn't hear anything coming to the RCACs about going out and supporting with one's Legislator. L.A. Care has a large membership, and it's very important for them to hear from their constituency regarding this legislation, about Medi-Cal and what Governor Newsom has done. Some of those issues impact her as a consumer. As a member and in trying to be an informed person, she*	

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Health Care Services (DHCS)	*would hope, Chairperson and Members of the Board that you sort of encourage members to be more involved, not politically involved, but involved on those issues. So the Legislators can hear from the people who vote for them and who their constituency is. That is most important and she appreciates what she was discussing today and she appreciates what Mr. Baackes was saying, about what they tried to do. But one final thing, the voter's going to decide and those who write to their Legislator will be important to Governor Newsom. She writes to him.* Augustavia J. Haydel, Esq., *General Counsel*, introduced Nadia Grochowski, *Associate Counsel,* and she presented a motion for an amendment to the Dual-eligible Special Needs Plan (DSNP) agreement that L.A. Care currently has with the California Department of Health Care Services (DHCS). This is an amendment extending the term of the contract from December 31, 2024 to December 31, 2025. When the amendment was received from DHCS, L.A. Care was asked to sign by June 20 2024. Ms. Grochowski asked approval of a motion to ratify the execution of the amendment by Mr. Baackes. **Motion EXE 100.0724** **To ratify L.A. Care Chief Executive Officer's, John Baackes, execution of Amendment A04 to L.A. Care's Exclusively Aligned Enrollment (EAE) D-SNP Contract Number 22-20236 with the Department of Health Care Services (DHCS).**	**Approved unanimously.** **3 AYES**
Approve the revisions to the Operating Rules of the Consumer Advisory Committee, and related changes, in accordance to the delegated authority from the Board of Governors as outlined in Motion BOG 104.0624	**Public Comment** *Estela Lara, a former Chair of Regional Community Advisory Committee (RCAC) 2 in the San Fernando Valley, and a member of RCAC 4 in Metro LA. She would like the Committee to approve the Operating Rules and the modifications that were made. She thinks it will be really beneficial for RCAC members with just one little modification. The stipend will be increased to $100. She suggests to increase the stipend to $200 because they have not had one in a very long time, and since there are modifications it is better to include it right now. Demares Hernandez de Cordero, has been here for 24 years, Ms. Lara has been here for eight years. Fatima Vazquez has been here for 13 years. There was one more on the list and between just the four of them they have 50 years of experience. There are many more members on all RCACs. She thinks their experience is under utilized. L.A. Care pays consultants but should just pay them the additional stipend because they can tell you specifically what will improve the plan and what needs to be done to have it go forward. She asked for that change in the modifications.*	

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	Elizabeth Cooper commented that she understands comments are two minutes. She can talk fast, but sometimes she cannot. Chairperson, this is one of the most important things or issues before the Board, the changes in the operating rules. Although she didn't have a chance to vote on them. She only had a brief time. But this has not been explained. The money is important too, and it is a help, she concurs with the money, but she was concerned about some of the changes. What will happen? Who will be the ones who select under the operating rules, and what about the ECAC? Will they have terms where they do not have to go through the changes that the members go through? You need to think about this motion, how it is going to affect the members, because we did hear this, but where the members did not have a vote on this operating rules before the ECAC voted on it. If we did not get the final say, the ECAC members did not communicate with the chair. That's why I'm speaking. But on these operating rules, I wonder who would make that decision on selection, who be on the committee? Would that be a prejudicial thing? It should be consideration of who would make those decisions. She appreciates the leadership that Mr. Baackes has shown members and she thinks he's been very sensitive to some of the concerns. But she's concerned about the operating rules because it's going to make changes. For the record, in the enabling legislation SB 2092, there was no term limits in the legislation for term limits. She doesn't matter because even if she's termed out, she still has a voice. But please take notice SB 2092, the enabling legislation, does not set term limits. It's alright with her because she will go to any meeting. But please take notice, Board, SB 2092, the enabling legislation, and legislators will have to agree to term limits, she believes. That's her point. But please take notice how you vote on the operating rules, making sure the RCACs are able to sustain themselves. *(This comment from Ms. McLain was read at the end of the meeting because it was received via email after this topic was discussed, but it is included here for relevancy.)* *Deaka McLain, ECAC Member at Large (Representative for Senior and People w/ Disabilities(SPD), TTECAC Vice-Chair. I would like to thank the executive committee for assisting the advisory committees with this process. I am in support of the changes as long as it's written and clear what was promised by Mr. Baakes and that if we are unhappy with any aspect of the changes, the ECAC has the ability to make amendments as necessary to ensure the RCACs are meeting the needs of members. Deaka McClain*	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Mr. Baackes responded that it is a new requirement in the Medi-Cal contract with the DHCS that Medi-Cal managed care plans have consumer advisory committees. L.A. Care has always had them, and that makes L.A. Care an outlier from other managed care plans in California. For most plans, this is a new issue being addressed from scratch. L.A. Care worked to bring the long-standing RCACs and ECAC in alignment with the new DHCS requirements. A principal new requirement was that plans have a selection committee for community advisory committees, and that a report is sent annually on the composition of the community advisory committees. The members of the advisory committees must match the composition of membership in the health plan. L.A. Care has multiple RCACs while most other health plans will have only one. L.A. Care took this opportunity to create a selection committee and after listening to RCAC member concerns that the selection committee would be made up of members of the staff, the new operating rules call for a selection committee of six, consisting of three RCAC chairs selected by the ECAC, two members of the L.A. Care community based organization advisory group, and one staff member, the Chief Health Equity Officer, Dr. Alex Li. The committee of six will select the members of the eight RCACs. The eight RCACs (instead of the current eleven) will align with LA County Service Planning Areas (SPAs). This will enable L.A. Care to provide the members of those eight committees with current data from Los Angeles County about the health status of the community they live in. The data can be used in making recommendations to L.A. Care. Members will have two 4-year terms, which matches the term limits of the Board of Governors. L.A. Care reviewed the issue that was raised about no term limits and cannot find any substantiation, so the term limits are allowed. The structure was presented to the ECAC, and as the previous speaker mentioned, ECAC approved it. There was significant discussion about, what if we don't approve, what if it doesn't work out the way we think it can. So there is an opportunity in the operating rules for the ECAC to revisit the operating rules and make recommendations if things aren't working, so it can be adjusted going forward. Those are the highlights of what the operating rules contain. On the behalf of staff, Mr. Baackes stated they are anxious to get this implemented and over with and start meetings again on the new basis. Assuming it is approved, two meetings are planned in August including all RCAC members meeting together to go over the new operating rules, the new configurations and the new agendas. The Agendas we'll use will encourage more participation by the members. There will be a two-day training sessions	

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	held two weeks apart in August and then the regular schedule will start in September. There will be six meetings annually for each RCAC. Mr. Baackes noted that is a quick summary of discussions, and topics were discussed many times. In the last round of RCAC meetings, Sameer Amin, MD, *Chief Medical Officer,* and Mr. Baackes tried to attend every RCAC meeting. Each of them attended four and there were three they couldn't get to that other staff attended. Modifications were made after listening to the members in those meetings. One concern was that they didn't like the idea of only four meetings, and the number of meetings was raised to six meetings annually. Another was that they really didn't like the idea of roundtable meetings, so that was eliminated. L.A. Care will incorporate member focused discussion in the agendas of the RCAC meetings. The purpose of the proposed roundtables was to have topic specific items on every agenda. Mr. Baackes asked that the Executive Committee consider a motion to adopt the operating rules. Board Member Booth noted there are typos and some grammar that needs to change and would not affect the document. She asked specifically about the wording on page 11, described as “substantial” violation of the Code of Conduct. She recommends the language be revised to indicate a CAC member is removed for violation of the Code of Conduct, without the word substantial. The section is about eligibility to re-apply for membership, the word substantial should not be there because it gives the appearance that there could be violations that are not substantial. She thinks a violation of the Code of Conduct is substantial. She was told that the word fighting just under that section as a one of the potential reasons for action taken against a CAC member. She thinks that's pretty unclear and was told that it could be better defined in the CAC member handbook, which also has conduct rules. Also on page 9, she noted the intention for 25 members in a group, this includes a maximum membership of 35. She suggested discussing whether 35 or 25 should be the maximum. She recommended aiming for a maximum of 25 because she is a member of committees with 35 members and it is way too many to get anything done. She noted there are a couple of other places with some inconsistencies that should be fixed. Mr. Baackes noted that the original operating rules included things about fighting and so forth, so that wording has been in the document for some time. The reason for the maximum of 35 members is because one RCAC will have 32 members in the new structure. Those 32 members will carry over into the new RCAC. L.A. Care agreed that	

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	current RCAC members would be "grandfathered in" and wouldn't need to go through the selection process. Board Member Booth agreed that is fine to start the process, but as people leave they should not be replaced the RCAC membership is down to 25. She doesn't think the maximum needs to be described if it will be 25. Augustavia Haydel, *General Counsel*, noted that the enabling legislation sets the maximum number of each RCAC at 35, so this language reflects the number that was in the legislation, which is 35. The operating rules should not contain language that contradicts the enabling legislation. Mr. Baackes noted that the stipend is being raised to $140 per meeting, which is doubling the previous stipend. A proposal to make certain revisions to the Operating Rules for the Consumer Advisory Committees (CAC) was presented at the June 12, 2024 Temporary Transitional Executive Community Advisory Committee (TTECAC) meeting. The members of the TTECAC endorsed the revisions to the Operating Rules that included changes to CAC operations previously approved by the TTECAC at its meeting on May 12, 2024. The most substantive revisions to the Operating Rules are summarized below: 1. <u>Section II – Function and Role</u> – Additional subject areas added to align with new language in L.A. Care's contract with the Department of Health Care Services (DHCS) to provide Medi-Cal services. 2. <u>Section III – Membership, Paragraph A – Selection Committee</u> – A new section added describing the structure and role of a new CAC Member Selection Committee. The section also adds language referring to the submission of an Annual CAC Membership Demographic report by April 1 of each year. 3. <u>Section III – Membership, Paragraph F – CAC Member Term</u> – Language added describing term limits for CAC members (a maximum of two, four-year terms) and the setting of a target membership of 25 members for each CAC. 4. <u>Section III – Membership, Paragraph H – Replacement of Members</u> – Language added to specify that L.A. Care intends to replace CAC members who resign or are removed within 60 days. 5. <u>Section VII – CAC Meetings, Paragraph D - Additional Meeting Guidelines</u> – Additional language referring to posting of CAC meeting summaries, the deadline for submission of meeting summaries to DHCS and the length of the meeting summary record retention period.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	At its meeting of June 12, 2024, the TTECAC requested an additional revision to the Operating Rules: 1. Section V – Role and Term of ECAC Leadership – Sections A and B – In subparagraph e in each section, the TTECAC has requested that only unexcused absences be considered when determining if an ECAC Chairperson or Vice-Chairperson is considered to have resigned from their position due to missed meetings. In addition, the TTECAC asked that language that staff would consider each situation of this type on a case-by-case basis be added. Staff is in agreement with these additional revisions to the Operating Rules. Other non-substantive edits to the Operating Rules to remove mention of the CCI Council CAC that no longer exists and several minor corrections are also noted. **Motion EXE A.0624** **To authorize the Executive Committee of the Board of Governors to approve revisions to the Operating Rules for the Consumer Advisory Committees of L.A. Care Health Plan as presented during the June 12, 2024 meeting of the Temporary Transitional Executive Community Advisory Committee.** On behalf of the staff who have been working on this issue for a long time, Mr. Baackes thanked the Board Members and RCAC and ECAC members who have participated in the meetings, and he looks forward to a regular cadence of community advisory committee meetings to discuss issues that are important to the to the RCAC members and will help inform L.A. Care on how the organization can add value for members and providers. He thanked everyone extending patience through this process. Board Member Booth also thanked Francisco Oaxaca for his response to her questions even though he is out of the office. Mr. Baackes recognized the work by Auleria Eakins, a senior member of the staff who has been extremely helpful in this process. He also thanked the public for being involved in the discussion.	**Approved unanimously, with non-substantive edits.** **3 AYES**

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Discussion/ Recommendation on Temporary Transitional Executive Community Advisory Committee's tabled motions from May 2, 2024 Board of Governors meeting	*<u>Public Comments</u>* *Estela Lara from RCAC four asked the Committee to please approve the motion.* *Elizabeth Cooper commented that she approves this motion, with one correction. She knows it's out of order, Chairperson, when she speaks, she refers to the point of authority, the enabling legislation. Anything that she has spoken about is referred to in the enabling legislation, just like Counselor Haydel. So she hopes everything is going. She approves this, she doesn't object to this motion, she just wanted to say, you might say she's out of order, but Elizabeth Cooper referred to the enabling legislation that was signed by Governor Wilson and the legislature approved it. So that's when she's speaking.*	
• Placement of Closed session on the Board Meeting Agenda	Ms. Haydel noted that this motion was brought forward by the TTECAC in response to changing the closed session from the end to the beginning of the Board meeting Agenda. TTECAC brought this motion forward and it was tabled by the Board at the May meeting, and delegated by the Board to the Executive Committee for further discussion about whether the public portion of the Board meeting could be moved back up to the beginning of the Board meeting. Chairperson Ballesteros asked Executive Committee members about their thoughts on reverting back a closed session at the end of the Board meeting. The Board heard from the public in recent meetings that having the closed session at the beginning of the meeting has been problematic for their schedule. Board Member Booth commented that the closed session was moved to the beginning of the Board meeting because the members present for the quorum goes down near the end of the meeting and action could not be taken without quorum. Action items were then placed in the early part of the meeting and the more informational items were moved to the end. The Board members are here to do the business of L.A. Care. She acknowledges the issue expressed in public comment, and the Board also needs to accomplish the action items on the Agenda. Board Member Shapiro agreed with Board Member Booth and noted it is a balance of making sure that the public can participate and the Board can do its business. He suggested a shorter 30 minute closed session at the beginning of the meeting as a compromise, understanding that it would be the middle ground between what we have and what we can offer. That way the Board can vote on action items. Board Chairperson talked to consumers. He has a general sense that the Board wants to	

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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	make meetings as accessible to the public as possible. The Board members do not want the public to get the impression that they are not considered as the agenda is structured. A main concern is that Board Members did not want the public to feel as if they were not important, and that might appear to be reflected in the fact that the closed session was moved to the beginning of the meeting. There are also some issues around meeting management that we need to think of: when many public comments come forward and there are many agenda items on the Agenda, he has been willing to move public comment from 3 to 2 minutes. There is a set amount of time for the meeting. He is also comfortable with pointing out to the speakers before the Board when the topic that they want to speak to in their comments are not germane to the Agenda topic. He suggested these additional meeting management tools be used. He has no issue with moving the closed session to the end of the agenda. He advised Board Members and the public that he will have to exercise those options to bring public comment from 3 to 2 minutes, perhaps to 1 minute if the agenda's cramped. He thinks that if the public is aware of that he will be okay with moving the closed session item back to the end of the agenda given that we're going to begin exercising more of the meeting management tools. He recommended going back to having the closed session to the end of the meeting. **MOTION TTECA 100.0524** **To request the Board of Governors to consider returning the BOG monthly meetings to the first Thursday 1 pm – 4 PM BOG "public" session meetings which would cause the BOG "closed" sessions to begin before or after the "public" session meetings designated hours.** Chairperson Ballesteros directed staff that starting at the next board meeting, the closed session will be held at the end of the meeting.	 **Approved unanimously.** **3 AYES**
• Consider the placement of push buttons on any door accessible to the public at any site used by L.A. Care for public meetings	Darren Lee, *Deputy Chief Human Resources Officer*, noted that in a previous session, the Board Members requested additional information about adding automatic opening doors to L.A. Care Community Resource Centers and sites visited by the public. The request was reviewed, and it was determined that L.A. Care is in compliance with state and federal regulations with regard to those doors already in all public meeting spaces and larger forums. A review included researching any industry practice or standards for installation of automatic doors on bathrooms. It is noted that installing these automatic doors can create additional problems with blocking hallways and passageways as well as privacy issues when the doors stay open. He referred Board Members to the meeting	

DRAFT

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	materials which include positive and negative potential issues with regard to the automatic doors. There are maintenance costs included in the meeting materials. He also noted that if the power goes out, the automatic doors are more difficult to manage. Industry standard and practice for regular clinics is that they generally do not have automatic doors. Looking at the cost for installation, which was one of the concerns the Board asked about, would be somewhere between $25 and $30,000 per door. That number is closer to $40,000 to retrofit. Retrofitting all of L.A. Care's doors at Community Resource Centers would cost somewhere in the neighborhood of $500,000. If that is something the Board would like to consider, additional information is included with regard to the time remaining on each lease. Board Member Shapiro asked Mr. Lee to confirm that the information indicates L.A. Care is doing all the legal things that it needs to be doing and is compliant, and this would be something extra. Mr. Baackes noted the staff recommendation in the meeting materials. Board Member Booth asked about the difference in cost from a regular door. Mr. Lee noted that there is a different door and framing, electrical and switches. A retrofit would include the deconstruction of the old door as well as installation of the automatic door. Board Member Booth commented that she has worked in hospitals that have a lot of these doors, and there seems to always be work on them or they get stuck. She hasn't found them to be reliable. Mr. Lee noted there would be a cost for regular maintenance as well as parts to repair them. **<u>Motion TTECA 101.0524</u>** **L.A. Care Board of Governors to consider the placement of push door buttons on any door accessible to the public at any site used by L.A. Care for public meetings.** Board Member Booth commented to the members present that this is the input the Board would like to see. This is wonderful. She thanked the members for bringing it forward.	**Not approved.** **2 NAYS,** **1 ABSTENTION (Ballesteros)**
Approve Human Resources Policies HR 306 (Equal	*<u>Public Comment</u>* *Elizabeth Cooper thanked the Chair and Board Members. This issue of human resource policy that's the employment is very important. She knows as member of*	

DRAFT

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Employment Opportunity) and HR 603 (Overtime Pay)	*the public, and she hopes board members will listen to their concerns. She is concerned because when she first came here she saw a lack of Afro Americans employed here, and this is the employment issue. Also Afro Americans and others not given high positions. So she would like to know how does equal opportunity fit because I see some Afro Americans now who are in very high academic, but they are not getting elevated to top positions. And she also would like to see disabled members, which she hopes you do, but on the equal opportunity they hire and they fire, and they also recommend. She would also like to see diversity which she appreciates, she works with all groups, but she does like this board to consider diversity. As the one who has preached this since she's been a member of L.A. Care on the RCACs. She appreciates all cultures, but she finds that there's been a lack of elevation of Afro Americans in top positions. She's not saying others aren't just as important, but she would like to see the human relations department start elevating some. That doesn't mean they are all right or all wrong, but she's seen African Americans with high position and they're still in the same position. They don't get a chance. They go to the family resource centers, they don't get those positions. So she would like the human resources department to be more proactive on that. She appreciates all the employees. In fact, she has supported all the employees, but she sees a lack of Afro Americans in high positions.* Mr. Lee presented a motion requesting approval of the revised Human Resources Policies 306 (Equal Employment Opportunity) and HR 603 (Overtime Pay).	

Policy Number	Policy	Section	Description of Modification
HR-306	Equal Employment Opportunity	Employment	Including recommended verbiage to meet NCQA Health Equity HE1A Factor 1
HR-603	Overtime Pay	Benefits	Transferred Policy to new template and made minor changes

	<u>Motion EXE B.0624</u> **To approve the Human Resources Policies HR 306 (Equal Employment Opportunity) and HR 603 (Overtime Pay), as presented.**	**Approved unanimously.** **3 AYES**

DRAFT

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Mr. Baackes commented that the changes approved were suggested as part of the accreditation process whereby L.A. Care achieved Health Equity Accreditation from the National Committee on Quality Assurance.	
Approve Consent Agenda	Approve the list of items that will be considered on a Consent Agenda for July 25, 2024 Board of Governors Meeting. • June 6, 2024 meeting minutes • Ratify L.A. Care Chief Executive Officer's, John Baackes, execution of Amendment A04 to L.A. Care's Exclusively Aligned Enrollment (EAE) D-SNP Contract Number 22-20236 with the Department of Health Care Services (DHCS)	**Approved unanimously.** **3 AYES**
PUBLIC COMMENTS		
ADJOURN TO CLOSED SESSION	The Joint Powers Authority Executive Committee meeting adjourned at 3:30 pm. Augustavia J. Haydel, Esq., *General Counsel* announced the items for discussion in closed session. She announced there is no report anticipated from the closed session. The meeting adjourned to closed session at 3:30 pm. REPORT INVOLVING TRADE SECRET Pursuant to Welfare and Institutions Code Section 14087.38(n) Discussion Concerning New Service, Program, Business Plan Estimated date of public disclosure: *June 2026* CONTRACT RATES Pursuant to Welfare and Institutions Code Section 14087.38(m) • Plan Partner Rates • Provider Rates • DHCS Rates THREAT TO PUBLIC SERVICES OR FACILITIES Government Code Section 54957 Consultation with: Tom MacDougall, *Chief Information & Technology Officer*, and Gene Magerr, *Chief Information Security Officer* CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION Significant exposure to litigation pursuant to Section 54956.9(d)(2) of Ralph M. Brown Act: Three Potential Cases	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act L.A. Care Health Plan's Notice of Contract Dispute under Contract No. 04-36069 Department of Health Care Services (Case No. Unavailable) CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act • Department of Managed Health Care Enforcement Matter Numbers: 18-799, 20-063, 21-428, 21-509, 21-680 • Department of Health Care Services, Office of Administrative Hearings and Appeals, In the matter of: L.A. Care Health Care Plan Appeal No. MCP22-0322-559-MF PUBLIC EMPLOYEE PERFORMANCE EVALUATION, PUBLIC EMPLOYMENT and CONFERENCE WITH LABOR NEGOTIATOR Sections 54957 and 54957.6 of the Ralph M. Brown Act Title: Chief Executive Officer Agency Designated Representative: Alvaro Ballesteros, MBA Unrepresented Employee: John Baackes	
RECONVENE IN OPEN SESSION	The meeting reconvened in open session at 3:50 pm. No reportable actions were taken during the closed session.	
ADJOURNMENT	The meeting adjourned at 3:50 pm	

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

APPROVED BY:

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

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Legislative Matrix 8.19.2024

Last Updated: August 19, 2024

Bills by Issue

2024 Legislation (99)

Bill Number	Status	Position
AB 106	**Enacted**	**Monitor**

Title
Budget Acts of 2022 and 2023.

Description
AB106, Gabriel . Budget Acts of 2022 and 2023. The Budget Act of 2022 and the Budget Act of 2023 made appropriations for the support of state government for the 2022–23 and 2023–24 fiscal years. This bill would amend the Budget Act of 2022 and the Budget Act of 2023 by amending, adding, and repealing items of appropriation and making other changes. This bill would declare that it is to take effect immediately as a Budget Bill.

Primary Sponsors
Jesse Gabriel

Bill Number	Status	Position
AB 177	**In Senate**	**Monitor**

Title
Budget Act of 2023.

Description
AB 177, as amended, Committee on Budget. Budget Act of 2023. This bill would express the intent of the Legislature to enact statutory changes, relating to the Budget Act of 2023.

Primary Sponsors
House Budget Committee

Bill Number
AB 869

Status
In Senate

Position
Monitor

Title
Hospitals: seismic safety compliance.

Description
AB 869, as amended, Wood. Hospitals: seismic safety compliance. Existing(1) Existing law requires, no later than January 1, 2030, owners of all acute care inpatient hospitals to either demolish, replace, or change to nonacute care use all hospital buildings not in substantial compliance with specified seismic safety standards or to seismically retrofit all acute care inpatient hospital buildings so that they are in substantial compliance with those seismic safety standards. Existing law requires the Department of Health Care Access and Information to issue a written notice upon compliance with those requirements.The bill would require all rural, district, and distressed acute care hospitals to provide the department with a seismic safety compliance plan by no later than July 1, 2026, that describes how the hospital intends to meet the seismic safety requirements described above.
(2) Existing law establishes the Distressed Hospital Loan Program to provide interest-free cashflow loans to not-for-profit hospitals and public hospitals in significant financial distress or to governmental entities representing a closed hospital, except as otherwise provided, to prevent the closure of, or facilitate the reopening of, those hospitals.This bill would qualify a general acute care hospital that received a distressed hospital loan for an extension of the seismic safety standards described above until January 1, 2032. If the department determines that the cost of design and construction for compliance with these seismic safety standards will result in a financial hardship for a distressed hospital that may result in hospital closure, and state funds, federal grants, or private funds are not available to assist with the cost of compliance, the bill would authorize the distressed hospital to delay compliance until January 1, 2035. The bill would require the department to confirm a distressed hospital’s lack of ability to comply and that the cost of compliance may result in hospital closure, or would substantially impact the accessibility to health care in communities surrounding the distressed hospital. The bill would authorize the department to implement these provisions through emergency regulations.Existing(3) Existing law establishes the Small and Rural Hospital Relief Program for the purpose of funding seismic safety compliance with respect to small hospitals, rural hospitals, and critical access hospitals in the state. Existing law requires the department to provide grants to small, rural, and critical access hospital applicants that meet certain criteria, including that seismic safety compliance, as defined, imposes a financial burden on the applicant that may result in hospital closure. Existing law also creates the Smal... (click bill link to see more).

Primary Sponsors
Jim Wood, Eduardo Garcia

Bill Number	Status	Position
AB 892	**In Senate**	**Monitor**

Title
Kern County Hospital Authority.

Description
AB 892, as introduced, Bains. Kern County Hospital Authority. Existing law, the Kern County Hospital Authority Act, establishes the Kern County Hospital Authority, which maintains and operates the Kern Medical Center and is governed by a board of governors that is appointed, both initially and continually, by the board of supervisors. Existing law requires the authority to provide management, administration, and other controls as needed to operate the medical center, and maintain its status as a designated public hospital. The Meyers-Milias-Brown Act contains various provisions that govern collective bargaining of local represented employees, and requires the governing body of a public agency to meet and confer in good faith regarding wages, hours, and other terms and conditions of employment with representatives of recognized employee organizations. Existing law, the Ralph M. Brown Act, requires each legislative body of a local agency to provide notice of the time and place for its regular meetings and also requires that all meetings of a legislative body be open and public, and that all persons be permitted to attend unless a closed session is authorized. The California Public Records Act requires state and local agencies to make their records available for public inspection, unless an exemption from disclosure applies.This bill would require that all entities controlled, owned, administered, or funded by the authority be subject to the Meyer-Milias-Brown Act, the Ralph M. Brown Act, and the California Public Records Act. By imposing new duties on the authority, 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
Jasmeet Bains

Bill Number	Status	Position
AB 1282	**In Senate**	**Monitor**

Title
Mental health: impacts of social media.

Description
AB 1282, as amended, Lowenthal. Mental health: impacts of social media. Existing law, the Mental Health Services Act, an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the Mental Health Services Oversight and Accountability Commission, and authorizes the commission to take specified actions, including advising the Governor or the Legislature regarding actions the state may take to improve care and services for people with mental illness.This bill would require the commission to report to specified policy committees of the Legislature, on or before July 1, 2025, a statewide strategy to understand, communicate, and mitigate mental health risks associated with the use of social media by children and youth. The bill would require the report to include, among other things, (1) the degree to which individuals negatively impacted by social media are accessing and receiving mental health services and (2) recommendations to strengthen children and youth resiliency strategies and California's use of mental health services to reduce the negative outcomes that may result from untreated mental illness, as specified. The bill would require the commission to explore, among other things, the persons and populations that use social media and the negative mental health risks associated with social media and artificial intelligence, as defined. The bill would repeal these provisions on January 1, 2029.

Primary Sponsors
Josh Lowenthal

Bill Number
AB 1316

Status
In Senate

Position
Monitor

Title
Emergency services: psychiatric emergency medical conditions.

Description
AB 1316, as amended, Irwin. Emergency services: psychiatric emergency medical conditions. Existing law, the Lanterman-Petris-Short Act, provides for the involuntary commitment and treatment of a person who is a danger to themselves or others or who is gravely disabled, as defined. 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. Pursuant to a schedule of covered benefits, existing law requires Medi-Cal coverage for inpatient hospital services, subject to utilization controls, and with respect to fee-for service beneficiaries, coverage for emergency services and care necessary for the treatment of an emergency medical condition and medical care directly related to the emergency medical condition, as specified.Existing law provides for the licensing and regulation of health facilities by the State Department of Public Health and makes a violation of those provisions a crime. Existing law defines “psychiatric emergency medical condition,” for purposes of providing treatment for emergency conditions, as a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either an immediate danger to the patient or to others, or immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder. Existing law includes various circumstances under which a patient is required to be treated by, or may be transferred to, specified health facilities for treatment that is solely necessary to relieve or eliminate a psychiatric emergency medical condition.This bill would revise the definition of “psychiatric emergency medical condition” to make that definition applicable regardless of whether the patient is voluntary, or is involuntarily detained for evaluation and treatment, under prescribed circumstances. The bill would make conforming changes to provisions requiring facilities to provide that treatment. By expanding the definition of a crime with respect to those facilities, the bill would impose a state-mandated local program.The bill would require the Medi-Cal program to cover emergency services and care necessary to treat an emergency medical condition, as defined, including all professional physical, mental, and substance use treatment services, including screening examinations necessary to determine the presence or absence of an emergency medical condition and, if an emergency medical condition exists, all services medically necessary to stabilize the beneficiary. The bill would require coverage for emerge... (click bill link to see more).

Primary Sponsors
Jacqui Irwin, Chris Ward

Bill Number
AB 1470

Status
Passed Senate

Position
Monitor

Title
Medi-Cal: behavioral health services: documentation standards.

Description
AB 1470, as amended, Quirk-Silva. Medi-Cal: behavioral health services: documentation standards. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including behavioral health services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes the California Advancing and Innovating Medi-Cal (CalAIM) initiative, subject to receipt of any necessary federal approvals and the availability of federal financial participation, in order to, among other things, improve quality outcomes and reduce health disparities.The bill, as part of CalAIM, and with respect to behavioral health services provided under the Medi-Cal program, would require the department to standardize data elements relating to documentation requirements, including, but not limited to, medically necessary criteria, and would require the department to develop standard forms containing information necessary to properly adjudicate claims pursuant to CalAIM Terms and Conditions. The bill would require the department to consult with representatives of specified associations and programs for purposes of implementing these provisions.The bill would require the department to conduct, on or before July 1, 2025, regional trainings for personnel and provider networks of applicable entities, including county mental health plans, Medi-Cal managed care plans, and entities within the fee-for-service delivery system, on proper completion of the standard forms. The bill would require each applicable entity to distribute the training material and standard forms to its provider networks, and to commence, no later than July 1, 2025, using the standard forms. The bill would require providers of applicable entities to use those forms, as specified. The bill would authorize the department to restrict the imposition of additional documentation requirements beyond those included on standard forms, as specified.The bill would require the department to conduct an analysis on the status of utilization of the standard forms by applicable entities, and on the status of the trainings and training material, in order to determine the effectiveness of implementation of the above-described provisions. The bill would require the department to prepare a report containing findings from the analysis no later than July 1, 2026, and a followup report no later than July 1, 2028, and to submit each report to the Legislature and post it on the department’s internet website.

Primary Sponsors
Sharon Quirk-Silva

Bill Number	Status	Position
AB 1537	**In Senate**	**Monitor**

Title
Skilled nursing facilities: direct care spending requirement.

Description
AB 1537, as introduced, Wood. Skilled nursing facilities: direct care spending requirement. Existing law provides for the licensure and regulation of health facilities, including skilled nursing facilities, by the State Department of Public Health. A violation of those provisions is a crime. Existing law requires health facilities to submit specified financial reports to the Department of Health Care Access and Information. 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.This bill would require, no later than July 1, 2024, the establishment of a direct patient-related services spending, reporting, and rebate requirement for skilled nursing facilities, with exceptions. Under the direct patient-related services spending requirement, the bill would require that a minimum of 85% of a facility’s total non-Medicare health revenues from all payer sources in each fiscal year be expended on residents’ direct patient-related services, as defined.The bill would require a facility to report total revenues collected from all revenue sources, along with the portion of revenues that are expended on all direct patient-related services and nondirect patient-related services, to the State Department of Health Care Services by June 30 of each calendar year, with certification signed by a duly authorized official, as specified.The bill would require the State Department of Health Care Services to conduct an audit of the financial information reported by the facilities, to ensure its accuracy and to identify and recover any payments that exceed the allowed limit, as specified. The bill would require the department to conduct the audit every 3 years, at the same time as the facility’s Medi-Cal audit.If a skilled nursing facility fails to comply with the direct patient-related services spending requirement, the bill would require the facility to issue a pro rata dividend or credit to the state and to all individuals and entities making non-Medicare payments to the facility for resident services, as specified. The bill would require the State Department of Health Care Services to ensure that those payments are made and to impose sanctions, as specified. The bill would also authorize the department to withhold certain payments from a skilled nursing facility licensee for failure to fully disclose information, as specified.Because a violation of these requirements 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 pro... (click bill link to see more).

Primary Sponsors
Jim Wood

Bill Number
AB 1842

Status
In Senate

Position
Monitor

Title
Health care coverage: Medication-assisted treatment.

Description
AB 1842, as amended, Reyes. Health care coverage: Medication-assisted treatment. Existing law, the Knox–Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law authorizes health care service plans and health insurers that cover prescription drugs to utilize reasonable medical management practices, including prior authorization and step therapy, consistent with applicable law. This bill would prohibit a medical service plan and a health insurer from subjecting a naloxone product or another opioid antagonist approved by the United States Food and Drug Administration, or a buprenorphine product or long-acting injectable naltrexone for detoxification or maintenance treatment of a substance use disorder, to prior authorization or step therapy. 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.

Primary Sponsors
Eloise Reyes

Organizational Notes

Last edited by Joanne Campbell at Mar 22, 2024, 6:00 PM
California Association of Health Plans - Oppose America’s Health Insurance Plans - Oppose Association of California Life and Health Insurance Companies - Oppose Support: California Academy of Child and Adolescent Psychiatry - Support California Black Health Network - Support California Hospital Association - Support California State Association of Psychiatrists (CSAP) - Support County Behavioral Health Directors Association of California - Support Ella Baker Center for Human Rights - Support Health Access California - Support Steinberg Institute - Support

Bill Number
AB 1876

Status
In Senate

Position
Monitor

Title
Developmental services: individual program plans and individual family service plans: remote meetings.

Description
AB 1876, as introduced, Jackson. Developmental services: individual program plans and individual family service plans: remote meetings. Existing law, the Lanterman Developmental Disabilities Services Act, requires the State Department of Developmental Services to contract with regional centers for the provision of community services and supports for persons with developmental disabilities and their families. Existing law, until June 30, 2024, requires a meeting regarding the provision of services and supports by the regional center, including a meeting to develop or revise a consumer’s individual program plan (IPP), to be held by remote electronic communications if requested by the consumer or, if appropriate, if requested by the consumer’s parents, legal guardian, conservator, or authorized representative. Existing law, the California Early Intervention Services Act, provides a statewide system of coordinated, comprehensive, family-centered, multidisciplinary, and interagency programs that are responsible for providing appropriate early intervention services and supports to all eligible infants and toddlers and their families. Under the act, direct services for eligible infants and toddlers and their families are provided by regional centers and local educational agencies. The act requires an eligible infant or toddler receiving services under the act to have an individualized family service plan (IFSP), as specified. Existing law, until June 30, 2024, requires, at the request of the parent or legal guardian, an IFSP meeting to be held by remote electronic communications. This bill, beginning January 1, 2025, would indefinitely extend the requirements that, if requested, IPP and IFSP meetings be held by remote electronic communications. By extending a requirement for local educational agencies, 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, 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
Corey Jackson

Bill Number
AB 1895

Status
In Senate

Position
Monitor

Title
Public health: maternity ward closures.

Description
AB 1895, as amended, Weber. Public health: maternity ward closures. Existing law establishes the licensure and regulation of health facilities by the State Department of Public Health, including, among others, general acute care hospitals. A violation of these provisions is a crime. Under existing law, a general acute care hospital is required to provide certain basic services, including medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services. Existing law authorizes a general acute care hospital to provide various special or supplemental services if certain conditions are met. Existing regulations define a supplemental service as an organized inpatient or outpatient service that is not required to be provided by law or regulation. Existing law requires a health facility to provide 90 days of public notice, with specified requirements, of the proposed closure or elimination of a supplemental service, such as maternity services.This bill would require an acute care hospital that operates a perinatal unit and expects challenges in the next 6 months that may result in a reduction or loss of perinatal services, to provide specified information to the Department of Health Care Access and Information, including, but not limited to, the number of medical staff and employees working in the perinatal unit and the hospital’s prior performance on financial metrics. The bill would require the Department of Health Care Access and Information to forward the provided information to various entities, including the State Department of Health Care Services. The bill would require this information be kept confidential to the extent permitted by law. The bill would require, within 3 months of receiving this notice from the hospital, the Department of Health Care Access and Information, in conjunction with the State Department of Public Health and the State Department of Health Care Services, to conduct a community impact assessment to identify the 3 closest hospitals operating a perinatal unit, their distance from the challenged facility, and whether those hospitals have any restrictions on their reproductive health services. The bill would require the Department of Health Care Access and Information to provide the community impact assessment to specified entities and would require these entities to keep the community impact assessment confidential. If the hospital closes its perinatal unit, the bill would require the hospital to provide public notice of the closure, including the results of the community impact assessment, and other specified information on the hospital’s internet website 90 days in advance of the closure. The bill would require the public to be permitted to com... (click bill link to see more).

Primary Sponsors
Akilah Weber

Organizational Notes

Last edited by Joanne Campbell at Apr 22, 2024, 6:00 PM
Local Health Plans of California- Support

Bill Number	Status	Position
AB 1936	**Passed Senate**	**Monitor**

Title
Maternal mental health screenings.

Description
AB 1936, as amended, Cervantes. Maternal mental health screenings. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan or health insurer to develop a maternal mental health program designed to promote quality and cost-effective outcomes, as specified.This bill would require the program to consist of at least one maternal mental health screening during pregnancy, at least one additional screening during the first 6 weeks of the postpartum period, and additional postpartum screenings, if determined medically necessary and clinically appropriate in the judgment of the treating provider. 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
Sabrina Cervantes, Susan Rubio

Bill Number
AB 1975

Status
In Senate

Position
Monitor

Title
Medi-Cal: medically supportive food and nutrition interventions.

Description
AB 1975, as amended, Bonta. Medi-Cal: medically supportive food and nutrition interventions. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Existing law requires the department to establish the Medically Tailored Meals Pilot Program and the Short-Term Medically Tailored Meals Intervention Services Program, to operate in specified counties and during limited periods for the purpose of providing medically tailored meal intervention services to eligible Medi-Cal beneficiaries with certain health conditions, including congestive heart failure, cancer, diabetes, chronic obstructive pulmonary disease, or renal disease.Existing law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, authorizes a Medi-Cal managed care plan to elect to cover community supports approved by the department as cost effective and medically appropriate in a comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services. Under existing law, community supports that the department is authorized to approve include, among other things, medically supportive food and nutrition services, including medically tailored meals.This bill would make medically supportive food and nutrition interventions a covered benefit under the Medi-Cal program, through both the fee-for-service and managed care delivery systems, no sooner than July 1, 2026, upon appropriation and subject to federal approval and the issuance of final guidance by the department. The bill would require those interventions to be covered if determined to be medically necessary by a health care provider or health care plan, as specified. The bill would require the provision of interventions for 12 weeks, or longer if deemed medically necessary.The bill would require the department to define the qualifying medical conditions for covered interventions and delineate the services included in the definition of a medically supportive food and nutrition intervention. The bill would require a health care provider, to the extent possible, to match the acuity of a patient’s condition to the intensity and duration of the covered intervention and to include culturally appropriate foods.The bill would require the department, upon appropriation, to establish a medically supportive food and nutrition benefit stakeholder group, with a specified composition, to advise the department on certain related items, such as the scope of the benefit, among others.

Primary Sponsors
Mia Bonta

Organizational Notes

Last edited by Cherie Compartore at May 14, 2024, 3:52 PM
Support: Local Health Plans of California , California Association of Health Plans

Bill Number	Status	Position
AB 1977	**In Senate**	**Monitor**

Title
Health care coverage: behavioral diagnoses.

Description
AB 1977, as amended, Ta. Health care coverage: behavioral diagnoses. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or health insurance policy to provide coverage for behavioral health treatment for pervasive developmental disorder or autism.This bill would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, from requiring an enrollee or insured previously diagnosed with pervasive developmental disorder or autism to be reevaluated or receive a new behavioral diagnosis to maintain coverage for behavioral health treatment for their condition. The bill would require a treatment plan to be made available to the plan or insurer upon request. Because a willful violation of this provision 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
Tri Ta

Bill Number
AB 2013

Status
In Senate

Position
Monitor

Title
Artificial intelligence: training data transparency.

Description
AB 2013, as amended, Irwin. Artificial intelligence: training data transparency. Existing law requires the Department of Technology, in coordination with other interagency bodies, to conduct, on or before September 1, 2024, a comprehensive inventory of all high-risk automated decision systems, as defined, that have been proposed for use, development, or procurement by, or are being used, developed, or procured by, state agencies, as defined.This bill would require, on or before January 1, 2026, and before each time thereafter that an artificial intelligence system or service, as defined, is made available to Californians for use, regardless of whether the terms of that use include compensation, a developer of the system or service to post on the developer's internet website documentation, as specified, regarding the data used to train the artificial intelligence system or service, including, among other requirements, a high-level summary of the datasets used in the development of the system or service, as specified. For an artificial intelligence system or service made available for use before January 1, 2025, the bill would instead require the high-level summary to use information reasonably available to the developer and would require a developer who is unable to locate information for a high-level summary to post a description of the methods used to search for information, as specified.

Primary Sponsors
Jacqui Irwin

Bill Number
AB 2063

Status
In Senate

Position
Monitor

Title
Health care coverage.

Description
AB 2063, as amended, Maienschein. Health care coverage. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law exempts a health care service plan from the requirements of the act if the plan is 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. Existing law authorizes the Director of the Department of Managed Health Care, no later than May 1, 2021, 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 (VEBA) 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, for independent periods of time beginning no earlier than January 1, 2022, to December 31, 2025, inclusive, if certain criteria are met. Existing law requires the association or trust fund and each health care provider participating in each pilot program to report to the department information regarding cost savings and clinical patient outcomes compared to a fee-for-service payment model, and requires the department to report those findings to the Legislature no later than January 1, 2027. Existing law repeals these provisions on January 1, 2028. This bill would instead authorize the director to authorize one pilot program in southern California, under which providers approved by the department may undertake risk-bearing arrangements with a VEBA, as specified above, if certain criteria are met. The bill would extend that repeal date to January 1, 2030. The bill would extend the period of time authorized for the pilot program to operate from December 31, 2025, to December 31, 2027. The bill would extend the deadline for the department to report the findings to the Legislature from January 1, 2027, to January 1, 2029.

Primary Sponsors
Brian Maienschein

Organizational Notes

Last edited by Cherie Compartore at May 14, 2024, 3:53 PM
Oppose: California Association of Health Plans

Bill Number
AB 2072

Status
In Senate

Position
Monitor

Title
Group health care coverage: biomedical industry.

Description
AB 2072, as amended, Weber. Group health care coverage: biomedical industry. 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 also provides for the regulation of health insurers by the Department of Insurance. Existing law provides for the regulation of individual, small employer, grandfathered small employer, and nongrandfathered small employer health care service plan contracts and health insurance policies, as defined.Existing federal law, the federal Employee Retirement Income Security Act of 1974 (ERISA), authorizes multiple employer welfare arrangements (MEWAs) in which 2 or more employers join together to provide health care coverage for employees or to their beneficiaries. Under existing state law, the status of each distinct member of an association determines whether that member’s association coverage is individual, small group, or large group health coverage.Existing law, until January 1, 2026, authorizes an association of employers to offer a large group health care service plan contract or large group health insurance policy to small group employer members of the association consistent with ERISA if certain requirements are met, including that the association is the sponsor of a MEWA that has offered a large group health care service plan contract since January 1, 2012, in connection with an employee welfare benefit plan under ERISA, provides a specified level of coverage, and includes coverage for common law employees, and their dependents, who are employed by an association member in the biomedical industry with operations in California. Existing law also requires an association and MEWA to annually file evidence of ongoing compliance with these requirements in a manner specified by the departments.This bill would require the departments, on or before June 30, 2026, to provide the health policy committees of the Legislature the most recent annual filings of compliance. The bill would require the Department of Managed Health Care to conduct an analysis of the impacts on the small employer health insurance market in California of health care service plans currently issuing large group contracts to small employers through MEWAs, as specified. The bill would require the Department of Insurance to conduct an analysis of the impacts on the small employer health insurance market in California of health insurers currently issuing large group policies to small employers through MEWAs, as specified. The bill would authorize the departments to coordinate with each other. The bill would require the departmen... (click bill link to see more).

Primary Sponsors
Akilah Weber

Bill Number
AB 2105

Status
In Senate

Position
Monitor

Title
Coverage for PANDAS and PANS.

Description
AB 2105, as amended, Lowenthal. Coverage for PANDAS and PANS. 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 sets forth specified coverage requirements for health care service plan contracts and health insurance policies, and limits the copayment, coinsurance, deductible, and other cost sharing that may be imposed for specified health care services.This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to provide coverage for the prophylaxis, diagnosis, and treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) that is prescribed or ordered by the treating physician and surgeon and is medically necessary, as specified. The bill would prohibit coverage for PANDAS and PANS from being subject to a copayment, coinsurance, deductible, or other cost sharing that is greater than that applied to other benefits. The bill would prohibit a plan or insurer from denying or delaying coverage for PANDAS or PANS therapies because the enrollee or insured previously received treatment for PANDAS or PANS or was diagnosed with or received treatment for the condition under a different diagnostic name. 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
Josh Lowenthal

Organizational Notes

Last edited by Cherie Compartore at May 14, 2024, 3:54 PM
Oppose: California Association of Health Plans

Bill Number
AB 2115

Status
In Senate

Position
Monitor

Title
Controlled substances: clinics.

Description
AB 2115, as amended, Haney. Controlled substances: clinics. Existing law, the Pharmacy Law, provides for the licensure and regulation of pharmacists by the California State Board of Pharmacy and makes a violation of the act a crime. Under existing law, specified clinics, including surgical clinics, may purchase drugs at wholesale for administration or dispensing to the clinic's patients. Existing law requires these clinics to maintain certain records and to obtain a license from the board. Existing law prohibits specified substances from being dispensed by a nonprofit or free clinic, as defined.This bill would authorize a practitioner authorized to prescribe a narcotic drug at a nonprofit or free clinic, as specified, to dispense the narcotic drug from clinic supply for the purpose of relieving acute withdrawal symptoms while arrangements are being made for referral for treatment, as described, and would require the clinic dispensing the narcotic to be subject to specified reporting, labeling, and recordkeeping requirements. The bill would require clinics with a supply of narcotic drugs being dispensed pursuant to these provisions to establish policies or procedures for dispensing the narcotics, as specified. Because the bill would specify additional requirements under the Pharmacy Law, a violation of which would be a crime, it would impose a state-mandated local program.Existing law classifies certain controlled substances into designated schedules. Existing law prohibits a controlled substance classified in Schedule II from being dispensed without a prescription, except when dispensed directly to the user in an amount not to exceed a 72-hour supply for the patient when the patient is not expected to require any additional amount of the controlled substance beyond the 72 hours.This bill would instead authorize a practitioner to directly dispense no more than a 3-day supply of a Schedule II controlled substance to be dispensed to one person or for one person's use at one time for the purpose of initiating maintenance treatment or detoxification treatment, as specified.Existing law requires the State Department of Health Care Services to regulate and license narcotic treatment programs, including in the use of narcotic replacement therapy and medication-assisted treatment. Existing regulation specifies certain requirements and considerations for a patient to be eligible for treatment at a licensed narcotic treatment program, such as a medical evaluation conducted by the program, laboratory tests for disease, and minimum monthly participation in counseling, among others. Existing regulation also imposes specified criteria to be considered before a patient is eligible for take-home doses of medication.This bill ... (click bill link to see more).

Primary Sponsors
Matt Haney

Bill Number
AB 2129

Status
Passed Senate

Position
Monitor

Title
Immediate postpartum contraception.

Description
AB 2129, as amended, Petrie-Norris. Immediate postpartum contraception. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally regulates contractual provisions between health care service plans and health insurers and their contracting health care providers.This bill would require a contract between a health care service plan or health insurer and a health care provider issued, amended, or renewed on or after January 1, 2025, to authorize a provider to separately bill for devices, implants, or professional services, or a combination thereof, associated with immediate postpartum contraception if the birth takes place in a general acute care hospital or licensed birth center. The bill would prohibit that provider contract from considering those devices, implants, or services to be part of a payment for a general obstetric procedure. Because a violation of the bill’s requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Cottie Petrie-Norris

Bill Number
AB 2132

Status
In Senate

Position
Monitor

Title
Health care services: tuberculosis.

Description
AB 2132, as amended, Low. Health care services: tuberculosis. Existing law provides for the licensure and regulation of health facilities and clinics, including primary care clinics, by the State Department of Public Health. A violation of these provisions is generally a crime. Existing law requires an adult patient receiving primary care services in certain health care settings to be offered a screening test for hepatitis B and hepatitis C, as specified.This bill would require a patient who is 18 years of age or older receiving health care services in a facility, clinic, center, office, or other setting, where primary care services are provided, to be offered tuberculosis screening, if tuberculosis risk factors are identified, to the extent these services are covered under the patient's health care coverage, except as specified. The bill would also require the health care provider to offer the patient followup health care or refer the patient to a health care provider who can provide followup health care if a screening test is positive. The bill would prohibit a health care provider that fails to comply with these provisions from being subject to any disciplinary action related to their licensure or certification, or to any civil or criminal liability, for that failure. The bill would make related findings and declarations.Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services through managed care or fee-for-service delivery systems. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires the department to adopt an option made available under federal Medicaid law to pay allowable tuberculosis-related services for persons infected with tuberculosis, as specified.This bill would require a Medi-Cal managed care plan to ensure access to care for latent tuberculosis infection and active tuberculosis disease and coordination with local health department tuberculosis control programs for plan enrollees with active tuberculosis disease, as specified.

Primary Sponsors
Evan Low

Bill Number
AB 2198

Status
In Senate

Position
Monitor

Title
Health information.

Description
AB 2198, as amended, Flora. Health information. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plans and health insurers to establish and maintain specified application programming interfaces (API), including patient access API, for the benefit of enrollees, insureds, and contracted providers.This bill would, except for Medi-Cal dental managed care contracts, exclude a specialized plan or insurer that issues, sells, renews, or offers a contract or policy covering dental or vision services from the above-described API requirements, and would instead require a specialized plan or insurer that issues, sells, renews, or offers a contract or policy covering dental or vision services and meets specified enrollment requirements to comply with the above-described API requirements beginning January 1, 2027, or when the final federal rules for impacted payers are implemented, whichever is later.

Primary Sponsors
Heath Flora

Bill Number
AB 2237

Status
In Senate

Position
Monitor

Title
Children and youth: transfer of specialty mental health services.

Description
AB 2237, as amended, Aguiar-Curry. Children and youth: transfer of specialty mental health services. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services (department), under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, specialty mental health services include federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services provided to eligible Medi-Cal beneficiaries under 21 years of age.This bill would require, when a child or youth 21 years of age or younger who is receiving Medi-Cal specialty mental health services changes residence from one county to another, the receiving county to provide specialty mental health services to the child or youth, if the transfer of those services from one county to another is not otherwise governed by a process established in statute. The bill also would require the State Department of Health Care Services to collect specified data related to the receipt of specialty mental health services by children and youth who move outside of the county where they originally received specialty mental health services, and to include the data in the department’s Medi-Cal specialty mental health services performance dashboard. The bill would require the department to issue guidance, as specified, to define the requirements on a receiving county for the continued provision of specialty mental health services, to coordinate and expedite the transfer of services from one county to another, and reduce the burden on children and youth and their caregivers to reestablish services in the receiving county. The bill would authorize the department to implement, interpret, or make specific its provisions by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, until regulations are adopted, as specified.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Cecilia Aguiar-Curry

Bill Number
AB 2250

Status
In Senate

Position
Monitor

Title
Social determinants of health: screening and outreach.

Description
AB 2250, as amended, Weber. Social determinants of health: screening and outreach. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plans and health insurers to include coverage for screening for various conditions and circumstances, including adverse childhood experiences. Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2027, to include coverage for screenings for social determinants of health, as defined. The bill would require providers to use specified tools or protocols when documenting patient responses to questions asked in these screenings. The bill would require a health care service plan or health insurer to provide physicians who provide primary care services with adequate access to peer support specialists, lay health workers, social workers, or community health workers in counties where the plan or insurer has enrollees or insureds, as specified. The bill would authorize the respective departments to adopt guidance to implement its provisions until regulations are adopted, and would require the departments to coordinate in the development of guidance and regulations. Because a violation of the bill’s requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.This bill would make social determinants of health screenings a covered benefit for Medi-Cal beneficiaries and would require the State Department of Health Care Services or a Medi-Cal managed care plan to provide reimbursement for those screenings, as specified.The bill would provide that these provisions will be implemented only upon an appropriation by the Legislature.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Akilah Weber

Organizational Notes

Last edited by Joanne Campbell at Apr 22, 2024, 6:05 PM
Local Health Plans of California, California Academy of Family Physicians (sponsor) - Support

Bill Number	Status	Position
AB 2258	**In Senate**	**Monitor**

Title
Health care coverage: cost sharing.

Description
AB 2258, as amended, Zbur. Health care coverage: 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 requires a group or individual nongrandfathered health care service plan contract or health insurance policy to provide coverage for, and prohibits a contract or policy from imposing cost-sharing requirements for, specified preventive care services and screenings.This bill would prohibit a group or individual nongrandfathered health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, from imposing a cost-sharing requirement for items or services that are integral to the provision of the above-described preventive care services and screenings. The bill would require those contracts and policies to cover items and services for those preventive care services and screenings, including home test kits for sexually transmitted diseases and specified cancer screenings. 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 bill would authorize the Insurance Commissioner to impose a civil penalty of not more than $5,000 against an insurer for each violation of these provisions, or not more than $10,000 per violation if the violation was willful.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
Rick Zbur

Organizational Notes

Last edited by Joanne Campbell at Mar 7, 2024, 9:18 PM
California Association of Health Plans - Oppose

Bill Number
AB 2271

Status
In Senate

Position
Monitor

Title
St. Rose Hospital.

Description
AB 2271, as amended, Ortega. St. Rose Hospital. Existing law creates the Distressed Hospital Loan Program, until January 1, 2032, for the purpose of providing loans to not-for-profit hospitals and public hospitals, as defined, in significant financial distress or to governmental entities representing a closed hospital to prevent the closure or facilitate the reopening of a closed hospital. Existing law requires the Department of Health Care Access and Information (HCAI) to administer this loan program. Existing law authorizes the Board of Supervisors of the County of Alameda to establish the Alameda Health System Hospital Authority for the management, administration, and control of the medical center in that county. Existing law authorizes the hospital authority to acquire and possess real or personal property and to dispose of real or personal property other than that owned by the county, as may be necessary for the performance of its functions.This bill would require HCAI, subject to review and approval by the Department of Finance, as specified, to approve the forgiveness of any loans under the Distressed Hospital Loan Program for the St. Rose Hospital in the City of Hayward if the hospital is acquired by the Alameda Health System Hospital Authority. The bill would require HCAI to forgive the full amounts of the principal, interests, fees, and any other outstanding balances of the loan.This bill would make legislative findings and declarations as to the necessity of a special statute for the City of Hayward.This bill would declare that it is to take effect immediately as an urgency statute.

Primary Sponsors
Liz Ortega

Bill Number
AB 2293

Status
In Senate

Position
Monitor

Title
Joint powers agreements: health care services.

Description
AB 2293, as amended, Mathis. Joint powers agreements: health care services. (1) Existing law, the Joint Exercise of Powers Act, authorizes 2 or more public agencies by agreement to exercise any power common to the contracting parties, subject to meeting certain conditions with respect to that agreement. Existing law authorizes a private, nonprofit corporation, until January 1, 2032, formed for the purposes of providing services to zero-emission transportation systems or facilities, to join a joint powers authority or enter into a joint powers agreement with a public agency to facilitate the development, construction, and operation of zero-emission transportation systems or facilities that lower greenhouse gases, reduce vehicle congestion and vehicle miles traveled, and improve public transit connections.This bill, until January 1, 2034, would authorize one or more private, nonprofit mutual benefit corporations formed for purposes of providing health care services to join a joint powers authority or enter into a joint powers agreement with one or more public entities established under the act, as specified. The bill would deem any joint powers authority formed pursuant to this provision to be a public entity, except that the authority would not have the power to incur debt or to engage in specified other acts, including employing physicians and surgeons or charging for professional services rendered by physicians and surgeons. The bill would require an authority formed to be governed by a board of directors, composed as determined by the participating public agency or agencies. The bill would prohibit the representation of private, nonprofit mutual benefit corporations on the board of directors from exceeding 50%. The bill would define terms for its purposes. (2) Existing law sets forth requirements for the solicitation and evaluation of bids and the awarding of contracts by public entities, including requirements applicable if the public entity is required by statute or regulation to obtain an enforceable commitment that a bidder, contractor, or other entity will use a skilled and trained workforce, as defined, to complete a contract or project. Except as specified, existing law requires that, for workers employed on public works, as defined, not less than the general prevailing rate of per diem wages, determined as provided by the Director of Industrial Relations, for work of a similar character in the locality in which the public work is performed be paid to those workers, as provided. This bill, except as specified, would require a joint powers authority formed pursuant to the bill, when undertaking a project applicable to the construction or refurbishment of health facilities, to obtain an enforceable commitm... (click bill link to see more).

Primary Sponsors
Devon Mathis

Bill Number	Status	Position
AB 2297	**In Senate**	**Monitor**

Title
Hospital and Emergency Physician Fair Pricing Policies.

Description
AB 2297, as amended, Friedman. Hospital and Emergency Physician Fair Pricing Policies. Existing law requires a hospital to maintain a written charity care policy and a discount payment policy for uninsured patients or patients with high medical costs who are at or below 400 percent of the federal poverty level. Existing law requires the written policy regarding discount payments to also include a statement that an emergency physician who provides emergency medical services in a hospital that provides emergency care is also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 400 percent of the federal poverty level. Existing law authorizes an emergency physician to choose to grant eligibility for a discount payment policy to patients with incomes over 350% of the federal poverty level. Existing law defines “high medical costs” for these purposes to mean, among other things, specified annual out-of-pocket costs incurred by the individual at the hospital or a hospital that provided emergency care.This bill would authorize an emergency physician to choose to grant eligibility for a discount payment policy to patients with incomes over 400% of the federal poverty level. The bill would also clarify that out-of-pocket costs for the above-described definition of “high medical costs” means any expenses for medical care that are not reimbursed by insurance or a health coverage program, such as Medicare copays or Medi-Cal cost sharing.Existing law requires a hospital’s discount payment policy to clearly state the eligibility criteria based upon income, and authorizes a hospital to consider the income and monetary assets of the patient or the patient’s family, as defined, in determining eligibility under its charity care policy.This bill would prohibit a hospital from considering the monetary assets of the patient in determining eligibility for both the charity care and the discount payment policies, but would authorize the hospital to consider the availability of a patient’s health savings account held by the patient or the patient’s family, as specified. The bill would revise the definition of patient’s family, as specified. The bill would instead require that the eligibility for charity care or discounted payments be determined at any time the hospital is in receipt of recent pay stubs or income tax returns. The bill would prohibit a hospital or an emergency physician from imposing time limits for applying for charity care or discounted payments, and would prohibit a hospital or emergency physician from denying eligibility based on the timing of a patient’s application. The bill would authorize a hospital or emergency physician to waive or reduce Medi-Cal and ... (click bill link to see more).

Primary Sponsors
Laura Friedman

Bill Number
AB 2302

Status
In Senate

Position
Monitor

Title
Open meetings: local agencies: teleconferences.

Description
AB 2302, as introduced, Addis. Open meetings: local agencies: teleconferences. Existing law, the Ralph M. Brown Act, requires, with specified exceptions, that all meetings of a legislative body, as defined, of a local agency be open and public and that all persons be permitted to attend and participate. The act generally requires for teleconferencing that the legislative body of a local agency that elects to use teleconferencing post agendas at all teleconference locations, identify each teleconference location in the notice and agenda of the meeting or proceeding, and have each teleconference location be accessible to the public. Existing law also requires that, during the teleconference, at least a quorum of the members of the legislative body participate from locations within the boundaries of the territory over which the local agency exercises jurisdiction. The act provides an exemption to the jurisdictional requirement for health authorities, as defined.Existing law, until January 1, 2026, authorizes the legislative body of a local agency to use alternative teleconferencing in specified circumstances if, during the teleconference meeting, at least a quorum of the members of the legislative body participates in person from a singular physical location clearly identified on the agenda that is open to the public and situated within the boundaries of the territory over which the local agency exercises jurisdiction, and the legislative body complies with prescribed requirements. Existing law imposes prescribed restrictions on remote participation by a member under these alternative teleconferencing provisions, including establishing limits on the number of meetings a member may participate in solely by teleconference from a remote location, prohibiting such participation for a period of more than 3 consecutive months or 20% of the regular meetings for the local agency within a calendar year, or more than 2 meetings if the legislative body regularly meets fewer than 10 times per calendar year.This bill would revise those limits, instead prohibiting such participation for more than a specified number of meetings per year, based on how frequently the legislative body regularly meets. The bill, for the purpose of counting meetings attended by teleconference, would define a “meeting” as any number of meetings of the legislative body of a local agency that begin on the same calendar day.The California Constitution requires local agencies, for the purpose of ensuring public access to the meetings of public bodies and the writings of public officials and agencies, to comply with a statutory enactment that amends or enacts laws relating to public records or open meetings and contains findings demonstrating that the enactment furthe... (click bill link to see more).

Primary Sponsors
Dawn Addis

Bill Number
AB 2319

Status
In Senate

Position
Monitor

Title
California Dignity in Pregnancy and Childbirth Act.

Description
AB 2319, as amended, Wilson. California Dignity in Pregnancy and Childbirth Act. Existing law requires the State Department of Public Health to maintain a program of maternal and child health, which may include, among other things, facilitating services directed toward reducing infant mortality and improving the health of mothers and children. Existing law requires the Office of Health Equity within the department to serve as a resource for ensuring that programs collect and keep data and information regarding ethnic and racial health statistics, and strategies and programs that address multicultural health issues, including, but not limited to, infant and maternal mortality. Existing law makes legislative findings relating to implicit bias and racial disparities in maternal mortality rates. Existing law requires a hospital that provides perinatal care, and an alternative birth center or a primary clinic that provides services as an alternative birth center, to implement an evidence-based implicit bias program, as specified, for all health care providers involved in perinatal care of patients within those facilities. Existing law requires the health care provider to complete initial basic training through the program and a refresher course every 2 years thereafter, or on a more frequent basis if deemed necessary by the facility. Existing law requires the facility to provide a certificate of training completion upon request, to accept certificates of completion from other facilities, and to offer training to physicians not directly employed by the facility. Existing law requires the department to track and publish data on pregnancy-related death and severe maternal morbidity, as specified.This bill would make a legislative finding that the Legislature recognizes all birthing people, including nonbinary persons and persons of transgender experience. The bill would extend the evidence-based implicit bias training requirements to specified health care providers at hospitals that provide perinatal care, alternative birth centers, or primary care clinics, as specified. The bill would require an implicit bias program to include recognition of intersecting identities and the potential associated biases. The bill would require initial basic training for the implicit bias program to be completed by June 1, 2025, for current health care providers, and within 6 months of their start date for new health care providers, unless exempted. The bill would require specified facilities to, by February 1 of each year, commencing in 2026, provide the Attorney General with proof of compliance with these provisions, as specified. The bill would authorize the Attorney General to pursue civil penalties for violations of these provisions, as s... (click bill link to see more).

Primary Sponsors
Lori Wilson, Akilah Weber, Mia Bonta, Steve Bradford, Isaac Bryan, Mike Gipson, Chris Holden

Bill Number
AB 2327

Status
In Senate

Position
Monitor

Title
Optometry: mobile optometric offices.

Description
AB 2327, as amended, Wendy Carrillo. Optometry: mobile optometric offices. Existing law, the Optometry Practice Act, establishes the State Board of Optometry within the Department of Consumer Affairs and sets forth the powers and duties of the board relating to the licensure and regulation of the practice of optometry. Existing law regulates the ownership and operation of mobile optometric offices, as defined, including, among other things, requiring the owner and operator of a mobile optometric office to file a quarterly report containing specified information. Existing law requires the board, by January 1, 2023, to adopt regulations establishing a registry for the owners and operators of mobile optometric offices, as specified. Existing law prohibits the board, before January 1, 2023, from bringing an enforcement action against an owner and operator of a mobile optometric office based solely on its affiliation status with an approved optometry school in California for remotely providing optometric service. Existing law makes these and other provisions related to the permitting and regulation of mobile optometric offices effective only until July 1, 2025, and repeals them as of that date.This bill would authorize the owner and operator of a mobile optometric office to instead file the above-described quarterly reports as a single, annual report during the first renewal period of 2 years, as specified. The bill would also extend the deadline for the board to adopt the above-described regulations to January 1, 2026. The bill would prohibit the board from bringing the above-described enforcement action before January 1, 2026, or before the board adopts those regulations, whichever is earlier. The bill would extend the repeal date of the provisions related to the permitting and regulation of mobile optometric clinics to July 1, 2035.

Primary Sponsors
Wendy Carrillo

Bill Number
AB 2339

Status
In Senate

Position
Monitor

Title
Medi-Cal: telehealth.

Description
AB 2339, as introduced, Aguiar-Curry. Medi-Cal: telehealth. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Under existing law, subject to federal approval, in-person, face-to-face contact is not required under Medi-Cal when covered health care services are provided by video synchronous interaction, asynchronous store and forward, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual communication modalities, when those services and settings meet certain criteria. Existing law defines “asynchronous store and forward” as the transmission of a patient’s medical information from an originating site to the health care provider at a distant site.This bill would expand that definition, for purposes of the above-described Medi-Cal provisions, to include asynchronous electronic transmission initiated directly by patients, including through mobile telephone applications.Existing law prohibits a health care provider from establishing a new patient relationship with a Medi-Cal beneficiary via asynchronous store and forward, telephonic (audio-only) synchronous interaction, remote patient monitoring, or other virtual communication modalities, except as specified. Among those exceptions, existing law authorizes a health care provider to establish a new patient relationship using an audio-only synchronous interaction when the visit is related to sensitive services, as defined, and when established in accordance with department-specific requirements and consistent with federal and state law, regulations, and guidance.This bill would expand that exception to include asynchronous store and forward when the visit is related to sensitive services, as specified. The bill would also authorize a health care provider to establish a new patient relationship using asynchronous store and forward when the patient requests an asynchronous store and forward modality, as specified.Existing law authorizes a health care provider to establish a new patient relationship using an audio-only synchronous interaction when the patient requests an audio-only modality or attests that they do not have access to video, as specified.This bill would remove, from that exception, the option of the patient attesting that they do not have access to video.

Primary Sponsors
Cecilia Aguiar-Curry

Bill Number
AB 2340

Status
In Senate

Position
Monitor

Title
Medi-Cal: EPSDT services: informational materials.

Description
AB 2340, as amended, Bonta. Medi-Cal: EPSDT services: informational materials. 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, through fee-for-service or managed care delivery systems. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, early and periodic screening, diagnostic, and treatment (EPSDT) services are covered under Medi-Cal for an individual under 21 years of age in accordance with certain federal provisions.Existing federal regulations require the state to provide for a combination of written and oral methods designed to inform individuals eligible for EPSDT services, or their families, about the EPSDT program, within 60 days of the individual's initial Medicaid eligibility determination and, in the case of families that have not utilized EPSDT services, annually thereafter, as specified. Under those regulations, required information includes, among other components, the benefits of preventive health care and the services available under the EPSDT program and where and how to obtain those services.This bill would require the department to prepare written informational materials that effectively explain and clarify the scope and nature of EPSDT services, as defined, that are available under the Medi-Cal program. Under the bill, the materials would include, but would not be limited to, the information required in the above-described federal regulations or their successor. Under the bill, the informational materials would also include content designed for youth, for purposes of delivery of that content to a beneficiary who is 12 years of age or older but under 21 years of age.The bill would authorize the department to standardize the materials, as specified, and would require the department to regularly review the materials to ensure that they are up to date. The bill would require the department to test the quality, clarity, and cultural concordance of translations of the informational materials with Medi-Cal beneficiaries, in order to ensure that the materials use clear and nontechnical language that effectively informs beneficiaries.The bill would require the department or a Medi-Cal managed care plan, to provide to a beneficiary who is eligible for EPSDT services, or to the parent or other authorized representative of that beneficiary, as applicable, the informational materials within a maximum number of calendar days after that beneficiary's enrollment in a managed care plan or initial Medi-Cal eligibility determination and annually thereafter, as specified by the depar... (click bill link to see more).

Primary Sponsors
Mia Bonta

Bill Number
AB 2428

Status
In Senate

Position
Monitor

Title
Medi-Cal: Community-Based Adult Services.

Description
AB 2428, as amended, Calderon. Medi-Cal: Community-Based Adult Services. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires the department to standardize applicable covered Medi-Cal benefits provided by Medi-Cal managed care plans under comprehensive risk contracts with the department on a statewide basis and across all models of Medi-Cal managed care, in accordance with the Terms and Conditions of the California Advancing and Innovating Medi-Cal (CalAIM) initiative.Existing law requires, commencing January 1, 2022, that Community-Based Adult Services (CBAS) continue to be available as a capitated benefit for a qualified Medi-Cal beneficiary under a comprehensive risk contract with an applicable Medi-Cal managed care plan. For contract periods during which that provision is implemented, existing law requires each applicable plan to reimburse a network provider furnishing CBAS to a Medi-Cal beneficiary enrolled in that plan, and requires each network provider of CBAS to accept the payment amount that the network provider of CBAS would be paid for the service in the Medi-Cal fee-for-service delivery system, as specified, unless the plan and network provider mutually agree to reimbursement in a different amount.This bill, for purposes of the mutual agreement between a Medi-Cal managed care plan and a network provider, would require that the reimbursement be in an amount equal to or greater than the amount paid for the service in the Medi-Cal fee-for-service delivery system.

Primary Sponsors
Lisa Calderon, Bill Dodd

Bill Number
AB 2434

Status
In Senate

Position
Monitor

Title
Health care coverage: multiple employer welfare arrangements.

Description
AB 2434, as amended, Grayson. Health care coverage: multiple employer welfare arrangements. 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 federal law, the federal Employee Retirement Income Security Act of 1974 (ERISA), authorizes multiple employer welfare arrangements (MEWAs) in which 2 or more employers join together to provide health care coverage for employees or to their beneficiaries. Existing law authorizes an association of employers to offer a large group health care service plan contract, consistent with ERISA, if certain requirements are met. Until January 1, 2026, existing law also authorizes an association of employers to offer a large group health care service plan contract to small group employer members of the association, consistent with ERISA, if certain requirements are met, including that the association is headquartered in this state, was established before March 23, 2010, and is the sponsor of a MEWA, and that the contract includes coverage of employees of an association member in the biomedical industry.This bill would authorize an association of employers to offer a large group health care service plan contract to small group employer members of the association, consistent with ERISA, if certain requirements are met, including that the association was established before January 1, 1966, and is the sponsor of a MEWA, and that the contract includes coverage of employees of an association member in the engineering, surveying, or design industry. The bill would require an association and MEWA to annually file evidence of ongoing compliance with those requirements in a manner specified by the department. This bill would require the department, on or before June 30, 2028, to provide the health policy committees of the Legislature with the most recent filings. The bill would require the department to conduct an analysis of the impacts of MEWAs on the small employer health insurance market, as specified, authorize the department to coordinate with the Department of Insurance for the analysis, require health care service plans, health insurers, and MEWAs to comply with requests for information, and require the department to post a report summarizing its analysis on its internet website on or before July 1, 2026. The bill, on or after June 1, 2025, would prohibit a plan from marketing, issuing, amending, renewing, or delivering large employer coverage to an association or MEWA that provides a benefit to a resident in this state unless the association and MEWA have registered and are in compliance with th... (click bill link to see more).

Primary Sponsors
Tim Grayson

Bill Number	Status	Position
AB 2435	**In Senate**	**Monitor**

Title
California Health Benefit Exchange.

Description
AB 2435, as introduced, Maienschein. California Health Benefit Exchange. Existing federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. Existing state law creates the California Health Benefit Exchange, also known as Covered California, governed by an executive board, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Existing law specifies the powers of the executive board. Existing law authorizes the executive board to adopt necessary rules and regulations by emergency regulations until January 1, 2025, with the exception of regulations implementing prescribed provisions relating to criminal background history checks for persons with access to confidential, personal, or financial information. Existing law authorizes the Office of Administrative Law to approve more than 2 readoptions of emergency regulations until January 1, 2030. Existing law provides that these extensions apply to a regulation adopted before January 1, 2022.This bill would extend the authority of the executive board to adopt necessary rules and regulations by emergency regulations until January 1, 2030, and would extend the authority of the Office of Administrative Law to approve more than 2 readoptions of emergency regulations until January 1, 2035. The bill would provide that these prescribed time extensions apply to a regulation adopted before January 1, 2025.

Primary Sponsors
Brian Maienschein

Bill Number	Status	Position
AB 2442	**In Senate**	**Monitor**

Title
Healing arts: expedited licensure process: gender-affirming health care and gender-affirming mental health care.

Description
AB 2442, as amended, Zbur. Healing arts: expedited licensure process: gender-affirming health care and gender-affirming mental health care. Existing law requires the Medical Board of California, the Osteopathic Medical Board of California, the Board of Registered Nursing, and the Physician Assistant Board to expedite the licensure process for an applicant who demonstrates that they intend to provide abortions within the scope of practice of their license, and specifies the manner in which the applicant is required to demonstrate their intent. This bill would also require those boards to expedite the licensure process for an applicant who demonstrates that they intend to provide gender-affirming health care and gender-affirming mental health care, as defined, within the scope of practice of their license, and would specify the manner in which the applicant would be required to demonstrate their intent. The bill would repeal its provisions on January 1, 2029.

Primary Sponsors
Rick Zbur

Bill Number	Status	Position
AB 2446	**In Senate**	**Monitor**

Title
Medi-Cal: diapers.

Description
AB 2446, as amended, Ortega. Medi-Cal: diapers. 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 by, and funded pursuant to, federal Medicaid program provisions. Existing law establishes a schedule of covered benefits under the Medi-Cal program, including incontinence supplies.This bill would add to the schedule of Medi-Cal benefits diapers for infants or toddlers with certain conditions, such as a urinary tract infection and diseases of the skin. The bill would establish diapers as a covered benefit for a child greater than 3 years of age who has been diagnosed with a condition that contributes to incontinence and would establish diapers as a covered benefit for individuals under 21 years of age, if necessary to correct or ameliorate a condition pursuant to specified standards. The bill would limit the diapers provided pursuant to these provisions to an appropriate supply based on the diagnosed condition and the age of the beneficiary. The bill would require the department to seek any necessary federal approval to implement this section. The bill would make these provisions contingent upon an appropriation by the Legislature.

Primary Sponsors
Liz Ortega

Bill Number
AB 2467

Status
In Senate

Position
Monitor

Title
Health care coverage for menopause.

Description
AB 2467, as amended, Bauer-Kahan. Health care coverage for menopause. 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 sets forth specified coverage requirements for health care service plan contracts and health insurance policies.This bill would require a health care service plan contract or health insurance policy, except for a specialized contract or policy, that is issued, amended, or renewed on or after January 1, 2025, to include coverage for evaluation and treatment options for perimenopause and menopause. The bill would require a health care service plan or health insurer to annually provide clinical care recommendations, as specified, for hormone therapy to all contracted primary care providers who treat individuals with perimenopause and menopause. 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
Rebecca Bauer-Kahan

Organizational Notes

Last edited by Cherie Compartore at May 14, 2024, 3:59 PM
Oppose: California Association of Health Plans

Bill Number
AB 2556

Status
Passed Senate

Position
Monitor

Title
Behavioral health and wellness screenings: notice.

Description
AB 2556, Jackson. Behavioral health and wellness screenings: notice. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. This bill would require a health care service plan, except as specified, or health insurer to provide to enrollees and insureds a written or electronic notice regarding the benefits of a behavioral health and wellness screening, as defined, for children and adolescents 8 to 18 years of age. The bill would require a health care service plan or insurer to provide the notice annually. Because a violation of the bill's requirements relative to a health care service plan would be crimes, 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
Corey Jackson

Organizational Notes

Last edited by Joanne Campbell at Mar 18, 2024, 5:29 PM
California Association of Health Plans - Oppose

Bill Number
AB 2630

Status
In Senate

Position
Monitor

Title
Pupil health: oral health assessment.

Description
AB 2630, as introduced, Bonta. Pupil health: oral health assessment. Existing law requires a pupil, while enrolled in kindergarten in a public school, or while enrolled in first grade in a public school if the pupil was not previously enrolled in kindergarten in a public school, to present proof of having received an oral health assessment by a licensed dentist or other licensed or registered dental health professional operating within the professional’s scope of practice that was performed no earlier than 12 months prior to the date of the initial enrollment of the pupil, as provided.This bill would define “kindergarten” for these purposes as including both transitional kindergarten and kindergarten, and would require the above-described proof only once during a two-year kindergarten program. To the extent the bill would impose additional duties on public schools, 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
Mia Bonta

Bill Number
AB 2636

Status
Passed Senate

Position
Monitor

Title
Mello-Granlund Older Californians Act.

Description
AB 2636, as amended, Bains. Mello-Granlund Older Californians Act. Existing law requires the California Department of Aging to administer the Mello-Granlund Older Californians Act (act), which establishes various programs that serve older individuals, defined as persons 60 years of age or older, except as specified. The act requires the department to designate various private nonprofit or public agencies as area agencies on aging to work within a planning and service area and provide a broad array of social and nutritional services. Under the act, the department's mission is to provide leadership to those agencies in developing systems of home- and community-based services that maintain individuals in their own homes or least restrictive homelike environments.This bill would recast and revise various provisions of the act, including updating findings and declarations relating to statistics and issues of concern to the older adult population, and replacing references throughout the act from "senior" and similar terminology to "older adult." The bill would repeal obsolete provisions, such as the Senior Center Bond Act of 1984.Existing law establishes the Senior Housing Information and Support Center within the department to serve as a clearinghouse for information for seniors and their families regarding available innovative resources and senior services, subject to appropriation for these purposes.This bill, instead, would require the department to partner with other state departments, the area agencies on aging, and other stakeholders in developing and maintaining an electronic clearinghouse of information of available statewide services and supports for older adults and people with disabilities and providing referral services, if appropriate, and would repeal the provisions establishing the Senior Housing Information and Support Center.This bill would repeal the provisions establishing the Senior Housing Information and Support Center.

Primary Sponsors
Jasmeet Bains

Bill Number
AB 2703

Status
In Senate

Position
Monitor

Title
Federally qualified health centers and rural health clinics: psychological associates.

Description
AB 2703, as amended, Aguiar-Curry. Federally qualified health centers and rural health clinics: psychological associates. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including federally qualified health center (FQHC) services and rural health clinic (RHC) services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Existing law requires that FQHC services and RHC services be reimbursed on a per-visit basis and defines a visit as a face-to-face encounter, or other modality of interaction, as specified, between a patient and specified practitioners.This bill would add to that list of practitioners a licensed professional clinical counselor.Existing law authorizes an FQHC or RHC to apply for an adjustment to its per-visit rate based on a change in the scope of services provided by the FQHC or RHC and includes in the definition of a change in the scope of services any changes in any of the federally defined FQHC services or RHC services, among other things. Existing law requires an FQHC or RHC that does not provide certain services, including marriage and family therapist services, and later elects to add those services and bill them as a separate visit to process the addition of the services as a change in scope of service, as specified.This bill would remove the requirement for an FQHC or RHC that does not provide marriage and family therapist services, but later elects to add those services and bill them as a separate visit, to file for a change in scope of service.Existing law requires the department to seek any necessary federal approvals and issue appropriate guidance to allow an FQHC or RHC to bill, under a supervising licensed behavioral health practitioner, for an encounter between an FQHC or RHC patient and an associate clinical social worker or associate marriage and family therapist when certain conditions are met, including, among others, that the FQHC or RHC is otherwise authorized to bill for services provided by the supervising practitioner as a separate visit.This bill would add a psychological associate or associate professional clinical counselor to those provisions, requiring the department to seek any necessary federal approvals and issue appropriate guidance to allow an FQHC or RHC to bill for an encounter between a patient and a psychological associate or associate professional clinical counselor under those conditions. The bill would make conforming changes with regard to supervision by a licensed behavioral health practitioner, as required by the associate’s applicable clinical licensing board.

Primary Sponsors
Cecilia Aguiar-Curry

Organizational Notes

Last edited by Cherie Compartore at Jul 29, 2024, 9:07 PM
Support: Local Health Plans of California

Bill Number
AB 2715

Status
In Senate

Position
Monitor

Title
Ralph M. Brown Act: closed sessions.

Description
AB 2715, as amended, Boerner. Ralph M. Brown Act: closed sessions. Existing law, the Ralph M. Brown Act, generally requires that all meetings of a legislative body of a local agency be open and public and that all persons be permitted to attend and participate. Existing law authorizes a legislative body to hold a closed session with specified individuals on, among other things, matters posing a threat to the security of essential public services, as specified.This bill would additionally authorize a legislative body to hold a closed session with other law enforcement or security personnel and to hold a closed session on a threat to critical infrastructure controls or critical infrastructure information, as defined, relating to cybersecurity.Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.This bill would make legislative findings to that effect.The California Constitution requires local agencies, for the purpose of ensuring public access to the meetings of public bodies and the writings of public officials and agencies, to comply with a statutory enactment that amends or enacts laws relating to public records or open meetings and contains findings demonstrating that the enactment furthers the constitutional requirements relating to this purpose.This bill would make legislative findings to that effect.

Primary Sponsors
Tasha Boerner

Bill Number
AB 2749

Status
In Senate

Position
Monitor

Title
California Health Benefit Exchange: financial assistance.

Description
AB 2749, as amended, Wood. California Health Benefit Exchange: financial assistance. Existing federal law, the federal 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. PPACA authorizes a state to apply to the United States Department of Health and Human Services for a state innovation waiver of any or all PPACA requirements, if certain criteria are met, including that the state has enacted a law that provides for state actions under a waiver. Existing state law creates the California Health Benefit Exchange (Exchange), also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Existing law requires the Exchange, upon appropriation by the Legislature, to administer a program of financial assistance beginning July 1, 2023, to help Californians obtain and maintain health benefits through the Exchange if they lose employer-provided health care coverage as a result of a labor dispute, as specified. Under existing law, if specified eligibility requirements are met, an individual who has lost minimum essential coverage from an employer or joint labor management trust fund as a result of a strike, lockout, or other labor dispute receives the same premium assistance and cost-sharing reductions as an individual with a household income of 138.1% of the federal poverty level, and is also not required to pay a deductible for any covered benefit if the standard benefit design for a household income of 138.1% of the federal poverty level has zero deductibles. Existing law excludes from gross income any subsidy amount received pursuant to that program of financial assistance.This bill would revise various provisions of the financial assistance program, including deleting the exclusion of financial assistance received under the program from gross income, and specifying the criteria required for an individual to be qualified to receive coverage under the program. The bill would specify that an individual would no longer be eligible for financial assistance under the program when the Exchange verifies that employer-provided minimum essential coverage from the employer has been reinstated for the individual and dependents, as specified. The bill would require an employer or labor organization to notify the Exchange before employer-provided coverage is affected by a strike, lockout, or labor dispute, and would authorize the Exchange to contact the employer, labor organization, or other appropriate representative to determine information necessa... (click bill link to see more).

Primary Sponsors
Jim Wood

Bill Number
AB 2756

Status
Passed Senate

Position
Monitor

Title
Pelvic Floor and Core Conditioning Pilot Program.

Description
AB 2756, Boerner. Pelvic Floor and Core Conditioning Pilot Program. Existing law finds and declares that postpartum care, among other things, is an essential service necessary to ensure maternal health. Existing law establishes the State Department of Health Care Services, and requires the department to, among other things, maintain programs relating to maternal health.This bill would, commencing January 1, 2026, until January 1, 2029, authorize San Diego County to establish a pilot program for pelvic floor and core conditioning group classes that would be provided to people twice a week between their 6 to 12 week postpartum window to help people rebuild their pelvic floor after pregnancy. The bill would require the program to record specified information to directly assess pelvic floor changes.This bill would make legislative findings and declarations as to the necessity of a special statute for San Diego County.

Primary Sponsors
Tasha Boerner

Bill Number
AB 2767

Status
Enacted

Position
Monitor

Title
Financial Solvency Standards Board: membership.

Description
AB 2767, Santiago. Financial Solvency Standards Board: membership. Existing law establishes the Department of Managed Health Care, which, among other duties, ensures the financial stability of managed care plans. Existing law establishes within the department the Financial Solvency Standards Board for the purpose of, among other things, developing and recommending to the director of the department financial solvency requirements and standards relating to health care service plan operations. Existing law requires the board to be composed of the director, or their designee, and 7 members appointed by the director, and authorizes the director to appoint individuals with training and experience in specified subject areas or fields.This bill would instead require the director to appoint 10 members to the board, and would additionally authorize the director to appoint health care consumer advocates and individuals with training and experience in large group health insurance purchasing.

Primary Sponsors
Miguel Santiago

Bill Number
AB 2843

Status
In Senate

Position
Monitor

Title
Health care coverage: rape and sexual assault.

Description
AB 2843, as amended, Petrie-Norris. Health care coverage: rape and sexual assault. 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 victim of sexual assault who seeks a medical evidentiary examination to be provided with one, as specified. Existing law prohibits costs incurred by a qualified health care professional, hospital, clinic, sexual assault forensic examination team, or other emergency medical facility for the medical evidentiary examination portion of the examination of the victim of a sexual assault, as described in a specified protocol, when the examination is performed as specified, from being charged directly or indirectly to the victim of the assault. This bill would require a health care service plan or health insurance policy that is issued, amended, renewed, or delivered on or after January 1, 2025, to provide coverage without cost sharing for emergency room medical care and followup health care treatment for an enrollee or insured who is treated following a rape or sexual assault. The bill would prohibit a health care service plan or health insurer from requiring, as a condition of providing coverage, (1) an enrollee or insured to file a police report, (2) charges to be brought against an assailant, (3) or an assailant to be convicted of rape or sexual assault. 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
Cottie Petrie-Norris

Bill Number
AB 2859

Status
In Senate

Position
Monitor

Title
Emergency medical technicians: peer support.

Description
AB 2859, as amended, Jim Patterson. Emergency medical technicians: peer support. Existing law establishes a statewide system for emergency medical services (EMS) and establishes the Emergency Medical Services Authority, which is responsible for establishing training, scope of practice, and continuing education for emergency medical technicians and other prehospital personnel.Existing law authorizes a public fire agency or law enforcement agency to establish a peer support and crisis referral program, to provide a network of peer representatives who are available to come to the aid of their fellow employees on a broad range of emotional or professional issues. This bill would authorize an EMS provider to establish a peer support and crisis referral program to provide a network of peer representatives available to aid fellow employees on emotional or professional issues. The bill would provide that EMS personnel, whether or not a party to an action, have a right to refuse to disclose, and to prevent another from disclosing, a confidential communication between the EMS personnel and a peer support team member, crisis hotline, or crisis referral service, except under limited circumstances, including, among others, if disclosure is reasonably believed to be necessary to prevent death, substantial bodily harm, or commission of a crime, or in a civil or criminal proceeding. The bill would also provide that, except for an action for medical malpractice, a peer support team member and the EMS provider that employs them are not liable for damages, as specified, relating to an act, error, or omission in performing peer support services, unless the act, error, or omission constitutes gross negligence or intentional misconduct. To be eligible for these confidentiality protections, the bill would require a peer support team member to complete a training course or courses on peer support approved by the local EMS agency. By imposing a higher level of service on a local agency, 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
Jim Patterson

Bill Number
AB 2860

Status
In Senate

Position
Monitor

Title
Licensed Physicians and Dentists from Mexico programs.

Description
AB 2860, as amended, Garcia. Licensed Physicians and Dentists from Mexico programs. Existing law, the Licensed Physicians and Dentists from Mexico Pilot Program, allows up to 30 licensed physicians and up to 30 licensed dentists from Mexico to practice medicine or dentistry in California for a period not to exceed 3 years, in accordance with certain requirements. Existing law requires the Medical Board of California and the Dental Board of California to provide oversight pursuant to these provisions. Existing law requires appropriate funding to be secured from nonprofit philanthropic entities before implementation of the pilot program may proceed.Existing law requires physicians participating in the Licensed Physicians and Dentists from Mexico Pilot Program to be enrolled in English as a second language classes, to have satisfactorily completed a 6-month orientation program, and to have satisfactorily completed a 6-month externship at the applicant’s place of employment, among various other requirements.This bill would repeal the provisions regarding the Licensed Physicians and Dentists from Mexico Pilot Program, and would instead establish two bifurcated programs, the Licensed Physicians from Mexico Program and the Licensed Dentists from Mexico Pilot Program. Within these 2 programs, the bill would generally revise and recast certain requirements pertaining to the Licensed Physicians and Dentists from Mexico Pilot Program, including deleting the above-described requirement that Mexican physicians participating in the program enroll in adult English as a second language classes. The bill would instead require those physicians to have satisfactorily completed the Test of English as a Foreign Language or the Occupational English Test, as specified. The bill would remove the requirement that the orientation program be 6 months, and would further require the orientation program to include electronic medical records systems utilized by federally qualified health centers and standards for medical chart notations. The bill would also delete the requirement that the physicians participate in a 6-month externship. The bill would further delete provisions requiring an evaluation of the pilot program to be undertaken with funds provided from philanthropic foundations, and would make various other related changes to the program.Commencing January 1, 2025, the bill would authorize the board to issue a limited number of active licenses to eligible applicants to participate in the program, as specified. Under the bill, each additional physician selected for the program would not be eligible to renew their 3-year license.The bill would require the federally qualified health centers employing physicians pursuant to the program to con... (click bill link to see more).

Primary Sponsors
Eduardo Garcia

Organizational Notes

Last edited by Cherie Compartore at May 29, 2024, 7:01 PM
Support: Local Health Plans of California, California Primary Care Association (Co-Sponsor), Clinica De Salud Del Valle De Salinas (Co-Sponsor)

Bill Number
AB 2885

Status
In Senate

Position
Monitor

Title
Artificial intelligence.

Description
AB 2885, as amended, Bauer-Kahan. Artificial intelligence. Existing law establishes the Government Operations Agency, which is governed by the Secretary of Government Operations. Existing law requires the Secretary of Government Operations to develop a coordinated plan to, among other things, evaluate the impact of the proliferation of deepfakes, defined to mean audio or visual content that has been generated or manipulated by artificial intelligence that would falsely appear to be authentic or truthful and that features depictions of people appearing to say or do things they did not say or do without their consent, on state government, California-based businesses, and residents of the state.Existing law establishes within the Government Operations Agency the Department of Technology, which is supervised by the Director of Technology. Existing law requires the Department of Technology to conduct, in coordination with other interagency bodies as it deems appropriate, a comprehensive inventory of all high-risk automated decision systems that have been proposed for use, development, or procurement by, or are being used, developed, or procured by, any state agency. Existing law defines an “automated decision system” as a computational process derived from machine learning, statistical modeling, data analytics, or artificial intelligence that issues simplified output, including a score, classification, or recommendation, that is used to assist or replace human discretionary decisionmaking and materially impacts natural persons.Existing law requires each local agency, as defined, to provide specified information to the public before approving an economic development subsidy, as defined, within its jurisdiction, and to, among other things, hold hearings and issue annual reports on those subsidies, as provided. Existing law requires those reports to contain, among other things, information about any net job loss or replacement due to the use of automation, artificial intelligence, or other technologies, if known.Existing law establishes the California Online Community College, under the administration of the Board of Governors of the California Community Colleges, for purposes of creating an organized system of accessible, flexible, and high-quality online content, courses, and programs focused on providing industry-valued credentials compatible with the vocational and educational needs of Californians who are not currently accessing higher education. Existing law requires the California Online Community College to develop a Research and Development Unit to, among other things, focus on using technology, data science, behavioral science, machine learning, and artificial intelligence to build out student supports, as provided... (click bill link to see more).

Primary Sponsors
Rebecca Bauer-Kahan, Tom Umberg

Bill Number	Status	Position
AB 2914	**In Senate**	**Monitor**

Title
Health care coverage: essential health benefits.

Description
AB 2914, as amended, Bonta. Health care coverage: essential health benefits. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service plans. Existing law requires the Department of Insurance to regulate health insurers. Existing law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, to include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act. Existing law requires a health care service plan contract or health insurance policy to cover the same health benefits that the benchmark plan, the Kaiser Foundation Health Plan Small Group HMO 30 plan, offered during the first quarter of 2014, as specified.This bill would express the intent of the Legislature to review California’s essential health benefits benchmark plan and establish a new benchmark plan for the 2027 plan year. The bill would limit the applicability of the current benchmark plan benefits to plan years on or before the 2027 plan year.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 requires a plan to annually report to the department on its compliance with network adequacy standards. Existing regulations authorize a health care service plan to propose to the department alternative standards of accessibility if access requirements are unreasonably restrictive for a portion of a service area or if specified criteria are met for a portion of a service area.This bill would require the department to report to the Legislature on or before April 1, 2025, and on or before each April 1 thereafter, regarding alternative access proposals approved by the department in the prior year.

Primary Sponsors
Mia Bonta

Organizational Notes

Last edited by Joanne Campbell at Apr 19, 2024, 8:09 PM
California Association of Health Plans - Support in Concept

Bill Number
AB 2930

Status
In Senate

Position
Monitor

Title
Automated decision tools.

Description
AB 2930, as amended, Bauer-Kahan. Automated decision tools. The Unruh Civil Rights Act provides that all persons within the jurisdiction of this state are free and equal and, regardless of their sex, race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, sexual orientation, citizenship, primary language, or immigration status, are entitled to the full and equal accommodations, advantages, facilities, privileges, or services in all business establishments of every kind whatsoever.The California Fair Employment and Housing Act establishes the Civil Rights Department within the Business, Consumer Services, and Housing Agency and requires the department to, among other things, bring civil actions to enforce the act.Existing law, the California Consumer Privacy Act of 2018 (CCPA), grants to a consumer various rights with respect to personal information, as defined, that is collected by a business, as defined, including the right to request that a business delete personal information about the consumer that the business has collected from the consumer. Existing law, the California Privacy Rights Act of 2020, an initiative measure approved by the voters as Proposition 24 at the November 3, 2020, statewide general election, amended, added to, and reenacted the CCPA. The CCPA establishes the California Privacy Protection Agency with full administrative power, authority, and jurisdiction to implement and enforce the CCPA.This bill would, among other things, require, as prescribed, a deployer, as defined, and a developer of an automated decision tool, as defined, to perform an impact assessment on any automated decision tool before the tool is first deployed and annually thereafter that includes, among other things, a statement of the purpose of the automated decision tool and its intended benefits, uses, and deployment contexts.This bill would require the California Privacy Protection Agency to, by January 1, 2027, establish a staggered schedule that identifies when each state government deployer, as defined, is required to comply with specified deployer requirements for each deployed automated decision tool. The bill would require full compliance by January 1, 2031. The bill would require a state government deployer to, by January 1, 2026, provide to the agency a list of automated decision tools initially deployed before January 1, 2025.This bill would require a deployer to, prior to an automated decision tool making a consequential decision, as defined, or being a substantial factor, as defined, in making a consequential decision, notify any natural person that is subject to the consequential decision that an automated decision tool is being used and to provi... (click bill link to see more).

Primary Sponsors
Rebecca Bauer-Kahan

Organizational Notes

Last edited by Joanne Campbell at Aug 19, 2024, 7:15 PM
Oppose - California Association of Health Plans

Bill Number
AB 2998

Status
Passed Senate

Position
Monitor

Title
Opioid overdose reversal medications: pupil administration.

Description
AB 2998, as amended, McKinnor. Opioid overdose reversal medications: pupil administration. Existing law authorizes a public or private elementary or secondary school to determine whether or not to make emergency naloxone hydrochloride or another opioid antagonist and trained personnel available at its school, and to designate one or more volunteers to receive related training to address an opioid overdose, as specified. Existing law prohibits a person who has completed that training and who administers naloxone hydrochloride or another opioid antagonist, in good faith and not for compensation, to a person who appears to be experiencing an opioid overdose from being subject to professional review, liable in a civil action, or subject to criminal prosecution for the person's acts or omissions in administering the naloxone hydrochloride or another opioid antagonist, unless the person's acts or omissions constituted gross negligence or willful and wanton misconduct, as provided.This bill would prohibit a school district, county office of education, or charter school from prohibiting a pupil 12 years of age or older, while on a schoolsite or participating in school activities, from carrying or administering, for the purposes of providing emergency treatment to persons who are suffering, or reasonably believed to be suffering, from an opioid overdose, a naloxone hydrochloride nasal spray or any other opioid overdose reversal medication that is federally approved for over-the-counter, nonprescription use, as provided. The bill would prohibit a pupil 12 years of age or older of those local educational agencies who administers those opioid antagonists on a schoolsite or while participating in school activities, in good faith and not for compensation, to a person who appears to be experiencing an opioid overdose, from being held liable in a civil action or being subject to criminal prosecution for their acts or omissions, unless the pupil's acts or omissions constitute gross negligence or willful and wanton misconduct, as provided. The bill would also prohibit those local educational agencies, or an employee of those local educational agencies, from being subject to professional review, liable in a civil action, or subject to criminal prosecution for a pupil's acts or omissions in administering those opioid antagonists, unless an act or omission of the local educational agency, or the employee of the local educational agency, constitutes gross negligence or willful and wanton misconduct connected to the administration of those opioid antagonists.

Primary Sponsors
Tina McKinnor

Bill Number	Status	Position
AB 3030	**In Senate**	**Monitor**

Title
Health care services: artificial intelligence.

Description
AB 3030, as amended, Calderon. Health care services: artificial intelligence. Existing law provides for the licensure and regulation of health facilities and clinics by the State Department of Public Health. Existing law, the Medical Practice Act, establishes the Medical Board of California for the licensing, regulation, and discipline of physicians and surgeons. Existing law, the Osteopathic Act, enacted by an initiative measure, establishes the Osteopathic Medical Board of California for the licensing and regulation of osteopathic physicians and surgeons. This bill would require a health facility, clinic, physician’s office, or office of a group practice that uses generative artificial intelligence to generate written or verbal patient communications pertaining to patient clinical information, as defined, to ensure that those communications include both (1) a disclaimer that indicates to the patient that a communication was generated by generative artificial intelligence, as specified, and (2) clear instructions describing how a patient may contact a human health care provider, as specified. The bill would exempt from this requirement a communication read and reviewed by a human licensed or certified health care provider. Under the bill, a violation of these provisions by a physician would be subject to the jurisdiction of the Medical Board of California or Osteopathic Medical Board of California, as appropriate.

Primary Sponsors
Lisa Calderon

Bill Number
AB 3059

Status
In Senate

Position
Monitor

Title
Human milk.

Description
AB 3059, as amended, Weber. Human milk. Existing law licenses and regulates tissue banks and generally makes a violation of the requirements applicable to tissue banks a crime.This bill would specify that a general acute care hospital is not required to have a license to operate a tissue bank to store or distribute pasteurized donor human milk that was obtained from a tissue bank licensed by the State Department of Public Health.Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service plans and makes a willful violation of the act a crime. Other existing law requires the Department of Insurance to regulate health insurers. Existing law requires health care service plans and health insurers, as specified, to provide certain health benefits and services, including, among others, maternity hospital stays, inpatient hospital and ambulatory maternity services, and maternal mental health programs. This bill would require a health care service plan contract or health insurance policy that is issued, amended, delivered, or renewed on or after January 1, 2025, to cover medically necessary pasteurized donor human milk obtained from a tissue bank licensed by the State Department of Public Health.Because a violation of the bill’s 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
Akilah Weber

Organizational Notes

Last edited by Joanne Campbell at Apr 19, 2024, 8:10 PM
California Association of Health Plans - Opposed

Bill Number	Status	Position
AB 3063	**In Senate**	**Monitor**

Title
Pharmacies: compounding.

Description
AB 3063, as introduced, McKinnor. Pharmacies: compounding. Existing law, the Pharmacy Law, requires the California State Board of Pharmacy to license and regulate the practice of pharmacy by pharmacists and pharmacy corporations in this state. Existing law prohibits a pharmacy from compounding sterile drug products unless the pharmacy has obtained a sterile compounding pharmacy license from the board. Existing law requires the compounding of drug preparations by a pharmacy for furnishing, distribution, or use to be consistent with standards established in the pharmacy compounding chapters of the current version of the United States Pharmacopeia-National Formulary, including relevant testing and quality assurance. Existing law authorizes the board to adopt regulations to impose additional standards for compounding drug preparations.This bill would, notwithstanding those provisions, specify that compounding does not include reconstitution of a drug pursuant to a manufacturer’s directions, the sole act of tablet splitting or crushing, capsule opening, or the addition of a flavoring agent to enhance palatability. The bill would require a pharmacy to retain documentation that a flavoring agent was added to a prescription and to make that documentation available to the board or its agent upon request. The bill would make those provisions operative until January 1, 2030.This bill would declare that it is to take effect immediately as an urgency statute.

Primary Sponsors
Tina McKinnor

Bill Number
AB 3129

Status
In Senate

Position
Monitor

Title
Health care system consolidation.

Description
AB 3129, as amended, Wood. Health care system consolidation. Existing law requires a nonprofit corporation that operates or controls a health facility or other facility that provides similar health care to provide written notice to, and to obtain the written consent of, the Attorney General prior to entering into any agreement or transaction to sell, transfer, lease, exchange, option, convey, or otherwise dispose of the asset, or to transfer control, responsibility, or governance of the asset or operation, to a for-profit corporation or entity, to a mutual benefit corporation or entity, or to a nonprofit corporation, as specified.This bill would require a private equity group or a hedge fund, as defined, to provide written notice to, and obtain the written consent of, the Attorney General before a transaction between the private equity group or hedge fund and a health care facility, provider, or provider group, as those terms are defined, and any of those entities that directly or indirectly control, are controlled by, are under common control of, or are otherwise affiliated with a payor, except as specified. The bill would require the notice to be submitted at the same time that any other state or federal agency is notified pursuant to state or federal law, and otherwise at least 90 days before the transaction. The bill would authorize the Attorney General to extend that 90-day period under certain circumstances. The bill would additionally require a private equity group or hedge fund to provide advance written notice to the Attorney General before a transaction between a private equity group or hedge fund and a nonphysician provider or a provider, with specified gross annual revenue.The bill would authorize the Attorney General to give the private equity group or hedge fund a written waiver or the notice and consent requirements if specified conditions apply, including, but not limited to, that the party makes a written waiver request, the health care facility’s, provider group’s, or provider’s operating costs have exceeded its operating revenue in the relevant market for 3 or more years and the party cannot meet its debts, and the transaction will ensure continued health care access in the relevant markets. The bill would require the Attorney General to grant or deny the waiver within 45 days, as prescribed.The bill would authorize the Attorney General to consent to, give conditional consent to, or not consent to a transaction between a private equity group or hedge fund and a health care facility, provider group, or provider if the transaction may have a substantial likelihood of anticompetitive effects or may create a significant effect on the access or availability of health care services to the affected co... (click bill link to see more).

Primary Sponsors
Jim Wood, Melissa Hurtado

Bill Number
AB 3130

Status
In Senate

Position
Monitor

Title
County board of supervisors: disclosure.

Description
AB 3130, as amended, Quirk-Silva. County board of supervisors: disclosure. Existing law prohibits certain public officials, including, but not limited to, state, county, or district officers or employees, from being financially interested in any contract made by them in their official capacity, or by any body or board of which they are members, except as provided. A willful violation of these provisions is a crime.Existing law excepts from the above conflict-of-interest provisions certain remote interests, as described, including those of officers or employees of a nonprofit entity exempt from taxation or a nonprofit corporation, except as prescribed. Existing law requires a remote interest to be disclosed to the body or board of which the officer is a member and noted in its official records, and thereafter the body or board to authorize, approve, or ratify the contract in good faith by a vote of its membership sufficient for the purpose without counting the vote or votes of the officer or member with the remote interest.This bill would require a member of the board of supervisors to disclose a known family relationship with an officer or employee of a nonprofit entity before the board of supervisors appropriates money to that nonprofit entity.

Primary Sponsors
Sharon Quirk-Silva, Avelino Valencia

Bill Number
AB 3156

Status
In Senate

Position
Monitor

Title
Medi-Cal managed care plans: regional center services: beneficiaries with other primary coverage.

Description
AB 3156, as amended, Joe Patterson. Medi-Cal managed care plans: regional center services: beneficiaries with other primary coverage. (1)ExistingExisting 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, under fee-for-service or managed care delivery systems. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing federal law, in accordance with third-party liability rules, Medicaid is generally the payer of last resort if a beneficiary has another source of health care coverage in addition to Medicaid coverage.Existing law authorizes the department to standardize those populations that are subject to mandatory enrollment in a Medi-Cal managed care plan across all aid code groups and Medi-Cal managed care models statewide, with certain exemptions, as specified. Existing law requires the Medi-Cal managed care plan to comply with certain continuity-of-care requirements that involve completion of covered services by a terminated or nonparticipating provider subject to certain criteria, including a 12-month limit for that continuity of care under specified circumstances.Existing law, the Lanterman Developmental Disabilities Services Act, requires the State Department of Developmental Services to contract with regional centers to provide community services and supports for persons with developmental disabilities and their families.This bill would apply to Medi-Cal beneficiaries who receive services from a regional center, who have coverage under the federal Medicare Program or another primary form of health care coverage and for whom the Medi-Cal program is a secondary payer, and whose provider for covered benefits is not participating in a Medi-Cal managed care plan’s provider network. The bill would exempt, from mandatory enrollment in a managed care plan, a beneficiary with those criteria if the provider would be unable to bill and receive reimbursement from the beneficiary’s primary source of health care coverage if the beneficiary were enrolled in the managed care plan.Under the bill, in the case of a beneficiary with the above-described criteria and who is already enrolled in a managed care plan through mandatory enrollment, the beneficiary would have the right to continue receiving covered benefits from that nonparticipating provider as part of the beneficiary’s coverage under the managed care plan, subject to certain conditions.(2)UnderUnder the bill, in the case of a Medi-Cal managed care plan enrollee who has other health coverage, as specified, the department would be required to ensure that a provider billing the manage... (click bill link to see more).

Primary Sponsors
Joe Patterson, Stephanie Nguyen

Bill Number
AB 3161

Status
In Senate

Position
Monitor

Title
Health and care facilities: patient safety and antidiscrimination.

Description
AB 3161, as amended, Bonta. Health and care facilities: patient safety and antidiscrimination. (1) Existing law provides for the licensure and regulation of health facilities by the State Department of Public Health. Existing law requires health facilities, as defined, to report an adverse event, as described, to the department within prescribed timeframes. A violation of these provisions is a crime.This bill would also require health facilities to provide certain demographic information to the department when reporting the adverse event. By creating a new crime, this bill would impose a state-mandated local program.Existing(2) Existing law allows for patients to submit complaints to the department regarding health facilities. Existing law also requires the department to establish a centralized consumer response unit within the Licensing and Certification Division of the department to respond to consumer inquiries and complaints.This bill would require the department to include a section for complaints involving specified health facilities to collect information about outlined demographic factors of affected patients. The bill would require the department to include a section on the Complaint Against a Health Care Facility/Provider form on the department's internet website, and provide means for complaints submitted via mail, fax, or by telephone, for complaints involving specified health facilities. The bill would require the department to inform complainants that the information collected is voluntary, is to ensure patients receive the best care possible, and will not affect the department's investigation. The bill would require complainants to be provided with information on how to file a complaint with the Civil Rights Department.(2)(3) Existing law requires a health facility to develop, implement, and comply with a patient safety plan to improve the health and safety of patients and to reduce preventable patient safety events. The patient safety plan requires specified elements, including, but not limited to, a reporting system for patient safety events that allows anyone involved to make a report of a patient safety event to the health facility, and a process for a team of facility staff to conduct analyses related to root causes of patient safety events.This bill would require the reporting system to include anonymous reporting options. The bill would also require analysis of patient safety events by sociodemographic factors to identify disparities in these events. The bill would require that the safety plan include a process for addressing racism and discrimination and its impacts on patient health and safety, including monitoring sociodemographic disparities in patient safety events and developing interventi... (click bill link to see more).

Primary Sponsors
Mia Bonta

Bill Number
AB 3215

Status
In Assembly

Position
Monitor

Title
Medi-Cal: mental health services for children.

Description
AB 3215, as introduced, Soria. Medi-Cal: mental health services for children. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, specialty mental health services include federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services provided to eligible Medi-Cal beneficiaries under 21 years of age.This bill would express the intent of the Legislature to enact legislation to expand access to behavioral mental health services to children receiving Medi-Cal benefits.

Primary Sponsors
Esmeralda Soria

Bill Number
AB 3221

Status
In Senate

Position
Monitor

Title
Department of Managed Health Care: review of records.

Description
AB 3221, as amended, Pellerin. Department of Managed Health Care: review of records. Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (hereafter the act), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law requires the records, books, and papers of a health care service plan and other specified entities to be open to inspection by the director of the department during normal business hours.This bill would instead require the records, books, and papers of a health care service plan and other specified entities to be open to inspection by the director, including through electronic means. The bill would require a plan and other specified entities to furnish in electronic media records, books, and papers that are possessed in electronic media and to conduct a diligent review of records, books, and papers and make every effort to furnish those responsive to the director’s request. The bill would require records, books, and papers to be furnished in a format that is digitally searchable, to the greatest extent feasible. The bill would require records, books, and papers to be preserved until furnished, if requested by the department. The bill would authorize the director to inspect and copy these records, books, and papers, and to seek relief in an administrative law proceeding if, in the director’s determination, a plan or other specified entity fails to fully or timely respond to a duly authorized request for production of records, books, and papers. Because a willful violation of these requirements would be a crime, the bill would impose a state-mandated local program.Existing law requires the department to conduct periodically an onsite medical survey of the health delivery system of each plan. Existing law requires the director to publicly report survey results no later than 180 days following the completion of the survey, and requires a final report to be issued after public review of the survey. Existing law requires the department to conduct a followup review to determine and report on the status of the plan’s efforts to correct deficiencies no later than 18 months following release of the final report.This bill would state that nothing in those provisions prohibits the director from taking any action permitted or required under the act in response to the survey results before the followup review is initiated or completed, including, but not limited to, taking enforcement actions and opening further investigations. The bill would declare that these provisions are declaratory of and clarify existing law with regard to the director’s enforcement authority.Existing law enumerates ... (click bill link to see more).

Primary Sponsors
Gail Pellerin

Organizational Notes

Last edited by Joanne Campbell at Feb 28, 2024, 9:06 PM
National Union of Healthcare Workers, Sponsor

Bill Number
AB 3245

Status
In Senate

Position
Monitor

Title
Coverage for colorectal cancer screening.

Description
AB 3245, as amended, Joe Patterson. Coverage for colorectal cancer screening. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally requires a health care service plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2022, to provide coverage without cost sharing for a colorectal cancer screening test, and for a colorectal cancer screening examination in specified circumstances, assigned either a grade of A or a grade of B by the United States Preventive Services Task Force.This bill would additionally require that coverage if the test or screening examination is assigned either a grade of A or a grade of B, or equivalent, in accordance with the most current recommendations established by another accredited or certified guideline agency approved by the California Health and Human Services Agency.

Primary Sponsors
Joe Patterson

Organizational Notes

Last edited by Joanne Campbell at Apr 22, 2024, 5:03 PM
California Association of Health Plans - Opposed (removed)

Bill Number
AB 3275

Status
In Senate

Position
Monitor

Title
Health care coverage: claim reimbursement.

Description
AB 3275, as amended, Soria. Health care coverage: claim reimbursement. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health insurer or health care service plan, including a specialized health care service plan, to reimburse a claim or portion of a claim no later than 30 working days after receipt of the claim, unless the plan contests or denies the claim, in which case the plan is required to notify the claimant within 30 working days that the claim is contested or denied. Under existing law, if a claim or portion thereof is contested on the basis that a health insurer or health care service plan has not received all information necessary to determine payer liability for the claim or portion thereof and notice has been provided, the health insurer or health care service plan has 30 working days after receipt of the additional information to complete reconsideration of the claim. Existing law extends these timelines to 45 working days for a health care service plan that is a health maintenance organization. Under existing law, if a claim is not reimbursed, contested, or denied pursuant to these timelines, as specified, interest accrues at a rate of 15% per annum for a health care service plan and 10% per annum for a health insurer. This bill would increase that interest accrual rate for a health insurer to 15% per annum. The bill would delete the provisions that extend the timelines for a health maintenance organization. The bill would require a health care service plan or health insurer to reimburse a claim within 15 working days after receipt of the claim, or, if the health care service plan or health insurer contests or denies the claim, to notify the claimant within 15 working days that the claim is contested or denied. Under the bill, if a claim for reimbursement is contested on the basis that the health care service plan or health insurer has not received all information necessary to determine payer liability for the claim and notice has been provided, the health care service plan or health insurer would have 15 working days after receipt of the additional information to complete reconsideration of the claim. The bill would require the departments to develop respective lists for categories of claims that, commencing January 1, 2026, would be required to be paid by a health insurer or health care service plan no later than 5 days after receipt of the claim, as specified. Existing law requires a health care service... (click bill link to see more).

Primary Sponsors
Esmeralda Soria, Robert Rivas

Organizational Notes

Last edited by Cherie Compartore at May 14, 2024, 4:03 PM
Oppose: Local Health Plans of California, California Association of Health Plans

Bill Number
SB 136

Status
Enacted

Position
Monitor

Title
Medi-Cal: managed care organization provider tax.

Description
SB 136, Committee on Budget and Fiscal Review. Medi-Cal: managed care organization provider tax. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, one of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care plans.Existing law imposes a managed care organization (MCO) provider tax, administered and assessed by the department, on licensed health care service plans and managed care plans contracted with the department. Under existing law, all revenues, less refunds, derived from the taxes are deposited into the Managed Care Enrollment Fund, to be available to the department, upon appropriation, for the purpose of funding specified subcomponents to support the Medi-Cal program.Existing law sets forth certain taxing tiers and tax amounts for purposes of the tax periods of April 1, 2023, to December 31, 2023, inclusive, and the 2024, 2025, and 2026 calendar years. Under existing law, the Medi-Cal per enrollee tax amount for Medi-Cal taxing tier II, as defined, is $182.50 for the 2024 calendar year, $187.50 for the 2025 calendar year, and $192.50 for the 2026 calendar year.This bill would raise that tax amount for that tier to $205 for all 3 of those calendar years.This bill would declare that it is to take effect immediately as an urgency statute.

Primary Sponsors
Senate Budget and Fiscal Review Committee

Organizational Notes

Last edited by Joanne Campbell at Mar 18, 2024, 5:17 PM
California Association of Health Plans - Support

Bill Number
SB 157

Status
In Assembly

Position
Monitor

Title
Budget Act of 2024.

Description
SB157, as amended, span.DottedLeaders::after {content:".................";}Committee on Budget and Fiscal Review Wiener . span.DottedLeaders::after {content:".................";}Budget Act of 2023. Budget Act of 2024. The Budget Act of 2024 made appropriations for the support of state government for the 2024–25 fiscal year. This bill would amend the Budget Act of 2024 by amending, adding, and repealing items of appropriation and making other changes. This bill would declare that it is to take effect immediately as a Budget Bill. span.DottedLeaders::after {content:".................";}This bill would express the intent of the Legislature to enact statutory changes relating to the Budget Act of 2023.

Primary Sponsors
Scott Wiener

Bill Number
SB 242

Status
In Assembly

Position
Monitor

Title
California Hope, Opportunity, Perseverance, and Empowerment (HOPE) for Children Trust Account Program.

Description
SB 242, as amended, Skinner. California Hope, Opportunity, Perseverance, and Empowerment (HOPE) for Children Trust Account Program. Existing law establishes the California Hope, Opportunity, Perseverance, and Empowerment (HOPE) for Children Trust Account Program to provide a trust fund account to an eligible child, defined to include minor California residents who are specified dependents or wards under the jurisdiction of juvenile court in foster care with reunification services terminated by court order, or who have a parent, Indian custodian, or legal guardian who died due to COVID-19 during the federally declared COVID-19 public health emergency and meet the specified family household income limit. Under the program, all assets of the fund and moneys allocated to individual HOPE trust accounts shall be considered to be owned by the state until an eligible youth withdraws or transfers money from their HOPE trust account. This bill would, among other things, require the Treasurer to verify the cause of death of the parent, Indian custodian, or legal guardian and to verify the minor’s family household income prior to the death of the parent, Indian custodian, or legal guardian once the Treasurer receives government-issued documents or a statement signed by a person who is eligible to do so under penalty of perjury that establishes the identity of the child and that the person whose death certificate was provided was the child’s parent, Indian custodian, or legal guardian. By expanding the crime of perjury, this bill would impose a state-mandated local program. The bill would also state the intent of the Legislature that all eligible children will be automatically enrolled for a HOPE trust account to the extent possible, and would require the Treasurer to, in order to achieve this goal, collaborate with the State Department of Social Services and any other relevant governmental agencies to gather deidentified data to maximize participation in the HOPE trust account program for eligible youth, as specified.Existing law establishes various means-tested public social services programs administered by counties to provide eligible recipients with certain benefits, including, but not limited to, cash assistance under the California Work Opportunity and Responsibility to Kids (CalWORKs) program, nutrition assistance under the CalFresh program, and health care services under the Medi-Cal program.This bill would, to the extent permitted by federal law, prohibit funds deposited and investment returns accrued in a HOPE trust account from being considered as income or assets when determining eligibility and benefit amount for any means-tested program until an eligible youth withdraws or transfers the funds from the HOPE trust ac... (click bill link to see more).

Primary Sponsors
Nancy Skinner

Bill Number	Status	Position
SB 339	**Enacted**	**Monitor**

Title
HIV preexposure prophylaxis and postexposure prophylaxis.

Description
SB 339, Wiener. HIV preexposure prophylaxis and postexposure prophylaxis. Existing law, the Pharmacy Law, provides for the licensure and regulation of pharmacists by the California State Board of Pharmacy. Existing law authorizes a pharmacist to furnish at least a 30-day supply of HIV preexposure prophylaxis, and up to a 60-day supply of those drugs if certain conditions are met. Existing law also authorizes a pharmacist to furnish postexposure prophylaxis to a patient if certain conditions are met.This bill would authorize a pharmacist to furnish up to a 90-day course of preexposure prophylaxis, or preexposure prophylaxis beyond a 90-day course, if specified conditions are met. The bill would require the California State Board of Pharmacy to adopt emergency regulations to implement these provisions by October 31, 2024.Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law prohibits a health care service plan or health insurer from covering preexposure prophylaxis that has been furnished by a pharmacist in excess of a 60-day supply once every 2 years, except as specified.Existing law provides for the Medi-Cal program administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services pursuant to a schedule of benefits. The existing schedule of benefits includes coverage for preexposure prophylaxis as pharmacist services, limited to no more than a 60-day supply furnished by a pharmacist once every 2 years, and includes coverage for postexposure prophylaxis, subject to approval by the federal Centers for Medicare and Medicaid Services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.This bill would require a health care service plan and health insurer to cover preexposure prophylaxis and postexposure prophylaxis furnished by a pharmacist, including the pharmacist’s services and related testing ordered by the pharmacist, and to pay or reimburse for the service performed by a pharmacist at an in-network pharmacy or a pharmacist at an out-of-network pharmacy if the health care service plan or health insurer has an out-of-network pharmacy benefit, except as specified. The bill would include preexposure prophylaxis furnished by a pharmacist as pharmacist services on the Medi-Cal schedule of benefits. Because a willful violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated l... (click bill link to see more).

Primary Sponsors
Scott Wiener, Mike Gipson

Organizational Notes

Last edited by Joanne Campbell at Jan 11, 2024, 5:48 PM
California Association of Health Plans: Oppose Unless Amended

Bill Number
SB 427

Status
Passed Assembly

Position
Monitor

Title
Health care coverage: antiretroviral drugs, drug devices, and drug products.

Description
SB 427, as amended, Portantino. Health care coverage: antiretroviral drugs, drug devices, and drug products. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally prohibits a health care service plan, excluding a Medi-Cal managed care plan, or health insurer from subjecting antiretroviral drugs that are medically necessary for the prevention of HIV/AIDS, including preexposure prophylaxis or postexposure prophylaxis, to prior authorization or step therapy. Under existing law, a health care service plan or health insurer is not required to cover all the therapeutically equivalent versions of those drugs without prior authorization or step therapy if at least one is covered without prior authorization or step therapy.This bill would prohibit a health care service plan, excluding a Medi-Cal managed care plan, or health insurer from subjecting antiretroviral drugs, drug devices, or drug products that are either approved by the United States Food and Drug Administration (FDA) or recommended by the federal Centers for Disease Control and Prevention (CDC) for the prevention of HIV/AIDS, to prior authorization or step therapy, but would authorize prior authorization or step therapy if at least one therapeutically equivalent version is covered without prior authorization or step therapy and the plan or insurer provides coverage for a noncovered therapeutic equivalent antiretroviral drug, drug device, or drug product without cost sharing pursuant to an exception request. The bill would require a plan or insurer to provide coverage under the outpatient prescription drug benefit for those drugs, drug devices, or drug products, including by supplying participating providers directly with a drug, drug device, or drug product, as specified.This bill would require a nongrandfathered or grandfathered health care service plan contract or health insurance policy to provide coverage for antiretroviral drugs, drug devices, or drug products that are either approved by the FDA or recommended by the CDC for the prevention of HIV/AIDS, and would prohibit a nongrandfathered or grandfathered health care service plan contract or health insurance policy from imposing any cost-sharing or utilization review requirements for those drugs, drug devices, or drug products. The bill would exempt Medi-Cal managed care plans from these provisions and would delay the application of these provisions for an individual and small group health care service plan contract or ... (click bill link to see more).

Primary Sponsors
Anthony Portantino

Organizational Notes

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

Bill Number
SB 516

Status
Passed Assembly

Position
Monitor

Title
Health care coverage: prior authorization.

Description
SB 516, as amended, Skinner. Health care coverage: prior authorization. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or health insurer to use prior authorization and other utilization review or utilization management functions, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Existing law requires a health care service plan or health insurer, including those plans or insurers that delegate utilization review or utilization management functions to medical groups, independent practice associations, or to other contracting providers, to comply with specified requirements and limitations on their utilization review or utilization management functions. Existing law requires the criteria or guidelines used to determine whether or not to authorize, modify, or deny health care services to be developed with involvement from actively practicing health care providers.On or after January 1, 2026, this bill would prohibit a health care service plan or health insurer from requiring a contracted health professional to complete or obtain a prior authorization for any covered health care services if the plan or insurer approved or would have approved not less than 90% of the prior authorization requests they submitted in the most recent completed one-year contracted period. The bill would set standards for this exemption and its denial, rescission, and appeal. The bill would authorize a plan or insurer to evaluate the continuation of an exemption not more than once every 12 months, and would authorize a plan or insurer to rescind an exemption only at the end of the 12-month period and only if specified criteria are met. The bill would require a plan or insurer to provide an electronic prior authorization process. The bill would also require a plan or insurer to have a process for annually monitoring prior authorization approval, modification, appeal, and denial rates to identify services, items, and supplies that are regularly approved, and to discontinue prior authorization on those services, items, and supplies that are approved 95% of the time. 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 Constit... (click bill link to see more).

Primary Sponsors
Nancy Skinner

Organizational Notes

Last edited by Joanne Campbell at Apr 22, 2024, 6:16 PM
Local Health Plan of California - Oppose

Bill Number	Status	Position
SB 607	**In Assembly**	**Monitor**

Title
Controlled substances.

Description
SB 607, as amended, Portantino. Controlled substances. Existing law requires a prescriber, with certain exceptions, before directly dispensing or issuing for a minor the first prescription for a controlled substance containing an opioid in a single course of treatment, to discuss specified information with the minor, the minor’s parent or guardian, or another adult authorized to consent to the minor’s medical treatment.This bill would extend that requirement for the prescriber by applying it to any patient, not only a minor, under those circumstances.

Primary Sponsors
Anthony Portantino

Bill Number
SB 729

Status
In Assembly

Position
Monitor

Title
Health care coverage: treatment for infertility and fertility services.

Description
SB 729, as amended, Menjivar. Health care coverage: treatment for infertility and fertility services. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of disability insurers by the Department of Insurance. Existing law imposes various requirements and restrictions on health care service plans and disability insurers, including, among other things, a requirement that every group health care service plan contract or disability insurance policy that is issued, amended, or renewed on or after January 1, 1990, offer coverage for the treatment of infertility, except in vitro fertilization.This bill would require large and small group health care service plan contracts and disability insurance policies issued, amended, or renewed on or after January 1, 2024, to provide coverage for the diagnosis and treatment of infertility and fertility services. With respect to large group health care service plan contracts and disability insurance policies, the bill would require coverage for a maximum of 3 completed oocyte retrievals, as specified. The bill would revise the definition of infertility, and would remove the exclusion of in vitro fertilization from coverage. The bill would also delete a requirement that a health care service plan contract and disability insurance policy provide infertility treatment under agreed-upon terms that are communicated to all group contractholders and policyholders. The bill would prohibit a health care service plan or disability insurer from placing different conditions or coverage limitations on fertility medications or services, or the diagnosis and treatment of infertility and fertility services, than would apply to other conditions, as specified. The bill would make these requirements inapplicable to a religious employer, as defined, and specified contracts and policies.With respect to a health care service plan, the bill would not apply to a specialized health care service plan contract or Medi-Cal managed care health care service plan contracts or any entity that enters into a contract with the State Department of Health Care Services for the delivery of health care services pursuant to specified provisions. With respect to a disability insurer, the bill would not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, or specialized disability insurance policies.Because the 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 sta... (click bill link to see more).

Primary Sponsors
Caroline Menjivar, Buffy Wicks

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 6:01 PM
California Association of Health Plans: Oppose

Bill Number
SB 819

Status
In Assembly

Position
Monitor

Title
Medi-Cal: certification.

Description
SB 819, as amended, Eggman. Medi-Cal: certification. Existing law requires the State Department of Public Health to license and regulate clinics. Existing law exempts from those licensing provisions certain clinics that are directly conducted, maintained, or operated by federal, state, or local governmental entities, as specified. Existing law also exempts from those licensing provisions a clinic that is operated by a primary care community or free clinic, that is operated on separate premises from the licensed clinic, and that is only open for limited services of no more than 40 hours per week.Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services (department) and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Existing law sets forth various procedures, including the submission of an application package, for providers to enroll in the Medi-Cal program. Under existing law, an applicant or provider that is a government-run license-exempt clinic as described above is required to comply with those Medi-Cal enrollment procedures.Under existing law, an applicant or provider that is operated on separate premises and is license exempt, including an intermittent site or mobile health care unit that is operated by a licensed primary care clinic that provides all staffing, protocols, equipment, supplies, and billing services, is not required to enroll in the Medi-Cal program as a separate provider or comply with the above-described enrollment procedures, if the licensed primary care clinic has notified the department of its separate locations, premises, intermittent sites, or mobile health care units.This bill would additionally exempt from the Medi-Cal enrollment procedures an intermittent site or mobile health care unit that is operated by the above-described government-run license-exempt clinic if that clinic has notified the department of its separate locations, premises, sites, or units.The bill would make legislative findings stating that this bill is declaratory of existing law, as specified.

Primary Sponsors
Susan Eggman

Bill Number
SB 895

Status
In Assembly

Position
Monitor

Title
Community colleges: Baccalaureate Degree in Nursing Pilot Program.

Description
SB 895, as amended, Roth. Community colleges: Baccalaureate Degree in Nursing Pilot Program. Existing law establishes the California Community Colleges, under the administration of the Board of Governors of the California Community Colleges. Existing law establishes community college districts throughout the state, under the administration of community college district governing boards, and authorizes these districts to provide instruction at the community college campuses they operate. Existing law establishes a statewide baccalaureate degree program that authorizes up to a total of 30 baccalaureate degree programs at community college districts to be approved per academic year, as provided.This bill would require the office of the Chancellor of the California Community Colleges to develop a Baccalaureate Degree in Nursing Pilot Program that authorizes select community college districts to offer a Bachelor of Science in Nursing degree. The bill would limit the pilot program to 15 community college districts statewide and would require the chancellor’s office to identify and select eligible community college districts based on specified criteria. The bill would require the chancellor’s office to develop a process designed to assist community college districts with nursing programs that are applying for national accreditation for the purpose of qualifying for the pilot program, as provided. The bill would require each participating community college district to give priority registration for enrollment in the pilot program to students with an associate degree in nursing from that community college district. The bill would require the Legislative Analyst’s Office to conduct an evaluation of the pilot program to determine the effectiveness of the program and the need to continue or expand the program, as specified, to be submitted to the Legislature on or before July 1, 2032. The bill would repeal these provisions as of January 1, 2034.

Primary Sponsors
Richard Roth, Anna Caballero, Eloise Reyes

Bill Number
SB 942

Status
In Assembly

Position
Monitor

Title
California AI Transparency Act.

Description
SB 942, as amended, Becker. California AI Transparency Act. Existing law requires the Secretary of Government Operations to develop a coordinated plan to, among other things, investigate the feasibility of, and obstacles to, developing standards and technologies for state departments to determine digital content provenance. For the purpose of informing that coordinated plan, existing law requires the secretary to evaluate, among other things, the impact of the proliferation of deepfakes, defined to mean audio or visual content that has been generated or manipulated by artificial intelligence that would falsely appear to be authentic or truthful and that features depictions of people appearing to say or do things they did not say or do without their consent, on state government, California-based businesses, and residents of the state.This bill, the California AI Transparency Act, would, among other things, require a covered provider, as defined, to create and make freely available an artificial intelligence (AI) detection tool that meets certain criteria, including that the AI detection tool is publicly accessible through the covered provider’s internet website and its mobile application, as applicable. The bill would require a covered provider to offer the user an option to include a manifest disclosure in image, video, audio, or other digital content created or altered by the covered provider’s generative artificial intelligence (GenAI) system that, among other things, identifies content as AI-generated content and is clear, conspicuous, appropriate for the medium of the content, and understandable to a reasonable person. The bill would require a covered provider to include a latent disclosure in AI-generated image, video, audio, or other digital content created by the covered provider’s GenAI system that, among other things, conveys certain information, either directly or through a link to a permanent internet website, regarding the provenance of the content. The bill would require a covered provider that knows a third-party licensee modified a licensed GenAI system such that it is no longer capable of including the disclosures described above in content the system creates or alters to revoke the license within 72 hours of discovering the licensee’s action and would require a third-party licensee to cease using a licensed GenAI system after the license for the system has been revoked by the covered provider.This bill would make a covered provider that violates these provisions liable for a civil penalty in the amount of $5,000 per violation to be collected in a civil action filed by the Attorney General, a city attorney, or a county counsel, as prescribed. The bill would, for a violation by a third-party licens... (click bill link to see more).

Primary Sponsors
Josh Becker

Bill Number
SB 957

Status
In Assembly

Position
Monitor

Title
Data collection: sexual orientation, gender identity, and intersex status.

Description
SB 957, as amended, Wiener. Data collection: sexual orientation, gender identity, and intersex status. (1) Existing law, the Lesbian, Gay, Bisexual, and Transgender Disparities Reduction Act, requires the State Department of Public Health, among other specified state entities, in the course of collecting demographic data directly or by contract as to the ancestry or ethnic origin of Californians, to collect voluntary self-identification information pertaining to sexual orientation, gender identity, and intersexuality.This bill would replace the term “intersexuality” with the term “variations in sex characteristics/intersex status” and would make conforming changes to related provisions.Existing law, as an exception to the provision above, authorizes those state entities, instead of requiring them, to collect the demographic data under either of the following circumstances: (a) pursuant to federal programs or surveys, whereby the guidelines for demographic data collection categories are defined by the federal program or survey; or (b) demographic data are collected by other entities, including other state agencies, surveys administered by third-party entities and the state department is not the sole funder, or third-party entities that provide aggregated data to a state department.This bill, notwithstanding the exception above, would require the State Department of Public Health to collect the demographic data from third parties, including, but not limited to, local health jurisdictions, on any forms or electronic data systems, unless prohibited by federal or state law. To the extent that the bill would create new duties for local officials in facilitating the department’s data collection, the bill would impose a state-mandated local program.The bill would prohibit the provisions above from being construed to require health care providers to collect, disclose, or report information that is not voluntarily provided self-identification information pertaining to sexual orientation, gender identity, and variations in sex characteristics/intersex status (SOGISC). Existing law requires the above-described state entities to report to the Legislature the data collected and the method used to collect the data, and to make the data available to the public, except for personally identifiable information. Existing law deems that personally identifiable information confidential and prohibits its disclosure. Existing law sets forth different deadlines, depending on the specified state entity, for complying with those requirements.This bill would require the State Department of Public Health, for purposes of the data collected by the department on SOGISC, to comply with the above-described requirements by July 1, 2026.(2) Existi... (click bill link to see more).

Primary Sponsors
Scott Wiener

Bill Number	Status	Position
SB 966	**In Assembly**	**Monitor**

Title
Pharmacy benefits.

Description
SB 966, as amended, Wiener. Pharmacy benefits. Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (the Knox-Keene Act), a violation of which is a crime, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. The Knox-Keene Act requires a pharmacy benefit manager under contract with a health care service plan to, among other things, register with the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance.This bill would additionally require a pharmacy benefit manager, as defined, to apply for and obtain a license from the Department of Insurance to operate as a pharmacy benefit manager no later than January 1, 2027. The bill would establish application qualifications and requirements, and would require initial license and renewal fees to be collected into the newly created Pharmacy Benefit Manager Account in the Insurance Fund, to be available to the department for use, upon appropriation by the Legislature, as specified, for costs related to licensing and regulating pharmacy benefit managers.This bill would require a pharmacy benefit manager to file with the department at specified annual intervals 2 reports, one of which discloses product benefits specific to the purchaser, and the other of which includes information about categories of drugs and the pharmacy benefit manager’s contracts and revenues. The bill would specify that the contents of the reports are not to be disclosed to the public. The bill would require the department, at specified annual intervals, to submit 2 reports to the Legislature based on the reports submitted by pharmacy benefit managers, and would require the department to post the reports on the department’s internet website.This bill would impose specified duties on pharmacy benefit managers and requirements for pharmacy benefit manager services and pharmacy benefit manager contracts, including requiring the pharmacy benefit manager to use a passthrough pricing model, in which the payment made by the health care service plan or health insurer client to the pharmacy benefit manager for a covered outpatient drug is equivalent to the payment the pharmacy benefit manager makes to the pharmacy or provider for the drug, and is passed through in its entirety by the health care service plan or health insurer client or the pharmacy benefit manager to the pharmacy or provider, as specified. The bill would make a violation of the above-specified provisions subject to specified civil penalties. The bill would establish various filing and service requirements when a proceeding is brought for a violation of specified requirements by a pharmacy benefit manager. ... (click bill link to see more).

Primary Sponsors
Scott Wiener, Aisha Wahab

Organizational Notes

Last edited by Joanne Campbell at Apr 19, 2024, 8:12 PM
California Association of Health Plans - Oppose

Bill Number	Status	Position
SB 1099	**In Assembly**	**Monitor**

Title
Newborn screening: genetic diseases: blood samples collected.

Description
SB 1099, as amended, Nguyen. Newborn screening: genetic diseases: blood samples collected. Existing law requires the State Department of Public Health to administer a statewide program for prenatal testing for genetic disorders and birth defects, including, but not limited to, ultrasound, amniocentesis, chorionic villus sampling, and blood testing. Existing law requires the department to expand prenatal screening to include all tests that meet or exceed the current standard of care as recommended by national recognized medical or genetic organizations. Existing law requires the department to set guidelines for invoicing, charging, and collecting fee amounts from approved researchers in order to cover the costs of, among other things, data linkage, retrieval, and data processing. Existing law establishes the continuously appropriated Birth Defects Monitoring Program Fund, consisting of fees paid for prenatal screening, and states the intent of the Legislature that all costs of the genetic disease testing program be fully supported by fees paid for prenatal screening tests, which are deposited in the fund. Existing law requires funds to be available, upon appropriation by the Legislature, in order to support pregnancy blood sample storage, testing, and research activities of the Birth Defects Monitoring Program.This bill would require the department, commencing July 1, 2026, and each July 1 thereafter, as part of its research activities, to report various data to the Legislature, including the number of research projects utilizing residual screening samples from the program and the number of inheritable conditions identified by the original screening tests the previous calendar year. The bill would require the department to additionally set fee guidelines to cover the costs of reporting. The bill would also require the annual report to be made available to the public on the department’s internet website.This bill would make other conforming changes.

Primary Sponsors
Janet Nguyen

Bill Number
SB 1112

Status
In Assembly

Position
Monitor

Title
Medi-Cal: families with subsidized childcare.

Description
SB 1112, as amended, Menjivar. Medi-Cal: families with subsidized childcare. Existing law establishes a system of childcare and development services, administered by the State Department of Social Services, for children from infancy to 13 years of age. Existing law authorizes, upon departmental approval, the use of appropriated funds for alternative payment programs to allow for maximum parental choice. Existing law authorizes those programs to include, among other things, a subsidy that follows the family from one childcare provider to another, or choices among hours of service. Existing law requires the department to contract with local contracting agencies for alternative payment programs so that services are provided throughout the state.Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, through managed care or fee-for-service delivery systems. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, early and periodic screening, diagnostic, and treatment (EPSDT) services are covered Medi-Cal benefits for individuals under 21 years of age.This bill, subject to any necessary federal approvals and the availability of federal funding, would require the State Department of Health Care Services and the State Department of Social Services to develop a model memorandum of understanding (MOU), and would require the department to authorize Medi-Cal managed care plans and alternative payment agencies to enter an MOU that includes, at a minimum, the provisions included in the model.For purposes of children of families receiving subsidized childcare services through an alternative payment program, and upon the consent of the parent or guardian, the bill would require the plans and agencies to collaborate on informing and directing the family of a child who is eligible but not a beneficiary of the Medi-Cal program on how to enroll the child and on referring a child who is a Medi-Cal beneficiary to developmental screenings that are available under EPSDT services and administered through the plan. The bill would authorize the agency to perform certain related functions.

Primary Sponsors
Caroline Menjivar

Organizational Notes

Last edited by Joanne Campbell at Mar 22, 2024, 6:14 PM
Child Care Resource Center (sponsor) - Support Child Care Alliance Los Angeles - Support Thriving Families California (formerly California Alternative Payment Program Association) - Support

Bill Number
SB 1119

Status
In Assembly

Position
Monitor

Title
Hospitals: seismic compliance.

Description
SB 1119, as introduced, Newman. Hospitals: seismic compliance. Existing law, the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983, establishes a program of seismic safety building standards for certain hospitals. Existing law requires hospitals that are seeking an extension for their buildings to submit an application to the Department of Health Care Access and Information by April 1, 2019, subject to certain exceptions. Existing law requires that final seismic compliance be achieved by July 1, 2022, if the compliance is based on a replacement or retrofit plan, or by January 1, 2025, if the compliance is based on a rebuild plan. Notwithstanding the above provisions, existing law authorizes the department to waive the requirements of the act for the O’Connor Hospital and Santa Clara Valley Medical Center in the City of San Jose if the hospital or medical center submits a plan for compliance by a specified date, and the department accepts the plan based on it being feasible to complete and promoting public safety. Existing law requires, if the department accepts the plan, the hospital or medical center to report to the department on its progress to timely complete the plan by specified dates. Existing law imposes penalties to a hospital that fails to meet its deadline.This bill would add Providence St. Joseph Hospital and Providence Eureka General Hospital in the City of Eureka, Providence St. Jude Medical Center in the City of Fullerton, and Providence Cedars-Sinai Tarzana Medical Center in the City of Tarzana to the hospitals for which the department may waive the requirements of the act. The bill would add additional dates for the hospital or medical center to report to the department on its progress.This bill would declare that it is to take effect immediately as an urgency statute.

Primary Sponsors
Josh Newman

Bill Number
SB 1120

Status
In Assembly

Position
Monitor

Title
Health care coverage: utilization review.

Description
SB 1120, as amended, Becker. Health care coverage: utilization review. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of disability insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or disability insurer to use prior authorization and other utilization review or utilization management functions, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Existing law requires a health care service plan or disability insurer, including those plans or insurers that delegate utilization review or utilization management functions to medical groups, independent practice associations, or to other contracting providers, to comply with specified requirements and limitations on their utilization review or utilization management functions. Existing law authorizes the Director of the Department of Managed Health Care or the Insurance Commissioner to assess an administrative penalty to a health care service plan or disability insurer, as applicable, for failure to comply with those requirements. This bill would require a health care service plan or disability insurer, including a specialized health care service plan or specialized health insurer, that uses an artificial intelligence, algorithm, or other software tool for the purpose of utilization review or utilization management functions, or that contracts with or otherwise works through an entity that uses that type of tool, to ensure compliance with specified requirements, including that the tool bases its determination on specified information and is fairly and equitably applied. 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.

Primary Sponsors
Josh Becker

Organizational Notes

Last edited by Cherie Compartore at Jul 9, 2024, 5:26 PM
Oppose Unless Amended: California Association of Health Plans

Bill Number
SB 1131

Status
In Assembly

Position
Monitor

Title
Medi-Cal providers: family planning.

Description
SB 1131, as amended, Gonzalez. Medi-Cal providers: family planning. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.This bill would similarly make services provided by a licensed physician assistant covered under the Medi-Cal program and would require the department to permit a certified nurse practitioner to bill Medi-Cal independently for their services. Existing law establishes the Family Planning, Access, Care, and Treatment (Family PACT) Program, administered by the Office of Family Planning, under which comprehensive clinical family planning services are provided as a benefit under the Medi-Cal program. Existing law also creates the State-Only Family Planning Program, under which family planning services are provided to eligible individuals. Existing law requires enrolled providers in each program to attend a specific orientation approved by the department and requires providers who conduct specified services to have prior training in those services.Existing law establishes, under the Medi-Cal program, the Family Planning, Access, Care, and Treatment (Family PACT) Program, administered by the Office of Family Planning within the department. Under Family PACT, 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 meets other eligibility criteria to receive those services.Existing law makes the Family PACT Program inoperative if the program is determined to no longer be cost effective, as specified. If the program becomes inoperative, existing law requires all persons who have received, or are eligible to receive, comprehensive clinical family planning services pursuant to Family PACT to receive family planning services under other specified provisions of the Medi-Cal program or under the State-Only Family Planning Program, which is also established within the department.Existing law requires enrolled providers in the Family PACT Program or the State-Only Family Planning Program to attend a specific orientation approved by the department and requires providers who conduct certain services to have prior training in those services.This bill would, for both of the above-described programs, require the department to allow a provider a minimum of 6 months from the date of enrollment to complete the orientation. The bill would, for the Family PACT Program, require a site certifier of a primary care clinic or affiliate primary care clinic, as those terms are defined, to be a clinician who oversees t... (click bill link to see more).

Primary Sponsors
Lena Gonzalez

Bill Number
SB 1180

Status
In Assembly

Position
Monitor

Title
Health care coverage: emergency medical services.

Description
SB 1180, as amended, Ashby. Health care coverage: emergency medical 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 health care service plan contracts and health insurance policies to provide coverage for certain services and treatments, including medical transportation services. Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including emergency medical transport. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Existing law, until January 1, 2031, authorizes a local emergency medical services (EMS) agency to develop a community paramedicine or triage to alternate destination program that, among other things, provides case management services to frequent EMS users or triage paramedic assessments, respectively.This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after July 1, 2025, to establish a process to reimburse for services provided by a community paramedicine program, a triage to alternate destination program, and a mobile integrated health program, as defined.The bill would require those contracts and policies to require an enrollee or insured who receives covered services from a noncontracting program to pay no more than the same cost-sharing amount that they would pay for the same covered services received from a contracting program. The bill would prohibit reimbursement rates adopted pursuant to this provision from exceeding the health care service plan’s or health insurer’s usual and customary charges for services rendered.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 bill would also make services provided by these programs covered benefits under the Medi-Cal program. The bill would condition this Medi-Cal coverage on an appropriation, receipt of any necessary federal approvals, and the availability of federal financial participation.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Angelique Ashby

Organizational Notes

Last edited by Joanne Campbell at Apr 19, 2024, 8:14 PM
California Association of Health Plans - Oppose

Bill Number
SB 1184

Status
In Assembly

Position
Monitor

Title
Mental health: involuntary treatment: antipsychotic medication.

Description
SB 1184, as amended, Eggman. Mental health: involuntary treatment: antipsychotic medication. Existing law, the Lanterman-Petris-Short Act, provides for the involuntary commitment of persons who are a danger to themselves or others, or who are gravely disabled, due to a mental disorder or chronic alcoholism or drug abuse for 72 hours for evaluation and treatment, as specified. If certain conditions are met after the 72-hour detention, the act authorizes the certification of the person for a 14-day maximum period of intensive treatment and then another 14-day or 30-day maximum period of intensive treatment after the initial 14-day period of intensive treatment. Existing law, during the 30-day period of intensive treatment, as specified, also authorizes up to an additional 30 days of intensive treatment if certain conditions are met. Existing law authorizes the administration of antipsychotic medication to a person who is detained for evaluation and treatment for any of those detention periods, except for the second 30-day period.This bill would authorize the administration of antipsychotic medication to a person who is detained for the second 30-day period. The bill would requireExisting law establishes a process for hearings to determine a person’s capacity to refuse the treatment. Existing law requires a determination of a person’s incapacity to refuse treatment with antipsychotic medication to remain in effect only for the duration of the 72-hour period or initial 14-day intensive treatment period, or both, until capacity is restored, or by court determination. Existing law generally requires the capacity hearings described above to be held within 24 hours of the filing of a petition to determine a person’s capacity to refuse treatment. Existing law authorizes the hearing to be postponed in certain circumstances, but prohibits the hearing from being held beyond 72 hours of the filing of the petition.This bill would authorize, except as specified, a person’s treating physician to request a hearing for a new determination of a person’s capacity to refuse treatment with antipsychotic medication at any time in the 48 hours prior to the end of the duration of the current detention period when it reasonably appears to the treating physician that it is necessary for the person to be detained for a subsequent detention period and their capacity has not been restored.The bill would require, under exigent circumstances, the hearing to determine a person’s capacity to refuse treatment to be held as soon as reasonably practicable and within 24 hours. The bill would require, under exigent circumstances, an order for treatment with antipsychotic medication to remain in effect at the beginning of the 14-day period, or the add... (click bill link to see more).

Primary Sponsors
Susan Eggman

Organizational Notes

Last edited by Joanne Campbell at Mar 22, 2024, 6:11 PM
California State Association of Psychiatrists (sponsor) - Support Psychiatric Physicians Alliance of California - Support Disability Rights California - Oppose

Bill Number
SB 1213

Status
In Assembly

Position
Monitor

Title
Health care programs: cancer.

Description
SB 1213, as amended, Atkins. Health care programs: cancer. Existing law requires the State Department of Health Care Services to perform various health functions, including providing breast and cervical cancer screening and treatment for low-income individuals. Existing law provides that an individual is eligible to receive treatment services if, among other things, the individual has a family income at or below 200% of the federal poverty level as determined by the provider performing the screening and diagnosis.This bill would provide that an individual is eligible to receive treatment services if the individual has a family income at or below 300% of the federal poverty level as determined by the provider performing the screening and diagnosis.

Primary Sponsors
Toni Atkins, Anthony Portantino

Bill Number
SB 1238

Status
In Assembly

Position
Monitor

Title
Health facilities.

Description
SB 1238, as amended, Eggman. Health facilities. (1) Existing law defines “health facility” to include a “psychiatric health facility” that is licensed by the State Department of Health Care Services and provides 24-hour inpatient care for people with mental health disorders. Existing law requires that such care include, but is not limited to, psychiatry, clinical psychology, psychiatric nursing, social work, rehabilitation, drug administration, and food services for persons whose physical health needs can be met in an affiliated hospital or in outpatient settings.This bill would expand the definition of “psychiatric health facility” to also include a facility that provides 24-hour inpatient care for people with severe substance use disorders, or cooccurring mental health and substance use disorders. The bill would expand that 24-hour inpatient care also include substance use disorder services, as medically necessary and appropriate. The bill would specify that psychiatric health facilities to only admit persons with stand-alone severe substance use disorders involuntarily pursuant to specified requirements.The bill would authorize a psychiatric health facility to admit persons diagnosed only with a severe substance use disorder when specified conditions are met. The bill would authorize the department to implement, interpret, or make specific these provisions, in whole or in part, by means of plan or county letters, information notices, plan or provider bulletins, or other similar instructions, until the time when regulations are adopted no later than December 31, 2027.(2) Under existing law, regulations adopted by the department are to include standards appropriate for 2 levels of disorder: (1) involuntary ambulatory psychiatric patients, and (2) voluntary ambulatory psychiatric patients.This bill would instead require regulations to include standards appropriate for 3 levels of disorder: (1) involuntary ambulatory patients receiving treatment for a mental health disorder, (2) voluntary ambulatory patients receiving treatment for a mental health disorder, and (3) involuntary ambulatory patients receiving treatment for a severe substance use disorder.(3) Existing law requires the program aspects of a psychiatric health facility to be reviewed and approved by the department to include, among others, activities programs, interdisciplinary treatment teams, and rehabilitation services. Existing law requires proposed changes in the standards or regulations affecting health facilities that serve persons with mental health disorders to be effected only with review and coordination of the California Health and Human Services Agency.This bill would expand these program aspects to also include substance use disorder servic... (click bill link to see more).

Primary Sponsors
Susan Eggman

Bill Number	Status	Position
SB 1249	**In Assembly**	**Monitor**

Title
Mello-Granlund Older Californians Act.

Description
SB 1249, as amended, Roth. Mello-Granlund Older Californians Act. Existing law, the Mello-Granlund Older Californians Act, establishes the California Department of Aging in the California Health and Human Services Agency and sets forth its mission to provide leadership to the area agencies on aging in developing systems of home- and community-based services that maintain individuals in their own homes or the least restrictive homelike environments. Existing law requires the department to designate various private nonprofit or public agencies as area agencies on aging to work within a planning and service area and provide a broad array of social and nutritional services. Existing law includes various findings and declarations relating to the purposes of the act.This bill would update and revise those legislative findings and declarations, including recognizing the state’s major demographic shift towards an older, more diverse population and declaring the intent to reform provisions of the act related to various functions of the area agencies on aging. The bill would require the department, by September 30, 2026, to take various actions, including, among others, identifying older adult and family caregiver support programs and services and developing a statewide consumer engagement plan. The bill would require the department to develop regulations that address specified topics relating to area agency on aging designations and to maintain the Data Dashboard for Aging, as specified.

Primary Sponsors
Richard Roth

Bill Number
SB 1257

Status
Enacted

Position
Monitor

Title
Geographic Managed Care Pilot Project: County of San Diego: advisory board.

Description
SB 1257, Blakespear. Geographic Managed Care Pilot Project: County of San Diego: advisory board. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Existing law authorizes the department, upon approval by the board of supervisors of the County of San Diego, to implement a multiplan managed care pilot project for the provision of Medi-Cal services. Existing law authorizes the County of San Diego to establish 2 advisory boards, with certain compositions, to advise the Department of Health Services of the County of San Diego and review and comment on the implementation of the multiplan project. Existing law requires that at least one member of each board be appointed by the board of supervisors and requires the board of supervisors to establish the number of members on each board.This bill would instead authorize the County of San Diego to establish one board, as specified, and would require the board to advise the Health and Human Services Agency of the County of San Diego on the implementation of the state Medi-Cal policy as it pertains to Medi-Cal managed care plans in the county. The bill would require each supervisor of the board to appoint at least one member to the advisory board, with each supervisor appointing an equal number of members.Existing law prohibits the compensation of the advisory board members for activities relating to their duties, but requires that members who are Medi-Cal recipients be reimbursed an appropriate amount by the county for travel and child care expenses incurred in performing their duties in the pilot project.This bill would also authorize advisory board members who are Medi-Cal recipients to be reimbursed by the county for their time in performing their duties in the pilot project, at the discretion of the county.

Primary Sponsors
Catherine Blakespear

Bill Number
SB 1289

Status
In Assembly

Position
Monitor

Title
Medi-Cal: call centers: standards and data.

Description
SB 1289, as amended, Roth. Medi-Cal: call centers: standards and data. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law sets forth various responsibilities for counties relating to eligibility determinations and enrollment functions under the Medi-Cal program.Existing federal law sets forth Medicaid reporting requirements for each state during the period between April 1, 2023, and June 30, 2024, inclusive, relating to eligibility redeterminations, including, among other information, the total call-center volume, average wait times, and average abandonment rate for each call center of the state agency responsible for administering the state plan, as specified.This bill would require the department to establish, with stakeholder input, statewide minimum standards for assistance provided by a county's call center to applicants or beneficiaries applying for, renewing, or requesting help in obtaining or maintaining Medi-Cal coverage. The bill would require promulgation of the standards in regulation by July 1, 2026, as specified.The bill would require a county with a call center as described above, commencing on April 1, 2025, and each quarter thereafter, to collect and submit to the department call-center data metrics, including, among other information, call volume, average call wait times by language, and callbacks. By creating new duties for counties relating to call-center data, the bill would impose a state-mandated local program.The bill would require the department to prepare a report, excluding any personally identifiable information, on call-center data. The bill would require the department to post the report on its internet website on a quarterly basis no later than 45 calendar days after the conclusion of each quarter, with the initial report due on May 15, 2025.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Primary Sponsors
Richard Roth

Bill Number
SB 1290

Status
In Assembly

Position
Monitor

Title
Health care coverage: essential health benefits.

Description
SB 1290, as introduced, Roth. Health care coverage: essential health benefits. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service plans and makes a willful violation of the act a crime. Other existing law requires the Department of Insurance to regulate health insurers. Existing law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, to include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act. Existing law requires a health care service plan contract or health insurance policy to cover the same health benefits that the benchmark plan, the Kaiser Foundation Health Plan Small Group HMO 30 plan, offered during the first quarter of 2014, as specified.This bill would express the intent of the Legislature to review California's essential health benefits benchmark plan and establish a new benchmark plan for the 2027 plan year. The bill would limit the applicability of the current benchmark plan benefits to plan years on or before the 2027 plan year.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Richard Roth

Bill Number
SB 1300

Status
In Assembly

Position
Monitor

Title
Health facility closure: public notice: inpatient psychiatric and maternity services.

Description
SB 1300, as amended, Cortese. Health facility closure: public notice: inpatient psychiatric and maternity services. Existing law requires the State Department of Public Health to license, regulate, and inspect health facilities, as specified, including general acute care hospitals. A violation of these provisions is a crime. Under existing law, a general acute care hospital is required to provide certain basic services, including medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services. Existing law authorizes a general acute care hospital to provide various special or supplemental services if certain conditions are met. Existing regulations define a supplemental service as an organized inpatient or outpatient service that is not required to be provided by law or regulation. Existing law requires a health facility to provide 90 days of public notice of the proposed closure or elimination of a supplemental service, and 120 days of public notice of the proposed closure or elimination of an acute psychiatric hospital.This bill would change the notice period required before proposed closure or elimination of the supplemental service of inpatient psychiatric service or maternity service from 90 days to 120 days. By changing the definition of a crime, this bill would impose a state-mandated local program. The bill would authorize the hospital to close the inpatient psychiatric service or maternity service 90 days after providing public notice of the closure if the department determines that the use of resources to keep the inpatient psychiatric services or maternity services open for the full 120 days threatens the stability of the hospital or if the department determines the hospital cannot maintain required staffing levels due to employee attrition.Before a health facility may provide notice of a proposed closure or elimination of an inpatient psychiatric service or maternity service, this bill would require the facility to provide an impact analysis report, as specified, regarding the impact on the health of the community resulting from the proposed elimination of the services. By changing the requirements on a health care facility, the violation of which is a crime, this bill would impose a state-mandated local program. The bill would require that the impact analysis report be delivered to the local county board of supervisors and to the department. The bill also would require the cost of preparing the impact analysis report to be borne by the hospital. The bill would strongly encourage the board of supervisors to hold a public hearing within 15 days of receipt of the report, as specified, and to post the impact analysis report on its internet website. The bill would require, if... (click bill link to see more).

Primary Sponsors
Dave Cortese

Bill Number
SB 1319

Status
In Assembly

Position
Monitor

Title
Skilled nursing facilities: approval to provide therapeutic behavioral health programs.

Description
SB 1319, as amended, Wahab. Skilled nursing facilities: approval to provide therapeutic behavioral health programs. Existing law provides for the licensure and regulation of health facilities, including, but not limited to, skilled nursing facilities, by the State Department of Public Health. Existing law, the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983, establishes, under the jurisdiction of the Department of Health Care Access and Information (HCAI), a program of seismic safety building standards for certain hospitals constructed on and after March 7, 1973. The act requires the governing board or other governing authority of a hospital, before adopting plans for the hospital building, as defined, to submit to HCAI an application for approval, accompanied by the plans, as prescribed.Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services (DHCS), and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law authorizes DHCS to adopt regulations to certify providers enrolled in the Medi-Cal program, and applicants for enrollment as providers, including providers and applicants licensed as health care facilities.This bill would require a licensed skilled nursing facility that proposes to provide therapeutic behavioral health programs in an identifiable and physically separate unit of a skilled nursing facility, and that is required to submit an application and receive approvals from multiple departments, as specified above, to apply simultaneously to those departments for review and approval of application materials. The bill, when an applicant for approval from one of the specified departments is unable to complete the approval process because the applicant has not obtained required approvals and documentation from one or both of the other departments, would authorize the applicant to submit all available forms and supporting documentation, along with a letter estimating when the remaining materials will be submitted. The bill would require the receiving department to initiate review of the application, and would require final approval of the application to be granted only when all required documentation has been submitted by the applicant to each department from which approval is required. The bill would require the departments to work jointly to develop processes to allow applications to be reviewed simultaneously and in a coordinated manner, as specified.

Primary Sponsors
Aisha Wahab

Bill Number	Status	Position
SB 1320	**Enacted**	**Monitor**

Title
Mental health and substance use disorder treatment.

Description
SB 1320, Wahab. Mental health and substance use disorder treatment. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of disability insurers by the Department of Insurance. Existing law requires a health care service plan contract or disability insurance policy issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of mental health and substance use disorders, as defined, under the same terms and conditions applied to other medical conditions.This bill would require a plan or insurer subject to the above-described coverage requirement, and its delegates, to establish a process to reimburse providers for mental health and substance use disorder treatment services that are integrated with primary care services and provided under a contract or policy issued, amended, or renewed on or after July 1, 2025. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Aisha Wahab

Bill Number
SB 1354

Status
In Assembly

Position
Monitor

Title
Long-term health care facilities: payment source and resident census.

Description
SB 1354, as amended, Wahab. Long-term health care facilities: payment source and resident census. Existing law provides for the licensing and regulation of long-term health care facilities, including, among others, skilled nursing facilities and intermediate care facilities, by the State Department of Public Health. A violation of those provisions is generally a crime. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Existing law prohibits a long-term health care facility that participates as a provider under the Medi-Cal program from discriminating against a Medi-Cal patient on the basis of the source of payment for the facility’s services that are required to be provided to individuals entitled to services under the Medi-Cal program. Existing law prohibits that facility from seeking to evict out of the facility, or transfer within the facility, any resident as a result of the resident changing their manner of purchasing the services from private payment or Medicare to Medi-Cal, except as specified.This bill would require the facility to provide aid, care, service, or other benefits available under Medi-Cal to Medi-Cal beneficiaries in the same manner, by the same methods, and at the same scope, level, and quality as provided to the general public, regardless of payment source.Existing federal regulations require certain nursing facilities to post their resident census and specified nurse staffing data on a daily basis.This bill would require a skilled nursing facility that participates as a provider under the Medi-Cal program to make publicly available its current daily resident census and nurse staffing data, as defined. The bill would require the facility to make the information available either by posting it on the facility’s internet website or by providing the information to a requester by telephone or email, as specified. The bill would exempt these requirements from the above-described and other related criminal penalties.Existing law requires that a contract of admission to a long-term health care facility state that, except in an emergency, a resident may not be involuntarily transferred or discharged from the facility unless the resident and, if applicable, the resident’s representative, are given reasonable notice in writing and transfer or discharge planning as required by law. Existing law requires that the written notice state the reason for the transfer or discharge.This bill would require that the notice also include a specified statement relating to, among other ... (click bill link to see more).

Primary Sponsors
Aisha Wahab

Bill Number
SB 1369

Status
Passed Assembly

Position
Monitor

Title
Dental providers: fee-based payments.

Description
SB 1369, as amended, Limón. Dental providers: fee-based payments. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act’s requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law imposes specified coverage and disclosure requirements on health care service plans and health insurers, including specialized plans and insurers, that cover dental services.This bill would require a health care service plan contract or health insurance policy, as defined, issued, amended, or renewed on and after April 1, 2025, that provides payment directly or through a contracted vendor to a dental provider to have a non-fee-based default method of payment, as specified. The bill would require a health care service plan, health insurer, or contracted vendor to obtain written authorization from a dental provider opting in to a fee-based payment method before the plan or vendor provides a fee-based payment method to the provider and would authorize the dental provider to opt out of the fee-based payment method at any time by providing written authorization to the health care service plan, health insurer, or contracted vendor. The bill would require a health care service plan, health insurer, or contracted vendor that obtains written authorization to opt in or opt out of fee-based payment to apply the decision to include both the dental provider’s entire practice and all products or services covered pursuant to a contract with the dental provider, as specified.Because a violation of the bill’s requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Monique Limon

Bill Number
SB 1385

Status
Enacted

Position
None

Title
Medi-Cal: community health workers: supervising providers.

Description
SB 1385, Roth. Medi-Cal: community health workers: supervising providers. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services through various delivery systems, including fee-for-service and managed care. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Under existing law, community health worker services are a covered Medi-Cal benefit subject to any necessary federal approvals. Under existing law, a community health worker is a liaison, link, or intermediary between health and social services and the community to facilitate access to services and to improve the access and cultural competence of service delivery. Existing law requires a Medi-Cal managed care plan to engage in outreach and education efforts to enrollees, and to notify providers, about the community health worker services benefit, as specified.This bill would require a Medi-Cal managed care plan, no later than July 1, 2025, to adopt policies and procedures to effectuate a billing pathway for supervising providers to claim for the provision of community health worker services to enrollees during an emergency department visit and as an outpatient followup to an emergency department visit. The bill would require that the policies and procedures be consistent with guidance developed by the department for use by supervising providers to claim for community health worker services to Medi-Cal members in the fee-for-service delivery system in the settings described above.The bill would define a “supervising provider” for purposes of these provisions as an enrolled Medi-Cal provider that is authorized to supervise a community health worker pursuant to the federally approved Medicaid state plan amendment and that ensures that a community health worker meets the qualifications as required by the department, as specified.

Primary Sponsors
Richard Roth

Bill Number
SB 1423

Status
In Assembly

Position
Monitor

Title
Medi-Cal: Rural Hospital Technical Advisory Group.

Description
SB 1423, as amended, Dahle. Medi-Cal: Rural Hospital Technical Advisory Group. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, each hospital designated by the department as a critical access hospital, and certified as such by the Secretary of the United States Department of Health and Human Services under the federal Medicare rural hospital flexibility program, is eligible for supplemental payments for Medi-Cal covered outpatient services rendered to Medi-Cal eligible persons. Existing law sets forth various other provisions regarding Medi-Cal reimbursement in consideration of small and rural hospitals.This bill would require that each critical access hospital that elects to participate receive a base reimbursement at 100% of the hospital's projected reasonable and allowable costs for covered Medi-Cal services, as defined, furnished in the Medi-Cal fee-for-service and managed care delivery systems for each subject calendar year, effective for dates of service on or after January 1, 2026. The bill would require the department to develop and maintain one or more reimbursement methodologies, or revise one or more existing reimbursement methodologies applicable to participating critical access hospitals, or both, to implement the cost-based payment levels.The bill would set forth a timeline and a procedure for the department to notify each critical access hospital of the ability to elect to participate in those methodologies, and for a critical access hospital to inform the department of its election to participate, its discontinuance, or its later participation. The bill would require a critical access hospital that elects to participate to make available to the department relevant financial information upon request by the department. Under the bill, these provisions would not be construed to preclude a participating critical access hospital from receiving any other Medi-Cal payment for which it is eligible, including, but not limited to, supplemental payments, with specified exceptions.The bill would require the department to determine the projected reasonable and allowable Medi-Cal costs prior to each applicable calendar year, as specified. The bill would require the department to require each applicable Medi-Cal managed care plan to reimburse a participating hospital for covered services, and would require the department to develop and pay actuarially sound capitation rates to each applicable managed care plan, as specified.The bill would require the departmen... (click bill link to see more).

Primary Sponsors
Brian Dahle

Bill Number
SB 1511

Status
In Assembly

Position
Monitor

Title
Health omnibus.

Description
SB 1511, as amended, Committee on Health. Health omnibus. (1) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law defines a “group contract,” for purposes of the act, as a contract that by its terms limits the eligibility of subscribers and enrollees to a specified group.This bill would clarify that reference to a “group” in the act does not include a Medi-Cal managed care contract between a health care service plan and the State Department of Health Care Services to provide benefits to beneficiaries of the Medi-Cal program.(2) Existing law, the Compassionate Access to Medical Cannabis Act or Ryan’s Law, requires specified health care facilities to allow a terminally ill patient’s use of medicinal cannabis within the health care facility, as defined, subject to certain restrictions. Existing law requires the State Department of Public Health to enforce the act. Existing law prohibits a general acute care hospital, as specified, from permitting a patient with a chronic disease to use medicinal cannabis.This bill would authorize a general acute care hospital to allow a terminally ill patient, as defined, to use medicinal cannabis.(3) Existing law establishes the Distressed Hospital Loan Program, administered by the Department of Health Care Access and Information, in order to provide interest-free cashflow loans to not-for-profit hospitals and public hospitals in significant financial distress or to governmental entities representing a closed hospital, except as otherwise provided, to prevent the closure of, or facilitate the reopening of, those hospitals. Existing law establishes the Distressed Hospital Loan Program Fund, with moneys in the fund being continuously appropriated for the department. Existing law authorizes the Department of Finance to transfer up to $150,000,000 from the General Fund and $150,000,000 from the Medi-Cal Provider Payment Reserve Fund to the Distressed Hospital Loan Program Fund in state fiscal year 2023–24 to implement the program. Existing law requires any funds transferred to be available for encumbrance or expenditure until June 30, 2026.This bill would instead require any funds transferred to be available for encumbrance or expenditure until December 31, 2031. By extending the amount of time continuously appropriated funds are available for encumbrance and expenditure, this bill would make an appropriation.(4) 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 by, a... (click bill link to see more).

Primary Sponsors
Senate Health Committee

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Board of Governors

MOTION SUMMARY

Date: August 28, 2024 **Motion No.** **EXE 100.0924**

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

Issue: Approval of 2025 schedule of meetings for the Board of Governors and Committees.

Background: The meetings are scheduled according to these guidelines established by the Board:

- Eight Board meetings in 2025, with two tentatively scheduled meetings in March and October; with meeting cancellations determined by agenda content.
- Finance & Budget and Executive Committee meetings on the fourth Wednesday. Ten Finance & Budget and ten Executive Committee meetings are scheduled; with meeting cancellations determined by agenda content.
- Ten Compliance & Quality Committee meetings on the 3rd Thursday; with meeting cancellations determined by agenda content.
- Four Provider Relations Advisory Committee meetings on the 3rd Wednesday; with meeting cancellations determined by agenda content.
- Audit, Governance and Services Agreement Committees meet as needed.
- Ten Executive Community Advisory Committee meets on 2nd Wednesday.
- Five Children's Health Consultant Advisory Committee meets on 2nd Tuesday every two months; with meeting cancellations determined by agenda content.
- Four Technical Advisory Committee meets on 2nd Thursday quarterly; with meeting cancellations determined by agenda content.

The schedule is consistent with L.A. Care's enabling statute (California Welfare & Institutions Code Section 14087) which requires six board meetings per year, and the proposed meeting frequency is in line with other public health plans in California.

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

Budget Impact: None.

Motion: **To approve the attached 2025 Board of Governors & Committees meeting schedule.**

2025 Regular Board and Committee Meeting schedule

BoG: Board of Governors, meets 1st Thursdays of the month at 1:00 pm, and meets all day in September for strategic discussion

C&Q: Compliance and Quality Committee, meets 3rd Thursdays of the month at 2:00 p.m.

Exec: Executive Committee meets 4th Wednesdays of the month at 2:00 p.m.

F&B: Finance & Budget Committee meets 4th Wednesday of the month at 1:00 p.m.

PRAC: Provider Relations Advisory Committee meets Quarterly 3rd Wednesday of meeting month at 9:30 a.m.

CHCAC: Children's Health Consultant Advisory Committee meets 3rd Tuesdays every 2 months at 8:30 a.m.

ECAC: Executive Community Advisory Committee meets 2nd Wednesdays of the month at 10:00 a.m.

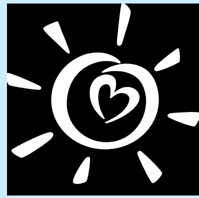
TAC: Technical Advisory Committee meets 2nd Thursday of meeting month at 2:00 PM

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

Meetings are usually held at 1200 W. 7th Street, 90017, Except where *offsite* meetings are indicated below or if a different address is posted on the meeting agenda.

January 2025	February 2025	March 2025
No Board meeting 1/9 - TAC 1/21 – CHCAC 1/16 – C&Q 1/22 –F&B, Exec	2/6 – BoG 2/12 – ECAC 2/19 – PRAC 2/20 – C&Q 2/26 –F&B, Exec	***3/6 BoG (tentative)*** 3/12 – ECAC 3/18 – CHCAC 3/20 - C&Q 3/26 – F&B, Exec TBD – GOV
April 2025	**May 2025**	**June 2025**
4/3 – BoG 4/9 – ECAC 4/10 - TAC 4/17 – C&Q 4/23 – F&B, Exec	5/1– BoG 5/14 – ECAC 5/15 – C&Q 5/20 – CHCAC 5/21 - PRAC 5/28 – F&B, Exec	6/5 – BoG (*offsite)** 6/11 – ECAC 6/19 – C&Q 6/25 – F&B, Exec
July 2025	**August 2025**	**September 2025**
No Committee Meetings 7/9 - ECAC 7/24 – BOG	*No Board meeting* *No ECAC meeting* 8/14 – TAC 8/21 – C&Q 8/19 – CHCAC 8/20 - PRAC 8/27 – F&B, Exec TBD – Audit	9/4 – BoG (*all day retreat)* 9/10 - ECAC 9/18 – C&Q 9/24 - F&B, Exec TBD –GOV
October 2025	**November 2025**	**December 2025**
10/2 BoG (tentative) 10/9 - TAC 10/8 – ECAC 10/16 – C&Q 10/21 - CHCAC 10/22 - F&B, Exec	11/6 – BoG 11/12 – ECAC 11/19 – PRAC 11/19 - F&B, Exec** ***Due to Thanksgiving holiday* 11/20 – C&Q	12/4 – BoG 12/10 – ECAC TBD – Audit *No other meetings*

**Offsite locations are tentative*



Board of Governors
MOTION SUMMARY

Date: August 28, 2024 **Motion No. EXE 101.0924**

Committee: Executive **Chairperson:** Alvaro Ballesteros

Issue: To approve delegated authority to the Chief Executive Officer, John Baackes, to issue up to $1 million in Elevating the Safety Net funds to Pacifica Hospital of the Valley to support safety net access to health care for L.A. Care members.

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

Background: L.A. Care's mission is to serve low income and vulnerable populations and to support the safety net providers that serve them. Pacifica Hospital of the Valley is a 231-bed acute care hospital servicing underserved communities primarily in the San Fernando Valley. The majority of their patients, 84%, live in poverty. The requested funding is part of a larger proposal to serve as a bridge while executing their redesign plan. L.A. Care funding would help avoid an interruption of services.

Since the COVID pandemic and while working toward seismic compliance, Pacifica has experienced financial hardship. The recent delay of QAF program reimbursement and the Change Healthcare cyberattack worsened the financial situation. Pacifica is working on a redesign plan to improve its financial position. The redesign will include both financial and operational processes to improve its revenue position.

Pacifica has a strong focus on behavioral health, including mental health and substance abuse. The redesign includes:

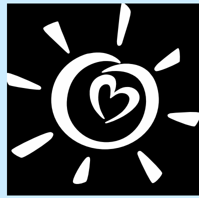
- Beds for dually diagnosed patients, with or without COVID-19, an area of shortage statewide.
- An intake program for released incarcerated patients to assess and treat mental health issues for former prisoners being transitioned into the community.
- Additional capacity of 12 emergency unit chairs in the Empath unit, providing enhanced patient care for behavioral health patients in the emergency room.
- A pilot project with Care Solace to provide extensive resources to mental health clients post-acute care discharge.

Pacifica is in the process of securing financing for this capital project, which also includes a seismic retrofit, and L.A. Care's grant will serve as a bridge until funding is secured. Without this funding, Pacifica will have to reduce staffing, bed capacity, and other clinical services, and may ultimately lead to permanent closure.

Member Impact: Supporting Pacifica is consistent with L.A. Care's mission of ensuring access and providing high quality care to vulnerable and low-income populations in underserved areas.

Budget Impact: In October 2023, the L.A. Care Board of Governors approved adding $50 million from unassigned reserves to the Board Designated Fund for workforce development (Elevating the Safety Net) to address emerging safety net and community needs through FY 2026-27. The requested funds for Pacifica will come from this allocation.

Motion: **To approve delegated authority to Chief Executive Officer, John Baackes, to issue up to a $1 million award to Pacifica Hospital of the Valley to support safety net access to health care for L.A. Care members with behavioral health needs.**



Board of Governors

Date: August 28, 2024 **Motion No. EXE A.0824**

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

Issue: L.A. Care Policy HR-501 (Use of Sign-On and Retention Bonuses) requires that the Executive Committee annually review substantial changes to the Human Resources Policies.

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

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

Policy Number	Policy	Section	Description of Modification
HR-628	Use of Sign-On and Retention Bonuses	Wage & Salary	Added the Definitions and Procedures which were in a separate document

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

Budget Impact: None

Motion: **To approve the Human Resources Policy HR-628 (Use of Sign-On and Retention Bonuses) as presented.**

	USE OF SIGN-ON AND RETENTION BONUSES	HR-628

DEPARTMENT	HUMAN RESOURCES
Supersedes Policy Number(s)	6530

DATES					
Effective Date	10/7/2010	Review Date	3/5/2024	Next Annual Review Date	3/5/2025
Legal Review Date	Click here to enter a date.	Committee Review Date	8/28/2024		

LINES OF BUSINESS			
☐ Medi-Cal – Plan Partners	☐ MCLA	☐ Cal MediConnect	☐ L.A. Care Covered
☐ L.A. Care Covered Direct	☐ PASC-SEIU Plan	☐ Healthy Kids	☒ Internal Operations

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

ACCOUNTABILITY MATRIX			

ATTACHMENTS

- ~~HR-628 Use of Sign on and Retention Bonuses Desk Top Procedures~~
- ~~HR-628 Use of Sign on and Retention Bonuses Definitions~~

~~**SUBJECT MATTER EXPERT**~~		
~~**NAME**~~	~~**DEPARTMENT**~~	~~**TITLE**~~
~~Terry Brown~~	~~Human Resources~~	~~Senior Director, Human Resources Total Rewards~~

ELECTRONICALLY APPROVED BY THE FOLLOWING		
	OFFICER	**DIRECTOR** ~~**COMMITTEE CHAIR**~~
NAME	~~Robert John Turner~~Terry Brown	Sarah Viloria Diaz~~Augustavia Haydel~~
DEPARTMENT	Human Resources	Human Resources~~General Counsel~~
TITLE	Chief Human Resources Officer	Director Total Rewards~~General Counsel~~

HISTORY	
REVISION DATE	DESCRIPTION OF REVISIONS
April 2014	Review
05/24/2017	Revision
3/5/2024	Review, added the Definitions and Procedures which were in a separate document

~~REVIEW DATE~~	~~COMMENTS~~
~~April 2014~~	~~Review~~
~~05/24/2017~~	~~Revision~~

1.0 OVERVIEW:

1.1 L.A. Care Health Plan's (L.A. Care) compensation philosophy is to maintain and administer a performance-based total compensation program designed to attract and retain a diverse, talented and effective workforce. The total compensation program is designed to balance internal and external considerations, including but not limited to market competitiveness, and to reinforce and focus employee energy on L.A. Care's mission, vision and values. L.A. Care endeavors to administer this total compensation program in a consistent manner throughout the organization. L.A. Care has identified a need to provide sign-on or retention bonuses in limited situations where it may be difficult to fill a position due to demand for particular skill sets or experience, where the position is a key or essential position within L.A. Care, or where the employee is critical to the completion of a key initiative or internal project..

~~1.0~~2.0 POLICY:

2.1 Upon CHRO approval, L.A Care may offer a Sign-on Bonus or Retention Bonus as needed to attract or retain needed talent. ~~If the a Sign-On or Retention Bonus exceeds $20,000.00, the Chief Human Resources Officer (CHRO) will obtain the authorization of the Chief Executive Officer (CEO) before approving the payment of the Sign-On or Retention Bonus.~~ The CHRO may consider all relevant factors, including but not limited to, the nature of the position, the difficulty of filling the position, internal compensation information, and external compensation information, in making this~~eir~~ decision~~s~~. If a Sign-On or Retention Bonus exceeds $25,000.00, the Chief Human Resources Officer (CHRO) will obtain the authorization of the Chief Executive Officer (CEO) before approving the payment of the Sign-On or Retention Bonus.

3.0 DEFINITIONS:

3.1 Retention Bonus: a lump sum of money that is designed to encourage~~tice~~ an employee to stay employed with L.A. Care through a specified date. The specified date is generally a date no more than two years in the future. The Retention Bonus payment is not part of and does not increase the employee's base rate of pay compensation.

3.2 Sign-on Bonus: a one-time lump sum payment of money that is provided to a prospective employee, as part of the initial offer of employment, for the purpose of enticing the applicant to come to work at L.A. Care. The Sign-on Bonus payment is not part of and does not increase the employee's base rate of pay compensation.

3.3 Total Compensation: the aggregate base salary or wages, incentives, recognition awards and employee benefits as well as all other cash and non-cash compensation.

4.0 PROCEDURES:

4.1 The terms and conditions for receipt of a Sign-On Bonus, including any repayment obligation, shall be set forth in writing in the offer of employment letter at the time of hire. Human Resources is responsible for preparing the offer of employment letter. The expectation is that an individual who resigns or is terminated on or before the first anniversary of their date of hire will be required to pay back all sign-on or retention monies provided within three months from termination date.

4.2 The terms and conditions for receipt of a Retention Bonus shall be set forth in writing and a record is created in the Human Resources Information System (HRIS). The expectation is that an individual must remain employed with L.A. Care through an agreed-upon date, set forth in HRIS Record, in order to receive the Retention Bonus.

5.0 MONITORING:

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

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

~~**1.1**~~

~~**1.2** L.A. Care reserves the right to modify, rescind, delete, or add to this policy at any time, with or without notice.~~