LOS ANGELES COUNTY
COMMISSION ON HIV

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# PUBLIC POLICY COMMITTEE

## EXTENDED MEETING

**Monday, May 6, 2024**
**1:00pm-3:30pm (PST)**

**Vermont Corridor**
**510 S. Vermont Ave. Terrace Conference Room TK11**
****Valet Parking: 523 Shatto Place, LA 90020****

Agenda and meeting materials will be posted on our website at http://hiv.lacounty.gov/Meetings

As a building security protocol, attendees entering the building must notify the parking attendant and security personnel that they are attending a Commission on HIV meeting to access the Terrace Conference Room (9th Floor).

**Members of the Public May Join in Person or Virtually.**
**For Members of the Public Who Wish to Join Virtually, Register Here:**
https://lacountyboardofsupervisors.webex.com/weblink/register/r9e8a17ffd692f5db8453251c026d841e
**To Join by Telephone:** +1-213-306-3065 U.S. Toll
**Password**: POLICY **Meeting ID/Access Code:** 2531 892 8574

**Notice of Teleconferencing Sites:**
Bartz-Altadonna Community Health Center
43322 Gingham Ave, Lancaster, CA 93535

Scan QR code to download an electronic copy of the meeting agenda and packet on your smart device. Please note that hard copies of materials will not be made available during meetings unless otherwise determined by staff in alignment with the County's green initiative to recycle and reduce waste. **If meeting packet is not yet available, check back 2-3 days prior to meeting; meeting packet subject to change. Agendas will be posted 72 hours prior to meeting per Brown Act.*

# together.

**WE CAN END HIV IN OUR COMMUNITIES ONCE & FOR ALL**

**Apply to become a Commission member at:**
**https://www.surveymonkey.com/r/COHMembershipApp**
**For application assistance, call (213) 738-2816 or email hivcomm@lachiv.org**

LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave., 14th Floor, Los Angeles CA 90020
MAIN: 213.738.2816 EML: hivcomm@lachiv.org WEBSITE: https://hiv.lacounty.gov

# AGENDA FOR THE REGULAR MEETING OF THE LOS ANGELES COUNTY COMMISSION ON HIV

## PUBLIC POLICY COMMITTEE

**MONDAY, MAY 6, 2024 | 1:00 PM – 3:30 PM**

510 S. Vermont Ave
Terrace Level Conference Room TK11
Los Angeles, CA 90020
Validated Parking: 523 Shatto Place, Los Angeles 90020

*For those attending in person, as a building security protocol, attendees entering form the first-floor lobby must notify security personnel that they are attending the Commission on HIV meeting in order to access the Terrace Conference Room (9th floor) where our meetings are held.*

**NOTICE OF TELECONFERENCING SITE:**
Bartz-Altadonna Community Health Center
43322 Gingham Ave, Lancaster, CA 93535

**MEMBERS OF THE PUBLIC:**
To Register + Join by Computer:
https://lacountyboardofsupervisors.webex.com/weblink/register/r9e8a17ffd692f5db8453251c026d841e
To Join by Telephone: 1-213-306-3065 U.S. Toll
Password: POLICY Meeting ID/Access Code: 2531 892 8574

| Public Policy Committee Members: | | | |
|---|---|---|---|
| Katja Nelson, MPP *Co-Chair* | Lee Kochems, MA *Co-Chair* | Alasdair Burton | Mary Cummings |
| Felipe Findley, PA-C, MPAS, AAHIVS | Leonardo Martinez-Real | Paul Nash, PhD, CPsychol, AFBPsS, FHEA | Ricky Rosales |
| Ronnie Osorio *(Alternate)* | | | |
| QUORUM: 5 | | | |

**AGENDA POSTED:** May 1, 2024.

**SUPPORTING DOCUMENTATION:** Supporting documentation can be obtained via the Commission on HIV Website at: http://hiv.lacounty.gov or in person. The Commission Offices are located at 510 S. Vermont Ave., 14th Floor Los Angeles, 90020. Validated parking is available at 523 Shatto Place, Los Angeles 90020. ***Hard copies of materials will not be made available during meetings unless otherwise determined by staff in alignment with the County's green initiative to recycle and reduce waste.***

**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 here. 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.

## I. ADMINISTRATIVE MATTERS

| | | | |
|---|---|---|---|
| 1. | Call to Order & Meeting Guidelines/Reminders | | 1:00 PM – 1:03 PM |
| 2. | Introductions, Roll Call, & Conflict of Interest Statements | | 1:03 PM – 1:05 PM |
| 3. | Approval of Agenda | **MOTION #1** | 1:05 PM – 1:07 PM |
| 4. | Approval of Meeting Minutes | **MOTION #2** | 1:07 PM – 1:10 PM |

## II. PUBLIC COMMENT

1:10 PM – 1:15 PM

5. Opportunity for members of the public to address the Committee of items of interest that are within the jurisdiction of the Committee. For those who wish to provide public comment may do so in person, electronically by clicking here, or by emailing hivcomm@lachiv.org.

## III. COMMITTEE NEW BUSINESS ITEMS

1:15 PM – 1:20 PM

6. Opportunity for Committee 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

7. Executive Director/Staff Report 1:20 PM – 1:30 PM
   a. Operational and Programmatic Updates
   b. Draft Statement on Palestine | Understanding the Scope of COH's Functions
8. Co-Chair Report 1:30 PM – 1:40 PM

a. 2024 Workplan and Meeting Calendar—Updates
b. Act Now Against Meth and other Harm Reduction Initiatives—Updates

**V. DISCUSSION ITEMS**

10. 2024 Legislative Docket—Review 1:40 PM – 3:00 PM

**VI. DISCUSSION ITEMS CONT.**

11. 2023-2024 Policy Priorities 3:00 PM – 3:05 PM
12. State Policy & Budget—Updates 3:05 PM – 3:10 PM
13. Federal Policy-- Updates 3:10 PM – 3:15 PM
14. County Policy-- Updates 3:15 PM – 3:20 PM
    a. DPH Memo in response to STD Board of Supervisors (BOS) motion

**VII. NEXT STEPS** 3:20 PM – 3:25 PM

13. Task/Assignments Recap
14. Agenda development for the next meeting

**VIII. ANNOUNCEMENTS** 3:25 PM – 3:30 PM

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

**IX. ADJOURNMENT** 3:30 PM

16. Adjournment for the meeting of May 6, 2024.

| PROPOSED MOTIONS | |
|---|---|
| **MOTION #1** | Approve the Agenda Order as presented or revised. |
| **MOTION #2** | Approve the Public Policy Committee minutes, as presented or revised. |
| **MOTION #3** | Approve the 2023-2024 Legislative Docket, as presented or revised, and elevate to the Executive Committee for approval. |

# HYBRID MEETING GUIDELINES, ETTIQUETTE & REMINDERS

**(Updated 3.22.23)**

☐ This meeting is a **Brown-Act meeting** and is being recorded.

- The conference room speakers are *extremely* sensitive and will pick up even the slightest of sounds, i.e., whispers. If you prefer that your private or side conversations, not be included in the meeting recording which, is accessible to the public, we respectfully request that you step outside of the room to engage in these conversations.
- Turn off your ringers/notifications on your smart devices so as not to disrupt the meeting.
- Your voice is important, and we want to ensure that it is captured accurately on the record. Please be respectful of one another and minimize crosstalk.

☐ The **meeting packet** can be found on the Commission's website at https://hiv.lacounty.gov/meetings/ or accessed via the QR code provided. Hard copies of materials will not be provided in compliance with the County's green initiative to recycle and reduce waste.

☐ Please comply with the **Commission's Code of Conduct** located in the meeting packet

☐ **Public Comment** for members of the public can be submitted in person, electronically @ https://www.surveymonkey.com/r/public_comments or via email at hivcomm@lachiv.org. *For members of the public attending virtually, you may also submit your public comment via the Chat box. Should you wish to speak on the record, please use the "Raised Hand" feature or indicate your request in the Chat Box and staff will call upon and unmute you at the appropriate time. Please note that all attendees are muted unless otherwise unmuted by staff.*

☐ For individuals joining in person, to mitigate any potential streaming interference for those joining virtually, we respectfully ask that you **not simultaneously log into the virtual option of this meeting via WebEx.**

☐ Committee members invoking **AB 2449 for "Just Cause" or "Emergency Circumstances**" must communicate their intentions to staff and/or co-chairs no later than the start of the meeting. Members requesting to join pursuant to AB 2449 must have their audio and video on, at all times, and disclose whether there is a person over the age of 18 in the room in order to be counted toward quorum and have voting privileges. For members joining virtually due to "Emergency Circumstances", a vote will be conducted by the Committee/COH for approval.

☐ Members will be required to explicitly state their agency's **Ryan White Program Part A and/or CDC prevention conflicts of interest** on the record (versus referring to list in the packet). A list of conflicts can be found in the meeting packet and are recorded on the back of members' name plates, courtesy of staff.

LOS ANGELES COUNTY
COMMISSION ON HIV

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

*Presence at meetings is recorded based on the attendance roll call. Only members of the Commission on HIV (COH) are accorded voting privileges and must verbally acknowledge their attendance in order to vote. Approved meeting minutes are available on the COH's website; meeting recordings are available upon request.*

# PUBLIC POLICY COMMITTEE MEETING MINUTES

**Draft**

April 1, 2024

| COMMITTEE MEMBERS<br>P = Present \| A = Absent \|EA = Excused Absence | | | |
|---|---|---|---|
| Katja Nelson, MPP, Co-Chair | P | Paul Nash, PhD, CPsychol, AFBPsS, FHEA | P |
| Lee Kochems, MA, Co-Chair | P | Ricky Rosales | P |
| Alasdair Burton | P | Ronnie Osorio | A |
| Mary Cummings | A | | |
| Felipe Findley, PA-C, MPAS, AAHIVS | P | | |
| **COMMISSION STAFF AND CONSULTANTS** | | | |
| Cheryl Barrit, Lizette Martinez, and Jose Rangel-Garibay | | | |

*Some participants may not have been captured. 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 and agenda materials can be found on the Commission's website at https://hiv.lacounty.gov/public-policy-committee/**

## I. ADMINISTRATIVE MATTERS

1. **CALL TO ORDER & MEETING GUIDELINES/REMINDERS**
   The meeting was called to order at 1:03pm.
2. **INTRODUCTIONS, ROLL CALL, & CONFLICTS OF INTEREST STATEMENTS**
   Joseph Green, COH co-chair *pro tem*, led introductions and asked attendees to state their conflicts of interest.
3. **APPROVAL OF AGENDA**
   **MOTION #1:** Approve the Agenda Order as presented or revised. ***(Passed by consensus).***
4. **APPROVAL OF MEETING MINUTES**
   **MOTION #2:** Approve the February 5, 2024 Public Policy Committee minutes, as presented or revised. ***(Passed by consensus).***

## II. PUBLIC COMMENT

5. **OPPORTUNITY FOR MEMBERS OF THE PUBLIC TO ADDRESS THE COMMITTEE ON ITEMS OF INTEREST THAT ARE WITHIN THE JURISDICTION OF THE COMMITTEE. FOR THOSE WHO WISH TO PROVIDE PUBLIC COMMENT MAY DO SO IN PERSON, ELECTRONICALLY BY CLICKING HERE, OR BY EMAILING HIVCOMM@LACHIV.ORG.**

There were no public comments.

## III. COMMITTEE NEW BUSINESS ITEMS

**6. 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.**

There were no committee new business items.

## IV. REPORTS

**7. EXECUTIVE DIRECTOR/STAFF REPORT**

- Cheryl Barrit, Executive Director of COH, welcomed Leonardo Martinez-Real to the PPC. L. Martinez-Real shared they are happy to participate in the COH and added that he also serves in the UCLA Community Advisory Board.
- C. Barrit reported that the staff from the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) will conduct a site visit of the COH from May 21st 2024 thru May 23rd, 2024. The site visit will focus on a series of technical assistance modules aimed at improving COH operations and core functions. COH staff are compiling documents requested by HRSA/HAB in preparation for the site visit. COH staff will share more details with COH leadership as they become available.
  Paul Nash, PPC member, asked how often do site visits happen? C. Barrit noted that typically, they take place every 5 years however, HRSA/HAB can conduct an audit or site visit at any point when given appropriate notice. She added that this site visit is part of a pilot Technical Assistance program Ryan White Planning Councils; Los Angeles County was selected as one of the 6 pilot sites.
- C. Barrit reminded PPC members that the next COH meeting will take place on April 11, 2024 at the Martin Luther King Behavioral Health Center. The meeting agenda will be posted later this week.
- C. Barrit shared that COH staff are interested in getting a head start in planning the 2024 Annual Conference and requested for commissioners to join the Annual Conference planning committee. P. Nash, Katja Nelson, and Alasdair Burton volunteered to join the planning committee. C. Barrit will follow-up with more information for the kick-off meeting.

**8. CO-CHAIR REPORT**

**a. Draft 2024 Workplan and Meeting Calendar**

K. Nelson noted that the target date for item 3 on the workplan is not May 2024; the item will be completed in April 2024. See the meeting packet for a copy of the workplan document.

**b. Draft Statement on Palestine**

Katja Nelson and Lee Kochems, PPC co-chairs led a discussion on the draft statement on Palestine. The co-chairs noted that at the March PPC meeting, the PPC had discussed drafting a statement that relates to the work of the COH. Felipe Findley, PPC member, provided additional background for the statement in an attempt to answer the question "Why is this relevant for the COH to make a statement?". The PPC discussed the statement and the merit for the PPC and COH to make a statement on Palestine. C. Barrit noted that the statement is outside the purview of the COH and advised the PPC to reach consensus on how the PPC would like to proceed. The PPC decided to share the document with all PPC members and solicit revisions.

## V. DISCUSSION ITEMS

**9. 2023-2024 LEGISLATIVE DOCKET – UPDATES**

The Committee will review bill recommendations and hold their deliberations at the May 6, 2024 PPC meeting.

**10. 2024 POLICIES PRIORITY**

For 2024, the PPC will focus on policy issues related to sexual health, substance use, and housing. Jose Rangel-Garibay, COH staff, noted that the language in the preface section of the document was updated to express the ongoing impact the COVID-19 pandemic had on the HIV service delivery in Los Angeles County. The PPC approved the document and elevated it to the Executive Committee and the COH for review and approval.

**11. STATE POLICY & BUDGET UPDATE**

K. Nelson shared that the state budget deficit will be bigger than anticipated. The ETE will finalize their budget askes by March 20, 2024 and will meet in preparation for the "Day of Action" on April 23, 2024.

**12. FEDERAL POLICY UPDATE**

K. Nelson shared that Continuing Resolutions will be common this fiscal year and will monitor and changes to the 2024 federal budget.

**13. COUNTY POLICY UPDATE**

- **DPH Memo in Response to STD Board of Supervisors (BOS) Motions**
  K. Nelson will work with COH staff to encourage Commissioners to participate in BOS meetings when HIV-related items are on the meeting agenda.
- **2023 Public Comment Schedule for Health Deputies Meetings and BOS Meetings**
  C. Barrit has sent reminders to the PPC members that signed up to provide public comment. In the reminder, she includes the agenda for the BOS and Health Deputies meetings and a confirmation that the meeting is taking place.

## VI. NEXT STEPS

**14. TASK/ASSIGNMENTS RECAP**

- COH staff will send the draft statement on Palestine to Committee members and solicit feedback. The Committee will vote on the statement at their May meeting.
- PPC co-chairs will review the 2023-24 legislative docket in preparation for an extended meeting on May 6, 2024.

**15. AGENDA DEVELOPMENT FOR THE NEXT MEETING**

- Review and approve the 2023-24 Legislative Docket

## VII. ANNOUNCEMENTS

**16. OPPORTUNITY FOR MEMBERS OF THE PUBLIC AND THE COMMITTEE TO MAKE ANNOUNCEMENTS**

There were no announcements.

## VIII. ADJOURNMENT

**17. ADJOURNMENT FOR THE MEETING OF APRIL 1, 2024.**

The meeting was adjourned at 3:28pm.

LOS ANGELES COUNTY
COMMISSION ON HIV

# COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 4/12/24

In accordance with the Ryan White Program (RWP), conflict of interest is defined as any financial interest in, board membership, current or past employment, or contractual agreement with an organization, partnership, or any other entity, whether public or private, that receives funds from the Ryan White Part A program. These provisions also extend to direct ascendants and descendants, siblings, spouses, and domestic partners of Commission members and non-Commission Committee-only members. Based on the RWP legislation, HRSA guidance, and Commission policy, it is mandatory for Commission members to state all conflicts of interest regarding their RWP Part A/B and/or CDC HIV prevention-funded service contracts prior to discussions involving priority-setting, allocation, and other fiscal matters related to the local HIV continuum. Furthermore, Commission members must recuse themselves from voting on any specific RWP Part A service category(ies) for which their organization hold contracts. ***An asterisk next to member's name denotes affiliation with a County subcontracted agency listed on the addendum.***

| COMMISSION MEMBERS | | ORGANIZATION | SERVICE CATEGORIES |
|---|---|---|---|
| **ALVAREZ** | **Miguel** | No Affiliation | No Ryan White or prevention contracts |
| **ARRINGTON** | **Jayda** | Unaffiliated consumer | No Ryan White or prevention contracts |
| **BALLESTEROS** | **Al** | JWCH, INC. | HIV Testing Storefront |
| | | | HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV) |
| | | | STD Screening, Diagnosis, and Treatment |
| | | | Health Education/Risk Reduction (HERR) |
| | | | Mental Health |
| | | | Oral Healthcare Services |
| | | | Transitional Case Management |
| | | | Ambulatory Outpatient Medical (AOM) |
| | | | Benefits Specialty |
| | | | Biomedical HIV Prevention |
| | | | Medical Care Coordination (MCC) |
| | | | Transportation Services |
| **BURTON** | **Alasdair** | No Affiliation | No Ryan White or prevention contracts |
| **CAMPBELL** | **Danielle** | T.H.E. Clinic, Inc. | Ambulatory Outpatient Medical (AOM) |
| | | | Medical Care Coordination (MCC) |
| | | | Transportation Services |
| **CIELO** | **Mikhaela** | LAC & USC MCA Clinic | Biomedical HIV Prevention |
| **CONOLLY** | **Lilieth** | No Affiliation | No Ryan White or prevention contracts |
| **CUEVAS** | **Sandra** | Pacific AIDS Education and Training - Los Angeles | No Ryan White or prevention contracts |
| **CUMMINGS** | **Mary** | Bartz-Altadonna Community Health Center | No Ryan White or prevention contracts |
| **DAVIES** | **Erika** | City of Pasadena | HIV Testing Storefront |
| | | | HIV Testing & Sexual Networks |
| **DONNELLY** | **Kevin** | Unaffiliated consumer | No Ryan White or prevention contracts |

| COMMISSION MEMBERS | | ORGANIZATION | SERVICE CATEGORIES |
|---|---|---|---|
| **FERGUSON** | **Kerry** | ViiV Healthcare | No Ryan White or prevention contracts |
| **FINDLEY** | **Felipe** | Watts Healthcare Corporation | Transportation Services |
| | | | Ambulatory Outpatient Medical (AOM) |
| | | | Medical Care Coordination (MCC) |
| | | | Oral Health Care Services |
| | | | Biomedical HIV Prevention |
| | | | STD Screening, Diagnosis and Treatment |
| **FRAMES** | **Arlene** | Unaffiliated consumer | No Ryan White or prevention contracts |
| **FULLER** | **Luckie** | Invisible Men | No Ryan White or prevention contracts |
| **GERSH (SBP Member)** | **Lauren** | APLA Health & Wellness | Case Management, Home-Based |
| | | | Benefits Specialty |
| | | | Nutrition Support |
| | | | HIV Testing Social & Sexual Networks |
| | | | STD Screening, Diagnosis and Treatment |
| | | | Sexual Health Express Clinics (SHEx-C) |
| | | | Health Education/Risk Reduction |
| | | | Biomedical HIV Prevention |
| | | | Oral Healthcare Services |
| | | | Ambulatory Outpatient Medical (AOM) |
| | | | Medical Care Coordination (MCC) |
| | | | HIV and STD Prevention Services in Long Beach |
| | | | Transportation Services |
| | | | Residential Care Facility - Chronically Ill |
| | | | Data to Care Services |
| **GONZALEZ** | **Felipe** | Unaffiliated consumer | No Ryan White or Prevention Contracts |
| **GORDON** | **Bridget** | Unaffiliated consumer | No Ryan White or prevention contracts |
| **GREEN** | **Joseph** | Unaffiliated consumer | No Ryan White or prevention contracts |
| **HALFMAN** | **Karl** | California Department of Public Health, Office of AIDS | Part B Grantee |
| **HARDY** | **David** | LAC-USC Rand Schrader Clinic | No Ryan White or prevention contracts |
| **HERRERA** | **Ismael "Ish"** | Unaffiliated consumer | No Ryan White or prevention contracts |
| **KOCHEMS** | **Lee** | Unaffiliated consumer | No Ryan White or prevention contracts |
| **KING** | **William** | W. King Health Care Group | No Ryan White or prevention contracts |

| COMMISSION MEMBERS | | ORGANIZATION | SERVICE CATEGORIES |
|---|---|---|---|
| **MARTINEZ (PP&A Member)** | **Miguel** | Children's Hospital Los Angeles | Ambulatory Outpatient Medical (AOM) |
| | | | HIV Testing Storefront |
| | | | STD Screening, Diagnosis and Treatment |
| | | | Biomedical HIV Prevention |
| | | | Medical Care Coordination (MCC) |
| | | | Transportation Services |
| | | | Promoting Healthcare Engagement Among Vulnerable Populations |
| **MARTINEZ-REAL** | **Leonardo** | Unaffiliated consumer | No Ryan White or prevention contracts |
| **MAULTSBY** | **Leon** | Charles R. Drew University | Biomedical HIV Prevention |
| | | | HIV Testing Storefront |
| | | | HIV Testing Social & Sexual Networks |
| **MENDOZA** | **Vilma** | Unaffiliated consumer | No Ryan White or prevention contracts |
| **MINTLINE (SBP Member)** | **Mark** | Western University of Health Sciences (No Affiliation) | No Ryan White or prevention contracts |
| **MOLETTE** | **Andre** | Men's Health Foundation | Biomedical HIV Prevention |
| | | | Ambulatory Outpatient Medical (AOM) |
| | | | Medical Care Coordination (MCC) |
| | | | Promoting Healthcare Engagement Among Vulnerable Populations |
| | | | Sexual Health Express Clinics (SHEx-C) |
| | | | Transportation Services |
| | | | Data to Care Services |
| **MURRAY** | **Derek** | City of West Hollywood | No Ryan White or prevention contracts |
| **NASH** | **Paul** | University of Southern California | Biomedical HIV Prevention |

| COMMISSION MEMBERS | | ORGANIZATION | SERVICE CATEGORIES |
|---|---|---|---|
| **NELSON** | **Katja** | APLA Health & Wellness | Case Management, Home-Based |
| | | | Benefits Specialty |
| | | | Nutrition Support |
| | | | HIV Testing Social & Sexual Networks |
| | | | STD Screening, Diagnosis and Treatment |
| | | | Sexual Health Express Clinics (SHEx-C) |
| | | | Health Education/Risk Reduction |
| | | | Biomedical HIV Prevention |
| | | | Oral Healthcare Services |
| | | | Ambulatory Outpatient Medical (AOM) |
| | | | Medical Care Coordination (MCC) |
| | | | HIV and STD Prevention Services in Long Beach |
| | | | Transportation Services |
| | | | Residential Care Facility - Chronically Ill |
| | | | Data to Care Services |
| **OSORIO** | **Ronnie** | Center For Health Justice (CHJ) | Transitional Case Management - Jails |
| | | | Promoting Healthcare Engagement Among Vulnerable Populations |
| **PATEL** | **Byron** | Los Angeles LGBT Center | Ambulatory Outpatient Medical (AOM) |
| | | | HIV Testing Storefront |
| | | | HIV Testing Social & Sexual Networks |
| | | | STD Screening, Diagnosis and Treatment |
| | | | Health Education/Risk Reduction |
| | | | Biomedical HIV Prevention |
| | | | Medical Care Coordination (MCC) |
| | | | Promoting Healthcare Engagement Among Vulnerable Populations |
| | | | Transportation Services |
| **PERÉZ** | **Mario** | Los Angeles County, Department of Public Health, Division of HIV and STD Programs | Ryan White/CDC Grantee |
| **RICHARDSON** | **Dechelle** | AMAAD Institute | Community Engagement/EHE |
| **ROBINSON** | **Erica** | Health Matters Clinic | No Ryan White or prevention contracts |
| **ROSALES** | **Ricky** | City of Los Angeles AIDS Coordinator | No Ryan White or prevention contracts |
| **RUSSEL** | **Daryl** | Unaffiliated consumer | No Ryan White or prevention contracts |
| **SATTAH** | **Martin** | Rand Schrader Clinic<br>LA County Department of Health Services | No Ryan White or prevention contracts |

| COMMISSION MEMBERS | | ORGANIZATION | SERVICE CATEGORIES |
|---|---|---|---|
| **SAN AGUSTIN** | **Harold** | JWCH, INC. | HIV Testing Storefront |
| | | | HIV Testing & Syphilis Screening, Diagnosis, & inked Referral…(CSV) |
| | | | STD Screening, Diagnosis and Treatment |
| | | | Health Education/Risk Reduction |
| | | | Mental Health |
| | | | Oral Healthcare Services |
| | | | Transitional Case Management |
| | | | Ambulatory Outpatient Medical (AOM) |
| | | | Benefits Specialty |
| | | | Biomedical HIV Prevention |
| | | | Medical Care Coordination (MCC) |
| | | | Transportation Services |
| **SPENCER** | **LaShonda** | Oasis Clinic (Charles R. Drew University/Drew CARES) | Biomedical HIV Prevention |
| | | | HIV Testing Storefront |
| | | | HIV Testing Social & Sexual Networks |
| **STALTER** | **Kevin** | Unaffiliated consumer | No Ryan White or prevention contracts |
| **TALLEY** | **Lambert** | Grace Center for Health & Healing (No Affiliation) | No Ryan White or prevention contracts |
| **VALERO** | **Justin** | No Affiliation | No Ryan White or prevention contracts |
| **WEEDMAN** | **Jonathan** | ViaCare Community Health | Biomedical HIV Prevention |
| **YBARRA** | **Russell** | Capitol Drugs | No Ryan White or prevention contracts |

LOS ANGELES COUNTY
COMMISSION ON HIV

# 2024 TRAINING SCHEDULE

## SUBJECT TO CHANGE

- "*" Asterisk denotes mandatory training for all commissioners.
- All trainings are open to the public.
- Click on the training topic to register.
- Certifications of Completion will be provided.
- All trainings are virtual.

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|---|---|
| Co-Chair Roles and Responsibilities | February 13, 2024<br>4:00-5:00PM |
| General Orientation and Commission on HIV Overview * | March 26, 2024<br>3:00-4:30PM |
| Priority Setting and Resource Allocation Process & Service Standards Development * | April 23, 2024<br>3:00-4:30PM |
| Ryan White Care Act Legislative Overview Membership Structure and Responsibilities * | July 17, 2024<br>3:00-4:30PM |
| Policy Priorities and Legislative Docket Development Process | October 2, 2024<br>3:00-4:30PM |

LOS ANGELES COUNTY COMMISSION ON HIV

# 2024 WORK PLAN – PUBLIC POLICY COMMITTEE—ADOPTED

| Committee Name: **PUBLIC POLICY COMMITTEE (PPC)** | | | | |
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| Co-Chairs: Katja Nelson, Lee Kochems | | | Committee Adoption Date: 3/4/24 | |
| **Purpose of Work Plan**: To focus and prioritize key activities for COH Committees and subgroups for 2024 | | | | |
| **#** | **TASK/ACTIVITY** | **DESCRIPTION** | **TARGET DATE** | **STATUS/NOTES/OTHER COMMITTEES INVOLVED** |
| 1 | Review and refine 2024 workplan | COH staff to review and update 2024 workplan monthly | Ongoing, as needed | Workplan revised/updated on: 12/04/23, 01/04/24, 1/31/24, 2/29/24, 3/28/24, 4/30/24 |
| 2 | Develop 2023-2024 Legislative Docket and update as needed. | 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. | MAY 2024 | The COH staff will monitor bill status and update docket as needed. |
| 3 | Develop 2023-2024 Policy Priorities document and update as needed. | The Committee will revise the Policy Priorities document to include the alignment of priorities from Commission stakeholder groups | COMPLETE | The Committee will review and update their policy priorities document as needed. |
| 4 | Continue to advocate for an effective County-wide response to the STI crisis in Los Angeles County. | The Committee will review government actions that impact funding and implementation of sexual health and HIV services. Assess and monitor federal, state, and local government policies and budgets that impact HIV, STIs, Viral Hepatitis and other sexual health issues. | Ongoing | Track and monitor BOS correspondence website and BOS agenda items related to the County-wide response to the STI crisis in Los Angeles County. Commissioners are encouraged to provide public comments at BOS meetings. |
| 5 | Continue to advocate for an effective County-wide response to the Act Now Against Meth (ANAM) platform. | The Committee will review government actions that impact funding and implementation of sexual health and HIV services. Assess and monitor federal, state, and local government policies and budgets that impact activities under the ANAM platform. | Ongoing | Track and monitor BOS correspondence website and BOS agenda items related to the County-wide response to the ANAM platform. Commissioners are encouraged to provide public comments at BOS meetings. |
| 6 | Monitor and support Harm Reduction efforts in LA County and LA City | The Committee will review government actions that impact funding and implementation of harm reduction efforts in Los Angeles and Los Angeles County. | Ongoing | Track and monitor legislation related to the investment of Opioid settlement funds. |
| 7 | Efforts to Modernize the Ryan White Care Act (RWCA) | The Committee developed a policy brief outline. The policy brief will summarize key issues to address and include in a modernized RWCA legislation. | Postponed to 2025 | Committee co-chairs met with COH staff and determined to postpone the development of a white paper on RWCA modernization to 2025. |

LOS ANGELES COUNTY
COMMISSION ON HIV

2023-2024 Legislative Docket | Approval Date: Last approved by COH on 6/8/23. Updated 04/30/24.
**POSITIONS:** SUPPORT | OPPOSE | SUPPORT w/AMENDMENTS | OPPOSE unless AMENDED | WATCH

| BILL | TITLE | DESCRIPTION / COMMENTS | Recommended Position | STATUS |
|---|---|---|---|---|
| *AB 2007 (Boerner)* | *Establish Unicorn Homes Pilot Program* | *Establishes a 3-year pilot program—the Unicorn Homes Transitional Housing for Homeless LGBTQ+ Youth Program—to place unhoused LGBTQ+ youth with affirming volunteer host families and provide trauma-informed crisis intervention care, with the ultimate goal of reunification with the youth's family when possible.*<br><br>*https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB2007* | | *24-APR-24*<br><br>*Referred to Com. on APPR.* |
| *AB 2034 (Rodriguez)* | *Crimes: loitering for the purpose of engaging in a prostitution offense* | *This bill would make it a misdemeanor to loiter in a public place with the intent to commit prostitution, as defined, and make other conforming changes. By creating a new crime, this bill would impose a state-mandated local program.*<br><br>*https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB2034* | | *07-MAR-24*<br><br>*In Committee Hearing postponed.* |
| *AB 2523 (Patterson)* | *Needle and syringe exchange services* | *Existing law authorizes a clean needle and syringe exchange project in any city, county, or city and county upon the action of a county board of supervisors and the local health officer or health commission of that county, or upon the action of the city council, the mayor, and the local health officer in a city with a health department, or upon the action of the city council and the mayor of a city without a health department. Existing law requires the department to authorize the entity after consultation with local health officer and local law enforcement leadership and authorizes the department to reauthorize the program in consultation with local health officer and local law enforcement leadership.*<br><br>*This bill would instead authorize a clean needle and syringe exchange project in any city, county, or city and county that chooses to participate. The bill would instead require the department to authorize the entities to apply to the department after the approval from the participating city, county, or city and county, and would instead authorize the department to reauthorize the program with the approval of the participating city, county, or city and county. The bill would prohibit the department from authorizing a clean needle and syringe exchange project without the approval of the city, county, or city and county. This bill would require the department to send a written and an email notice to the affected city, county, or city and county. The bill would require the department to provide the biennial report to the city, county, or city and county.*<br>*https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB2523* | | *01-APR-24*<br><br>*Re-referred to Com. on HEALTH.* |

| BILL | TITLE | DESCRIPTION / COMMENTS | Recommended Position | STATUS |
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| *AB 2229 (Wilson)* | *California Healthy Youth Act: menstrual health education* | *This bill would include in the definition of "comprehensive sexual health education" the topic of menstrual health, defined to mean a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in relation to the menstrual cycle. The bill would that instruction and materials also teach pupils about the menstrual cycle, premenstrual syndrome and pain management, menstrual hygiene, menstrual disorders, menstrual irregularities, menopause, menstrual stigma, and any other relevant topics related to the menstrual cycle.* *https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB2229* | | *17-APR-24*<br><br>*In APPR Com. referred to suspense file.* |
| *AB 2258 (Zbur)* | *Health care coverage: cost sharing* | *This bill would prohibit a group or individual non-grandfathered health care service plan contract or health insurance policy issued, amended, or renewed on or after 1/1/2025, from imposing a cost-sharing requirement for items or services that are integral to the provision of preventive care services and screenings. The bill would require those contracts and policies to cover items and services for preventive care services and screenings, including home test kits for sexually transmitted disease and specified cancer screenings.* *https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB2258* | | *10-APR-24*<br><br>*Referred to Committee on APPR.* |
| *AB 2442 (Zbur)* | *Expedite Licensure for Gender-Affirming Care Providers* | *Expands the network of gender-affirming care providers in the state to improve accessibility of care by expediting licensure applications for health care providers who intend to provide gender-affirming health care or gender-affirming mental health care in California. This bill's provisions will be sunset on January 1, 2029.* *https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB2442* | | *25-APR-24*<br><br>*Read second time. Ordered to third reading.* |
| *AB 2498 (Zbur and Quirk-Silva)* | *Housing: the California Housing Security Act* | *This bill would establish the California Housing Security Program to provide a housing subsidy to eligible persons to reduce housing insecurity and help Californians meet their basic housing needs. The bill would require the Department of Housing and Community Development to establish a 2-year pilot program in up to 4 counties and to establish guidelines that include the amount of the subsidy necessary to cover the portion of a person's rent to prevent homelessness but shall not exceed $2,000 per month. Under the bill, the subsidy would not be considered income for purposes of determining eligibility or benefits for any other public assistance program, nor would participation in other benefits exclude a person from eligibility for the subsidy. Under the bill, an undocumented person, as specified, who otherwise qualifies for the subsidy would be eligible for the subsidy.* *https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB2498* | | *29-APR-24*<br><br>*Referred to Committee on APPR..* |

| BILL | TITLE | DESCRIPTION / COMMENTS | Recommended Position | STATUS |
|---|---|---|---|---|
| *AB 3031 (Lee and Low)* | *LGBTQ+ Commission* | *Establishes a statewide LGBTQ+ Commission representing California's diverse LGBTQ+ community to shine a light on the unique challenges LGBTQ+ people face, assess and monitor programs and legislation to address systemic barriers, and make recommendations to improve the health, safety, and well-being of LGBTQ+ Californians.* *https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB3031* | | *24-APR-24*<br><br>*In Com. APPR. Referred to suspense file.* |
| *SB 953 (Menjivar)* | *Medi-Cal: Menstrual products* | *This bill would add menstrual products as a covered benefit to the Medi-Cal schedule of benefits, subject to federal approval and federal financial participation. Requires DHCS to seek any federal approval necessary to implement this benefit. Defines "menstrual products" as a device for use in connection with a person's menstrual cycle.* https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB953 | | *08-APR-24*<br><br>*Placed on APPR suspense file.* |
| *SB 954 (Menjivar)* | *Sexual health: contraceptives* | *This bill requires all public high schools to make condoms available to students by the start of the 2025-26 school year and requires schools to provide information to students on the availability of condoms and other sexual health information. Prohibits public schools from preventing distribution of condoms or preventing a school-based health center from making condoms available and easily accessible to students at the school-based health center site. Prohibits from restricting sales of nonprescription contraception on the basis of age.* *https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB954* | | *25-APR-24*<br><br>*Referred to Committee on APPR.* |
| *SB 957 (Wiener)* | *Data collection: sexual orientation and gender identity* | *Requires the California Departments of Public Health (CDPH) to collect demographic data, including sexual orientation, gender orientation, and intersexuality (SOGI) data, from third parties on any forms of electronic data systems, unless prohibited by federal or state law. Adds SOGI to the information reported for the purpose of statewide or local immunization information systems. Requires CDPH to prepare an annual report concerning SOGI data.* *https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB957* | | *15-APR-24*<br><br>*April 15 hearing: Placed on APPR suspense file.* |
| *SB 959 (Menjivar)* | *Trans-inclusive care: resources and support services* | *Creates an online resource for transgender, gender non-conforming, and intersex (TGI) Californians and their families to combat misinformation and provide accurate information about access to trans-inclusive health care, existing legal protections for patients and providers, and other available support services.* *https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB959* | | *15-APR-24*<br><br>*April 15 hearing: Placed on APPR Suspense file.* |

| BILL | TITLE | DESCRIPTION / COMMENTS | Recommended Position | STATUS |
|---|---|---|---|---|
| *SB 990 (Padilla)* | *Office of Emergency Services: State Emergency Plan: LGBTQ+ individuals* | *Requires California to update the State Emergency Plan to include LGBTQ+ inclusive policies and best practices to ensure that LGBTQ+ people can access affirming services and resources before, during, and after an emergency or natural disaster.*<br><br>*https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB990* | | *24-APR-24*<br><br>*Referred to Committee on APPR.* |
| *SB 996 (Wilk)* | *Comprehensive Sexual health Education and 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 and HIV prevention education are made available at each school site and publicly posted on the school district's internet website or on a school district's parent or guardian portal.*<br>*https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB996* | | *29-APR-24*<br><br>*April 29 hearing: placed on APPR suspense file.* |
| *SB 1022 (Skinner)* | *Enforcement of Civil Rights* | *Enables the Civil Rights Department to investigate and prosecute long-running civil rights violations affecting groups or classes of people by making technical changes to the Fair Employment and Housing Act more effectively.*<br>*https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB1022* | | *26-APR-24*<br><br>*Set for hearing May 6.* |
| *SB 1278 (Laird)* | *World AIDS Day* | *This bill would require the Governor to annually proclaim December 1 as World AIDS day.*<br>*https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB1278* | | *24-APR-24*<br><br>*Read second time. Ordered to third reading.* |
| *SB 1290 (Roth)* | *Health care coverage: essential health benefits* | *This bill would sunset the Kaiser Foundation Health Plan Small Group HM 30 plan as CA's Essential Health Benefit benchmark for individual and small group health plan contracts and health insurance policies after the 2026 plan year.*<br>*https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB1290* | | *23-APR-24*<br><br>*Read second time. Ordered to third reading.* |

| BILL | TITLE | DESCRIPTION / COMMENTS | Recommended Position | STATUS |
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| *SB 1333 (Eggman and Roth)* | *Communicable diseases: HIV reporting* | *This bill authorizes the California Department of Public Health (CDPH) and local health departments (LHDs) to disclose personally identifying information in public health records of persons with HIV/AIDS for the coordination of, linkage to, or reengagement in care, as determined by CDPH or LHD. This bill removes certain limitations on disclosure, such as that disclosure is authorized only when certain coinfections are involved. The bill requires CDPH and LHD employees and their contractors to sign confidentiality agreements annually, rather than signing the agreements once, and deletes the requirement that CDPH and LHDs review the confidentiality agreements annually.* *https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB1333* | | *22-APR-24*<br><br>*April 22 hearing: Placed on APPR suspense file.* |
| *SB 1346 (Durazo)* | *Worker's compensation: aggregate disability payments* | *This bill allows the Worker's Compensation Appeals Board the discretion to extend the potential duration of temporary disability payments for up to 90 days if an injured employee prevails at a worker's compensation independent medical review.* *https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB1346* | | *22-APR-24*<br><br>*April 22 hearing: Placed on APPR suspense file.* |
| *SB 1368 (Bogh)* | *School curriculum: sexual health education and HIV prevention education: health framework: pregnancy centers* | *This bill would require the Instructional Quality Commission, when the Health Framework for California Public Schools is next revised after 1/1/2025, to include information on pregnancy centers as a resource in that health framework. Additionally, this bill would require the department to make information about pregnancy centers available on its internet website and would require pregnancy centers to be included by school districts in the above-described information about local resources.*<br><br>*https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240SB1368* | | *24-APR-24*<br><br>*April 24 set for first hearing. Failed passaged in committee.* |
| *AB 1487 (Santiago)* | *Public health: Transgender, Gender Variant, and Intersex Wellness Reentry Fund* | *Establishes the Transgender, Gender Variant, and Intersex (TGI) Wellness Reentry Fund in the State Treasury to fund grant programs focused on reentry programs to support TGI people who have experiences carceral systems.*<br><br>*https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB1487* | | *13-OCT-23*<br><br>*Approved by Governor.* |
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| ACA 8 (Wilson) | Slavery | This would prohibit slavery in any form, including forced labor compelled by the use or threat of physical or legal coercion.<br>**Follow-up questions regarding the phrasing:** The ACA removed "Involuntary servitude is prohibited except to punish a crime" from phrasing and added "Slavery in any form."<br>https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240ACA8 | Support with follow-up questions | 13-SEP-23<br>In Senate. To Com. on RLS for assignment. |

| BILL | TITLE | DESCRIPTION / COMMENTS | Recommended Position | STATUS |
|---|---|---|---|---|
| AB 4 (Arambula) | Covered California: Expansion | Requires Covered California to develop options for expanding access to affordable health care coverage to Californians regardless of immigration status and report these options to the Governor and Legislature.<br>**Follow-up questions regarding the phrasing:** Starting Jan. 2024, undocumented Californians 26-49 years of age will be eligible for full scope Medi-Cal coverage; however, undocumented Californians who earn too much money to qualify for Medi-Cal are excluded from being able to purchase coverage through Covered California since the federal Affordable Care Act did not extend eligibility to undocumented individuals. The Centers for Medicare and Medicaid Services would need to approve a 1332 waiver which would allow Covered California to offer coverage to undocumented immigrants.<br>https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB4 | Support with follow-up questions | 13-JUL-23<br><br>In Senate. Read second time and amended. Re-referred to Com. on APPR. |
| AB 598 (Wicks) | Sexual health education and HIV prevention education: school climate and safety: CA Health Kids Survey | This bill requires local educational agencies and charter schools to provide students participating in comprehensive sexual health education to receive physical or digital resources and administer the California Healthy Kids Survey in specified grades, related to sexual and reproductive health.<br><br>https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB598 | Support | 05-JUL-23<br><br>In Senate. Hearing canceled at the request of author. |
| AB 793 (Bonta) | Privacy: reverse demands | The bill bans reverse-location searches, which allow law enforcement agencies to obtain cell phone data about unspecified individuals near a certain location, and reverse-keyword searches, which allow law enforcement agencies to obtain data about unspecified individuals who used certain search terms on an internet website.<br><br>https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB793 | Support with Amendment | 30-JUN-23<br><br>In Senate. Hearing canceled at the request of author. |

| BILL | TITLE | DESCRIPTION / COMMENTS | Recommended Position | STATUS |
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| SB 427 (Portantino) | Health care coverage: antiretroviral drugs, devices, and products | Prohibits a non-grandfathered or grandfathered health plan contract or health insurance policy from imposing any cost-sharing or utilization review requirements for antiretroviral drugs, drug devices, or drug products that are either approved by the United States Food and Drug Administration (FDA) or recommended by the federal Centers for Disease Control and Prevention (CDC) for the prevention of HIV/AIDS. Prohibits a health plan or health insurer from subjecting ARVs that are either approved by the FDA or recommended by the CDC for the prevention HIV/AIDS, to prior authorization or step therapy, but authorizes prior authorization or step therapy if at least one therapeutically equivalent version is covered without prior authorization or step therapy and the insurer provides coverage for a noncovered therapeutic equivalent antiretroviral drug, device, or product without cost sharing pursuant to an exception request. Does not require coverage by an out-of-network pharmacy, unless in the case of an emergency or if there is an out-of-network benefit. Delays implementation of this bill for an individual and small group health plan contract or insurance policy until 1/1/2025<br><br>https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB427 | Watch | *26-FEB-24*<br><br>*From inactive file. Ordered to third reading.* |
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| AB 367 (Maienschein) | Controlled Substances: Enhancements | This bill, until 1/1/2029, applies the "great bodily injury" enhancement to any person who sells, furnishes, administers, or gives away fentanyl or an analog of fentanyl when the person to whom the fentanyl was sold, furnished, administered, or given suffers a significant or substantial physical injury from using the substance.<br>**Follow-up questions:** The bill applies a 3-year sentence enhancement. Provides that the enhancement does not apply to juvenile offenders.<br>https://leginfo.legislature.ca.gov/faces/billHistoryClient.xhtml?bill_id=202320240AB367 | Watch | *01-FEB-24*<br><br>*Filed with the Chief Clerk pursuant to Joint Rule 56.* |
| AB 1022 (Mathis) | Medi-Cal: Program of All-Inclusive Care for the Elderly | This bill, among other things relating to the Program of All-Inclusive Care for the Elderly (PACE) would require those capitation rates to also reflect the frailty level and risk associated with those populations. The bill would also expand an approved PACE organization's authority to use video telehealth to conduct all assessments, as specified.<br><br>https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB1022 | Support | *01-FEB-24*<br><br>*Filed with the Chief Clerk pursuant to Joint Rule 56.* |

| BILL | TITLE | DESCRIPTION / COMMENTS | Recommended Position | STATUS |
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| AB 1314 (Essayli and Gallagher) | Gender identity: parental notification | This bill would, notwithstanding the consent provisions described above, provide that a parent or guardian has the right to be notified in writing within 3 days from the date any teacher, counselor, or employee of the school becomes aware that a pupil is identifying at school as a gender that does not align with the child's sex on their birth certificate, other official records, or sex assigned at birth, using sex-segregated school programs and activities, including athletic teams and competitions, or using facilities that do not align with the child's sex on their birth certificate, other official records, or sex assigned at birth. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB1314 | Oppose | *01-FEB-24*<br><br>*Filed with the Chief Clerk pursuant to Joint Rule 56.* |
| AB 1431 (Zbur) | Housing: the California Housing Security Act | This bill would establish the California Housing Security Program to provide a housing subsidy to eligible persons to reduce housing insecurity and help Californians meet their basic housing needs. To create the program, the bill would require the Department of Housing and Community Development to establish a 2-year pilot program in up to 4 counties, as specified. The bill would require the department to issue guidelines to establish the program that include, among other things, the amount of the subsidy that shall be the amount necessary to cover the portion of a person's rent to prevent homelessness but shall not exceed $2,000 per month. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB1431 | Support | *01-FEB-24*<br><br>*Filed with the Chief Clerk pursuant to Joint Rule 56.* |
| AB 1549 (Carrillo) | Medi-Cal: federally qualified health centers and rural health clinics | This bill revises the prospective payment system (PPS) per-visit rate calculation to account for staffing and care delivery models for Medi-Cal services provided by Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) (collectively, health centers). https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB1549 | Support | *01-FEB-24*<br><br>*Filed with the Chief Clerk pursuant to Joint Rule 56.* |
| SB 36 (Skinner) | Out-of-state criminal charges: prosecution related to abortion, contraception, reproductive care, and gender-affirming care | This bill would prohibit the issuance of warrants for persons who have violated the laws of another state relating to abortion, contraception, reproductive care, and gender-affirming care, that are legally protected in California. The bill would also prohibit apprehending, detaining, or arresting a bail fugitive based on such offenses, and impose criminal and civil liability for doing so. In addition, the bill would restrict the sharing of information by law enforcement related to such protected activity and provide that convictions in other states would not result in ineligibility for state benefits. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB36 | Support | *01-FEB-24*<br><br>*Returned to Secretary of Senate pursuant to Joint Rule 56.* |

| BILL | TITLE | DESCRIPTION / COMMENTS | Recommended Position | STATUS |
|---|---|---|---|---|
| SB 37 (Caballero) | Older Adults and Adults with Disabilities Housing Stability Act | This bill establishes the Older Adults and Adults with Disabilities Housing Stability Pilot Program to provide housing subsidies to older adults and adults with disabilities who either are experiencing or at risk of experiencing homelessness, in up to five geographic regions or counties. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB37 | Support | *29-JAN-24*<br><br>*In Assembly. Held at Desk.* |
| SB 524 (Caballero) | Pharmacists: furnishing prescription medications | This bill authorizes a pharmacist to furnish medications to treat various diseases and conditions based on the results of a federal Food and Drug Administration test the pharmacist ordered, performed, or reported and adds these additional pharmacy services to the Medi-Cal schedule of benefits.<br><br>https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB524 | Support | *01-FEB-24*<br><br>*Returned to Secretary of Senate pursuant to Joint Rule 56.* |
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| AB 957 (Wilson) | Family law: gender identity | Requires a court to consider a minor's gender identity or gender expression when determining the best interest of the child, as specified.<br>**Governor's Veto Message:**<br>This legislation would require a court, when determining the best interests of a child in a child custody or visitation proceeding, to consider, among other comprehensive factors, a parent's affirmation of the child's gender identity or gender expression. I appreciate the passion and values that led the author to introduce this bill. I share a deep commitment to advancing the rights of transgender Californians, an effort that has guided my decisions through many decades in public office. That said, I urge caution when the Executive and Legislative branches of state government attempt to dictate - in prescriptive terms that single out one characteristic - legal standards for the Judicial branch to apply. Other-minded elected officials, in California and other states, could very well use this strategy to diminish the civil rights of vulnerable communities. Moreover, a court, under existing law, is required to consider a child's health, safety, and welfare when determining the best interests of a child in these proceedings, including the parent's affirmation of the child's gender identity.<br>https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB957 | Support | 22-SEP-23<br><br>Vetoed by Governor. |

| BILL | TITLE | DESCRIPTION / COMMENTS | Recommended Position | STATUS |
|---|---|---|---|---|
| AB 1060 (Ortega) | Health care coverage: naloxone hydrochloride (NH) | Requires coverage of prescription or nonprescription NH under a health plan contract or health insurance policy, and the Medi-Cal program and prohibits a them from imposing any cost-sharing requirements exceeding $10/package of NH or another drug approved by the U.S. Food and Drug Administration (FDA) for the complete or partial reversal of an opioid overdose.<br>**Governor's Veto Message:**<br>This bill would require health plans to cover prescription and over the counter naloxone and all other U.S. FDA approved drugs for opioid overdose reversal, with a maximum of $10 cost sharing. Combating the opioid crisis is one of my top priorities. I appreciate the author's shared commitment to this critical public health and public safety imperative. Together with the Legislature, we have invested more than $1 billion to combat overdoses, support those with opioid use disorder, raise awareness, and crack down on trafficking. Further, the 2023 Budget Act included $30 million for the CalRx Naloxone Access Initiative, to support partners in developing, manufacturing, procuring, and distributing a low-cost naloxone nasal product. While I support providing access to opioid antagonists to individuals with opioid use disorder or other risk factors, this bill would exceed the state's set of essential health benefits, which are established by the state's benchmark plan under the provisions of the federal Affordable Care Act. As such, this bill's mandate would require the state to defray the costs of coverage in Covered California. This would not only increase ongoing state General Fund costs, but it would set a new precedent by adding requirements that exceed the benchmark plan. A pattern of new coverage mandate bills like this could open the state to millions to billions of dollars in new costs to cover services relating to other health conditions. This creates uncertainty for our healthcare system's affordability. For these reasons, I cannot sign this bill.<br>https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB1060 | Support | 07-OCT-23<br><br>Vetoed by Governor. |

| BILL | TITLE | DESCRIPTION / COMMENTS | Recommended Position | STATUS |
|---|---|---|---|---|
| AB 1432 (Carrillo) | Health insurance: policy | This bill subjects an out-of-state policy, or certificate of group health insurance that is marketed, issued, or delivered to a Californian resident to specified provisions of the Insurance Core requiring coverage of abortion, abortion-related services, and gender-affirming care, regardless of the origin of the contract, subscriber, or master group policyholder.<br>**Governor's Veto Message:**<br>This bill would require any out-of-state health insurance plan regulated by the California Department of Insurance that is marketed, issued, or delivered to a California resident to provide coverage for abortion, abortion-related services, and gender-affirming care. I commend the author for working to provide additional assurances that California residents can access abortion services and gender affirming care. It is a priority of my Administration to ensure that abortion and gender-affirming care are safe, legal, and accessible. However, it is not evident that out-of-state health insurance plans serving Californians do not already cover this care. Further, though well intentioned, this bill could invite litigation where an adverse ruling would outweigh a potential benefit.<br>https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB1432 | Support | 07-OCT-23<br><br>Vetoed by Governor. |

| BILL | TITLE | DESCRIPTION / COMMENTS | Recommended Position | STATUS |
|---|---|---|---|---|
| AB 1645 (Zbur) | Health care coverage: cost sharing | Prohibits a large group health plan contract or health insurance policy issued, amended, or renewed on or after 1/1/2024, or an individual or small group contract or policy issued, amended, or renewed on or after 1/1/2025, from imposing a cost-sharing requirement for office visits of specified preventive care services and screenings and for items or services that are integral to their provision. Prohibits health plan contracts and insurance policies from imposing a cost-sharing requirement, utilization review, or other specified limits on a recommended sexually transmitted infections (STI) screening, and from imposing a cost-sharing requirement for any items and services integral to a STI screening, as specified. Requires a health plan or insurer to directly reimburse specified nonparticipating providers or facilities of STI screening, specified rates for screening tests and integral items and services rendered and prohibits the nonparticipating provider from billing or collecting a cost-sharing amount for a STI screening from an enrollee or insured.<br>**Governor's Veto Message:**<br>This bill would prohibit health plans from imposing cost sharing for specified preventive or screening services and associated office visits and would require plans to directly reimburse nonparticipating essential community providers for STI screenings and services. I appreciate the author's efforts to increase access to preventive health care, including HIV and STI testing, colorectal screening, and other services. However, components of this proposal depart from structures in federal and state law, such as the existing policies for reimbursement to non-contracted providers. Further, because this bill exceeds the cost-sharing provisions under the Affordable Care Act, it would result in increased costs to health plans passed on to consumers through premiums. The State must weigh the potential benefits of all new mandates with the comprehensive costs to the entire delivery system.<br>https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB1645 | Support | 07-OCT-23<br><br>Vetoed by Governor. |

| BILL | TITLE | DESCRIPTION / COMMENTS | Recommended Position | STATUS |
|---|---|---|---|---|
| SB 541 (Menjivar) | Sexual Health: contraceptives: Immunization | This measure seeks to address the sexually transmitted infection epidemic among California youth and improve equitable public health outcomes statewide by expanding teen access to condoms and the HPV vaccine.<br>**Governor's Veto Message:**<br>This bill requires all public high schools to make free condoms available to students and would prohibit retailers from refusing to sell condoms to youth. While evidence-based strategies, like increasing access to condoms, are important to supporting improved adolescent sexual health, this bill would create an unfunded mandate to public schools that should be considered in the annual budget process. In partnership with the Legislature, we enacted a budget that closed a shortfall of more than $30 billion through balanced solutions that avoided deep program cuts and protected education, health care, climate, public safety, and social service programs that are relied on by millions of Californians. This year, however, the Legislature sent me bills outside of this budget process that, if all enacted, would add nearly $19 billion of unaccounted costs in the budget, of which $11 billion would be ongoing. With our state facing continuing economic risk and revenue uncertainty, it is important to remain disciplined when considering bills with significant fiscal implications, such as this measure.<br>https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB541 | Support | 08-OCT-23<br>Vetoed by Governor. |
| | | | | |
| ACA 5 (Low) | Marriage Equality | This measure would express the intent of the Legislature to amend the Constitution of the State relating to marriage equality.<br>https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240ACA5 | Support | 20-JUL-23<br>Chaptered by Secretary of State. |
| AB 5 (Zbur) | The Safe and Supportive Schools Program | Requires the California Department of Education to complete the development of an online training curriculum and online delivery platform by 7/1/2025 and requires local educational agencies to provide and require at least one hour of training annually to all certificated staff, beginning with the 2025-26 school year through the 2029-30 school year, on cultural competency in supporting lesbian, gay, bisexual, transgender, queer, and questioning students.<br>https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB5 | Support | 23-SEP-23<br>Approved by Governor. |
| AB 223 (Ward) | Change of gender and sex identifier | This bill enhances protections for minors seeking changes of name or gender by making the proceedings presumptively confidential.<br>https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB223 | Support | 23-SEP-23<br>Approved by Governor. |

| BILL | TITLE | DESCRIPTION / COMMENTS | Recommended Position | STATUS |
|---|---|---|---|---|
| AB 254 (Bauer-Kahan) | Confidentiality of Medical Info. Act: reproductive or sexual health application info. | This bill includes "reproductive or sexual health application information" in the definition of "medical information" and the businesses that offer reproductive or sexual health digital services to consumers in the definition of a provider of health care for purposes of the Confidentiality of Medical Information Act. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB254 | Support | 27-SEP-23 Approved by Governor. |
| AB 352 (Bauer-Kahan) | Health Information | This bill limits the sharing of information related to sensitive services in electronic health records without specific authorization from the patient. This bill also requires a specified stakeholder advisory group to include providers of sensitive services and to identify policies and procedures to prevent electronic health information related to sensitive services form automatically being shared with individuals and entities in another state. **Follow-up questions regarding phrasing:** "Sensitive services" are gender affirming care, abortion and abortion-related services, and contraception. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB352 | Support with follow-up questions | 27-SEP-23 Approved by Governor. |
| AB 470 (Valencia) | Continuing medical education: physicians and surgeons | This bills specifies how an association that accredits continuing medical education courses taken by Medical Board of California licensed physicians and surgeons should update standards for those courses, if they choose to update any standards. https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202320240AB470 | Support | 07-OCT-23 Approved by Governor. |
| AB 760 (Wilson) | California State University and University of California: records: affirmed name and gender identification | This bill would require California State University (CSU) and requests the Regents of the University of California (UC), to implement a process by which students, staff, and faculty can declare an affirmed name, gender, or both name and gender identification to be used in records where legal names are not required by law. **Support w/Amendments:** Due to the constitutional autonomy of the UC system, the Donahue Higher Education Act, which governs postsecondary education in the State of California, does not apply to the UC system. As a result, a bill must request the UC Regents to make education code provisions applicable to the UC system. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB760 | Support with Amendments | 23-SEP-23 Approved by Governor. |
| AB 1078 (Jackson) | Instructional materials: removing instructional materials and curriculum: diversity | Makes various changes to the adoption of instructional materials for use in schools, including a provision that would prohibit a governing board form disallowing the use of an existing textbook, other instructional material, or curriculum that contains inclusive and diverse perspectives, as specified. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB1078 | Support | 25-SEP-23 Approved by Governor. |

| BILL | TITLE | DESCRIPTION / COMMENTS | Recommended Position | STATUS |
|---|---|---|---|---|
| AB 1163 (Luz Rivas) | Lesbian, Gay, Bisexual, and Transgender Disparities Reduction Act | This bill expands the data collection requirements in the Lesbian, Gay, Bisexual, and Transgender Disparities Reduction Act, to additionally apply to the State Department of State Hospitals, the Department of Rehabilitation, the State Department of Developmental Services, and the Department of Community Services and Development. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB1163 | Support | 13-OCT-23<br><br>Approved by Governor. |
| SB 339 (Wiener) | HIV preexposure prophylaxis and postexposure prophylaxis | This bill authorizes a pharmacists to furnish up to a 90-day course of preexposure prophylaxis (PrEP), or beyond 90-days if specified conditions are met and requires the Board of Pharmacy to adopt emergency regulations to implement these provisions by 7/1/2024. This bill requires a health care service plan and health insurer to cover PrEP and postexposure prophylaxis (PEP) furnished by a pharmacist, including costs for the pharmacist's services and related testing ordered by the pharmacist. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB339 | Support | *06-FEB-24*<br><br>*Approved by Governor.* |
| SB 372 (Menjivar) | Department of Consumer Affairs: licensee and registrant records: name and gender changes | This bill requires a board within the Department of Consumer Affairs to update licensee or registrant records with that individual's updated legal name or gender upon receiving government-issued documentation, as specified.<br><br>https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB372 | Support | 23-SEP-23<br><br>Approved by Governor. |
| SB 525 (Durazo) | Minimum wages: health care workers | This bill **(1)** enacts a phased in multi-tiered statewide minimum wage schedule for health care workers employed by covered healthcare facilities, as defined; **(2)** requires, following the phased-in wage increases, the minimum wage for health care workers employed by covered healthcare facilities to be adjusted, as SB 525; **(3)** provides a temporary waiver of wage increases under specified circumstances; **(4)** and establishes a 10-year moratorium on wage ordinances, regulations, or administrative actions for covered health care facility employees, as specified. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB525 | Support with Amendments | 13-OCT-23<br><br>Approved by Governor. |

| FEDERAL BILLS | | | | |
|---|---|---|---|---|
| **Bill** | **Title** | **Description / comments** | **Recommended position** | **Status** |
| H.R. 62 (Jackson Lee) | SHIELD Act | SHIELD = Safeguarding Healthcare Industry Employees from Litigation and Distress<br>This bill establishes a framework to limit interference with persons seeking to provide or access reproductive health services at the state level. The bill reduces the allocation of funds under certain law enforcement grant programs for a state that has in effect a law authorizing state or local officers or employees to interfere with persons seeking to provide or access reproductive health services. The bill authorizes civil remedies for a violation, including damages and injunctive relief. Additionally, it authorizes criminal penalties for a violation involving the use of deadly or dangerous weapon or the infliction of bodily injury.<br>https://www.congress.gov/bill/118th-congress/house-bill/62/actions?s=8&r=5&q=%7B%22search%22%3A%5B%22%5C%22reproductive+health%5C%22%22%5D%7D | SUPPORT | 09-Jan-23<br><br>Introduced in House. Referred to the Committee on Energy Commerce, and in addition to the Committee on the Judiciary. |
| H.R. 73 (Biggs) | No Pro-Abortion Task Force Act | This bill prohibits federal funding of the Reproductive Healthcare Access Task Force. The Department of Health and Human Services launched the task force on January 21, 2022, to identify and coordinate departmental activities related to accessing sexual and reproductive health care.<br>https://www.congress.gov/bill/118th-congress/house-bill/73?q=%7B%22search%22%3A%5B%22%5C%22reproductive+health%5C%22%22%5D%7D&s=8&r=7 | OPPOSE | 09-JAN-23<br><br>Introduced in House. Referred to Committee on Energy and Commerce. |
| H. Res. 185 (Hayes) | Declaring racism a public health crisis | This resolution declares racism a public health crisis and support efforts to address health disparities and inequities across all sectors.<br><br>https://www.congress.gov/bill/118th-congress/house-resolution/185/text?s=1&r=15&q=%7B%22search%22%3A%5B%22%5C%22HIV%5C%22%22%5D%7D | SUPPORT | 10-MAR-23<br><br>Referred to the Subcommittee on Health. |
| H.R. 407 (Clyde) | Protect the UNBORN Act | UNOBORN: Undo the Negligent Biden Orders Right Now<br>This bill prohibits federal implementation of and funding for specified executive orders that address access to reproductive care services, including services related to pregnancy or the termination of a pregnancy.<br>https://www.congress.gov/bill/118th-congress/house-bill/407?q=%7B%22search%22%3A%5B%22%5C%22reproductive+health%5C%22%22%5D%7D&s=8&r=6 | OPPOSE | 27-JAN-23<br><br>Introduced in House. Referred to the Subcommittee on Health. |
| H.R. 445 (Williams) | HHS Reproductive and Sexual | This bill creates a position within the Department of Health and Human Services to support access to reproductive and sexual health services (including services relating to pregnancy and the termination of a pregnancy) that are evidence-based and medically | SUPPORT | 27-JAN-23 |

| | | | | |
|---|---|---|---|---|
| | health Ombuds Act of 2023 | accurate. Functions of the position include **(1)** educating the public about medication abortions and other sexual and reproductive health services, **(2)** collecting and analyzing data about consumer access to and health insurance coverage for those services, and **(3)** coordinating with the Federal Trade Commission on issues related to consumer protection and data privacy for those services.<br>https://www.congress.gov/bill/118th-congress/house-bill/445?q=%7B%22search%22%3A%22%5C%22sexual+health%5C%22%22%7D | | Introduced in House. Referred to the Subcommittee on Health. |
| H.R. 459 (Eshoo)/ S. 323 (Hirono) | SAFER health Act of 2023 | SAFER: Secure Access For Essential Reproductive Health<br>This bill would ensure the privacy of pregnancy termination or loss under the HIPAA privacy regulations and the HITECH Act.<br>https://www.congress.gov/bill/118th-congress/house-bill/459/text?s=8&r=8&q=%7B%22search%22%3A%5B%22%5C%22reproductive+health%5C%22%22%5D%7D<br><br>https://www.congress.gov/bill/118th-congress/senate-bill/323/text?s=8&r=9&q=%7B%22search%22%3A%5B%22%5C%22reproductive+health%5C%22%22%5D%7D | SUPPORT | 09-FEB-23 |
| H.R. 517 (Mace) | Standing with Moms Act | This bill requires the Department of Health and Human Services (HHS) to disseminate information about pregnancy-related resources. Specifically, HHS must maintain a public website (life.gov) that lists such resources that are available through federal, state, and local governments and private entities.<br><br>The bill excludes from life.gov, the portal and the hotline resources provided by entities (1) perform, induce, refer for, or counsel in favor of abortions; or (2) financially support such entities. The bill also requires HHS to report on traffic to life.gov and the portal, gaps in services available to pregnant and postpartum individuals, and related matters.<br>https://www.congress.gov/bill/118th-congress/house-bill/517?q=%7B%22search%22%3A%5B%22%5C%22reproductive+health%5C%22%22%5D%7D&s=8&r=19 | OPPOSE | 03-FEB-23<br><br>Referred to the Subcommittee on Health. |
| H.R. 561 (Lee) | EACH Act of 2023 | This bill requires federal health care programs to provide coverage for abortion services and requires federal facilities to provide access to those services. The bill also permits qualified health plans to use funds attributable to premium tax credits and reduced cost sharing assistance to pay for abortion services.<br>https://www.congress.gov/bill/118th-congress/house-bill/561?q=%7B%22search%22%3A%5B%22%5C%22transgender%5C%22%22%5D%7D&s=8&r=8 | SUPPORT | 21-FEB-23<br><br>Referred to the Subcommittee on Indian and Insular Affairs |
| H.R. 1224 (Trahan) | INFO for Reproductive | INFO= Informing New Factors and Options<br>This bill requires the Department of Health and Human Services to carry out a campaign to educate health care professionals (and health care professions students) about | SUPPORT | 27-FEB-23 |

| BILL | TITLE | DESCRIPTION / COMMENTS | Recommended Position | STATUS |
|---|---|---|---|---|
| | Care ACT OF 2023 | assisting patients to navigate legal issues related to abortions and other reproductive health care services. https://www.congress.gov/bill/118th-congress/house-bill/1224?q=%7B%22search%22%3A%5B%22%5C%22reproductive+health%5C%22%22%5D%7D&s=8&r=4 | | Referred to the House Committee on Energy and Commerce. |
| *S. 3892* | *Community Health Worker Access Act* | *To amend XVIII and XIX of the Social Security Act to increase access to community health workers under the Medicare and Medicaid programs.* *https://www.congress.gov/bill/118th-congress/senate-bill/3892/text* | | 07-MAR-2024 Read twice and referred to the Committee on Finance. |
| *S. 644 (Markey)* | *Modernizing Opioid Treatment Access Act* | *This bill expands access to methadone for an individual's unsupervised use to treat opioid use disorder (OUD). The bill (1) waives provisions of the Controlled Substances Act that require qualified practitioners to obtain a separate registration from the Drug Enforcement Administration (DEA) to prescribe and dispense methadone to treat OUD, and (2) requires the Substance Abuse and Mental Health Services Administration and the DEA to jointly report on the waiver. Additionally, the bill directs the DEA to register certain practitioners to prescribe methadone that is dispensed through a pharmacy for an individual's unsupervised use. Qualified practitioners must be licensed or authorized to prescribe controlled substances, and they must either work for an opioid treatment program or be a physician or psychiatrist with a specialty certification in addiction medicine. Individuals who receive methadone for unsupervised use must continue to have access to other care through an opioid treatment program. https://www.congress.gov/bill/118th-congress/senate-bill/644* | | 01-FEB-2024 Placed on Senate Legislative Calendar under General Orders. |
| S. 701 (Baldwin) | Women's Health Protection Act of 2023 | To protect a person's ability to determine whether to continue or end a pregnancy, and to protect a health care provider's ability to provide abortion services. https://www.congress.gov/bill/118th-congress/senate-bill/701 | SUPPORT | 09-MAR-23 Placed on Senate Legislative Calendar under General Orders. |

**Footnotes:**

(1) Under Joint Rule 56, bills introduced in the first year of the regular session that do not become carry-over bills shall be returned to the Chief Clerk of the Assembly or the Secretary of the Senate.

**Notes:**

Items italicized in blue indicate a new status or a bill for consideration for inclusion in the docket.

**Transgender Caucus Recommendations/Feedback for the 2023-24 Legislative Docket**

| BILL | RECOMMENDED POSISTION | NOTES/COMMENTS |
|---|---|---|
| AB 2007 | SUPPORT | Who is doing the pilot? What is the selection process for the pilot sites/organizations? Priority should be given to<br>• Community Based Organizations that have existing housing programs versus starting new programs.<br>Housing for youth is a form of HIV prevention |
| AB 2034 | OPPOSE | What is the purpose of this bill? Will it help community?<br>• Interested in expanding solutions not punitive actions |
| AB 2523 | WATCH | Need more information on the impact this would have in LAC |
| AB 2442 | SUPPORT | |
| AB 3031 | SUPPORT | Recommend having the Commission consist of 50% TGI membership |
| SB 957 | SUPPORT | |
| SB 959 | SUPPORT | |
| SB 1022 | SUPPORT | |
| SB 1278 | SUPPORT | |
| AB 1487 | SUPPORT | |

# Assemblymember Tasha Boerner, 77th District

## AB 2007 Unicorn Homes Transitional Housing for Homeless LGBTQ+ Youth Program

*(As Introduced January 31, 2024)*

## SUMMARY

AB 2007 would, upon an appropriation by the Legislature, establish a three-year pilot project expansion of the Unicorn Homes Transitional Housing for Homeless LGBTQ+ Youth Program in up to five selected counties. LGBTQ+ centers within each county would administer the program to house eligible youth in LGBTQ+ affirming host homes.

## BACKGROUND

People who identify as LGBTQ+ and are experiencing homelessness have greater difficulty finding shelters that accept and respect them, and are often at a greater risk of assault, trauma, and early death compared to their heterosexual peers. Transgender people are particularly at risk due to a lack of acceptance and are regularly turned away from shelters.

In 2023, the US Department of Housing and Urban Development (HUD) reported that there are over 10,000 youth experiencing homelessness in California, accounting for 29 percent of the homeless youth population nationwide. According to the UCLA School of Law Williams Institute, 22 percent of youth experiencing homelessness across 22 US counties identify as LGBTQ+.

Additionally, Black, Indigenous, and People of Color (BIPOC) comprised a disproportionate share of the population experiencing homelessness. In 2020, Black people comprised 5.8 percent of California's population, but 30.7 percent of people experiencing homelessness. Rates of homelessness have also been increasing faster for BIPOC communities, with a 64.7 percent increase for Latinx Californians, and a 53.8 percent increase for Black Californians, both much greater than the 40.1 percent increase in overall homelessness in California.

People experiencing homelessness often have multiple co-occurring physical and mental health conditions, such as substance use disorders or physical disabilities. These conditions contribute to homelessness, but homelessness could also worsen conditions. Every day of housing instability and the associated stress represents a missed opportunity to support healthy development and transitions to productive adulthood.

Addressing the housing crisis is a key priority for the state, but there is no state housing program targeted directly at LBGTQ+ youth experiencing homelessness. Unicorn Homes is a program within the North San Diego County LGBTQ Resource Center that aims to provide crisis intervention and transitional housing to LGBTQ+ youth who are experiencing homelessness with an ultimate goal to reunite families whenever possible. Unicorn Homes is an alternative to the traditional group home setting by placing eligible youth with LGBTQ+ affirming volunteer host homes and provides paths to mental health resources, job readiness, life coaching, and independent living skills.

Similar programs, called Host Homes, exist at the San Diego LGBT Community Center and Sacramento LGBT Community Center that help house LGBTQ+ youth experiencing homelessness in LGBTQ+ affirming homes. Most programs provide some type of financial support to hosts to offset the costs associated with youth staying in their homes, critical to making Host Homes sustainable over time. But due to resource constraints and challenges attributed to the pandemic, the Host Homes program at the Sacramento LGBT Community Center had to end its operation, making the difficult decision to divert the funds from Host Homes, to continue operating their youth shelter.

There is a lag between the time housing production is funded, and when buildings open to provide services. Housing and shelter take time to build, and programs take time to hire and train staff. The Unicorn Homes program does not require the development of new built infrastructure, making it a low cost, flexible, and valuable stepping stone while youth wait for more permanent solutions.

Young adults want to be accepted and seen as holistic and valuable human beings with multidimensional identities and stories of both struggle and resilience. Unicorn Homes can help support state efforts to prevent and end homelessness among LGBTQ+ youth.

## EXISTING LAW

Existing law establishes homeless youth emergency service pilot projects in the City of Los Angeles and the City and County of San Francisco providing services to homeless minors, including food and access to an overnight shelter and counseling to address immediate emotional crises or problems.

Existing law also requires similar programs to be established in the Counties of San Diego and Santa Clara, and all of these programs to be operated by an agency in accordance with a grant award agreement with the Office of Emergency Services.

## THIS BILL

Specifically, AB 2007 would, upon an appropriation by the Legislature, establish a three-year pilot project expansion of the Unicorn Homes Transitional Housing for Homeless LGBTQ+ Youth Program, under the Department of Housing and Community Development, in up to five counties. The program would be administered by LGBTQ+ centers located within each county providing crisis intervention with a trauma-informed approach to house eligible LGBTQ+ youth in LGBTQ+ affirming host homes.

The centers would conduct background checks on the host families and provide annual reports to the Legislature on youth participation in the program.

## SUPPORT

- North County LGBTQ Resource Center (Co-sponsor)
- Equality California (Co-sponsor)
- California Legislative LGBTQ Caucus

## OPPOSITION

- None on file

## FOR MORE INFORMATION

Edwin Borbon, Legislative Director
(916) 319-2077 Office
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Date of Hearing: April 17, 2024

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Buffy Wicks, Chair
AB 2229 (Wilson) – As Amended April 8, 2024

Policy Committee: Education Vote: 7 - 0

Urgency: No State Mandated Local Program: Yes Reimbursable: Yes

**SUMMARY**:

This bill adds menstrual health to the instruction in comprehensive sexual health education students are to receive in grades seven through 12.

**FISCAL EFFECT**:

Unknown, one-time Proposition 98 General Fund costs, potentially in the tens of thousands of dollars to low hundreds of thousands of dollars, to schools for teacher training on including information about menstrual health as part of comprehensive sexual health education. Ongoing costs would likely be minimal once teachers are trained in the material. Costs would be lower to the extent this content is already provided by schools.

According to the California Department of Education, the state has about 1,000 full-time equivalent teachers assigned to health education. If 25% of these teachers received three hours of training at the rate of $70 per hour, costs would be about $50,000 statewide. If 100% of teachers received training, costs would be about $200,000 statewide.

If the Commission on State Mandates determines the bill's requirements to be a reimbursable state mandate, the state would need to reimburse these costs to schools or provide funding through the K-12 Mandate Block Grant.

According to the Legislative Analyst's Office, the General Fund faces a structural deficit in the tens of billions of dollars over the next several fiscal years.

**COMMENTS**:

1) **Purpose.** According to the author:

> Menstrual education is important because it will help pupils understand the naturally occurring role it plays in a healthy body and break the stigma surrounding menstruation. The stigma surrounding menstruation causes unnecessary shame, including body shaming, and prevents those menstruating from seeking medical advice when needed.

2) **Background.** Current law requires school districts to ensure students in grades seven to 12 receive comprehensive sexual health education. Current law defines comprehensive sexual health education as education regarding human development and sexuality, including

education on pregnancy, contraception, and sexually transmitted infections. This bill adds menstrual health to the definition of comprehensive sexual health education, therefore requiring schools to begin providing instruction in this area of health.

The state's Health Education Curriculum Framework is intended to assist schools in teaching comprehensive sexual health education, among other health topics. While schools are not required to use the framework, the framework makes several references to menstruation.

3) **Related Legislation.** AB 2053 (Mathis) requires schools to include additional information related to adolescent relationship abuse and intimate partner violence as part of comprehensive sexual health education. The bill is pending on the Assembly floor.

**Analysis Prepared by**: Natasha Collins / APPR. / (916) 319-2081


# AB 2258 (Zbur) – Protecting Access to Preventive Services

## SUMMARY

Every Californian deserves access to preventive health care that is comprehensive, inclusive, and affordable. AB 2258 would codify federal guidance requiring health plans and health insurers to cover services that are integral to the delivery of recommended preventive services without out-of-pocket cost.

## BACKGROUND

Out-of-pocket cost for preventive care is a barrier to care. A recent study found that as little as $10 in cost sharing for HIV prevention medication (PrEP) doubled the rate at which patients abandon their prescriptions, leading to a higher incidence of HIV infection in those patients.[1]

Federal guidance under the Affordable Care Act (ACA) requires health insurers and health plans to cover both recommended preventive care and health care that is integral to providing recommended preventive care ("integral services") without out-of-pocket cost to the consumer. Although California codified the ACA statute on preventive services, it has not codified the guidance pertaining to integral services.

On March 30, 2023, a federal judge in Texas struck down national protections for preventive care benefits under the ACA in *Braidwood Management Inc. v. Becerra*. If *Braidwood* is upheld by the Supreme Court, California law will still require coverage of recommended preventive care benefits. However, the federal guidance on covering integral services without cost sharing will be unenforceable, unless it is codified by California law. Consequently, health plans and insurers could require consumers to pay cost sharing for integral services for PrEP and other preventive care, such as colonoscopies, birth control, and screening for sexually transmitted infections (STIs).

## SOLUTION

AB 2258 would remove barriers to accessing zero-dollar preventive care by incorporating federal guidance on integral services into state law.

The bill codifies longstanding federal guidance that health plans and insurers must cover services that are integral to providing recommended preventive care – including anesthesia and polyp removal during a colonoscopy; placement, management, and removal of long-acting reversible contraceptives; and ancillary and support services for PrEP including HIV and other STI screening – without cost sharing.

Under AB 2258, integral services will remain covered without cost sharing, even if *Braidwood* is upheld.

[1] Dean *et. al.*, *Estimating The Impact Of Out-Of-Pocket Cost Changes On Abandonment Of HIV Pre-Exposure Prophylaxis*, Health Affairs Vol. 43 No.1 (Jan. 2024).

## SUPPORT

California Insurance Commissioner Ricardo Lara (Sponsor)
Equality California (Sponsor)
San Francisco AIDS Foundation (Sponsor)
Los Angeles LGBT Center (Sponsor)
APLA Health (Sponsor)

## FOR MORE INFORMATION

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# AB 2442 (Zbur) – Expedited Medical Licensure for Gender-Affirming Care

## SUMMARY

In response to growing efforts to restrict access to medically necessary gender-affirming care across the country, AB 2442 ensures that licensure applications for providers of gender-affirming care are prioritized to ensure a robust network of providers and timely access to care for both in-state and out-of-state patients.

## BACKGROUND

Gender-affirming care encompasses a range of services, including mental health care, medical care, and social services. These services are specifically designed to help transgender and non-binary people who experience symptoms of gender dysphoria – or distress that results from having one's gender identity not match their sex assigned at birth – live openly and authentically as their true selves.

Gender affirming care is supported by every major medical and mental health organization – including the American Medical Association, the American Academy of Pediatrics, and the American Psychological Association – and decisions to provide care are always made in consultation with doctors and parents.

In recent years, the number of states with laws or policies restricting access to gender-affirming care has increased dramatically – climbing from just four states in June 2022 to 23 states in January 2024.[1] These laws and policies often impose severe professional or criminal penalties on medical providers and other professionals offering gender-affirming care. The pervasive wave of anti-LGBTQ+ legislation has particularly harmed transgender youth, as highlighted by the Williams Institute's estimation that approximately 105,200 transgender youth – about one-third of transgender youth in the U.S. – live in states that ban access to gender-affirming care.[2]

In 2021, AB 657 (Cooper) expedited medical licensure for providers of abortion services, elevating California as a safe haven for reproductive health care. Building upon that model, AB 2442 seeks to improve access to gender-affirming care in anticipation of a surge in out-of-state patients seeking care in California. According to the U.S. Transgender Survey, which included 92,239 respondents from across the U.S., nearly half (47%) considered moving to another state because their state government introduced or passed laws targeting transgender people, and 5% of the respondents did end up leaving.[3] It is imperative that California proactively fortifies its gender-affirming care provider network to meet the growing demand and ensure timely access to care for both in-state and out-of-state patients. By championing this initiative, California can continue to be a nationwide leader in providing access to quality gender-affirming care.

[1] Dawson, L., Kates, J. (2024). The Proliferation of State Actions Limiting Youth Access to Gender Affirming Care. KFF, Washington, DC.
[2] Mallory, C., Redfield, E. (2023). The Impact of 2023 Legislation on Transgender Youth. The Williams Institute, UCLA School of Law, Los Angeles.
[3] James, S.E., Herman, J.L., Durso, L.E., & Heng-Lehtinen, R. (2024). Early Insights: A Report of the 2022 U.S. Transgender Survey. National Center for Transgender Equality, Washington, DC.

## SOLUTION

AB 2442 requires the expedited processing of licensure applications by the Medical Board of California, the Osteopathic Medical Board of California, the Board of Registered Nursing, the Physician Assistant Board, the Board of Behavioral Sciences, and the Board of Psychology for applicants demonstrating a commitment to providing gender-affirming health care or gender-affirming mental health care services within their licensed scope of practice.

## SUPPORT

Planned Parenthood Affiliates of California (Sponsor)
Equality California (Sponsor)

## FOR MORE INFORMATION

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ASSEMBLY THIRD READING
AB 2442 (Zbur)
As Amended April 10, 2024
Majority vote

## SUMMARY

Requires specified healing arts boards under the Department of Consumer Affairs (DCA) to expedite the licensure process for applicants who demonstrate that they intend to provide gender-affirming health care or gender-affirming mental health care services.

**Major Provisions**

1) Requires the Medical Board of California (MBC), the Osteopathic Medical Board of California (OMBC), the Board of Registered Nursing (BRN), and the Physician Assistant Board (PAB) to expedite the licensure process for applicants who demonstrate that they intend to provide gender-affirming health care or gender-affirming mental health care services within the scope of practice of their license.

2) Defines "gender-affirming health care" as medically necessary health care that respects the gender identity of the patient, as experienced and defined by the patient, which may include, but is not limited to, the following:

   a) Interventions to suppress the development of endogenous secondary sex characteristics.

   b) Interventions to align the patient's appearance or physical body with the patient's gender identity.

   c) Interventions to alleviate symptoms of clinically significant distress resulting from gender dysphoria, as defined in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition.

3) Defines "gender affirming mental health care" as mental health care or behavioral health care that respects the gender identity of the patient, as experienced and defined by the patient, which may include, but is not limited to, developmentally appropriate exploration and integration of identity, reduction of distress, adaptive coping, and strategies to increase family acceptance.

4) Provides that an applicant shall demonstrate their intent to provide gender-affirming health care or gender-affirming mental health care by providing documentation, including a letter from an employer or contracting entity indicating that the applicant has accepted employment or entered into a contract to provide gender-affirming health care or gender-affirming mental health care, the applicant's starting date, and the location where the applicant will be providing gender-affirming health care or gender-affirming mental health care within the scope of practice of their license.

5) Clarifies that the bill does not change existing licensure requirements, and that applicants applying for expedited licensure must meet all applicable licensure requirements.

6) Subjects the bill's provisions to repeal on January 1, 2029 unless extended by the Legislature.

## COMMENTS

*Expedited Licensure.* The DCA consists of 36 boards, bureaus, and other entities responsible for licensing, certifying, or otherwise regulating professionals in California. As of March 2023, there are over 3.4 million licensees overseen by programs under the DCA, including health professionals regulated by healing arts boards under Division 2 of the Business and Professions Code. Each licensing program has its own unique requirements, with the governing acts for each profession providing for various prerequisites including prelicensure education, training, and examination. Most boards additionally require the payment of a fee and some form of background check for each applicant.

The average time between the submission of an initial license application and approval by an entity under the DCA can vary based on a number of circumstances, including increased workload, delays in obtaining an applicant's criminal history, and deficiencies in an application. Boards typically set internal targets for application processing timelines and seek adequate staffing in an effort to meet those targets consistently. License processing timelines are then regularly evaluated through the sunset review oversight process by the Assembly Committee on Business and Professions and the Senate Committee on Business, Professions, and Economic Development.

The first expedited licensure laws specifically related to the unique needs of military families. The Syracuse University Institute for Veterans and Military Families found that up to 35% of military spouses are employed in fields requiring licensure. Because each state possesses its own licensing regime for professional occupations, military family members are required to obtain a new license each time they move states, with one-third of military spouses reportedly moving four or more times while their partner is on active duty. Because of the barriers encountered by military family members who seek to relocate their licensed work to a new state, it is understood that continuing to work in their field is often challenging if not impossible.

In an effort to address these concerns, AB 1904 (Block) Chapter 399, Statutes of 2012 was enacted in 2012 to require boards and bureaus under the DCA to expedite the licensure process for military spouses and domestic partners of a military member who is on active duty in California. Two years later, SB 1226 (Correa) Chapter 657, Statutes of 2014 was enacted to similarly require boards and bureaus under the DCA to expedite applications from honorably discharged veterans, with the goal of enabling these individuals to quickly transition into civilian employment upon retiring from service.

Statute requires entities under the DCA to annually report the number of applications for expedited licensure that were submitted by veterans and active-duty spouses and partners. For example, in Fiscal Year 2022-23, the MBC received 14 applications from military spouses or partners and 101 applications from honorably discharged veterans subject to expedited processing. In 2023, the federal Servicemembers Civil Relief Act (SCRA) imposed new requirements on states to recognize qualifying out-of-state licenses for service members and their spouses. This new form of enhanced license portability potentially displaces the need for expedited licensure for these applicants.

A decade after the first expedited licensure laws were enacted for military families, the Legislature enacted AB 2113 (Low) Chapter 186, Statutes of 2020 to require licensing entities under the DCA to expedite licensure applications for refugees, asylees, and Special Immigrant Visa holders. The intent of this bill was to address the urgency of allowing those forced to flee

their homes to restart their lives upon acceptance into California with refugee status. It is understood that the population of license applicants who have utilized this new expedited licensure program across all DCA entities is, to date, relatively small.

Subsequently in 2022, the Legislature enacted AB 657 (Cooper) Chapter 560, Statutes of 2022 to add another category of applicants eligible for expedited licensure. This bill required the Medical Board of California (MBC), Osteopathic Medical Board of California (OMBC), the Board of Registered Nursing (BRN), and the Physician Assistant Board (PAB) to expedite the license application for an applicant who demonstrates that they intend to provide abortions. This bill was passed in the wake of the Supreme Court's decision to overturn *Roe v. Wade*, which led to concerns that with approximately half of all states likely to seek to ban abortion, patients in those states would come to California to receive abortion services, creating a swell in demand for abortion providers. AB 657 was passed to ensure that there is an adequate health care provider workforce to provide urgent reproductive care services.

*Gender Affirming Care.* In recent years, there has been a growing recognition of the importance of addressing the systemic barriers and discrimination faced by transgender, non-binary, and gender-diverse individuals in accessing appropriate healthcare. Studies have demonstrated that social stigma and a lack of access to support systems has led to healthcare avoidance by transgender individuals; these patients also report a higher rate of negative interactions with healthcare providers. As acceptance of the communities grows, there has also been a corresponding backlash within reactionary conservative movements, leading to an even greater increase in trauma and oppression for those simply seeking to live as their authentic selves.

One of the central aspects of transgender healthcare is access to gender-affirming care. Gender-affirming care encompasses medical interventions such as hormone therapy, surgical procedures, and mental health support aimed at aligning an individual's physical body with their gender identity. For many transgender individuals, these interventions are not merely elective but are necessary for alleviating gender dysphoria and improving overall well-being. Ensuring access to gender-affirming care is critical for affirming transgender identities and reducing the psychological distress associated with gender dysphoria.

Another important aspect of gender-affirming care relates to mental and behavioral health. Gender dysphoria, characterized by significant distress or discomfort due to a misalignment between an individual's gender identity and assigned sex at birth, can have profound effects on mental health and well-being. Health professionals play a critical role in assessing and addressing symptoms of gender dysphoria through therapeutic interventions, including counseling, psychotherapy, and, in some cases, psychiatric treatment.

This bill seeks to support increased access to health professions who commit to providing gender-affirming care by replicating existing expedited licensure processes. Similarly to how applications for abortion providers are currently expedited, applicants would demonstrate their intent to provide gender-affirming health care or gender-affirming mental health care by providing documentation, including a letter from an employer or contracting entity indicating that the applicant has accepted employment or entered into a contract to provide that care. The respective healing arts boards would then prioritize the processing of those applications. The author and sponsors of this bill believe that this expedited processing will help California more quickly deliver health care providers to communities in urgent need of gender affirming care.

**According to the Author**
"Transgender, gender nonconforming, and intersex (TGI) people, especially TGI youth, are confronting an alarming rise in discrimination and political attacks. Over 500 anti-LGBTQ+ bills were introduced in 2023 in more than 40 states, and 84 were passed into law. These bills disproportionately targeted TGI youth and adults, particularly access to health care. The number of states with laws or policies restricting access to gender-affirming care has increased dramatically, with estimates suggesting that about one-third of trans youth in the U.S. now live in states that ban access to gender-affirming care. Many TGI people and their families are now facing agonizing decisions about whether to relocate to continue receiving this lifesaving health care. At the same time, TGI people in California continue to have trouble finding providers for routine care and identifying health care providers who offer gender-affirming care can be even harder. AB 2442 will ensure that licensure applications for providers of gender-affirming care are prioritized to ensure a robust network of providers and timely access to care for both in-state and out-of-state patients."

**Arguments in Support**
*Planned Parenthood Affiliates of California* (PPAC) is a co-sponsor of this bill. PPAC writes: "AB 2442 seeks to ensure that licensure applications for providers of gender-affirming care are prioritized to ensure a robust network of trained providers and timely access to care for both in-state and out-of-state patients. This bill increases access to care for people by ensuring that there are more medical professionals in California who are trained in gender-affirming care and helps to eliminate instances of discrimination and bias within the health care delivery system in California."

*Equality California* (EQCA) is also a co-sponsor of this bill. According to EQCA: "In recent years, the number of states with laws or policies restricting access to gender-affirming care has increased dramatically – climbing from just four states in June 2022 to 23 states in January 2024. These laws and policies often impose severe professional or criminal penalties on medical providers and other professionals offering gender-affirming care. The pervasive wave of anti-LGBTQ+ legislation has particularly harmed transgender youth, as highlighted by the Williams Institute's recent report estimating that approximately 105,200 transgender youth – about one-third of transgender youth in the country – live in states that ban access to gender-affirming care." EQCA argues that "AB 2442 seeks to improve access to gender-affirming care in anticipation of a surge in out-of-state patients seeking care in California.

**Arguments in Opposition**
*Protection of the Educational Rights of Kids – Advocacy* (PERK Advocacy) opposes this bill, writing: "There is a moral obligation to treat each person with equal care and prioritizing gender affirming care is no more important than other care. Comparing this to the abortion laws does not make sense as there is no time expiration for the rush on treating a patient. In fact, the licensure process for anyone treating gender issues should be more stringent, and should receive additional specialized training. With higher rates of depression and suicide for this demographic, there is a real concern that rushed licensure to treat this demographic can lead to higher rates of financial and legal challenges that will burden the system, as well as greater rates of detransitioning if said candidates are not well trained in how to observe, diagnose, and properly treat this demographic of patients. Moreover, the percentage of the population with gender issues does not justify the push for expediting licensure."

## FISCAL COMMENTS

According to the Assembly Committee on Appropriations, minor and absorbable to the PAB, OMBC, and BRN; $18,000 in workload to the MBC; and absorbable information technology costs of $31,000.

## VOTES

**ASM BUSINESS AND PROFESSIONS: 13-1-4**
**YES:** Berman, Bains, Juan Carrillo, Grayson, Irwin, Jackson, Low, Lowenthal, McKinnor, Stephanie Nguyen, Pellerin, Soria, Zbur
**NO:** Sanchez
**ABS, ABST OR NV:** Flora, Alanis, Chen, Dixon

**ASM APPROPRIATIONS: 11-4-0**
**YES:** Wicks, Arambula, Bryan, Calderon, Wendy Carrillo, Mike Fong, Grayson, Haney, Hart, Pellerin, Villapudua
**NO:** Sanchez, Dixon, Jim Patterson, Ta

## UPDATED

VERSION: April 10, 2024

CONSULTANT: Robert Sumner / B. & P. / (916) 319-3301 FN: 0002778

Date of Hearing: April 24, 2024

ASSEMBLY COMMITTEE ON HOUSING AND COMMUNITY DEVELOPMENT
Christopher M. Ward, Chair
AB 2498 (Zbur) – As Amended April 16, 2024

**SUBJECT**: Housing: the California Housing Security Act

**SUMMARY**: Establishes the California Housing Security Program (the Program) to provide counties with funding to administer a housing subsidy to eligible persons to reduce housing insecurity and help Californians meet their basic housing needs, subject to an appropriation. Specifically, **this bill**:

1) Defines the following terms, for purposes of the Program:

    a) "Adult with a disability" means an individual or head of household who is 18 years of age or older and is experiencing a condition that limits a major life activity, including, but not limited to, one of the following:

        i) A "developmental disability," as defined;

        ii) A "medical condition," as defined;

        iii) A "mental disability," as defined, and which shall also include a substance use condition;

        iv) A "physical disability," as defined;

        v) A chronic illness, including, but not limited to, HIV; or

        vi) A traumatic brain injury.

    b) "Department" means the Department of Housing and Community Development (HCD).

    c) "Eligible population" means a low-income person that meets at least one of the following criteria:

        i) A former foster youth who qualifies for the Independent Living Program, as specified;

        ii) An older adult, which means a person 55 years of age or older;

        iii) An adult with disabilities;

        iv) A person experiencing unemployment;

        v) An incarcerated person with a scheduled release date within 60 to 180 days and who is likely to experience homelessness upon release;

        vi) A person experiencing homelessness; or

vii) A "veteran," as defined.

d) "Grantee" means any of the following entities that administer housing subsidies under the Program:

i) A city, including a charter city;

ii) A city, including a charter city, and a county;

iii) A housing authority, as defined; or

iv) A nonprofit corporation, as defined.

e) "Low-income person" has the same meaning as "lower income households," as defined.

2) Requires HCD, upon appropriation by the Legislature, to establish the Program pursuant to the bill to provide counties with funding to administer a housing subsidy to persons who meet the definition of eligible population to reduce housing insecurity and help Californians meet their basic housing needs.

3) Requires HCD to do all of the following by January 1, 2026:

a) Establish a two-year pilot program in six counties;

b) Select one county from the northern; three counties from the southern, including at least the County of San Diego, Imperial, or Orange; and two counties from the central regions of the state to participate in the pilot program and take into account representation of urban, rural, and suburban areas;

c) Issue suggested guidelines establishing the program, which must include criteria for program eligibility, the duration of the subsidy, and the amount of the subsidy, which shall be the amount necessary to cover the portion of a person's rent to prevent homelessness, but which shall not exceed a total amount of $2,000 per month or as a one-time subsidy during the period of the pilot program, or for two years, whichever is longer; and

d) Provide each county selected to participate in the pilot program with funding for the purposes of administering the housing subsidies in an amount equal to the ratio of the total number of counties participating in the pilot program compared to the total amount of funding available.

4) Requires a county participating in the pilot program to perform both of the following duties by July 1, 2026, and in consultation with the cities located in the county and any nonprofit organizations or housing authorities partnering with the county or those cities for purposes of administering the housing subsidies:

a) Review HCD's suggested guidelines and develop final guidelines for administering the housing subsidies based on the needs of the county, which must address all of the information described in HCD's suggested guidelines and be subject to the subsidy amount requirements in 3)c); and

b) Develop program applications for persons who meet the definition of eligible population to apply for a housing subsidy.

5) Requires a county participating in the pilot program to administer housing subsidies to persons who meet the definition of eligible population beginning January 1, 2027.

6) Allows a county participating in the pilot program to administer housing subsidies through a grantee, as defined, or through an existing housing program that is operated by the county or the grantee that has the same or similar purpose as the pilot program, and which must be subject to the final guidelines in 4).

7) Requires a county to enter into a written agreement with HCD to use funds in a manner consistent with this bill in order to be eligible to receive program funding to administer housing subsidies under the bill.

8) Requires the written agreement in 7) to include terms and conditions consistent with the bill's requirements.

9) Prohibits HCD from providing program funding to a county that refuses or otherwise does not agree to administer the program funds in a manner consistent with the bill.

10) Allows HCD to require a county to pay back program funds that are administered in a manner inconsistent with the bill's requirements.

11) Allows HCD to reallocate any program funds paid back under 10) for purposes of administering the bill.

12) Provides that a county shall be solely responsible for compliance with all applicable requirements in the bill.

13) Provides, notwithstanding any other law and to the extent allowable under federal law, that assistance, services, or supports received under the Program are not income of the participant for purposes of determining eligibility for, or benefits pursuant to, any public assistance program.

14) Provides that participation in other benefits or housing or housing-based services programs shall not disqualify an individual or household from being a participant for a subsidy under the Program.

15) Includes a finding and declaration that an undocumented person, as specified, who meets the definition of eligible population is eligible to receive a subsidy under the Program.

16) Requires HCD, beginning January 1, 2028 and annually thereafter for the duration of the program, to include programmatic performance metrics for program funds administered under the Program within HCD's existing annual report. Requires the information to include, at a minimum, all of the following:

a) The amount of program funds dispersed by any county or grantee providing housing subsidies under the Program;

b) The amount of program funding used by eligible persons under the Program; and

c) Demographic information, including household income, of eligible persons that received program funding under the Program.

17) Requires a county or grantee that administers housing subsidies under the Program to provide information necessary for HCD to comply with the reporting requirement in 16).

18) Provides that this Program shall become operative only upon appropriation by the Legislature of sufficient funds for the purposes of the Program.

**EXISTING LAW**:

1) Establishes the Housing Choice Voucher (HCV) program within the federal Department of Housing and Urban Development (HUD) to pay rental subsidies directly to eligible families for selection and rental of affordable and safe housing. The HCV program is generally administered by state or local public housing agencies (PHAs). (2 CFR Part 982)

2) Establishes the CalWORKS Housing Support Program (HSP) to provide housing supports to CalWORKs recipients who are experiencing homelessness or at risk of homelessness, including recipients who have not yet received an eviction notice, and for whom housing instability would be a barrier to self-sufficiency or child well-being. Supports provided may include, but shall not be limited to, all of the following:

   a) Financial assistance, including rental assistance, security deposits, utility payments, moving cost assistance, and motel and hotel vouchers; and

   b) Housing stabilization and relocation, including outreach and engagement, landlord recruitment, case management, housing search and placement, legal services, and credit repair. (Welfare and Institutions Code (WIC) Section 11330 et al.)

3) Establishes the Bring Families Home Program (BFH) to provide families receiving child welfare services who are homeless, at risk of homelessness, or in a living situation that cannot accommodate the child or multiple children in the home with financial assistance, housing stabilization, and relocation. (WIC 16523)

4) Establishes the State Emergency Rental Assistance Program (ERAP) within HCD for the provision of federal rental assistance funds in response to the COVID-19 pandemic. (Health and Safety Code Section 50897)

**FISCAL EFFECT**: Unknown.

**COMMENTS**:

***Author's Statement***: According to the author, "One key to reducing the number of Californians experiencing homelessness is to empower people who are currently housed to stay in their homes. This bill will reduce housing insecurity by providing rent subsidies to some of California's most vulnerable communities: low income former foster youth, older adults, adults with disabilities, people experiencing unemployment or homelessness, and recently incarcerated individuals. It requires the California Department of Housing and Community Development to establish a pilot program to do this in up to [six] counties in different geographic regions across the state."

***California's Housing Crisis:*** California is in the midst of a severe housing crisis. Over two-thirds of low-income renters are paying more than 30% of their income toward housing, a "rent burden" that means they have to sacrifice other essentials such as food, transportation, and health care.[1] In 2023, over 181,000 Californians experienced homelessness on a given night, with a sharp increase in the number of people who became homeless for the first time.[2] The crisis is driven in large part by the lack of affordable rental housing for lower income people. According to the California Housing Partnership's (CHP) Housing Need Dashboard, in the current market, nearly 2 million extremely low-income and very low-income renter households are competing for roughly 687,000 available and affordable rental units in the state. Over three-quarters of the state's extremely low-income households and over half of the state's very low-income households are severely rent burdened, paying more than 50% of their income toward rent each month. CHP estimates that the state needs an additional 1.3 million housing units affordable to very low-income Californians to eliminate the shortfall.[3] By contrast, production in the past decade has been under 100,000 housing units per year – including less than 10,000 units of affordable housing per year.[4]

***Homelessness Prevention***: Housing subsidies are highly effective in both preventing and reducing homelessness. Studies show low-income renters accessing "shallow" housing subsidies of $200-$500 per month, or larger one-time infusions of emergency cash, are able to remain stably housed. Moreover, people experiencing homelessness are able to move into permanent housing quickly, and remain stably housed, with a housing subsidy and the right services interventions. The state has focused homelessness prevention on those who are receiving benefits through safety net programs like CalWORKS and the foster care system, as well as through the ERAP program which was intended to stem evictions for nonpayment of rent due to COVID-19 related hardships.

***Housing Assistance Programs***: The state offers several programs that provide rental assistance and housing navigation services targeted at vulnerable populations that are homeless or housing insecure. The Department of Social Services operates two programs, CalWORKs HSP and BFH. HSP provides families who are receiving CalWORKs benefits financial assistance, including rental assistance, security deposits, utility payments, moving cost assistance, and motel and hotel vouchers, landlord recruitment, case management, housing search and placement, legal services, and credit repair. In addition, the Homeless Housing, Assistance, and Prevention (HHAP) program has provided roughly $1 billion annually for the last few years to large cities, counties, and Continuums of Care to address homelessness in their communities. Rental subsidies are an allowable use of HHAP funds.

***Housing Choice Vouchers (HCVs)***: The federal HCV program provides households at or below 80% of area median income with vouchers that can be used in the private rental market or in subsidized affordable housing. Voucher holders generally pay 30% of their income towards the fair market rent and the voucher covers the remaining amount. PHAs administer the program.

According to the 2022 Statewide Housing Plan, federal support and funding for addressing housing need has not kept up with demand and is a contributing factor to the state's housing

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[1] https://chpc.net/housingneeds/
[2] https://www.huduser.gov/portal/datasets/ahar/2023-ahar-part-1-pit-estimates-of-homelessness-in-the-us.html
[3] https://chpc.net/housingneeds/
[4] https://www.hcd.ca.gov/policy-research/housing-challenges.shtml

crisis. Despite modest increases in the amount of money allocated by the federal government for rental housing assistance in the form of deep-subsidy programs, an increase in the total number of renter households and mounting rental costs render these federal subsidies insufficient to meet demand. Only a fraction of renters that need assistance receive it, and this housing assistance gap is expected to worsen.

***The Program***: This bill would create a pilot grant program within HCD to provide rental subsidies for qualifying low-income individuals in six counties to reduce housing insecurity. The bill's definition of "eligible population" include low-income individuals (who may be undocumented) with any of the following characteristics:

- A former foster youth who qualifies for the Independent Living Program;
- An older adult, 55 years of age or older;
- An adult with disabilities;
- A person experiencing unemployment;
- An incarcerated person with a scheduled release date within 60 to 180 days and who is likely to experience homelessness upon release;
- A person experiencing homelessness; or
- A veteran, as defined.

The program would allow for counties or grantees to provide a subsidy to any eligible individuals in an amount necessary to cover the portion of the person's rent to prevent them from falling into homelessness, not to exceed either $2,000 as a one-time subsidy or $2,000 per month for the duration of the pilot, or two years, whichever is longer. Any subsidy would be prohibited from being considered as "income" for purposes of other public benefit programs. HCD would have to establish the program and associated guidelines and provide appropriated funds to counties by January 1, 2026, counties would have to establish their local program criteria by July 1, 2026, and would have to begin administering subsidies January 1, 2027. Counties could choose to administer the funding through a city, a local housing authority, or a nonprofit corporation, in the event that these entities have similar programs and infrastructure that could be utilized or are better equipped to handle program administration.

***Budget Challenges:*** Although final revenues are not in, the Legislative Analyst's Office estimates that the state is facing a $58 billion budget deficit. The Governor's January budget proposes to cut $1.2 billion in existing budget commitments to affordable housing programs, including eliminating $500 million for the state Low Income Housing Tax Credit, a core program necessary to fund affordable multi-family housing programs. The last voter-approved housing bond, Proposition 1 from 2018, provided $3 billion for various affordable housing programs, which has been fully spent down. In addition, although the January budget preserved $1 billion in funds intended for a fifth round of the HHAP program through 2024-25, no new HHAP funding has been proposed beyond 2025.

***Arguments in Support***: According to Los Angeles County, the bill's sponsor, "Many vulnerable populations, such as older adults and adults with disabilities, are particularly susceptible to housing insecurity and homelessness. In addition, individuals who have experienced homelessness or are at risk of experiencing homelessness face significant challenges in finding and maintaining stable housing. AB 2498 addresses these challenges by establishing the California Housing Security Program, which will provide housing subsidies to eligible low-income individuals and families not to exceed $2,000 a month. This program would target

populations at a high risk of experiencing homelessness, including older adults, adults with disabilities, and individuals experiencing homelessness."

***Arguments in Opposition***: According to the Valley Industry and Commerce Association, "…California grapples with a significant budget deficit, making it financially irresponsible to embark on costly pilot programs. While acknowledging the importance of preventive measures, the exorbitant expenses associated with this initiative could exacerbate the state's financial challenges rather than address them. As responsible stewards of public funds, it is crucial to prioritize initiatives that demonstrate tangible and sustainable impacts on homelessness without overburdening the state's already strained budget."

***Committee Amendments***: Staff recommends the bill be amended as follows:

- Make technical changes to the definition of "eligible population" to include specific cross-references to definitions of former foster youth and homeless youth;
- Modify the amount and distribution of counties that are eligible for the Program; and
- Clarify that counties may begin administering subsidies by January 1, 2027, rather than "beginning January 1, 2027."

Health and Safety Code Section 50489.1. (c) "Eligible population" means a low-income person that meets at least one of the following criteria:

(1) A former foster youth who qualifies for the Independent Living Program, established pursuant to the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272).

***(2) A former foster youth, who is 18 to 24 years of age, inclusive, as defined in Section 50807.***

(2) An older adult.

(3) An adult with disabilities.

(4) A person experiencing unemployment.

(5) An incarcerated person with a scheduled release date within 60 to 180 days and who is likely to experience homelessness upon release.

(6) A person experiencing homelessness, ***including a homeless youth, as defined in Section 8260 of the Welfare and Institutions Code***.

(7) A "veteran," as defined in Section 980 of the Military and Veterans Code.

50489.2. (a) Upon appropriation by the Legislature pursuant to Section 50489.5, the department shall establish the California Housing Security Program pursuant to the requirements of this chapter to provide counties with funding to administer a housing subsidy to persons who meet the definition of eligible population to reduce housing insecurity and help Californians meet their basic housing needs.

(b) By January 1, 2026, the department shall do the following to create the program:

(1) (A) Establish a two-year pilot program in ~~six~~ ***eight*** counties.

(B) The department shall select ~~one county~~ ***two counties*** from the northern, ~~three~~ ***four*** counties from the southern, including at least the ***County of Los Angeles,*** ~~County of~~ San Diego, ~~Imperial,~~ or Orange, and two counties from the central regions of the state to participate in the pilot program and shall take into account representation of urban, rural, and suburban areas.

(2) Issue suggested guidelines establishing the program. The guidelines shall include all of the following:

(A) Criteria for program eligibility.

(B) Duration of the subsidy.

(C) (i) Amount of the subsidy.

(ii) The amount of the subsidy shall be the amount necessary to cover the portion of a person's rent to prevent homelessness, but the subsidy shall not exceed a total amount of two thousand dollars ($2,000) per month or as a one-time subsidy during the period of the pilot program, or for two years, whichever is longer.

(c) By January 1, 2026, the department shall provide each county selected to participate in the pilot program with funding for the purposes of administering the housing subsidies in an amount equal to the ratio of the total number of counties participating in the pilot program compared to the total amount of funding available.

(d) By July 1, 2026, a county participating in the pilot program shall, in consultation with the cities located in the county and any nonprofit organizations or housing authorities partnering with the county or those cities for purposes of administering the housing subsidies, perform both of the following duties:

(1) Review the department's suggested guidelines and develop final guidelines for administering the housing subsidies based on the needs of the county.

(A) The final guidelines shall address all of the information described in the department's suggested guidelines.

(B) The final guidelines shall be subject to the requirements described in clause (ii) of subparagraph (C) of paragraph (2) of subdivision (b).

(2) Develop program applications for persons who meet the definition of eligible population to apply for a housing subsidy.

(e) ~~Beginning~~ ***By*** January 1, 2027, a county participating in the pilot program shall administer housing subsidies to persons who meet the definition of eligible population.

***Related Legislation***:

SB 37 (Caballero) of the current legislative session would establish the Older Adults and Adults with Disabilities Housing Stability Pilot Program, administered by HCD, to provide housing subsidies to older adults and adults with disabilities who either are experiencing or at risk of experiencing homelessness, in up to five geographic regions or counties. This bill is currently pending on the Senate Floor.

AB 1431 (Zbur) of the 2022 session was substantially similar to this bill. That bill died pending a hearing in this committee.

**REGISTERED SUPPORT / OPPOSITION**:

**Support**

Los Angeles County Board (Sponsor)
Apartment Association of Greater Los Angeles
California Coalition for Youth
California Legislative LGBTQ Caucus
California Rental Housing Association
CalPACE
Los Angeles County Democratic Party
PowerCA Action
Santa Monica Democratic Club
Santa Monicans for Renters' Rights
Southern California Rental Housing Association

**Opposition**

Valley Industry and Commerce Association

**Analysis Prepared by**: Nicole Restmeyer / H. & C.D. / (916) 319-2085

# Senate Bill 1022

Defending Housing, Employment & Other Civil Rights Violations
Senator Nancy Skinner (D-Berkeley)

## THIS BILL

California's Civil Rights Department (CRD) is the institutional centerpiece that defends against discrimination, harassment, hate crimes, and other civil rights violations in employment, housing, and more. This bill would clarify the law that allows the Civil Rights Department (CRD) to effectively investigate and prosecute violations that impact those rights.

## ISSUE

Each year, CRD investigates thousands of complaints of civil rights violations, mediating and settling many of those complaints, and prosecuting where necessary, to protect the rights of many Californians .

The Fair Employment and Housing Act authorizes CRD to:

- investigate complaints brought to CRD ;
- initiate complaints (also known as Director's complaints) when there is evidence of civil rights violations; and
- aggregate individual complaints affecting groups or classes of people as "group/class complaints."

Complaints initiated by CRD and group/class complaints involve practices that affect many individuals and have long histories. However, two recent superior court rulings impacted CRD's ability to remedy long-standing employment discrimination based on sex and race, limiting the department to remedying violations going back just one year. In other words, the courts read the statute to find that *systemic* cases pursued by the state are subject to the same statutes of limitations as an *individual* worker pursuing their own private case.

Additionally, for individual complaints brought to CRD, the department is required by statute to complete its investigative work within one year. This strict deadline can pose challenges when a complainant, business, landlord, or witness needs additional time to respond to CRD's requests for information or to provide CRD investigators adequate time to gather information.

The one-year deadline also leads to administrative inefficiency when individuals file complaints with CRD that are *already* the subject of ongoing CRD group/class investigations. The ability to aggregate complaints is more efficient and cost-effective, as CRD must often investigate and close an individual complaint that was filed after the group investigation has begun, but *before* the larger group/class investigation or litigation ends.

Finally, recent legislative changes allowed CRD to file a civil action in any county in which it has an office but neglected to make corresponding changes in the section governing CRD's housing discrimination cases, creating a conflict in the law.

## SOLUTION

SB 1022 will:

- Clarify that deadlines that apply to individual complaints do not apply to complaints initiated by CRD or to group/class claims being prosecuted by CRD;
- Allow CRD to rectify long-running civil rights violations for the benefit of all victims, not only *recent* victims;
- Allow CRD to pause investigations when the parties agree;
- Allow housing discrimination cases to be brought in any county where CRD has an office.

## SUPPORT

Equality California (sponsor)
Equal Rights Advocates (sponsor)
Legal Aid at Work (sponsor)

## CONTACT

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**SENATE RULES COMMITTEE** SB 1290
Office of Senate Floor Analyses
(916) 651-1520 Fax: (916) 327-4478

THIRD READING

Bill No: SB 1290
Author: Roth (D)
Introduced: 2/15/24
Vote: 21

SENATE HEALTH COMMITTEE: 11-0, 4/10/24
AYES: Roth, Nguyen, Glazer, Gonzalez, Grove, Hurtado, Limón, Menjivar, Rubio, Smallwood-Cuevas, Wiener

SENATE APPROPRIATIONS COMMITTEE: Senate Rule 28.8

**SUBJECT:** Health care coverage: essential health benefits

**SOURCE:** Author

**DIGEST:** This bill sunsets the Kaiser Foundation Health Plan Small Group HMO 30 plan as California's Essential Health Benefit benchmark for individual and small group health plan contracts and health insurance policies after the 2026 plan year.

**ANALYSIS:**

Existing law:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act); California Department of Insurance (CDI) to regulate health and other insurance; and, the Department of Health Care Services (DHCS) to administer the Medi-Cal program. [HSC §1340, et seq., INS §106, et seq., and WIC §14000, et seq.]

2) Requires an individual or small group health plan contract or insurance policy issued, amended, or renewed on or after January 1, 2017, to include at a minimum, coverage for essential health benefits (EHBs) pursuant to the Patient Protection and Affordable Care Act (ACA), and as outlined below:

a) Health benefits within the categories identified in the ACA:

   i) Ambulatory patient services;
   ii) Emergency services;
   iii) Hospitalization;
   iv) Maternity and newborn care;
   v) Mental health and substance use disorder services;
   vi) Prescription drugs;
   vii) Rehabilitative and habilitative services and devices;
   viii) Laboratory services;
   ix) Preventive and wellness services and chronic disease management; and,

b) Pediatric services, including oral and vision care;
c) Health benefits covered by the Kaiser Foundation Health Plan Small Group HMO 30 (Kaiser Small Group HMO), as this plan was offered during the first quarter of 2014, regardless of whether the benefits are specifically referenced in the evidence of coverage or plan contract for that plan;
d) Medically necessary basic health care services, as specified;
e) Health benefits mandated to be covered by the plan pursuant to statutes enacted before December 31, 2011, as described; and,
f) Health benefits covered by the plan that are not otherwise required to be covered, as specified. [HSC §1367.005 and INS §10112.27]

3) Establishes federal EHB requirements including that the Secretary of the federal Department of Health and Human Services (HHS) not make coverage decisions, determine reimbursement rates, establish incentive program, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life. [42 U.S.C. §§18022]

This bill:

1) Sunsets the Kaiser Small Group HMO plan, as offered in 2014, as California's EHB benchmark plan.

2) States legislative intent to review California's EHB and establish a new benchmark plan for the 2027 plan year.

**Comments**

1) *Author's statement.* According to the author, California's EHBs are based upon the same 2014 benchmark plan established when California first implemented

the ACA. Updates were adopted in 2015 (effective in 2017) to incorporate the federal definition of habilitative, to base pediatric vision benefits on the Federal Employees Dental and Vision Insurance Program vision plan, and to base pediatric dental benefits on the Children's Health Insurance Program benefits. California's benchmark does not include coverage for hearing aids, infertility treatment, adult dental, chiropractic, or nutritional counseling, among other benefits. Inclusion of any of these benefits in California's EHBs requires the state to update our benchmark plan through a stakeholder process and to notify the federal Centers for Medicare and Medicare Services (CMS) by May of 2025, in order for those benefits to be in place for the 2027 plan year. This bill will help begin the review process, which requires actuarial analysis, and a stakeholder process to inform the options for policymakers, and ultimately codify any changes to California's benchmark plan. Any added health insurance mandates outside of this process require the state to pay for or "defray" the added costs of insurance mandates not included in the benchmark.

2) *California's benchmark plan.* California's current benchmark plan is the Kaiser Small Group HMO plan. The benchmark plan and other state mandates existing prior to December 31, 2011 are used to determine EHBs. Any state mandate exceeding EHBs requires the state to defray the costs associated with the mandate. California last reviewed its benchmark plan in 2015. At that time, the California Health Benefits Review Program (CHBRP) asked Milliman to analyze and compare the health services covered by the ten plans available to California as options for California's EHB benchmark effective January 1, 2017, similar to an analysis completed for Covered California in 2012. Milliman found relatively small differences in average healthcare costs among the ten benchmark options. Among the plan options, Milliman found differing coverage of acupuncture, infertility treatment, chiropractic care, and hearing aids. The three California small group plans were essentially the same average cost as the California EHB plan and the California large group and CalPERS plans were approximately 0.2% to 1% higher in cost. The estimated average costs for the three federal employee plan options was approximately 0.8% to 1.2% higher than the California EHB plan. On April 17, 2015, the Secretary of California's Health and Human Services Agency sent a letter to the federal Center for Consumer Information and Insurance Oversight (CCIIO) selecting the same Kaiser Small Group Plan to remain as California's benchmark plan.

3) *Updating EHBs.* According to a 2022 CHBRP brief on EHBs, federal HHS issued final rules in 2018 and 2019, which provided new flexibility for states by allowing three new options for the EHB benchmark plan, in addition to the

option of retaining the current EHB benchmark plan. Beginning with the 2020 plan year, states could: (a) select an EHB benchmark plan used by another state for the 2017 plan year; (b) replace one or more of the ten EHB categories in the state's EHB benchmark plan with the same category or categories of EHBs from another state's 2017 EHB benchmark plan; or, (c) otherwise select a set of benefits that would become the state's EHB benchmark plan. At a minimum, the EHB benchmark plan must provide a scope of benefits equal to or greater than a typical employer plan. Furthermore, a new "generosity test" requires that EHBs cannot exceed the generosity of the most generous among the set of ten previous 2017 benchmark comparison plan options. A mandate that is added through the benchmark plan process is not subject to the requirement that the state defray those mandate costs if it is not a state mandated benefit enacted after December 31, 2011. According to the CMS website, for plan years between 2020 and 2025, nine states have updated their EHB benchmark plans.

4) *Updated process rules.* CMS has finalized new rules for EHB benchmark updates through the HHS Notice of Benefit and Payment Parameters for 2025. As part of this update, CMS removed a regulatory prohibition on plans and insurers from including routine non-pediatric dental services as an EHB. This allows states to add routine adult dental services as an EHB by updating their EHB benchmark plans. For plan years beginning on or after January 1, 2026, CMS has approved three revisions to the standards for state selection of EHB-benchmark plans to address long-standing requests from states to improve, and reduce the burden of, the EHB-benchmark plan update process. First, CMS will allow states to consolidate the options for states to change EHB-benchmark plans such that a state may change its EHB-benchmark plan by selecting a set of benefits that would become the state's EHB-benchmark plan. Any changes to state EHB-benchmark plan options would also be applicable to states when choosing a benchmark plan used to define EHBs in a state Basic Health Programs (BHPs) established under section 1331 of the ACA and Medicaid Alternative Benefit Plans (ABPs) implemented pursuant to section 1937 of the ACA. Second, CMS has removed the generosity standard and revised the typicality standard so that, in demonstrating that a state's new EHB-benchmark plan provides a scope of benefits that is equal to the scope of benefits of a typical employer plan in the state, the scope of benefits of a typical employer plan in the state would be defined as any scope of benefits that is as or more generous than the scope of benefits in the state's least generous typical employer plan, and as or less generous than the scope of benefits in the state's most generous typical employer plan. Third, CMS removed the requirement for

states to submit a formulary drug list as part of their documentation to change EHB-benchmark plans unless the state changes its prescription drug EHBs.

5) *State-mandated benefits and defrayal.* Under the final rule, CMS indicates that state-mandated benefits would not be considered "in addition to EHB" under CMS' defrayal policy if the mandated benefit is an EHB in the state's EHB-benchmark plan. This proposal would help protect consumers by ensuring that existing EHB benefits in states' EHB-benchmark plans remain subject to EHB nondiscrimination rules, the annual limitation on cost-sharing, and restrictions on annual or lifetime dollar limits.

6) *Relevant stakeholder comments on federal rules*. There are many organizations that submitted comments in response to the proposed federal rule changes. Some relevant comments are summarized here, but not all comments have been included:

   a) *Insurance Commissioner Lara.* Insurance Commissioner Lara writes that due to defrayal requirements, limitations imposed upon benefits that constitute state EHBs contribute to the ongoing health care inequities faced by members of historically disadvantaged communities. The Insurance Commissioner writes that in California, most durable medical equipment, as well as external prosthetic and orthotic devices, are not EHBs. Therefore, persons with disabilities and the chronically ill continue to be subjected to discriminatory plan designs. The Insurance Commissioner believes having a more efficient process for updating EHBs will allow, and encourage, states to revisit and update their benchmark plans to address historical insurance inequalities. The Insurance Commissioner also supports allowing states to include coverage of adult dental care in the EHBs, indicating that long-standing systemic inequities in our health care system have resulted in members of historically disadvantaged communities receiving inadequate access to dental care due to lack of coverage.
   b) *Covered California.* Covered California writes that they appreciate and value the proposed state flexibility within the EHB framework. In addition to promoting efficiency, the proposal would allow states to tailor their benchmark plans to meet the specific needs of individuals in their respective states.
   c) *National Health Law Program (NHeLP).* NHeLP urges federal HHS to outline a process for states to take advantage of the defrayal exception. NHeLP cites Washington's statute requiring coverage of behavioral health crisis and their Insurance Commissioner's memo explaining it was necessary

to comply with the federal Mental Health Parity and Addiction Equity Act, and, Colorado's action to enact a coverage mandate for infertility treatment and their Division of Insurance's explanation that the mandate ensures compliance with federal nondiscrimination requirements. NHeLP has extensive additional comments including support for removing the prohibitions on adult oral health services, non-pediatric eye exam services, and long-term/custodial nursing home care benefits.

d) *California Dental Association (CDA).* CDA writes in support of the inclusion of adult dental services and urges CMS to consider uniform minimum standards to address variation across the dental insurance market. CDA recommends a dental loss ratio be applied to adult dental benefits of 85% and a separate dental deductible, no annual or lifetime limit on covered dental services, and an annual out-of-pocket maximum for dental services.

e) *Kaiser Permanente.* Kaiser Permanente expresses concern with HHS' approach related to EHBs and state benchmark plans, including the proposal to permit inclusion of non-pediatric dental services as an EHB. Kaiser believes that some of these proposals could have a significant negative impact on affordability of coverage options across all markets, which may be exacerbated in the individual market if the current expanded premium subsidies sunset next year. Kaiser raises concerns that the rule could cause the benchmark plan design to be moved further away from popular large group major medical coverage options in the same geographic market.

f) *Delta Dental Plans Association.* Delta Dental Plans Association indicates that it does not oppose the proposal, but requests that CMS provide guidance for states on model adult dental benchmark plans so that they are comparable to commercially available dental plans in terms of coverage and cost. Additionally, Delta Dental Plans Association requests clarification that a medical qualified health plan (exchange plan) would not have to embed the adult dental EHB if there is a stand-alone dental plan on an exchange that offers such benefits, and further requests that CMS issue additional guidance on the applicability of the premium tax credit and the limitations on enrollee cost-sharing with respect to the proposed adult dental EHBs.

7) *Other ACA EHB requirements:*

a) *Annual and Lifetime Dollar Limits.* The EHB benchmark plans cannot apply annual and lifetime dollar limits to EHBs in accordance with 45 CFR 147.126. Annual and lifetime dollar limits can be converted to actuarially equivalent treatment or service limits.

b) *Coverage Limits.* Pursuant to 45 CFR 156.115(a)(2), with the exception of coverage for pediatric services, a plan may not exclude an enrollee from coverage in an entire EHB category, regardless of whether such limits exist in the EHB-benchmark plan. For example, a plan may not exclude dependent children from the category of maternity and newborn coverage.

**FISCAL EFFECT:** Appropriation: No Fiscal Com.: Yes Local: Yes

**SUPPORT:** (Verified 4/23/24)

Children Now
Let California Kids Hear
National Health Law Program
Western Center on Law & Poverty

**OPPOSITION:** (Verified 4/23/24)

None received

**ARGUMENTS IN SUPPORT:** Western Center on Law and Poverty appreciates the opportunity that this bill will provide to conduct a comprehensive evaluation of the essential health benefit benchmark plan and look forward to the stakeholder process to ensure that the real-life impact of state policies on Californians is considered. Western Center on Law and Poverty writes that California is currently out of compliance with federal law, including federal discrimination law, and steps must be taken to correct this inequity without further delay.

National Health Law Program (NHeLP) writes like many other states, California did not select, at the time, the most comprehensive benchmark plan possible. As a result, California's benchmark plan has given way to significant and persistent gaps in coverage in areas that are contributing to health disparities, such as access to midwives and doula care that are instrumental to address and reduce Black maternal mortality and lack of access to methadone services for individuals with opioid use disorders, among others. Fortunately, California now has the chance to address those gaps. Since 2019, states can select new benchmark plans, including creating a new plan altogether. To date, this process has allowed ten states to expand access to key services to address the ongoing overdose epidemic, add new requirements to treat mental health conditions, expand upon requirements to provide services via telehealth, and strengthen prescription drug requirements to ensure access to hepatitis C medications and medications for other conditions impacting underserved populations. NHeLP also cautions that this effort should in

no way interfere with parallel efforts to enforce federal nondiscriminatory benefit design requirements in California.

Children Now and Let California Kids Hear write that they strongly support a policy solution that will permanently close coverage gaps and ensure that all children in California have access to affordable and comprehensive health insurance that meets all of their health needs. With recent federal EHB flexibilities and the introduction of this bill, California lawmakers now have the opportunity to update the benchmark, close the coverage gap, and ensure that all children in California have comprehensive coverage and services – including hearing aids – to meet their health and developmental needs. Thirty-two states already require that private individual and group health insurance plans include coverage for children's hearing aids & services through a state insurance benefit mandate or by way of the state's EHB benchmark selection, but California is not one of them.
The California Association of Health Plans (CAHP) writes that while reopening California's EHB package is not without its challenges, it offers policymakers the opportunity to engage in a more thoughtful and comprehensive analysis of affordability and accessibility to health care coverage. Together, health plans, legislators, and the administration can work on a logical approach to benefits and coverage, instead of continuing to introduce benefit mandate bills that increase premiums for everyone. This bill potentially offers this logical path. CAHP writes any discussion around EHBs should factor in and not conflict with the work that is being done by the Office of Health Care Affordability and its underlying mission of consumer affordability. Reexamining the EHB package will allow policymakers to look at the bigger picture by cumulatively reviewing how changing coverage will impact the affordability of health care premiums for Californians.

Prepared by: Teri Boughton / HEALTH / (916) 651-4111
4/24/24 11:16:24

****** END ******

# SENATE COMMITTEE ON HEALTH
**Senator Richard Roth, Chair**

**BILL NO:** SB 954
**AUTHOR:** Menjivar
**VERSION:** January 22, 2024
**HEARING DATE:** April 24, 2024
**CONSULTANT:** Margarita Niemann and Melanie Moreno

**SUBJECT:** Sexual health: contraceptives

**SUMMARY:** Prohibits a retail establishment from refusing to furnish nonprescription contraception to a person solely on the basis of age.

**Existing law:** Enacts the Sherman Food, Drug and Cosmetic Law (Sherman Law), which provides broad authority for the California Department of Public Health (CDPH) to enforce requirements related to food, cosmetics, drugs, and home medical devices. [HSC §109875, et seq.]

**This bill:**
1) Prohibits a retail establishment from refusing to furnish nonprescription contraception to a person solely on the basis of age by any means, including, but not limited to, requiring the customer to present identification to demonstrate their age. Exempts a violation of this prohibition from penalties for violating the Sherman Law.

2) Defines "retail establishment" as any vendor that, in the regular course of business, furnishes nonprescription contraception at retail directly to the public, including, but not limited to, a pharmacy, grocery store, or other retail store.

3) Specifies that this prohibition does not apply to the refusal to furnish nonprescription contraception on the basis of age if, under other provisions of federal or state law, the contraception is subject to restrictions on the basis of age.

Education Code provisions
4) Requires public schools to make condoms available to all 9 to 12 grade pupils free of charge, and requires related information to be made available to students. Requires public schools serving grades 7 to 12 to allow condoms to be made available during the course of, or in connection with, educational or public health programs and initiatives, as specified. Requires public schools serving grades 7 to 12 to allow a school-based health center to make condoms available and easily accessible to pupils at their site.

**FISCAL EFFECT:** This bill has not been analyzed by a fiscal committee.

**COMMENTS:**
1) *Author's statement.* According to the author, we cannot continue ignoring the sexually transmitted infection (STI) epidemic among our youth when some high schools and retailers are enacting dangerous policies that deny them the ability to protect themselves. This bill aims to safeguard the health and futures of high school students statewide by increasing equitable access to condoms while also increasing fiscal responsibility. Investing in prevention is a fraction of the cost compared to the millions California spends on the

treatment of STIs every year. This isn't about a catchy headline, but rather the health and safety of our youth.

2) *Background.* The Centers for Disease Control and Prevention (CDC) estimates that one in five people in the U.S. had an STI on any given day in 2018, which amounts to nearly 68 million infections across the nation total. In 2021, more than 2.5 million cases of chlamydia, gonorrhea, and syphilis were reported in the U.S. Between 2018 and 2022, reported syphilis cases increased by 80% in the U.S. (115,000 to over 207,000), the highest number of cases in the nation since the 1950s. STIs are often asymptomatic (especially in women) and are therefore often undiagnosed and unreported. Untreated STIs can have severe health consequences, including chronic pelvic pain, infertility, miscarriage or newborn death, and increased risk of HIV infection, genital and oral cancers, neurological and rheumatological effects. The CDC estimates that untreated STIs cause at least 24,000 women in the U.S. each year to become infertile. Untreated syphilis can also lead to negative maternal child health outcomes, including infant deaths. Of pregnant women who acquire syphilis up to four years before delivery, approximately 80% will transmit the infection to the fetus, and 40% may result in stillbirth or death. The World Health Organization (WHO) asserts that condoms continue to be the most effective method of preventing most STIs through consistent and correct use by stopping or greatly reducing people's exchange of bodily fluids.

3) *Inequities persist.* The STI crisis affects communities across the state, but California youth, people of color, and gay, bisexual, and transgender people are disproportionately impacted. CDPH reports that the highest STI rates continue to occur among young people between the ages of 15 and 24, Black/African Americans, and gay and bisexual men. Young people make up 46% of all new STIs in the country. Furthermore, African Americans are 500% more likely to contract gonorrhea and chlamydia than their white counterparts. CDC studies suggest a range of factors may contribute to rising STI rates, including inequitable access to health care and culturally competent medical services, race, poverty, stigma, discrimination, and drug use.

4) *Cost of STIs.* According to the most recent information available from the CDC, STI infections acquired in 2018 totaled nearly $16 billion in direct lifetime medical costs nationwide. Chlamydia, gonorrhea, and syphilis accounted for more than $1 billion of the total cost. Sexually acquired HIV and HPV were the costliest due to lifetime treatment for HIV at $13.7 billion and treatment for HPV-related cancers at $755 million.

5) *Prior legislation.* SB 541 (Menjivar of 2023) was substantially similar to this bill. *SB 541 was vetoed by the Governor, who stated, in part: While evidence-based strategies, like increasing access to condoms, are important to supporting improved adolescent sexual health, this bill would create an unfunded mandate to public schools that should be considered in the annual budget process.*

   AB 2312 (Lee of 2022) would have prohibited retail establishments from refusing to furnish nonprescription contraception solely on the basis of age, sex, race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, sexual orientation, citizenship, primary language, or immigration status. *AB 2312 was not heard in the Assembly Health Committee.*

6) *Support.* The sponsors of this bill along with other supporting organizations write that statewide data indicates over half of all STIs in the state are experienced among California

youth ages 15 to 24 years old. Young people in this age group make up more than half of the chlamydia cases in California, and over 87% are youth of color. Since most STIs are asymptomatic, they are often left undetected and can potentially cause serious life-threatening health problems later in life. They argue that condom use has declined over the last decade for California youth, reiterating that teens are often deterred from seeking and securing the resources they need to protect themselves against STIs and unintended pregnancy. Youth with low-incomes are often left without the option to purchase and regularly utilize condoms altogether. In a survey conducted by TeenSource among California teens from December 2023 to January 2024, 68% of teens indicated that they do not have access to condoms in schools, 98% agreed that more already sexually active teens would use condoms if they were easier to obtain, and 92% said that schools should make condoms available. The Health Officers Association of California also writes that prohibiting retail establishments from refusing to furnish nonprescription contraception based on age helps to ensure that Californians have equal access to contraceptives for purchase, thereby promoting health equity and autonomy.

7) *Opposition.* The California Family Council asserts that comprehensive sex education did not successfully lower STI rates in California and that condoms do not protect people from STIs that are spread from skin-to-skin contact. Additionally, Concerned Women for America Legislative Action Committee states that this policy does not serve any educational purposes and thereby should be a decision left to families. Parents should have the right to decide when such decisions are appropriate for the children.

**SUPPORT AND OPPOSITION:**

**Support:** Black Women for Wellness Action Project (co-sponsor)
California School-Based Health Alliance (co-sponsor)
Essential Access Health (co-sponsor)
Generation Up (co-sponsor)
Unite for Reproductive & Gender Equity (co-sponsor)
Access Reproductive Justice
AIDS Healthcare Foundation
Alliance for Children's Rights
American Academy of Pediatrics, California
American Civil Liberties Union California Action
American College of Obstetricians and Gynecologists District IX
APLA Health
Asian Americans Advancing Justice - Southern California
Bienestar Human Services
Buen Vecino
California Association for Health, Physical Education, Recreation, & Dance
California Coalition for Youth
California Legislative LGBTQ Caucus
California Nurse-Midwives Association
California Pan-Ethnic Health Network
California School-Based Health Alliance
California Teachers Association
Children Now
Citizens for Choice
County of Alameda, Board of Supervisors
Courage California

Equality California
GLIDE
Health Officers Association of California
Indivisible CA StateStrong
Los Angeles LGBT Center
Maternal and Child Health Access
National Health Law Program
Period @ Irvine, CA
Reproductive Freedom for All California
Rising Communities formerly Community Health Councils
Sacramento LGBT Community Center
San Francisco AIDS Foundation
San Francisco Black & Jewish Unity Coalition
The Los Angeles Trust for Children's Health
The Source LGBT+ Center
Training in Early Abortion for Comprehensive Healthcare
Women's Health Specialists
Voters of Tomorrow
Young Invincibles
One individual

**Oppose:** California Baptist for Biblical Values
California Family Council
Concerned Women for America Legislative Action Committee
Lighthouse Baptist Church
Real Impact
One individual

**-- END --**

# Senator Scott Wiener, 11th Senate District

## Senate Bill 957 – SOGI Data

### SUMMARY

Senate Bill 957 will require the California Department of Public Health (CDPH) to collect sexual orientation and gender identity (SOGI) data from third-party entities, including local health jurisdictions, on any forms or electronic data systems, unless prohibited by federal or state law. The bill will also require CDPH to provide an annual report to the public and to the Legislature on its efforts to collect, analyze, and report SOGI data.

### BACKGROUND/PROBLEM

Collecting accurate SOGI data is essential to understanding the extent to which LGBTQ+ people in California are experiencing disparities in health and well-being and whether government programs are reaching LGBTQ+ people in need of care and assistance.

AB 959 (Chiu, Chapter 565, Statutes of 2015) required specified state departments, including CDPH, to collect and report voluntarily provided self-identification SOGI data when collecting other demographic data, such as ethnicity, age, and race.

More recently, in the wake of the COVID-19 pandemic, SB 932 (Wiener, Chapter 183, Statutes of 2020) required that electronic reporting tools used by local health officers for reporting communicable diseases include the capacity to collect and report SOGI data, and mandated that health care providers in California report SOGI data, if known, for all reportable communicable diseases.

In 2023, the California State Auditor conducted an audit of CDPH and its role in collecting, reporting, and using SOGI data. The audit found that CDPH has been slow to adopt and enforce standardized definitions, guidelines, and training to ensure the consistent collection and reporting of SOGI data, which has limited its ability to identify and address health disparities among LGBTQ+ people.

Specifically, the report found that CDPH collects SOGI data on only a small portion of the forms it uses to gather demographic data. The Department is able to sidestep the requirements of SB 959 because most of the forms it uses to collect data are administered by third parties, not the Department directly. Of the 129 forms reviewed that collect demographic data, 105 were exempt from collecting SOGI data. Ninety of those forms were exempt because a third party, such as a local health jurisdiction – or health care provider – collects the data separately. The other 15 forms were exempt due to federal guidelines on demographic data collection. Of the 24 forms required to collect SOGI data, only 17 collect complete SOGI data and the remaining 7 only collect partial data.

Failing to collect accurate SOGI data makes the LGBTQ+ community invisible and undermines opportunities to ensure that all Californians receive the care and services they need. This oversight can have significant consequences for LGBTQ+ people, including stigma, misinformation, ineffective service provision, and a delayed response to public health emergencies like COVID-19 and the recent MPX (monkeypox) outbreak.

### SOLUTION

The Legislature has acknowledged the need to collect accurate and comprehensive SOGI data to understand and apply that data for the enhancement and improvement of public services for California's LGBTQ+ community.

To ensure that CDPH collects complete SOGI data to effectively implement and deliver critical services for LGBTQ+ people, SB 957 will amend existing law to require CDPH to collect SOGI data from third-party entities, including local health jurisdictions, on any forms or electronic data systems unless prohibited by federal or state law. SB 957 will also allow voluntarily provided SOGI data to be included in the statewide immunization registry to better identify immunization-related disparities among LGBTQ+ people. The bill will also require CDPH to provide an annual report to the public and to the Legislature on its efforts to collect, analyze, and report SOGI data; improve services or program outcomes for

underserved LGBTQ+ communities; and implement the recommendations from the audit report.

**SUPPORT**

- **Equality California (Sponsor)**
- **California LGBTQ Health & Human Services Network (Sponsor)**
- **San Francisco AIDS Foundation (Sponsor)**

**FOR MORE INFORMATION**

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**SENATE JUDICIARY COMMITTEE**
**Senator Thomas Umberg, Chair**
**2023-2024 Regular Session**

SB 1333 (Eggman)
Version: February 16, 2024
Hearing Date: April 9, 2024
Fiscal: Yes
Urgency: No
AM

## SUBJECT

Communicable diseases: HIV reporting

## DIGEST

This bill authorize the California Department of Public Health (CDPH) and local health departments (LHDs) to disclose personally identifying information in public health records of persons with HIV or AIDS for the coordination of, linkage to, or reengagement in care, as determined by CDPH or a LHD. The bill removes certain limitations on disclosure, such as that disclosure is authorized only when certain coinfections are involved. The bill requires CDPH and LHD employees and their contractors to sign confidentiality agreements annually, rather than signing the agreements once, and deletes the requirement that CDPH and LHDs review the confidentiality agreements annually.

## EXECUTIVE SUMMARY

The mpox outbreak in 2022 highlighted a deficit in California's existing statutes related to the ability of state and local public health officials to access and share personal information about those infected with HIV or AIDS. The existing statutes only allow information to be disclosed if a person has HIV alone or HIV and certain coinfections that are specified in statute. As mpox, was not one of the specified coinfections health officials were unable to effectively track how mpox was affecting the population of those with HIV. This bill will allow state and local health officials to disclose information for any coinfection, which will allow them to be prepared for any future outbreaks that may occur, subject to existing confidentiality provisions. The bill would also requires CDPH and LHD employees and their contractors to sign confidentiality agreements annually, rather than signing the agreements once. The bill is sponsored by APLA Health, the California Legislative LGBTQ Caucus, Equality California, and the San Francisco Aids Foundation. The bill is supported by numerous organizations representing the LGBTQ community. This bill passed the Senate Health Committee on a vote of 11 to 0.

## PROPOSED CHANGES TO THE LAW

Existing federal law:

1) Establishes the Health Insurance Portability and Accountability Act (HIPAA), which provides privacy protections for patients' protected health information and generally prohibits a covered entity, as defined (health plan, health care provider, and health care clearing house), from using or disclosing protected health information except as specified or as authorized by the patient in writing. (45 C.F.R. § 164.500 et seq.)

2) Provides that if HIPAA's provisions conflict with a provision of state law, the provision that is the most protective of patient privacy prevails. (45 C.F.R. § 164.500 et seq.)

Existing state law:

1) Establishes the Confidentiality of Medical Information Act, which establishes protections for the use of medical information. (Civ. Code § 56 et seq.)
    a) Prohibits providers of health care, health care service plans, or contractors, as defined, from sharing medical information without the patient's written authorization, subject to certain exceptions. (Civ. Code § 56.10.)

2) Requires CDPH to establish a list of diseases and conditions to be reported by local health officers (LHOs) to CDPH.
    a) CDPH must specify requirements related to the timeliness of reporting each disease and condition, the mechanisms required for reports, and the content that must be included in the reports.
    b) Authorizes the list to include both communicable and non-communicable diseases.
    c) Authorizes the list to be modified at any time by CDPH, after consultation with the California Conference of Local Health Officers. (Health & Saf. Code § 120130.)

3) Requires health care providers and laboratories to report cases of HIV infection to the LHO using patient names on a form developed by CDPH.
    a) CDPH and LHD employees and contractors are required to sign confidentiality agreements, which include information related to the penalties for a breach of confidentiality and the procedures for reporting a breach of confidentiality, prior to accessing confidential HIV-related public health records.
    b) Those agreements are required to be reviewed annually by either CDPH or the appropriate LHD. (Health & Saf. Code § 121022.)

4) Prohibits public health records relating to HIV/AIDS containing personally identifying information that were developed or acquired by CDPH or an LHD, or their agent, from being disclosed, except for public health purposes or pursuant to a written authorization by the person who is the subject of the record or by that person's guardian or conservator. (Health & Saf. Code §121025(a).)
    a) Authorizes CDPH or an LHD, or their agent, to disclose personally identifying information in public health records to other local, state, or federal public health agencies or to corroborating medical researchers, when the confidential information is necessary to carry out the duties of the agency or researcher in the investigation, control, or surveillance of disease, as determined by CDPH or an LHD. (*Id*. at (b).)
    b) Any disclosures made are to include only the information necessary for the purpose of the disclosure and only upon agreement that the information will be kept confidential. (*Id*. at (c).)

5) Authorizes the following disclosures for the purpose of enhancing the completeness of reporting to the federal Centers for Disease Control and Prevention (CDC) of HIV/AIDS and coinfection with certain diseases:
    a) disclosure to the health care provider who provides HIV care to the HIV-positive person who is the subject of the record by LHD HIV surveillance staff;
    b) disclosure by LHD tuberculosis control staff to CDPH tuberculosis control staff, who are authorized to further disclose information to the CDC, except for identifying patient information and only to the extent the information is requested by the CDC for purposes of the investigation, control, or surveillance of HIV and tuberculosis coinfections;
    c) disclosure by LHD sexually transmitted disease (STD) control staff to CDPH STD control staff, who are authorized to further disclose information to the CDC, except for identifying patient information and only to the extent the information is requested by the CDC for the purposes of the investigation, control, or surveillance of HIV and syphilis, gonorrhea, or chlamydia coinfection; and
    d) disclosure by LHD staff to CDPH staff for purposes of the investigation, control, or surveillance of HIV and its coinfection with hepatitis B, hepatitis C, and meningococcal infection, who are authorized to further disclose information to the CDC, except for identifying patient information and only to the extent the information is requested by the CDC. (Health & Saf. Code § 121025(c)(1).)

6) Authorizes specified LHD staff to further disclose information to CDPH or control staff, for the purpose of facilitating appropriate medical care and treatment of persons coinfected with HIV and tuberculosis, syphilis, gonorrhea, chlamydia, hepatitis B, hepatitis C, or meningococcal infection, the HIV-positive person who is

the subject of the record or the health care provider who provides their care. (Health & Saf. Code § 121025(c)(3).)

This bill:

1) Authorizes CDPH and LHDs to disclose personally identifying information in public health records for the coordination of, linkage to, or reengagement in care, as determined by CDPH or a LHD.
    a) Removes the limitations on disclosure described in 5)(b) through d), above.
    b) Removes the requirement that the disclosure is for the purpose of enhancing the completeness of reporting to the CDC of HIV/AIDS and coinfection with certain diseases.

2) Authorizes LHD HIV surveillance staff to disclose information to a health care provider who provides care to the HIV-positive person who is the subject of the record for the purpose of facilitating appropriate case management or care coordination or delivery of medical care and treatment.

3) Requires CDPH and LHD employees and their contractors to sign confidentiality agreements annually, rather than signing the agreements once, and deletes the requirement that CDPH and LHDs review the agreements annually.

## COMMENTS

1. Stated need for the bill

The authors write:

> California law only allows state and local public health personnel to communicate with each other or with health care providers about a person's HIV status to facilitate medical care and treatment if the person has HIV alone or has HIV coinfection with specific diseases (tuberculosis, hepatitis B, hepatitis C, meningococcal infection, chlamydia, gonorrhea, syphilis, or meningococcal infection). Sharing of information for other reportable communicable diseases, such as hepatitis A, mpox, or Shigella, is not allowed. During the 2022-23 mpox outbreak, CDPH could not disclose a patient's HIV status to an LHD or health care provider even when responding to an urgent request for clinical consultation on a complex mpox case, potentially resulting in more fragmented patient care and delaying appropriate treatment risking more severe infections. Not being able to record an mpox case's HIV status in the secure and confidential data systems for mpox investigations meant that LHDs were also unable to determine whether people diagnosed with mpox needed linkages to HIV care or prevention services, resulting in missed opportunities to prevent HIV transmission. California laws limiting the sharing of HIV data has seriously hindered the ability of LHDs and health care

providers to triage mpox cases and delivery of timely, client-centered mpox services for the people at highest risk of mpox complications. This bill will improve California's ability to ensure timely, quality health care for people with HIV and other reportable communicable diseases.

2. Recent outbreak of mpox revealed deficiency in current statutes related to authority of CDPH and LHDs to share confidential personally identifying information of persons affected with HIV or AIDS to coordinate care

Under existing law, CDPH and LHDs are only authorized to share personally identifying information of a person infected with HIV if they have HIV alone or have a coinfection with one or more of seven reportable diseases: chlamydia, gonorrhea, hepatitis B, hepatitis C, meningococcal infection, syphilis, and tuberculosis. In 2022, there was an mpox outbreak in the U.S., and since mpox was not included on this list of conditions for which CDPH and LHDs can cross reference HIV data, both local and state public health officials were unable to document and understand whether people with mpox were infected with HIV. This delayed their ability to understand if those infected with HIV were adversely impacted by mpox and subsequently delayed the ability to develop specific guidance and outreach, which would have more promptly enabled local public health and clinical partners to prevent severe mpox disease in this population.

As noted in the Senate Health Committee analysis of this bill:

> According to CDPH, the recent mpox outbreak disproportionately affected people with HIV. The CDC estimates 38% of mpox infections nationally from May through July 2022 were among people with HIV. According to CDC, people with HIV, particularly people whose HIV is not virally suppressed, are more likely to be hospitalized and can be at the highest risk of severe mpox infection and death if they are infected with mpox compared with people who are infected with mpox who do not have HIV. Through March 2024, 40.2% of mpox infections in California have occurred in people with HIV. All three of the mpox deaths in California during the recent outbreak were among people with advanced AIDS. People with advanced HIV are most likely to experience severe manifestations of their mpox infection; these are also the patients about whom CDPH was most often consulted on at the height of the mpox outbreak in 2022. People with HIV whose viral load is not fully suppressed have a greater clinical need both for mpox vaccination and for mpox treatment due to increased risk for severe disease and death. CDC recommends considering administration of mpox treatment for people with HIV who are not virally suppressed, and knowing this information is critical to facilitate prompt treatment which can prevent severe health outcomes of HIV/mpox coinfection, including death.[1]

[1] Sen. Health Comm. analysis of SB 1333 (2023-24 reg. session) as introduced Feb. 16, 2024 at p. 3.

In response to the experience of CDPH and LDHs during the mpox outbreak, this bill seeks to remove the existing limitations on disclosing personally identifying information to only those instances where coinfection of specified diseases exist to enable public health officials to have the necessary tools to respond to any future outbreaks of disease. The author and sponsors of the bill state that this will lead to better public health outcomes for those infected with HIV and the state as a whole. The bill still keeps all existing confidentiality requirements around sharing of personally identifying information and requires CDPH and LHD employees and their contractors to sign confidentiality agreements annually, as opposed to only signing the agreements once.

3. Statements in support

The sponsors of the bill write:

> [C]urrent law prohibits state and local public health officials from sharing HIV information with health care providers for a person coinfected with a communicable disease not specified in the law, even in response to requests for CDPH clinical consultation during a public health emergency (such as COVID-19 or mpox). As a result, people coinfected with HIV and other communicable diseases are at increased risk for severe health outcomes when their care is delayed or suboptimal because their health care provider is unable to consider the patient's HIV status as a part of their care and treatment plan.
>
> SB 1333 will allow confidential HIV reporting and data sharing between public health officials and health care providers for all reportable communicable diseases to promote the health and wellbeing of people with HIV, without needing to amend California law for each new or existing reportable infection. Expanding the sharing of HIV data for all reportable communicable diseases will allow CDPH to respond quickly to an emerging disease affecting people with HIV, including during a public health emergency, and promote improved health outcomes for people with HIV. Strong federal and state privacy laws will remain in place to protect the confidentiality and privacy rights of patients while better addressing the health needs of people with HIV.

**SUPPORT**

APLA Health (sponsor)
California Legislative LGBTQ Caucus (sponsor)
County Health Executives Association of California
Equality California (sponsor)
San Francisco Aids Foundation (sponsor)
Amador County Arts Council
Bienestar Human Services

Christie's Place
Courage California
End the Epidemics
GLIDE
Los Angeles LGBT Center
PRC
Pride Panthers Coalition Inc.
Radiant Health Centers
The Source LGBT+ Center
One individual

## OPPOSITION

None received

## RELATED LEGISLATION

Pending Legislation: None known.

Prior Legislation: SB 246 (Leno, Ch. 445, Stats. 2013), among other things, authorized CDPH and LHD to access reports of HIV infection that are electronically submitted by laboratories, and authorized LHD staff to further disclose information to the HIV-positive person or the health care provider.

## PRIOR VOTES

Senate Health Committee (Ayes 11, Noes 0)

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# SENATE COMMITTEE ON APPROPRIATIONS
**Senator Anna Caballero, Chair**
**2023 - 2024 Regular Session**

**SB 1333 (Eggman) - Communicable diseases: HIV reporting**

**Version:** February 16, 2024
**Urgency:** No
**Hearing Date:** April 22, 2024

**Policy Vote:** HEALTH 11 - 0, JUD. 11 - 0
**Mandate:** Yes
**Consultant:** Agnes Lee

**Bill Summary:** SB 1333 would revise and recast existing law regarding the reporting and disclosure of human immunodeficiency virus (HIV) cases.

**Fiscal Impact:**

- The California Department of Public Health (CDPH) estimates minor and absorbable costs.

- Unknown costs to local health departments to annually obtain signed confidentiality agreements. Cost to counties for administration would be potentially reimbursable by the state, subject to a determination by the Commission on State Mandates.

**Background:** Current law requires health care providers and laboratories to report cases of HIV infection to the local health officer using patient names on a form developed by CDPH. CDPH and local health department (LHD) employees and contractors must sign confidentiality agreements, which include information related to the penalties for a breach of confidentiality and the procedures for reporting a breach of confidentiality, prior to accessing confidential HIV-related public health records. Those agreements must be reviewed annually by either CDPH or the appropriate LHD. CDPH indicates it currently reviews and confirms that all required LHD and CDPH staff have completed and signed the annual confidentiality agreements.

Current law prohibits public health records relating to HIV or acquired immunodeficiency syndrome (AIDS), containing personally identifying information that were developed or acquired by CDPH or an LHD, from being disclosed, except for public health purposes or pursuant to a written authorization by the person who is the subject of the record or by the person's guardian or conservator. CDPH or an LHD may disclose personally identifying information in public health records to other local, state, or federal public health agencies or to corroborating medical researchers, when the confidential information is necessary to carry out the duties of the agency or researcher in the investigation, control, or surveillance of disease, as determined by CDPH or an LHD. Current law permits specific disclosures for the purpose of enhancing the completeness of reporting to the federal Centers for Disease Control and Prevention (CDC) of HIV/AIDS and coinfection with tuberculosis, syphilis, gonorrhea, chlamydia, hepatitis B, hepatitis C, and meningococcal infection.

Current law also permits certain public health staff, for the purpose of facilitating appropriate medical care and treatment of persons coinfected with HIV and tuberculosis, syphilis, gonorrhea, chlamydia, hepatitis B, hepatitis C, or meningococcal

infection, to further disclose the information to other specified public health staff, the HIV-positive person who is the subject of the record, or the health care provider, as specified.

**Proposed Law:** Specific provisions of the bill would:

- Require CDPH and LHD employees and their contractors to sign confidentiality agreements annually (rather than signing the agreements once); and delete the requirement that CDPH and LHDs review the agreements annually.

- Delete existing authority which only allows the disclosure of HIV/AIDS public health records specific to the purpose of enhancing the completeness of reporting to the CDC of HIV/AIDS and coinfection with and tuberculosis, syphilis, gonorrhea, chlamydia, hepatitis B, hepatitis C, or meningococcal infection.

- Additionally authorize CDPH or an LHD to disclose personally identifying information in HIV/AIDS public health records when necessary for the coordination of, linkage to, or reengagement in care for the person.

- Allow the disclosure of HIV cases between public health staff, the HIV-positive person, and the HIV-positive person's health care provider for purposes of facilitating appropriate care for persons coinfected with HIV and other communicable diseases, not only tuberculosis, syphilis, gonorrhea, chlamydia, hepatitis B, hepatitis C, or meningococcal infection.

**-- END --**

# SENATE COMMITTEE ON EDUCATION
**Senator Josh Newman, Chair**
**2023 - 2024 Regular**

| | | | |
|---|---|---|---|
| **Bill No:** | SB 1368 | **Hearing Date:** | April 24, 2024 |
| **Author:** | Ochoa Bogh | | |
| **Version:** | February 16, 2024 | | |
| **Urgency:** | No | **Fiscal:** | Yes |
| **Consultant:** | Kordell Hampton | | |

**Subject:** School curriculum: sexual health education and human immunodeficiency virus (HIV) prevention education: health framework: pregnancy centers.

## SUMMARY

This bill requires pregnancy centers to be included in the next revision of the Health framework and for information about pregnancy centers to be made available by the California Department of Education (CDE) and local educational agencies (LEA), as specified.

## BACKGROUND

Existing Law:

*Education Code (EC)*

1) Establishes the California Healthy Youth Act (CHYA), which requires LEAs to provide comprehensive sexual health and HIV prevention instruction to all students in grades 7 to 12, at least once in middle school and once in high school. (EC § 51933)

2) Authorizes an LEA to contract with outside consultants or guest speakers, including those who have developed multilingual curricula or curricula accessible to persons with disabilities, to deliver comprehensive sexual health education and HIV prevention education or to provide training for school district personnel. All outside consultants and guest speakers shall have expertise in comprehensive sexual health education and HIV prevention education and have knowledge of the most recent medically accurate research on the relevant topic or topics covered in their instruction. (EC § 51936)

3) Requires that pupils in grades 7 to 12, inclusive, receive comprehensive sexual health education at least once in junior high or middle school and at least once in high school. (EC § 51934)

4) Requires that the instruction and related instructional materials be, among other things:

   a) Age appropriate.

   b) Medically accurate and objective.

c) Appropriate for use with pupils of all races, genders, sexual orientations, and ethnic and cultural backgrounds, pupils with disabilities, and English learners.

d) Made available on an equal basis to a pupil who is an English learner, consistent with the existing curriculum and alternative options for an English learner pupil.

e) Accessible to pupils with disabilities. (EC § 51934)

5) Authorizes LEA to provide comprehensive sexual health education and HIV prevention education earlier than grade 7 using instructors trained in the appropriate courses and age-appropriate and medically-accurate information. (EC § 51933)

6) Requires LEAs to provide parents and guardians with a notice at the beginning of each school year, or, for a pupil who enrolls in a school after the beginning of the school year, at the time of that pupil's enrollment the following:

a) About instruction in comprehensive sexual health education and HIV prevention education and research on pupil health behaviors and risks planned for the coming year.

b) Advise the parent or guardian that the educational materials used in sexual health education are available for inspection.

c) Advise the parent or guardian whether the comprehensive sexual health education or HIV prevention education will be taught by school district personnel or by an outside consultant, as provided.

d) Advise the parent or guardian that the parent or guardian has the right to excuse their child from comprehensive sexual health education and HIV prevention education and that in order to excuse their child, they must state their request in writing to the LEA. (EC § 51938)

7) Provides that the parent or guardian of a pupil has the right to excuse their child from all or part of that education, including related assessments, through a passive consent ("opt-out") process. (EC § 51938)

**ANALYSIS**

This bill:

1) Requires the Instructional Quality Commission (IQC) to include in the next revision of the Health Framework for California Public Schools, after January 1, 2025, information on pregnancy centers as a resource.

2) Requires the CDE, on or before July 1, 2025 to make information about pregnancy centers available on its internet website.

3) Require each LEA to ensure that all pupils in grades 7 to 12, at least once in junior high and high school, receive information about local resources, including but not limited to, pregnancy centers.

**STAFF COMMENTS**

1) ***Need for the bill.*** According to the author, "SB 1368 would provide an additional resource for middle and high school students alongside the resources that are already provided under the CYHA. Our goal is not to change existing law but to add options, specifically to increase awareness for already available free services provided by local pregnancy centers. It is our duty to present women with all choices when it comes to pregnancy. Young women who want to explore all of their choices should have the right to do so and when organizations like pregnancy centers provide exceptional services at little to no cost they should be recognized."

2) ***What is a Pregnancy Center?*** In September 2012, the Guttmacher Institute released a report regarding Crisis Pregnancy Centers (CPCs). The report cites that "these centers offer counseling and prenatal services with an anti-abortion (pro-life) perspective. CPCs are typically associated with national anti-abortion organizations and evangelical Christian networks. Women who visit these centers need accurate medical information and timely medical attention. However, CPCs often offer misleading information that may delay or deny women access to proper reproductive health services, influence their decisions, and ultimately lead to more unintended births."

   Recently, on April 8, 2022, California Attorney General Rob Bonta sent a letter to Modesto Pregnancy Center, also known as Personal Health Now, demanding that the entity substantiate its claims that it provides medically accurate and unbiased sexual education to public school students. The Center currently provides sexual education curriculum to Modesto City Schools District and advertises that its program meets the requirements of the CHYA, which requires sexual education in California's public schools be "comprehensive" and medically accurate, and may not promote religious doctrine. However, the Department of Justice (DOJ) has received parent complaints indicating that the Center's sexual education curriculum does not, in fact, appear to comply with state law. Under Business and Professions Code section 17508, the Attorney General demands that the Center substantiate their claims within 20 days of letter issuance. Failure to provide substantiation by that deadline may result in legal action.

   *California Health and Human Services Agency (Abortion.ca.gov).*
   In 2022, the Legislature passed SB 1142 (Caballero, Chapter 566, Statutes of 2022), which required the California Health and Human Services Agency (CHHSA), or a designated entity, to create an internet website that provides information on abortion services in the state. Recently, the website abortion.ca.gov was launched, and it offers information on the types of abortion and the steps involved, as well as a tool to find abortion providers. The website also features telehealth-only options, alerts on CPCs providing false and medically incorrect information to discourage abortion, and a link to the consumer alert from the DOJ titled "Know the Difference: Crisis Pregnancy Centers v. Reproductive Health Facilities."

*Current statute already requires LEAs to provide students, at least once in junior high and once in high school, information, including but not limited to Information about local resources, how to access local resources, and pupils' legal rights to access local resources for sexual and reproductive health care such as testing and medical care for HIV and other sexually transmitted infections and pregnancy prevention and care, as well as local resources for assistance with sexual assault and intimate partner violence (EC 51934 § (a)(8)).*

3) ***Health Education Framework (2019).*** On May 8, 2019, the State Board of Education (SBE) officially adopted the 2019 Health Education Curriculum Framework for California Public Schools (the Health Education Framework) after over two years of development. The Health Education Framework is aligned to the 2008 California Health Education Content Standards, which support the development of knowledge, skills, and attitudes in eight overarching standards: (1) essential health concepts; (2) analyzing health influences; (3) accessing valid health information; (4) interpersonal communication; (5) decision making; (6) goal setting; (7) practicing health-enhancing behaviors; and (8) health promotion in six content areas of health education, including sexual health.

   *This bill would require the IQC in the next revision of the Health Framework for California Public Schools include information on pregnancy centers as a resource. The committee may wish to consider if it is appropriate to bind the IQC to a future obligation when considering the next revision of the Health Framework.*

4) ***California Healthy Youth Act.*** The CHYA took effect in 2003 and was initially known as the Comprehensive Sexual Health and HIV/AIDS Prevention Education Act (Act). Originally, the Act required LEAs to provide comprehensive sexual health education in any grade, including kindergarten, so long as it consisted of age-appropriate instruction and used instructors trained in the appropriate courses. Beginning in 2016 with AB 329 (Weber, 2015), the act was renamed the CHYA and, for the first time, required LEAs to provide comprehensive sexual health education and HIV prevention education to all students at least once in middle school and at least once in high school. From its inception in 2003 through today, the CHYA has always afforded parents the right to opt their child out of a portion, or all, of the instruction and required LEAs to notify parents and guardians of this right. Parents and guardians can exercise this right by informing the LEA in writing of their decision.

   *In addition to the CHYA, CDE also provide information on its website regarding resources for sexual and reproductive health for LEAs.*

5) ***Instructional Quality Commission. How Curriculum, Standards, Frameworks, and Model Curricula Are Created and Adopted.*** The Legislature has vested the IQC and SBE with the authority to develop and adopt state curriculum and instructional materials. The IQC develops curriculum frameworks in each subject by convening expert panels, developing drafts, and holding public hearings to solicit input. Changes are frequently made in response to public comment. The SBE then adopts the frameworks in a public meeting. The SBE also adopts, in a public process, instructional materials aligned to those frameworks for grades K-8. School district governing boards and charter schools then adopt instructional materials

aligned to these standards and frameworks. Local adoption of new curricula involves significant local cost and investment of resources and professional development.

These existing processes involve practitioners and experts who have an in-depth understanding of curriculum and instruction, including the full scope and sequence of the curriculum in each subject and at each grade level, constraints on instructional time and resources, and the relationship of curriculum to state assessments and other measures of student progress.

*The committee has adopted a joint policy with the Assembly Education Committee that prohibits the introduction of measures which propose to require, or require consideration of, modifications to state curriculum frameworks, to require that specified content be taught, or to require the development of new model curricula, must comply with requirements set forth in this policy. A portion of this bill violates the policy adopted by this committee.*

6) **Related Legislation.**

SB 1142 (Caballero, Chapter 566, Statutes of 2022) requires CHHSA, or an entity designated by the agency, to establish an internet website where the public can find information on abortion services in California. Requires CHHSA to also develop, implement, and update, as necessary, a statewide educational and outreach campaign to inform the public on how to access abortion services in the state.

AB 2134 (Akilah Weber, Chapter 562, Statutes of 2022) among various provisions, establishes the California Abortion and Reproductive Equity Program, and the California Reproductive Health Equity Program within the Department of Health Care Access and Information, to ensure abortion and contraception services are affordable for and accessible to all patients and to provide financial support for safety net providers of these services.

AB 315 (Bauer-Kahan, 2023) would have specified a person doing business who performs or intends to perform pregnancy-related services cannot advertise using false or misleading statements about whether they provide abortion services, and allows public prosecutors to file lawsuits against businesses that violate this provision. This bill also creates a private right of action that allows any individual who is harmed by a business's false or misleading advertising about abortion services, as specified, to bring a civil lawsuit against the business. *This bill was held in Assembly Appropriations Committee.*

AB 710 (Schiavo, 2023) would have required the Department of Public Health (DPH) to conduct an awareness campaign to communicate with local health departments, health care providers, and the public, regarding facilities that provide health care services, including, but not limited to, primary care and specialty clinics. *This bill was held in Assembly Appropriations Committee.*

**SUPPORT**

Life Choice Pregnancy Center (sponsor)

California Baptist for Biblical Values
California Catholic Conference
California Family Council
Informed Choices
Moreno Valley Women's Health Center
National Institute of Family and Life Advocates
The American Council
The National Center for Law & Policy
41 individuals

**OPPOSITION**

1 individual

**-- END --**

FEDERAL AIDS POLICY PARTNERSHIP
AIDS BUDGET & APPROPRIATIONS COALITION

The Honorable Tom Cole
Chairman
Committee on Appropriations
United States House of Representatives
Washington, DC 20515

The Honorable Rosa DeLauro
Ranking Member
Committee on Appropriations
United States House of Representatives
Washington, DC 20515

The Honorable Patty Murray
Chair
Committee on Appropriations
United States Senate
Washington, DC 20515

The Honorable Susan Collins
Vice Chair
Committee on Appropriations
United States Senate
Washington, DC 2051

April 16, 2024

**Subject: HIV Community Funding Requests for FY2025 Domestic HIV Programs**

Dear Chairman Cole, Ranking Member DeLauro, Chair Murray, and Vice Chair Collins:

The undersigned **121 organizations** of the AIDS Budget and Appropriations Coalition (ABAC), a work group of the Federal AIDS Policy Partnership (FAPP), urge you to increase crucial funding for domestic HIV/AIDS programs. We hope that Congress takes this opportunity to commit to ending the HIV epidemic and at the same time, combatting the STI, hepatitis, TB, and overdose syndemics that continue to ravage vulnerable communities in this Nation.

Now more than ever, we are missing the opportunity to put an end to an epidemic that is over 40 years old. We currently have biomedical, behavioral, and scientific tools that can effectively stop the transmission of HIV, ensure people living with HIV have full lives, and protect someone who may be at risk of HIV. There is now scientific and community consensus that if a person living with HIV is on treatment and achieves viral suppression, they cannot pass HIV on to a partner. Additionally, people who are HIV-negative have an ever-expanding toolbox of HIV prevention options, most notably pre-exposure prophylaxis (PrEP), medications that effectively prevent HIV. However, to finally end the HIV epidemic, public health programs across the country must have sufficient resources so that these tools can equitably reach the communities most impacted by HIV.

We thank you for ensuring that funding for these programs was maintained in the FY2024 appropriations bills and urge you to invest now so that we can save lives, save money by preventing illness, and finally end the HIV epidemic.

**Below are detailed domestic HIV and related programs funding requests that we urge you to include in the FY2025 appropriations bills.** A chart detailing each request as well as previous fiscal year funding levels for each program is available here: http://federalaidspolicy.org/fy-abac-chart/

**Ending the HIV Epidemic Initiative**

Over the last four fiscal years, on a bipartisan basis, Congress has appropriated additional funding for the Ending the HIV Epidemic Initiative, which sets the goal of reducing new HIV infections by 50% by 2025, and 90% by 2030. The initial focus has been on the 57 jurisdictions across the U.S. where the majority of new HIV

infections occur and have demonstrated results. Community Health Centers provided 85,000 people with PrEP in 2022 - nearly one-quarter of all PrEP prescriptions nationwide - and conducted 3.5 million HIV tests with this funding. The Ryan White Program has brought 37,731 people into or re-engaged them in HIV care. With the funding, CDC has conducted over 831,000 HIV tests, distributed 518,000 at-home HIV tests, and helped diagnosed 3,000 people living with HIV, and 55,000 persons were prescribed PrEP These accomplishments have occurred as the program has not received the funding needed as originally designed.

**We ask Congress to fund the Ending the HIV Epidemic Initiative by the amounts listed below in the following operating divisions in FY2025:**

- **$395 million** for *CDC Division of HIV/AIDS Prevention* for testing, linkage to care, and prevention services, including $100 million to continue support for a national PrEP program to implement more equitable access to PrEP (+$175 million);
- **$358.6 million** for *HRSA Ryan White HIV/AIDS Program* to expand comprehensive treatment for people living with HIV (+$193.6 million);
- **$207 million** for *HRSA Community Health Centers* to increase clinical access to prevention services, particularly PrEP (+$50 million)
- **$52 million** for *The Indian Health Service (IHS)* to address the combat the disparate impact of HIV and hepatitis C on American Indian/Alaska Native populations (+$47 million); and
- **$26 million** for *NIH Centers for AIDS Research* to expand research on implementation science and best practices in HIV prevention and treatment.

**<u>The Ryan White HIV/AIDS Program</u>**

For over 30 years, the Ryan White HIV/AIDS Program has provided medications, medical care, and essential coverage completion services to low-income, uninsured, and/or underinsured individuals living with HIV. With over 561,000 clients, the Ryan White Program provides comprehensive care to populations disproportionately impacted by the HIV epidemic. Nearly three-quarters of Ryan White Program clients are racial and ethnic minorities, and nearly two-thirds are under the federal poverty level. The Ryan White Program will continue to remain vital for this population as they grow older and begin experiencing comorbidities associated with aging. It is estimated that by 2030, 64% of Ryan White clients will be 50 years and older. With 90% of Ryan White Program clients achieving viral suppression, which means a person can live longer and healthier lives and cannot transmit HIV, the program is a model for a successful public health response to an infectious disease.

An increase in funding could expand access to effective HIV care and treatment to more people living with HIV. When adjusted for inflation, Ryan White Program funding has not increased since 2001, and funding has slowly decreased since 2013 based on 2001 dollars.[1] Since HIV treatment is a lifelong endeavor, it is essential that funding for this program be maintained and increased to address client growth and inflation.

**We urge Congress to fund the Ryan White HIV/AIDS Program at a total of $3.082 billion in FY2025, an increase of $510.8 million over FY2024, distributed in the following manner:**

- **Part A: $809 million**
- **Part B (Care): $520 million**
- **Part B (ADAP): $968.3 million**
- **Part C: $231 million**
- **Part D: $85 million**
- **Part F/AETC: $58 million**
- **Part F/Dental: $18 million**
- **Part F/SPNS: $34 million**
- **EHE Initiative: $358.6 million**

[1] Kaiser Family Foundation, The Ryan White HIV/AIDS Program: The Basics. 2022, Nov 3; https://www.kff.org/hivaids/fact-sheet/the-ryan-white-hivaids-program-the-basics/

**CDC Prevention Programs**

*CDC HIV Prevention and Surveillance*

HIV prevention methods are more effective than ever, offering options such as PrEP, HIV testing, behavioral interventions, and advanced scientific knowledge. However, HIV disproportionately affects specific communities, including Black and Latinx gay and bisexual men, Black heterosexual women, transgender and gender nonconforming individuals, people who inject drugs, and those in the South. Tailored prevention approaches are essential for success, recognizing the diversity of risks and needs within each community.

Investing in evidence-based prevention now can prevent thousands of new HIV infections and save billions in lifetime medical costs. The CDC's **Division of HIV Prevention** leads federal efforts in developing innovative prevention strategies, working closely with state, local, and community partners to address racial and geographic disparities. Funding supports expanded, targeted programs, including non-traditional HIV testing such as at-home testing to reduce stigma. Effective prevention strategies include testing, linkage to care, condom distribution, syringe service programs, and PrEP, with jurisdictions employing a combination of these approaches to combat HIV transmission.

***We urge you to fund the CDC Division of HIV Prevention at $822.7 million in FY2025, an increase of $67 million over FY2024. This is in addition to the $395 million for EHE Initiative work within the Division.***

Pre-Exposure Prophylaxis

Pre-exposure prophylaxis, or PrEP, are medications that effectively prevent HIV transmission when taken as prescribed. PrEP medication was approved by the FDA twelve years ago, and now there are multiple types of medications available, including generics and a long-acting regimen. Increasing access to PrEP has been a key strategy in ending the HIV epidemic, yet more progress must be made. Currently, only about one in three people who need PrEP are on a prescription. In 2022, only 13% of Black individuals, 24% of Hispanic individuals, and 15% of women assessed to be most in need of PrEP had a prescription. Reducing these disparities must be a priority as we work to expand PrEP use.

We are thankful that there has been an increased focus on PrEP both in Congress and from President Biden. In his FY2025 Budget Request, President Biden again called for a National PrEP Program to expand PrEP through providing medication to un- and under-insured individuals, as well as supporting and expanding PrEP programs across a variety of agencies. To increase equitable access to PrEP nationwide, we urge the Committee to support FY25 funding to continue work on a National PrEP Program and to expand PrEP access through other programs, including Ending the HIV Epidemic Initiative programs.

*CDC Division of Adolescent and School Health (DASH)*

Twenty percent of new HIV infections are among young people between the ages of 13 and 24, however, less than half of high schools and less than one-fifth of middle schools teach CDC's recommended sexual health topics. **CDC's Division of Adolescent and School Health** has provided funding for schools to increase access to health services, implement evidence-based sexual health education, and foster supportive environments for young people to learn. These programs have shown tremendous success in reducing risk factors related to HIV and other STIs, but only reach a small number of middle and high school students. To create a generation free of HIV, we must start in schools and ensure young people have the tools they need to make healthy decisions.

***We urge you to fund the CDC Division of Adolescent and School Health at $100 million in FY2025, an increase of $61.9 million over FY2024.***

*CDC STD Prevention*

Sexually transmitted infection (STI) rates remain at all-time highs in the United States, with syphilis reaching levels not seen since 1950 and congenital syphilis rates increasing tenfold in the last decade. Infections such as chlamydia, gonorrhea, and syphilis come at a steep price, with new cases each year resulting in more than a billion dollars in direct lifetime medical costs. However, the COVID-19 pandemic and the 2022 mpox outbreak, coupled with more than seventeen years of level funding for STD programs, has resulted in a 40% reduction in buying power for those working in STI prevention, further impeding efforts to get STIs under control. Last year's rescission of the remaining funding for the disease intervention specialist workforce expansion threatens the future of more than 1,000 full-time employees working to break transmission chains of STIs, HIV, viral hepatitis, and tuberculosis.

Additional funding for the **CDC's Division of STD Prevention** will allow STD programs to increase capacity, invest in disease intervention, monitor trends in STI cases throughout their jurisdictions, and quickly respond to new outbreaks. We are also requesting continuation of the funds begun in the FY2023 appropriations bill and continued in FY2024, including $20 million to move the grant year by one month, and $5 million to hold harmless grantee funding levels.

***We urge you to fund the CDC Division of STD Prevention at $322.5 million in FY2025, an increase of $148.2 million over FY2024.***

*CDC Viral Hepatitis Prevention*

Viral hepatitis prevention programs have been dramatically underfunded in the US over the past decade, despite the costly impact to the health system and the significant disease burden and mortality for people living with viral hepatitis. HBV and HCV are preventable diseases; however, of the nearly 5 million people now living with hepatitis B virus (HBV) and 2.4 million people living with hepatitis C virus (HCV) in the U.S., as many as 65% are undiagnosed.

The **CDC Division of Viral Hepatitis** (DVH) is the lead agency combating viral hepatitis at the national level by coordinating hepatitis education and technical assistance for providers and providing funding to the state and local health departments. DVH is currently funded at only $43 million–a debilitatingly small amount of funding compared to the financial resources required to reverse course on the worsening HBV and HCV epidemics, prevent more cases, and link those living with the disease to care, treatment, and for HCV, a cure. Now is the time to fully fund DVH and strengthen the public health infrastructure needed to respond to infectious diseases, particularly those caused and exacerbated by the nation's opioid crisis. We also encourage Congress to enact President Biden's proposal for a mandatory funded national initiative to eliminate Hepatitis C.

**We urge you to fund the CDC DVH Division of Viral Hepatitis at $150 million in FY2025, an increase of $107 million over FY2024.**

*CDC Infectious Diseases and Opioid Epidemic Funding*

Funding is also needed for the CDC to combat infectious diseases commonly associated with injection drug use in areas most impacted by the opioid crisis. The U.S. is experiencing an ongoing public health emergency crisis with the U.S. nearing 112,000 annual drug overdose deaths in 2023. Preventable outbreaks or significant spikes in infections of viral hepatitis and HIV continue to occur throughout the U.S. among people who inject drugs. Syringe Services Providers (SSPs) are first responders to the overdose and infectious disease crisis. They have the knowledge, contacts, and ability to reach people who use drugs, providing them with naloxone and other overdose prevention resources connecting people to medical care and support services, and increasing the likelihood that they seek treatment for their substance use disorder by 500%. A recent study shows

overdose deaths alone cost the U.S. economy over $1 trillion per year, costs that SSPs can help prevent. Funding would provide a critical down payment for services needed to help stop the spread of opioid-related infectious diseases.

***We urge you to fund the CDC's Infectious Diseases and Opioid Epidemic program in FY2025 at $150, an increase of $127 million over FY2024.***

*CDC Division of Tuberculosis Elimination (DTBE)*

The CDC's **Division of Tuberculosis Elimination** (DTBE) spearheads the fight against TB in the U.S., providing support and guidance to state and local TB programs. These programs, crucial in combating emerging outbreaks, played a pivotal role in responding to COVID-19 due to their expertise in managing airborne infectious diseases. Despite their vital role, TB cases persist in all states, with approximately 13 million Americans carrying latent TB infections. However, flat funding has undermined the capacity of TB programs, leading to outbreaks, increased TB rates, and the emergence of drug-resistant strains. In 2023, programs reported 9,615 TB cases (a rate of 2.9 per 100,000 persons), an increase of 1,295 cases, the first increase over pre-pandemic case numbers and rates, and the highest case count in a decade. Case counts increased in all age groups, in both US-born and non-US-born persons, and in 40 states and the District of Columbia. Delays in diagnosis due to the pandemic have exacerbated the situation, resulting in more complex cases, including infant fatalities. In 2021, the most recent year for which data are available, TB-related deaths in the U.S. reached a 16-year high.

DTBE is integral to TB research and development, notably through its TB Trials Consortium (TBTC), which accelerates the development of new, safer, and more effective drug regimens. However, stagnant funding has impeded the pace and scope of these critical trials, hampering our ability to prevent and treat TB effectively, especially among vulnerable populations like children and those with HIV. To support DTBE in its essential functions, including research and supporting domestic TB programs, and to address the National Action Plan to Combat Multidrug-Resistant Tuberculosis (NAP), increased funding is imperative. This includes funding for a national prevention initiative, prioritizing high-risk individuals, and resources to address ongoing infrastructure challenges such as treatment shortages.

***We urge you to fund the CDC Division of Tuberculosis Elimination at $225 million in FY2025, an increase of $88 million over FY2024.***

*Harm Reduction Programs*

Syringe service programs (SSPs) are proven to be highly effective in preventing HIV and hepatitis, as well as reducing overdose deaths. These programs offer sterile syringes and connect individuals to substance use treatment, HIV and hepatitis testing, and other healthcare services. With nearly 112,000 overdose deaths in 2023, expanding these cost-effective programs, especially in areas most impacted by the overdose crisis, is crucial. To combat the overdose epidemic, we must support harm reduction programs that meet individuals where they are and adhere to best practices. Unfortunately, the FY2024 omnibus retained a policy rider limiting federal funds for the purchase of sterile syringes, hindering the expansion of SSPs by state and local public health agencies.

***We urge you to fund the SAMHSA Community Harm Reduction and Engagement Initiative at $50 million in FY2025 and to remove bill language restricting the use of federal funds for the purchase of syringes while also not adding additional restrictions.***

**HIV/AIDS Housing**

Housing is the number one unmet need for people living with HIV and 2 out of 5 PLWHA who need housing assistance do not get it. Stable housing is associated with a 20% higher rate of viral suppression than those who are unhoused and is not only a matter of quality of life, but health. The Department of Housing and Urban Development's **Housing Opportunities for People With AIDS (HOPWA**) program is the only federal program that directly provides supportive and affordable housing for low-income people living with HIV. HOPWA is a highly effective housing program, providing housing to 55,000 households and supportive services to over 100,000 individuals. The program provides critical supportive services that are specialized to help low-income PLWHA obtain and retain housing. However, there is only enough HOPWA funding to house PLWHA who need housing for 1.24 months, per person, per year. To end HIV in America, we must robustly fund the HOPWA program.

***We urge you to fund the HOPWA program at least at $600 million in FY2025, an increase of $95 million over FY2024.***

**Minority HIV/AIDS Initiative (MAI)**

Racial and ethnic minorities in the U.S. are disproportionately affected by HIV/AIDS, with African Americans bearing the greatest burden. Three-quarters of new HIV infections occur among people of color, and rates are not decreasing among Black and Latinx gay and bisexual men, or transgender women of color. Targeted investments in minority populations are urgently needed. The **Minority AIDS Initiative** (MAI), established two decades ago, aims to improve HIV-related health outcomes for racial and ethnic minorities and reduce disparities. MAI resources complement federal HIV/AIDS funding, fostering collaboration between agencies to enhance effectiveness. The **Minority HIV/AIDS Fund** supports cross-agency initiatives for HIV prevention, care, treatment, and education. **SAMHSA's MAI program** provides tailored services, including prevention, treatment, and support for individuals at risk of mental illness and/or substance abuse, along with HIV testing and linkage services.

***We urge you to fund the Minority HIV/AIDS Fund at $105 million, and SAMHSA's MAI program at $160 million in FY2025, an increase of $48 million and $44 million over FY2024 levels, respectively. We also urge you to fund Minority AIDS Initiative programs across HHS agencies at $610 million in FY2025.***

**Bio-Preparedness Workforce Pilot Program**

It is estimated that 80% of the counties in 14 Southern states where some of the highest numbers of new HIV infections are occurring have no experienced HIV clinicians, with the disparities being most significant in rural areas. We urge your committee to fund the **Bio-Preparedness Workforce Pilot Program** within HRSA. This program will ensure a robust workforce of healthcare professionals is available to provide ID and HIV services in health professional shortage areas with underserved patient populations and at certain federally funded facilities and clinics, including Ryan White HIV/AIDS clinics.

***We urge you to fund the Bio-Preparedness Workforce Pilot Program at $50 million in FY 2025.***

**HIV/AIDS Research at the National Institutes of Health**

Far-reaching AIDS research at the NIH supports innovative basic science for better drug therapies and behavioral and biomedical prevention interventions, which have saved and improved the lives of millions around the world. One area where investment in HIV research is showing its critical value is in developing a

COVID-19 vaccine, where years of painstaking work by the NIH to develop HIV vaccines is now making possible the record-breaking timelines for the development of COVID-19 vaccines and other therapeutics.

The NIH Office of AIDS Research's FY2025 Professional Judgment Budget identified promising unfunded research priorities, such as reducing incidence through vaccines, more effective treatments, cure research, addressing the relationship between HIV and aging, as well as HIV co-morbidities research involving opioid co-epidemics, viral hepatitis, tuberculosis, and cancer. Without increases in HIV research funding, advances in these areas will be slowed or even stopped, research support for the EHE Initiative and the National HIV/AIDS Strategy for the United States will falter, and the early career researchers so critical to the future of HIV will move to other fields. While HIV treatment and prevention are the primary beneficiaries of HIV research, advances in basic medicine funded through HIV research at NIH have led to new vaccines, treatments, and medication for many other diseases such as cancer, Alzheimer's, kidney disease, tuberculosis, and now COVID-19.

**We urge you to fund HIV/AIDS research at the NIH at $3.953 billion for FY2025. This request is based on the FY2025 NIH HIV/AIDS Professional Judgment Budget.**

***Federal HIV/AIDS Coordination***

ABAC is requesting increased funding for two important offices that coordinate the implementation of the NHAS and EHE activities. The **White House Office of National AIDS Policy** and the **HHS Office of Infectious Disease and HIV/AIDS Policy** both play an important role in developing and implementing government-wide HIV strategies, as well as coordinating efforts among the wide range of federal agencies working to end the HIV epidemic and the syndemics of STDs, hepatitis, TB, and overdoses.

***We urge you to provide a total of $20 million for the Office of Infectious Disease and HIV/AIDS Policy and $3 million for the White House Office of National AIDS Policy in FY2025.***

***Sexual Health Programs***

The **Teen Pregnancy Prevention Program** provides young people with evidence-informed or evidence-based information to prevent unintended pregnancies, HIV, and other STDs. As noted above, HIV and STDs disproportionately impact young people, so they must receive age-appropriate medically accurate, and complete information. This program is an important tool in our quest to end HIV and STDs.

***We urge you to fund the Teen Pregnancy Prevention Program at $150.0 million in FY2025, an increase of $49 million over FY2024.***

Despite decades of research that shows that **"sexual risk avoidance" abstinence-only programs** are ineffective at their sole goal of abstinence until marriage for young people, more than $2 billion has been spent on abstinence-only programs since its emergence in 1982. These programs withhold necessary and lifesaving information, reinforce gender stereotypes, often ostracize LGBTQIA+ youth, and stigmatize young people who are sexually active or survivors of sexual violence.

***We urge you to eliminate funding for the failed and incomplete abstinence-only-until-marriage "Sexual Risk Avoidance Education" competitive grant program and the Title V "Sexual Risk Avoidance Education" state grant program in FY2025, which would render a $35 million savings based upon FY2024 funding levels.***

**The Title X program** is the only dedicated federal family planning program and is a vital tool in fighting the HIV and STD epidemics in the United States. Title X-funded health centers provide millions of people with high-

quality care—including contraceptive care, HIV and STD screening, STD treatment, cancer screening, and sexual health education—each year and are a particularly important lifeline for low-income women, especially women of color.

***We urge you to fund Title X at $512 million in FY2025, an increase of $225.5 million over FY2024.***

To treat the rising costs of new STI infections and address healthcare access issues, we request $200 million for a new demonstration project within the Bureau of Primary Health Care at HRSA to award grants to eligible public and private nonprofit clinics for **STI clinical services**, which will address staffing shortages, enhance training, and expand capacity. Testing and prompt treatment for bacterial STIs are the best tools to reduce STI rates in the US. However, there is currently no dedicated federal program to directly support high-quality and accessible STI clinical services. This demonstration project will provide long-overdue support for patients seeking care, and their public and nonprofit providers.

***We urge you to fund a new STI clinical services demonstration project within HRSA at $200.0 million in FY2025.***

**SAMHSA HIV Block Grant**

We urge you to include language, as was proposed in the President's budget, that would modernize how states qualify to be eligible for the HIV set-aside of the Substance Abuse Block Grant (SABG). Instead of using the outdated measurement of AIDS cases for a state to qualify for the 5 percent HIV set-aside, the number of HIV cases in the state should be used.

Thank you for considering these requests and your continued support for domestic HIV/AIDS programs. We hope your Fiscal Year 2025 Appropriations Bills demonstrate Congress's commitment to fighting HIV/AIDS and help set our nation on a path to eradicating HIV as we know it in the United States.

Should you have any questions, please contact the ABAC co-chairs Nick Armstrong at narmstrong@taimail.org, Drew Gibson at dgibson@aidsunited.org, Emily McCloskey Schreiber at eschreiber@nastad.org, or Carl Schmid at cschmid@hivhep.org.

Sincerely,

ACR Health (NY)

Act Now End AIDS (ANEA) Coalition (SC)

ADAP Advocacy (NC)

Advocacy House Services, Inc. (NC)

Advocates for Youth (DC)

AGAPE Missions, NFP (IL)

AIDS Action Baltimore (MD)

AIDS Alabama (AL)

AIDS Alabama South (AL)

AIDS Alliance for Women, Infants, Children, Youth & Families (DC)

AIDS Foundation Chicago (IL)

AIDS Treatment Activist Coalition (NY)

AIDS United (DC)

Aliveness Project (MN)

Alliance Care 360 (IL)

Alliance Community Healthcare, Inc. (NJ)

American Academy of HIV Medicine (DC)

American Psychological Association (DC)

American Sexual Health Association (NC)

Amida Care (NY)

APLA Health (CA)

Appalachian Learning Initiative Inc. (WV)

Argus Community, Inc. (NY)

Arianna's Center (FL, PR)

Association of Nurses in AIDS Care (OH)

AVAC (NY)

Big Bend Cares (FL)

Big Cities Health Coalition (MD)

Black AIDS Institute (GA)

BOOM!Health (NY)

CAEAR Coalition (DC)

CARES of Southwest Michigan (MI)

Cascade AIDS Project (OR)

Center for Health Law and Policy Innovation (MA)

CenterLink: The Community of LGBT Centers (FL)

Chicago House and Social Service Agency (IL)

Colorado Organizations and Individuals Responding to HIV/AIDS (CORA) (CO)

Community Access National Network (LA)

Community Liver Alliance (PA)

Community Resource Initiative (MA)

Drug Policy Alliance (NY)

Elizabeth Glaser Pediatric AIDS Foundation (MA)

Equality California (CA)

Equitas Health (OH)

Fatty Liver Foundation (ID)

Five Horizons Health Services (AL)

Food for Thought (CA)

Georgia AIDS Coalition (GA)

Georgia Equality (GA)

Grady Health System (GA)

Harlem United (NY)

HealthHIV (DC)

Healthy Teen Network (MD)

Heartland Alliance Health (IL)

HEP (WA)

HIV + Hepatitis Policy Institute (DC)

HIV AIDS Alliance of Michigan (MI)

HIV Dental Alliance (GA)

HIV Medicine Association (VA)

Hope and Help Center of Central Florida, Inc. (FL)

Hope House of St. Croix Valley (MN)

Housing Works (NY)

Howard Brown Health (IL)

Human Rights Campaign (DC)

Hyacinth Foundation (NJ)

iHealth (NY)

In Our Own Voice: National Black Women's Reproductive Justice Agenda (DC)

Indiana Recovery Alliance (IN)

Infectious Diseases Society of America (VA)

International Association of Providers of AIDS Care (DC)

JSI (MA)

Korean Community Services of Metropolitan New York (NY)

Lansing Area AIDS Network (MI)

Latino Commission on AIDS (NY)

LGBTQ Community Center of the Desert (CA)

Medical Students for Choice (PA)

NASTAD (DC)

National Association of County and City Health Officials (DC)

National Black Gay Men's Advocacy Coalition (DC)

National Black Women's HIV/AIDS Network (SC)

National Coalition of STD Directors (DC)

National Tuberculosis Coalition of America (GA)

National Viral Hepatitis Roundtable (WA)

National Working Positive Coalition (NY)

NMAC (DC)

Northeast Florida AIDS Network, Inc. (FL)

Poderosos (TX)

Positive Impact Health Centers (GA)

Positive Women's Network-Ohio (OH)

Positive Women's Network-USA (CA)

PrEP4All (NY)

Proactive Community services (IL)

Reproductive Health Access Project (NY)

Rural AIDS Action Network (RAAN) (MN)

Ryan White Medical Providers Association (VA)

SAGE (NY)

San Francisco AIDS Foundation (CA)

San Francisco Community Health Center (CA)

SIECUS: Sex Ed for Social Change (DC)

SisterLove, Inc. (GA)

Southern AIDS Coalition (AL)

Southwest Center for HIV/AIDS (AZ)

Southwest Recovery Alliance (AZ)

The AIDS Institute (DC)

The Aliveness Project, Inc. (MN)

The Well Project (NY)

Thomas Judd Care Center at Munson Medical Center (MI)

Thrive Alabama (AL)

Treatment Action Group (NY)

Trellus (IL)

Truckee Meadows Community College (NV)

UChicago | Care2Prevent (IL)

Unconditional Love, Inc. (FL)

UNIFIED- HIV Health and Beyond (MI)

University of Illinois at Chicago - Community Outreach Intervention Projects (IL)

URGE: Unite for Reproductive & Gender Equity (DC)

US People Living with HIV Caucus (DC)

Valley AIDS Council (TX)

Vivent Health (CO, MO, TX, WI)

Wellness AIDS Services, Inc. (MI)

Whitman-Walker Institute (DC)

Chief Executive Office.

**COUNTY OF LOS ANGELES**
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(213) 974-1101 ceo.lacounty.gov

**CHIEF EXECUTIVE OFFICER**
Fesia A. Davenport

April 23, 2024

To: Supervisor Lindsey P. Horvath, Chair
Supervisor Hilda L. Solis
Supervisor Holly J. Mitchell
Supervisor Janice Hahn
Supervisor Kathryn Barger

From: Fesia A. Davenport FAD
FAD (Apr 19, 2024 12:50 PDT)
Chief Executive Officer

**SACRAMENTO UPDATE – 2024 COUNTY-SPONSORED BILL AND BUDGET PROPOSALS**

## Executive Summary

This is an update to the memorandum my office submitted to your Board on November 20, 2023, related to County-sponsored legislative and budget proposals for the second year of the 2023-24 Legislative Session.

The Chief Executive Office's Legislative Affairs and Intergovernmental Relations (CEO-LAIR) staff was successful in identifying and partnering with key legislators to author the County's sponsored legislative proposals by the Legislature's bill introduction deadline of February 16, 2024.

The attachment includes a summary of the legislative and budget proposals and the status of each proposal.

Should you have any questions concerning this matter, please contact me or Samara Ashley, Assistant Chief Executive Officer, at (213) 974-1464 or sashley@ceo.lacounty.gov.

FAD:JMN:SA:AM:gr

Attachment

c: All Department Heads

**County-Sponsored Legislative Proposals**

**AB 1948 (Rendon): Increasing Access to Homeless Prevention Services (Department of Health Services – Housing for Health Branch Submission)** – This proposal would delete the January 1, 2025, sunset date for AB 728 (Chapter 337, Statutes of 2019), which authorizes the implementation of Homeless Multidisciplinary Personnel Teams for purposes of serving individuals at high-risk of homelessness, while preserving client privacy and confidentiality protections, through January 1, 2025.

AB 1948 is currently on the Assembly Floor.

**AB 2213 (Rubio): Los Angeles County Oversight Boards (Executive Office of the Board of Supervisors - Commission Services Submission)** – This proposal would amend Health and Safety Code Section 34179(q)(2) to ensure that the territorial jurisdictions of the Los Angeles County's (County) five Oversight Boards are updated immediately after each decennial redistricting plan.

Specifically, this proposal would ensure that the Oversight Board's encompass the same exact territory as the County's five supervisorial districts to enable the oversight boards to have jurisdiction over each successor agency located within each of the respective supervisorial district borders.

AB 2213 is currently in the Assembly Local Government Committee.

**AB 2455 (Gabriel) - Whistleblower Protection: State and Local Government Procedures (Auditor-Controller Submission)** – This proposal modernizes current law that authorizes the County to operate a whistleblower hotline to identify and investigate fraud, waste, and abuse of government resources. Specifically, the bill updates the way an individual may submit a whistleblower tip to modern forms of communication, such as online form submission, email, text, etc., whereas current law explicitly allows for whistleblower tips to be submitted via phone call. Further, AB 2455 would explicitly authorize whistleblower tips and investigations to cover county contractors and subcontractors, whereas current law explicitly allows for whistleblower tips and investigations to encompass county employees. Lastly, this bill would authorize the auditor-controller to delegate whistleblower hotline duties to their staff, such as receiving, referring, and investigating whistleblower tips.

AB 2455 is currently in the Assembly Judiciary Committee.

**Assembly Bill (AB) 2498 (Zbur): The California Housing Security Act (Related to an April 18, 2023, Board-approved motion)** – This proposal would establish a statewide housing subsidy program to reduce housing insecurity for low-income individuals and families. The California Housing Security Program would provide housing subsidies to eligible low-income individuals and families to not exceed $2,000 a month. The program would target populations that are at high risk of experiencing homelessness, including older adults, adults with disabilities, and individuals experiencing homelessness regardless of their immigration status. This proposal is co-sponsored with the City of Santa Monica.

AB 2498 is currently in the Assembly Housing and Community Development Committee.

**AB 2502 (L.Rivas): Cutting the Yellow Tape for Homeless Housing Construction (Department of Public Works Submission)** – This proposal seeks to provide flexibility to local governments for the selection of construction procurement and delivery methods by adjusting the definition of "emergency." This proposal would broaden the definition of an emergency as defined in the Public Contract Code to enable local governments more options to expedite the construction of homeless housing by foregoing the typical competitive bidding processes.

AB 2502 is currently in the Assembly Local Government Committee.

**AB 3197 (Lackey): Modernizing Local Elections (Registrar-Recorder/County Clerk Submission)** – This proposal would authorize a county election's official to require a standardized form for the circulation of petitions within the county and would authorize the county elections official to allow candidates to submit online candidate statements for nonpartisan elective offices of local jurisdictions within the county.

AB 3197 is currently in the Assembly Elections Committee.

**SB 987 (Menjivar): Establishing an Independent Pre-Trial Release Department in Los Angeles County (Justice, Care and Opportunities Department [JCOD] Submission)** – This proposal is specific to Los Angeles County only and would expand the definition of "criminal justice agencies" to include pretrial release departments, allowing an independent agency like JCOD to establish an independent pretrial division capable of offering a wide array of client services along with the traditional aspects of a pretrial operation. The proposal would also protect discussions between clients and service providers from use by law enforcement in any subsequent court action. Additionally, it would allow JCOD to access criminal history information necessary to run the traditional components of a pretrial operation.

SB 987 is currently in the Senate Appropriations Committee.

**SB 1169 (Stern): Modernizing Flood Control Borrowing Capacity (Department of Public Works Submission) -** This proposal would modernize the Los Angeles County Flood Control Act by eliminating the outdated $4.5 million debt limit on federal loans, and aligning repayment terms with those of the standardized, federal Water Infrastructure Finance and Innovation Act Program and the U.S. Army Corps of Engineers Water Infrastructure Financing Program. Modernizing borrowing capacity and aligning with these federal programs' terms will provide the County access to critical financial assistance programs to finance projects which will safeguard communities from climate-induced flood risks and bolster water infrastructure.

SB 1169 is currently in the Senate Local Government Committee.

**SB 1441 (Allen): Examination of Petitions (Registrar-Recorder/County Clerk Submission) -** This proposal would require the examination of insufficient petitions requested by petition proponents to conclude no later than 60 days after it commenced and, would require the proponent to reimburse all costs incurred by the county elections official due to the examination.

SB 1441 is currently in the Senate Elections and Constitutional Amendments Committee.

**County-Sponsored Budget Proposals**

**Repurpose and Reimagine the Challenger Memorial Youth Center (Requested by the Department of Economic Opportunity related to a May 17, 2022, Board-adopted motion)** – This proposal will continue to advocate for $25 million in one-time funding for the Challenger Reimagined Project, which is a multiphase repurposing of the Challenger Memorial Youth Probation Facility in the Antelope Valley led by the Department of Economic Opportunity, in collaboration with the Board and other County departments providing subject matter expertise during each phase. The Challenger Project aims to help under-served and under-resourced youth transition safely and securely to an independent adulthood. The program will serve participants (ages 18-25 who were involved with the criminal justice or foster care systems, or who are homeless) who will live on the Challenger campus for 6-18 months while they are offered educational pathways and career training, as well as mental health services and robust life-skills instruction.

This budget proposal has been carried over from the 2023 legislative year.

**Public Defenders/Community Assistance, Recovery, and Empowerment (CARE) Act (Public Defender's Office Submission)** – This proposal would amend language in the CARE Act related to funding for legal representation for respondents in CARE Act proceedings. Current law authorizes the Legal Services Trust Fund Commission at the State Bar (State Bar) to appoint a qualified legal services project (QLSP), as defined, to represent the respondent. If no legal services project has agreed to accept these appointments, a public defender or other counsel working in that capacity shall be appointed to represent the respondent.

While existing law states that the Legal Services Trust Fund Commission may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis, or award grants, the statute is silent on how often the State Bar will disburse these funds or seek qualified legal services projects to provide legal counsel. In response, the State Bar has determined it will allocate funds after a Request for Proposals (RFP) on an annual basis. Note that in Los Angeles County, as with six of the seven counties in Cohort 1 of the CARE Act, no QLSP applied to manage the legal services funding. The only county in which there is a QLSP is San Francisco. As such, in Los Angeles County, the office of the Public Defender is providing legal representation.

The State Bar's decision to issue RFPs for annual funding would provide inconsistent funding for respondent's counsel and be disruptive to either the qualified legal services projects or the public defenders operations, as well as to respondents who may have to switch counsel during their participation in CARE Court. CEO-LAIR staff is currently working with the California Department of Finance (DOF) to develop a budget proposal for the May Revise or inclusion in a Budget Trailer Bill, to ensure funding is allocated for a period of three to five years for legal representation for CARE Court respondents.

**Legislative Proposals not Moving Forward in the 2024 Legislative Year**

Below is a list of legislative proposals included in the November 2023 memo that will not move forward during the 2024 Legislative Year:

**Public Employee Forfeiture of Pensions for Crimes Related to Child Sexual Abuse (Department of Human Resources Submission)** – This proposal would have expanded existing forfeiture statutes under the California Public Employee's Pension Reform Act to include all crimes of child sexual abuse. Specifically, it would have required a public officer or employee who is found responsible for a crime of child sexual abuse arising out of or in the performance of their official duties, not just limited to felony convictions, to forfeit all rights, benefits, and membership in any public retirement system at the time the act is committed retroactive to the first commission date of the crime.

CEO-LAIR worked to advance this proposal and secure an author with over 10 State legislative offices. As part of the efforts to advance the proposal, CEO-LAIR also coordinated with labor organizations, sought the advice of senior legislators, and met with the Assembly's Public Employment and Retirement Committee staff. As a result of challenges related to finding an author and the political climate in Sacramento, this proposal will not advance this legislative year.

**Housing Status as a Medical Necessity for Residential Treatment Services (Department of Public Health Submission)** – This proposal would have requested that the California Department of Health Care Services (DHCS) amend the California Advancing and Innovating Medi-Cal (CalAIM) waiver, which ends in 2026, to maximize the consideration of living environment or housing status for ongoing authorization of residential substance use disorder treatment services until appropriate housing or living arrangements are secured. This proposal would have allowed California to consider an individual's housing status or living environment as a core determination for ongoing authorization of residential treatment services until post-discharge housing is identified and allow federal expenditure authority for recovery-oriented housing.

CEO-LAIR and the County's Department of Public Health-Substance Abuse Prevention and Control (DPH-SAPC) are working directly with DHCS to address the issue of permitting housing as a medical necessity for substance use disorder treatment as an operational change with the DHCS, in lieu of a legislative proposal. CEO-LAIR and DPH-SAPC are currently working with DHCS to address the following: 1) ensure that DHCS issues the Behavioral Health Information Notice with clarifying language for pre-existing authority in an current Centers for Medicare and Medicaid

(CMS) waiver related to housing status as a consideration in medical necessity; and 2) monitor the status of the CMS approval of the proposed CalAIM amendments which would allow for coverage of transitional rent services for the remainder of the CalAIM demonstration period. As a result of these ongoing discussions with DHCS, the County is no longer pursuing a legislative proposal to address this matter.

Board offices were briefed on this matter and provided an update.

**Budget Proposal not Moving Forward in the 2024 Legislative Year**

Below is a budget proposal included in the November 2023 memo that will not move forward during the 2024 Legislative Year:

**Improving the Cannabis Industry through Equity Programming and Capacity Building (Department of Consumer and Business Affairs [DCBA] Submission)** – This proposal was a budget request for $20 million in one-time State General Fund in Fiscal Year (FY) 2024-25 to augment the State's Cannabis Equity Grants Program for Local Jurisdictions. In December of 2023, the Legislative Analyst's Office (LAO), the California Legislature's nonpartisan fiscal and policy advisor, published its Fiscal Outlook for the FY 2024-25 budget, citing a projected $68 billion deficit. On January 10, 2024, Governor Gavin Newsom unveiled his proposed budget for FY 2024-25, estimating a shortfall of $37.9 billion, largely due to the stock market decline in 2022 and delay in income tax collections.

In March 2024, DOF released its February Finance Bulletin, which provides an economic update and cash report for the State. The bulletin indicates that preliminary cash receipts were $5 billion, or 19.7 percent, below the Governor's budget forecast for January, and $5.9 billion, or 4.8 percent, below the fiscal year-to-date forecast of $121.5 billion. In response to DOF's latest economic update, the LAO revised its budget outlook, expanding the State's deficit to $73 billion. In addition, Los Angeles County is currently ineligible to apply for the Cannabis Equity Grants Program for Local (CEG) Type 2 Funding until it formally adopts a local equity program.

In light of the growing fragility of the State's budget and CEG funding eligibility, CEO-LAIR and DCBA recommend no longer pursing the $20 million augmentation of the CEG. Board offices were briefed on this matter and provided an update.

**Next Steps**

CEO-LAIR will continue to spearhead advocacy efforts with the Board of Supervisors, Board staff, County departments, members of the State Legislature and coalition partners to advance the County's sponsored legislative and budget proposals.

CALIFORNIA HIV/AIDS POLICY RESEARCH CENTERS

# *Implementation Models for Linkage to HIV Prevention Services in California Emergency Departments*

Pre-exposure prophylaxis (PrEP) is safe, well tolerated, and significantly reduces the risk of risk of acquiring HIV when taken as prescribed.[1–3] Improving PrEP uptake is a goal of the National HIV/AIDS Strategy and the Ending the HIV Epidemic initiative.[4] Despite substantial progress in improving access to HIV prevention, the Centers for Disease Control (CDC) estimates that only 30% of people who could benefit from PrEP are prescribed it, a gap occurring against a backdrop of major inequities in PrEP use among racial, ethnic, gender, and economic lines.[5–9]

Strategies are needed to address these disparities in PrEP access, awareness, and use. Expanding HIV prevention services to reach populations at increased risk of acquiring HIV who might not otherwise have access to healthcare services should be promoted. Emergency departments (ED) are critical access points for many Californians, often serving as their sole point of entry with the healthcare system. Over the past 20 years, EDs have successfully implemented opt-out HIV screening programs leading to the identification, linkage, and treatment of individuals who might otherwise have remained undiagnosed.[10–15] Until recently, HIV prevention counseling and delivery of prevention services, including PrEP, for ED patients screening HIV negative have not been prioritized. Consequently, best practices for implementing ED HIV prevention services (HPS) are emerging but not yet well defined.[16–23]

In 2023 we had the opportunity to study seven California EDs that were implementing HIV prevention program linkage demonstration projects. The goal of the research described here was to describe and synthesize the various implementation strategies utilized by the seven EDs to integrate HPS, highlight the challenges and successes of these strategies, and provide actionable information on how future programs might consider implementing HIV prevention in the ED setting.

## Methods

We conducted a mixed-methods, type 3 hybrid effectiveness-implementation study of seven California EDs implementing HPS linkage programs.[24] Each of the EDs received Gilead FOCUS funding to identify patients without HIV via their routine HIV screening infrastructure who were also eligible for linkage to comprehensive HPS and to provide linkage to such services between September 2021 and March 2023. The implementation research described here was approved by the UC Berkeley Committee for the Protection of Human Subjects.

The FOCUS program is a public health initiative that supports HIV and viral hepatitis screening, prevention, and linkage to a first appointment for care.[25] Comprehensive HIV prevention services were defined by FOCUS as “a combination of structural, biomedical, and behavioral prevention interventions that have demonstrated efficacy in helping to reduce the transmission of HIV infection”.[26] Participating sites independently developed their HIV prevention protocols and all had established HIV screening programs in place prior to the integration of HPS.

For the implementation research described in this report, a list of EDs funded by FOCUS to develop HPS programs in California was obtained from the regional FOCUS program officer. The seven recipients were contacted in March 2023 via email and asked to voluntarily participate in this study. All sites agreed to participate and provided basic ED demographic data and Gilead FOCUS indicator data using a structured form. Next, using an interview guide informed by the structured data we received, interviews were conducted between July – September 2023 with key personnel at each ED (including clinical champions, navigators/case managers, data managers). The guide asked respondents to describe their FOCUS program, review basic outcome data, discuss successes and challenges related to implementation, and share their perspectives on whether they would recommend continuing the program if funding were continued. Interviews were conducted over a videoconferencing platform and recorded. Interview recordings and transcripts were reviewed for gaps in our understanding, and we followed up with sites via email to gather additional data as needed.

We then reviewed quantitative and qualitative information to summarize each program, identify points of commonality across ED implementation strategies, define and categorize the programs into implementation models for the integration of HPS into ED settings, and qualitatively explored the success and challenges with each model.

**Summary of Findings**

- In 2023, we conducted a mixed-methods, effectiveness-implementation study of seven California emergency departments (ED) implementing HIV prevention services (HPS).
- The goal was to provide actionable information about implementing HPS in the ED and highlight the challenges and successes of various implementation strategies.
- Staffing capacity, existing screening programs, access to technology, and patient interest in PrEP were revealed as factors contributing to the success of HPS linkage programs in EDs.
- Based on common themes across the seven participating EDs, we identified three primary models for implementing HPS linkage in the ED: Behavioral Risk Assessment, STI Risk Assessment, and Automated Risk Assessment.
- Interacting with ED patients is an opportunity for HIV education, prevention, and counseling for patients who may otherwise lack information about PrEP. This is important even if people don't initiate PrEP after their ED encounter.
- Linkage to HIV prevention services from the ED is feasible and can increase access to PrEP for those at risk of acquiring HIV. However, the number of patients who are screened and meet the criteria for linkage to HPS often exceeds ED capacity for this service.
- As the California Department of Public Health expands screening recommendations to include HIV, syphilis, and hepatitis C within the ED, there is an opportunity to extend those recommendations to include prevention services as an adjunct to these screening programs.

## Results

Stakeholders in the participating ED programs were enthusiastic about HPS delivery in EDs and recognized its potential public health value in increasing awareness and uptake of PrEP. For example, one ED-based patient navigator shared, "*I feel like the work is definitely important. It's worth it because some people need the information but don't know where to look, and that [conversation] can change everything for them*." Additionally, some EDs chose to continue their HPS linkage programs even after the end of their funding period. An ED physician shared that they "*pitched [the program] to the CEO of*

*[their] health system and were able to give them the numbers as far as screening to show that it was a self-sustainable program*."

### Enabling Factors and Barriers to Implementation for ED HPS linkage

In interviews conducted with staff at the seven participating EDs, common themes emerged regarding the factors contributing to their implementation pilots' success. First, having existing navigator staff in place was a common factor mentioned that supported the programs. In most cases, chart reviews, risk assessments, the offer of HIV prevention education in the ED, and/or linkage to outpatient HPS were conducted by ED-based patient navigators. Second, all sites had existing opt-out HIV screening programs, which enabled them to identify patients who screened negative for HIV, serving as the foundation for their HPS efforts. Third, in some settings, having adequate technology infrastructure and support staff for that technology allowed ED staff to integrate new workflows and more easily prioritize patients by risk level. These sites relied heavily on electronic health record (EHR) systems and recurring data reports to gather information on eligible patients within the ED. Finally, patient interest in HIV prevention methods, including PrEP, and consent to be referred to HPS proved to be an important determinant of the pilots' impact. Many sites shared that it was not uncommon for patients to show a lack of interest in PrEP or referrals to HPS, in which case the navigators respected the patient's requests and did not offer further education or offers of linkage.

### Emergency Department-Delivered HIV Prevention: Implementation Models

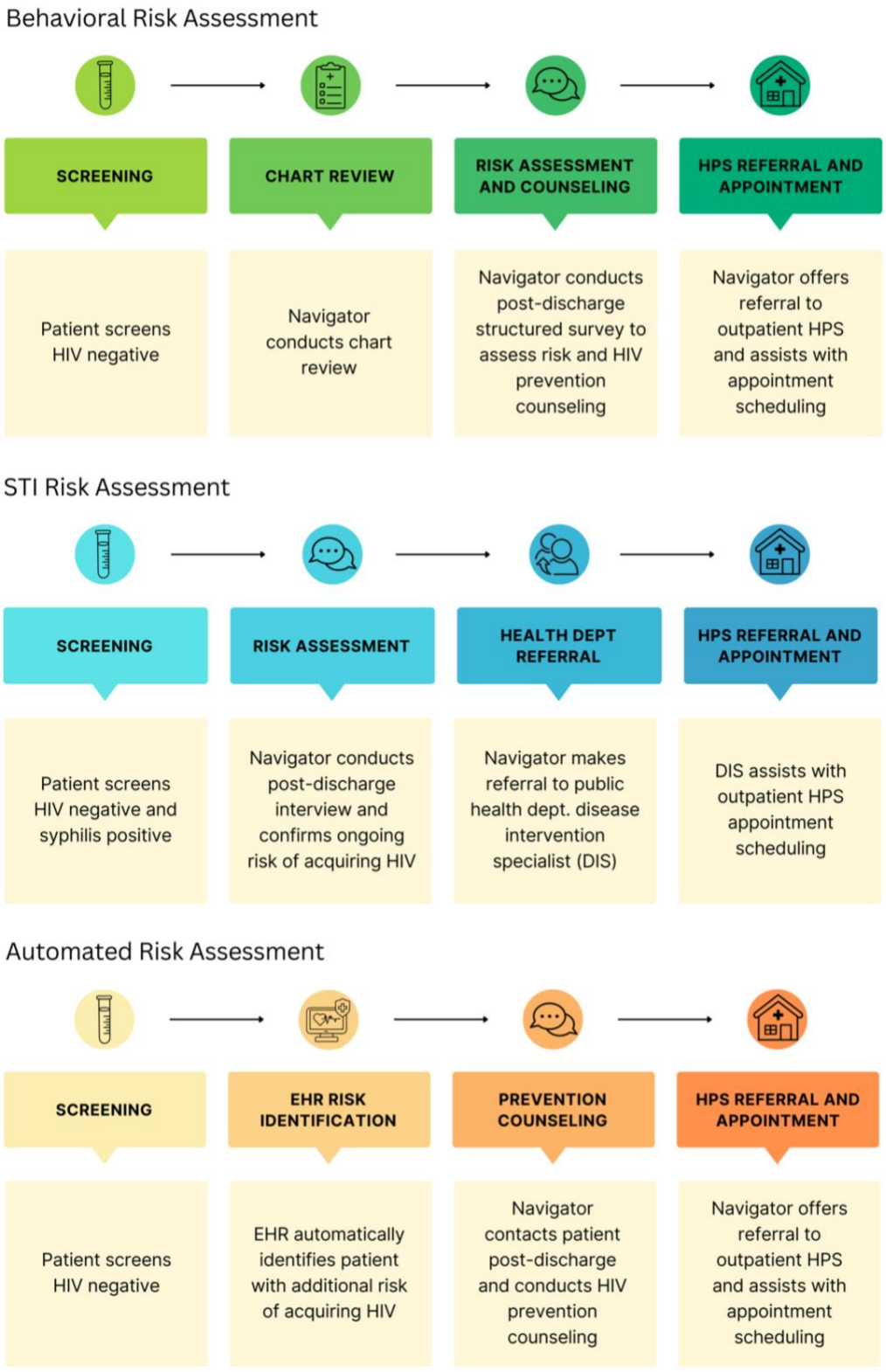
Based on the ED sites' experience and common themes across the implementation strategies, three primary HPS implementation models in the ED were identified: 1) Behavioral Risk Assessment, 2) Sexually Transmitted Infection (STI) Risk Assessment, and 3) Automated Risk Assessment (**Figure 1**).

> **I feel like the work is definitely important. It's worth it because some people need the information, but don't know where to look, and that [conversation] can change everything for them."**
>
> *- Patient Navigator discussing use of the HIV Behavioral Risk Assessment model in the ED*

*Model 1: Behavioral Risk Assessment (3 sites)*. In this model, ED patients receiving a blood draw are screened for HIV as part of the existing opt-out HIV screening program. A patient navigator in the ED then performs chart reviews of patients screening HIV negative to identify those who may be eligible for an assessment to determine their risk for acquiring HIV infection. The navigator contacts eligible patients in person while they are still in the ED or after discharge via phone and conducts a structured or semi-structured HIV risk assessment survey to identify individuals who could benefit from HIV prevention counseling. Although the specific risk assessments differed by sites, the questions were based on CDC recommended criteria to identify people at an increased risk for HIV acquisition.[27,28] Patients identified to be at an increased risk are offered a referral to outpatient HPS. Once consent is obtained, the navigator assists patients in scheduling an appointment at an outpatient clinic that can provide comprehensive prevention services, including PrEP.

*Model 2: STI Risk Assessment (3 sites)*. In this model, ED patients receiving a blood draw are screened for HIV and syphilis as part of the existing opt-out infectious disease screening program. A patient navigator in the ED conducts post-discharge interviews of patients screening HIV negative and syphilis positive to identify those who may be at an ongoing risk of acquiring HIV, using site-specific, non-structured

**Figure 1. Emergency Department Delivered HIV Prevention Services (HPS): Implementation Models.**




Abbreviations: DIS - Disease Intervention Specialists; EHR - Electronic Health Record; HPS - HIV Prevention Services; DIS - Disease Intervention Specialists

assessment of risk based on CDC guidance.[27,28] Patients testing positive for syphilis determined to be at ongoing risk for acquiring HIV are referred by the navigator to a public health department disease intervention specialist (DIS) who assists patients with scheduling an appointment at an outpatient clinic that can provide comprehensive prevention services, including PrEP.

*Model 3: Automated Risk Assessment (1 site)*. In this model, ED patients receiving a blood draw are screened for HIV as part of the existing opt-out HIV screening program. The EHR automatically identifies patients who screen HIV negative and whose medical record indicates additional risk factors for acquiring HIV in the past 12 months, such as a prior laboratory documented STI diagnosis or ICD-diagnostic code signifying a behavioral risk characteristic. A patient navigator in the ED receives this information via an electronic alert and contacts eligible patients via phone post discharge to offer HIV prevention counseling and a referral to outpatient HPS. Once consent for referral is obtained, the navigator assists patients in scheduling an appointment at an outpatient clinic that can provide comprehensive prevention services, including PrEP.

### Model Strengths and Limitations

Each of the three implementation models for ED-based HPS exhibited unique strengths, limitations, and settings under which they would be best suited (**Table 1**).

*Model 1: Behavioral Risk Assessment*. This implementation model relied on a combination of chart review and individualized risk assessments to identify patients who were at the highest risk of acquiring HIV. An ED-based patient navigator then provided HIV prevention education and linkage to outpatient HPS. One of the key strengths of this model is the expanded role of a traditional ED-based navigator to contribute to HIV prevention, whereby the navigator can tailor their conversation with the patient to best fit their needs and reported risk factors. This personal approach to HIV prevention also allows the hospital to address social determinants of health, such as making referrals to substance use treatment programs, helping with insurance enrollment, working with social services to provide temporary housing, and providing transportation assistance to attend appointments through contracts with ride-sharing services. Navigators can also share patient-specific risk and social determinants of health needs with outpatient HPS staff who can provide continued assistance in these areas. Furthermore, because navigators interact directly with many patients while they are still present in the ED, this model could be expanded to support the same-day provision of PrEP. With support from treating emergency physicians, protocols that use EHR PrEP order sets and eligibility checklists can be implemented to ensure the safe and correct initiation of ED-based PrEP for interested patients.

Limitations of this model include the requirement for routine opt-out HIV screening. Additionally, performing chart review and risk assessments for all ED patients who screen HIV negative is time-intensive and requires prioritization of those who exhibit the greatest perceived risk of acquiring HIV. These time and resource constraints mean the program may not reach everyone who could benefit from linkage to HPS. For example, one patient navigator shared, "*I would like to have another person on our team help with chart reviews because they are needed, it's most important, but they do take a lot of time. You don't want to rush through them and miss*

**I would like to have another person on our team help with chart reviews because they are needed, it's most important, but they do take a lot of time. You don't want to rush through them and miss something."**

*- Patient Navigator in ED on implementing the Behavioral Risk Assessment model for HPS*

*something*." Finally, though ED-based navigators engaged in outreach should receive training on best practices for sensitive and confidential conversations about HIV risk, these conversations could be unintentionally stigmatizing.

*Ideal Setting:* The Behavioral Risk Assessment model would be best suited for EDs with existing HIV screening programs, those with ED-based patient navigators, and those who prefer a model with one-on-one, patient-centered conversations.

> **Especially in [our] county, with the rates that we have for all the STIs, I think there is a huge opportunity for education for the people in this community."**
>
> *- Patient Navigator in ED using the STI Risk Assessment model*

*Model 2: STI Risk Assessment*. This model was implemented by EDs with comprehensive screening programs for syphilis (and sometimes hepatitis C) in addition to HIV. A strength of this model is the efficient use of existing testing infrastructure to identify a subset of patients who are at increased risk for acquiring HIV infection: those who test HIV negative but who are syphilis and/or hepatitis C positive. This population then serves as the foundation for navigator-led HIV prevention efforts and linkage activities. Another benefit of building a prevention program that engages patients with syphilis and/or hepatitis C is that existing linkage pathways for the treatment of these infections can be leveraged for co-localized prevention services, including PrEP. When reflecting on their program which used the STI Risk Assessment model, an ED staff member shared, "*Especially in [our] county, with the rates that we have for all the STIs, I think there is a huge opportunity for education for the people in this community*." An additional benefit of this model is that it could be expanded to focus on additional STI screening programs that do not incorporate linkage to the health department, such as chlamydia, gonorrhea, or trichomoniasis.

We also identified several limitations of the STI Risk Assessment Model. Most EDs in California, however, do not have integrated screening programs that provide comprehensive testing for syphilis and hepatitis C, in addition to HIV, thereby limiting the scalability of this approach at this time. Furthermore, although the model is efficient for identifying populations with objective risk for acquiring HIV, there are undoubtedly missed opportunities for HIV prevention among other patients without syphilis and/or hepatitis C. The population-level impact of this model is dependent on rates of syphilis and/or hepatitis C among people with risk of HIV; therefore, the model might be less impactful among populations with low rates of these infections. Lastly, sites implementing this model frequently relied on the local health department and DIS to provide services, which may not be available in some jurisdictions. Furthermore, the reliance on the local health department for HPS linkage and PrEP initiation means that there is less control over the outcome of the intervention and also less access to data on patient outcomes after linkage.

*Ideal Setting:* The STI Risk Assessment model is best suited for settings that have a strong collaboration with a well-resourced local health department, strong local DIS systems, and robust syphilis and hepatitis C ED screening programs in place.

*Model 3: Automated Risk Assessment*. This model uses automated EHR alerts to identify possibly eligible patients who are at an increased risk of acquiring HIV. Like the Behavioral Risk Assessment model, an ED-based patient navigator provides HIV prevention education and linkage to outpatient HPS once the patient has been discharged. However, this model's greatest strength is its efficiency, as the first time-consuming step of chart reviews and risk assessments is automated in the EHR. Additionally, this model

**Table 1. Emergency Department Delivered HIV Prevention Services (HPS): Implementation Models Strengths and Limitations.**

| | Behavioral Risk Assessment | STI Risk Assessment | Automated Risk Assessment |
|---|---|---|---|
| **Strengths** | • Expanded role of ED-based navigator<br>• One-on-one patient-centered approach<br>• Can address SDOH<br>• Navigator can advocate for PrEP initiation when scheduling HPS visit<br>• Can be expanded to support same-day PrEP provision | • Uses existing ED infrastructure, such as screening programs for syphilis and hepatitis C and partnerships with local public health departments<br>• Can be modified to focus on additional STI screenings, such as chlamydia, gonorrhea, or trichomoniasis | • Automation via EHR precludes time-consuming chart review and risk assessments<br>• Expanded role of ED-based navigator<br>• Navigator can advocate for PrEP initiation when scheduling HPS visit<br>• Potential to incorporate ML, AI, NLP, etc. |
| **Limitations** | • Not all EDs have opt-out HIV screening programs<br>• Time-consuming and requires prioritizing and tailoring counseling and referrals by HIV risk<br>• Limited reach | • Limited availability of syphilis and hepatitis C screening programs in EDs<br>• Narrow eligibility criteria may limit impact and lead to missed opportunities for prevention<br>• Reliance on the health department reduces control over linkage and access to outcome data | • Requires internal political and technical support to make EHR modifications<br>• EHR modifications may take months to years<br>• Lack of face-to-face interaction between navigator and patient<br>• Strict coding requirements for EHR alerts may narrow reach |
| **Ideal Settings** | • EDs with existing screening programs<br>• EDs with ED-based patient navigators<br>• Preference for one-on-one patient-centered approach | • EDs with a strong collaboration with a well-resourced health department<br>• Areas with strong local DIS systems<br>• EDs with existing, robust syphilis and/or hepatitis C screening programs | • EDs with a customizable EHR system<br>• EDs with internal political and technical support for EHR system modifications<br>• EDs without on-site navigators or other screening programs to leverage |

Abbreviations: AI - Artificial Intelligence; DIS - Disease Intervention Specialists; ED - Emergency Department; EHR - Electronic Health Record; HPS - HIV Prevention Services; ML - Machine Learning; NLP - Natural language processing; PrEP - Pre-exposure Prophylaxis; SDOH - Social Determinants of Health; STI - Sexually Transmitted Infection

could conceivably increase in sophistication by incorporating artificial intelligence (AI), natural language processing (NLP), and other emerging technologies. Finally, like other models, the Automated Risk Assessment model's use of navigators to assist patients in scheduling an appointment for outpatient HPS allows navigators to communicate the patient's risk factors and advocate for PrEP referral to HPS staff.

A limitation of this implementation model is the need for political and technical support within the hospital to make modifications to the EHR system, which may take time (in this case, over a year).

Additionally, while the other implementation models can occur while the patient is still in the ED, this model does not identify people who could benefit from HPS until after discharge, which decreases opportunities for face-to-face interaction between the patient and the navigator. Lastly, though this model is likely to miss the least number of people who would benefit from linkage to HPS depending on the algorithm used, the strict coding requirements to implement the algorithm in the EHR alert system may still create missed opportunities to identify people who present with unique attributes but still experience HIV-related risk. An ED physician at the only site that implemented this model shared their thought process behind automating the chart review and risk assessment: "*The thought was that by not automating the [process] like this, it would be difficult in terms of time and effort and cost to train everyone and go through the entire process. However, we would definitely capture more people* [if we assessed risk on a case-by-case basis]."



**The thought was that by not automating the [process] like this, it would be difficult in terms of time and effort and cost to train everyone and go through the entire process. However, we would definitely capture more people [if we assessed risk on a case-by-case basis]."**

*- Physician in ED using the Automated Risk Assessment model*

*Ideal Setting:* The Automated Risk Assessment model is best suited for settings with a customizable EHR system, that have political and technical support for EHR system modifications, and those without on-site navigators or other screening programs to leverage.

## Conclusion

Our mixed-methods evaluation of HPS linkage programs implemented in seven California EDs identified three models for integrating HPS which can serve as a guide for future protocol development. Healthcare systems wishing to integrate HPS in their EDs can use these models as a framework, adapting them as necessary to meet their population needs, resources, and existing screening program infrastructure.

All three implementation models exhibited unique strengths and limitations, and no one model emerged as superior to the other. Integrating HPS into the ED workflow was not without its challenges, requiring dedicated staff, additional resources, and out-of-the-box development of novel policies and procedures. In all models, ED-based HIV screening programs served as the foundation for HPS delivery. Assessment of risk for acquiring HIV, an essential step for ED prevention programs, was approached uniquely at all sites and was a major protocol branch point, driving decisions for prevention service delivery, staffing needs, and linkage protocols. In addition to providing access to a population of patients without HIV for whom an assessment of prevention needs can be made, HPS programs leveraged the infrastructure already employed with HIV screening, such as existing linkage to care pathways, navigators, and experience working in parallel with ED staff to minimize the impact on ED workflows.

There are several observations from the three models worth highlighting. First, automating the EHR to identify objective risk laboratory data may require less in-ED staff time and does not rely on potentially stigmatizing questioning of patients, making this a highly recommended strategy wherever it is possible. Second, linking HPS efforts and PrEP to already existing screening programs and linkage pathways that prioritize the diagnosis and treatment of diseases that are associated with an increased risk of acquiring HIV infections (such as syphilis, STIs, and substance use disorders) has the potential to be highly

efficient, targeting prevention efforts towards populations that are most in need of these services. In addition, the capacity for ED-based HPS to close some of the earliest gaps in the prevention care cascade, particularly with regard to awareness of personal risk and PrEP knowledge, should be emphasized.[29] We heard from several sites across all three models that EDs create an opportunity to increase awareness of HPS and PrEP specifically, even if patients were not interested in referral for outpatient HPS.

The opportunity for California EDs to expand screening for communicable infectious diseases and integrate HPS is at hand. In March 2022, the California Department of Public Health (CDPH) issued recommendations for EDs statewide to integrate syndemic screening for HIV, syphilis, and hepatitis C into routine care.[30] Since that time, the CDPH has invested $13 million to support 28 EDs in 14 counties to implement, expand, or sustain routine opt-out screening programs, and provide patient navigation linkage to treatment and prevention.[31] Once these programs are in place, they can be leveraged as the foundation for linkage to HPS and other preventive services, a necessary next step in reaching the goals set forth in the California Office of AIDS *Ending the Epidemics* plan.[32]

## Research Limitations

This implementation science study has three main limitations. First, the three implementation models described in this report emerged from seven California EDs funded as Gilead FOCUS sites. This limited the reporting of key (quantitative) programmatic outcomes for several sites, including whether PrEP was provided or not. Other promising HPS models not used in our study have been implemented in other states.[20,33] Second, a direct comparison of the effectiveness of the models is not possible due to a lack of data on appointment follow-up and subsequent PrEP initiation. Finally, as the purpose of the brief was to capture common practices across the seven ED sites, additional ancillary HIV prevention activities were not described, such as the scope and yield of patient referral by ED clinicians to prevention navigators.

## Areas of Future Research

Although this report focuses on implementation models for linkage to HPS in the ED, it was evident that standardized outcome definitions and more consistent data collection of those outcomes, such as readiness for PrEP, PrEP initiation, adherence, and retention with outpatient PrEP, are needed. Once standardized outcomes are in place, ED HPS linkage implementation models can be directly compared based on the reported HIV prevention care cascades and thus, allow determination of feasibility, efficacy, and the identification of foci for program refinement and improvement.

Initiation of same-day PrEP and long-acting PrEP formulations are emerging implementation strategies that may lower barriers to the receipt of PrEP among populations most at need but the least likely to receive treatment.[34,35] Experience with these strategies, however, remain largely unexplored in the ED setting and studies evaluating their feasibility and effectiveness are needed.

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Chief Executive Office.

BUDGET FACTS

# 2024-25 RECOMMENDED BUDGET

## $45.4 Billion

## 116,159 Budgeted Positions

- The **2024-25 Recommended Budget** totals **$45.4 billion** and includes **116,159 budgeted positions**.
- It reflects a decrease of nearly $1.4 billion from the 2023-24 Final Adopted Budget, as this is the first phase of the annual budget, which does not reflect fiscal year-end surpluses likely to be allocated on a one-time basis in October. At this point in our budget process, the amount of the closing balance is uncertain, as are the mid-year demands on those funds.
- New ongoing funding totaling $390.2 million is recommended in this budget phase based on a forecasted increase in revenues. Although significant, this represents a lower revenue growth rate than in recent years.
- These additional funds are needed to fund substantial increases in wages and benefits for the County's workforce as it provides vital services to our residents. Other existing commitments or mandated responsibilities include growing public assistance caseload costs and the Board's 10% set aside for Care First and Community Investment (CFCI) programming, as well as legal judgments and settlements. This leaves limited funds for new programs and initiatives, which have been prioritized as directed by the Board.
- However, we are adding to our workforce, not reducing it, thanks to fair and responsible agreements with our labor partners. This is especially true in the area of mental health care, which is a critical component of multiple Board priorities, from fighting homelessness to reducing our jail population and ensuring that there are ultimately sufficient resources for our communities. To that end, this budget includes an increase of 835 budgeted positions, funded almost entirely with State and federal dollars.
- This Recommended Budget provides funding for vital programs such as:
  - **$728.2 million** for the **County's multi-layered approach to combatting homelessness facilitated by the Homeless Emergency Declaration**, including strengthening partnerships with and supporting local jurisdictions and unincorporated areas; hiring additional frontline staff such as outreach workers, housing navigators, mental health clinicians and substance use counselors; and investing in innovative strategies to increase our housing stock such as hotel and motel acquisitions) and Project Homekey.
  - **$60.4 million and 263 positions** for **various mental health services**, including: 169 positions for an Interim Housing Outreach Program providing mental health care and support to unhoused people to facilitate housing stability, identity permanent housing, and prevent a return to homelessness; and 58 positions to expand directly-operated clinics and full service partnership services to expand capacity in the mental health care network.

- **$12.3 million**, for a total ongoing investment of $300.6 million, for **Care First and Community Investment (CFCI) projects and programs** that support direct community investments and alternatives to incarceration.
- **$4.9 million and 24 positions** to support the initial launch of the Justice, Care and Opportunities Department's **independent pretrial services**, delivering on the Board's *Care First, Jails Last* vision for integrated, equitable and culturally competent pretrial and diversion services.
- **$3.9 million** for Integrated Correctional Health Services (ICHS) to contract mental health group services to support structured out-of-cell time for individuals in High Observation Housing in the County's jails under the terms of the **US Department of Justice (DOJ) consent decree**.

❖ This budget phase, we implemented the Fiscal Resilience protocol that assigns tiered rankings to Board motions for which Net County Cost (NCC) is a primary or secondary funding source -- to ensure that funding is aligned with programs that are ready to implement in the near term rather than holding money aside for work unlikely to be accomplished within the budget year.

❖ The following are NCC funding recommendations totaling $13.6 million that were recommended for approval under the new Fiscal Resilience protocol:

- ✓ **$5.9 million** plus $75.1 million in State funding for a total of $81.1 million **to replace EBT benefits** for victims of EBT card theft resulting from statewide skimming/scamming instances;
- ✓ **$1.8 million and 5 positions** for the Department of Public Health **to establish a new Sexual Assault Council,** which will support survivors in their recovery and develop policy recommendations to help prevent sexual violence;
- ✓ **$1.5 million** for the Department of Economic Opportunity (DEO) **to continue and expand PLACE**, a program that prepares and places people with high barriers to employment into entry-level, permanent County jobs with a career pathway, with a goal of 150 placements into County employment;
- ✓ **$1.3 million** for DEO's Development and Bonding Assistance Program, which provides technical assistance, capacity building, and contract financing and bonding assistance to eligible contractors;
- ✓ **$1.2 million** to **expand the Organizational Grants Program**, a program that provides critical support and stability to arts and culture nonprofit organizations, including those that have been historically or are currently underfunded and under-resourced;
- ✓ **$0.9 million** for contract services for **doula hub** operations that will provide technical support to the doula provider workforce and expand access throughout the County;
- ✓ **$0.6 million and 2 positions** within the CEO's ARDI unit to **implement the Racial Equity Strategic Plan countywide**; and
- ✓ **$0.5 million and 3 positions** for DCBA's Office of Labor Equity to **expand worker protections and support the enforcement of labor laws and minimum wage**, as well as the development of local ordinances.

❖ Other significant funding recommendations included in this budget are:

- ✓ **$71.2 million** in State and federal funding to support the **Stage One Child Care Program**, which provides full-time childcare services for CalWORKS participants;
- ✓ **$2.4 million** in intrafund transfer from DCFS to DCBA to **expand the Guaranteed Income program** to include a minimum of 200 additional transition age youth for two years, each of whom will each receive $1,000 in monthly income support. Taken together with the County's other guaranteed income programs, including Breathe, this would bring the number of people receiving these no-strings stipends to approximately 2,100;
- ✓ **$17.4 million** set aside to ensure that the County draws down all available CalFresh State and federal dollars to support individuals and families in need of food benefits;
- ✓ **$6.1 million** to **reduce cybersecurity risks**;
- ✓ **$2.0 billion** for the continued development, design, and construction of **369 capital projects in support of the Board-directed priorities**;
- ✓ **$234.1 million** in continued funding for **environmental stewardship** program for water conservation projects; and
- ✓ **$167.7 million** in continued funding to **enhance and expand access to County recreational sites**.

## VULNERABILTIES ON THE HORIZON

❖ The County faces sobering budget challenges and pressures that may require significant investments in future budget phases, including:

- End of American Rescue Plan Act funding totaling $1.9 billion
  - With no other source of funding to replace this loss, impactful existing programs and services will not be sustainable on an ongoing basis once the federal funding is exhausted;
- Retrofit of County buildings deemed seismically challenged
  - Funding may also be needed as a result of the report back for the February 28, 2023 Board motion for Equitable Earthquake Resilience in the County and the Board's adoption of a proposed building code ordinance for high-rise non-ductile concrete buildings; and
- Work towards compliance with DOJ consent decree and jails settlement agreements
  - Additional resources will be required to retain and hire adequate staff to meet the terms of the US DOJ consent decree.

❖ The most serious fiscal challenge remains the liability and settlement costs related to claims alleging childhood sexual assault at various County and non-County facilities spurred by AB 218, the Child Victims Act, which puts the County's financial exposure at more than $3 billion (this is a rough forecasted estimate of maximum exposure and not a statement regarding whether all cases will be settled or the value of any settlements).

# 2024-25 RECOMMENDED BUDGET SUMMARY

**($ in Millions)**

| Total Budget by Fund | 2021-22 Budget | 2022-23 Budget | 2023-24 Final Adopted | 2024-25 Recommended | Change From Final Adopted | % Change |
|---|---|---|---|---|---|---|
| Total General County | $ 29,882 | $ 33,333 | $ 35,934 | **$ 35,284** | $ (650) | **-1.8%** |
| Special Funds/Special Districts | 9,442 | 11,309 | 10,809 | **10,093** | (716) | **-7.1%** |
| **Total Budget** | $ 39,324 | $ 44,642 | $ 46,743 | **$ 45,377** | $ (1,366) | **-3.0%** |
| | | | | | | |
| **Budgeted Positions** | 111,038 | 113,592 | 115,324 | **116,159** | 835 | **0.7%** |

| Major Budget Changes by Fund | Net Change |
|---|---|
| **General Fund/Hospital Enterprise** | |
| Additional Fund Balance | $ (822) |
| Dept'l Additional Fund Balance | (222) |
| Carryover | (281) |
| NCC Changes | 832 |
| Ministerial Changes | 37 |
| Revenue Offset | (196) |
| **Subtotal General County** | (650) |
| | |
| **Special Funds/Special Districts** | |
| Special Revenue Funds | (264) |
| Capital Project Special Funds | (54) |
| Special Districts | (511) |
| Other Enterprise Funds | (4) |
| Internal Services Fund | 3 |
| Agency Fund | 115 |
| **Subtotal Special Funds/Districts** | (716) |
| | |
| **Total County Change** | **$ (1,366)** |

| Position Change by Department | Net Change |
|---|---|
| Mental Health | 452 |
| Public Social Services | 122 |
| Public Health | 52 |
| Children and Family Services | 48 |
| Health Services | 40 |
| Sheriff | 25 |
| Justice, Care and Opportunities | 24 |
| Assessor | 22 |
| Chief Executive Office | 22 |
| Medical Examiner | 13 |
| County Counsel | 12 |
| Military and Veterans Affairs | 10 |
| Consumer and Business Affairs | 9 |
| Board of Supervisors | 7 |
| Aging and Disabilities | 5 |
| Econmic Opportunity | 5 |
| Treasurer and Tax Collector | 5 |
| Auditor-Controller | 4 |
| Public Works | 4 |
| Animal Care and Control | 3 |
| Fire | 1 |
| Public Defender | 1 |
| Registrar-Recorder/County Clerk | 1 |
| Youth Development | 1 |
| Parks and Recreation | (1) |
| Internal Services | (2) |
| Agricultural Commissioner/Weights and Measures | (3) |
| Museum of Art | (3) |
| District Attorney | (5) |
| Alternate Public Defender | (12) |
| Probation | (27) |
| **TOTAL** | **835** |

# We're Listening

*share your concerns with us.*

## HIV + STD Services Customer Support Line

## (800) 260-8787

## Why should I call?

The Customer Support Line can assist you with accessing HIV or STD services and addressing concerns about the quality of services you have received.

## Will I be denied services for reporting a problem?

No. You will not be denied services. Your name and personal information can be kept confidential.

## Can I call anonymously?

Yes.

## Can I contact you through other ways?

Yes.

**By Email:**
dhspsupport@ph.lacounty.gov

**On the web:**
http://publichealth.lacounty.gov/dhsp/QuestionServices.htm

County of Los Angeles Public Health
Division of HIV and STD Programs

# Estamos Escuchando

*Comparta sus inquietudes con nosotros.*

**Servicios de VIH + ETS**
**Línea de Atención al Cliente**

**(800) 260-8787**

## ¿Por qué debería llamar?

La Línea de Atención al Cliente puede ayudarlo a acceder a los servicios de VIH o ETS y abordar las inquietudes sobre la calidad de los servicios que ha recibido.

## ¿Se me negarán los servicios por informar de un problema?

No. No se le negarán los servicios. Su nombre e información personal pueden mantenerse confidenciales.

## ¿Puedo llamar de forma anónima?

Si.

## ¿Puedo ponerme en contacto con usted a través de otras formas?

Si.

**Por correo electronico:**
dhspsupport@ph.lacounty.gov

**En el sitio web:**
http://publichealth.lacounty.gov/dhsp/QuestionServices.htm

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