LOS ANGELES COUNTY
COMMISSION ON HIV

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PUBLIC POLICY COMMITTEE

Virtual Meeting

Monday, November 7, 2022

1:00PM-3:00PM (PST)

***Meeting Agenda + Packet will be available on our website at: http://hiv.lacounty.gov/Public-Policy-Committee**

REGISTER VIA WEBEX ON YOUR COMPUTER OR SMART PHONE:

https://tinyurl.com/yfu36evd

**Link is for non-Committee members only*

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For a brief tutorial on how to use WebEx, please check out this video: https://www.youtube.com/watch?v=iQSSJYcrgIk

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PUBLIC COMMENTS

Public Comment is an opportunity for members of the public to comment on an agenda item, or any item of interest to the public, before or during the Commission's consideration of the item, that is within the subject matter jurisdiction of the Commission.

To submit Public Comment, you may join the virtual meeting via your smart device and post your Public Comment in the Chat box -or- email your Public Comment to hivcomm@lachiv.org -or- submit your Public Comment electronically via https://www.surveymonkey.com/r/PUBLIC_COMMENTS .

All Public Comments will be made part of the official record.

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LOS ANGELES COUNTY
COMMISSION ON HIV

AGENDA FOR THE VIRTUAL MEETING OF THE LOS ANGELES COUNTY COMMISSION ON HIV

PUBLIC POLICY COMMITTEE

MONDAY, November 7, 2022 | 1:00 PM – 3:00 PM

To Join by Computer:

https://tinyurl.com/yfu36evd

Link is for non-committee members only

To Join by Phone: 1-415-655-0001
Access code: 2599 146 0790

Public Policy Committee Members:			
Katja Nelson, MPP Co-Chair	Lee Kochems, MA Co-Chair	Alasdair Burton, (Alternate)	Felipe Findley
Jerry D. Gates, PhD	Eduardo Martinez (Alternate)	Ricky Rosales	Martin Sattah, MD
Courtney Armstrong			
QUORUM: 5			

AGENDA POSTED November 2, 2022

VIRTUAL MEETINGS: Assembly Bill (AB) 361 amends California's Ralph M. Brown Act Section 54953 to allow virtual board meetings during a state of emergency. Until further notice, all Commission meetings will continue to be held virtually via WebEx. For a schedule of Commission meetings, please click here.

PUBLIC COMMENT: Public Comment is an opportunity for members of the public to comment on an agenda item, or any item of interest to the public, before or during the Commission's consideration of the item, that is within the subject matter jurisdiction of the Commission. To submit Public Comment, you may join the virtual meeting via your smart device and post your Public Comment in the Chat box -or- email your Public Comment to hivcomm@lachiv.org -or- submit your Public Comment electronically via https://www.surveymonkey.com/r/PUBLIC_COMMENTS. All Public Comments will be made part of the official record.

ATTENTION: Any person who seeks support or endorsement from the Commission on any official action may be subject to the provisions of Los Angeles County Code, Chapter 2.160 relating to lobbyists. Violation of the lobbyist ordinance may result in a fine and other penalties. For information, call (213) 974-1093.

ACCOMMODATIONS: Interpretation services for the hearing impaired and translation services for languages other than English are available free of charge with at least 72 hours notice before the meeting date. To arrange for these services, please contact the Commission Office at (213) 738-2816 or via email at HIVComm@lachiv.org.

Los servicios de interpretación para personas con impedimento auditivo y traducción para personas que no hablan Inglés están disponibles sin costo. Para pedir estos servicios, póngase en contacto con Oficina de la Comisión al (213) 738-2816 (teléfono), o por correo electrónico á HIVComm@lachiv.org, por lo menos setenta y

dos horas antes de la junta.

SUPPORTING DOCUMENTATION can be obtained at the Commission on HIV Website at: http://hiv.lacounty.gov. The Commission Offices are located at 510 S. Vermont Ave. 14th Floor, one building North of Wilshire on the eastside of Vermont just past 6th Street. Validated parking is available.

NOTES on AGENDA SCHEDULING, TIMING, POSTED and ACTUAL TIMES, TIME ALLOTMENTS, and AGENDA ORDER: Because time allotments for discussions and decision-making regarding business before the Commission's standing committees cannot always be predicted precisely, posted times for items on the meeting agenda may vary significantly from either the actual time devoted to the item or the actual, ultimate order in which it was addressed on the agenda. Likewise, stakeholders may propose adjusting the order of various items at the commencement of the committee meeting (Approval of the Agenda), or times may be adjusted and/or modified, at the co-chairs' discretion, during the course of the meeting.

If a stakeholder is interested in joining the meeting to keep abreast of or participate in consideration of a specific agenda item, the Commission suggests that the stakeholder plan on attending the full meeting in case the agenda order is modified or timing of the items is altered. All Commission committees make every effort to place items that they are aware involve external stakeholders at the top of the agenda in order to address and resolve those issues more quickly and release visiting participants from the obligation of staying for the full meeting.

External stakeholders who would like to participate in the deliberation of discussion of a posted agenda item, but who may only be able to attend for a short time during a limited window of opportunity, may call the Commission's Executive Director in advance of the meeting to see if the scheduled agenda order can be adjusted accordingly. Commission leadership and staff will make every effort to accommodate reasonable scheduling and timing requests - from members or other stakeholders - within the limitations and requirements of other possible constraints.

Call to Order, Introductions and Check-in, Conflict of Interest Statements 1:00 PM – 1:05 PM

I. ADMINISTRATIVE MATTERS 1:05 PM – 1:08 PM

1. Approval of Agenda **MOTION #1**

2. Approval of Meeting Minutes **MOTION #2**

II. PUBLIC COMMENT 1:08 PM – 1:10 PM

3. Opportunity for members of the public to address the Commission on items of interest that are within the jurisdiction of the Commission.

III. COMMITTEE NEW BUSINESS ITEMS 1:10 PM – 1:15 PM

4. Opportunity for Commission members to recommend new business items for the full body or a committee level discussion on non-agendized Matters not posted on the agenda, to be discussed and (if requested) placed on the agenda for action at a future meeting, or matters requiring immediate action because of an emergency situation, or where the need to take action arose subsequent to the posting of the agenda.

IV. REPORTS

5. Executive Director/Staff Report 1:15 PM – 1:25 PM
   a. Operational Updates
   b. Annual Meeting Announcement

c. Co-Chair Nominations
d. Comprehensive HIV Plan (CHP) Update

6. Co-Chair Report 1:25 PM – 1:45 PM
a. Act Now Against Meth (ANAM) Update
b. Workplan Update
c. Annual Meeting Discussion/Preparation

V. DISCUSSION ITEMS

7. Legislative Docket 1:45 PM – 1:50 PM

8. Policies Priority – Action Plan 1:50 PM – 2:10PM

9. State Policy & Budget Update 2:10 PM – 2:20 PM

10. Federal Policy Update 2:20 PM – 2:30 PM

11. County Policy Update 2:30 PM – 2:50 PM
a. COH Response to the STD Crisis

VI. NEXT STEPS 2:50 PM – 2:55 PM

12. Task/Assignments Recap

13. Agenda development for the next meeting

VII. ANNOUNCEMENTS 2:55 PM – 3:00 PM

14. Opportunity for members of the public and the committee to make announcements

VIII. ADJOURNMENT 3:00 PM

15. Adjournment for the meeting of November 7, 2022

PROPOSED MOTIONS	
MOTION #1	**Approve the Agenda Order as presented or revised.**
MOTION #2	**Approve the Public Policy Committee minutes, as presented or revised.**

LOS ANGELES COUNTY COMMISSION ON HIV

510 S. Vermont Ave., 14th Floor• Los Angeles, CA 90020 • TEL (213) 738-2816 •
FAX (213) 637-4748HIVCOMM@LACHIV.ORG • http://hiv.lacounty.gov ORG •
VIRTUAL WEBEX MEETING

Presence at virtual meetings is recorded based on the attendance roll call. Only members of the Commission on HIV are accorded voting privileges and must verbally acknowledge their attendance in order to vote.

Approved meeting minutes are available on the Commission's website; meeting recordings are available upon request.

PUBLIC POLICY COMMITTEE MEETING MINUTES

Draft

October 3, 2022

COMMITTEE MEMBERS P = Present | A = Absent |EA = Excused Absence			
Katja Nelson, MPP, Co-Chair	P	Eduardo Martinez (Alternate)	A
Lee Kochems, MA, Co-Chair	P	Ricky Rosales	P
Alasdair Burton (Alternate)	P	Martin Sattah, MD	P
Felipe Findley	P	Courtney Armstrong	P
Jerry Gates, PhD	P		
COMMISSION STAFF AND CONSULTANTS			
Cheryl Barrit, Catherine Lapointe, Lizette Martinez, Jose Rangel-Garibay			

*Some participants may not have been captured electronically. Attendance can be corrected by emailing the Commission.
*Members of the public may confirm their attendance by contacting Commission staff at hivcomm@lachiv.org.
*Meeting minutes may be corrected up to one year from the date of approval.

Meeting agenda and materials can be found on the Commission's website at https://assets-us-01.kc-usercontent.com/0234f496-d2b7-00b6-17a4-b43e949b70a2/6ad0d7f1-19e9-40c1-987d-7399f4e5aa89/Pkt-PPC-10.03.22.pdf

CALL TO ORDER-INTRODUCTIONS-CONFLICTS OF INTEREST

Katja Nelson, Co-Chair, called the meeting to order at 1:07 PM, led introductions, and stated that conflicts of interest can be found in the meeting packet.

I. ADMINISTRATIVE MATTERS

1. APPROVAL OF AGENDA

MOTION #1: Approval of the Agenda Order as presented or revised ✓Passed by Consensus

2. APPROVAL OF MEETING MINUTES

MOTION #2: Approval of the September 12, 2022 Public Policy Committee meeting minutes as presented or revised ✓Passed by Consensus

II. PUBLIC COMMENT

3. OPPORTUNITY FOR MEMBERS OF THE PUBLIC TO ADDRESS THE COMMISSION ON ITEMS OF INTEREST THAT ARE WITHIN THE JURISDICTION OF THE COMMISSION. *No public comments.*

III. COMMITTEE NEW BUSINESS ITEMS

4. OPPORTUNITY FOR COMMISSION MEMBERS TO RECOMMEND NEW BUSINESS ITEMS FOR THE FULL BODY OR A COMMITTEE LEVEL DISCUSSION ON NON-AGENDIZED MATTERS NOT POSTED ON THE AGENDA, TO BE DISCUSSED AND (IF REQUESTED) PLACED ON THE AGENDA FOR ACTION AT A FUTURE MEETING, OR MATTERS REQUIRING IMMEDIATE ACTION BECAUSE OF AN EMERGENCY SITUATION, OR WHERE THE NEED TO TAKE ACTION AROSE SUBSEQUENT TO THE POSTING OF THE AGENDA. *No committee new business items.*

IV. REPORTS

5. EXECUTIVE DIRECTOR/STAFF REPORT

a. Operational and Staffing Updates

- Cheryl Barrit welcomed new Commission on HIV (COH) staff member, Lizette Martinez, who will serve as the lead staff for the Planning, Priorities and Allocations (PP&A) Committee and Prevention Planning Workgroup (PPW).
- C. Barrit announced that on September 27, 2022, the Board of Supervisors (BOS) voted to extend the continuation of virtual meetings for 30 days. At the October COH meeting, commissioners will hold a vote to either continue meeting virtually or resume meeting in-person. C. Barrit informed the group that if the COH begins meeting in-person, those who join remotely will need to have their location posted on the agenda in accordance with Brown Act meeting guidelines requiring accessibility to the public.

6. CO-CHAIR REPORT

a. Act Now Against Meth (ANAM) Update

- At their September meeting, the Public Policy Committee (PPC) heard from a representative from the Act Now Against Meth (ANAM) Coalition. ANAM is awaiting a report back on the BOS Motion requiring several County departments to state what they are going to do to address the meth epidemic in LA County. The report is expected in December 2022.

b. Workplan Updates

- K. Nelson provided an overview of the revisions made to the PPC's 2022 Workplan. See meeting packet for details. Key changes are as follows:
    - The Committee has included "COH Response to STD Crisis" as a standing item on the meeting agenda to track BOS motions related to the BOS STD response and the ANAM platform.
    - The Committee will develop an Action Plan to align with the Policy Priorities document.
    - The Committee will begin making efforts to modernize the Ryan White CARE Act and will facilitate a discussion at the COH Annual Meeting.
- The PPC held a robust discussion on the modernization of the Ryan White CARE Act. Key points from the conversation were as follows:
    - Ricky Rosales recommended identifying specific areas to target when holding this discussion at the Annual Meeting.
    - Lee Kochems suggested discussing arguments made against reauthorization at the Presidential Advisory Council on HIV/AIDS (PACHA) Conference. He reiterated that the conversation at the Annual Meeting is solely the beginning of the thought process and will not result in a concrete document.
    - Courtney Armstrong stated that key considerations around different counties and states may affect the reauthorization process. She offered to bring this conversation back to the Division of HIV and STD Programs (DHSP).
    - Jerry Gates discussed his time working with the AIDS Education and Training Center (AETC) in the past, and how the group decided not to reauthorize the Ryan White CARE Act because it would have hurt Los Angeles. He identified programmatic issues, such as the political climate, and suggested that this be studied carefully before making any recommendations. J. Gates recommended that at the County level, the Ryan White CARE Act should stay the same.
    - Felipe Findley inquired if a subject matter expert can present to the PPC at their November meeting to better inform the Committee on the issue prior to the Annual Meeting. C. Armstrong offered to reach out to Emily McCloskey, National Alliance of State & Territorial AIDS Directors (NASTAD).

V. DISCUSSION ITEMS

7. LEGISLATIVE DOCKET

- K. Nelson provided an update on the Legislative Docket. The following bills were **vetoed** by the Governor.

  - AB 240 (Rodriguez): Local health department workforce assessment
  - SB 57 (Wiener): Controlled substances: overdose prevention program
  - SB 1234 (Pan): Family Planning, Access, Care, and Treatment Program
- The following bills were **signed** by the Governor:
  - AB 2195 (Ward and Lee): Pharmacists and pharmacy technicians: continuing education: cultural competency
  - AB 2223 (Wicks): Reproductive Health
  - AB 2521 (Santiago): Transgender, Gender Nonconforming, or Intersex Fund
  - SB 225 (Wiener): Medical procedures: individuals born with variations in their physical sex characteristics
  - SB 357 (Wiener): Crimes: loitering for the purpose of engaging in a prostitution offense
  - SB 353 (Leyva): Health care coverage: contraceptives
  - SB 923 (Wiener): Gender-affirming care
  - SB 1338 (Umberg): Community Assistance, Recovery, and Empowerment (CARE) Program

8. POLICIES PRIORITY – ACTION PLAN

- The PPC will present their Policy Priorities document to the Executive Committee for approval, and then to the full COH.
- The PPC will start filling in their Action Plan template. L. Kochems noted that it would be helpful to begin planning for presentations for the topics listed on the Action Plan.

9. STATE POLICY & BUDGET UPDATE

- K. Nelson reminded the group that the Midterm Elections are on November 8, 2022. She suggested having an update in January on redistricting following the election.
- K. Nelson announced that the Ending the Epidemic (EHE) Coalition Community Engagement Committee will be holding an informational session on October 4, 2022 at 2 PM to review the ballot propositions and will be making recommendations.
- The EHE State Coalition will be holding their annual meeting in early November 2022 to discuss budget and bill ideas for 2023.

10. FEDERAL POLICY UPDATE

- K. Nelson referred the group to a flyer regarding the Section 1557 of the Affordable Care Act. See meeting packet for details.
- K. Nelson informed the PPC that the $3.4 billion ask to address COVID-19 and monkeypox was not included in the federal budget.

11. COUNTY POLICY UPDATE

The 2022 homeless count has been released. See meeting packet for details. The report found that the number of people living with HIV (PLWH) experiencing homelessness has not changed since 2020. K. Nelson suggested meeting with a representative from the Los Angeles Homeless Services Authority (LAHSA). C. Barrit will reach out to Stephen Simon, Interim Executive Director, for a data presentation from LAHSA; however, she noted that scheduling the presentation may take several months.

a. COH Response to the STD Crisis

- K. Nelson commented that more funding is needed to address the STD crisis in LA County. She recommended reaching out to County Health Deputies to schedule a meeting.
- R. Rosales commented that STD care can be stigmatizing and can hinder people from seeking care. He also recommended improving workforce infrastructure through trainings.
- Dr. Martin Sattah recommended improving electronic health systems.
- F. Findley suggested divesting in incarceration.

VI. NEXT STEPS

12. TASK/ASSIGNMENTS RECAP

- The PPC will start reaching out to different subject matter experts for each of the items on the action plan to present at future meetings.
- C. Barrit will reach out to LAHSA for a data presentation on PLWH experiencing homelessness.
- COH staff will begin planning for a meeting with County Health Deputies to discuss the STD crisis.

13. AGENDA DEVELOPMENT FOR THE NEXT MEETING

- The PPC will identify main points regarding the Modernization of the Ryan White CARE Act to be discussed at the Annual Meeting.

VII. ANNOUNCEMENTS

14. OPPORTUNITY FOR MEMBERS OF THE PUBLIC AND THE COMMITTEE TO MAKE ANNOUNCEMENTS *No announcements.*

VIII. ADJOURNMENT

15. ADJOURNMENT FOR THE MEETING OF OCTOBER 3, 2022

The meeting was adjourned by K. Nelson.

SAVE THE DATE

Planning for Action: 2023 and Beyond

Thursday, Nov. 10, 2022
9:00 AM - 4:30 PM (PST)

DISCUSSION TOPICS

- HIV and STDs in LA County Update
- Comprehensive HIV Plan 2022-2026
- Transgender Empathy Training
- Real Talk: The Effects of Trauma on People Living with HIV
- Undetectable=Untransmittable (U=U): Moving from Awareness to Full Integration in HIV Care
- Dreaming Big: Community Wishlist for a Better and Modernized Ryan White Care System

REGISTER TODAY!

Scan the QR code below or click here.

For technical assistance contact:
dmcclendon@lachiv.org or
(213) 509-9199

Meeting will be held virtually
Agenda and meeting materials will be available HERE
Spanish interpretation will be provided

LOS ANGELES COUNTY
COMMISSION ON HIV

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COMMISSION ON HIV

DUTY STATEMENT

COMMITTEE CO-CHAIR

(APPROVED 3-28-17)

In order to provide effective direction and guidance for the Commission on HIV, Committee Co-Chairs must meet the following demands of their office, representation and leadership:

COMMITTEE LEADERSHIP:

① Serves as Co-Chair of a standing Commission Committee, and leads those monthly meetings
② Leads Committee decision-making processes, as needed
③ Meets monthly with Executive Director, or his/her designee, to prepare the Committee meeting agendas, course of action and assists Commission staff in the preparation of motions, backup materials and information for meetings, as necessary and appropriate
④ Assigns and delegates work to Subcommittees, task forces and work groups
⑤ Serves as a member of the Commission's **Executive Committee**

MEETING MANAGEMENT:

① Serves as the Presiding Officer at the Committee meetings
② In consultation with other Co-Chair and senior Commission staff member(s), leads the Committee meetings,
- conducting business in accordance with Commission actions/interests
- recognizing speakers, stakeholders and the public for comment at the appropriate times
- controlling decorum during discussion and debate and at all times in the meeting;
- imposing meeting rules, requirements and limitations
- calling meetings to order, for recesses and adjournment in a timely fashion and according to schedule, or extending meetings as needed
- determining consensus, objections, votes, and announcing roll call vote results
- ensuring fluid and smooth meeting logistics and progress
- finding resolution when other alternatives are not apparent
- ruling on issues requiring settlement and/or conclusion

③ Ability to put aside personal advocacy interests, when needed, in deference to role as the Committee's Presiding Officer.

REPRESENTATION:

In consultation with the Executive Director, Committee Co-Chairs:

① May ONLY serve as Committee spokesperson at various events/gatherings, in the public, with public officials and to the media if approved by the Commission Co-Chairs and Executive Director
② Take action on behalf of the Committee, when necessary

③ Generates, signs and submits official documentation and communication on behalf of the Committee
③ Present Committee findings, reports and other information to the full Commission, Executive Committee, and, as appropriate, other entities
⑤ Represent the Committee to the Commission, on the Executive Committee, and to other entities
⑥ Support and promote decisions resolved and made by the Committee when representing it, regardless of personal views

KNOWLEDGE:
① CDC HIV Prevention Program, Ryan White Program (RWP), and HIV/AIDS and STI policy and information
② LA County Comprehensive HIV Plan and Comprehensive HIV Continuum
③ LA County's HIV/AIDS and STI, and other service delivery systems
④ County policies, practices and stakeholders
⑤ Ryan White Program legislation, State Brown Act, applicable conflict of interest laws
⑥ County Ordinance and practices, and Commission Bylaws
⑦ Topical and subject area of Committee's purview
⑧ **Minimum of one year active Committee membership prior to Co-Chair role**

SKILLS/ATTITUDES:
① Sensitivity to the diversity of audiences and able to address varying needs at their levels
② Life and professional background reflecting a commitment to HIV/AIDS and STI-related issues
③ Ability to demonstrate parity, inclusion and representation
④ Take-charge, "doer", action-oriented; ability to recruit involvement and interest
⑤ Unintimidated by conflict/confrontation, but striving for consensus whenever possible
⑥ Firm, decisive and fair decision-making practices

COMMITMENT AND ACCOUNTABILITY TO THE OFFICE:
① Put personal agenda aside and advocate for what's in the best interest of the Commission
② Devote adequate time and availability to the Commission and its business
③ Assure that members' and stakeholders' rights are not abridged
④ Advocate strongly and consistently on behalf of Commission's and people living with and at risk for HIV, interests
⑤ Always consider the views of others with an open mind
⑥ Actively and regularly participate in and lead ongoing, transparent decision-making processes
⑦ Respect the views of other regardless of their race, ethnicity, sexual orientation, HIV status or other factors

PUBLIC COMMENT NOW OPEN!

LOS ANGELES COUNTY COMPREHENSIVE HIV PLAN 2022-2026

- The public comment period is open from November 1 to November 21, 2022 (by 4:00 PM).
- Please e-mail comments to hivcomm@lachiv.org.
- The Comprehensive HIV Plan will guide how HIV and STDs will be addressed in LA County. Your feedback will help shape and refine the plan.

LOS ANGELES COUNTY
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2022 WORK PLAN – PUBLIC POLICY

Committee Name: **PUBLIC POLICY COMMITTEE (PPC)**	Co-Chairs: Katja Nelson, Lee Kochems
Committee Adoption Date: January 3, 2022	Revision Dates: 8/9/22, 8/22/22, 9/27/22, 11/2/22
Purpose of Work Plan: To focus and prioritize key activities for COH Committees and subgroups for 2022	

#	TASK/ACTIVITY	DESCRIPTION	TARGET COMPLETION DATE	STATUS/NOTES/OTHER COMMITTEES INVOLVED
1	Develop the Comprehensive HIV Plan 2022-26	The Committee will gather, discuss and provide policy issues for inclusion in the plan.	10/2022	The Committee will agendize the CHP and information will flow to the consultant on an ongoing basis.
2	Address Areas of Improvement from the HealthHIV Planning Council Effectiveness Assessment	The Committee will hold public hearing(s) to encourage community engagement and representation in Commission legislative policy making. Public Policy priorities will be streamlined and barriers for community participation reduced.	06/2022	The Committee is scheduled to hold a public hearing in February or March of 2022.
3	Continue to advocate for an effective County-wide response to the STD epidemic. Assess and monitor federal, state, and local government policies and budgets that impact HIV, STD, STIs, Hep C and other sexual health issues. Follow up with BOS motions that include recommendations from the ANAM platform and track reporting.	The Committee will better inform the development of legislative and policy priorities with public hearings. The Committee will review government actions that impact funding and implementation of sexual health and HIV services.	Ongoing	The Committee has included "COH Response to STD crisis" as a standing item on the meeting agenda to track BOS motions related to the BOS STD response and the ANAM platform.
4	Prepare Policy Priorities for 2022 to include the alignment of priorities with the Black/African American Community (BAAC) Task Force, Women Caucus, Aging Task Force, Consumer Caucus, Prevention Workgroup and Trans-gender Caucus recommendations.	The Committee will discuss and craft policy priorities for 2022, ensuring policy efforts prioritize recommendations.	~~04/2022~~ 12/2022	Once established policy recommendations are submitted to the Commission for approval The Committee approved the Policy Priorities 2022-2023 document on 9/12/22. The document will move to the Executive Committee for approval at their 12/7/22

LOS ANGELES COUNTY COMMISSION ON HIV

2022 WORK PLAN – PUBLIC POLICY—APPROVED 7/14/22

				meeting and to the Full Commission at the 12/8/22 meeting.
5	Develop an Action Plan to align with the Policy Priorities document	The Committee will craft a document to describe and track the goals and action steps related to the recommendations outlined in the Policy Priorities document.	Early 2023	Commission staff developed a template to populate with action steps.
6	Develop 2022 Legislative Docket	Review legislation aligned with information gathered from public hearing(s) as well as recommendations from Commission taskforces, caucuses and workgroups to develop the Commission docket, and discuss legislative position for each bill.	~~5/2022~~ 07/2022	The Committee will begin legislative bill review in 2/2022. Once the docket is established it will be submitted to the Commission for approval. The legislative docket was approved by the Commission on 7/14/22. The document was edited on 9/27/22 to reflect the Governor's decisions on listed Bills.
7	Monitor and support the City of Los Angeles safe consumption site project.	Coordinate with the City of LA AIDS Coordinator's Office	03/2022 - Ongoing	The Committee is scheduling a presentation with the City of Los Angeles Safe Consumption site providers.
8	Efforts to Modernize the Ryan White Care Act	The Committee will facilitate a discussion for the interest in modernizing the Ryan White Care Act at the Commission's Annual meeting.	2023-Ongoing	The Committee Co-chairs will be listed as topic sponsors on the annual meeting agenda. COH staff and Co-chairs met on 11/3 to review the facilitation questions for the "Dreaming Big: Community Wishlist for a Better and Modernized Ryan White Care System" discussion at the COH annual meeting

LOS ANGELES COUNTY COMMISSION ON HIV

ANNUAL MEETING NOVEMBER 10, 2022

DREAMING BIG| COMMUNITY WISH LIST FOR A BETTER AND MODERNIZED RYAN WHITE (RW) CARE SYSTEM (2:45-3:30)

Session Highlights:

- DHSP staff will provide a brief RW CARE Act overview
- Session objectives:
  - Increase understanding of the Ryan White Care Act (services funded, payor of last resort)
  - Hold an initial conversation aimed at improving access and quality of HIV care in LA County
  - Hear from providers and consumers on what is working well and what challenges they are experiencing with Ryan-White-funded services in LA County
- The packet will include a handout with a list of Ryan White-funded agencies

Suggested facilitation questions:

1. What is working well with the HIV care services in Los Angeles County? If you are a consumer, what is working well for you? How is the HIV care you are getting from County-funded/RW-funded services meeting your needs? What do you like about the care or services you are receiving now?
2. If you are a provider, what is working well? Share examples of how County-funded/ RW-funded services you provide help PLWH? What do you like about the care or services you provide now?
3. What are some challenges you have faced receiving or offering RW services?
4. What ideas do you have that would improve HIV care services?
5. What gets in the way of receiving or providing quality HIV care?
6. If you could rewrite the Ryan White CARE Act, what would you change?

The Ryan White HIV/AIDS Program: The Basics

Published: Oct 22, 2020

Key Facts

- The Ryan White HIV/AIDS Program, first enacted in 1990, is the largest federal program designed specifically for people with HIV, serving over half of all those diagnosed.[1,2] It is a discretionary, grant program dependent on annual appropriations from Congress"
- It is the nation's safety net for people with HIV providing outpatient HIV care and treatment to those without health insurance and filling in gaps in coverage and cost for those with insurance.
- Most Ryan White clients are low-income, male, people of color, and sexual minorities.
- The program is the third largest source of federal funding for HIV care in the U.S., following Medicare and Medicaid. In FY20 it was funded at $2.5 billion which includes new funding for the federal "Ending the HIV Epidemic" initiative and supplemental funding related to the COVID-19 response.[3] Funding is distributed to states/territories, cities, and HIV organizations in the form of grants.
- While the Affordable Care Act (ACA), has expanded coverage for many people with HIV, Ryan White continues to remain a critical component of the nation's response to HIV, proving HIV care and treatment to those who remain uninsured and bolstering access for those with insurance.

Overview

The Ryan White HIV/AIDS Program (Ryan White), the largest federal program designed specifically for people with HIV in the United States, serves over half of those in the country diagnosed with the disease.[4] First enacted in 1990, the Ryan White Program has played an increasingly significant role as the number of people living with HIV has grown over time and people with HIV are living longer. It provides outpatient care and support services to individuals and families affected by the disease, functioning as the "payer of last resort" by filling the gaps for those who have no other source of coverage or face coverage limits or cost barriers.

The program has been reauthorized by Congress four times since it was first created (1996, 2000, 2006, and 2009) and each reauthorization has made adjustments to the program. The current authorization lapsed in FY 2013, but the program has continued to be funded through the annual appropriations process

as there is no “sunset” provision or end date attached to the legislation. The program is administered by the HIV/AIDS Bureau (HAB) at the Health Resources and Services Administration (HRSA) of the Department for Health and Human Services (HHS), and programs and services are delivered by grantees and sub-grantees at the state and local levels.

HRSA is one of the lead agencies in the federal government’s Ending the HIV Epidemic (EHE): A Plan for America initiative (https://www.kff.org/hivaids/issue-brief/the-u-s-ending-the-hiv-epidemic-ehe-initiative-what-you-need-to-know/), launched in 2019, and the Ryan White Program is set to play a key role in efforts to reach the goal of reducing new HIV infections by 75% in five years and by 90% in ten years. The initiative includes new federal funding, some of which has been channeled to Ryan White.

In the early months of 2020, the U.S. was hit by the COVID-19 pandemic which dramatically impacted health, health coverage, and health access for all people. The Ryan White Program quickly pivoted to new ways of providing care, seeking to ensure that people with HIV were retained in care, even when the programs that serve them were strained. Recognizing the new stresses the pandemic might mean for Ryan White, Congress appropriated emergency supplemental funding for the program through the CARES Act
(See Table 1).

Clients

More than half a million people receive at least one medical, health, or related support service through the program in 2018, with many clients receiving multiple types of services:[5]

- Nearly two-thirds (61%) had incomes at or below the federal poverty level (FPL) (which in 2018 was $12,140 for a single person or $25,100 for a family of four); 29% had incomes between 101% and 250% FPL.
- One-fifth (20%) were uninsured, a decrease from 28% in 2013, prior to enactment of the major coverage provisions under the Affordable Care Act (ACA). Most clients (80%) have some form of insurance coverage: Medicaid is the most important payer for this group, covering 39%, of clients, including those dually eligible for Medicare. Other coverage includes: private insurance (18%), Medicare only (10%), and other sources (12%).
- Reflecting the demographics of HIV in the U.S., clients are largely male (72%), 27% are female and 2% are transgender. Half (50%) are between the ages 45 and 64 and over one-third (37%) are between 25-44. Smaller shares are under 25 (5%) or over 64 (8%). Most clients are people of color (74%), including 47% who are Black and 23% who are Hispanic. Just over one-quarter of clients (26%) are White. Half (50%) are gay or bisexual men.

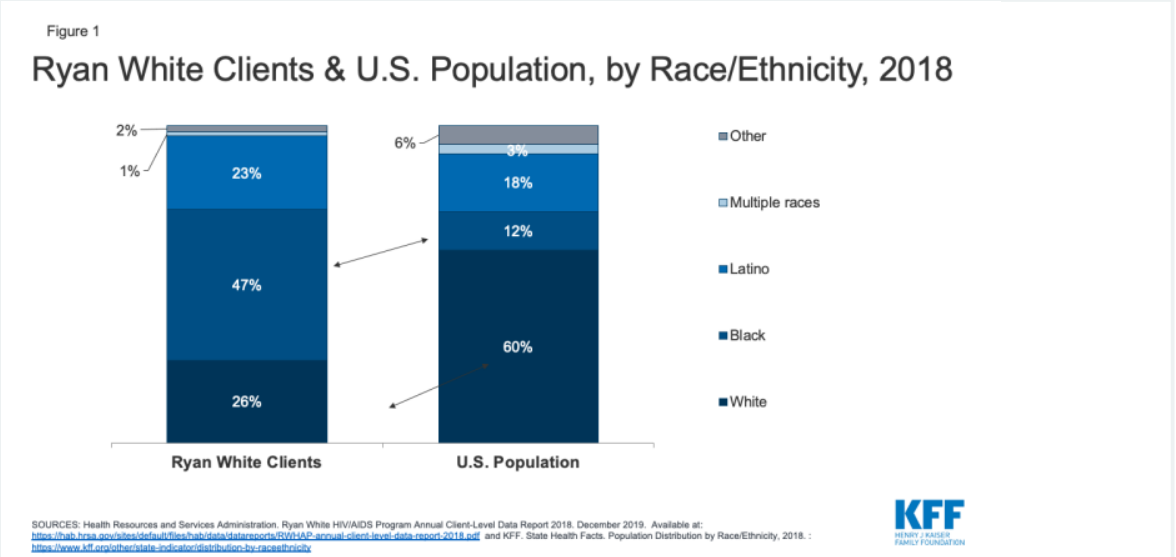

Figure 1: Ryan White Clients & U.S. Population, by Race/Ethnicity, 2018

Structure and Funding

The Ryan White Program is the third largest source of federal funding for HIV care in the U.S., after Medicare and Medicaid.[6] Federal funding for the program, which is appropriated by Congress annually, began in FY1991 and increased significantly in the mid-1990s, primarily after the introduction of highly active antiretroviral therapy (HAART).[7] For many years thereafter, funding continued to increase, but at slower rates, eventually leveling out and not keeping pace with inflation.[8] However, new funding as part of the EHE Initiative ($70 million in FY 2020) marked the first significant increase to the program in many years.[9] Additional funding was provided as part of one of the COVID-19 relief packages ($90 in FY2020).

The Ryan White HIV/AIDS Program is composed of "Parts," each with a different purpose and funded as a separate line item through annual appropriations. Funding is provided to states and territories (Part B) cities (Part A), and to providers, community-based organizations (CBOs), and other institutions (Parts C, D, and F), in the form of grants. In recognition of the varying nature of the HIV epidemic, grantees are given broad discretion to design key aspects of their programs, such as specifying client eligibility levels and service priorities. However, there are requirements, including that grantees are required to spend 75% or more of funds on "core medical services" under Parts A through C[10] and that all state AIDS Drug Assistance Programs (ADAPs) must have a minimum formulary for medications.[11] (See Table 1 for a description of program parts and FY2020 funding levels).

Table 1: Description of the Ryan White Program, by Part, FY20

Part	FY20 (Funding in Millions)	Part Description
Part A	$655.9	Funds provided to "eligible metropolitan areas" (EMAs), areas with 2,000+ reported AIDS cases over the past 5 years & "transitional grant areas" (TGAs), areas with 1,000-1,999 reported AIDS cases in the past 5 years. TGAs and EMAs must have a population of at least 50,000. Two-thirds of funds are distributed by formula based on area's share of living HIV (non-AIDS and AIDS) cases and the remainder is distributed via competitive supplemental grants based on "demonstrated need." EMAs must establish Planning Councils, local bodies tasked with assessing needs, developing HIV care delivery plans, and setting priorities for funding. Most TGAs are not required to have Planning Councils. *Number of Grantees: 24 EMAs; 28 TGAs.*
Part B	$1,315.0	Funds provided to states, Washington, D.C., and territories/associated jurisdictions. Grantees provide services directly, through sub-grantees and/or through Part B "Consortia" (associations set up to plan and deliver HIV care). Part B components include: • **Base & Supplemental:** Funds distributed by formula to states based on state's share of living HIV (non-AIDS and AIDS) cases, weighted to reflect the presence of EMAs/TGAs. Additional "supplemental" grants are available for states with "demonstrated need." • **Emerging Communities (ECs):** A portion of Part B base funds is set aside for grants to metropolitan areas with 500-999 cumulative reported AIDS cases over the most recent 5 years. Funding distributed via formula. *Number of grantees: 50 States, D.C., and 8 Territories/Associated Jurisdictions.*
ADAP (non-add)	*$900.3*	***ADAP & ADAP Supplemental:*** *Congress "earmarks" funds under Part B for ADAPs which provide medications and assists with costs related to insurance for people with HIV. ADAP supplemental grants (5% of earmark) available to states with "severe need".*
Part C	$201.1	Funds public and private organizations directly for: • **Early Intervention Services (EIS):** To provide comprehensive primary health

		care to people with HIV, including services to those newly diagnosed, such as HIV testing, case management, and risk reduction counseling. • **Capacity Development & Planning Grants:** To support organizations in planning for service delivery and building capacity to provide services. *Number of grantees: 348 EIS; 59 Capacity Development.*
Part D	$75.1	Funds public and private organizations to provide family-centered and community-based services to children, youth, and women living with HIV and their families, including outreach, prevention, primary and specialty medical care, and psychosocial services. Supports activities to improve access to clinical trials and research for these populations. *Number of grantees: 115.*
Part F	$33.6 (AETCs)/$13.1 (Dental)/$25 (SPNS)	Includes the following components: • **AIDS Education and Training Centers (AETCs):** National and regional centers proving education and training for health care providers who treat people with HIV. *Number of grantees: 14.* • **Dental Programs:** The "Dental Reimbursement Program," reimburses dental schools/providers for unreimbursed oral health services; the "Community-Based Dental Partnership Program" funds dental provider education and increases access to dental care for people with HIV. *Number of grantees: 51 Reimbursement, 12 Community Partnership.* • **Minority AIDS Initiative (MAI):** MAI, created in 1998, aims to address impact of HIV on racial/ethnic minorities. Provides funding across DHHS agencies/programs, including the Ryan White HIV/AIDS Program, to strengthen organizational capacity and expand HIV services in minority communities. The Ryan White HIV/AIDS Program's component of the MAI was codified in the 2006 reauthorization.[12,13] • **Special Projects of National Significance (SPNS):** Funded through "set-asides" of

		general federal Public Health Service evaluation funding, separately from the amount appropriated by Congress for the Ryan White HIV/AIDS Program, SPNS projects address emerging needs of clients and assist in developing a standard electronic client information data system.
Ending the HIV Epidemic Initiative	$70.0	Dedicated funding to support the "Ending the HIV Epidemic (EHE)" initiative which aims to reduce HIV infections by 90% in ten years. Ryan White plays a key role in delivering care to people with HIV in the initiative and seen as the agency lead for the initiative's "care pillar."
CARES Act (COVID-19 relief) Funding for Ryan White	$90.0	Supplemental emergency funding provided to the program through the Coronavirus Aid, Relief, and Economic Security (CARES) Act, the 3rd legislative initiative to address the COVID-19 pandemic. Funding provided to supplement existing contracts, grants, and cooperative agreements under Program parts A, B, C, and D, and to AIDS Education and Training. Traditional requirements related to spending share dedicated to core medical services in Parts A, B, and C do not apply.
Total	**$2,478.8**	

Ryan White HIV/AIDS Program and Care Outcomes

While many clients have gained coverage under the ACA, Ryan White continues to play a critical role as a safety net provider for those who remain uninsured and filling gaps for clients with traditional insurance, including assisting with insurance affordability. Importantly, Ryan White support appears to make a significant difference in achieving sustained viral suppression. Viral suppression affords optimal health outcomes at the individual level and, because when an individual is virally suppressed they cannot transmit HIV, significant public health benefit.[14] Overall, those with Ryan White support were significantly more likely to have sustained viral suppression compared to those without (68% v. 58%) and this pattern was observed across all coverage types (see Figure 2).[15]

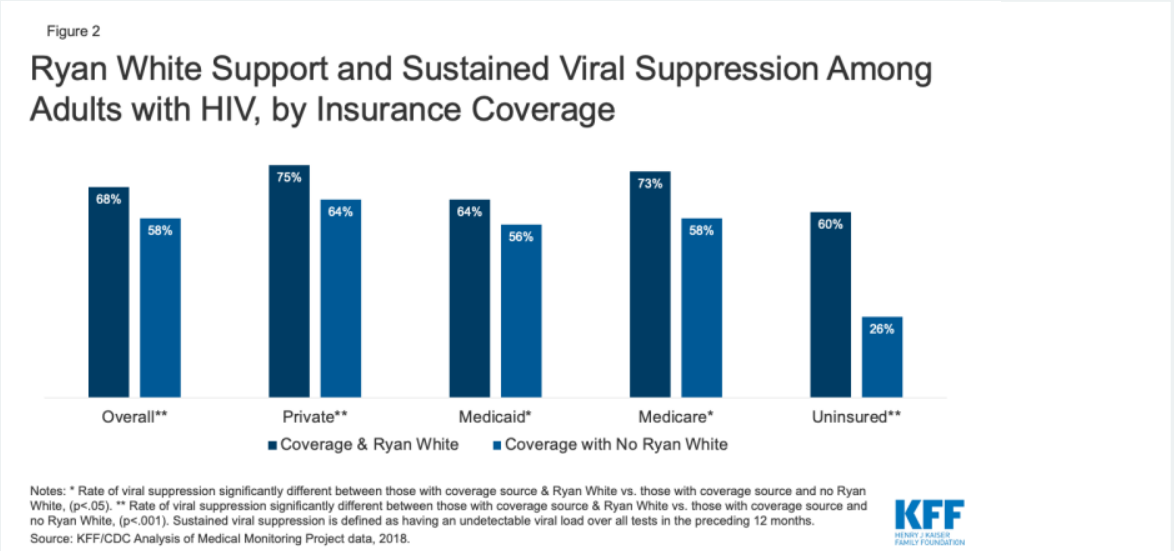

Figure 2: Ryan White Support and Sustained Viral Suppression Among Adults with HIV, by Insurance Coverage

Key Issues

First enacted as an emergency measure, the Ryan White program has grown to become a central component of HIV care in the U.S., playing a critical role in the lives of many low and moderate-income people with HIV. Looking ahead, there are several key issues facing the program that will be important to monitor, including:

- **Future funding**. As a federal grant program, funding is dependent on annual appropriations by Congress, and funding levels do not necessarily correspond to actual need (i.e. the number of people seeking services or the costs of services). As a result, historically not all states and communities have been able to meet the needs of their jurisdictions.
- **Possible future program reauthorization** and any impact on program structure and financing.
- **Major changes to the ACA,** including repeal and the impact of any changes on health coverage options for people with HIV and the Ryan White Program. In particular, if ACA era health programs are dismantled, lose their benefit design standards, or the nondiscrimination protections are weakened, it will be key to assess Ryan White's ability to make-up for any coverage losses among people with HIV.
- **Ryan White's ongoing role in the EHE initiative**, including future Congressional appropriations for EHE and the ability to address HIV in the face of the COVID-19 pandemic, among other factors.
- **The ability to simultaneously address the COVID-19 and HIV epidemics**. People with HIV need access to ongoing care and treatment to remain healthy and the ability to curb the HIV epidemic relies in part on improving rates of viral suppression among people with HIV. This must continue to happen at time when providers and systems that serve people with HIV, from the highest levels in federal government to the most local levels at community clinics, are facing

great strain in the wake of the pandemic and when people with HIV are at particular risk for facing personal challenges which may make engaging in care difficult.

Endnotes

1. Kaiser Family Foundation. *U.S. Federal Funding for HIV/AIDS: Trends Over Time*.. November 2017. Available at: http://kff.org/global-health-policy/fact-sheet/u-s-federal-funding-for-hivaids-trends-over-time/ (blank).
   ← Return to text (https://www.kff.org/hivaids/fact-sheet/the-ryan-white-hivaids-program-the-basics/#endnote_link_491855-1)

2. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2018. December 2019. Available at: https://hab.hrsa.gov/sites/default/files/hab/data/datareports/RWHAP-annual-client-level-data-report-2018.pdf (https://hab.hrsa.gov/sites/default/files/hab/data/datareports/RWHAP-annual-client-level-data-report-2018.pdf)
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3. Kaiser Family Foundation analysis of FY20 HHS omnibus spending bill.
   ← Return to text (https://www.kff.org/hivaids/fact-sheet/the-ryan-white-hivaids-program-the-basics/#endnote_link_491855-3)

4. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2018. December 2019. Available at: https://hab.hrsa.gov/sites/default/files/hab/data/datareports/RWHAP-annual-client-level-data-report-2018.pdf (https://hab.hrsa.gov/sites/default/files/hab/data/datareports/RWHAP-annual-client-level-data-report-2018.pdf).
   ← Return to text (https://www.kff.org/hivaids/fact-sheet/the-ryan-white-hivaids-program-the-basics/#endnote_link_491855-4)

5. Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2018. December 2019. Available at: https://hab.hrsa.gov/sites/default/files/hab/data/datareports/RWHAP-annual-client-level-data-report-2018.pdf (blank)
   ← Return to text (https://www.kff.org/hivaids/fact-sheet/the-ryan-white-hivaids-program-the-basics/#endnote_link_491855-5)

6. 7 Kaiser Family Foundation. *U.S. Federal Funding for HIV/AIDS: Trends Over Time*. November 2017. Available at: http://kff.org/global-health-policy/fact-sheet/u-s-federal-funding-for-hivaids-trends-over-time/ (blank).
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7. 8 KFF analysis of data provided by the Office of Management and Budget. See also: Kaiser Family Foundation. *U.S. Federal Funding for HIV/AIDS: Trends Over Time*. June 2016. Available at: http://kff.org/global-health-policy/fact-sheet/u-s-federal-funding-for-hivaids-trends-over-time/ (http://kff.org/global-health-policy/fact-sheet/u-s-federal-funding-for-hivaids-trends-over-time/).
   ← Return to text (https://www.kff.org/hivaids/fact-sheet/the-ryan-white-hivaids-program-the-basics/#endnote_link_491855-7)

8. 9 KFF analysis of data provided by the Office of Management and Budget. See also: Kaiser Family Foundation. *U.S. Federal Funding for HIV/AIDS: Trends Over Time*. June 2016. Available at: http://kff.org/global-health-policy/fact-sheet/u-s-federal-funding-for-hivaids-trends-over-time/ (blank).
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9. [10] Kaiser Family Foundation. The U.S. Ending the HIV Epidemic (EHE) Initiative: What You Need to Know. May 2020. Available at: https://www.kff.org/hivaids/issue-brief/the-u-s-ending-the-hiv-epidemic-ehe-initiative-what-you-need-to-know/ (https://www.kff.org/hivaids/issue-brief/the-u-s-ending-the-hiv-epidemic-ehe-initiative-what-you-need-to-know/)
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10. [13] Grantees may be able to get waivers from this requirement.
    ← Return to text (https://www.kff.org/hivaids/fact-sheet/the-ryan-white-hivaids-program-the-basics/#endnote_link_491855-10)

11. [14] Ryan White HIV/AIDS Treatment Modernization Act of 2006 (P.L. 109-415).

    [15] Kaiser Family Foundation. The U.S. Ending the HIV Epidemic (EHE) Initiative: What You Need to Know. May 15, 2020. Available at: https://www.kff.org/hivaids/issue-brief/the-u-s-ending-the-hiv-epidemic-ehe-initiative-what-you-need-to-know/ (https://www.kff.org/hivaids/issue-brief/the-u-s-ending-the-hiv-epidemic-ehe-initiative-what-you-need-to-know/).
    ← Return to text (https://www.kff.org/hivaids/fact-sheet/the-ryan-white-hivaids-program-the-basics/#endnote_link_491855-11)

12. [16] Ryan White HIV/AIDS Treatment Extension Act of 2009 (P.L. 111-87).

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13. [17] CRS. *The Ryan White HIV/AIDS Program*; June 2011.
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14. HHS. NIH. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV. (https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv/0) July 10, 2019. https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/whats-new-guidelines (https://clinicalinfo.hiv.gov/en/guidelines/adult-and-adolescent-arv/whats-new-guidelines)
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15. Dawson, L. and Kates, J. Kaiser Family Foundation. Insurance Coverage and Viral Suppression Among People with HIV, 2018. September 2020. https://www.kff.org/hivaids/issue-brief/insurance-coverage-and-viral-suppression-among-people-with-hiv-2018/ (https://www.kff.org/hivaids/issue-brief/insurance-coverage-and-viral-suppression-among-people-with-hiv-2018/)
← Return to text (https://www.kff.org/hivaids/fact-sheet/the-ryan-white-hivaids-program-the-basics/#endnote_link_491855-15)

LOS ANGELES COUNTY
COMMISSION ON HIV

2022-2023 Legislative Docket
Approval Date: COH 7-14-22

POSITIONS: SUPPORT | OPPOSE | SUPPORT w/AMENDMENTS | OPPOSE unless AMENDED | WATCH

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
AB 4 (Arambula)	Medi-Cal: eligibility	The bill would extend eligibility for full scope Medi-Cal benefits to anyone regardless of age, and who is otherwise eligible for those benefits but for their immigration status. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB4	Support	11-AUG-22 In Committee: Held Under Submission.
AB 15 (Chiu)	COVID-19 relief: tenancy: Tenant Stabilization Act of 2021	This bill would extend the definition of "COVID-19 rental debt" as unpaid rent or any other unpaid financial obligation of a tenant that came due between March 1, 2020, and December 31, 2021. The bill would also extend the repeal date of the act to January 1, 2026. The bill would make other conforming changes to align with these extended dates. By extending the repeal date of the act, the bill would expand the crime of perjury and create a state-mandated local program. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB15 Per Assembly Chiu Office the Assembly person will hold the bill until the next legislative cycle. Due to the passing of AB 3088, SB 91 and AB 832 which prevent eviction due to non-payment of rent for those whose income was negatively impacted by the pandemic.	Support with questions	01-FEB-22 From committee: Filed with the Chief Clerk pursuant to Joint Rule 56(1)

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
AB 16 (Chiu)	Tenancies: COVID-19 Tenant, Small Landlord, and Affordable Housing Provider Stabilization Act of 2021	This bill would establish the Tenant, Small Landlord, and Affordable Housing Provider Stabilization Program. https://leginfo.legislature.ca.gov/faces/billStatusClient.xhtml?bill_id=202120220AB16 Per Assembly Chiu Office the Assembly person will hold the bill until the next legislative cycle. Due to the passing of AB 3088, SB 91 and AB 832 which prevent eviction due to non-payment of rent for those whose income was negatively impacted by the pandemic.	Watch	01-FEB-22 From committee: Filed with the Chief Clerk pursuant to Joint Rule 56(1)
AB 65 (Low)	California Universal Basic Income Program: Personal Income Tax	This bill would declare the intent of the Legislature to enact legislation to create a California Universal Basic Income Program, with the intention of ensuring economic security for all Californians. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB65	Watch	01-FEB-22 From committee: Filed with the Chief Clerk pursuant to Joint Rule 56(1)
AB 77 (Petrie-Norris)	Substance use disorder treatment services	This bill would declare the intent of the Legislature to enact Jarrod's Law, a licensure program for inpatient and outpatient programs providing substance use disorder treatment services, under the administration of the State Department of Health Care Services. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB77	Support	01-FEB-22 From committee: Filed with the Chief Clerk pursuant to Joint Rule 56(1)
AB 240 (Rodriguez)	Local health department workforce assessment	This bill would require the department to contract with an appropriate and qualified entity to conduct an evaluation of the adequacy of the local health department infrastructure and to make recommendations for future staffing, workforce needs, and resources, in order to accurately and adequately fund local public health. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB240	Support with Questions	*27-SEP-22 Vetoed by Governor.*

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
AB 328 (Chiu)	Reentry Housing and Workforce Development Program	This bill would establish the Reentry Housing Program. The bill would require the Department of Housing and Community Development to, on or before July 1, 2022, take specified actions to, upon appropriation by the Legislature, provide grants to counties and continuums of care, as defined, for evidence-based housing and housing-based services interventions to allow people with recent histories of incarceration to exit homelessness and remain stably housed. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB328	Support	01-FEB-22 Filed with the Chief Clerk pursuant to Joint Rule 56. (1)
AB 835 (Nazarian)	Hospital emergency departments: HIV testing	This bill would require every patient who has blood drawn at a hospital emergency department to be offered an HIV test, as specified. The bill would specify the manner in which the results of that test are provided. The bill would state that a hospital emergency department is not required to offer an HIV test to a patient if the department determines that the patient is being treated for a life-threatening emergency or if they determine the person lacks the capacity to consent to an HIV test. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB835	Support	26-AUG-21 In Committee: Held Under Submission
AB 1038 (Gipson)	California Health Equity Program	This bill would establish the California Health Equity Program, a competitive grant program administered by the Office of Health Equity to community-based nonprofit organizations, community clinics, local health departments, and tribal organizations to take actions related to health equity. The bill would establish the California Health Equity Fund. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB1038	Support	26-AUG-21 In Committee: Held Under Submission

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
AB 1400 (Kalra)	Guaranteed Health Care for All	This bill, the California Guaranteed Health Care for All Act, would create the California Guaranteed Health Care for All program, or CalCare, to provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB1400	Support	01-FEB-22 Died on third reading file.
AB 1542 (McCarty)	County of Yolo: Secured Residential Treatment Program.	This bill would, until January 1, 2025, authorize the County of Yolo to offer a pilot program, known as the Secured Residential Treatment Program, for individuals suffering from substance use disorders (SUDs) who have been convicted of qualifying drug-motivated felony crimes, as specified. The bill would require the program to meet certain conditions relating to, among other things, a risk, needs, and psychological assessment, a comprehensive curriculum, a determination by a judge of the length of treatment, data collection, licensing and monitoring of the facility by the State Department of Health Care Services, and reporting to the department and the Legislature. Bill Text - AB-1542 County of Yolo: Secured Residential Treatment Program. (ca.gov)	Watch	3-FEB-22 VETOED BY THE GOVERNOR
AB 1928 (McCarty)	Hope California: Secured Residential Treatment Pilot Program	Existing law authorizes a court to grant pretrial diversion to a defendant in specified cases, including when the defendant is suffering from a mental disorder, specified controlled substances crimes, and when the defendant was, or currently is, a member of the United States military. This bill would, until January 1, 2026, the Counties of San Joaquin, Santa Clara, and Yolo to develop, manage, staff, and offer a secured residential treatment pilot program, known as Hope California, for individuals suffering from substance use disorders (SUDs) who have been convicted of qualifying drug-motivated felony crimes, as specified. The bill would require the program to meet certain conditions relating to, among other things, a risk, needs, and psychological assessment, a comprehensive curriculum, a determination by a judge of the length of treatment, data collection, licensing and monitoring of the facility by the State Department of Health Care Services, and reporting to the department and the Legislature. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB1928	Watch	19-MAY-22 In committee: Held under submission.

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
AB 2194 (Ward and Lee)	Pharmacists and pharmacy technicians: continuing education: cultural competency	Requires pharmacists and pharmacy technicians to complete at least one hour of continuing education through a cultural competency course focused on lesbian, gay, bisexual, transgender and queer or questioning (LGBTQ+) patients. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB2194	Support	*30-SEP-22 Approved by the Governor.*
AB 2223 (Wicks)	Reproductive Health	Existing law requires a county coroner to hold inquests to inquire into and determine the circumstances, manner, and cause of violent, sudden, or unusual deaths, including deaths related to or following known or suspected self-induced or criminal abortion. Existing law requires a coroner to register a fetal death after 20 weeks of gestation, unless it is the result of a legal abortion. If a physician was not in attendance at the delivery of the fetus, existing law requires the fetal death to be handled as a death without medical attendance. Existing law requires the coroner to state on the certificate of fetal death the time of fetal death, the direct causes of the fetal death, and the conditions, if any, that gave rise to these causes. This bill would delete the requirement that a coroner hold inquests for deaths related to or following known or suspected self-induced or criminal abortion, and would delete the requirement that an unattended fetal death be handled as a death without medical attendance. The bill would prohibit using the coroner's statements on the certificate of fetal death to establish, bring, or support a criminal prosecution or civil cause of damages against any person. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB2223	Support	*27-SEP-22 Approved by the Governor.*

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
AB 2312 (Lee)	Nonprescription contraception: access	This bill would, with certain exceptions, prohibit a retail establishment, as defined, from refusing to furnish nonprescription contraception to a person solely on the basis of age or any of the above-listed characteristics by means of any conduct, including, but not limited to, requiring the customer to present identification for purposes of demonstrating their age or other characteristic. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB2312	Watch	6-APR-22 In committee: Set, first hearing. Hearing canceled at the request of author.
AB 2521 (Santiago)	Transgender, Gender Nonconforming, or Intersex Fund	This bill would rename the fund as the Transgender, Gender Nonconforming, or Intersex Fund. The bill would require the office to establish a community advisory committee for the purpose of providing recommendations to the office on which organizations and entities to select for funding and recommendations on the amount of funding for each organization or entity. The bill would require the community advisory committee to be composed of multiple marginalized members of the TGI community for whom the services provided by the funds are intended. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB2521 Sponsored by TransLatin@ Coalition	Support	*30-SEP-22 Approved by the Governor.*
SB 17 (Pan)	Office of Racial Equity	This bill would state the intent of the Legislature to enact legislation to require the department to address racism as a public health crisis. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB17	Support	31-AUG-22 Ordered to inactive file on request of Assembly Member Reyes
SB 56 (Durazo)	Medi-Cal: eligibility	This bill would, subject to an appropriation by the Legislature, and effective July 1, 2022, extend eligibility for full-scope Medi-Cal benefits to individuals who are 65 years of age or older, and who are otherwise eligible for those benefits but for their immigration status. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB56	Support	23-JUNE-21 From Committee: Do Pass and Re-refer to Committee on Appropriation

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
SB 57 (Wiener)	Controlled Substances: Overdose Prevention Program	This bill would, until January 1, 2027, authorize the City and County of San Francisco, the County of Los Angeles, and the City of Oakland to approve entities to operate overdose prevention programs for persons that satisfy specified requirements, including, among other things, providing a hygienic space supervised by trained staff where people who use drugs can consume preobtained drugs, providing sterile consumption supplies, and providing access or referrals to substance use disorder treatment. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB57 The City of Los Angeles approved a pilot site for this program and requested a bill amendment to include the City of Los Angeles. The sponsor held the bill for this legislative session and will continue the legislative process in January 2022 (Legislative Session 2022-23).	Support	22-AUG-22 Vetoed by the Governor. In Senate. Consideration of Governor's item veto pending.
SB 217 (Dahle)	Comprehensive sexual health education and human immuno-deficiency virus (HIV) prevention education.	This bill would require the governing board of a school district to adopt a policy at a publicly noticed meeting specifying how parents and guardians of pupils may inspect the written and audiovisual educational materials used in comprehensive sexual health education. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB217	Opposed Unless Amended	01-FEB-22 Returned to Secretary of Senate pursuant to Joint Rule 56(1)
SB 225 (Wiener)	Medical procedures: individuals born with variations in their physical sex characteristics	This bill would prohibit a physician and surgeon from performing certain sex organ modification procedures on an individual born with variations in their physical sex characteristics who is under 12 years of age unless the procedure is a surgery required to address an immediate risk of physical harm, as specified. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB225	Support	*27-SEP-22 Approved by the Governor.*

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
SB 316 (Eggman)	Medi-Cal: federally qualified health centers and rural health clinics	This bill would authorize reimbursement for a maximum of 2 visits taking place on the same day at a single location if after the first visit the patient suffers illness or injury requiring additional diagnosis or treatment, or if the patient has a medical visit and a mental health visit or a dental visit, as defined. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB316	Support	09-SEP-21 Ordered to inactive file on request of Assembly Member Reyes.
SB 357 (Wiener)	Crimes: loitering for the purpose of engaging in a prostitution offense	Existing law prohibits soliciting or engaging in an act of prostitution. This bill would repeal those provisions related to loitering with the intent to commit prostitution and would make other conforming changes. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220SB357	Support	01-JULY-22 Approved by the Governor
SB 464 (Hurtado)	California Food Assistance Program: eligibility and benefits	This bill, commencing January 1, 2023, would instead make a noncitizen applicant eligible for the California Food Assistance Program if the noncitizen satisfies all eligibility criteria for participation in the CalFresh program except any requirements related to immigration status. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB464	Support	01-JULY-21 From Committee: Do Pass and Re-refer to Committee on Approp-riation. Re-referred to Committee Appropriation
SB 523 (Leyva)	Health care coverage: contra-ceptives	This bill would make various changes to expand coverage of contraceptives by a health care service plan contract or health insurance policy issues, amended, renewed, or delivered on and after January 1, 2022. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220SB523	Support	*27-SEP-22 Approved by the Governor.*

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
SB 679 (Kamlager)	*Los Angeles County: Affordable Housing*	*This bill, the Los Angeles County Regional Housing Finance Act, would establish the Los Angeles County Affordable Housing Solutions Agency and would state that the agency's purpose is to increase the supply of affordable housing in Los Angeles County by providing for significantly enhanced funding and technical assistance at a regional level for renter protections, affordable housing preservation, and new affordable housing production, as specified. The bill would require a board composed of 21 voting members and one nonvoting member from Los Angeles County, as specified, to govern the agency.* *https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220SB679*		*28-SEP-22 Approved by the Governor.*
SB 923 (Wiener)	Gender-affirming care	This bill requires health plans and insurers to require all of its support staff who are in direct contact with enrollees or insureds to complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care for individuals who identify as transgender, gender nonconforming, or intersex. This bill adds processes to continuing medical education requirements related to cultural and linguistic competency for physician and surgeons specific to gender-affirming care services, as specified. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220SB923	Support	*29-SEP-22 Approved by Governor.*
SB 939 (Pan)	Prescription drug pricing	This bill prohibits payers and drug manufacturers from imposing requirements, conditions, or exclusions that discriminate against certain health care entities participating in a federal drug discount program, including contracted pharmacies of the health care entities. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB939	Support	28-JUNE-22 June 28 set for first hearing canceled at the request of author.

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
SB 1033 (Pan)	Healthcare Coverage	This bill would require the Department of Managed Health Care (DMHC) and the Insurance Commissioner, no later than July 1, 2023, to revise specified regulations that would require health plans, specialized health plans, or insurance policies, excluding Medi-Cal beneficiaries, for cultural and health-related social needs in order to improve health disparities, health care quality and outcomes, and addressing population health. This bill is referred by the community as the health equity and data bill. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB1033	Support	11-AUG-22 Joint Rule 62(a) suspended. August 11 hearing: Held in committee and under submission.
SB 1234 (Pan)	Family Planning, Access, Care, and Treatment Program	The bill would require reimbursement, subject to an appropriation by the Legislature and any potential draw down of federal matching funds, for services related to the prevention and treatment of sexually transmitted diseases (STDs), including counseling, screening, testing, follow-up care, prevention and treatment management, and drugs and devices outlined as reimbursable in the Family PACT Policies, Procedures and Billing Instructions manual, to uninsured, income-eligible patients or patients with health care coverage who are income-eligible and have confidentiality concerns, including, but not limited to, lesbian, gay, bisexual, transgender (LGBTQ+) patients, and other individuals who are not at risk for experiencing or causing an unintended pregnancy, and who are not in need of contraceptive services. In addition, the bill would require any office visits, including in-person and visits through telehealth modalities, to be reimbursed at the same rate as office visit. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB1234	Support	25-SEP-22 Vetoed by the Governor. In Senate. Consideration of Governor's veto pending.

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
SB 1338 (Umberg)	Community Assistance, Recovery, and Empowerment (CARE) Program	Senate Bill 1338 would establish the Community Assistance, Recovery, and Empowerment (CARE) Court Program, which would authorize specified persons to petition a civil court to create a CARE plan and implement services for individuals suffering from specified mental health disorders. If the court determines the individual is eligible for the CARE Court Program, the court would order the implementation of a CARE plan, as devised by the relevant county behavioral services agency, and would oversee the individual's participation in the plan. https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=202120220SB1338 Supported by the Los Angeles County Board of Supervisors	Watch with reservations	14-SEP-22 Approved by the Governor.
FEDERAL BILLS				
BILL	**TITLE**	**DESCRIPTION / COMMENTS**	**RECOMMENDED POSITION**	**STATUS**
H.R.5 (Cicilline)	Equality Act	This bill prohibits discrimination based on sex, sexual orientation, and gender identity in areas including public accommodations and facilities, education, federal funding, employment, housing, credit, and the jury system. https://www.congress.gov/bill/117th-congress/house-bill/5	Support	17-March-2021 Senate Committee on the Judiciary Hearings Held
H.R. 1201 (Lowenthal-Markey)	International Human 5 Rights Defense Act of 2021	The bill is to establish in the Bureau of Democracy, Human Rights, and Labor of the Department of State a Special Envoy for the Human Rights of LGBTQI Peoples. The Special Envoy shall serve as the principal advisor to the Secretary of State regarding human rights for LGBTQI people internationally. https://www.congress.gov/bill/117th-congress/house-bill/1201/text	Support	02-APRIL-21 Referred to the Subcommittee on Africa, Global Health and Global Human Rights

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
H.R. 1280 (Bass)	George Floyd Justice and Policing Act of 2021	This bill addresses a wide range of policies and issues regarding policing practices and law enforcement accountability. It increases accountability for law enforcement misconduct, restricts the use of certain policing practices, enhances transparency and data collection, and establishes best practices and training requirements. The Commission on HIV refer this bill back to the Committee because funding for the police is included in the bill. This is at odds with the movement for Black Lives which opposes the bill. https://www.congress.gov/bill/117th-congress/house-bill/1280?q=%7B%22search%22%3A%5B%22George+Floyd+Justice+and+Policing+Act+of+2021%22%5D%7D&s=2&r=1	Watch with reservations	09-March-21 Received in the Senate Referred Back to Committee in Discussion
Federal Bill Proposal (Sponsored Movement for Black Lives)	The BREATHE Act	Divesting Federal Resources from Policing and Incarceration & Ending Federal Criminal-Legal System Harms Investing in New Approaches to Community Safety Utilizing Funding Incentives Allocating New Money to Build Healthy, Sustainable & Equitable Communities for All People Holding Officials Accountable & Enhancing Self-Determination of Black Communities	Watch with discussion	Referred Back to Committee in Discussion

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
HR 5611 (Blunt Rochester)/ S. 1902 (Cortez Masto)	Behavioral Health Crisis Services Expansion Act	This bill establishes requirements, expands health insurance coverage, and directs other activities to support the provision of behavioral health crisis services along a continuum of care. https://www.congress.gov/bill/117th-congress/house-bill/5611?q=%7B%22search%22%3A%5B%22hr5611%22%2C%22hr5611%22%5D%7D&s=1&r=1 https://www.congress.gov/bill/117th-congress/senate-bill/1902?q=%7B%22search%22%3A%5B%22S1902%22%2C%22S1902%22%5D%7D&s=2&r=1	Support	**HR 5611** 02-NOV-21 House Referred to the Subcommittee on Health **S. 1902** 27-MAY-21 Read Senate twice and referred to the Committee on Health, Education, Labor, and Pensions
S.1 (Merkley)	For the People Act	This bill addresses voter access, election integrity and security, campaign finance, and ethics for the three branches of government. https://www.congress.gov/bill/117th-congress/senate-bill/1?q=%7B%22search%22%3A%5B%22S+1%22%5D%7D&s=1&r=1	Support	11-AUG-21 Placed on Senate Legislative Calendar Under General Orders. Calendar No. 123
S. 854 (Feinstein)	Methampheta-mine Response Act of 2021	This bill designates methamphetamine as an emerging drug threat (a new and growing trend in the use of an illicit drug or class of drug). It directs the Office of National Drug Control Policy to implement a methamphetamine response plan. https://www.congress.gov/bill/117th-congress/senate-bill/854	Support	14-MARCH-22 Became Public Law/Signed by the President

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
S.4263/ H.R.4 (Leahy)	John Lewis Voting Rights Advancement Act 2021	To amend the Voting Rights Act of 1965 to revise the criteria for determining which States and political subdivisions are subject to section 4 of the Act, and for other purposes. https://www.congress.gov/bill/117th-congress/house-bill/4?q=%7B%22search%22%3A%5B%22H.4%22%2C%22H.4%22%5D%7D&r=1&s=4	Support	14-SEP-20 Received in the Senate.

LOS ANGELES COUNTY
COMMISSION ON HIV

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PUBLIC POLICY COMMITTEE (PPC)[1]
2022-2023 POLICY PRIORITIES

HIV has been raging in communities across the world for almost 40 years and with advancements in biomedical interventions, research and vaccines, the time for the HIV cure is now.

With a renewed sense of optimism and urgency, the PPC remains steadfast in its commitment to universal health care, eradication of racism in all forms, and unfettered access to trauma informed care and supportive services, including comprehensive harm reduction services, to ensure that all people living with HIV and communities most impacted by HIV and STDs, live full, productive lives.

The COVID-19 global pandemic has demonstrated that with political will, funding, and most important of all, urgency, rapid and safe vaccine development is possible. Nevertheless, like the HIV epidemic, (globally, nationally, and locally), it is our most marginalized communities, including youth, who are disproportionately impacted with higher rates of disease and death. In addition, The COVID-19 global pandemic is severely impacting the delivery of HIV prevention and care services. The PPC is compelled to encourage and support innovative efforts to reduce bureaucracy, increase funding, enhance HIV prevention, and care service. This effort is to address the negative impacts of COVID-19 and restore pre-COVID service levels, preferably exceeding the quantity and quality of HIV and prevention services.

The PPC recommends the Commission on HIV endorse the prioritization of the following issues. PPC will identify support legislation, local policies, procedures, and regulations that address Commission priorities in calendar years 2022 and 2023. (Issues are in no order.)

Systemic and Structural Racism

a. Establish health equity through the elimination of barriers and addressing of social determinants of health such as: implicit bias; access to care; education; social stigma, (i.e., homophobia, transphobia, and misogyny); housing; mental health; substance abuse; income/wealth gaps; as well as criminalization.

[1] The Public Policy Committee acts in accordance with the role of the Commission on HIV, as dictated by Los Angeles County Code 3.29.090. Consistent with Commission Bylaws Article VI, Section 2, no Ryan White resources are used to support Public Policy Committee activities.

b. Reduce and eliminate the disproportionate impact of HIV/AIDS and STIs in the Black/African American community. To include the identification of and rooting out of systemic and systematic racism as it affects Black/African American communities.

Racist Criminalization and Mass incarceration[2]

a. Eliminate discrimination against or the criminalization of people living with or at risk of HIV/AIDS including those who exchange sex for money (e.g., Commercial Sex Work).
b. Support the efforts of Measure J, the Alternatives to Incarceration and closure of Men's Central Jail and seek increased funding for services and programming through Measure J as well as through redistribution of funding for policing and incarceration. [3]

Housing[4]

a. Focus b, c, and d below especially in service to LGBTQIA+ populations
b. Improve systems, strategies and proposals that expand affordable housing, as well as prioritize housing opportunities for people living with, affected by, or at risk of transmission of HIV/AIDS
c. Improve systems, strategies, and proposals that prevent homelessness for people living with, affected by, or at risk of contracting HIV/AIDS.
d. Promote Family housing and emergency financial assistance as a strategy to maintain housing.

[2] Black/African Americans, while making up only 8% of the LA County population, represent over 30% of the jail population. In the Los Angeles County Alternatives to Incarceration Report, "Los Angeles County operates the largest jail system in the United States, which imprisons more people than any other nation on Earth." As documented in the Los Angeles County HIV/AIDS Strategy for 2020 and Beyond; "Incarceration destabilizes communities, disrupts family relationships, and magnifies the accumulation of health and social disadvantage for already marginalized populations. Incarceration is associated with harmful effects on viral suppression, lower CD4/T-cell counts, and accelerated disease progression."

[3] DEVELOPING A PLAN FOR CLOSING MEN'S CENTRAL JAIL AS LOS ANGELES COUNTY REDUCES ITS RELIANCE ON INCARCERATION (ITEM #3 JULY 7, 2020 BOARD MEETING)

[4] Homelessness is a risk factor for HIV transmission and acquisition. LGBTQIA+ experience a number of factors which increased the risk of being unhoused, from family discrimination at home to discrimination in employment. Such discrimination contributes to higher rates of poverty; undermines their ability to thrive; and increases the risk of arrest and incarceration. Homelessness is a risk factor for HIV transmission and acquisition.

Mental Health

a. Expand and enhance mental health services for people living with, affected by, or at risk of contracting HIV/AIDS.
b. By increasing services for those with underlying mental health issues, there will be less reliance on incarceration. Los Angeles County Jail has also become the largest mental health institution in the country.
c. Support the building of community-based mental health services.
d. Support the placement in mental health facilities of the estimated 4,000+ individuals currently incarcerated and in need of mental health services and support closing of Men's Central Jail. (See footnote 3)

Sexual Health

a. Increase access to prevention, care and treatment and bio-medical intervention (such as PrEP and PEP) services. Promote the distribution of services to people at risk for acquiring HIV and people living with HIV/AIDS.
b. Increase comprehensive HIV/STD counseling, testing, education, outreach, research, harm reduction services including syringe exchange, and social marketing programs.
c. Maximize HIV prevention to reduce and eliminate syphilis and gonorrhea cases; especially among young MSM (YMSM), African American MSM, Latino MSM, transgender persons and women of color.
d. Advance and enhance routine HIV testing and expanded linkage to care.
e. Maintain and expand funding for access and availability of HIV, STD, and viral hepatitis services.
f. Promote women centered prevention services to include domestic violence and family planning services for women living with and at high-risk of acquiring HIV/AIDS.
g. Preserve full funding and accessibility to Pre-Exposure Prophylaxis Assistance Program (PrEP-AP).

Substance Abuse

a. Advocate for substance abuse services to PLWHA.
b. Advocate for services and programs associated with methamphetamine use and HIV transmission.
c. Expand alternatives to incarceration/diversion programs to provide a "care first" strategy and move those who need services away from incarceration to substance abuse programs.
d. Expand harm reduction services (including and not limited to syringe exchange, safe administration sites, over-dose prevention strategies) across all of Los Angeles County.
e. Support trauma informed services for substance users.

Consumers

a. Advocate and encourage the empowerment and engagement of People Living with HIV/AIDS (PLWH/A) and those at risk of acquiring HIV. Focusing on young MSM (YMSM), African American MSM, Latino MSM, transgender persons (especially of color), women of color, and the aging.

Aging

a. Create and expand medical and supportive services for PLWHA ages fifty (50) and over.

Women

a. Create and expand medical and supportive services for women living with HIV/AIDS. This includes services such as family housing, transportation, mental health, childcare, and substance abuse.
b. Advocate for women's bodily autonomy in all areas of health care services including and not limited to full access to abortions, contraception, fertility/infertility services and family planning.

Transgender

a. Create and expand medical and supportive services for transgender PLWHA.
b. Promote and maintain funding for the Transgender Wellness Fund created by the passage of AB2218.

General Health Care

a. Provide access to and continuity of care for PLWHA focusing on communities at highest risk for the acquisition and transmission of HIV disease.
b. Fund and expand eligibility for Medicaid, Medicare, and HIV/AIDS programs and health insurance coverage for individuals with pre-existing conditions.
c. Increase and enhance compatibility and effectiveness between RWP, Medicaid, Medicare, and other health systems. This includes restructuring funding criteria to **not** disincentives contractors from referring clients to other contractors.
d. Expand access to and reduction of barriers (including costs) for HIV/AIDS, STD, and viral hepatitis prevention and treatment medications.
e. Preserve full funding and accessibility to the AIDS Drug Assistance Program (ADAP), Office of AIDS Health Insurance Premium Payment (OA-HIPP) Assistance, Employer Based Health Insurance Premium Payment (EB-HIPP), and Medigap.
f. Provide trauma informed care and harm reduction strategies in all HIV Disease health care settings

Service Delivery

a. Enhance the accountability of healthcare service deliverables. This would include a coordinated effort between federal, state, and local governments.
b. Incorporate COVID strategies to reduce administrative barriers, increase access to health services and encourage the development of an HIV vaccine mirroring the COVID 19 vaccine process.

Data

a. Use data, without risking personal privacy and health, with the intention of improving health outcomes and eliminating health disparities among PLWHA.
b. Promote distribution of resources in accordance with the HIV burden within Los Angeles County.

Health Care in Motion
Timely, Substantive Updates on Policy Shifts · Actionable Advocacy to Protect Health Care

October 21, 2022

1557 Proposed Rule: A New Life for Non-Discrimination Protections

Late this summer, the Department of Health and Human Services (HHS) released its proposed rule overhauling the Affordable Care Act's (ACA) non-discrimination protections. Section 1557 is the ACA provision applying four pre-existing federal civil rights protections (Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, and Section 504 of the Rehabilitation Act of 1973) to a range of federal health programs and activities, including health insurance. Its implementation, however, has been fraught. The rule – which was first promulgated in 2016 under the Obama Administration and went through a major revision and rollback during the Trump Administration – has been the subject of multiple court challenges. The proposed rule released by the Biden Administration reinstates many of the provisions in the original 2016 rule and expands and revises other protections. Below, we provide a summary of the history of Section 1557 rulemaking and a review of some prominent changes proposed in its current iteration. Based off of HHS' past rulemaking timeline, readers can expect to see the next steps of rulemaking sometime in 2023.

1557: A Dramatic History

The Obama Administration first gave life to section 1557 of the ACA when it released a massive rule implementing the provision in 2016. Legal challenges were mounted almost immediately, aimed squarely at the rule's definition of discrimination "on the basis of sex" and specifically at inclusion of discrimination based on "gender identity" and "termination of pregnancy" in that definition. In 2020, the Trump Administration released a revised rule implementing Section 1557. The 2020 rule limited the scope of the rule's application, removed the definition regarding discrimination based on sex, removed protections against discriminatory plan designs, and gutted language access, notice, and enforcement provisions. Between informal release of the 2020 rule to the public and its formal publication in the Federal Register, the Supreme Court issued its ruling in *Bostock v. Clayton County, Georgia*, finding that discrimination based on sex encompasses sexual orientation and gender identity in the context of employment. Several lawsuits were filed against the Trump Administration for the rollback of protections, including *BAGLY v. HHS* (CHLPI along with others represent the plaintiffs). Courts instituted nationwide preliminary injunctions on some parts of

the 2020 rule, including its repeal of the definition of discrimination on the basis of sex and incorporation of Title IX's religious exemptions.

The Biden Administration has taken a different tack when it comes to discrimination protections. On his first day in office, President Biden issued the Executive Order on Preventing and Combating Discrimination on the Basis of Gender Identity or Sexual Orientation, which among other things, directed federal agencies to review existing guidance and regulations to ensure that sex-based protections extended to discrimination on the basis of gender identity and sexual orientation. In May 2021, the Office of Civil Rights (OCR) announced that in light of the Court's decision in *Bostock*, OCR would interpret section 1557 to include protections against discrimination based on gender identity and sexual orientation and that the Administration would release a revised 1557 rule that conformed with *Bostock*. (Despite these moves, discriminatory plans were still being sold on HealthCare.gov in 2022.) More than a year later, HHS published its proposed rule in the Federal Register on August 4, 2022.

"On the Basis of Sex"

The 2016 rule included explicit prohibitions on discrimination based on pregnancy and gender identity in its definition of discrimination on the basis of sex. The 2020 1557 rule eliminated the definition section, throwing confusion into what a covered entity's obligations were under Section 1557 and what rights consumers had, particularly when it came to discrimination based on gender identity. Following the Supreme Court's decision in *Bostock* and the Biden Administration's public announcements regarding its application of *Bostock* onto other nondiscrimination protections, advocates expected that the newly proposed 1557 rule would explicitly codify prohibition of discrimination based on gender identity. The proposed rule does this, clarifying that discrimination on the basis of sex includes discrimination on the basis of sex stereotypes; sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; and gender identity. The preamble to the rule includes examples of how these protections apply to providers and insurers (specific examples of plan design discrimination based on gender identity are discussed in more detail below).

The proposed rule does not include a separate specific provision related to pregnancy-related conditions; however, HHS asked for comments on whether a provision should be added, particularly in light of the Supreme Court's decision in *Dobbs v. Jackson's Women's Health Organization*. *Advocates, such as the National Women's Law Center*, urged HHS to include a stand-alone provision with language "outlining the full scope of pregnancy or related conditions" and "clarify[ing] that sex discrimination based on pregnancy or related conditions includes, but is not limited to, pregnancy, childbirth, termination of pregnancy, other pregnancy outcomes, miscarriage, miscarriage management, ectopic pregnancy, or recovery from any of these conditions or related conditions, contraception, and fertility treatment."

Covered Entities

The strength of nondiscrimination protections rely not just on the breadth of what discrimination is prohibited, but on *who* must comply with them. The statutory language of Section 1557 states that individuals shall not be discriminated against by "any health program or activity, any part of which is

receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments)."

The 2016 rule had interpreted this to include "the provision or administration of health-related services, health-related insurance coverage, or other health-related coverage, and the provision of assistance to individuals" in obtaining those services. The Obama Administration not only considered Section 1557 protections to apply to health insurance, they also interpreted the rule such that when an entity accepted federal financial assistance in one of its programs, the nondiscrimination protections would apply to the entity's *entire* operations. For example, if a health insurance company accepted Advanced Premium Tax Credits from members in one of its plans, the company would not be permitted to discriminate in *any* of its other offerings. The 2020 rule walked back these understandings. The Trump Administration determined that selling health insurance was *not* considered a health program/activity and thus could not, on that factor alone, subject an entity to comply with Section 1557. Furthermore, the Trump Administration promulgated a narrow understanding of Section 1557 compliance, such that if an entity is not principally engaged in providing health care and they accept federal financial assistance that would subject them to Section 1557, only the part of the entity accepting the federal financial assistance would need to comply, not the entire operation.

In the current proposed rule, the Biden Administration has returned to the 2016 rule's understanding of a covered entity (health insurers are considered health programs and activities). The proposed rule also reinstates the understanding that that the entirety of covered entity must comply with these nondiscrimination protections – not just the part accepting federal financial assistance.

Discriminatory Plan Design and Practices

The proposed rule also reinstates prohibitions on discriminatory plan designs that were in the 2016 rule, but eliminated in 2020, and adds new provisions to protect consumers in light of changing technology and health care delivery innovation.

- *Discriminatory plan design*

  The 2020 rule had eliminated sections prohibiting benefit designs and marketing practices that discriminate on the basis of race, color, national origin, sex, age, or disability. The proposed rule reinstates this protection, and specifically prohibits covered entities from "denying, cancelling, limiting, or refusing to issue or renew health insurance coverage or other health-related coverage, or denying or limiting coverage of a claim, or imposing additional cost sharing or other limitations or restrictions on coverage, on the basis of race, color, national origin, sex, age, or disability."

  In recognition of the need to strengthen protections against discrimination based on gender identity, the proposed rule adds new provisions that explicitly address benefit designs that impermissibly limit coverage based on a person's sex at birth, gender identity, or gender otherwise recorded, including, for example, imposing cost sharing or additional limitations/restrictions on services based on gender identity and categorically excluding gender affirming care. The proposed rule deviates slightly from the 2016 rule and prohibits a covered entity from applying any policy or practice of treating

individuals differently or separating them on the basis of sex "in a manner that subjects any individual to more than de minimis harm." This standard recognizes that there may be some legitimate bases for different treatment based on sex, but centers the inquiry on whether the practice harms an individual based on sex. Finally, the proposed rule makes it clear that Section 1557 does not require insurers to cover a particular service related to gender transition or gender affirming care if it is not otherwise covered. However, plans must ensure non-discriminatory administration of benefits.

With the exception of the specifics on discrimination based on gender identity, the rule does not explicitly define what constitutes a discriminatory benefit design or marketing practice, but provides some broad examples in the preamble and cross-references the examples of discriminatory benefit designs that were included in the Notice of Benefit and Payment Parameters for 2023 following advocacy from many in the HIV community. Additional examples of discriminatory benefit design or marketing practice can be found in the comments submitted on behalf of the Federal AIDS Policy Partnership's HIV Health Care Access Working Group.

- *Clinical Algorithms*

  The proposed rule adds a new section addressing growing concern about the use of algorithms in clinical decision making. The proposed rule states that a covered entity must not discriminate against any individual on the basis of race, color, national origin, sex, age, or disability through the use of clinical algorithms in its decision-making. The preamble to the rule cites several recent examples of clinical algorithms used to justify clinical decisions that harm Black enrollees and people living with disabilities, including over the course of the COVID-19 pandemic when jurisdictions operated under crisis standards of care. Studies have shown that these algorithms are sometimes based on incomplete data and that without a more nuanced individualized assessment, can lead to clinical decisions that systematically harm patients based on race and ethnicity. The preamble also notes that it is not the intention of HHS to prohibit use of algorithms. Rather, HHS notes that algorithms are not a substitute for clinical decision making and encourages providers to interrogate the underlying data assumptions used in clinical decision making algorithms and whether they are based on faulty, inaccurate, or harmful assumptions about race/ethnicity and other traits.

  CHLPI, the Disability Law Center, Disability Policy Consortium, the Center for Public Representation, and the RDMH Dialysis Patient Support Group submitted comments to HHS about the proposed rule's clinical algorithm provision. While supportive of the prohibition of discriminating through the use of clinical algorithms, we highlighted the need for clear and robust legal standards, along with dedicated financial and staff resources, so this provision can adequately and timely address discrimination in health care decision-making.

- *Telehealth*

  In recognition of the growing use of telehealth, particularly as a result of the COVID-19 pandemic, the proposed rule adds new provisions addressing telehealth and prohibiting discriminatory plan designs and practices specific to telehealth. The proposed rule imposes an affirmative duty on covered entities to not discriminate in their delivery of services through telehealth. The rule also requires telehealth to be accessible to individuals with disabilities and provide meaningful program access to limited English proficient (LEP) individuals.

Enforcement: Private Right of Action, Uniform Enforcement, and Disparate Impact

Since the original Section 1557 rule was finalized in 2016, a legal disagreement has unfolded regarding enforcement against covered entities found to be engaged in discrimination. Who is permitted to hold such bad actors to account? Can they be sued by the victims of discrimination in court (known as a "private right of action")? If so, what standards apply in these cases, especially given that Section 1557 references four separate civil rights statutes, each with its own body of court decisions? What rules should courts apply to determine liability, to discern causation for harm, or to determine what a plaintiff's burden of proof is?

In 2015, a federal court considered a case brought by Jakob Rumble, a transgender man from Minnesota who experienced sex discrimination at the hands of hospital staff. Writing before the Obama Administration had released the first final rule interpreting Section 1557, the judge concluded that by enacting Section 1557, Congress had created a new, uniform right to be free from discrimination in health care. She ruled that private litigants – such as Mr. Rumble – were permitted a private right of action to sue under the new law, and could claim any and all of the protections included in the referenced underlying civil rights laws. How else could a court decide cases of intersectional discrimination where the claimant experienced discrimination related to more than one protected status? The court concluded that "Congress intended to create a new, health-specific, anti-discrimination cause of action that is subject to a singular standard, regardless of a plaintiff's protected class status."

In the years since, this position has been questioned by other federal courts and dismissed by the Trump Administration. With regard to the question of whether a victim may bring a lawsuit in federal court to enforce Section 1557, the Trump Administration took no position. On the question of what rules to apply, the preamble to the 2020 final rule explicitly rejected the *Rumble* approach. It interpreted Section 1557 claims to be limited to the specific rules for whichever of the four individual civil rights statute related to the protected status claimed. Claims of sex discrimination, for example, would be subject to the rules for Title IX claims. Where intersectional claims are brought, the Trump Administration's rule concluded that "the Department analyzes the elements of each claim according to the statute applicable to that ground." As with much of the Trump Administration's rulemaking, this interpretation limited the protection afforded to victims of discrimination.

In the current proposed rule, the Biden Administration included a proposed section entitled "Enforcement Mechanisms." The preamble to the proposed rule cites a recent Supreme Court case to recognize that Section 1557 does indeed provide a "private cause of action" for victims of discrimination to seek enforcement in court. In *Cummings v. Premier Rehab Keller*, the Supreme Court ruled that a patient may sue in federal court for disability discrimination under the Rehabilitation Act and Section 1557. It was a Pyrrhic victory, however, as the Supreme Court passed this conclusion on its way to ruling that the same victim was not permitted to seek emotional distress damages for the injury she suffered as a result of the discrimination. Section 1557 – as interpreted by the Supreme Court – might represent the old legal maxim that a right without a remedy is no right at all.

The 2022 proposed rule does not mention the issue of *which* rules should apply in lawsuits arising from intersectional discrimination or any other actions. The effect of this silence is to leave in place the status

quo in which the *Rumble* court's view of a uniform enforcement standard is a minority position, unlikely to be implemented in the future. The only difference in the 2022 proposed rule is that the enforcement mechanism regulation itself uses an "and" in listing the underlying civil rights statues; the statute itself, as well as both the 2016 and 2020 regulations, use "or" in that same spot. Whether that change is intentional or an oversight remains to be seen.

A parallel legal disagreement exists in the context of "disparate impact" liability under Section 1557. "Disparate impact" describes a method of proving that a policy is discriminatory without having to show intent. For example, where a government agency relies for its hiring and promotion on non-job related standardized testing methods that have been discredited as producing racially disproportionate results, disparate impact can be used to prove discrimination without a need to show specific intent by the testing authorities. In a 1985 Medicaid case, the Supreme Court assumed without deciding that disparate impact liability was possible for disability discrimination claims under the Rehabilitation Act, crafting a standard that inquires whether disabled individuals are denied "meaningful access" to benefits to which they are otherwise entitled. In 2021, the Supreme Court agreed to hear an HIV discrimination case that revisited this same question in the context of a Section 1557 disability discrimination claim. The parties agreed to withdraw the case from the Supreme Court shortly before it was argued, so the legal question of whether and how Section 1557 permits disparate impact liability remains unresolved.

HHS has offered its interpretation on this question before. The 2016 rule included a statement in its preamble that "OCR interprets Section 1557 as authorizing a private right of action for claims of disparate impact discrimination on the basis of any of the criteria enumerated in the legislation." Unsurprisingly, the Trump Administration changed course, withdrawing the disparate impact interpretation in favor of regulatory silence. "[T]o the extent any of the underlying statutes authorize disparate impact claims, this final rule will recognize such claims by virtue of its reliance on the governing statutes, regulations, guidance and case law applicable to such claims, without needing to delineate the availability or lack of availability of all possible claims in this final rule." Consistent with its other reversals of course, the Trump Administration undermined any freestanding effect that Section 1557 might have relative to prior civil rights laws. The outer limit of those preexisting laws defined the boundary of Section 1557's reach.

Noting that the Trump Administration removed examples of sex discrimination in the nature of disparate impact, the Biden Administration proposes to leave this omission in place. "The Department has determined not to include [the 2016] provision here as the Department believes it is important to preserve—and not expand—the longstanding treatment of disparate impact in the referenced statutes' implementing regulations." While this preserves the ability of federal agencies to seek disparate impact liability in some circumstances, private litigants will find no support in this interpretation. Optimists will view this proposal as the Biden Administration choosing to keep its powder dry for regulatory interpretations that do not stretch the language of Section 1557 in a way that many courts have condemned. Critics will characterize this omission as a missed opportunity to promote systemic reform efforts through the courts.

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The 2022 proposed rule has been a long time coming and breathes new life back into an ACA provision that has held much promise, but also attracted much controversy. The comment period for the proposed rule ended in early October, and now HHS is tasked with considering thousands of comments in the finalization of the new rule. Previous rulemaking suggests that we may not expect to see a new final rule until late summer 2023, and that a new final rule – like its predecessors in 2016 and 2020 – will be subject to litigation quickly. Until then, however, we operate under the 2020 rule (with some parts enjoined) and rely on the Biden Administration for robust enforcement of the law.

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Health Care in Motion is written by Robert Greenwald, Faculty Director; Kevin Costello, Litigation Director and Associate Director; Elizabeth Kaplan, Director of Health Care Access; Maryanne Tomazic, Clinical Instructor; Rachel Landauer, Clinical Instructor; and Suzanne Davies, Clinical Fellow. This issue was written with the assistance of Amy Killelea of Killelea Consulting.

*For further questions or inquiries please contact us at **chlpi@law.harvard.edu**.*

New Protections for People Who Need Abortion Care and Birth Control

Published: Sep 27, 2022

Bill package builds upon more than $200 million in state funding to create abortion.ca.gov, cover uninsured care, support providers, bolster security and more

SACRAMENTO – As other states throughout the country outlaw abortion and criminalize patients and doctors, California continues to lead the nation's fight for reproductive health care access and privacy.

Today, Governor Gavin Newsom signed additional bills into law to further protect people from legal retaliation and prohibit law enforcement and corporations from cooperating with out-of-state entities regarding lawful abortions in California, while also expanding access to contraception and abortion providers in California.

"An alarming number of states continue to outlaw abortion and criminalize women, and it's more important than ever to fight like hell for those who need these essential services. We're doing everything we can to protect people from any retaliation for accessing abortion care while also making it more affordable to get contraceptives," said Governor Newsom. "Our Legislature has been on the frontlines of this fight, and no other legislative body in the country is doing more to protect these fundamental rights – I'm proud to stand with them again and sign these critical bills into law."

The package signed today includes:

- **PROTECTIONS FROM CRIMINAL & CIVIL LIABILITIES:** AB 2223 by Assemblymember Buffy Wicks (D-Oakland) helps to ensure that pregnancy loss is not criminalized, prohibiting a person from being criminally or civilly liable for miscarriage, stillbirth, abortion, or perinatal death due to causes that occurred in utero.
- **KEEPS MEDICAL RECORDS PRIVATE:** AB 2091 by Assemblymember Mia Bonta (D-Oakland) prohibits a health care provider from releasing medical information on an individual seeking abortion care in response to a subpoena or request from out-of-state.
- **PROHIBITS COOPERATION WITH OUT-OF-STATE ENTITIES:** AB 1242 by Assemblymember Rebecca Bauer-Kahan (D-Orinda) prohibits law enforcement and California corporations from cooperating with out-of-state entities regarding a lawful abortion in California. It also prohibits law enforcement from knowingly arresting a person for aiding in a lawful abortion in California.
- **EXPANDS BIRTH CONTROL ACCESS:** SB 523 by Senator Connie Leyva (D-Chino) expands birth control access – regardless of gender or insurance coverage status – by requiring health plans to cover certain over-the-counter birth control without cost sharing. It also prohibits employment-related discrimination based on reproductive health decisions.
- **MORE HEALTH CARE PROVIDERS:** SB 1375 by Senate President pro Tempore Toni G. Atkins (D-San Diego) expands training options for Nurse Practitioners and Certified Nurse-Midwives for purposes of performing abortion care by aspiration techniques.

Governor Newsom signs legislation to advance California's leadership on reproductive health care access and privacy.

"During this unprecedented time, I'm grateful to the Governor and the California Legislature for taking critical measures to protect a woman's right to choose and to enshrine the right to reproductive freedom into California's constitution," said First Partner Jennifer Siebel Newsom. "No person should be denied access to contraceptive services and abortion care because of a lack of resources or a fear of retribution. And we will not accept the status quo of rendering women powerless to determine their own destiny. In California, we trust women, we believe in women, and we see their value beyond their reproductive capabilities."

"My colleagues and I saw the imminent danger headed for national abortion access more than a year ago and have spent every day since working to not only protect reproductive rights, but expand them. Our package of bills ensures that all Californians, and anyone who needs to come here, will receive the essential health care they need and the respect they deserve. Creating laws is like a marathon and today, we are only able to cross the finish line because of months of hard work, and leadership from the Legislative Women's Caucus and our partners on the California Future of Abortion Council." – Senate President pro Tempore Toni Atkins.

In addition to the bills detailed above, the Governor also signed into law:

- **AB 657 by Assemblymember Jim Cooper (D-Elk Grove):** Expedites licensure for health care practitioners that come to California to provide abortion care services.
- **AB 2626 by Assemblymember Lisa Calderon (D-Whittier):** Prohibits specified licensing boards from suspending or revoking a license solely for performing an abortion in accordance with the licensee's practice act.
- **AB 2205 by Assemblymember Wendy Carrillo (D-Los Angeles):** Requires Covered California plans to report annually the total amounts of funds collected in special accounts for abortion care which was established under the ACA to hold premium payment of $1 per member per month and from which claims for abortion care must be paid.
- **SB 1142 by Senator Anna Caballero (D-Merced) and Senator Nancy Skinner (D-Berkeley):** Requires the establishment of an abortion care services website and an evaluation of the Abortion Practical Support Fund.
- **SB 1245 by Senator Sydney Kamlager (D-Los Angeles):** Establishes a reproductive health pilot project in LA County to support innovative approaches and collaborations to safeguard abortion access.
- **AB 1918 by Assemblymember Cottie Petrie-Norris (D-Laguna Beach):** Creates the CA Reproductive Health Scholarship Corps to recruit, train and retain a diverse workforce of health care professionals who will provide reproductive health services in underserved areas of the state.
- **AB 2134 by Assemblymember Dr. Akilah Weber (D-San Diego):** Establishes the CA Reproductive Health Equity Program which will provide grants to providers who provide uncompensated care to patients with low-incomes and those who face other financial barriers.
- **AB 2586 by Assemblymember Cristina Garcia (D-Bell Gardens):** Establishes the CA Reproductive Justice and Freedom Fund to support CBOs in providing comprehensive reproductive/sexual health education, inclusive of abortion care, to disproportionately impacted communities.

The Governor previously signed SB 245 to eliminate cost-sharing for abortion services and AB 1666, which seeks to protect those in California from civil liability for providing, aiding, or receiving abortion care in the state.

“As extreme politicians across the country pursue personal political agendas seeking to restrict and criminalize people seeking and providing abortion services – essential health care that should be available to people where they live and when they want or need it – California is showing what is possible when leaders listen to experts, facts, science and from the people who are directly impacted,” said Jodi Hicks, President and CEO of Planned Parenthood Affiliates of California. “Patients and providers across California and the country are living in a state of fear and confusion as we collectively try to navigate this new post-Roe reality. Today’s bold and comprehensive actions provide reassurance to all that California is a Reproductive Freedom state and all are welcome to seek the care they want or need here in California.”

“California continues to take historic steps towards its promise to be a Reproductive Freedom state – not just protecting access to abortion care in the face of *Roe v. Wade* being overturned, but moving forward centering equity and expanding access to help people, regardless of where they call home, get the essential care they want or need here in California. This bill package, in addition to the $200+ million in new funding, will go a long way in helping people seeking care in California and the community organizations and providers already on the ground doing the work across the state. By signing this bill package, Governor Newsom is putting an exclamation mark on a year-long effort by California reproductive health, rights, and justice leaders and policymakers to prepare and respond to the U.S Supreme Court overturning 50 years of precedent and eliminating the federally protected right to abortion.” – Steering Committee of the California Future of Abortion Council.

“California is committed to upholding and expanding protections that ensure reproductive health care is a right and not a privilege. The legislative package signed into law today strengthens the budget actions taken by the Governor earlier this summer to protect and expand reproductive care in California, while also breaking down barriers that have caused historic inequities in access and the health outcomes of our most vulnerable communities,” said Secretary of the California Health & Human Services Agency, Dr. Mark Ghaly. “We stand ready to deliver on this vision of a Healthy California for All, which protects the health and wellbeing of anyone seeking critical reproductive services in California.”

These actions build upon California’s nation-leading actions to cut costs, expand access and strengthen protections for abortion care:

- Allocated more than $200 million to help pay for travel costs, cover uninsured care, support health care facilities and providers, bolster security and more.
- Signed legislation to help protect patients and providers in California from civil liability for providing, aiding or receiving abortion care in the state.
- Launched a new Multi-State Commitment to defend access to reproductive health care and protect patients and providers.
- Signed an executive order preventing medical records, patient data and other information from being shared by state agencies in response to inquiries or investigations brought by other states or individuals within those states looking to restrict abortion access, and declining to extradite any person in California sought by another state for lawful abortion services provided in California.
- Eliminating copays for abortion care services and signed into law a legislative package to further strengthen access and protect patients and providers.
- In November, California voters will have an opportunity to amend the state’s constitution to enshrine the right to an abortion following the introduction of a constitutional amendment by state leaders.

# # #

State of California—Health and Human Services Agency
California Department of Public Health

TOMÁS J. ARAGÓN, M.D., Dr.P.H.
Director and State Public Health Officer

GAVIN NEWSOM
Governor

Training HIV Test Counselors to Use Rapid Tests for HIV, Hepatitis C Virus (HCV), and Sexually Transmitted Infections (STIs) - Senate Bill 306 (Pan, Chapter 486, Statutes of 2021) Fact Sheet

I. Background

Senate Bill (SB) 306 (Pan, Chapter 486, Statutes of 2021) became law effective January 1, 2022. SB 306, among other provisions, expands the abilities of HIV test counselors to meet the needs of clients who are at risk for HIV, HCV, and/or STIs (referenced in SB 306 as sexually transmitted diseases or STDs). As part of efforts to make STD testing widely available across the state, California law now allows HIV test counselors, under specified conditions, to perform HIV, HCV, and/or STD tests if the tests are classified as waived under the federal Clinical Laboratory Improvement Act of 1988 (CLIA) [1]. HIV test counselors who perform CLIA-waived HIV, HCV, and/or STD tests in California must meet specific performance and training requirements.

SB 306 applies only to HIV test counselors and does not apply to licensed medical personnel allowed to perform CLIA-waived tests as part of their regular scope of practice.[2] These personnel already are permitted under California law to perform CLIA-waived HIV, HCV and/or STD tests. It also does not apply to non-licensed staff operating under the authority of the local public health laboratory director with 20 hours phlebotomy training and under specified requirements, who are already permitted to perform CLIA-waived rapid tests specifically for syphilis[3].

[1] U.S. Centers for Disease Control and Prevention. Waived Tests. Accessed June 5, 2022, at https://www.cdc.gov/labquality/waived-tests.html.

[2] Medical personnel allowed to perform CLIA-waived tests under California law include physicians and surgeons, nurse practitioners, physician assistants, pharmacists and pharmacy student interns, registered nurses, and, if certain conditions are met, licensed vocational nurses and medical assistants. (Business and Professions Code (BPC) 1206.5).

[3] California Department of Public Health, STD Control Branch. Syphilis Health Check Rapid Point-of-Care Syphilis Testing Fact Sheet and Frequently Asked Questions. Accessed March 27, 2022, at https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/SyphilisHealthCheckFAQ.pdf.

II. Key Provisions of SB 306

1. Training Requirements for HIV Test Counselors

HIV test counselors may perform CLIA-waived HIV, HCV, and/or STD tests if they meet the following training requirements (along with other requirements as specified):

- Have been trained by the California Department of Public Health (CDPH), Office of AIDS (OA) and are working in a HIV testing site funded by CDPH through a local health jurisdiction, or its agents OR
- Are working in an HIV testing site that meets both of the following criteria:
    - Utilizes HIV counseling staff who are trained by OA or its agents and
    - Has a quality assurance plan approved by the local health department in the jurisdiction where the site is located and has HIV testing staff who comply with the quality assurance requirements specified in Section 1230 of Title 17 of the California Code of Regulations OR
- New: Have completed a training course approved by CDPH OA.

2. Use of CLIA-Waived STD tests by HIV Test Counselors

HIV test counselors may perform CLIA-waived tests for HIV, HCV, and/or STDs if, in addition to other requirements, all the following conditions are met:

a) The performance of the test meets the requirements of CLIA.
b) The HIV test counselor has been trained and demonstrates proficiency in administering the HIV, HCV, or STD test.
c) New: The HIV counselor demonstrates sufficient knowledge of HIV, HCV, or STDs to provide appropriate counseling and referrals to patients for the test they are performing. (HSC 120917(a)(1) (A)–(a)(1)(C)).
d) New: Unless they are also certified as a limited phlebotomy technician, an HIV test counselor certified by CDPH OA or its training agents before January 1, 2022, and who will administer rapid STD tests, must be trained to perform STD tests pursuant to this section before performing a CLIA-waived STD test.

HIV test counselors may not:

- Perform other HIV, HCV, or STD tests that are not waived under CLIA, or
- Perform any other test waived under CLIA unless the counselor meets the statutory and regulatory requirements for performing that other test.

3. Performing Fingerstick to Withdraw Blood for an HIV, HCV, or STD Test

HIV test counselors may perform skin puncture (fingerstick) to withdraw blood for an HIV, HCV, or STD test if they meet all the following requirements:

a) Are working under the direction of a licensed physician and surgeon.[4]
b) Have been trained in administering rapid HIV, HCV, or STD tests and in universal infection control precautions as specified.
c) New: The HIV counselor shall not administer a rapid HIV, HCV, or STD test until they demonstrate proficiency in administering the test. (HSC 120917(a)(1)(D)).

4. Explaining Test Results and Offering Referrals for Follow Up Testing

Clients receiving CLIA-waived HIV, HCV, or STD testing and receiving preliminary positive or reactive results must be informed that the preliminary test result is indicative of the likelihood of HIV infection, HCV exposure, or other STD exposure and that the result may need to be confirmed by an additional more specific test.[5]

Clients receiving "indeterminate" or "positive" test results must be referred to a licensed health care provider whose scope of practice includes the authority to refer patients for laboratory testing for further evaluation.

III. Implementation of SB 306

As of September 2022, CDPH OA is working on putting training infrastructure into place for HIV test counselors to perform integrated, CLIA-waived HIV, HCV, and/or STD testing. For more information, please email OA.Prevention.Training@cdph.ca.gov and cc cdph.hep@cdph.ca.gov. While updated training infrastructure remains pending, see the Resources section below on pages 3-4 for the "Hepatitis C Testing - Frequently Asked Questions, 2022," which has information on how to access HIV/HCV training for HIV test counselors, and the STD Control Branch website, which has information on syphilis rapid testing and training.

IV. Resources

CDPH Guidelines

Office of AIDS HIV and HCV Testing Information

[4] HIV test counselors typically work or volunteer under the direction of the clinician who serves as the laboratory director for the HIV test site's CLIA certificate of waiver. For more information on CLIA certificates of waiver for HIV/HCV testing in non-healthcare settings, see the HCV Rapid Testing FAQs.
[5] For hepatitis C, more specific tests may include HCV ribonucleic acid (RNA) tests, which are used to detect HCV in the blood and to diagnose current HCV infection. For syphilis, diagnosis is made using both non-treponemal and treponemal serologic tests and should not be made on the basis of a single test result. Clinical history and symptoms are also needed when diagnosing and staging syphilis infections.

OCTOBER 2022

QUICK TAKE

PREPARING FOR THE END OF THE COVID-19 PUBLIC HEALTH EMERGENCY

COVID-19 FORCED THE RAPID SHUTDOWN of many health care services and caused numerous disruptions to our everyday lives. This led to new guidance and short-term financial support offered to state, local, and tribal governments via legislative and administrative actions. In January 2020, a federal public health emergency (PHE) was declared, enabling temporary flexibilities in federal programs and stimulating other actions. Since then, the PHE has been extended eleven times, most recently from October 13th, 2022 until January 11th, 2023. The COVID-19 PHE has facilitated the rapid adaptation of services delivery, better access to care, and improved outcomes and quality of life for many communities most impacted by HIV.

Vaccination, the availability of rapid tests, and antiviral treatments are helping to mitigate the spread of COVID-19. At various points, large disparities have been observed with Black, Latinx, American Indian/Alaska Native, and other racial/ethnic minorities when compared to white Americans, including lower vaccination rates and higher case rates, hospitalizations, and deaths. COVID-19's impact on racial/ethnic minorities follows patterns observed with HIV and now MPX (i.e., monkeypox). New initiatives implemented by the PHE improved many lives, but when it ends, the disappearance of these initiatives' impacts will be deeply felt.

MAINTAINING BENEFICIAL POLICIES AND PROTECTING COMMUNITIES

The loss of COVID-19 programs may exacerbate inequities in health. As we move further away from the initial crisis, HIV stakeholders should work to preserve beneficial policies and prepare for future health threats.

SUMMARY OF COVID-19 EMERGENCY RESPONSES

IMPACTED AREA	RESPONSES THROUGHOUT THE PUBLIC HEALTH EMERGENCY
HEALTHCARE IN FEDERAL PROGRAMS	• State use of Section 1135 waivers of the Social Security Act ensures individuals enrolled in federal healthcare programs **still have access to health care and ensures reimbursement of healthcare** providers, regardless of compliance with otherwise applicable requirements • The American Rescue Plan Act (ARPA) **provided enhanced premium subsidies** for individuals buying their own health care (these have been extended through 2025 as part of the Inflation Reduction Act) • The Families First Coronavirus Response Act (FFCRA) **increased the federal government's share of Medicaid payments** to all states since they have all agreed to both maintain continuous coverage for Medicaid beneficiaries and not impose eligibility limits or new administrative enrollment barriers • The CARES Act appropriated $90 million to **help Ryan White HIV/AIDS Program (RWHAP) recipients offer COVID-19 related health service needs** and strategically support RWHAP national technical assistance programs • The Public Health and Social Services Emergency Fund **allocated $100 million to HRSA's Health Center Program's grants**, aiming to improve health care for geographically isolated and economically or medically vulnerable individuals
COVID-19 TESTS, TREATMENTS, AND VACCINES	• Medicare, Medicaid, and CHIP **offered COVID-19 testing (including over-the-counter COVID-19 tests), testing-related services, and vaccinations without any cost-sharing** • Private insurance covered the same COVID-19 testing, services, and vaccinations without cost-sharing, and **providers were reimbursed at pre-negotiated or reasonable rates** • The ARPA provided states **funding for COVID-19 testing and diagnostics for the uninsured**, regardless of income, and **emergency care for low-income and undocumented individuals**
TELEHEALTH	• Medicare, Medicaid, CHIP, and states **instituted waivers so that providers could treat patients located in other states or in rural areas via telehealth** (i.e., distant site providers) • HHS waived **penalties for HIPAA violations** when using communications technologies for telemedicine • DEA-registered providers could **issue Rxs for controlled-substances without an in-person evaluation**

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SUMMARY OF COVID-19 EMERGENCY RESPONSES

IMPACTED AREA	RESPONSES THROUGHOUT THE PUBLIC HEALTH EMERGENCY
HOUSING	• The ARP **provided $22 billion in rental assistance, including $5 billion to support the unstably housed** • The CARES Act **provided $65 million** in Housing Opportunities for Persons With AIDS (HOPWA) funding **for grants to respond to COVID-19 and made it easier for these funds to be used by grantees** • HUD-issued waivers **allowed for public housing rent adjustments** due to lost jobs and income, **home inspections to be conducted remotely, delayed annual reexaminations** of family incomes, the **self-certification of income**, and **housing voucher usability extensions** • Over 43 states, D.C., and many cities instituted an eviction moratorium within their locale; the CDC also **issued a federal eviction moratorium to help curb the spread of COVID-19**
FUNDING FOR COMMUNITY BASED ORGANIZATIONS (CBOS)	• The ARPA **provided $7.6 billion** to supplement the one-time funding offered to **community health centers to enhance services and infrastructure** • The Paycheck Protection Program **offered SBA-backed loans to help businesses retain employees** • The FFCRA and the ARPA **offered paid leave tax credits to employers and child and dependent tax credits to individuals and families**

FEDERAL HEALTHCARE PROGRAMS

Guaranteeing that Medicaid coverage could not be dropped during the PHE was pivotal. When the PHE ends, many individuals and families will need to recertify their eligibility, which could lead to significant coverage disruptions and losses. Maintaining Medicaid coverage among people living with HIV is critical and will also minimize cost shifts onto the Ryan White HIV/AIDS Program. Current proposals to strengthen the stability of individuals' coverage include providing guaranteed Medicaid eligibility for longer periods (e.g., 12 full months); enabling eligibility determinations from other federal programs to simplify applying for and verifying eligibility for Medicaid and CHIP; and funding culturally appropriate and geographically oriented educational campaigns regarding other marketplace coverage options and navigation services for those who will lose Medicaid eligibility.

FUNDING FOR COMMUNITY BASED ORGANIZATIONS

Although challenged by COVID-19, many frontline HIV CBOs provided essential services in response to community needs. Staff and resources at these organizations are often stretched thin, and the barriers to successfully applying for funding and utilizing federal funds in a flexible and strategic manner can be overwhelming, especially for smaller and less resource-equipped organizations. New consideration should be given to ways to blend funding streams across federal HIV programs, streamline grant applications to reduce administrative burdens, and provide CBOs with funding to improve their technical capacity and services offered to staff to combat trauma and burnout.

COVID-19 TESTS, TREATMENTS, AND VACCINES

It is critical that vaccines, boosters, treatments, and antivirals remain available without regard to cost and that Congress authorizes the pivotal funding necessary to acquire additional amounts of these pandemic-suppression tools.

TELEHEALTH

The relaxation of federal and state policies allowed health systems to swiftly adopt telehealth services in the face of COVID-19. Telehealth has proven its utility; several (but not necessarily all) program flexibilities should be made permanent. Consideration should be given to retaining licensure requirement waivers as well as the ability to be reimbursed for telephonic and video telehealth visits.

HOUSING

The pandemic spotlighted a housing crisis that has been inadequately addressed. HIV stakeholders should continue pushing for increased funding for HOPWA and other low-income assistance programs. Modifications to housing policies that address affordability challenges and the lack of adequate housing supply must be prioritized as well.

LONGSTANDING INEQUITIES have exacerbated difficulties caused by the pandemic, especially for people living with HIV. Emergency responses to COVID-19 should motivate community stakeholders and policymakers to use experiences of this pandemic to enact enduring programs and policies that bolster community health and well-being.

TO LEARN MORE

The **Kaiser Family Foundation** offers numerous resources detailing responses to COVID-19 that have been implemented throughout the U.S., including one on the widespread impacts that the ending of the COVID-19 emergency declaration will have on people, which is available at https://bit.ly/3Pel80V.

O'NEILL INSTITUTE
FOR NATIONAL & GLOBAL HEALTH LAW
GEORGETOWN LAW

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This Quick Take was authored by **Landon Myers**.

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http://bit.ly/USHIVpolicyproject

AGN. NO.

MOTION BY SUPERVISORS HILDA L. SOLIS AND JANICE HAHN

November 1, 2022

Support for Proposition 1: Constitutional Right to Reproductive Freedom

The United States Supreme Court's decision in *Dobbs v. Jackson* wrongly held that the United States Constitution does not protect the right to abortion. Some states are now emboldened by this decision, passing legislation to limit and ban abortions. And while *Dobbs* did not impact the right to contraception, that right is clearly on the chopping block.

The State of California, however, guarantees the right to privacy for all Californians. That right is a cornerstone of the rights to abortion and contraception. However, while the California Supreme Court found that the right to privacy includes the right to make reproductive choices, the California Constitution does not expressly define what the right to privacy includes.

Proposition 1, which is before the voters this 2022 General Election, would amend the California Constitution to specify that the State of California cannot deny or interfere with a persons' reproductive freedom, extending to their fundamental right to an abortion and contraception. This amendment would enhance the public policy of the state by explicitly guaranteeing in the State Constitution what previously was a matter of case law. It will ensure that Californians can make personal medical decisions regarding reproductive rights with dignity and freedom from infringement.

WE, THEREFORE, MOVE that the Board of Supervisors proclaims its support for Proposition 1: Constitutional Right to Reproductive Freedom.

	MOTION
SOLIS	
KUEHL	
HAHN	
BARGER	
MITCHELL	

Legislative Affairs & Intergovernmental Relations

Los Angeles County

Legislative Update

October 14, 2022

Greetings,

Below is an update on legislative items of interest to the County of Los Angeles.

COUNTY ADVOCACY POSITIONS

On October 4, 2022, the Board of Supervisors took action on the following measures:

- SUPPORT HOUSE RESOLUTION 1400 (SPEIER) AND SENATE RESOLUTION 797 (MENENDEZ

  Send a five-signature letter in support of House Resolution (H.Res) 1400 (Speier), which calls for the U.S. and the international community to hold Azerbaijan accountable for war crimes against the Armenian people, to Congresswoman Jackie Speier with copies to the L.A. County Congressional Delegation. Additionally, send a five-signature letter in support of Senate Resolution (S.Res) 797 (Menendez), which expresses the Senate's condemnation of Azerbaijani forces' illegal and unprovoked assault on Armenian territory and insists upon the cessation of security assistance to Azerbaijan in accordance with Federal law, to Senators Menendez and Rubio, with copies to Senators Feinstein and Padilla. More details regarding this motion can be found here.

VIRTUAL TOWN HALL ON FENTANYL

On Tuesday, October 12, 2022 the County Department of Public Health hosted a Virtual Town Hall on Fentanyl. The recording can be viewed on YouTube and additional resources can be found at:

- Recoverla.org
- LAOD Prevention.org
- Talking to Parents and Youth
- Learn more about Naloxone

- SUPPORT THE RELEASE OF EYVIN HERNANDEZ

  Send a five-signature letter to President Biden, Vice President Harris, U.S. Secretary of State Blinken, and the L.A. County Congressional Delegation urging them to investigate the matter of Eyvin Hernandez' detainment in Caracas, Venezuela with urgency and do all that is necessary to ensure the well-being of Mr. Hernandez. More details regarding this motion can be found here.

- SUPPORT FOR THE WHITE HOUSE TALENT PIPELINE CHALLENGE AND THE EQUITY IN INFRASTRUCTURE PLEDGE

  Send a five-signature letter to the Biden-Harris Administration to sign onto the Talent Pipeline Challenge and collaborate with the Biden-Harris Administration on public communications and other steps necessary to effectuate the County's support and endorsement of the Challenge, including leveraging the work of the County's High-Road talent development pipeline and work of InfrastructureLA. Additionally, join the founding agencies in signing the Equity in Infrastructure Pledge by, among other things, taking the pledge on behalf of the County of Los Angeles and sending a five-signature letter to the Equity in Infrastructure Project (EIP) leadership, including the EIP Advisory Council, the White House, and the U.S. Department of Transportation, to support and endorse the pledge publicly. More details regarding this motion can be found here.

- COOLING STRATEGIES FOR PARKS

  Advocate for State and Federal funding to provide cooling strategies (including erecting shade structures, planting trees and installation of hydration stations) in parks in Fiscal Year 2022-23. More details regarding this motion can be found here.

INTRODUCING THE COUNTY'S NEWEST DEPARTMENTS

LOS ANGELES COUNTY
Aging & Disabilities Department

The Los Angeles County Aging & Disabilities Department (AD) is dedicated entirely to improving the lives and supporting the self determination of older adults, people with disabilities, and the County's diverse communities. Key resources include:

Virtual Older Adults Resource Hub - Access to food resources, caregiver services, legal assistance, supportive services, and additional information.

Local Community and Senior Centers - The County has 14 local community hubs to access in-person support, congregate meals, adult & youth programming, and more.

Disability Information and Access Line - Community members can call 888-677-1199 Monday-Friday to order free at-home covid-19 tests, and make vaccinations appointments.

Elder and Dependent Abuse Hotline - Access online or call 1-877-477-3645, 24 hours a day, 7 days a week to report abuse; reporting may be anonymous.

www.lacountyad.org

department of economic opportunity
COUNTY OF LOS ANGELES

The Los Angeles County Department of Economic Opportunity (DEO) oversees a broad portfolio of economic and workforce development programs and initiatives to increase economic self-sufficiency and mobility for local workers, particularly individuals from historically marginalized communities and populations, while ensuring a thriving and inclusive local business community and economy. Significant and ongoing DEO programs and services include:

America's Job Centers of California (AJCC) - DEO operates 19 AJCCs which offer job preparation, job training, paid work experiences, supportive services and job connections for workers, and recruitment and training, layoff aversion, hiring incentives and high road training partnerships for businesses.

Office of Small Business (OSB) - Housed in the East LA Entrepreneur Center, OSB offers resources and services that include 1:1 counseling, workshops, referrals for legal assistance and financing; certifications and preference programs for County contracting; and technical assistance in competing for other public contracting opportunities.

RENOVATE Façade Improvement Program - Supports efforts to revitalize commercial corridors by partnering with local small businesses in County unincorporated areas to enhance the appearance of commercial facades and street-facing buildings.

Youth@Work Elevate - This program is open to all LA County youth ages 17-24 who are current or former foster youth, justice-impacted, identify as LGBTQ+ or are currently or previously experiencing housing instability. Elevate provides youth with career mentorship; wrap-around supportive services; trauma-informed personal enrichment training; and 400 hours of paid work experience with employers in high growth sectors that are willing to commit to post-program employment. The second cohort of Elevate begins January 2023.

opportunity.lacounty.gov

LEGISLATIVE AFFAIRS RESOURCES

- County's Legislative Policies & Priorities
- Federal & State Legislation of Interest
- Contact Legislative Affairs

Chief Executive Office.

LEGISLATIVE AFFAIRS AND INTERGOVERNMENTAL RELATIONS
500 West Temple Street, Room 723
Los Angeles, California 90012

legislativeaffairs@ceo.lacounty.gov

https://ceo.lacounty.gov/legislative-affairs-and-intergovernmental-relations/

BUILDING THE RESISTANCE

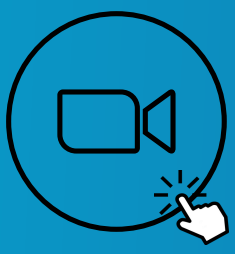
THE IMPACT OF SYSTEMIC RACISM AND MASS INCARCERATION ON HIV IN LOS ANGELES COUNTY

Wednesday, November 9, 2022
12:00pm-1:30pm PT

SEMINAR OBJECTIVES

1. **Describe how incarceration and interactions with law enforcement impact HIV/STI acquisition risk and treatment engagement.**
2. **Develop recommendations for improving partnerships and service integration in order to:**
   a. **Increase HIV/STI prevention, testing, and treatment engagement among people impacted by the criminal legal system and**
   b. **Reduce recidivism and improve diversion services for those affected by HIV.**
3. **Identify policy options and policy research priorities at the intersection of HIV and the criminal legal system.**

REGISTER AT bit.ly/buildresist



CE credits provided by the Pacific AIDS Education & Training Center Program Los Angeles Area.

Continuing Education
The Pacific AIDS Education and Training Center - Los Angeles Area is accredited to provide the following continuing education:

Continuing Nursing Education Credit: Course is approved for a maximum of 1.5 contact hours by the California Board of Registered Nursing. Provider #15484. Providers should claim only the credit commensurate with the extent of their participation in the activity. *Pharmacists registered in CA may use BRN CEs per their governing board.

Continuing LMFTs, LCSWs, LPCCs, and LEPs Education Credit Courses meet the qualification for a maximum of 1.5 hours of continuing education credit for LMFTs, LCSWs, LPCCs, and LEPs as required by the California Board of Behavioral Sciences. Provider #PCE 128280.

CHIPTS Center for HIV Identification, Prevention and Treatment Services
Watts healthcare a california health center
AETC AIDS Education & Training Center Program Pacific
iSTRIVE
Children's Hospital Los Angeles
Los Angeles Family AIDS Network
Dignity & Power NOW
ACO City of Los Angeles AIDS Coordinator's Office
HWE Healing With Hope

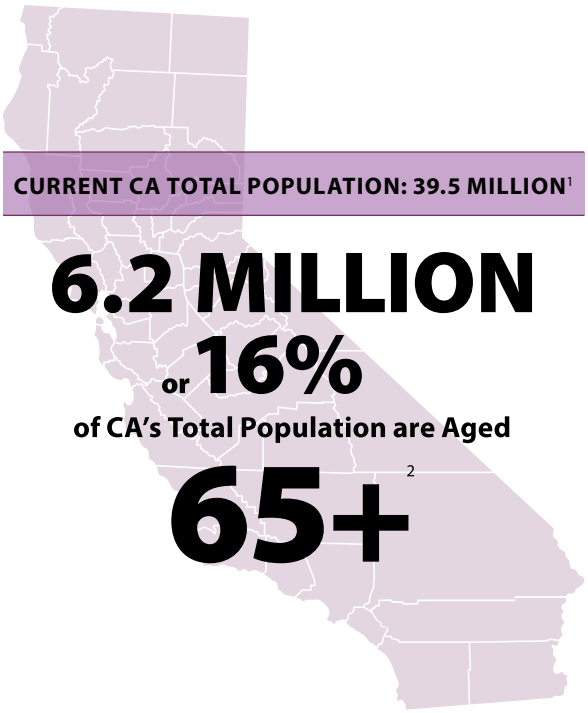
ITUP
Insure the Uninsured Project

» Fact Sheet

Transformation and Innovation: Advancing Health for California's Older Adults

OCTOBER 2022

Fast Facts



CURRENT CA TOTAL POPULATION: 39.5 MILLION[1]

6.2 MILLION
or 16%
of CA's Total Population are Aged
65+[2]

Figure 1: CA Health Insurance Enrollment Snapshot, 2022[3,4]

6.5 MILLION	3.2 MILLION	3.4 MILLION	1.5 MILLION
Total Medicare Enrollment	Medicare Advantage (MA)	Medicare Fee-for-Service (FFS)	Dual Eligibles (eligible for both Medicare & Medi-Cal)*

**Of the 6.5 million Medicare enrollees, 1.5 million are eligible for both Medicare and Medi-Cal.*

Figure 2: Race/Ethnicity of CA Medicare Members, 2020[2]

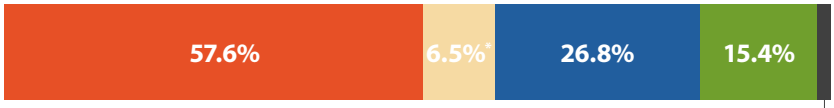
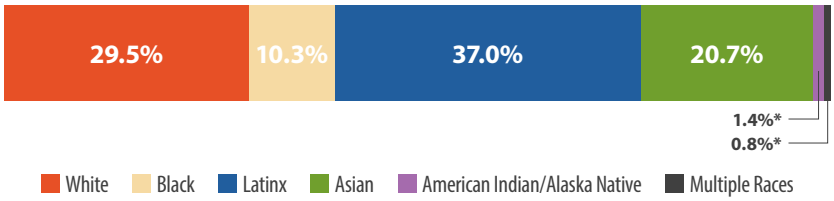


Figure 3: Race/Ethnicity of CA Dual Eligible Population, 2020[2]



Due to small sample size, there is no data available for the Native Hawaiian & Pacific Islander category.
**Data for race/ethnicity categories are considered statistically unstable.*

Figure 4: Income Breakdown by Percent of the Federal Poverty Level (FPL) Among Californians 65+ and Dual Eligibles, 2020[2]

	0-99% FPL	100-199% FPL	200-299% FPL	300% FPL and above
Californians 65+	10.7%	17.4%	14.3%	57.6%
Dual Eligibles	39.5%	39.5%	9.4%	11.7%

Figure 5: Social Drivers of Health (SDoH) Impacting Older Adults[5,6,7]

Californians Aged 65+ Years Experiencing Homelessness in 2021:
16,500*

California's Unhoused Population Aged 65+:
+108% increase between 2017 and 2020

CalFresh Enrollees Aged 60+ Years in 2021:
822,500*

**Note numbers are rounded to the nearest hundred.*

Master Plan for Aging (MPA)

California developed a Master Plan for Aging (MPA) to transform the health and well-being of the state's aging population. Learn more about stakeholder, public, and partner engagement with the MPA here.

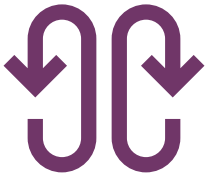
CURRENT SYSTEM:[8,9]

Complex

Fragmented

Uncoordinated

Siloed



Highlights of the MPA include:[10]

5
Bold Goals

Progress Tracking:
Data Dashboard for Aging

Local Stakeholders:
MPA Local Playbook

FIVE BOLD GOALS FOR 2030

GOAL ONE: Housing for All Stage & Ages
Live where we choose as we age in communities that are age-, disability-, and dementia-friendly and climate- and disaster-ready.

Target: Millions of New Housing Options to Age Well

GOAL TWO: Health Reimagined
Have access to services needed to live at home in our communities and to optimize our health and quality of life.

Target: Close the Equity Gap in and Increase Life Expectancy

GOAL THREE: Inclusion & Equity, Not Isolation
Have lifelong opportunities for work, volunteering, engagement, and leadership and will be protected from isolation, discrimination, abuse, neglect, and exploitation.

Target: Keep Increasing Life Satisfaction as We Age

GOAL FOUR: Caregiving That Works
Be prepared for and supported through the rewards and challenges of caring for aging loved ones.

Target: One Million High-Quality Caregiving Jobs

GOAL FIVE: Affording Aging
Have economic security for as long as we live.

Target: Close the Equity Gap in and Increase Elder Economic Sufficiency

What's Next: Implementing CalAIM

The California Advancing and Innovating Medi-Cal (CalAIM) is a multi-year initiative by the Department of Health Care Services (DHCS) to enhance care coordination and improve the quality of care provided to Medi-Cal members.

As part of CalAIM, services for dual eligibles will be delivered through a Managed Long-Term Services and Supports (MLTSS) and Dual Eligible Special Needs Plans (D-SNP) structure.

Dual Eligible Mandatory Enrollment in Medi-Cal Managed Care:
By January 1, 2023, CalAIM requires nearly all dual eligibles to receive their Medi-Cal benefits through Medi-Cal managed care plans.

Long-Term Care (LTC) Carve-In to Medi-Cal Managed Care: January 1, 2023, MCPs will be required to provide the full LTC benefit for freestanding and hospital-based skilled-nursing facilities (SNFs). July 1, 2023, MCPs will be required to provide the full LTC benefit at additional facility and home types, including intermediate care, intermediate care for the developmentally disabled, subacute, and pediatric subacute facilities. Currently, LTC benefits are provided by MCPs in the seven Coordinated Care Initiative (CCI) counties and in counties with a County-Organized Health Systems (COHS) MCP.

Population Health Management Initiative: On January 1, 2023, DHCS will launch the Population Health Initiative, a cohesive approach for keeping Medi-Cal members healthy, improving outcomes, and reducing disparities.

Medi-Medi Plans (MMPs), also known as Exclusively Aligned Enrollment Dual Eligible Special Needs Plans (EAE D-SNPs): January 1, 2023, CalAIM requires Medi-Cal managed care plans (MCPs) operating in the seven CCI counties to operate MMPs/EAE D-SNPs. MCPs in non-CCI counties must operate MMPs/EAE D-SNPs by January 1, 2026. Dual eligibles will be able to choose to receive their Medicare benefits through Medicare fee-for-service (FFS), regular Medicare Advantage (MA) plans, MMP/EAE D-SNPs, or Program for All-Inclusive Care for the Elderly (PACE) plans. If a dual eligible chooses to enroll in a MMP/EAE D-SNP, their Medi-Cal benefits will be delivered by the same MCP.

Managed Long-Term Services and Supports (MLTSS): CalAIM requires MLTSS (LTC and CBAS*) to be implemented in Medi-Cal managed care statewide by January 1, 2027.
**CBAS: Community-Based Adult Services*

Additional Transformational CalAIM Benefits and Services: Enhanced Care Management and Community Supports

Enhanced Care Management (ECM) is a Medi-Cal benefit available for members in Populations of Focus to provide in-person, intensive case management services for members with complex needs. Case managers help to navigate different systems of care and address both the clinical and non-clinical social needs of the highest-need members.

ECM Populations of Focus include:

- Individuals Experiencing Homelessness
- Individuals with Serious Mental Illness (SMI) or Substance Use Disorder (SUD)
- High Utilizers of Care
- Individuals Transitioning to the Community from Incarceration
- Children & Youth
- Individuals at Risk of LTC Institutionalization

Community Supports (CS): MCPs may choose to offer any or all of 14 CS that have been pre-approved by DHCS. These services, along with medical care services, are meant to comprehensively address a member's medical and social care needs.

CalAIM includes 14 DHCS-approved Community Supports

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Day Habilitation Programs
- Caregiver Respite Services
- Nursing Facility Transition/Diversion to Assisted Living Facilities
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Medically Supportive Food/Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

Key Considerations for Policymakers

1. How effective is CalAIM at comprehensively addressing the medical and social care needs of older adults and dual eligibles?
2. What are effective communication strategies for older adults and dual eligibles to prepare consumers for these changes and available benefits?
3. How will the state monitor ECM and CS use among dual eligibles and older adult Californians to ensure that services are accessible?
4. What other considerations outside of health care services and offered ECM and CS are needed to promote person-centered care and provide older adults and dual eligibles the best opportunity to live independently and healthily for as long as possible?

Key Terms

Direct Care Workers (DCWs): Essential workforce providing hands-on assistance with daily tasks and essential needs for older adults with disabilities.[11]

Independent Living Setting: When an individual has autonomy over their living situation, even if they cannot fully support themselves on their own. An independent living setting allows a person to make their own choices and pursue interests leading to a better quality of life.[12]

Institutional Long-Term Care: Refers to LTSS that are provided in a residential, live-in setting when a person can no longer live independently.[12]

Long-Term Services and Supports (LTSS): A broad range of medical and personal care assistance for those having difficulty completing tasks as a result of aging, chronic illness, or disability. Examples include home health assistance, adult daycare, and nursing home facilities.[12]

Person-centered Care: Integrated health care services delivered in response to the individual and their goals, values and preferences, in a system that empowers patients and providers to make effective care plans together.[13]

Skilled Nursing Facilities (SNFs): Designated by the Department of Public Health, these facilities provide 24-hour skilled care for chronic and short-term conditions that require medical, nursing care, and assistance for most or all activities of daily living.[14]

Policies and Programs

Area Agencies on Aging (AAAs): Local aging programs that provide a range of information and services for assistance for older adults and those who care for them; currently there are 33 for California.

Community-Based Adult Services (CBAS): A community-based health program providing daytime services to older adults and adults with chronic medical, cognitive, or behavioral health conditions and/or disabilities.

Dual Eligible Special Needs Plan (D-SNPs): A type of Medicare Advantage (MA) health plans which provide specialized care and wrap-around services for dual eligible beneficiaries (eligible for both Medicare and Medi-Cal). Medi-Medi Plans are the CA-specific name for EAE D-SNPs.

Health Homes Program (HHP): An optional Medi-Cal MCP benefit which integrates and coordinates care and LTSS for Medi-Cal enrollees with complex medical needs and chronic conditions. This program is being transitioned to similar benefits under CalAIM.

Home and Community-Based Services (HCBS): A program serving Medi-Cal members to receive services within their homes or communities.

In-Home Supportive Services (IHSS): A statewide program providing personal care and other services to enable Medi-Cal enrollees to remain safely in their homes as an alternative to longer-term facility-based care.[15]

Medi-Cal Managed Long-Term Services and Supports (MLTSS): Delivery of long-term services and supports through capitated Medi-Cal managed care programs.

Money Follows the Person (MFP): A Medicaid program that provides financial assistance so individuals who reside in nursing homes can move back into their homes. In California, this program is called the California Community Transitions (CCT) program which gives Medi-Cal members living in a facility the extra help they need to move from a medical facility to their own home. Federal funding for the CTT program has been extended through December 31, 2023.[16]

Multipurpose Senior Services Program (MSSP): Provides both social and health care management services to assist individuals remain in their homes and communities. MSSP provides on-going care coordination, links participants to other needed community services and resources, coordinates with health care providers, and purchases some needed services that are not otherwise available to prevent or delay institutionalization.

Older Americans Act (OAA): Enacted in 1965, supports a range of home and community-based services, such as meals-on-wheels and other nutrition programs, in-home services, transportation, legal services, elder abuse prevention and caregivers' support. [17]

Older Californians Act (OCA): In 1980, the California Legislature authorized the California Department of Aging (CDA) as the single state agency responsible for administering the OAA within California. The OCA also defined the duties and functions of CDA as well as the state's 33 Area Agencies on Aging (AAAs).[18]

Program for All Inclusive Care for the Elderly Programs (PACE): A program that coordinates care for each participant enrolled based on their individual needs with the goal of enabling older adults to remain living in their current communities. For Duals, 100% of premiums are paid for; Medicare members over 55 years of age pay out-of-pocket for the Medi-Cal share of the premium for this program.

ENDNOTES

All decimals rounded to nearest tenth.

1. United States Census Bureau, 2020 Census Redistricting Data, Accessed: March 16, 2022.
2. UCLA Center for Health Policy Research, 2020 California Health Interview Survey, Public Use File, Accessed: August 5, 2022.
3. Centers for Medicare and Medicaid Services, Medicare Monthly Enrollment, 2022, Public Use File, Accessed: October 12, 2022.
4. Department of Health Care Services, Medi-Cal Certified Eligibles Data Table by County and Dual Status, July 2022, Accessed: October 12, 2022.
5. California Interagency Council on Homelessness, Homeless Data Integration System, January 2021 through September 2021, Accessed: August 24, 2022. Note: This data updates on a quarterly basis and is dependent on county reporting, thus data may adjust over time.
6. Justice in Aging, California's Older Low-Income Renters Face Unaffordable Rents, Driving Housing & Homelessness, July 2021, Accessed: August 5, 2022.
7. California Department of Social Services, CalFresh Data Dashboard, Demographics General Population by Age Group, 2021, Accessed: August 5, 2022.
8. California Health Care Foundation, Medi-Cal Explained Fact Sheet: Long-Term Services and Supports in Medi-Cal, Accessed August 24, 2022.
9. California Health Care Foundation, Meeting the Moment: Strengthening Managed Care's Capacity to Serve California's Seniors and Persons with Disabilities, Accessed: August 24, 2022.
10. California For All, Master Plan of Aging, Accessed: August 24, 2022.
11. The Commonwealth Fund, The Invisible COVID Workforce: Direct Care Workers for Those with Disabilities, Accessed: August 24, 2022.
12. United Healthcare Community and State, Long-Term Services and Supports Glossary, Accessed: August 23, 2022.
13. Centers for Medicare & Medicaid Services, Innovation Center Key Concepts, Accessed: September 28, 2022.
14. Centers for Medicare and Medicaid Services, Glossary, Accessed: August 24, 2022.
15. California Advocates for Nursing Home Reform, In Home Support Services Factsheet, Accessed: August 24, 2022.
16. American Council on Aging, Money Follows the Person Programs, Accessed: August 24, 2022.
17. Administration for Community Living, Older Americans Act, Accessed: August 24, 2022.
18. California Department of Aging, Older Californians Act Cheat Sheet, Accessed: August 24, 2022.

About ITUP

ITUP is an independent, nonprofit, health policy institute that has been a central voice in the California health policy landscape for more than two decades. ITUP serves as a trusted expert, grounded in statewide and regional connections with a network of policymakers, health care leaders, and stakeholders. The mission of ITUP is to promote innovative and workable policy solutions that expand health care access and improve the health of all Californians.

ITUP is generously supported by the following funders:

- The SCAN Foundation
- California Community Foundation
- California Health Care Foundation
- The California Endowment
- The California Wellness Foundation

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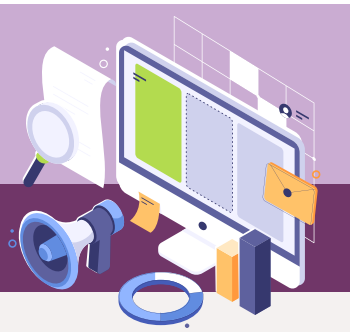
POLICY TOOLKIT

ITUP Insure the Uninsured Project

OCTOBER 2022

HEALTHY AGING IN CALIFORNIA



THIS TAILORED POLICY TOOLKIT combines the wide array of California initiatives and resources that support the physical health, independent living, and quality of life for older adults and people living with disabilities. It contains hyperlinks to help seamlessly navigate between the state agencies, programs and initiatives, policy plans, engagement opportunities, and additional resources that create California's healthy aging policy landscape.

ITUP Publications

- Transformation and Innovation: Advancing Health for California's Older Adults
- Medicare and Health for Aging Californians Fact Sheet
- CalAIM Summary and Timeline (2022 Update)
- 2022 Regional Health Coverage Fact Sheets
- ITUP Blog: California's Final 2022-23 Budget

California State Departments Administering Aging Services

- California Health and Human Services (CalHHS)
- California Department of Aging (CDA)
- California Department of Health Care Services (DHCS)
- DHCS Office of Medicare Innovation and Integration (OMII)
- California Department of Health Care Access and Information (HCAI)
- California Department of Social Services (CDSS) Adult Services
- California Department of Public Health (CDPH)
- California Department of Developmental Services (DDS)

Long-Term Care Facility and Service Regulators

- CDA Skilled Nursing Facilities
- CDSS Community Care Licensing Division
- CDPH Licensing and Certification Program

Aging Fast Facts ››

California 2020 Total Population: 39.5 million[1]

By **2030**, California's population ages 60 and over is expected to:

Total 11.1 million, or 26% of CA's Population[2]

1 in 4 CA Medicare Members

are eligible for both Medicare and Medi-Cal, known as "dual eligibles" or "Medi Medis," for a total of **1.5 million** or **23% of all CA Medicare members**[3,4]

2022 Health Insurance Enrollment Snapshot[4]

- Total Medicare Enrollment: 6.5 million (16% of the state)
  - Medicare Advantage (MA): 3.2 million
  - Medicare Fee-for-Service (FFS): 3.4 million

28.1% of CA adults 65+ live below their local county cost of living threshold in 2020[5]

1.4% of CA adults 65+ reside in nursing facilities/ skilled nursing facilities in 2020[2,6]

Explore more Aging Data through the Master Plan for Aging's Data Dashboard.

FEDERALLY-APPROVED MEDICAID WAIVER INITIATIVES

1915(c) Home and Community-Based Services (HCBS) Waivers

- DHCS: AIDS Medi-Cal Waiver Program
- DHCS: Assisted Living Waiver (ALW)
- DHCS Home and Community-Based Alternatives (HCBA) Waiver
- DDS: HCBS Waiver for the Developmentally Disabled (HCBS-DD) Waiver
- DHCS/CDA: Multipurpose Senior Services Program (MSPP)
- DDS: Self-Determination Program

Integration of the Home & Community-Based Alternatives Waiver and the Assisted Living Waiver

1115 & 1915(b) CalAIM Waivers

- Long-Term Care Carve-In Transition
- Enhanced Care Management and Community Supports

General Aging & Long-Term Care Services

- CDSS In Home Supportive Services (IHSS) Program
- CDA Agencies on Aging
- DHCS Caregiver Resource Centers (CRCs) & Locations
- CDA Family Caregiver Services

Programs for Medicare/Med-Cal Dual Eligible Members

- DHCS Program of All-Inclusive Care for the Elderly (PACE) & FAQs
- DHCS Senior Care Action Network (SCAN) Health Plan
- DHCS The Future of Cal MediConnect
- DHCS Dual Eligible Special Needs Plans in California
- DHCS Integrated Care for Dual Eligible Beneficiaries

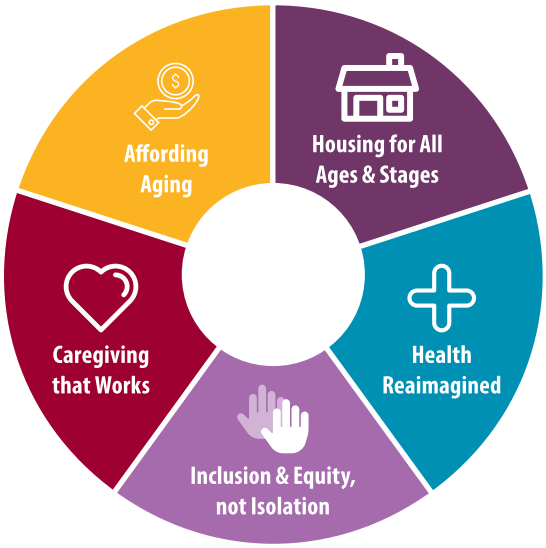
California Aging Policy Plans

- January 2021 Master Plan for Aging (MPA)
- MPA's First Annual Progress Report (January 2022)
- 2021-25 Older Americans Act (OAA) State Plan
- 2021-22 Enacted State Budget: Master Plan for Aging Investments
- CDA 2022-23 Budget Briefing Presentation and Recording

Data and Equity in Aging Policy: Learn More

- DHCS February 2022 Profile of the California Medicare Population Report
- SCAN Foundation Building a Master Plan for Aging: Key Elements from States Planning for an Aging Population
- CHCF Long-Term and End-of-Life Care in California: Is California Meeting the Need?
- CHCF Publication: Using Data for Good: Toward More Equitable Home and Community-Based Services in Medi-Cal

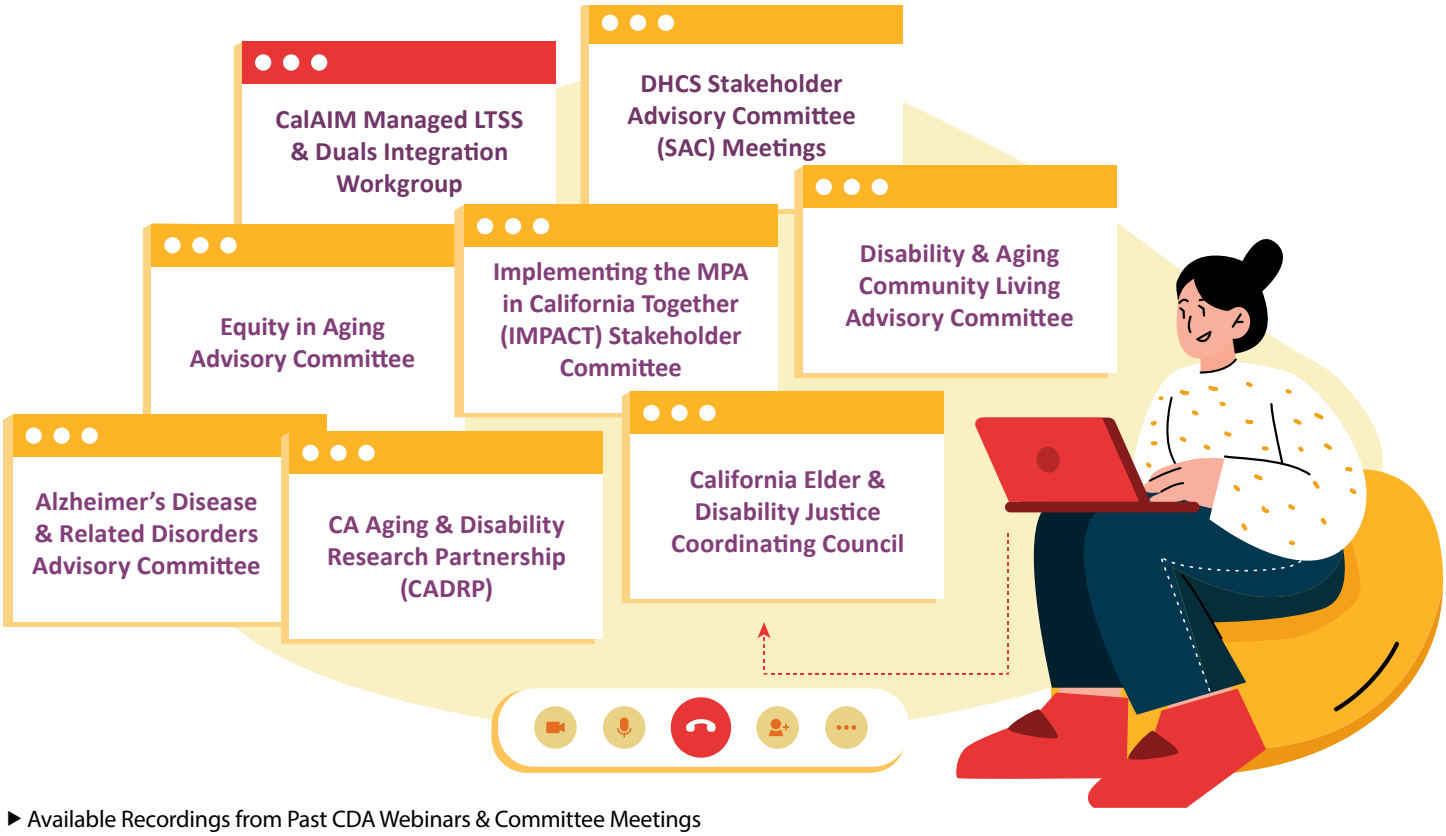
Master Plan for Aging: Five Bold Goals for 2030



Government Resources to Navigate California's Healthy Aging Policy Landscape

- Master Plan for Aging
- CalHHS Involvement in the Master Plan for Aging
- DHCS Seniors Information
- CalDuals
- DHCS Medi-Cal Long-Term Care Reimbursement
- DHCS Fast Facts and Other Long-Term Care Information
- National Institute on Aging
- Federal Administration on Aging

OPPORTUNITIES TO ENGAGE WITH AGING-RELATED STATE POLICYMAKING



▶ Available Recordings from Past CDA Webinars & Committee Meetings

Organizations Investing in California Aging Policy

- The SCAN Foundation
- California Collaborative for Long Term Services and Supports (CCLTSS)
- California Association of Healthcare Facilities
- California Association of Area Agencies on Aging
- California Future Health Workforce Commission
- West Health
- Weingart Foundation

Consumer Supports

- Medicare Counseling (HICAP)
- DHCS Medi-Cal Outreach & Enrollment for Older Californians
- DHCS California Partnership for Long-Term Care
- Federal Eldercare Locator
- CDA: A Consumer's Guide to Long-Term Care

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3. Department of Health Care Services, Medi-Cal Certified Eligibles Data Table by County and Dual Status, July 2022, Accessed: October 12, 2022.
4. Centers for Medicare and Medicaid Services, Medicare Monthly Enrollment, 2022, Public Use File, Accessed: October 12, 2022.
5. UCLA Center for Health Policy Research, 2020 California Health Interview Survey, Public Use File, Accessed: August 29, 2022.
6. United States Census Bureau, 2020 American Community Survey 5-Year Estimates S2602, Accessed: August 29, 2022.