LOS ANGELES COUNTY COMMISSION ON HIV

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Public Policy Committee Meeting

Monday, August 7, 2023
1:00pm-3:00pm (PST)

510 S. Vermont Ave, Terrace Conference Room TK 05
Los Angeles, CA 90020
Validated Parking: 523 Shatto Place, LA 90020

Agenda and meeting materials will be posted on our website at https://hiv.lacounty.gov/public-policy-committee/

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

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

MEMBERS OF THE PUBLIC WHO WISH TO JOIN VIRTUALLY, REGISTER HERE:
https://lacountyboardofsupervisors.webex.com/weblink/register/r7c99878269682c723365df44108630c3
To Join by Telephone: 1-213-306-3065
Password: POLICY Access Code: 2539 695 3809

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.*

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

PUBLIC POLICY COMMITTEE

MONDAY, August 7, 2023 | 1:00 PM – 3:00 PM

510 S. Vermont Ave
Terrace Level Conference Room TK05
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.

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To Join by Telephone: 1-213-306-3065
Password: POLICY Access Code: 2539 695 3809

Public Policy Committee Members:			
Katja Nelson, MPP Co-Chair	Lee Kochems, MA Co-Chair	Alasdair Burton	Mary Cummings
Pearl Doan	Felipe Findley, PA-C, MPAS, AAHIVS	Leon Maultsby	Paul Nash, PhD, CPsychol, AFBPsS, FHEA
Ricky Rosales			
QUORUM: 5			

AGENDA POSTED: August 2, 2023.

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

	Item	Motion	Time
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.	Assembly Bill 2449 Attendance Notification for "Emergency Circumstances"	**MOTION #1**	1:05 PM – 1:07 PM
4.	Approval of Agenda	**MOTION #2**	1:07 PM – 1:08 PM
5.	Approval of Meeting Minutes	**MOTION #3**	1:08 PM – 1:10 PM

II. PUBLIC COMMENT 1:10 PM – 1:15 PM

6. 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

7. 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

8. Executive Director/Staff Report 1:15 PM – 1:30 PM
    a. By-Laws Review Task Force—Updates
    b. HRSA Site Visit Findings
    c. Annual Meeting Update
9. Co-Chair Report 1:30 PM – 2:10 PM
    a. 2023 Workplan and Meeting Calendar Review
    b. ANAM Platform Update
    c. Ryan White Care Act (RWCA) Modernization Project

V. DISCUSSION ITEMS

10. 2023-2024 Legislative Docket—Updates 2:10 PM – 2:15 PM
11. 2023-2024 Policies Priority 2:15 PM – 2:20 PM
12. State Policy & Budget Update 2:25 PM – 2:30 PM
13. Federal Policy Update 2:30 PM – 2:40 PM
14. County Policy Update 2:40 PM – 2:50 PM
    a. DPH Memo in response to STD Board of Supervisors (BOS) motion
    b. 2023 Public Comment Schedule for Health Deputies Meetings and BOS Meetings

VI. NEXT STEPS 2:50 PM – 2:55 PM

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

VII. ANNOUNCEMENTS 2:55 PM – 3:00 PM

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

VIII. ADJOURNMENT 3:00 PM

16. Adjournment for the meeting of August 7, 2023

PROPOSED MOTIONS	
MOTION #1:	Approve remote attendance by members due to "emergency circumstances", per AB 2449.
MOTION #2	Approve the Agenda Order as presented or revised.
MOTION #3	Approve the Public Policy Committee minutes, as presented or revised.

LOS ANGELES COUNTY
COMMISSION ON HIV

510 S. Vermont Ave. 14th Floor • Los Angeles, CA 90020 • TEL (213) 738-2816 • FAX (213) 637-4748
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 are accorded voting privileges and must verbally acknowledge their attendance in order to vote. Approved meeting minutes are available on the Commission's website; meeting recordings are available upon request.

PUBLIC POLICY COMMITTEE MEETING MINUTES

Draft

July 10, 2023

COMMITTEE MEMBERS P = Present | A = Absent | EA = Excused Absence			
Katja Nelson, MPP, Co-Chair	P	Felipe Findley, PA-C, MPAS, AAHIVS	P
Lee Kochems, MA, Co-Chair	P	Leon Maultsby	A
Alasdair Burton (Alternate)	P	Paul Nash, PhD, CPsychol, AFBPsS, FHEA	P
Mary Cummings	A	Ricky Rosales	P
Pearl Doan	A		
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**
   Katja Nelson, Public Policy Committee (PPC) Co-Chair, called the meeting to order at 1:10 PM.
2. **INTRODUCTIONS, ROLL CALL, & CONFLICTS OF INTEREST STATEMENTS**
   K. Nelson invited meeting attendees to introduce themselves and state conflicts of interest, if any.
3. **ASSEMBLY BILL 2449 ATTENDANCE NOTIFICATION FOR "EMERGENCY CIRCUMSTANCES"**
   MOTION #1: Approve remote attendance by members due to "emergency circumstances," per AB 2449. ***There was no vote.***

4. **APPROVAL OF AGENDA**
   MOTION #2: Approve the Agenda Order as presented or revised. ***✓Passed by Consensus***
5. **APPROVAL OF MEETING MINUTES**

MOTION #3: Approve the April Public Policy Committee minutes, as presented or revised.
✓***Passed by Consensus***

II. PUBLIC COMMENT

6. 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.

No public comment.

III. COMMITTEE NEW BUSINESS ITEMS

7. 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

8. EXECUTIVE DIRECTOR/STAFF REPORT

- Cheryl Barrit, Executive Director, shared that the By-Law Review Taskforce (BRT) will meet on July 7th at 3:00pm. She noted that some changes to the Commission's by-laws may trigger an ordinance change to be presented to and approved by the Board of Supervisors (BOS). Commission staff are in the process of reviewing guidance from County counsel to determine if there is a work-around. She added that the Health Resource & Services Administration (HRSA) audit report will be included in the BRT meeting packet; the report outlines the HRSA auditor's five findings of the Commission. Commission staff developed a plan for corrective action and submitted it to HRSA. This document will be included in the August full-body Commission meeting.
- C. Barrit reminded attendees of the upcoming "Ryan White Care Act Legislation Overview & Membership Structure and Responsibilities," training and encouraged attendees to participate in the training. The training schedule is include in the meeting packet and available on the Commission website.
- C. Barrit reminded attendees that the July 13 Commission meeting has been cancelled; the Consumer Caucus will meet virtually on 7/13/23 from 1:30pm-3:30pm. She added that the August Commission meeting will take place on 8/10/23 at the St. Anne's Conference Center.

9. CO-CHAIR REPORT

a. 2023 Workplan Development and Meeting Calendar Review

- The committee decided to move the agenda item "Ryan White Modernization Project" to the Co-Chairs report section for the August PPC meeting.

b. ANAM Platform Update

There was no update. Commission staff have not heard from partners at the Substance Abuse Prevention and Control (SAPC) program or from The Wall Las Memorias. The Wall has been conducting townhalls to inform the community on how meth affects the community. K. Nelson added that Aids Project Los Angeles (APLA) is planning an event with SAPC late in the year. She will follow-up with the planning group to learn more information. C. Barrit noted that Commission staff are coordinating a meeting to have SAPC staff discuss policy and service coordination efforts at an upcoming full Commission meeting.

V. DISCUSSION ITEMS

10. 2023-2024 LEGISLATIVE DOCKET – DEVELOPMENT

The document was approved by the full Commission body on June 8, 2023 and forwarded to the Commission's County partners at the Office of Legislative Affairs and Intergovernmental Relations.

11. 2023-2024 POLICIES PRIORITY

The document was approved by the full Commission body and transmitted to the Commission's County partners at the Office of Legislative Affairs and Intergovernmental Relations.

12. STATE POLICY & BUDGET UPDATE

K. Nelson shared that a one-time $10 million appropriation over three years for Hepatitis C screening and linkage to care was included in the State budget. These items were part of the Ending the Epidemics (ETE) budget requests.

13. FEDERAL POLICY UPDATE

There were no updates.

14. COUNTY POLICY UPDATE

- **DPH Memo in Response to STD Board of Supervisors (BOS) Motions**
  There were no updates.
- **2023 Public Comment Schedule for Health Deputies Meetings and BOS Meetings**
  - C. Barrit reminded attendees to sign-up to volunteer and provide public comment at health deputy and BOS meetings.

15. Ryan White Care Act (RWCA) Modernization

- K. Nelson led a brainstorming session to develop an approach for the RWCA Modernization project. The purpose of the project is to develop a white paper with recommendations with how the PPC and by extension the Commission think the RWCA can be modernized to help Los Angeles County reach the Ending the Epidemic (EHE) goals.
- The group identified the following as potential issues to discuss/address in the modernization project.
  - Implementing a status neutral approach; using Ryan White funds for high-risk negatives.
  - Direct financial assistance to consumers (e.g. expanding the Emergency Financial Assistance service category).
  - Expanding service categories to cover costs of activities that would improve quality of life/allow more flexibility for use of funds.
  - Reduce administrative burden on the client and agencies to project the Payor of Last Resort provision and facilitate the eligibility process.
  - Analysis on how the RWCA can complement other health insurance sources now that the Affordable Care Act (ACA) has been implemented; address any service delivery issues.
  - Consider funding formula implications to Eligible Metropolitan Areas (EMAs) such as Los Angeles and San Francisco given that the Southern states currently have the highest HIV burden; find a balance of the formula for areas that have made progress.
- Alasdair Burton, PPC member, recommended having a presentation that outlines the successes and problem areas of the RWCA. C. Barrit noted that there have been many programmatic success for the Ryan White Program such as demonstrating the ability to keep people in care and achieving viral suppression.
- Felipe Findley, PPC member, recommended Commission staff coordinate a panel of organizations receiving Ryan White funding to gain insights on the program. He also asked about funding sources for implanting a status neutral approach and addressing social determinants of health (SDOH). C. Barrit noted that locally, Ryan white funding is organized by service categories to provide services to consumers. Currently, there is no opportunity to address SDOHs which are also caucuses of HIV inequities and drivers of new HIV infections. There is an opportunity to look at what the Ryan White Program can cover to address SDOHs and building the community infrastructure and capacity to do the work.
- Lee Kochems, PPC co-chair, asked Committee members to decide on the starting point for the project and determine the audience of the product resulting from the project. He proposed the following as potential approaches to the product document:

- Now that the ACA is implemented, what are the areas in the RWCA that could be improved upon? This would be a modernization approach that builds on the existing Ryan White Program but does not call for reauthorization.
  - Consider moving the Ryan White Program towards a chronic illness model with a focus on quality of life and addressing SDOHs.
- Determine that the RCWA needs to be reauthorized and outline the approach the PPC and the Commission can take to lead this effort locally and work with other jurisdictions and Ryan White Planning Councils.

- A. Burton asked if there was a way to develop an Identification Card (ID) system that consumers can use to access Ryan White services. The ID card would prove eligibility and potentially reduce the administrative burden of proving eligibility at multiple Ryan White providers. He added the following questions for the RWCA brainstorm: What are areas that the Ryan White Program should be covering but unable to cover with the current structure? What are the areas that the Ryan White Program does cover but for some reason provider organizations cannot operationalize?
- Ricky Rosales, PPC member, asked what is the trigger for acting? At what point is the PPC committed to action? He stressed the need to clarify what the trigger will be. He noted that the PPC has information and reports available and needs to organize it and decide of when to act. He posed a question to the group, "If we are pushing to integrate the continuum [status neutral approach], how will that impact the Centers for Disease Control and Prevention (CDC) funding, and other places that receive [federal] funding [for addressing the HIV epidemic]? Will their funding be pulled into one big pot?
- L. Kochems recommended preparing a draft document and sharing with other large EMAs such as San Francisco and New York and request their feedback and gain consumer and advocate support to later determine when to share the document more widely.
- Commission staff will prepare a summary of the issues discussed and opportunities for modernizing the RWCA. This summary will build on the 2008 Policy Brief the Commission developed in support of the last RWCA reauthorization in 2009. The brief outlined "Reauthorization Principles" for legislators and federal planners to consider.
- Paul Nash, PPC member, recommended drafting a document at the PPC and sharing it with the full Commission body first.
- C. Barrit noted that in 2022, the PPC presented the idea of modernizing the RWCA at their November meeting and the full body struggled to provide feedback. She recommended to start the effort at the PPC, then provide guidance to the full Commission body on how to move forward. The goal is to develop a preliminary analysis of the opportunity to modernize the RWCA to educate and inform stakeholders. She added that there are HRSA requirements for how to operationalize the RWCA; at the local level, the recipient can implement additional processes for provider agencies. This

can be an opportunity to remove redundancies and reduce the administrative burden at the agency level.

- R. Rosales shared there is no additional information on the homeless county beyond what is publicly available. He also shared that the Los Angeles City Council District 1 (CD1) has been trying to get money allocated to open a harm reduction center around Mac Arthur Park; the CD1 representative asked for $1.5 billion from opioid settlement funds. He added that the Office of AIDS got $200, 000 for harm reduction services.

VI. NEXT STEPS

16. TASK/ASSIGNMENTS RECAP

➲ Commission staff will add the agenda item "Ryan White Act Modernization" under the Co-chairs report and draft a summary of issues for discussion

➲ Commission staff will update the public comment schedule and assign volunteers

➲ Commission staff will connect with SAPC and The Wall Las Memories to determine how the committee can support them on the Act Now Against Meth (ANAM) recommendations

17. AGENDA DEVELOPMENT FOR THE NEXT MEETING

- The committee will continue discussions on Ryan White Act Modernization and share updates on the public comment schedule for health deputy and BOS meetings.

VII. ANNOUNCEMENTS

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

There were no announcements.

VIII. ADJOURNMENT

19. ADJOURNMENT FOR THE MEETING OF JULY 10, 2023.

The meeting was adjourned by K. Nelson at 2:32 PM.

LOS ANGELES COUNTY
COMMISSION ON HIV

Approved by COH 6/8/23

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CODE OF CONDUCT

The Commission on HIV welcomes commissioners, guests, and the public into a space where people of all opinions and backgrounds are able to contribute. In this space, we challenge ourselves to be self-reflective and committed to an ongoing understanding of each other and the complex intersectionality of the lives we live. We create a safe environment where we celebrate differences while striving for consensus in the fights against our common enemies: HIV and STDs. We build trust in each other by having honest, respectful, and productive conversations. As a result, the Commission has adopted and is consistently committed to implementing the following guidelines for Commission, committee, and associated meetings.

All participants and stakeholders should adhere to the following:

1) **We approach all our interactions with compassion, respect, and transparency.**
2) **We respect others' time by starting and ending meetings on time, being punctual, and staying present.**
3) **We listen with intent, avoid interrupting others, and elevate each other's voices.**
4) **We encourage all to bring forth ideas for discussion, community planning, and consensus.**
5) **We focus on the issue, not the person raising the issue.**
6) **Be flexible, open-minded, and solution-focused.**
7) **We give and accept respectful and constructive feedback.**
8) **We keep all issues on the table (no "hidden agendas"), avoid monopolizing discussions and minimize side conversations.**
9) **We have no place in our deliberations for racist, sexist, homophobic, transphobic, and other discriminatory statements, and "-isms" including misogyny, ableism, and ageism.**
10) **We give ourselves permission to learn from our mistakes.**

In response to violation of the Code of Conduct which results in meeting disruption, Include provisions of SB 1100 which states in part, ". . . authorize the presiding member of the legislative body conducting a meeting or their designee to remove, or cause the removal of, an individual for disrupting the meeting . . . . Removal to be preceded by a warning to the individual by the presiding member of the legislative body or their designee that the individual's behavior is disrupting the meeting and that the individual's failure to cease their behavior may result in their removal." Complaints related to internal Commission matters such as alleged violation of the Code of Conduct or other disputes among members are addressed and resolved in adherence to Policy/Procedure #08.3302." (Commission Bylaws, Article VII, Section 4.)

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

COMMISSION MEMBER "CONFLICTS-OF-INTEREST"

Updated 7/24/23

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
ALVIZO	**Everardo**	Long Beach Health & Human Services	Benefits Specialty
			Ambulatory Outpatient Medical (AOM)
			Medical Care Coordination (MCC)
			HIV and STD Prevention
			HIV Testing Social & Sexual Networks
			HIV Testing Storefront
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

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
CAMPBELL *	**Danielle**	T.H.E. Clinic, Inc.	See attached subcontractor's list
CIELO	**Mikhaela**	LAC & USC MCA Clinic	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
CONNOLLY	**Lilieth**	Unaffiliated consumer	No Ryan White or prevention contracts
CUMMINGS	**Mary**	Bartz-Altadonna Community Health Center	No Ryan White or prevention contracts
DANIELS	**Shonte**	Unaffiliated consumer	No Ryan White or prevention contracts
DAVIES	**Erika**	City of Pasadena	HIV Testing Storefront
			HIV Testing & Sexual Networks
DOAN	**Pearl**	No Affiliation	No Ryan White or prevention contracts
DONNELLY	**Kevin**	Unaffiliated consumer	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**	No Affiliation	No Ryan White or prevention contracts
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
KOCHEMS	**Lee**	Unaffiliated consumer	No Ryan White or prevention contracts
KING	**William**	W. King Health Care Group	No Ryan White or prevention contracts
MAGANA	**Jose**	The Wall Las Memorias, Inc.	HIV Testing Storefront
			HIV Testing Social & Sexual Networks

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
MAULTSBY	**Leon**	Charles R. Drew University	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
MILLS	**Anthony**	Southern CA Men's Medical Group	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
MINTLINE (SBP Member)	**Mark**	Western University of Health Sciences (No Affiliation)	No Ryan White or prevention contracts
MOLLETTE	**Andre**	Southern CA Men's Medical Group	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
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
			Nutrition Support
OROZCO	**Jesus ("Chuy")**	HOPWA-City of Los Angeles	No Ryan White or prevention contracts
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	**Mallery**	No Affiliation	No Ryan White or prevention contracts
ROBINSON	**Redeem**	All Souls Movement (No Affiliation)	No Ryan White or prevention contracts
ROSALES	**Ricky**	City of Los Angeles AIDS Coordinator	No Ryan White or prevention contracts

COMMISSION MEMBERS		ORGANIZATION	SERVICE CATEGORIES
SATTAH	**Martin**	Rand Schrader Clinic LA County Department of Health Services	Biomedical HIV Prevention
			HIV Testing Storefront
			HIV Testing Social & Sexual Networks
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
SOLIS *	**Juan**	UCLA Labor Center	See attached subcontractor's list
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
VALERO	**Justin**	No Affiliation	No Ryan White or prevention contracts
WEEDMAN	**Jonathan**	ViaCare Community Health	Biomedical HIV Prevention

2023 Training Schedule

- All trainings are open to the public.
- Click on the training topic to register.
- Recordings will be available on our website for those unable to join live trainings.
- Certifications of Completion will be provided.
- All trainings are virtual.

Topic	Date
General Orientation and Commission on HIV Overview *	March 29 3:00 - 4:30 PM
Priority Setting and Resource Allocation Process & Service Standards Development *	April 12 3:00 - 4:30 PM
Tips for Making Effective Written and Oral Public Comments	May 24 3:00 - 4:00 PM
Ryan White Care Act Legislative Overview **Membership Structure and Responsibilities** *	July 19 3:00 - 4:30 PM
Public Health 101	August 16 3:00 - 4:30 PM
Sexual Health and Wellness	September 20 3:00 - 5:00 PM
Health Literacy and Self-Advocacy	October 18 3:00 - 4:30 PM
Policy Priorities and Legislative Docket Development Process *	November 15 3:00 - 4:30 PM
Co-Chair Roles and Responsibilities	December 6 4:00 - 5:00 PM

Mandatory core trainings for all commissioners.

BYLAWS/ORDINANCE REVIEW TRACKER
Updated 6.27.23

The following information has been compiled from Commission discussions and 2023 HRSA site visit findings.

"Commission Bylaws Approval: The Commission's Bylaws must be amended accordingly following amendments to the Ordinance. Amendments or revisions to these Bylaws must be approved by a two-thirds vote of the Commission members present at the meeting, but must be noticed for consideration and review at least ten days prior to such meeting (see Article XVI)." July 11, 2013 Bylaws.

AREA OF CONCERN	RECOMMENDATION	REFERENCES	ORDINANCE TRIGGER	NOTES/COMMENTS
Stipends for Unaffiliated Consumer (UC) Members	Increase max $ of monthly stipends to UCs *current max $150 per month	Ordinance 3.29.080 Compensation Bylaws Section 5. Commission Member Compensation	YES	Staff polled other jurisdictions; we are one of very few jurisdictions that offer stipends; refer to compilation of feedback doc. I.e., Oregon assigns an $ amount to various meeting/event types.
Meeting Frequency	Reduce the number of required Commission meetings per year	Ordinance 3.29.060 Meetings and committees Bylaws Section 5. Regular meetings	YES	Bylaws and Ordinance currently state that the Commission must meet a minimum of 10x per year barring cancellation by COH Co-Chairs and/or EXEC Committee.
DHSP Staff, Membership & Voting Status	Per HRSA, remove DHSP representation on membership and from voting deliberations.	Ordinance 3.29.060 Meetings and committees		"Lack of compliance with the requirement to ensure separation of Planning Council and recipient roles. The Director of DHSP, who also functions as a CEO designee for the jurisdiction, is a voting member of the

AREA OF CONCERN	RECOMMENDATION	REFERENCES	ORDINANCE TRIGGER	NOTES/COMMENTS
		Ordinance 3.29.030 Membership Bylaws IX. COMMISSION WORK STRUCTURES Section 4. Committee Membership Bylaws X. EXECUTIVE COMMITTEE: Section 1. Voting Membership Bylaws XII. PLANNING, PRIORITIES AND ALLOCATIONS (PP&A) COMMITTEE: Section 1. Voting Membership Bylaws XIII. PUBLIC POLICY (PP) COMMITTEE: Section 1. Voting Membership Bylaws XIV. STANDARDS AND BEST PRACTICES (SBP) COMMITTEE: Section 1. Voting Membership	YES	LA Commission on HIV and a voting member of the Executive Committee." (Citation: Section 2602 (7)(a) of the PHS Act.) "A recipient's representative, whose positions are funded by RWHAP funds, provides in-kind services, or has significant involvement in the HIV award, shall not occupy a seat on the Planning Council, nor have a vote in the deliberation of the Planning Council." (HRSA Findings)

AREA OF CONCERN	RECOMMENDATION	REFERENCES	ORDINANCE TRIGGER	NOTES/COMMENTS
Annual Bylaw Review	Codify annual review in Bylaws; add sunset date.	Ordinance 03.29.110: Sunset Date	YES *if specifying sunset date	Ordinance currently states the sunset date as indefinite. Option to state sunset date or codify an annual review within the bylaws.
Conflict of Interest: Provider members participation in the Priority Setting & Resource Allocation (PSRA) decision making process.		Ordinance 3.29.046 Conflict of interest Bylaws III. MEMBER REQUIREMENTS: Section 3. Conflict of Interest Bylaws VII. POLICIES AND PROCEDURES: Section 5. Conflict of Interest Procedures	YES	Per HRSA site visit feedback, providers may no longer be able to participate in the PSRA decision making process regarding funding & services.
DHSP Ending the HIV Epidemic (EHE) Steering Committee	Include language re: required partnership with DHSP EHE Steering Committee and/or EHE initiative efforts			Requested by member(s)
Status Neutral Language Inclusion	TBD		TBD	Requested by member(s) and in alignment with national status neutral initiatives
Member composition does not include key alliances	Update membership composition to designate seats for key partners, i.e., County Commissions whose work intersects with the COH.	Ordinance 03.29.030: MEMBERS Bylaws II. MEMBERS: Section 2. Composition	YES	
COH's name is not comprehensive enough	Consider a more inclusive name.		YES	The Commission's name, in and of itself, is not comprehensive enough as the Commission's efforts should reach beyond HIV to truly make impactful en roads to

AREA OF CONCERN	RECOMMENDATION	REFERENCES	ORDINANCE TRIGGER	NOTES/COMMENTS
				ending HIV locally. "HIV-only days are over". See May 11, 2023 BRT Meeting Summary
Determine the minimum authorized/prescribed number of PC/PB members according to PC/PB bylaws	Specify minimum number of members authorized on the PC – half of membership seats		YES	HRSA has inquired as to what is the minimum number of members authorized per our bylaws. The bylaws do not currently prescribe a minimum number.

RYAN WHITE PART A SUBRECIPIENT SITE VISIT LOS ANGELES EMA

FEBRUARY 14-17, 2023

PLANNING COUNCIL

Summary of Planning Council/Body (Part A only): Los Angeles EMA established the Los Angeles (LA) Commission on HIV, a community planning body responsible for assessing the needs of people with HIV, establishing service priorities, and allocating grant funds. The commission is comprised of 37 representatives, including seven unaffiliated client representatives. The commission has formal bylaws, policies/procedures, and several standing committees: Executive, Operations, Standards and Best Practices, Planning, Priorities, and Allocation and Public Policy.

The LA commission also has various caucuses: Consumer Caucus, Black/African American Caucus, Women's Caucus, Transgender Caucus, and Aging Caucus. Los Angeles County has a designated LA Commission on HIV website www.hiv.lacounty.org. It is comprehensive and contains information on membership recruitment, bylaws, assessment of the administrative mechanism, service standards, committees/caucuses, grievance procedures, and membership application.

The commission strongly emphasizes member recruitment/retention, as evidenced by meeting minutes and focused membership drive activities. The commission also has a member reimbursement policy and a mentoring program to help acclimate new members and ensure their attendance/participation. The commission's Executive Committee's interaction with HRSAHAB's site visit team was substantive and enthusiastic. The commissioners were engaged, candid, and well-versed on the issues of requirements, operations, HIV service needs, available resources, and their unique challenges. Executive Committee members demonstrated a strong sense of commitment and dedication to the needs of people with HIV in the Los Angeles EMA area.

At the request of the LA Commission on HIV Consumer Caucus, the HRSA HAB's site visit team hosted a listen-only session on February 16, 2023. The session summary is uploaded as a separate document for the Project Officer's review. Summary of Persons with Lived Experience/Community Meeting: The people with lived HIV experiences panel consisted of six participants who self-identified their gender and race: one woman, five men, one Hispanic/Latinx, one African American and four White. Five participants were between 51 to 65 years. One participant reported being between 20-65 years. The number of years receiving HIV care ranged from 6 to 21 years. Participants reported receiving medical care, oral health, mental health, housing, emergency financial assistance, food, and medication assistance. All participants stated the providers generally well protected their confidentiality/privacy.

Most clients reported being aware of the formal grievance process at their agencies. Identified as most important services were medical, oral health, housing, and food. Identified concerns and unmet needs included dealing with non-HIV medical issues, such as diabetes, hypertension, and cancer. Homelessness, lack of housing options, and stigma were identified as significant barriers that impact clients' ability and willingness to access/remain in HIV care and support services. These barriers ultimately lead to poor viral suppression, negative overall health, and negative quality of life outcomes. Additional reported challenges included: health disparities in communities of color, mental health, financial assistance, better case management, status neutral housing, and the need to streamline the

system. Overall, participants were satisfied with the medical care and support services. They gave a rating of 7.9 out of 10 for the overall quality of RWHAP Part A services in the LA EMA service area. In addition, some participants expressed gratitude and appreciation for the services they received. The site visit team participated in a listen-only session at the request of the LA Commission on HIV Consumer Caucus. The summary of this session is captured in Appendix A at the end of this report. III. Finding Categories for Review: The information below provides guidance on the meaning of each option. applicable = this section is not part of the site visit and therefore not reviewed.

Finding identified = The recipient does not currently comply with a legislative requirement and/or programmatic expectation of the Ryan White HIV/AIDS Program (RWHAP). All identified findings must be addressed via a corrective action plan (CAP).

• Improvement Options: (optional) Any area of the program that complies with legislative and programmatic requirements of the program at a satisfactory level but was identified to have the capacity to improve.

• Program Strengths (optional): Any area of the program that complies with legislative and programmatic requirements of the program beyond a satisfactory level.

A. Administration: Finding(s) identified.

1. Findings and Recommendations Governance and Constituent Involvement:

Finding(s) identified Finding 1: Legislative Description: Lack of compliance with the requirement for consumer/stakeholder recruitment and/or involvement. (L) Finding Description: Lack of compliance with the requirement to ensure separation of Planning Council and recipient roles. The Director of DHSP, who also functions as a CEO designee for the jurisdiction, is a voting member of the LA Commission on HIV and a voting member of the Executive Committee. Citation: Section 2602 (7)(a) of the PHS Act

Recommendation: The recipient must ensure separation of Planning Council and recipient roles to avoid any actual and/or perceived conflict of interest. Per Section 2602 (7)(a) of the PHS Act, a separation of Planning Body and the recipient is necessary to avoid a conflict of interest. A recipient's representative, whose positions are funded by RWHAP funds, provides in-kind services, or has significant involvement in the HIV award, shall not occupy a seat on the Planning Council, nor have a vote in the deliberation of the Planning Council. For additional guidance, the recipient should review HRSA's Ryan White HIV/AIDS Program Planning Council and Planning Body Requirements and Expectation Letter which clarifies HRSA expectation on the required community input process for RWHAP Part A awards, specific to the separation of Planning Council and recipient roles.

Finding 2: Legislative Description: Lack of compliance with the requirement for Planning Council membership to comply with representation and reflectiveness. (L) Finding Description: Los Angeles (LA) Commission on HIV currently has three vacancies for the following legislatively mandated categories: a) RWHAP Part C Provider, b) Hospital Planning Agency or Health Care Planning Agency, and c) Representatives of Individuals who Formerly were Incarcerated. Citation: Section 2602(b)(5)(C) of the PHS Act

Recommendation: LA Commission on HIV must ensure that its operations committee prioritizes and expedites its efforts to recruit, review, and nominate qualified candidates for the currently vacant

legislatively mandated categories for subsequent submission for Chief Elected Official (CEO)'s review and appointment. The CEO should prioritize their review, consideration, and timely appointment of commissioners to ensure smooth and uninterrupted operations of the HIV Planning Council.

Finding 3: Legislative Description: Lack of compliance with the requirement for Planning Council membership to comply with representation and reflectiveness. (L) Finding Description: LA Commission on HIV currently has 37 CEO-appointed members, including seven unaffiliated client representatives. This represents 19 percent, which is below the 33 percent unaligned client representation requirement for planning bodies, as stated in Section 2602(b)(5)(C) of the PHS Act. Citation: Section 2602(b)(5)(C) of the PHS Act

Recommendation: The LA Commission on HIV, through its Operations Committee, should review, revise, prioritize, and expedite its efforts to recruit and nominate unaffiliated clients for subsequent submission for CEO review and appointment to ensure consistent compliance with the unaligned client participation requirement. To that effect:

1. Operations Committee should proactively and consistently solicit input and assistance from the established Commission on HIV Caucuses, specifically, its Consumer Caucus, Black/African American Caucus, Transgender Caucus, Women's Caucus and Aging Caucus. This will allow the Planning Council to increase the pool of potential eligible/qualified applicants from diverse backgrounds to improve overall representation and reflectiveness of the Commission.

2. Recipient and the Planning Council should engage its provider network in a deeper, more proactive, and consistent recruitment effort that may include a) conducting designated trainings for providers on the importance of recruitment, b) having hard-copy membership applications (in English and Spanish) available at funded agencies, c) conducting Planning Council recruitment "Meet and Greet" events at providers' agency support groups and other client meeting, etc.

3. Establish a "Bring a Friend" Day, when unaffiliated commissioners can bring their friends to PC meetings to get a better understanding of the PC and be able to apply for membership on the spot, if interested.

4. Establish a Commission on HIV Community Recruitment Annual Schedule that will ensure the Commission on HIV's prominent presence and participation in the most important community events, such as during Pride Events, World AIDS Day Events, (December), National HIV Black Awareness Events, (February), National Latino HIV Awareness Events (October), National Women's Awareness Events, (March), etc.

Finding 4: Legislative Description: Lack of compliance with the requirement for consumer/stakeholder recruitment and/or involvement. (L) Finding Description: Currently, there is one commissioner listed on the membership roster, (Mr. Stalter), whose membership term expired in July 2022. There is no documentation the commissioner was timely reappointed for any additional membership terms. This commissioner is a co-chair of the Standards and Best Practices Committee and a member of the Executive Committee. There is another commissioner listed on the membership roster, (Mr. Moreno), whose membership term expired in July 2022. There is no documentation the commissioner was timely reappointed for any additional membership terms. This commissioner represents the legislatively

mandated category of Health Care Providers and is a member of the Operations Committees. Citation: Section 2602(b)(5)(C) of the PHS Act

Recommendation: Steps recommended for compliance:

1. Recipient and the commission should review and consistently follow the nominating process outlined in the currently approved LA Commission on HIV Bylaws in Article 4: Nomination Process, p. 9, and LA Commission on HIV Policy and Procedure #09.4205, Commission Membership Evaluation and Nominations Process (approved in May 2018).

2. Recipient and the commission support staff should review HRSA's Ryan White HIV/AIDS Program Planning Council and Planning Body Requirements and Expectation Letter, which provides clarification on HRSA's expectation on the required community input process for RWHAP Part A awards, specific to PC term limits and membership rotation.

3. The commissioner nomination and re-appointment process should begin early to allow the CEO ample time to review, consider and make approval decisions on member applications.

4. The CEO should prioritize its review, consideration, and reappointment of commissioners whose term is expiring to avoid prolonged vacancies and to ensure smooth and uninterrupted operations of the commission.

Finding 5: Legislative Description: Lack of compliance with the requirement for consumer/stakeholder recruitment and/or involvement. (L) Finding Description: Lack of compliance with the conflict-of-interest requirement for PC members. The LA Commission on HIV currently has 37 duly appointed PC members. There is no documentation of current, completed, and signed Conflict of Interest (COI) declaration for any of the appointed commissioners. Most of the COI declarations are outdated, going back to 2018 and 2019. The most recent COI declaration is dated June 2021. In addition, several commissioners who are affiliated with currently funded providers declared "No Conflict" on their COI declarations. Based on the review of the meeting minutes for the commission and its Planning, Priority and Allocations Committee, it is evident that several of these commissioners participated in allocations/reallocation discussions and voted on allocations including for the service categories for which their agencies are funded, most recently in June 2022 on a revised FY 2023 RWHAP Part A funding allocation. Citation: Section 2602(b)(5)(C) of the PHS Act

Recommendation: As stated in the RWHAP Part A Manual, X. Ch 8. Conflict of Interest, p. 147, Conflict of Interest can be defined as an actual or perceived interest by the member in an action that results or has the appearance of resulting in a personal, organizational, or professional gain. The definition may cover both the member and a close relative, such as a spouse, domestic partner, sibling, parent, or child. This actual or perceived bias in the decision-making process is based on the dual role played by a planning council member who is affiliated with other organizations as an employee, a board member, a member, a consultant, or in some other capacity.

Recommended steps of action:

1. LA Commission on HIV support staff members must ensure that all commissioners have a current, completed, and signed COI declaration.

2. LA Commission on HIV support staff members should review the Conflict-of Interest requirements for Planning Councils, as outlined in the RWHAP Part A Manual, Section X, Chapter 8, pp. 143-152.

3. LA Commission of HIV support staff should review the Los Angeles County Conflict of Interest Policy #12.0001, approved in June 2008, specifically item 2 under the Procedures section on p. 4.

4. LA Commission of HIV support staff should conduct a COI refresher training for all commissioners to ensure uniform understanding with participation documentation on file.

5. The recipient and PC support staff members must maintain up-to-date documentation of all members' terms, appointments, representation categories, and agency affiliations.

Los Angeles Commission on HIV Consumer Caucus Listen-Only Session Summary (Reference only; not reviewed)

At the request of the LA Commission on HIV Consumer Caucus, the HRSA HAB's site visit team hosted a listen-only session on February 2, 2023. Below, please see a summary of the feedback provided by the Consumer Caucus members.

1. Introductions and Rationale: • We asked for this meeting, as it is important for HRSA to hear us and move on this. We are looking for action. • We would like to find a way for our messages to get through. • We are most grateful for this meeting. • We are not focusing on the past; we want to fix the problems. • Consumer Caucus is focusing on social determinates of health. This is what we are talking about today.

2. Ryan White and EHE: • I would not mind being on the EHE Steering Committee, but I have to be paid. I sent in my resume and never heard from anyone. Not sure if they need us. • There is a need to merge Ryan White and EHE money. • We need to better coordinate Ryan White and EHE efforts. • We are not included in EHE activities, as if we do not exist. • I would like to participate in the EHE Steering Committee and will bring information back. • There is no prevention for positives anymore. EHE is a whole another world. How do you do status neutral?

3. Incentives and reimbursements for persons with lived experiences: • Reimbursement rates for consumer participation do not work, they are low. • $5 gift card is not enough for my expertise. • Consumers on the Commission need help. How many people got their master's degrees and PhDs based on our stories? • Employees at agencies are getting raises and we are stuck with incentives, yet we are the ones dealing with HIV.

4. LA EMA Site Visit Client Meeting (2/15/2023) follow-up: • I am surprised that there were so few clients at yesterday's client meeting. • I did not receive any emails about the client meeting. • I did not receive the link to the client meeting, as if they did not want us there.

5. LA Commission on HIV concerns : • There are deep issues on the commission. Big stuff needs to be addressed. • There is an anti-white thing going on in the Commission. • Last site visit consumers were unhappy, but the report stated otherwise. • If we do not show up to meetings, there will be no programs.

6. Service Delivery System concerns: • There is lack of staff to help with the paperwork. • Proof of HIV diagnosis and proof of income should be enough for eligibility. • Services should be local, there are no services where I am. • Agencies are not listening to consumers. There is desperation. • I was ignored by

a staff member who now is promoted to supervisor. • Even as a Co-Chair of the Commission, I cannot get through sometimes, I have to ask for assistance from someone else. • If someone like me cannot get through the system, there is no way others can do it. • People are not getting the services that they need. The system delivery is wrong. • We need help. • We have had these issues for a long time, we have to be people friendly.

7. Services for Immigrants: • System is not set up to help immigrants, especially black immigrants. If we do not help them, they will use their bodies to get what they need. • I tried to initiate conversations about immigrant crisis. It is sad. Yes, there is treatment, but that is it. • I have a good family support, but not everyone has the kind of support that I have.

8. Stigma • Why do buildings for HIV services have HIV listings on them? We have to eliminate stigma. People still are ignorant. I would like to see change.

9. Housing : • Housing is very important. I experienced homelessness, spent nights walking. I tried to get into some services just to have an opportunity. • People live on the streets, there are no services available for them. • I applied for housing and heard from them 3 months later.

10. Peer Technical Assistance (TA) : • I participated in the RW Conference and heard from a lot of good programs. • There has to be a way to identify programs that are working well and to share their processes. • My local agency has excellent results, (90% viral suppression). This should be replicated in other places.

11. Follow-up: • We want to hear from HRSA, to acknowledge our words. Please provide a statement of things we talked about to us. • It is important to get true, quality feedback. We have to have back-and-forth capabilities to help each other. • We ask HRSA to send us a summary of the meeting notes, it will be useful and helpful for our collective efforts. • What can we, as consumers, change to improve our services? Some guidance will be helpful. • What can consumers do regarding what HRSA wants us to focus on? Please send us some guidance. • How can we as consumers help you, HRSA, to work towards common goals? • Consider grassroot agencies, women owned agencies for grants.

12. Acknowledgement and thank you: • The Consumer Caucus members are interested to work with HRSA. • We are grateful to be here today and to have an opportunity to speak. • We would like to give you credit for being dedicated civil servants. • Thank you for taking the time to meet with us.

LOS ANGELES COUNTY
CORRECTIVE ACTION PLAN (CAP) FOR 2023 HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA) SITE VISIT CONDUCTED ON FEB. 14-17, 2023 RWHAP PART A GRANT #H89HA00016 (Rev 7.14.23)

FINDING DESCRIPTION	PERSON(S) RESPONSIBLE	TARGET/DUE DATE	CORRECTIVE ACTION PLAN	PROGRESS TO DATE
#1: Lack of compliance with the requirement to ensure separation of Planning Council and recipient roles. The Director of DHSP, who also functions as a CEO designee for the jurisdiction, is a voting member of the LA Commission on HIV and a voting member of the Executive Committee. Citation: Section 2602 (7)(a) of the PHS Act	Commission on HIV (COH) staff, Commission on HIV Bylaws Review Task Force, Operations Committee, County Counsel	December 30, 2023	The Bylaws Review Taskforce (BRT) is working with COH staff and County Counsel to change the language in the bylaws to designate DHSP staff including the Director of DHSP as "non-voting representatives" rather than as "members". Guidance from County Counsel is an integral part of the process as the bylaws changes will trigger a corresponding ordinance change for the COH as well. Until the bylaws changes are approved, DHSP staff on the COH and committees will abstain from voting to separate roles between the grantee and PC to avoid any actual or perceived conflict of interest	Prior to the 2023 HRSA site visit, the Operations Committee has begun a review of the COH's bylaws and subsequently decided to form a taskforce to engage a broader group of Commissioners and stakeholders in the review process and facilitate a dedicated group and time for the sole purpose of updating the bylaws. The Bylaws Review Taskforce (BRT), formally convened for an initial meeting on April 10 to address findings from the HRSA site visit and other governance issues of importance to the COH. The COH is working with County Counsel in revising the PC bylaws and ordinance to address site visit findings. The BRT will continue to meet monthly and prioritize changing the section of the bylaws regarding DHSP membership on the COH.

#2: Los Angeles (LA) Commission on HIV currently has three vacancies for the following legislatively mandated categories: a) RWHAP Part C Provider, b) Hospital Planning Agency or Health Care Planning Agency, and c) Representatives of Individuals who Formerly were Incarcerated. Citation: Section 2602(b)(5)(C) of the PHS Act	Commission on HIV, Operations Committee, Commission on HIV staff	a) March 21, 2023 b) February 29, 2024 c) September 30, 2023	a) Part C Representative: At the time of the HRSA site visit, an application for the seat was being processed and was in the pipeline for the Board's approval. The Board approved Mr. Leon Maultsby's application to serve as the Part C representative on the COH on March 21, 2023. b) Hospital Planning Agency or Healthcare Planning Agency: Filling the hospital planning or healthcare planning agency has been a recuring challenge for the COH. COH staff will continue to reach out to LACare, Kaiser Permanente, Molina, Blue Shield, Anthem, and Hospital Association of Southern CA (HASC) to engage them in the work of the COH and fill this vacant seat.	a) Part C Representative: Seat was filled on March 21, 2023 b) Hospital Planning Agency or Healthcare Planning Agency: Recruitment efforts entail direct one-on-one outreach to HealthNet, Kaiser Permanente Southern CA, and LACare. The most recent outreach with Dr. Positron Kebebew, Regional Medical Director for HealthNet yielded a high level of interest, however, she regrettably declined, as advised by the Chief Medical Officer due to her expansive duties with HealthNet. Some consumers have also referred their HIV doctors from local health plans to staff for membership application support, however, none have submitted applications despite follow-up from staff. COH staff will continue to reach out LACare, Kaiser Permanente, Molina, Blue Shield, Anthem, and Hospital Association of Southern CA (HASC) to

			c) Representatives of Individuals who Formerly were Incarcerated: COH staff acknowledge the challenges with filling this seat (i.e., fear of disclosing status, life priorities, significant time commitment required for COH service). Outreach efforts with the Office of Diversion and Re-entry, and local agencies serving justice-involved individuals will continue until the seat is filled. Because of the exacerbated challenges faced by justice involved individuals in the re-entry process, COH staff will need to acclimate potential candidates to the work of the COH first and coach them through the application process. COH Operations Committee will fill this vacancy by the end of September 2023.	engage them in the work of the COH and solicit membership applications. c) Representatives of Individuals who Formerly were Incarcerated: COH staff has reached out to the Los Angeles County Office of Diversion and Re-entry (ODR) for recruitment opportunities. Additionally, COH staff continue to work with PC members who work with justice-involved individuals for recruitment opportunities and referrals. ODR provided referrals to the Los Angeles Centers for Alcohol and Drug Abuse (LACADA) for possible candidates. COH staff have subsequently made several attempts to connect with LACADA staff and is awaiting a response. A Commissioner also promoted membership applications at Healing Village and Resource Fair for formerly incarcerated on June 24, 2023. Additionally, staff will attend upcoming LA Re-entry

				Regional Partnerships to promote the COH and solicit membership applications. A membership application for a representative of formerly incarcerated individuals from the Center for Health Justice was received on July 12, 2023.
#3: LA Commission on HIV currently has 37 CEO-appointed members, including seven unaffiliated client representatives. This represents 19 percent, which is below the 33 percent unaligned client representation requirement for planning bodies, as stated in Section 2602(b)(5)(C) of the PHS Act. Citation: Section 2602(b)(5)(C) of the PHS Act	Commission on HIV Operations Committee, COH staff	January 31, 2024	The COH undertakes all the recommendations provided by HRSA noted in the site visit report for unaffiliated consumers (UCs) recruitment and will continue to work the caucuses to attract applications from UCs. Membership recruitments are scheduled for the following upcoming events/activities: • Taste of Soul (October 21, 2023) • Community listening sessions to be led by the Black Caucus (Sept-Dec 2023) • World AIDS Day community events • Planning, Priorities and Allocations Committee service	As of July 5, 2023, the COH has 40 members and 3 alternates. Among the 40 members, 10 are UCs (25%); among the alternates, 1 is a UC. As of July 6, 2023, there are five applicants who may potentially occupy a UC seat; staff are in the process of verifying their application information.

			needs townhalls (Jan-April 2024) • Local Community Advisory Board and Service Provider Network meetings • Women's Caucus Virtual Lunch and Learn educational events • Transgender Summit (Nov 2023) • HIV, Aging and Sexual Health educational event (Sept 2023) • Digital COH promotion toolkit on website • Ongoing social media promotion	
#4: Currently, there is one commissioner listed on the membership roster, (Mr. Stalter), whose membership term expired in July 2022. There is no documentation the commissioner was timely reappointed for any additional membership terms. This commissioner is a co-chair of the Standards and Best Practices Committee and a member of the Executive Committee. There is another commissioner listed on	Commission on HIV Operations Committee, COH staff	December 30, 2023 and ongoing	During the site visit and in a follow-up email, staff explained to HRSA auditors that all members, once appointed, serve at the pleasure of the Los Angeles County Board of Supervisors (BOS) and provided the following excerpts from the ordinance and examples of BOS motions on approved membership renewal with waivers of term limits:	**Kevin Stalter Update:** At its meeting held Tuesday, March 7, 2023, on recommendation of the Commission on HIV, the Los Angeles County Board of Supervisors reappointed Mr. Stalter as a member of the Commission on HIV for an unexpired term of office expiring on July 11, 2023. His application is also included in the membership renewal slate which is set to appear before the full body for approval in

the membership roster, (Mr. Moreno), whose membership term expired in July 2022. There is no documentation the commissioner was timely reappointed for any additional membership terms. This commissioner represents the legislatively mandated category of Health Care Providers and is a member of the Operations Committees. Citation: Section 2602(b)(5)(C) of the PHS Act			"All members and alternates shall serve at the pleasure of the Board of Supervisors. Any member whose employment, status or other factors no longer fulfill the requirements of the membership seat to which he/she was appointed shall be removed from the Commission as determined by the Board of Supervisors….No member may serve on the Commission for more than two (2) full consecutive terms, unless such limitation is waived by the Board of Supervisors." The BOS applies a general waiver of term limits in an effort to maintain all of its (400+) commissions' membership; without this waiver, all County commissions would find it incredibly difficult to maintain a reflective and representative membership, especially ours. This language is included in our County Ordinance as well as on the Board of Supervisors'	August which will thereafter move to the Board for approval. Seats are filled and active unless specifically vacated by the Board. **Carlos Moreno Update:** Mr. Moreno resigned from the COH on February 7, 2023.

			statement of proceedings when a member(s) is appointed. For corrective action and enhanced documentation for membership renewals, staff will include links to full BOS statement of proceedings to document waiver of term limits and place electronic copy in members' folders or in cohort renewal BOS approval folder. In addition, the COH Operations Committee will strengthen description of process in existing policies and procedures for seat changes/membership management; include approval process from Operations and Executive. Seat changes do not require BOS approval.	
5: Lack of compliance with the conflict-of-interest (COI) requirement for PC members. The LA Commission on HIV currently has 37 duly appointed PC members. There is no	Commission staff	a) Completed b) December 30, 2023	a) On March 23, 2023, the COH developed a separate Ryan White Program Part A-specific COI form to be filled out and signed by each	Ryan White Program Part A-specific COI forms have been collected from existing members; new members will complete Ryan White Program Part A-specific COI form during

documentation of current, completed, and signed Conflict of Interest (COI) declaration for any of the appointed commissioners. Most of the COI declarations are outdated, going back to 2018 and 2019. The most recent COI declaration is dated June 2021. In addition, several commissioners who are affiliated with currently funded providers declared "No Conflict" on their COI declarations. Based on the review of the meeting minutes for the commission and its Planning, Priority and Allocations Committee, it is evident that several of these commissioners participated in allocations/reallocation discussions and voted on allocations including for the service categories for which their agencies are funded, most recently in June 2022 on a revised FY 2023 RWHAP Part A funding allocation. Citation: Section 2602(b)(5)(C) of the PHS Act			member at the time of BOS appointment and annually, listing any agency contracts (if applicable). All County Commissioners fill out an IRS 700 form to declare their economic interests. At the time of the site visit, staff did not have access to the electronic files, however, moving forward, staff have been granted access and will use the completed electronic IRS 700 filings as additional records for conflicts of interest matters. b) In addition, as part of the bylaws update, the COH will add explicit language requiring members who are affiliated with contracted agencies to abstain from voting on allocations for which their agencies are funded. In addition, staff will work with the Co-Chairs and parliamentarian to remind	onboarding/new member orientation. Annually all members will fill out a new Ryan White Program Part A-specific COI form at the beginning of the year.

			and reinforce the section of the existing COH bylaws that states “all members must declare conflicts of interest involving Ryan White-funded agencies and their services, and the member is required to recuse him/herself from discussion concerning that area of conflict, or funding for those services and/or to those agencies.”	

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PUBLIC POLICY COMMITTEE 2023 MEETING SCHEDULE
(updated 08.02.23)

DATE	KEY AGENDA ITEMS/TOPICS (subject to change; for planning purposes)
January 24 1pm to 3pm *(Virtual)*	Elect Co-Chairs for 2023
February 6 1pm to 3pm *(Virtual)*	PACHA Resolution on MSM Blood Donation Deferral Policy 2023 Legislative Docket Development 2023 Policy Priorities Action Plan Development
March 6 1pm to 3pm *(In-Person)*	**MEETING CANCELLED**
April 3 1pm to 3pm *(In-Person)*	Adopt 2023 PPC Workplan Finalize and approve changes to 2023 Policy Priorities Document Discuss state bills for 2023-2024 Legislative Docket Approve Legislative Docket—PPC and Executive
May 1 1pm to 3pm *(In-Person)*	Approve Legislative Docket – COH Submit Legislative Docket to BOS Discuss federal bills for 2023-2024 Legislative Docket Discuss DPH Memo on STD crisis to Board of Supervisors (BOS)
June 5 1pm to 3pm *(In-Person)*	Discuss public comment schedule for Health Deputy/BOS meetings
July 10 1pm to 3pm *(In-Person)*	Determine strategy for Ryan White Care Act (RWCA) Modernization Outline presentation schedule for RWCA modernization
August 7 1pm to 3pm *(In-Person)*	Discuss the RWCA Modernization Project and determine next steps
September 4 1pm to 3pm *(In-Person)*	Consider rescheduling or canceling due to Labor Day Holiday on 9/4/23 *Note: The United States Conference on HIV/AIDS (USCHA) 9/6/23—9/9/23* RWCA Modernization Presentation
October 2 1pm to 3pm *(In-Person)*	Outline the framework for modernized RWCA Modernization white paper
November 6 1pm to 3pm *(In-Person)*	COH Annual Meeting
December 4 1pm to 3pm *(In-Person)*	Consider cancelling; poll committee members

2023 WORK PLAN – PUBLIC POLICY—UNDER REVIEW

Committee Name: **PUBLIC POLICY COMMITTEE (PPC)**				
Co-Chairs: Katja Nelson, Lee Kochems			Committee Adoption Date: TBD	
Purpose of Work Plan: To focus and prioritize key activities for COH Committees and subgroups for 2023				
#	**TASK/ACTIVITY**	**DESCRIPTION**	**TARGET DATE**	**STATUS/NOTES/OTHER COMMITTEES INVOLVED**
1	Review and refine 2023 workplan	COH staff to review and update 2023 workplan monthly	Ongoing, as needed	Workplan revised/updated on: 12/23/23, 2/23/23, 3/29/23, 8/3/23
2	Provide feedback on and monitor implementation of the Comprehensive HIV Plan (CHP)	Collaborate with the PP&A Committee to support the implementation of the CHP	Ongoing, as needed	
3	Develop 2023-2024 Legislative Docket	Review legislation aligned with information gathered from public hearing(s) as well as recommendations from Commission taskforces, caucuses, and workgroups to develop the Commission docket, and discuss legislative position for each bill.	May 2023 COMPLETED	The Committee will begin legislative bill review in 4/2023. Commission approved the legislative docket on 06/08/23. The document was forwarded to the Commission's County partners at the Office of Legislative Affairs and Intergovernmental Relations.
4	Continue to advocate for an effective County-wide response to the STD 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, STD, STIs, Hep C and other sexual health issues.	Ongoing	Track and monitor BOS correspondence website and BOS agenda items related to the County-wide response to the STD crisis in Los Angeles County. On 2/7/23, the Department of Public Health (DPH) submitted a response to the Board motions made on 8/2/22 and 11/1/2022. The report includes a chart listing funding needs to response to the County's STD crisis by tiers. DPH submitted a quarterly memo on 05/03/23.
5	Continue to advocate for an effective County-wide response to the meth crisis in Los Angeles County.	The Committee will review government actions that impact funding and implementation of items on the ANAM platform.	Ongoing	Track and monitor BOS correspondence website and BOS agenda items related to the County-wide response to the ANAM platform. Commission staff will coordinate a meeting with staff at the substance Abuse Prevention and Control (SAPC) Program to discuss policy and service coordination

2023 WORK PLAN – PUBLIC POLICY—UNDER REVIEW

				efforts at an upcoming full Commission meeting.
6	Update the 2022-2023 Policy Priorities document and Action Plan document.	The Committee will revise the Policy Priorities document to include the alignment of priorities from Commission stakeholder groups	April 2023 COMPLETED	The Committee and will finalize and approve changes for the 2023 Policy Priorities document. Commission approved the Policy Priorities document on 06/08/23. The document was forwarded to the Commission's County partners at the Office of Legislative Affairs and Intergovernmental Relations.
7	Efforts to Modernize the Ryan White Care Act (RWCA)	The Committee facilitated a discussion for the interest in modernizing the RWCA at the Commission's 2022 Annual meeting in November. "Dreaming Big: Community Wish List for a Better and Modernized Ryan White Care System & Ryan White CARE Act Legislation Overview"	Late 2023	Determine strategy for developing white paper on RWCA modernization to set foundation for future discourse around reauthorization. Issues discussed at Nov 2022 Commission Annual meeting: • Status neutral approach • Opportunity to expand service categories and allow more flexibility • Reduce administrative burden on the client and agencies to prove the Payor of Last Resort provision
8	Monitor and support the City of Los Angeles safe consumption site project.	Coordinate with the City of LA AIDS Coordinator's Office	TBD	The Committee is scheduling a presentation with the City of Los Angeles Safe Consumption site providers.

PUBLIC POLICY COMMITTEE RYAN WHITE PROGRAM MODERNIZATION PROJECT

PURPOSE: Provide guidance to the Public Policy Committee for developing a policy brief summarizing key issues to address and include in a modernized Ryan White HIV/AIDS Program Legislation.

BACKGROUND INFORMATION ON RYAN WHITE LEGISLATION FOUND ON HEALTH RESOURCES & SERVICES ADMINISTRATION (HRSA) WEBSITE[1]:
Ryan White Comprehensive AIDS Resources Emergency (CARE) Act Legislation first enacted in 1990. Amended and reauthorized four times in 1996, 2000, 2006, and 2009. The 2009 Ryan White HIV/AIDS Program legislation continues the Ryan White HIV/AIDS Program through fiscal year 2013 and beyond, so long as Congress appropriates funds.

ISSUES IDENTIFIED DURING PPC MEETINGS AND COH STAFF NOTES:
- Implement a status neutral approach to care and prevention efforts
- Expanding RWP to individuals and populations that carry the burden of new HIV infections
- Preserving MAI funds and ensuring these funds address not just HIV health needs but also systemic racial barriers
- Adding service categories that allow for local customization and flexibility

ISSUES/NEEDS NOTED ON LOS ANGELES COUNTY COMMISION ON HIV--COMPREHENSIVE HIV PLAN[2]:
- Increase Health literacy among PLWH
- Increase workforce capacity
- Meet the needs of PLWH age 50 years old and older
- Provide holistic services for cisgender and transgender women
- Develop models of care for meeting the health care needs of people with HIV who use drugs

ISSUES/NEEDS IDENTIFIED IN RESOURCE DOCUMENTS
- Reauthorization Principle #4: Ryan White's "Last Resort" response is not practical[3]
  - Recipients must first demonstrate that they have exhausted all other sources of funding before tapping into Ryan White resources
  - Re-engineer Ryan White as a critical wrap-around and supplementary component resource intended to enhance and expand other HIV prevention, care, and treatment services-- or supply those services where there are none.
- Reauthorization Principle #5: "Emergency" and "Urgency" are not synonymous[4]
  - Urgency is needed more, indicating a purposeful response, guided by expedited but thorough planning and implementation
    - Refocus efforts to facilitate health care access and early interventions (Rapid linkage to care)
    - Review program administration and reduce outdated procedures that slow down service delivery
    - Devote expenditures to integrated prevention and care (Status neutral approach)
  - Reauthorization Principle #9: Financially support quality and efficiency[5]

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[1] https://ryanwhite.hrsa.gov/livinghistory/legislation
[2] Microsoft Word - LA County Integrated HIV Prevention and Care Plan, 2022-2026.docx (kc-usercontent.com)
[3] "Ryan White Reauthorization Principles" Policy Brief No. 4, Los Angeles County Commission on HIV
[4] "Ryan White Reauthorization Principles" Policy Brief No. 4, Los Angeles County Commission on HIV
[5] "Ryan White Reauthorization Principles" Policy Brief No. 4, Los Angeles County Commission on HIV

        - Electronic Medical Record (EMR) systems can lead to more efficient administrative processes
        - Disease management models that rely on high quality care, incorporate inter-disciplinary, team-oriented service delivery, medical and primary health care accountability, and patient-centered focus
- Despite the expected benefits of the ACA to PLWH, access and linkage to care, reducing inequity in HIV risk and access to care, and coping with comorbidities remain pressing challenges.[6]
- Increase Ryan White program investments to build health department data management systems and capacity to better partner with Medicaid, Medicare, health plans, and HIV prevention programs to monitor engagement in care and intervene when care is interrupted[7]
- Making rapid start of ART the expectation for HIV health care systems is an urgent priority.[8]
    - The Ryan White HIV/AIDS Program is uniquely poised to lead the way, both in changing how its recipients operate and in demonstrating to Medicaid, Medicare, and private insurers how to make rapid start of ART (within 7 days of diagnosis) a reality.
    - Ryan White Program solutions for rapid start:
        - Make rapid start of ART a priority
            - Develop models for rapid start of ART in tandem with retention in care
            - Measure "time to ART" and "time to viral suppression"
        - Prioritize competitive funding for rapid start of ART
            - Prioritize funding through the ADAP supplemental grant programs
            - Revise guidance for the Part C program to promote the development of rapid start initiatives
        - Expedite ADAP eligibility and procure starter courses of drugs
            - Show states how to streamline ADAP eligibility
            - Facilitate purchase of ART starter packs
        - Support practice transformation
            - Special Projects of National Significance
            - AIDS Education and Training Centers
- When Congress next enacts a reauthorization to the Ryan White HIV/AIDS Program, they may consider a range of changes to improve outcomes and better support retention in care and adherence to treatment, including giving HRSA new tools to promote presumptive eligibility for ADAP and ensure that Medicaid, Medicare, and the marketplaces have the pharmacy benefits structures and staff capacity to operationalize rapid start of ART.

DRAFT

[6] The Ryan White HIV/AIDS Program after the Patient Protection and Affordable Care Act full implementation: a critical review of predictions, evidence, and future directions - PubMed (nih.gov)
[7] AligningwithInsurance1.pdf (georgetown.edu)
[8] Big-Ideas_Leveraging-the-Ryan-White-Program-to-Make-Rapid-Start-of-HIV-Therapy-Standard-Practice.pdf (georgetown.edu)

ITUP
Insure the Uninsured Project

Coverage in California at a Glance

Los Angeles County

July 2023

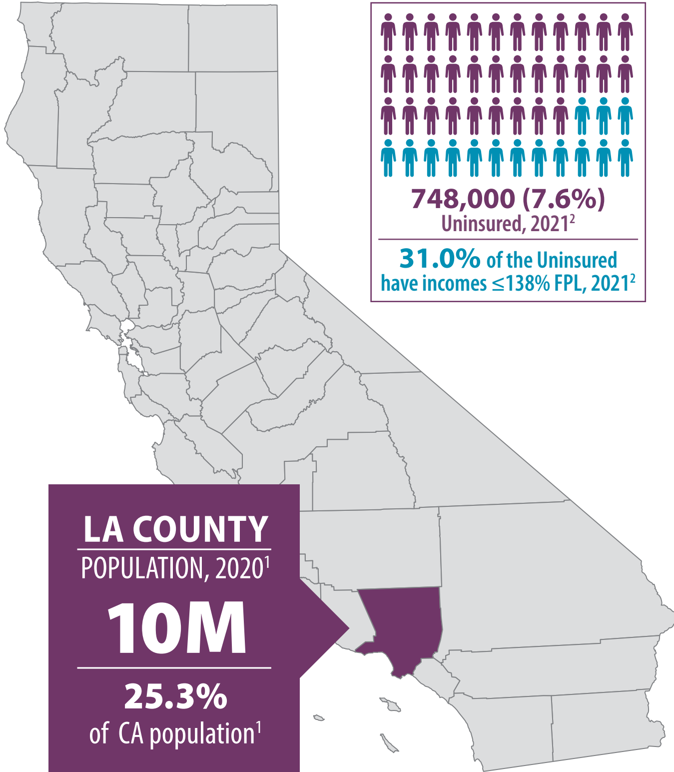
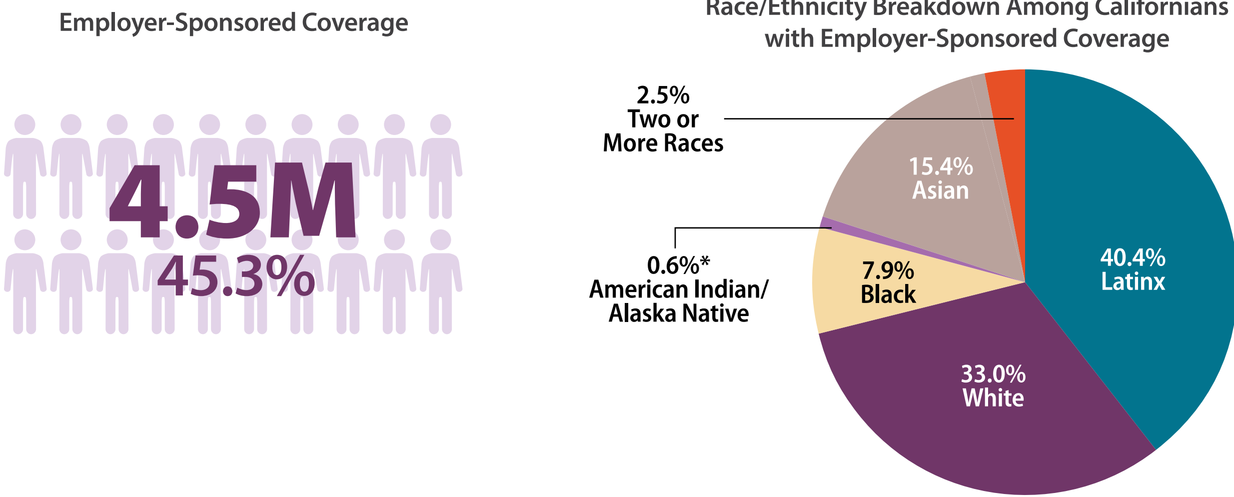


FIGURE 1. Race/Ethnicity Among the Uninsured, 2021[2]

Percent by Race	Population	Insured	Uninsured
Latinx	50.2%	88.9%	11.1%
White	26.0%	97.9%	2.1%
Black	7.9%	95.4%*	4.6%*
American Indian/ Alaska Native	0.3%*	100.0%*	-
Asian	13.4%	93.9%	6.1%
Native Hawaiian/ Pacific Islander	0.2%*	70.2%*	-
Two or More Races	2.1%	88.3%*	11.7%*

(-) Notes a value unavailable due to data masking
* Data for these counties are considered statistically unstable

FIGURE 2. Employer-Sponsored Coverage, 2021[2]

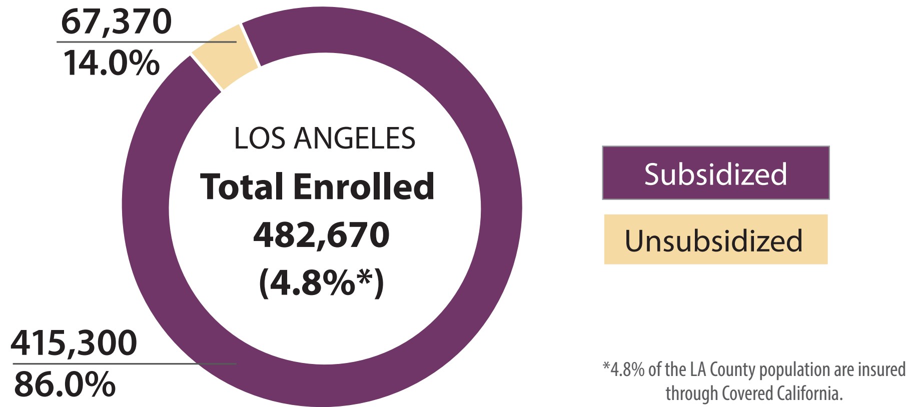


* Data for these counties are considered statistically unstable.

There was no data available for the Native Hawaiian/ Pacific Islander category.

COVERED CALIFORNIA

FIGURE 3. Percent of the County Population Enrolled in Covered California, September 2022[3]



*4.8% of the LA County population are insured through Covered California.

FIGURE 4. Covered California Enrollment in Los Angeles by Race/Ethnicity, September 2022[3]

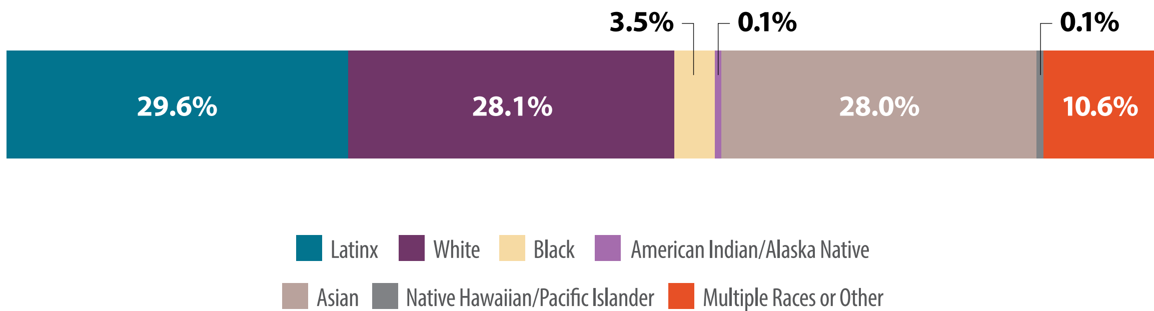
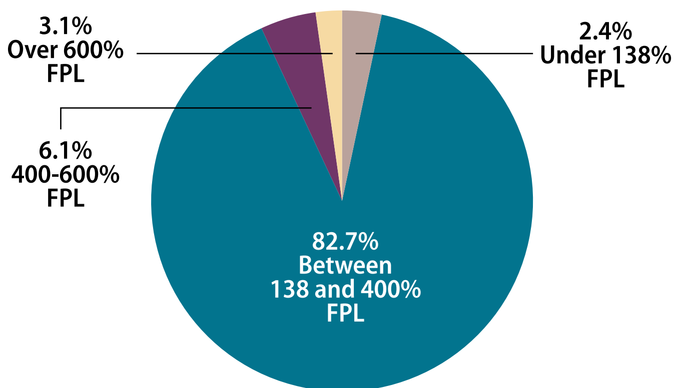


FIGURE 5. Covered California Enrollment by FPL, September 2022[3]



Enrollments where the FPL of the member is not known are not included here

FIGURE 6. Covered California Enrollment by Health Plan, September 2022[3]

Health Plan	Enrollment
Anthem Blue Cross	39,750
Blue Shield	130,420
Health Net	46,430
Kaiser Permanente	122,220
LA Care Health Plan	112,350
Molina Healthcare	9,940
Oscar Health Plan	21,550
Sharp Health Plan	10

Covered California's privacy policy rounds all figures to the nearest 10, as a result, grand totals shown may be slightly different from the totals in the individual plan data

MEDI-CAL

FIGURE 7. Medi-Cal Enrollment, January 2023

*45.7% of the LA County population are Medi-Cal eligible.

FIGURE 8. Medi-Cal Enrollment, by Race/Ethnicity, January 2023[6]

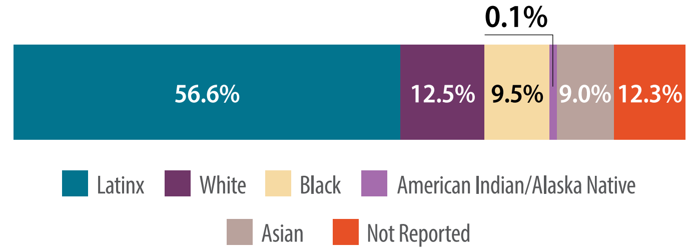


FIGURE 9. Medi-Cal Enrollment by Managed Care and Fee-for-Service (FFS), January 2023[7]

Total Managed Care Enrollment	3,766,336	
Enrollment by Managed Care Plans	LA Care	Health Net
	2,631,356	1,134,980
Medi-Cal FFS	805,539	

FIGURE 10. Community Supports Elections by Managed Care Plans, February 2023[8]

Health Net	14
LA Care	12

*Some Community Supports may not be available to all Members or in all areas of the county.

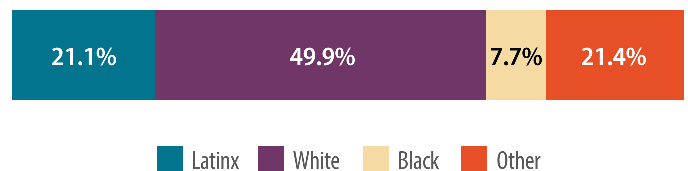
MEDICARE

FIGURE 11. Medicare Enrollment and Percent of Counties' Population, 2021[4,9]

Medicare	1,411,533 (14.1%*)
Medicare Advantage	857,701 (60.8%)
FFS Medicare	553,832 (39.2%)
Dual Eligible**	521,198 (36.9%)

*14.1% of the LA County population are enrolled in Medicare.
**Dual Eligibles are those eligible for Medicare and Medi-Cal, also referred to as Medi Medis.

FIGURE 12. Medicare Enrollment, by Race/Ethnicity, 2021[9]



NOTES

All decimals rounded to nearest tenth.

1. United States Census Bureau, 2020 Census Redistricting Data, Accessed: March 27, 2023.
2. UCLA Center for Health Policy Research, 2021 California Health Interview Survey, Public Use File, Accessed, March 27, 2023.
3. Covered California, September 2022, Active Member Profile, Accessed: March 27, 2023.
4. Department of Health Care Services, Medi-Cal Certified Eligibles Data Table by County and Dual Status, January 2023, Accessed: March 27, 2023.
5. Department of Health Care Services, Medi-Cal Certified Eligibles Data Table by County and Aid Code Group, January 2023, Accessed: March 27, 2023.
6. Department of Health Care Services, Medi-Cal Certified Eligibles Data Table Race/Ethnicity and Age, January 2023, Accessed: March 27, 2023.
7. Department of Health Care Services, Medi-Cal Managed Care Enrollment Report, January 2023, Accessed: March 27, 2023.
8. Department of Health Care Services, CalAIM Community Supports – Managed Care Plan Elections, February 2023, Accessed: March 27, 2023.
9. Centers for Medicare and Medicaid Services, Medicare Geographic Variation – by National, State & County, 2021, Public Use File: Accessed, March 27, 2023.

Each year ITUP releases Regional Health Coverage fact sheets for its 11 ITUP Regional Workgroup (listening session) locations. These publications are overviews highlighting key coverage facts across all coverage types county-by-county.

About ITUP

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

ITUP is generously supported by the following funders:

- California Health Care Foundation
- The California Endowment
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Medi-Cal Explained: Medi-Cal Financing and Spending

Authors: Athena Chapman, president, and Samantha Pellón, senior director of policy and strategy, Chapman Consulting

Introduction

California's Medicaid program, Medi-Cal, is an important source of health insurance coverage for millions of Californians and their families. In fiscal year (FY) 2021–22, the Medi-Cal program spent $121.9 billion of federal, state, and local funds providing a wide range of core health benefits — including primary, specialty, acute, and behavioral health care services; prescription drugs; and long-term care — for nearly 15 million Californians with low incomes.[1] This issue brief illustrates how California's Medicaid program is financed and the factors that impact total spending on health services through the program.

Overview of Medicaid Financing and the Medi-Cal Budget

Medicaid, a federal program administered by states, provides coverage for a wide range of core health benefits to people who meet certain criteria, most of which are based on family income. California's Medicaid program is administered by the Department of Health Care Services (DHCS) and is known as Medi-Cal and, like all Medicaid programs, is financed using federal and state dollars.

The federal share of a state's Medicaid budget is based on a formula called the Federal Medical Assistance Percentage (FMAP), which varies based on the type of enrollee (e.g., Affordable Care Act expansion population) and other criteria determined by federal law.[2] California's FMAP is generally 50%, meaning the federal government pays half of the cost of providing coverage to an enrollee, with no preset spending limit. The federal government may, however, finance a larger share of costs through an "enhanced," or increased, FMAP rate for certain populations and services, and during certain periods. For example, California received an enhanced FMAP rate with a temporary increase of 6.2 percentage points in federal match funding to address the COVID-19 public health emergency (PHE).[3]

States are responsible for the share of the overall Medicaid budget not financed by the federal government, often called the "state share" or "non-federal share" of costs. This includes both the state proportion of the FMAP and the entire proportion of costs for populations and services not eligible for FMAP funds (e.g., immigrants without documentation, abortion services). Within California, most of this funding comes from the state general fund, the predominant source of financing for most state operations. California also uses other state and local funding sources — including revenue from a statewide tax on tobacco products, financing

The California Health Care Foundation is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities that have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system. For more information, visit www.chcf.org.

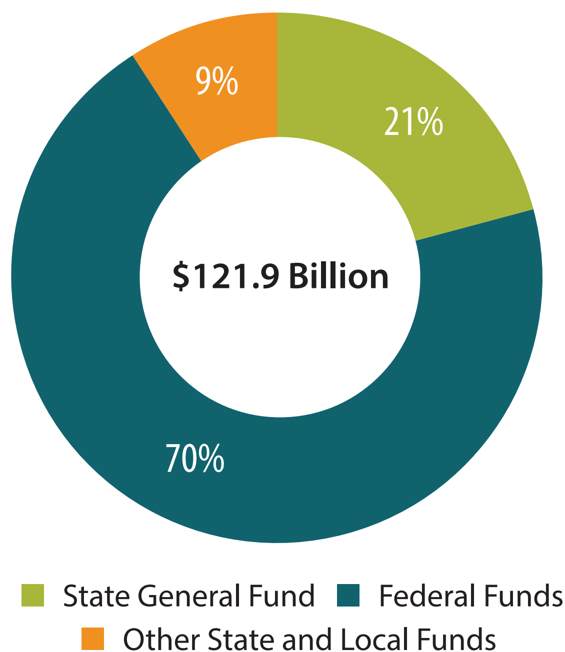
from cities and counties, and fees and taxes on providers, health plans, and health systems — to finance its share of the Medi-Cal program.

Medi-Cal Funding Sources

In FY 2021–22, California spent $121.9 billion on the Medi-Cal program, financed 70% by the federal government, 21% from the state general fund, and 9% using other state and local funds (Figure 1).[4]

Over time, these proportions have changed markedly; following the enactment of the Affordable Care Act, increases in federal funding for the Medi-Cal program vastly outpaced state funding growth. For example, from FY 2016–17 to FY 2021–22, the federal share of Medi-Cal spending increased by 5 percentage points as a proportion of total spending (from 65% to 70%), while the proportion attributed to the state general fund remained relatively flat (note that recent budget estimates indicate state general fund spending for Medi-Cal is expected to increase).[5] Other state and local spending sources have fluctuated as a proportion of total spending, from a high of 18%, or $17 billion, in FY 2017–18 to a low of 9%, or $11 billion, in FY 2021–22 (Figure 2, page 3).[6]

Figure 1. FY 2021–22 Medi-Cal Funding Sources



Source: Author calculation based on *Medi-Cal May 2022 Local Assistance Estimate for Fiscal Years 2021-22 and 2022-23* (PDF), California Department of Health Care Services, accessed February 24, 2023.

Medi-Cal Benefit Spending

Each year, California state officials prepare an overall Medi-Cal budget by examining spending in three categories: on medical benefits for enrollees, by counties to determine enrollee eligibility and administrative aspects of the program, and by the state or fiscal intermediary associated with processing claims.

In FY 2021–22, $116.4 billion was spent on medical care for Medi-Cal enrollees, $5.0 billion was spent on county administration, and $447.0 million was spent on the fiscal intermediary (Figure 3, page 3).[7] Spending on medical care for Medi-Cal enrollees can be further broken down into spending through the Medi-Cal managed care program and spending through the Medi-Cal fee-for-service program.

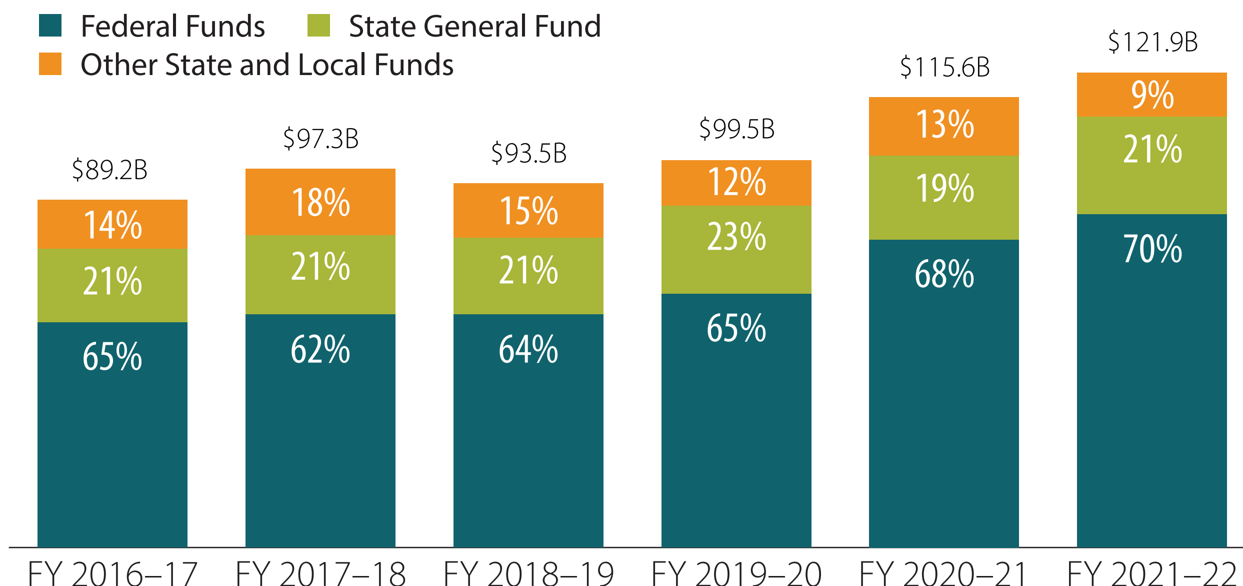
Medi-Cal Benefit Spending by Managed Care and Fee-for-Service Program

In FY 2021–22, nearly half (48%), or $55.5 billion, of Medi-Cal spending on medical care for enrollees went to Medi-Cal managed care plans (Figure 4, page 4).[8] Costs grouped in the "Other" category were the next largest spending category, at 13% of total Medi-Cal spending, and were driven largely by spending on miscellaneous services ($15 billion). Fee-for-service inpatient hospital costs followed closely behind, at 12% of total Medi-Cal spending ($14 billion).

Medi-Cal Managed Care

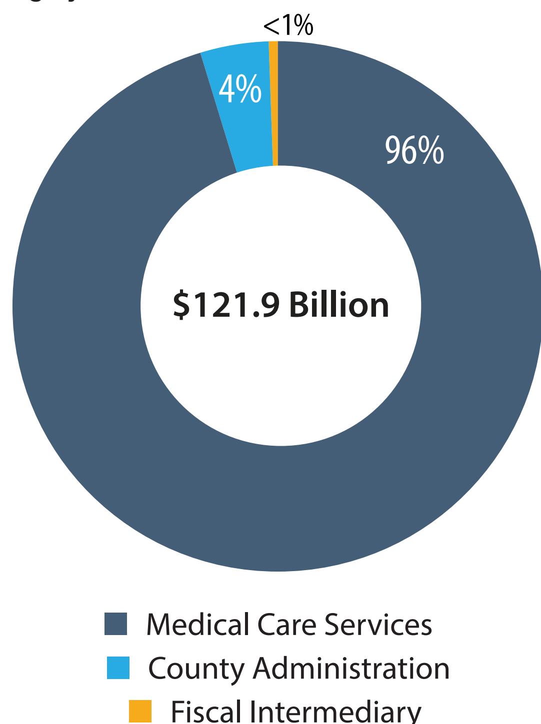
Under the Medi-Cal managed care program, the state pays a Medi-Cal managed care plan (MCP) a per-member per-month (PMPM) payment for all the contracted services provided to a Medi-Cal enrollee. PMPM payment rates to health plans are publicly available through the California Health and Human Services Open Data Portal and on the DHCS website.[9] As of September 2022, MCPs covered 13 million enrollees, or 86% of total Medi-Cal enrollment, across all 58 counties in California.[10]

Figure 2. FY 2016–17 to FY 2021–22 Medi-Cal Spending by Funding Source



Source: Author calculation based on "Local Assistance Estimates," California Department of Health Care Services, last modified May 12, 2023. See the Medi-Cal May 2017–22 Local Assistance Estimates for Fiscal Years 2016–17, 2017–18, 2018–19, 2019–20, 2020–21, and 2021–22.

Figure 3. FY 2021–22 Medi-Cal Spending by Budget Category



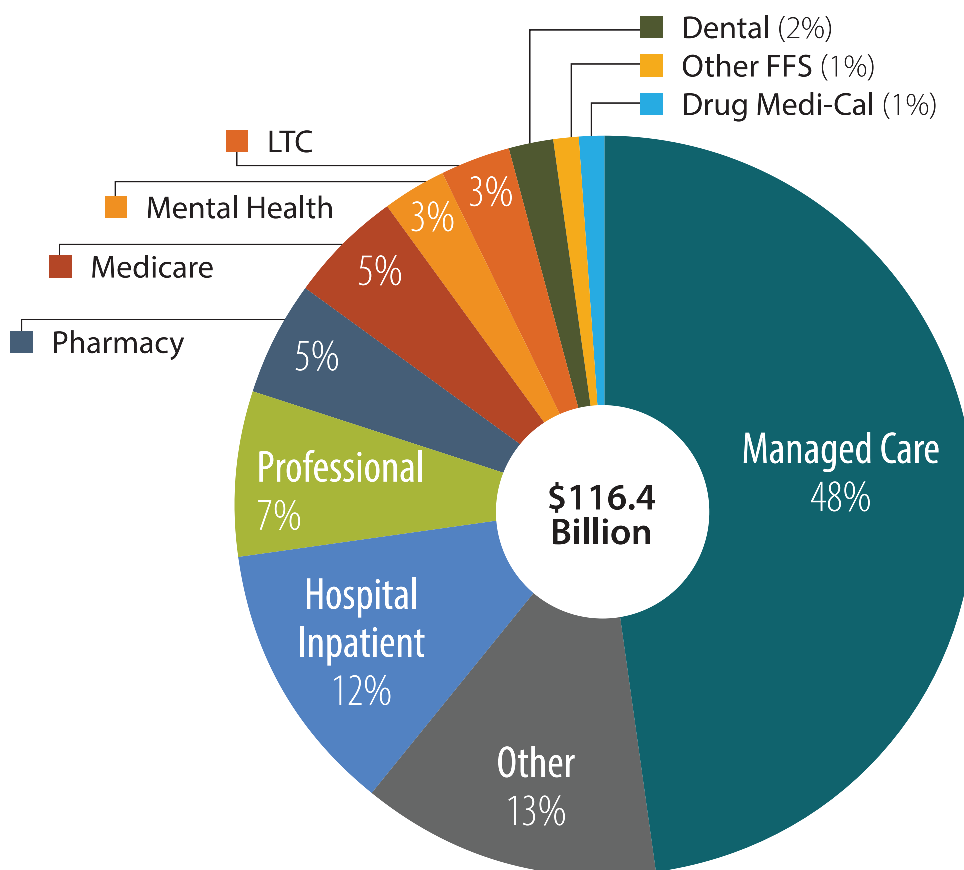
Source: Author calculation based on *Medi-Cal May 2022 Local Assistance Estimate for Fiscal Years 2021-22 and 2022-23* (PDF), California Department of Health Care Services, accessed February 24, 2023.

Detailed data on MCP categories of spending, payment rates to health care providers, and utilization data are often considered proprietary by managed care plans and are not generally reported by DHCS. However, scattered spending data may be available in reporting on specific programs or in individual plan documents for MCPs run by public agencies or as publicly traded companies. The Department of Managed Health Care, which regulates and licenses health plans in California, also publishes some utilization and financial reports.

Medi-Cal FFS

Under the Medi-Cal FFS program, the state pays health care providers directly for each service a Medi-Cal enrollee receives.[11] While Medi-Cal has increasingly covered more services and populations through Medi-Cal managed care, about 2.2 million enrollees received care through the state FFS program in FY 2021–22. The FFS program delivers several significant benefit "carve-outs," which refer to services paid and covered separately from a payer contract, including specialty mental health services, substance use disorder services,

Figure 4. FY 2021–22 Medi-Cal Spending by Service Category



Notes: *Other FFS* is fee-for-service and includes medical transportation, home health, and other services; *LTC* is long-term care and includes nursing facilities and intermediate care facilities for people with developmental disabilities (ICF-DD); *Other* includes audits/lawsuits, state hospitals/development centers, recoveries, and miscellaneous services.

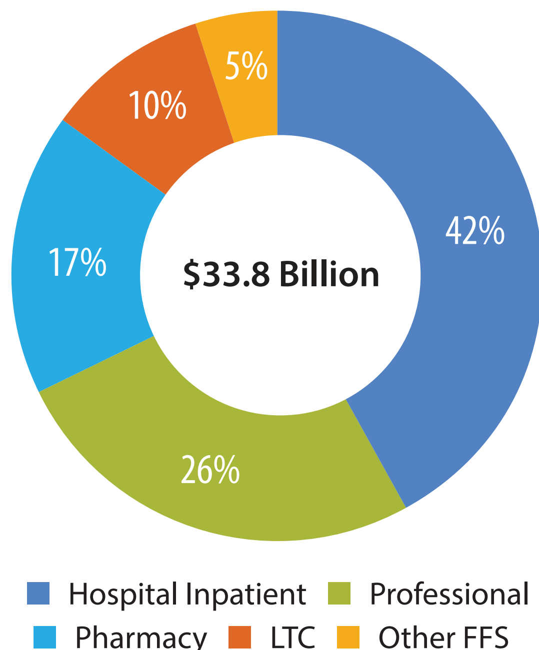
Source: Author calculation based on *Medi-Cal May 2022 Local Assistance Estimate for Fiscal Years 2021-22 and 2022-23* (PDF), California Department of Health Care Services, accessed February 25, 2023.

and dental services.[12] In FY 2022–23, spending on prescription drugs for all Medi-Cal enrollees will be covered through the FFS program.

California has significant discretion in determining provider payment rates in the FFS program as long as the payments follow "efficiency, economy, and quality of care, and are sufficient to provide access equivalent to the general population."[13] California has generally had some of the lowest FFS rates compared with other states and the national average. For example, FFS payment rates for office visits in California are 19% below the national Medicaid average, while Oklahoma pays 29% above the average.[14] However, FFS payments are typically just one of several revenue streams flowing to providers for the care of Medi-Cal enrollees.

DHCS regularly reports spending by specific service category within the FFS program, which totaled $33.8 billion in FY 2021–22 (Figure 5, page 5). Of that amount, $8.7 billion, or 26% of overall FFS spending on medical benefits, was allocated for professional services (e.g., doctors and other medical providers), while $14.2 billion, or 42% of overall FFS spending, was spent on hospital inpatient care. Other significant service categories included long-term care ($3.5 billion), pharmacy ($5.7 billion), and ancillary or other FFS services (e.g., transportation, home health) at $1.7 billion.[15]

Figure 5. FY 2021–22 Medi-Cal FFS Spending by Service Category



Notes: *Other FFS* is fee-for-service and includes medical transportation, home health, and other services; *LTC* is long-term care and includes nursing facilities and intermediate care facilities for people with developmental disabilities (ICF-DD).

Source: Author calculation based on *Medi-Cal May 2022 Local Assistance Estimate for Fiscal Years 2021-22 and 2022-23* (PDF), California Department of Health Care Services, accessed February 25, 2023.

Factors Impacting Medi-Cal Benefit Spending

Spending on medical care through the Medi-Cal program depends on several factors that may increase or decrease the overall Medi-Cal budget in any fiscal year. These include factors that change the quantity of services delivered, which can often be attributed to eligibility expansions or contractions, the addition or removal of specific benefits, and changes in care patterns or utilization among enrollees. In addition, the prices paid for medical goods and services — either directly to providers in the FFS program or indirectly through the PMPM payment rates to managed care plans — can impact total benefit spending and the overall Medi-Cal budget.

Eligibility expansions and contractions also have an outsized impact on the overall Medi-Cal budget. California has used state funds to incrementally expand comprehensive Medi-Cal coverage to include, according to the Office of Governor Newsom, "individuals who do not have satisfactory immigration status or are unable to establish satisfactory immigration status," including children under age 19, adults over age 49, and (effective by January 2024) adults age 26–49.[16] The expansion of full-scope Medi-Cal coverage to adults age 26–49 is estimated to cost $613.5 million in state general funds in 2023–24 and $2.2 billion yearly at full implementation.[17]

Medi-Cal is a countercyclical program impacted by the economy: Enrollment surges when unemployment increases. During the economic slowdown brought about by the COVID-19 pandemic, Medi-Cal enrollment between March 2020 and October 2021 increased by 14% to over 14.2 million.[18] While the PHE generated significant state general fund savings due to enhanced federal funding, it also raised total fund costs by increasing Medi-Cal caseload levels due to the "continuous coverage requirement," which stipulated that states provide continuous enrollment for Medicaid members.[19] The expiration of the PHE will likely result in net general fund costs due to the loss of enhanced federal funding and the unwinding of PHE-related policies, but these costs will be partially offset by declines in the Medi-Cal caseload.[20]

In addition to enrollment growth, caseload patterns (cost of services and utilization) differ across Medi-Cal enrollment categories (e.g., children, seniors and people with disabilities, and childless adults). Seniors and people with disabilities typically have higher acuity and costs, accounting for about half of total Medi-Cal spending, a trend estimated to increase as this group becomes a larger share of Medi-Cal's overall caseload.[21]

The addition and removal of covered benefits within the Medi-Cal program impacts the overall Medi-Cal budget significantly. While federal statute mandates that Medi-Cal cover a core set of essential health benefits, states have flexibility to cover optional benefits. California currently offers dental, vision, transportation, and long-term services and supports in addition to the mandated benefits.[22] These optional benefits are often targets for elimination during tight budget times, and over the years benefits such as dental, podiatry care, and acupuncture have been cut as one strategy to reduce state spending.

Changes in the prices paid to health providers directly through the Medi-Cal FFS program and indirectly through PMPM payments to managed care plans have an intuitive and linear impact on the overall Medi-Cal budget. For example, an increase in payments to primary care providers was financed through a 2016 statewide ballot proposition that increased taxes on tobacco products by $2. This primary care provider payment supplement increased overall Medi-Cal spending by $908 million in FY 2021–22.[23]

Looking Ahead: Medi-Cal Spending and Value

California recently established an Office of Health Care Affordability, which, among other responsibilities, will set and enforce underlying cost growth targets across California's entire acute care finance and delivery system, including the parts of the system related to the provision of services to Medi-Cal enrollees. The office will begin analyzing data on utilization trends and underlying cost drivers in the second half of 2024.[24]

Historically, states have often turned to cost containment approaches such as reductions in provider payment rates and benefit eligibility when trying to mitigate underlying growth in Medicaid spending. Alternatively, states have looked to deploy longer-term strategies that improve value through payment and delivery system reforms, including incentives to reduce unnecessary or wasteful care (e.g., NTSV [nulliparous, term, singleton, vertex] c-sections), increase the provision of high-value care (e.g., primary and preventive services), provide access to enhanced care coordination and social services for enrollees with complex needs, or some combination.

More data on where spending flows within the acute care delivery system, along with detailed information on enrollees' access to and experience with that care, will likely prove useful as policymakers continue to deploy these and other strategies to improve value in the Medi-Cal program over the near and longer term.

About the Authors

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Endnotes

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Medi-Cal Explained is an ongoing series on Medi-Cal for those who are new to the program, as well as those who need a refresher. To see other publications in this series, visit www.chcf.org/MC-explained.

Medi-Cal Explained: 2024 Managed Care Plans

Author: Ralph Silber

MEDI-CAL MANAGED CARE PLANS are becoming an even more critical part of the Medi-Cal landscape, with increasing responsibility for new services and management of new populations not previously part of managed care. In 2024, there will be major changes in many California counties as to which Medi-Cal managed care plans operate there.

To help providers and other delivery system stakeholders understand the coming changes, this fact sheet describes geographic changes as well as some unique managed care arrangements. The information is organized in two ways: by county and by managed care plan. First, Table 1 lists California's 58 counties alphabetically and indicates which Medi-Cal managed care plans will operate in each county beginning in January 2024. It also indicates which counties will have a managed care plan either enter or exit operations in 2024. Second, Table 2 lists managed care plans alphabetically and lists the counties each plan will operate in beginning in January 2024.

In addition to the geographic changes, there are some unique current and upcoming Medi-Cal managed care arrangements worth calling out:

- In Los Angeles County, L.A. Care Health Plan subcontracts with Anthem Blue Cross and Blue Shield of California Promise Health Plan as plan partners. In addition, Health Net subcontracts with Molina Healthcare as a plan partner. Under a "plan partner" arrangement, members can choose to receive their Medi-Cal managed care benefits directly through L.A. Care or Health Net, or from one of their plan partners.
- In Fresno, Kings, and Madera Counties, CalViva, a public plan, contracts with Health Net to carry out many health plan functions and responsibilities.
- In Imperial County, beginning in 2024, the Community Health Plan of Imperial Valley, a new public plan, will contract with Health Net to carry out many health plan functions and responsibilities.
- Statewide, beginning in 2024, Kaiser Permanente (Kaiser) will operate in 32 of California's 58 counties under a single, direct Medi-Cal contract with California's Department of Health Care Services. Under this contract, Kaiser will enter these markets for the first time: Fresno, Imperial, Kings, Madera, Mariposa, Santa Cruz, Stanislaus, Sutter, Tulare, and Yuba Counties.

The California Health Care Foundation is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

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Kaiser already participates in Medi-Cal in other counties through these two approaches:

- **Direct contract.** Amador, El Dorado, Placer, Sacramento, and San Diego Counties.
- **Subcontractor to public plan.** Alameda, Contra Costa, Kern, Los Angeles, Marin, Napa, Orange, Riverside, San Bernardino, San Francisco, San Joaquin, San Mateo, Santa Clara, Solano, Sonoma, Ventura, and Yolo Counties.

Of note, special enrollment criteria will apply for Kaiser Permanente in all counties.

Medi-Cal members may enroll with Kaiser Permanente if they have been Kaiser members in the 12 months preceding the effective date of their Medi-Cal eligibility or if they have a family linkage to a member living in the same home who is a current Kaiser member. Additionally, there will be open choice enrollment for foster youth and members who are dually eligible for Medi-Cal and Medicare. Medi-Cal members enrolled in Kaiser in December 2023 will remain with Kaiser.

Table 1. 2024 Medi-Cal Managed Care Plans and Counties of Operation, Alphabetical by County

County	2024 Plans		
	Public Plan*	Other Plans	Major Change†
Alameda	■ Alameda Alliance for Health	■ Kaiser Permanente	‹ Anthem Blue Cross — exiting
Alpine	■ Health Plan of San Joaquin	■ Anthem Blue Cross	‹ California Health & Wellness — exiting › Health Plan of San Joaquin — entering
Amador		■ Anthem Blue Cross ■ Health Net ■ Kaiser Permanente	
Butte	■ Partnership HealthPlan of California		‹ Anthem Blue Cross — exiting ‹ California Health & Wellness — exiting › Partnership HealthPlan of California — entering
Calaveras		■ Anthem Blue Cross ■ Health Net	
Colusa	■ Partnership HealthPlan of California		‹ Anthem Blue Cross — exiting ‹ California Health & Wellness — exiting › Partnership HealthPlan of California — entering
Contra Costa	■ Contra Costa Health Plan	■ Kaiser Permanente	‹ Anthem Blue Cross — exiting
Del Norte	■ Partnership HealthPlan of California		
El Dorado	■ Health Plan of San Joaquin	■ Anthem Blue Cross ■ Kaiser Permanente	‹ California Health & Wellness — exiting › Health Plan of San Joaquin — entering
Fresno	■ CalViva Health‡	■ Anthem Blue Cross ■ Kaiser Permanente	› Kaiser Permanente — entering
Glenn	■ Partnership HealthPlan of California		‹ Anthem Blue Cross — exiting ‹ California Health & Wellness — exiting › Partnership HealthPlan of California — entering
Humboldt	■ Partnership HealthPlan of California		

County	2024 Plans		
	Public Plan*	Other Plans	Major Change†
Imperial	■ Community Health Plan of Imperial Valley‡	■ Kaiser Permanente	‹ California Health & Wellness — exiting ‹ Molina Healthcare — exiting › Community Health Plan — entering › Kaiser Permanente — entering
Inyo		■ Anthem Blue Cross ■ Health Net	
Kern	■ Kern Health System	■ Anthem Blue Cross ■ Kaiser Permanente	‹ Health Net — exiting › Anthem Blue Cross — entering
Kings	■ CalViva Health‡	■ Anthem Blue Cross ■ Kaiser Permanente	› Kaiser Permanente — entering
Lake	■ Partnership HealthPlan of California		
Lassen	■ Partnership HealthPlan of California		
Los Angeles	■ L.A. Care Health Plan	**Direct:** ■ Health Net ■ Kaiser Permanente **L.A. Care plan partners:** ■ Anthem Blue Cross ■ Blue Shield of California Promise Health Plan **Health Net plan partner:** ■ Molina HealthCare	
Madera	■ CalViva Health‡	■ Anthem Blue Cross ■ Kaiser Permanente	› Kaiser Permanente — entering
Marin	■ Partnership HealthPlan of California	■ Kaiser Permanente	
Mariposa	■ Central California Alliance for Health	■ Kaiser Permanente	‹ Anthem Blue Cross — exiting ‹ California Health & Wellness — exiting › Central California Alliance — entering › Kaiser Permanente — entering
Mendocino	■ Partnership HealthPlan of California		
Merced	■ Central California Alliance for Health		
Modoc	■ Partnership HealthPlan of California		
Mono		■ Anthem Blue Cross ■ Health Net	
Monterey	■ Central California Alliance for Health		

County	2024 Plans		
	Public Plan*	Other Plans	Major Change†
Napa	■ Partnership HealthPlan of California	■ Kaiser Permanente	
Nevada	■ Partnership HealthPlan of California		‹ Anthem Blue Cross — exiting ‹ California Health & Wellness — exiting › Partnership HealthPlan of California — entering
Orange	■ CalOptima	■ Kaiser Permanente	
Placer	■ Partnership HealthPlan of California	■ Kaiser Permanente	‹ Anthem Blue Cross — exiting ‹ California Health & Wellness — exiting › Partnership HealthPlan of California — entering
Plumas	■ Partnership HealthPlan of California		‹ Anthem Blue Cross — exiting ‹ California Health & Wellness — exiting › Partnership HealthPlan of California — entering
Riverside	■ Inland Empire Health Plan	■ Kaiser Permanente ■ Molina Healthcare**	
Sacramento		■ Anthem Blue Cross ■ Health Net ■ Molina Healthcare ■ Kaiser Permanente	‹ Aetna — exiting
San Benito	■ Central California Alliance for Health		‹ Anthem Blue Cross — exiting › Central California Alliance — entering
San Bernardino	■ Inland Empire Health Plan	■ Kaiser Permanente ■ Molina Healthcare**	
San Diego		■ Blue Shield of California Promise Health Plan ■ Community Health Group ■ Kaiser Permanente ■ Molina Healthcare	‹ Aetna — exiting ‹ Health Net — exiting
San Francisco	■ San Francisco Health Plan	■ Anthem Blue Cross ■ Kaiser Permanente	
San Joaquin	■ Health Plan of San Joaquin	■ Health Net ■ Kaiser Permanente	
San Luis Obispo	■ CenCal Health		
San Mateo	■ Health Plan of San Mateo	■ Kaiser Permanente	
Santa Barbara	■ CenCal Health		
Santa Clara	■ Santa Clara Family Health Plan	■ Anthem Blue Cross ■ Kaiser Permanente	
Santa Cruz	■ Central California Alliance for Health	■ Kaiser Permanente	› Kaiser Permanente — entering
Shasta	■ Partnership HealthPlan of California		
Sierra	■ Partnership HealthPlan of California		‹ Anthem Blue Cross — exiting ‹ California Health & Wellness — exiting › Partnership HealthPlan of California — entering

County	2024 Plans		
	Public Plan*	Other Plans	Major Change†
Siskiyou	■ Partnership HealthPlan of California		
Solano	■ Partnership HealthPlan of California	■ Kaiser Permanente	
Sonoma	■ Partnership HealthPlan of California	■ Kaiser Permanente	
Stanislaus	■ Health Plan of San Joaquin	■ Health Net ■ Kaiser Permanente	› Kaiser Permanente — entering
Sutter	■ Partnership HealthPlan of California	■ Kaiser Permanente	‹ Anthem Blue Cross — exiting ‹ California Health & Wellness — exiting › Kaiser Permanente — entering › Partnership HealthPlan of California — entering
Tehama	■ Partnership HealthPlan of California		‹ Anthem Blue Cross — exiting ‹ California Health & Wellness — exiting › Partnership HealthPlan of California — entering
Trinity	■ Partnership HealthPlan of California		
Tulare		■ Anthem Blue Cross ■ Health Net ■ Kaiser Permanente	› Kaiser Permanente — entering
Tuolumne		■ Anthem Blue Cross ■ Health Net	
Ventura	■ Gold Coast Health Plan	■ Kaiser Permanente	
Yolo	■ Partnership HealthPlan of California	■ Kaiser Permanente	
Yuba	■ Partnership HealthPlan of California	■ Kaiser Permanente	‹ Anthem Blue Cross — exiting ‹ California Health & Wellness — exiting › Kaiser Permanente — entering › Partnership HealthPlan of California — entering

* In California there are public, nonprofit Medi-Cal managed care plans that are locally governed and publicly accountable. They were established in state statute and county ordinances to serve Medi-Cal enrollees and support the safety net.

† A *major change* is defined as a managed care plan entering or exiting the county. (In 2024, certain counties will transition from California Health & Wellness to Health Net. However, because both these plans are Centene companies, this is not considered a major change.)

‡ CalViva Health contracts out many health plan functions and responsibilities to Health Net. Community Health Plan of the Imperial Valley will also contract out many functions to Health Net.

** Currently, Health Net is a plan partner with Molina in Riverside and San Bernardino Counties. This arrangement will end on January 1, 2024.

Source: Author's review and analysis of 2023 California Department of Health Care Services Medi-Cal documents and interviews with Medi-Cal managed care key informants.

Table 2. 2024 Medi-Cal Managed Care Plans and Counties of Operation, Alphabetical by Managed Care Plan

Medi-Cal Managed Care Plan	County
Alameda Alliance for Health	Alameda
Anthem Blue Cross	**Direct:** Alpine, Amador, Calaveras, El Dorado, Fresno, Inyo, Kern, Kings, Madera, Mono, Sacramento, San Francisco, Santa Clara, Tulare, Tuolumne **Plan partner with L.A. Care:*** Los Angeles
Blue Shield of California Promise Health Plan	**Direct:** San Diego **Plan partner with L.A. Care:*** Los Angeles
CalOptima	Orange
CalViva Health	**Contracts out most health plan functions to Health Net in:** Fresno, Kings, Madera
CenCal Health	San Luis Obispo, Santa Barbara
Central California Alliance for Health	Mariposa, Merced, Monterey, San Benito, Santa Cruz
Community Health Group	San Diego
Community Health Plan of Imperial Valley	Contracts out most functions to Health Net in Imperial
Contra Costa Health Plan	Contra Costa
Gold Coast Health Plan	Ventura
Health Plan of San Joaquin	Alpine, El Dorado, San Joaquin, Stanislaus
Health Plan of San Mateo	San Mateo
Health Net†	**Direct:** Amador, Calaveras, Inyo, Los Angeles, Mono, Sacramento, San Joaquin, Stanislaus, Tulare, Tuolumne **Subcontract:** Fresno, Imperial, Kings, Madera
Inland Empire Health Plan	Riverside, San Bernadino
Kaiser Permanente	Alameda, Amador, Contra Costa, El Dorado, Fresno, Imperial, Kern, Kings, Los Angeles, Madera, Marin, Mariposa, Napa, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Sutter, Tulare, Ventura, Yolo, Yuba
Kern Health Systems	Kern
L.A. Care Health Plan	Los Angeles; delegates some membership to Anthem Blue Cross and Blue Shield of California Promise Health Plan
Molina Healthcare	**Direct:** Riverside, Sacramento, San Bernardino, San Diego **Plan partner with Health Net:†** Los Angeles
Partnership HealthPlan of California	Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Nevada, Placer, Plumas, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Yolo, Yuba
San Francisco Health Plan	San Francisco
Santa Clara Family Health Plan	Santa Clara

* L.A. Care Health Plan subcontracts with Anthem Blue Cross and Blue Shield of California Promise Health Plan as plan partners. These plan partners are offered as an option to L.A. Care members and carry out many health plan functions and responsibilities for Medi-Cal enrollees who select them. However, unlike managed care plans with a direct arrangement, they are subcontractors and do not hold a contract with the Department of Health Care Services in Los Angeles County.

† Health Net subcontracts with Molina as a plan partner in Los Angeles. This plan partner is offered as an option to Health Net members and carries out many health plan functions and responsibilities for Medi-Cal enrollees who select Molina. However, unlike a managed care plan with a direct arrangement, Molina is a subcontractor and does not hold a contract with the Department of Health Care Services in Los Angeles County.

Source: Author's review and analysis of 2023 California Department of Health Care Services Medi-Cal documents and interviews with Medi-Cal managed care key informants.

About the Authors

Ralph Silber, MPH, is an independent consultant with more than forty years of experience in the community health center movement and an affiliate with El Cambio Consulting. He previously served as the CEO of the Alameda Health Consortium and the Community Health Center Network, a Medi-Cal managed care organization.

El Cambio Consulting provides strategic guidance, analysis, and management consulting to safety net health care organizations in California that are rooted in their communities and committed to improving health outcomes through perseverance and innovation. This includes community health centers, county public health agencies and departments, Medi-Cal managed care plans, social service providers and the foundations and associations that support their work.

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The 2023-24 California State Budget Explained

July 2023 | By California Budget & Policy Center

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KEY TAKEAWAY

Policymakers avoided major cuts to critical services in the 2023-24 California state budget, but additional revenues are needed to make meaningful investments for Californians in the future.

The ink is now dry on the 2023-24 California state budget agreement. The Legislature has passed and the governor has signed the budget bills and a package of budget-related trailer bills. Policymakers avoided major cuts to critical services, but additional revenues are needed to make meaningful investments for Californians in the future.

The enacted budget includes $225.9 billion in General Fund spending, down from $234.6 billion in 2022-23. Surpluses turned to deficits as revenue estimates fell, creating a $30 billion budget problem. The enacted budget includes a variety of solutions to close this shortfall without any major cuts to core services. These solutions include delaying or reducing some previously committed spending, shifting some spending between state funds, and internal borrowing.

The budget also extends the Managed Care Organization (MCO) tax, which will draw down additional federal dollars and offset state Medi-Cal spending (see Health section). Some spending items that were reduced in the budget may be restored if sufficient resources are available in 2024. The governor's administration can delay one-time spending items until March 1, 2024, if a major revenue shortfall arises when the Legislature is not in session. However, the Legislature must approve further delays or

reductions. State leaders must address significant budget shortfalls in the coming years, despite the balanced nature of the 2023-24 budget.

This report highlights key components of the budget agreement that help to improve the social and economic well-being of:

- Californians with low incomes,
- Californians of color,
- women,
- immigrants,
- and others historically excluded from economic opportunities.

Areas where the budget agreement misses opportunities to support Californians are also highlighted.

Budget Overview

Revenues

What does the state budget include?

The enacted budget assumes General Fund revenues, including transfers, of $208.7 billion for 2023-24, in line with the governor's May Revision estimates. Revenues for the 2022-23 fiscal year were also revised down significantly from the 2022 budget estimates. This reflects economic challenges including:

- High inflation
- Interest rate increase
- Collapse of the Initial Public Offering (IPO) market

The final budget did not adopt the more conservative revenue estimates of the Legislative Analyst's Office (LAO). According to the LAO, the state's primary General Fund revenue sources would be about $11 billion lower across 2021-22 to 2023-24 than the administration's estimates. So if revenues fall short, budget amendments may be needed.

How can state leaders better support Californians?

Making tax policy changes to significantly increase revenues. This would be needed to make substantial new investments to improve the lives of Californians. Such changes could also make the tax system more fair. The Senate's April proposal to restructure corporate taxes and raise revenues was not included in the final budget. This would have addressed some of the state's most pressing challenges.

Reserves

What does the state budget include?

The budget does not withdraw any funds from the state's budget reserves. This leaves them fully available to help prevent budget cuts in the future during an economic downturn or budget emergency. This is in contrast to the governor's May proposal to withdraw $450 million of the current $900 million balance of the Safety Net Reserve, which is intended to be used to maintain CalWORKs and Medi-Cal benefits during economic downturns.

Under the enacted budget, the 2023-24 combined balance of the state's four budget reserves — the Budget Stabilization Account, the Public School System Stabilization Account, the Special Fund for Economic Uncertainties, and the Safety Net Reserve — is estimated to total nearly $38 billion.

Health

Managed Care Organization (MCO) Tax

What does the state budget include?

The budget includes the renewal of the MCO tax, effective April 1, 2023 through December 31, 2026. The MCO tax essentially reduces — or "offsets" — state General Fund spending on Medi-Cal by well over $1 billion per year. The MCO tax renewal, which requires federal approval, would result in $19.4 billion over the proposed tax period. Of this amount, $8.3 billion would support the Medi-Cal program, and $11.1 billion would support provider rate increases to drive greater Medi-Cal provider participation. For 2023-24, the budget includes $237.4 million to increase Medi-Cal provider rates effective January 1, 2024 for primary care, maternity care (including doulas), and non-specialty mental health services.

How can state leaders better support Californians?

Increasing education and training to prepare health workers to meet California's health needs. In 2019, the California Future Health Workforce Commission developed a strategic plan for addressing health workforce gaps. According to a recent progress report, policymakers have made progress on many of the

priority recommendations. However, state leaders can do more to recruit and train students from rural areas and other historically underserved communities to practice in community health centers.

Access to Medi-Cal

What does the state budget include?

The budget maintains the commitment to expand full-scope Medi-Cal eligibility to undocumented immigrants ages 26 to 49 starting January 1, 2024. This builds on previous steps state leaders have taken to end the racist and exclusionary policy that blocks Californians from accessing vital health services. To provide Medi-Cal for adults age 26 and over, the state is estimated to allocate $1.4 billion ($1.2 billion General Fund) in 2023-24 and $3.4 billion ($3.1 billion General Fund) at full implementation, inclusive of In-Home Supportive Services costs.

How can state leaders better support Californians?

Removing barriers to Covered California — the state's health insurance marketplace — based on immigration status. Undocumented Californians who are not income-eligible for Medi-Cal are unjustly excluded from accessing and purchasing health care coverage plans through Covered California.

Covered California Affordability

What does the state budget include?

The budget provides $82.5 million in 2023-24 and $165 million annually thereafter to reduce the cost of health coverage through Covered California. The budget also includes a $600 million loan to the General Fund to help address the state budget shortfall, which will be repaid in 2025-26. This compromise between the Legislature and the governor's administration will provide affordability assistance to Californians who lack access to affordable health care.

How can state leaders better support Californians?

Providing greater financial assistance for Californians who are uninsured and struggling to purchase coverage. Additionally, providing assistance for those who are insured but can't afford to access the care they need. Policymakers should ensure that dollars raised from the state's individual mandate penalty help people afford health insurance through Covered California, as was intended when the penalty was established.

Homelessness and Housing

Homelessness

What does the state budget include?

The budget upheld previously promised funds for critical homelessness services and supports, including another $1 billion one-time investment in local flexible funding to address homelessness in 2023-24. These funds will be contingent on local jurisdictions developing regionally coordinated homelessness action plans. Also allocated is $400 million one-time General Fund for local encampment resolution grants, and $265 million one-time for the Mental Health Services Fund in 2023-24 and $235 million General Fund in 2024-25 for bridge housing for people experiencing homelessness with serious mental illness. Funding adjustments were also made to support the CARE Act implementation starting in select counties this fall.

How can state leaders better support Californians?

Centering ongoing, at-scale funding to adequately resource local response systems and enable long-term planning for future years. Expanding affordable permanent housing, especially for Californians with the lowest incomes, is also needed to end to homelessness.

Affordable Housing

What does the state budget include?

The 2023-24 enacted budget largely maintains prior allocated funding for affordable housing development. It provides an additional $500 million for the state's Low Income Housing Tax Credit program and supplemented $100 million for the Multifamily Housing program for a total of $325 million in 2023-24. Other allocations in 2023-24 include:

- $250 million for adaptive reuse of underutilized commercial spaces
- $225 million for infrastructure for infill housing
- $82.5 million (for a total of $330 million over four years) to help preserve affordable housing and promote residential property ownership

The budget sustained $500 million one-time General Fund for the Dream for All program. It also reduced the CalHome program to $300 million one-time General Fund in 2023-24. Both of these programs promote first-time homeownership for low or moderate income Californians.

How can state leaders better support Californians?

Scaling affordable housing development and preservation investments to match our housing needs. Many Californians — especially those with low incomes, renters and people of color — continue to struggle to afford their homes. Addressing our housing shortage must be prioritized.

Economic Security

Safety Net

What does the state budget include?

The budget protects a 10 percent increase to the California Work Opportunity and Responsibility to Kids program (CalWORKs) grant. This grant was set to expire in 2024. Regarding food assistance, the budget allocates $47 million to phase in a Summer Electronic Benefit Transfer (EBT) program for children who qualify for free or reduced-price school meals, and $15 million for a pilot program that will increase the CalFresh minimum from $23 to $50 for selected participants.

The budget also moves up the expansion of the California Food Assistance Program (CFAP) to October 2025. This expansion will extend benefits to undocumented adults over 55. The budget also includes the governor's proposal of an 8.6% increase to the Supplemental Security Income/State Supplementary Payment (SSI/SSP) grants.

How can state leaders better support Californians?

Reforming CalWORKs. The exclusion of the Reimagine CalWORKs effort from this year's final budget was a significant missed opportunity. The effort could have impacted thousands of children by transforming the CalWORKs participation requirements to make the program more family-centered, anti-racist, and participant-inclusive.

Tax Credits

What does the state budget include?

The budget clarifies that recipients of the Foster Youth Tax Credit (FYTC) – in addition to recipients of the CalEITC and Young Child Tax Credit (YCTC) – cannot have their tax refunds intercepted for debt payments (with the exception of child or family support payments). This will provide critical relief for low-income foster youth once this provision goes into effect.

How can state leaders better support Californians?

Strengthening and expanding California's refundable tax credits. Important next steps include:

- Increasing the minimum CalEITC to provide a more meaningful credit to workers with low incomes.
- Extending the YCTC to all CalEITC-eligible families with children, not just those with kids ages 0 to 5.
- Increasing the renter's tax credit and making it refundable. This would help Californians with the lowest incomes who are currently excluded from the credit, even though they have the greatest difficulty affording rent.

Senate Bill 220 (Committee on Budget and Fiscal Review) would implement these CalEITC and renter's tax improvements as part of a broader package of policy changes.

Child Care

What does the state budget include?

The budget includes $56 million from the General Fund for permanent family fee reform beginning October 1, 2023. Under the new family fee structure, families below 75% of the state median income (SMI) will no longer pay a fee for subsidized child care. Additionally, families at or above 75% of the SMI will have fees capped at 1% of monthly income.

The budget also provides a total of nearly $1.4 billion in one-time funds for rate increases for providers reimbursed through the California Department of Social Services (CDSS). The agreement with Child Care Providers United specifies the amount of additional funds providers will receive per child, per month. The budget also authorizes CDSS to develop an alternative methodology for child care program reimbursement rates.

How can state leaders better support Californians?

Continuing to expand child care slots. While the slots created during the past two cycles (over 100,000) will be maintained, the budget delays 20,000 additional slots until 2024-25. Notably, the legislative budget agreement included these additional slots for 2023-24. However, this did not make it into the enacted budget.

Immigrant Californians

What does the state budget include?

The enacted budget maintains and further invests in funding for a variety of programs and services to support immigrant Californians. New investments include:

- $150 million in funding for shelters and services for people at the border.
- $5 million for organizations to provide education and employment services to all workers, regardless of immigration status.
- $5 million in one-time funding to support unaccompanied undocumented minors.

Additional support for immigrant Californians include further investments in food assistance, health insurance, and worker services. More details are available in the Safety Net, Health, and Labor sections, respectively.

How can state leaders better support Californians?

Better supporting undocumented Californians. This year's budget missed an opportunity to expand eligibility of the Cash Assistance Program for Immigrants (CAPI) to include immigrants who are undocumented. Another missed opportunity was failing to extend unemployment benefits to excluded immigrant workers (see Labor section).

Education

Early Learning and Pre-K

What does the state budget include?

The family fee and rate reform changes described in the child care section also apply to the California State Preschool Program (CSPP). Specifically, $22.4 million is allocated for family fee reform and $1.47 billion is provided for CSPP provider rate increases. The budget also provides $597 million for Transitional Kindergarten (TK) enrollment growth — 42,000 new enrollments — in 2023-24.

How can state leaders better support Californians?

Following up on the delays noted in the 2023-24 budget, including:

- Delaying the requirement to lower TK classroom ratios to 1:10 until 2025-26.
- Extending the deadline for TK teachers to earn 24 units (or equivalent), a child development permit, or an early child childhood education specialist credential from August 2023 to August 2025.
- Delaying $550 million to 2024-25 in facilities funding for TK, CSPP, and Kindergarten.

- Delaying the requirement that at least 7.5% of enrollment in CSPP enrollment is reserved for children with exceptional needs to July 1, 2025.

K-12 Education

What does the state budget include?

The budget provides some notable investments in K-12 education, including:

- An 8.22 percent cost-of-living adjustment (COLA) for the Local Control Funding Formula (LCFF). This is the largest COLA since the establishment of the LCFF a decade ago.
- $300 million ongoing for an "Equity Multiplier" add-on to the LCFF. This will be allocated to school sites on a per pupil basis based on a metrical called the "nonstability" rate.[1]
- $20 million one-time for a Bilingual Teacher Professional Development program. This will provide professional learning opportunities to increase the number of teachers authorized to teach in bilingual settings.

Lastly, the budget reduces two one-time block grants provided in last year's budget agreement:

- A $1.7 billion cut to the Learning Recovery Emergency Block Grant, from $7.94 to $6.25 billion.
- A $200 million cut to the Arts, Music, and Instructional Materials Discretionary Block Grant, from $3.56 billion to $3.36 billion.

How can state leaders better support Californians?

Targeting efforts to address major issues that impact student learning, including:

- High rates of absenteeism, especially among students of color and students from low-income households.
- Addressing staffing shortages in areas with high need.

Higher Education

What does the state budget include?

The budget maintains funding for the Higher Education Student Housing Grant program for the construction of affordable student housing at all three segments of higher education. However, funding for these projects will shift from the General Fund to bonds.

The 2023-24 budget also includes base funding increases for public colleges and universities. Specifically:

- $790 million for the California Community Colleges (CCCs), reflecting an 8.22 percent cost-of-living adjustment for the Student Centered Funding Formula.
- An increase of $227 million California State University (CSU) system.
- An increase of $215 million for the University of California (UC) system.

Notably, the budget also includes:

- An increase of $227 million one-time for the Middle Class Scholarship (MCS). This provides aid to eligible students who attend a UC or CSU university or those pursuing a bachelor's degree at the CCCs.
- Funding through the MCS and the Student Success Completion Grant program to cover the cost of college for current and former foster youth students.

How can state leaders better support Californians?

Ensuring next year's budget enacts the Cal Grant reform. Additionally, making the state's financial aid system more equitable for students from families with low incomes.

Other

Labor and Workforce

What does the state budget include?

The budget invests $35 million in the Domestic Worker and Employer Education and Outreach Program and makes this program permanent. This will help community based organizations ensure that domestic workers' rights and protections are upheld throughout the state.

The budget also provides $3 million to the Industrial Welfare Commission (IWC) to temporarily convene industry-specific wage boards. This prioritizes industries in which more than 10% of workers have incomes at or below the federal poverty line.

The IWC can convene wage boards to recommend minimum standards for pay, hours, and working conditions in industries or occupations where wages are inadequate or working conditions are harmful.

How can state leaders better support Californians?

Providing unemployment benefits to Californians who lose their jobs and are undocumented. Especially those who continue to be excluded from unemployment insurance benefits.

All California workers should have a financial cushion to help them stay housed and put food on the table when they lose a job. Establishing an Excluded Workers Program to provide this vital safety net was prioritized by the Senate, but was not included in the final budget deal with the governor. A joint house legislative agreement to establish a work group to explore options for establishing a permanent excluded workers fund was also left out of the final deal.

State Corrections

What does the state budget include?

The 2023-24 enacted budget continues plans to downsize the state's prison system. The budget addresses prison closures by declaring an intent to shut down additional prisons. This is accompanied by a requirement for the California Department of Corrections & Rehabilitation (CDCR) to assess the state prison system's capacity and needs and report back to the Legislature during 2023. This report should provide a foundation to understand where opportunities lie in closing more state prisons. Additionally, the enacted budget includes $361 million from the Public Buildings Construction Fund to build an educational and vocational center at San Quentin State Prison, which will be renamed the San Quentin Rehabilitation Center.

How can state leaders better support Californians?

Further downsizing the prison system. According to a report by the Legislative Analyst's Office, the state can safely close up to five additional prisons, saving the state around $1 billion per year. These savings could be used to provide services and supports for individuals after they are released from prison in order to help them rebuild their lives in their communities.

Public Safety

What does the state budget include?

The enacted budget funds a variety of public safety measures designed to improve the safety of all Californians, including:

- An additional $12 million to assist tribal police and prosecutors in cases of missing/murdered Indigenous persons.
- $20 million in one-time funding to enhance security at nonprofits that are at risk of hate-motivated violence.
- Restoring $40 million in one-time funding for the third year of a three-year Public Defense Pilot Program. This allocates funding to counties to provide public defenders for those who cannot afford legal services.
- Restructuring a gun buyback program in order to more quickly address mass shootings.
- Providing $113 million for the Safe Neighborhoods and Schools Fund (Proposition 47 of 2014) to help reduce recidivism, support truancy and dropout prevention programs, and fund services for crime victims. This funding reflects state-level savings due to declining incarceration following the implementation of Prop. 47.

Tax Policy Changes

What does the state budget include?

Although the budget agreement does not contain substantial tax revenue increases to support new spending, state leaders did take a positive step by limiting one strategy that wealthy people use to avoid state income taxes, which will increase state revenues by an estimated $17 million annually.

However, the enacted budget also commits the state to five additional years of the film tax credit starting in 2025-26 and will even allow businesses to get cash back if their credit amount exceeds the taxes they owe. The extension of this credit — which has not been shown to be very cost-effective — will cost the state around $1.6 billion over 12 years at a time when the state is facing budget shortfalls in future years.

How can state leaders better support Californians?

Meaningfully and equitably raising revenues to support the services that Californians need —including by reducing or eliminating tax breaks that mainly benefit highly profitable corporations and wealthy people.

^1 The definition of “nonstability rate” includes the percentage of pupils who are enrolled for less than 245 continuous days between July 1 and June 30 of the prior school year.

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Are California pharmacists ready to provide long-acting injectable pre-exposure prophylaxis (PrEP) for HIV prevention?

Pharmacists are recognized in the U.S. National HIV/AIDS Strategy for their potential role in amplifying access to HIV prevention and care services to end the HIV epidemic.[1] Pharmacies are located in most communities and may be perceived as a convenient and less stigmatizing access point for services such as HIV testing and pre-exposure prophylaxis (PrEP), a highly effective HIV prevention method. For this reason, an increasing number of states explicitly recognize pharmacists as health care providers and have expanded their scope of practice to enable PrEP provision.[2] In California, Senate Bill 159 (SB 159, 2019) permits pharmacists to initiate up to 60 days of oral PrEP before referral to a primary care provider.[3] This legislation was intended to mitigate the persistently low uptake of PrEP among people who could benefit by leveraging the largely untapped potential of pharmacy access.

Alongside the need for new PrEP delivery channels, a rapidly expanding marketplace of PrEP products is diversifying HIV prevention options. In December 2021, the U.S. FDA approved long-acting injectable cabotegravir (CAB-LA), the first alternative to daily oral PrEP.[4] Once established with two monthly injections, CAB-LA is administered every 60 days as an intramuscular injection in the gluteal muscle. Long-acting injectable PrEP has several potential advantages over oral PrEP, including more privacy and fewer adherence challenges, and may be preferred by some groups who experience higher risk of HIV acquisition (e.g., transgender people, people who inject drugs).[5,6] Recognizing the value of diverse PrEP options to increase equitable access to HIV prevention, proposed California legislation (SB 339) would expand SB 159 to explicitly permit pharmacists to initiate both current and future PrEP formulations, including injectables.[7]

In view of FDA approval of CAB-LA and the favorable policy environment in California for expanding pharmacists' role in HIV prevention, we evaluated pharmacists' potential as providers of long-acting injectable PrEP in the California Pharmacist Study. Specifically, we assessed pharmacists' attitudes about the provision of injectable PrEP, existing PrEP services (i.e., oral PrEP provision), and what characteristics of the pharmacy setting (e.g., availability of private rooms) could facilitate or hinder provision of injectable PrEP.

California Pharmacist Study

In late 2022, we recruited and surveyed 919 California pharmacists and pharmacy students about the provision of HIV prevention and other services in their pharmacies and their personal attitudes about and willingness to provide pharmacist-initiated PrEP. Detailed information about the methods and participants of the California Pharmacist Study has been previously reported.[8] Briefly, most survey participants (84%) were practicing licensed pharmacists, and 43% currently or most recently worked in a community pharmacy. These survey data were complemented with semi-structured interviews conducted among 30 pharmacists from diverse pharmacy settings in rural and urban areas across California. Qualitative data were analyzed via Rapid Analysis Process;[9] excerpts presented in this report have been edited for clarity.

Summary of Findings

- California pharmacists and pharmacy students are overwhelmingly supportive of providing HIV prevention services, including pharmacist-initiated oral PrEP as enabled by SB 159.
- More than half (53%) reported being willing to administer long-acting injectable PrEP, even with the knowledge that the current delivery method requires gluteal injection.
- Willingness was higher among those working in pharmacies that offer oral PrEP under SB 159 (65% vs. 51%), suggesting that addressing barriers to and increasing implementation of pharmacist-initiated oral PrEP may pave the way for injectable PrEP access in these settings.
- Space constraints may act as a barrier to long-acting injectable PrEP administration, yet almost half (48%) reported already having a private room or temporary pop-up space that may be suitable for provision of injectable PrEP.
- Pharmacies need support to develop appropriate models to fit oral and injectable PrEP delivery into their workflows in a manner that preserves clients' safety and privacy.
- Addressing implementation barriers related to medication access and payment is necessary to galvanize efforts of pharmacists who have demonstrated a clear interest and have the infrastructure needed to prescribe and deliver long-acting injectable PrEP.

Results

PrEP provision and attitudes

One in four participants (27%) had training on providing PrEP and/or post-exposure prophylaxis (PEP) in a pharmacy setting. One in ten (11%) reported that pharmacists at their pharmacy initiate daily oral PrEP as authorized by SB 159. Another 19% were unsure. Despite low training and implementation, participants expressed highly supportive attitudes around providing (oral) PrEP under SB 159, with 96% agreeing that pharmacy-based PrEP/PEP provision is important and 81% reporting being willing to prescribe PrEP to pharmacy clients.

Participants were also asked whether they would be willing to administer long-acting injectable PrEP at their pharmacy if provided with training, compensation, and a private room. Half (53%) reported that they would be willing, while the rest were unsure (23%) or unwilling (24%). Participants from pharmacies that currently provide PrEP under SB 159 (n=96) were somewhat more likely to report being willing to administer injectable PrEP than participants from pharmacies that were not implementing oral PrEP (65% vs. 51%).

Pharmacy characteristics

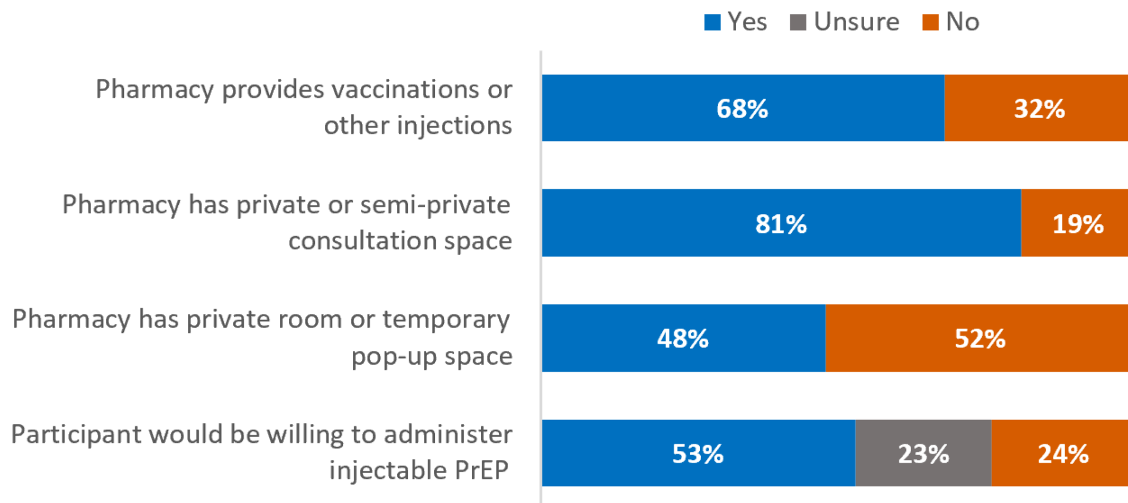
Two-thirds of participants (68%) reported that their pharmacy provides vaccinations or other injections (**Figure 1**). Participants from community pharmacies were more likely to report that their pharmacy provides injections than those from other settings (87% vs. 53%). Among all participants who reported injection provision, most indicated that pharmacists perform intramuscular (92%) and/or subcutaneous (74%) injections.

Most participants (81%) reported that their pharmacy has private or semi-private spaces for consultation and service provision, most commonly private rooms (40%), private consultation windows

(28%), permanent semi-private spaces such as cubicles (17%), and/or temporary pop-up spaces with flexible walls (9%). Among participants from community pharmacies only, more than 90% reported that their pharmacy has private or semi-private spaces, although private consultation windows (44%) were more common than private rooms (35%).

Overall and regardless of setting, 48% of participants reported having a private area that may be suitable for CAB-LA administration (i.e., private room or temporary pop-up space, not including consultation windows).

Figure 1. Indicators of pharmacist readiness to provide long-acting injectable HIV pre-exposure prophylaxis (PrEP) among participants in the California Pharmacist Study, 2022.



Pharmacist perspectives

As in the survey, participants in qualitative interviews expressed mixed views on administering injectable PrEP in pharmacies. Some welcomed the chance to provide injectable PrEP to their patients and considered it feasible based on pharmacists' scope of practice and existing pharmacy infrastructure.

> *We have private spaces, we have a little enclosure where we do the vaccinations. And some of [our other locations] also have health corners which are little offices where they can they do some of their vaccinations… Yeah, [long-acting injectable PrEP] is definitely possible. I would love to see that.*
> – Participant 28, community pharmacist/administrator at a national chain

> *I would prefer to give an injectable, because it's a lot easier, and I don't have to worry about compliance or adherence for patients. I'm very comfortable with giving vaccinations.*
> – Participant 9, community pharmacist/owner of a suburban independent pharmacy

However, others described multilevel barriers that could limit their ability to implement injectable PrEP. The most commonly reported barrier was a lack of training in administering gluteal injections.

> *There's a lot of things I just wish we could get trained on that would be within our scope… One would be gluteal injections. We're not trained on that. And so if we get the training, I'd do it, no hesitation… If [I] got some good training, I'm all over that.*
> – Participant 17, hospital pharmacist

A few pharmacists raised concerns about personal safety and liability administering gluteal injections in their pharmacy. A community pharmacist who owned an independent pharmacy in a mid-size city stated:

> *We already have the ability of doing flu shots and psychiatric injections [administered] in the gluteal area... I think [the] problem comes with if there is a pharmacist concern[ed] with the possibility of the patient being positive—that might change someone's opinion because… it could potentially involve blood. So yeah, there's still a relatively low chance of having a transmission, but you know, it's a higher chance than if they were to just take an oral pill.*
> – Participant 8

Some participants were also deterred by structural issues such as not having a private space and lack of payment for services. A community pharmacist who owned an independent pharmacy in a rural town explained the potential difficulty of creating a private space:

> *Well we can't. If it's going to be gluteal, we're going to have to build an enclosed meeting room, and we could not do that with our current physical structure. I'm not opposed to it. But it would take some more doing. We would have to revamp part of the pharmacy to accommodate that kind of privacy.*
> – Participant 7

Several other independent community pharmacists who owned their practices described challenges in ordering specialty drugs and receiving payment for administering injectable PrEP:

> *We couldn't even order the drugs. We couldn't order them because the doctor's office wants to prescribe and they want us to dispense. Only six pharmacies nationwide can order it because it's a specialty drug. For us pharmacists, even if we have patients coming in asking [about long-acting injectable PrEP]—which we do—we can't do anything for them. And that medication requires a doctor's prescription, and we're not yet able to provide it.*
> – Participant 3

> *In the setting of SB 159 where the pharmacists will be providing that long-acting injectable, I think there also needs to be a method of reimbursement for the pharmacist, for not only providing the assessment but also for administering the injection. So there need to be reimbursement mechanisms for pharmacists to be able to provide these services. I think it's essential.*
> – Participant 5

Despite these challenges, about half of interview participants supported expanding pharmacists' scope of practice to include gluteal injections for PrEP. Several mentioned that pharmacists have demonstrated their ability to administer various types of injectable drug formulations, including the COVID-19 vaccine.

> *There's precedent to doing gluteal injections. We have pharmacists engaged in long-acting antipsychotic injectables. So they're doing this already for other drugs. So I personally don't see that as a limitation.*
> – Participant 4, academic pharmacist with a clinical practice

> *I mean, we gave vaccinations even before COVID. We essentially are immunizing in pharmacies… I don't see the problem with giving injections. After all, most of the people we give the vaccinations, we don't know their HIV status, anyway.*
> – Participant 18, independent community pharmacist serving multiple suburban areas

Discussion

Pharmacies may be a valuable new delivery channel to increase access to PrEP, including long-acting injectable PrEP. In our survey of over 900 California pharmacists and pharmacy students, we found high support for pharmacy-based PrEP provision, despite low overall implementation of oral PrEP as authorized by SB 159. When asked about pharmacy provision of *injectable* PrEP, half of participants overall and two-thirds of those from pharmacies already providing pharmacist-initiated oral PrEP expressed willingness to administer injectable PrEP. The higher willingness observed among those at pharmacies that already provide oral PrEP suggests that addressing barriers to and increasing implementation of SB 159 for oral PrEP may pave the way for injectable PrEP access in pharmacy settings.

As was evident in both the survey and qualitative interviews, pharmacists are already key providers of injectable products, ranging from their critical role in community access to the COVID-19 vaccination to other specialty injections (e.g., antipsychotic medications). These findings are a promising signal that pharmacist delivery of CAB-LA and/or other future injectable PrEP products may be feasible in many pharmacy settings. Nearly half of those surveyed reported that their pharmacy already has a private space (whether permanent or temporary) that may be suitable for PrEP consultations, administration of injections, and/or the conduct of requisite HIV testing to verify HIV-negative status. Still, many other pharmacies would need to adapt existing semi-private spaces for long-acting injectable PrEP provision. In addition, pharmacies need support to develop appropriate implementation models to fit oral and injectable PrEP delivery into their workflows in a manner that both meets patient preferences and does not undermine the pharmacy's bottom line. Community-based demonstration projects are critical to understand in which pharmacy settings, including mobile pharmacies, injectable PrEP delivery could most benefit the surrounding community.

Previously documented barriers to implementing pharmacist-initiated oral PrEP in California, such as lack of training and staff time constraints, also remain relevant to injectable PrEP. Our qualitative data suggest that pharmacist provision of injectable PrEP may come with additional barriers related to access to the medication (e.g., specialty pharmacy status) and payment for the medication. Some, but not all, pharmacists expressed discomfort with administering gluteal injections specifically. Additional training and/or peer-to-peer knowledge sharing from pharmacists experienced with intramuscular injections may mitigate these concerns. Notably, the PrEP development pipeline includes injectable products which could be delivered through subcutaneous injections and administered in less private sites than the gluteal muscle;[10] these options may expand possibilities for pharmacy delivery.

To maximize the possibility that pharmacy-based PrEP could be widely scaled and increase equity in access to HIV prevention, research about pharmacist attitudes must be complemented with parallel research from people who could benefit from PrEP. The preferences of people interested in initiating or continuing PrEP through pharmacy access should guide the development of potential implementation

models in tandem with pharmacist input, consistent with an implementation science approach.[11] For example, although pharmacies are an HIV "status neutral" environment, HIV testing, PrEP counseling, and the delivery of injections related to HIV prevention can be highly sensitive. For this reason, identification of a pharmacy-based delivery model that preserves patients' dignity, safety, and privacy is essential to ensure the success of this PrEP delivery channel, especially for groups who may benefit from PrEP but have historically had less reliable access to HIV prevention due to the intersection of barriers related to racism, homophobia and transphobia, and stigma.

In summary, pharmacists' supportive attitudes, current scope of practice, and existing pharmacy infrastructure suggest that there is strong potential to increase access to new long-acting injectable forms of HIV prevention in California pharmacies. Addressing implementation barriers related to medication access and payment is necessary to galvanize efforts of pharmacists who have demonstrated a clear interest and the necessary infrastructure to prescribe and deliver long-acting injectable PrEP. Once complemented with information about the preferences of people who might benefit from PrEP, pharmacy access to long-acting injectable PrEP could become an important community-based delivery channel to accelerate the goals of the National HIV/AIDS Strategy.

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