LOS ANGELES COUNTY
COMMISSION ON HIV

Visit us online: http://hiv.lacounty.gov
Get in touch: hivcomm@lachiv.org

PUBLIC POLICY COMMITTEE
Virtual Meeting
Monday, February 1, 2021
1:00PM-3:00PM (PST)

Agenda + Meeting Packet will be available on the Commission's website at:
http://hiv.lacounty.gov/Public-Policy-Committee

REGISTER VIA WEBEX ON YOUR COMPUTER OR SMART PHONE:
https://tinyurl.com/y5agcmq9
**Link is for non-Committee members only*

JOIN VIA WEBEX ON YOUR PHONE:
1-415-655-0001US Toll
Access code: 145 394 8768

*Link is for members of the public only. Commission members, please contact staff for specific log-in information if not already

PUBLIC COMMENTS

Public Comments will open at the time referenced on the meeting agenda. For those who wish to provide live public comment, you may do so by joining the WebEx meeting through your computer or smartphone and typing PUBLIC COMMENT in the Chat box. For those calling into the meeting via telephone, you will not be able to provide live public comment. However, you may provide written public comments or materials by email to hivcomm@lachiv.org. Please include the agenda item and meeting date in your correspondence. All correspondence and materials received shall become part of the official record.

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

PUBLIC POLICY COMMITTEE

MONDAY, FEBRUARY 1, 2021 | 1:00 PM – 3:00 PM

To Join by Computer: https://tinyurl.com/y3qfyqja
Link is for committee members only

To Join by Phone: 1-415-655-0001
Access code: 145 394 8768

Public Policy Committee Members:			
Katja Nelson, MPP *Co-Chair*	Lee Kochems, MA *Co-Chair*	*(Alasdair Burton, Alternate)*	Jerry D. Gates, PhD
Eduardo Martinez	Nestor Kamurigi	Ricky Rosales	Martin Sattah, MD
Tony Spears (Alternate)			
QUORUM: 5			

AGENDA POSTED: January 28, 2021

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.

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

SUPPORTING DOCUMENTATION can be obtained at the Commission on HIV Website at: http://hiv.lacounty.gov. The Commission Offices are located in Metroplex Wilshire, one building west of the southwest corner of Wilshire and Normandie. Validated parking is available in the parking lot behind Metroplex, just south of Wilshire, on the west side of Normandie.

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

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

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

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

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

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

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

II. PUBLIC COMMENT — 1:08 PM – 1:10 PM

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

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

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

IV. REPORTS

5. Executive Director/Staff Report — 1:15 PM – 1:25 PM
   a. Committee and Caucus Updates

6. Co-Chair Report — 1:25 PM – 2:00 PM
   a. 2021 Workplan
   b. Act Now Against Meth (ANAM) Update
   c. Review of Policy Priorities

V. DISCUSSION ITEMS

7. Legislative Docket — 2:00 PM – 2:10 PM

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

9. Federal Policy Update — 2:20 PM – 2:30 PM

10. County Policy Update — 2:30 PM – 2:50 PM
   a. Transgender Wellness and Equity Fund Letter of Support

VI. NEXT STEPS 2:50 PM – 2:55 PM

11. Task/Assignments Recap

12. Agenda development for the next meeting

VII. ANNOUNCEMENTS 2:55 PM – 3:00 PM

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

VIII. ADJOURNMENT 3:00 PM

14. Adjournment for the meeting of February 1, 2021

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

Wellbeing Center Program

Ellen Sanchez, M.Ed
esanchez@ph.lacounty.gov

Wellbeing Center Program

Youth need access to safe spaces, caring adults and supportive peers

County of Los Angeles
Public Health

Wellbeing Center Program Partners

- Planned Parenthood of Greater Los Angeles (PPLA)
- L.A. County Department of Mental Health (DMH)
- L.A. Unified School District (LAUSD)
- L.A. County Office of Education (LACOE)

Wellbeing Center Schools

39 schools

29

LAUSD schools

10

Independent district schools

COUNTY OF LOS ANGELES
Public Health

Wellbeing Center Staffing

- Each school:
  - 1 Senior Health Educator
  - 2 Health Educators

COUNTY OF LOS ANGELES Public Health

Wellbeing Center Core Services

- Health education in the Center and in the classroom
- Mental health support
- Substance use prevention
- Sexual health services
- Peer advocate training
- Parent education and support
- After hours call line for support and referrals

Planned Parenthood On-site Services

- Education and confidential consultation
- Full range of sexual health services
- Well person exams
- Birth Control options
- STI testing and treatment
- HIV testing and referral

Wellbeing Center Virtual Services

- Virtual student education sessions
- Call line for students
- Virtual Department of Mental Health sessions
- Virtual leadership opportunities for students
  - Public Health Task Force
  - Public Health Ambassadors
- Virtual and phone parent education
- Virtual trainings for parents
  - Public Health Ambassadors

COUNTY OF LOS ANGELES
Public Health

Thank you!

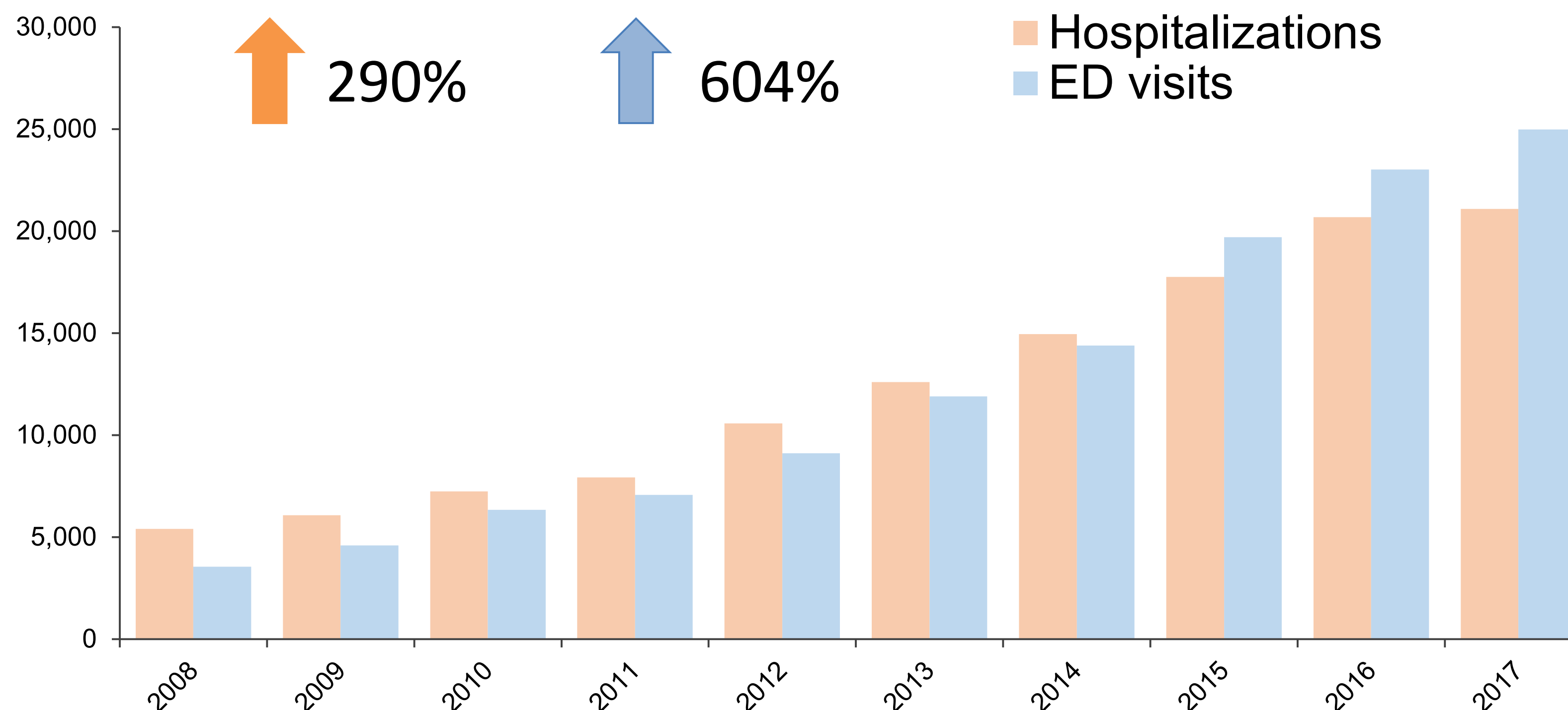
Los Angeles County's Methamphetamine Task Force

January 19, 2021

Rangell Oruga, MPH
Health Program Analyst
Substance Abuse Prevention & Control
Prevention Services
Community & Youth Engagement

COUNTY OF LOS ANGELES
Public Health

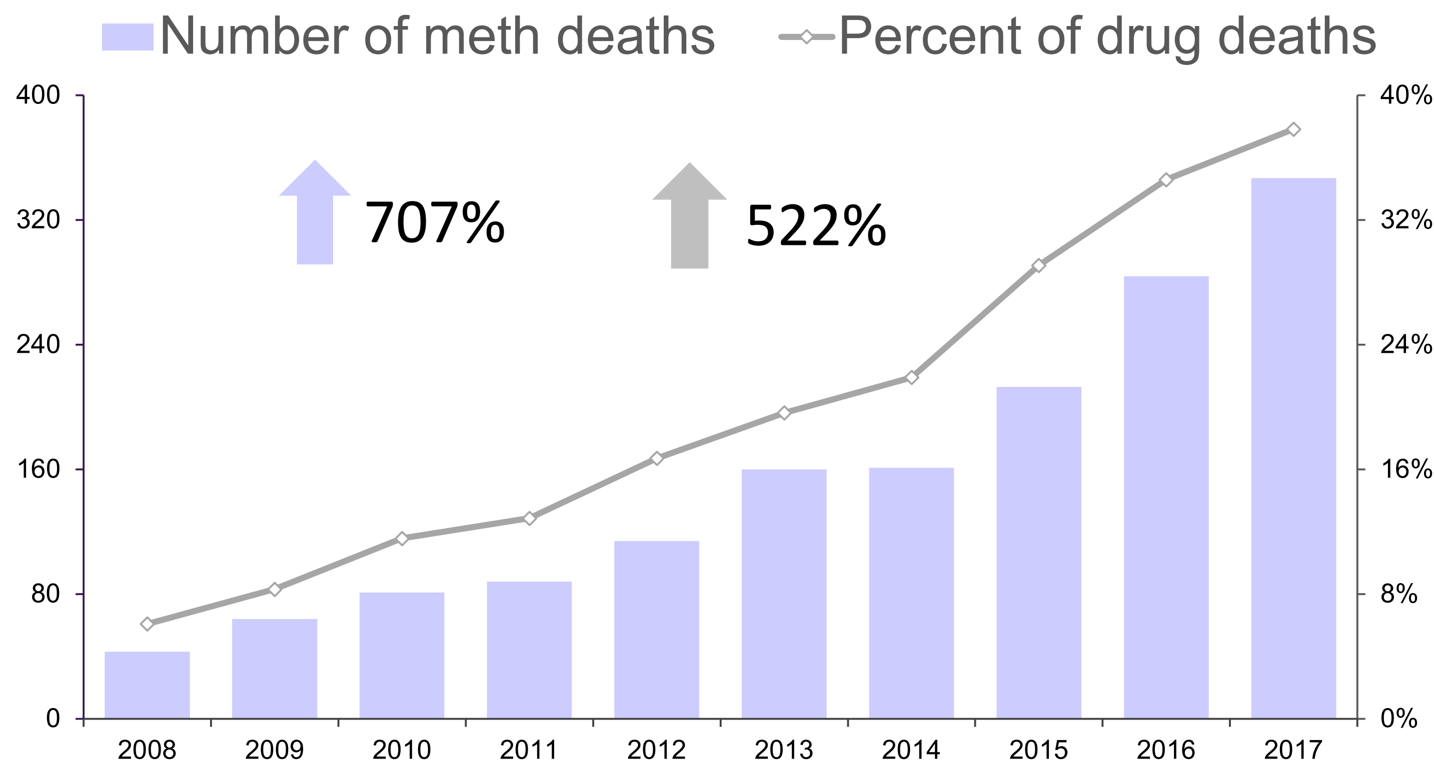
Meth-Related Hospitalizations and ED Visits in LAC Increased from 2008-2017



***Meth-related ED visits and hospitalizations include any records listing meth dependence, abuse, use, and poisoning as a diagnosis or external-cause-of-injury**.

Source: Office of Statewide Health Planning and Development (OSHPD). Inpatient and Emergency Department data. California Department of Public Health. Analysis by Health Outcomes and Data Analytics Unit, Substance Abuse Prevention and Control, Los Angeles County Dept of Public Health

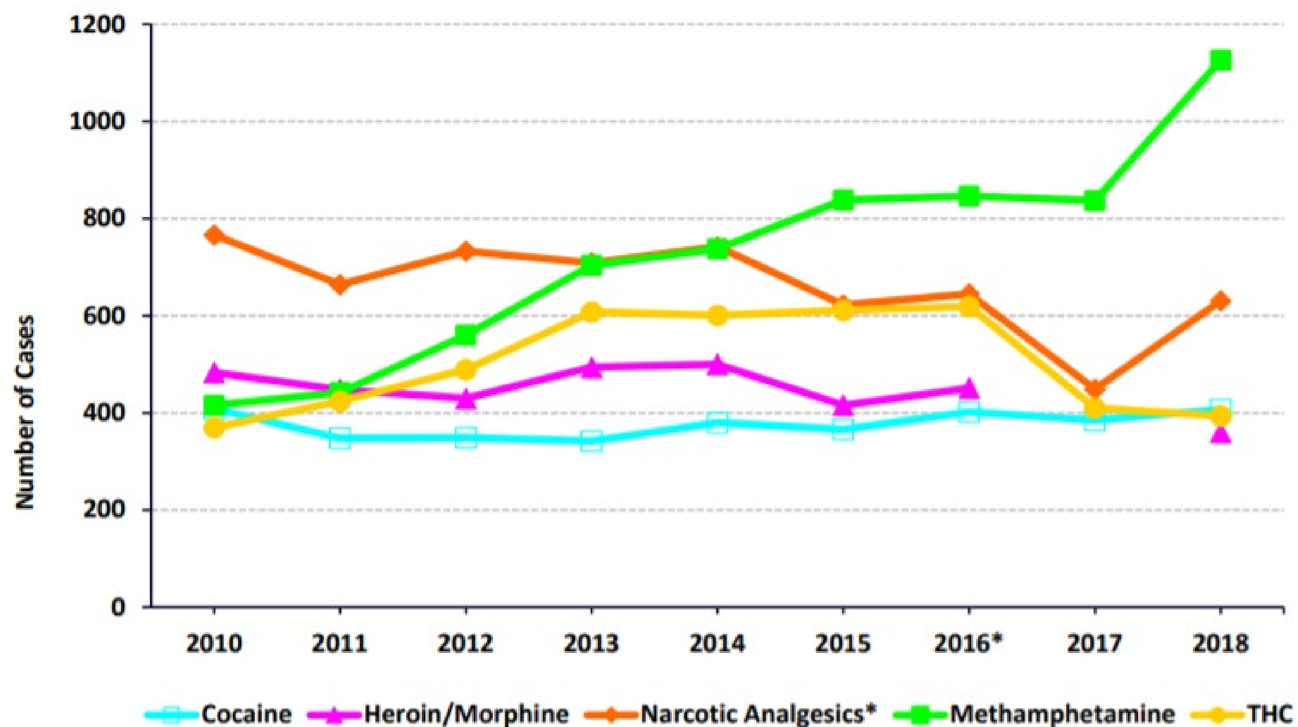
Meth-Related Deaths* in LAC, 2008-2017



***Meth-overdose related deaths include all deaths that listed meth poisoning as a cause of death, and drug overdose as the underlying cause of death.**

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death Files, 1999-2017 http://wonder.cdc.gov/mcd-icd10.html . Data prepared by Health Outcomes and Data Analytics Unit, Substance Abuse Prevention and Control, Los Angeles County Dept of Public Health

Meth is Involved* in More Deaths in LAC than Any Other Drug, 2010-2018



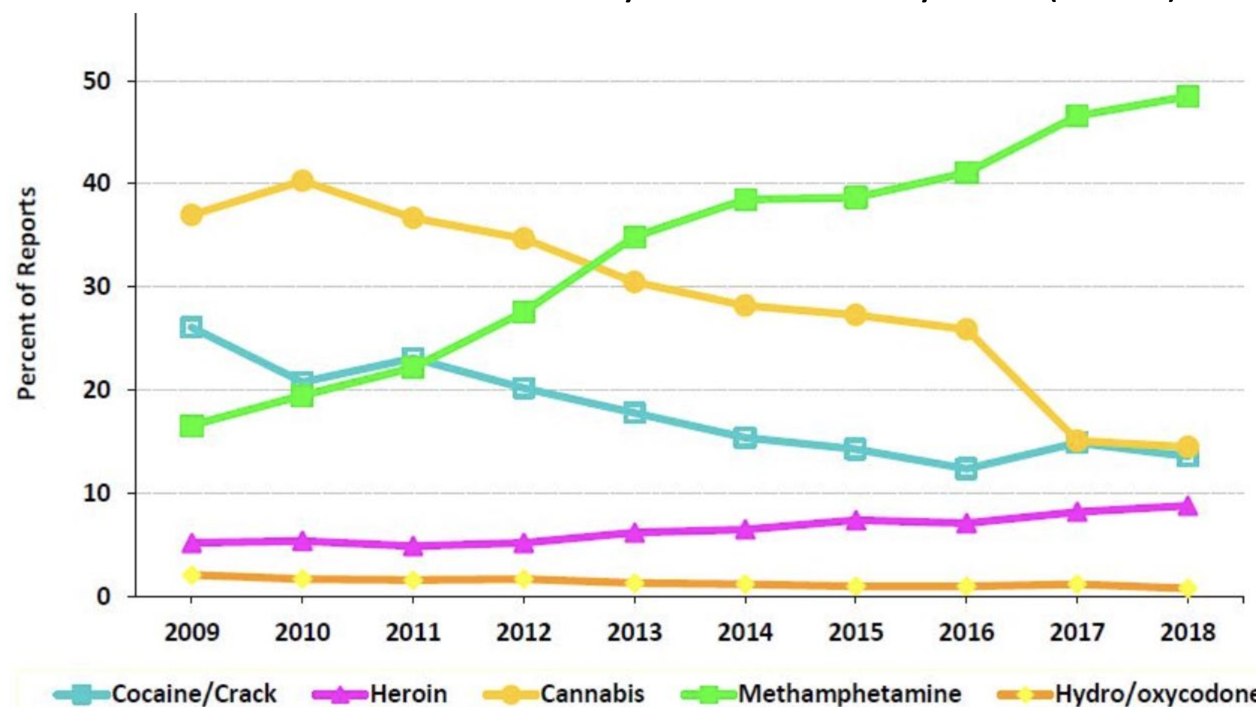
***Data reflects cases for which toxicology tests were (+) for at least one tested substance (e.g., not necessarily drug-related or drug-caused deaths). Each case may have more than one drug detected.**

National Drug Early Warning System. Los Angeles County Sentinel Community Site (SCS) Drug Use Patterns and Trends, 2019
https://ndews.umd.edu/sites/ndews.umd.edu/files/SCS-Report-2019-Los-Angeles-FINAL.pdf

Availability – Law Enforcement Seizures

- **Since 2013, methamphetamine has been the most commonly identified drug from law enforcement seizures in Los Angeles County (LAC).**
- In 2018, methamphetamine accounted for almost half (48.5%) of all reports of seized items according to the National Forensic Laboratory Information System (NFLIS).

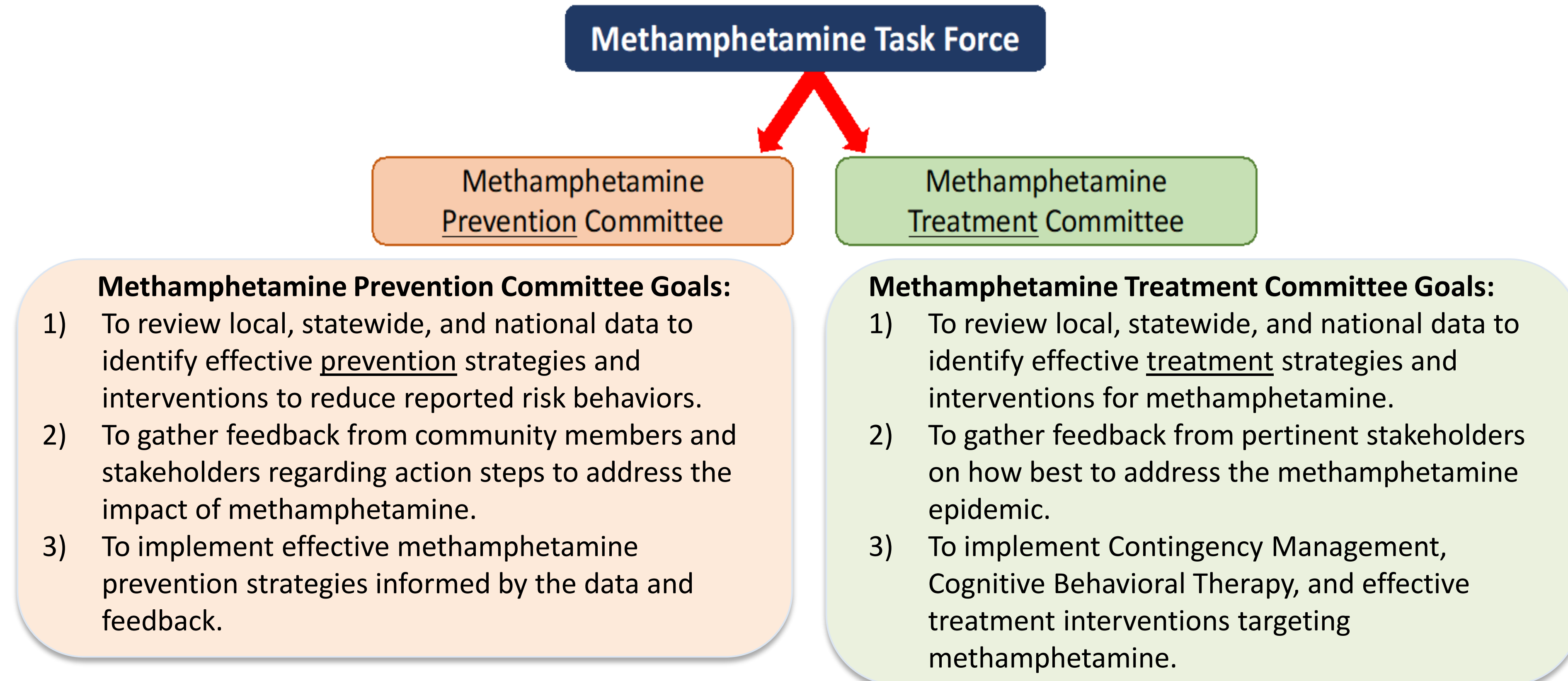
Drugs identified from law enforcement items submitted to forensic labs in LAC



1. National Drug Early Warning System (NDEWS), 2018.
2. Los Angeles County Methamphetamine Dashboard. https://insight.livestories.com/s/v2/meth-availability/121156dc-631a-4e8d-8487-b38c597dbb5e (Accessed 06/22/20)

Methamphetamine Task Force

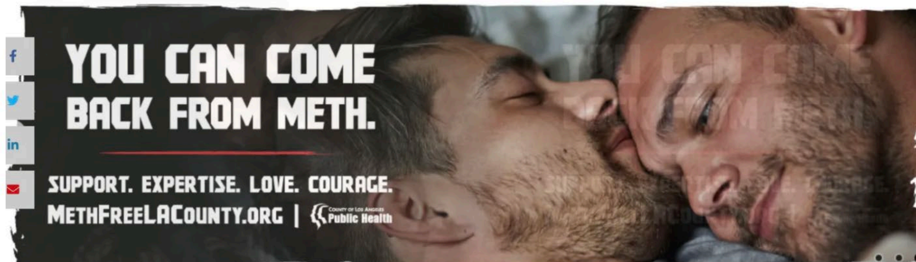
- **DPH-SAPC is convening a Meth Task Force to inform prevention and treatment strategies and address both the upstream and downstream drivers of meth use and abuse.**
  - Comprised of SAPC leads, substance use prevention and treatment providers, health and mental health providers, homeless and housing providers, first responders, and other pertinent stakeholders.

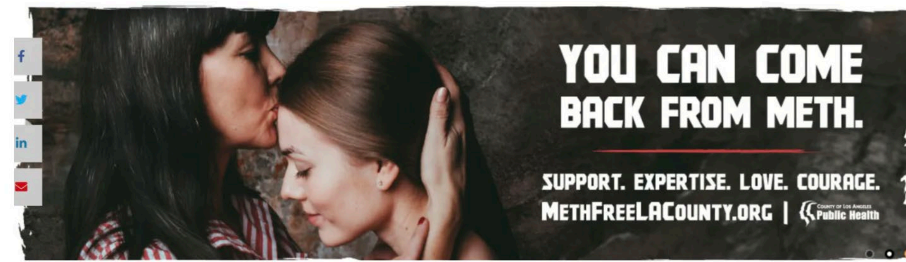


Meth Prevention Strategies

Prevention: Focus on Education, Outreach, Community Action

- **Focus on power of social connection as an upstream preventative intervention for meth and other substances.**
- **Community-Based Prevention Interventions.**
- **Methamphetamine Awareness Campaigns**
  - "Meth-Free LA County" – Launched Spring 2020.
  - A follow-up meth campaign will be launched in 2021 and focus on more targeted populations.



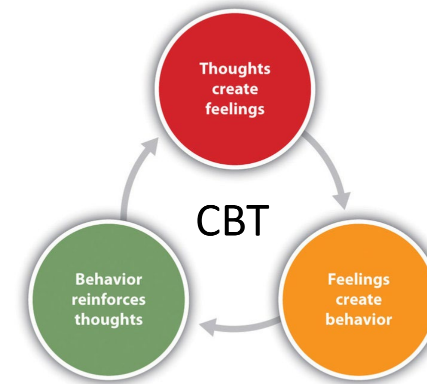


Meth Treatment Strategies

Behavioral strategies have demonstrated the greatest treatment benefit for methamphetamine use disorder thus far.

- **Contingency Management (CM):** Based on the operant conditioning principle that a behavior is more likely to be repeated when followed by positive consequences. Participants receive rewards such as privileges, points, or gift cards for achieving certain goals, such as specified periods of drug abstinence or negative urine toxicology screens.

- **Cognitive Behavioral Therapy (CBT):** Focuses on understanding the role of substance use in a person's life and fosters the development of coping skills to avoid addiction relapse.



Research is ongoing on identifying medications that can be helpful for meth use. Off-label medications for meth use/misuse currently include:

- Topiramate
- Methylphenidate
- Mirtazapine
- Buproprion

Thank You!

2021 WORK PLAN – PUBLIC POLICY
Draft 02/01/2021

Committee Name: **PUBLIC POLICY COMMITTEE (PPC)**	Co-Chairs: Katja Nelson, Lee Kochems

Committee Responsibilities:

1. Advocating public policy issues at every level of government to End of the HIV Epidemic (EHE).
2. Initiating policy initiatives in accordance with HIV service and prevention priorities.
3. Providing education and access to public policy arenas for Commission members, consumers, providers, and the public.
4. Facilitate Commission communication between government and legislative officials.
5. Recommend administrative policies and legislative actions to support prevention and HIV care services.
6. Advocating specific public policy matters to the appropriate County departments, interests, and bodies.
7. Research and implement public policy activities that support prevention and HIV care services.
8. Advancing Commission initiatives that support prevention and HIV care services.
9. Other duties as assigned by the Commission or the Board of Supervisors

Purpose of Work Plan: To focus and prioritize key activities for COH Committees and subgroups for 2021
Prioritization Criteria: Select activities that 1) represent the core functions of the COH; 2) advance goals to Ending the HIV Epidemic (EHE); and 3) Advance State and local government prevention and HIV care services.

#	TASK/ACTIVITY	DESCRIPTION	TARGET COMPLETION DATE	STATUS/NOTES/OTHER COMMITTEES INVOLVED
1	Review Policy Priorities for 2021	Committee discussion on policy priorities for 2021. Update accordingly.		
2	Develop 2021 Legislative Docket	Review legislation aligned with COH Policy Priorities, develop docket, and discuss legislative position for each bill.		
3	Monitor federal plan, *Ending the HIV Epidemic: A Plan for America*	Monitor updates, potential funding, and Presidential Advisory Council on HIV/AIDS' (PACHA) efforts		
4	Track *End the Epidemics* (Statewide HIV, STD, Hep C initiative)	Track advocacy efforts for End the Epidemics in regard to statewide joint budget asks for HIV, STDs, and Hep C		

2021 WORK PLAN – PUBLIC POLICY
Draft 02/01/2021

#	TASK/ACTIVITY	DESCRIPTION	TARGET COMPLETION DATE	STATUS/NOTES/OTHER COMMITTEES INVOLVED
5	STD Motion Follow Up	Prepare Board letter		
6	Assess State HIV and STD policy and budget	Transgender Wellness Fund		
7	Assess federal policy and budget	Future direction of the Ryan White Program.		
8	Align PPC efforts with Black/African American Community (BAAC) Task Force recommendations	Ensure policy efforts prioritize recommendations from the Task Force		

DRAFT

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
HIVCOMM@LACHIV.ORG • https://hiv.lacounty.gov

2021 POLICY PRIORITIES

The COVID-19 global pandemic has demonstrated that with political will, funding, and most important of all, urgency, rapid and safe vaccine development is possible. HIV has been raging in communities across the world for almost 40 years and with the advances in biomedical interventions, research, vaccines, the time for the HIV cure is now. With a renewed sense of optimism and urgency, the Public Policy Committee remains steadfast in its commitment to universal health care, eradication of racism in all forms, and unfettered access to care and supportive services to ensure that all people living with HIV and communities most impacted by HIV and STDs, live, full, productive lives.

The Public Policy Committee recommends the following issues as priorities (in no particular order) for the Commission on HIV in 2021:

Systematic Racism

a. Support legislation and local policies and procedures that promotion health equity, the elimination of barriers and addressing of social determinants of health such as: implicit bias; access to care; education; social stigma, (i.e. homophobia, transphobia and misogyny); housing; mental health; substance abuse; and income/wealth gaps.
b. Support legislation and local policies and procedures that reduce and eliminate the disproportionate impact of HIV/AIDS and STIs in the Black/African American community. To include the identification of and rooting out systemic and systematic racism as it affects Black/African American residents.

Housing

a. Support legislation and local policies and procedures that preserve and improve systems, strategies and proposals that expand affordable housing, as well as prioritize housing opportunities for people living with, affected by, or at risk of transmission of HIV/AIDS.
b. Support legislation and local policies and procedures that preserve and improve systems, strategies, and proposals that prevent homelessness for people living with, affected by, or at risk of contracting HIV/AIDS.
c. Support legislation and local policies that promote family housing and emergency financial assistance as a strategy to maintain housing.

Mental Health

a. Support legislation and local policies and procedures that prioritize mental health services for people living with, affected by, or at risk of contracting HIV/AIDS.

Prevention

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

Substance Abuse

a. Support legislation and local policies and procedures that advocate for substance abuse services to PLWHA.

Consumers

a. Support legislation and local policies and procedures that advocate and encourage the empowerment and engagement of People Living with HIV/AIDS (PLWHA) and those at risk of acquiring HIV. This includes young MSM (YMSM), African American MSM, Latino MSM, transgender persons and women of color, transgender and the aging.

Aging

a. Support legislation and local policies and procedures that create and expand medical and supportive services for PLWHA ages 50 and over.

Women

a. Support legislation and local policies and procedures that create and expand medical and supportive services for women living with HIV/AIDS. This includes services such as family housing, transportation, mental health, childcare and substance abuse.

Transgender

a. Support legislation and local policies and procedures that create and expand medical and supportive services for transgender PLWHA.
b. Support legislation and local policies and procedures that promote and maintain funding for the Transgender Wellness Fund created by the passage of AB2218.

General Health Care

a. Support legislation and local policies and procedures that provide access to and continuity of care for PLWHA focusing on communities at highest risk for the acquisition and transmission of HIV disease.
b. Support legislation and local policies and procedures that fund and expand eligibility for Medicaid, Medicare, and HIV/AIDS programs and health insurance coverage for individuals with pre-existing conditions.
c. Support legislation and local policies and procedures that support efforts to increase/enhance compatibility and effectiveness between RWP, Medicaid, Medicare, and other health systems. This includes restructuring funding criteria to **not** disincentives contractors from referring clients to other contractors.
d. Support legislation and local policies and procedures that expand access to and reduction of barriers (including costs) for HIV/AIDS, STD, and viral hepatitis prevention and treatment medications.
e. Support legislation and local policies and procedures that preserve full funding and accessibility to the AIDS Drug Assistance Program (ADAP), Office of AIDS Health Insurance Premium Payment (OA-HIPP) Assistance, Employer Based Health Insurance Premium Payment (EB-HIPP), and Medigap.

Service Delivery

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

Criminalization

a. Support legislation and local policies and procedures that eliminate discrimination against or the criminalization of people living with or at risk of HIV/AIDS.

Data

a. Support legislation and local policies and procedures that use data, without risking personal privacy and health, with the intention of improving health outcomes and eliminating health disparities among PLWHA.

b. Support legislation and local policies and procedures to promote distribution of resources in accordance with the HIV burden within Los Angeles County.

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

DRAFT - 2021-2022 Legislative Docket

POSITIONS: SUPPORT | OPPOSE | SUPPORT w/AMENDMENTS | OPPOSE unless AMENDED | WATCH | County bills noted w/asterisk

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
AB 4 (Arambula)	Medi-Cal: eligibility	The bill would extend eligibility for full scope Medi-Cal benefits to anyone regardless of age, and who is otherwise eligible for those benefits but for their immigration status. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB4		11-JAN-21 Referred to Committee on Health
AB 32 (Aguiar-Curry)	Telehealth	The bill would authorize a provider to enroll or recertify an individual in Medi-Cal programs through telehealth and other forms of virtual communication. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB32		11-JAN-21 Referred to Committee on Health
SB 17 (Pan)	Pan. Public health crisis: racism	This bill would state the intent of the Legislature to enact legislation to require the department, in collaboration with the Health in All Policies Program, the Office of Health Equity, and other relevant departments, agencies, and stakeholders, to address racism as a public health crisis. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB17		
SB 56 (Durazo)	Medi-Cal: eligibility	This bill would, subject to an appropriation by the Legislature, and effective July 1, 2022, extend eligibility for full-scope Medi-Cal benefits to individuals who are 65 years of age or older, and who are otherwise eligible for those benefits but for their immigration status. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB56		

BILL	TITLE	DESCRIPTION / COMMENTS	RECOMMENDED POSITION	STATUS
SB 57 (Wiener)	Controlled Substances: Overdose Prevention Program	This bill would, until January 1, 2027, authorize the City and County of San Francisco, the County of Los Angeles, and the City of Oakland to approve entities to operate overdose prevention programs for persons that satisfy specified requirements, including, among other things, providing a hygienic space supervised by trained staff where people who use drugs can consume preobtained drugs, providing sterile consumption supplies, and providing access or referrals to substance use disorder treatment. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB57		

ASSEMBLY BILL No. 4

Introduced by Assembly Members Arambula, Bonta, Chiu, Gipson, Lorena Gonzalez, Reyes, and Santiago
(Coauthor: Assembly Member Carrillo)
(Coauthors: Senators Caballero, Durazo, and Wiener)

December 7, 2020

An act to amend Section 14007.8 of the Welfare and Institutions Code, relating to Medi-Cal.

legislative counsel's digest

AB 4, as introduced, Arambula. Medi-Cal: eligibility.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. The federal Medicaid program provisions prohibit payment to a state for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.

Existing law requires individuals under 19 years of age enrolled in restricted-scope Medi-Cal at the time the Director of Health Care Services makes a determination that systems have been programmed for implementation of these provisions to be enrolled in the full scope of Medi-Cal benefits, if otherwise eligible, pursuant to an eligibility and enrollment plan, and extends eligibility for full scope Medi-Cal benefits to individuals who are under 25 years of age, and who are otherwise eligible for those benefits but for their immigration status. Existing law makes the effective date of enrollment for those individuals

the same day that systems are operational to begin processing new applications pursuant to the director's determination. Existing law requires an individual eligible for Medi-Cal under these provisions to enroll in a Medi-Cal managed care health plan. Existing law provides that Medi-Cal benefits for individuals who are 65 years of age or older, and who do not have satisfactory immigration statuses or are unable to establish satisfactory immigration statuses, as specified, are to be prioritized in the Budget Act for the upcoming fiscal year if the Department of Finance projects a positive ending balance in the Special Fund for Economic Uncertainties for the upcoming fiscal year and each of the ensuing 3 fiscal years that exceeds the cost of providing those individuals full scope Medi-Cal benefits.

Effective January 1, 2022, this bill would instead extend eligibility for full scope Medi-Cal benefits to anyone regardless of age, and who is otherwise eligible for those benefits but for their immigration status, pursuant to an eligibility and enrollment plan. The bill would delete the above-specified provisions regarding individuals who are under 25 years of age or 65 years of age or older and delaying implementation until the director makes the determination described above. The bill would require the eligibility and enrollment plan to ensure that an individual maintains continuity of care with respect to their primary care provider, as prescribed, would provide that an individual is not limited in their ability to select a different health care provider or Medi-Cal managed care health plan, and would require the department to provide monthly updates to the appropriate policy and fiscal committees of the Legislature on the status of the implementation of these provisions. Because counties are required to make Medi-Cal eligibility determinations and this bill would expand Medi-Cal eligibility, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 14007.8 of the Welfare and Institutions Code is amended to read:

~~14007.8. (a) (1) After the director determines, and communicates that determination in writing to the Department of Finance, that systems have been programmed for implementation of this section, but no sooner than May 1, 2016, an individual who is under 19 years of age and who does not have satisfactory immigration status or is unable to establish satisfactory immigration status as required by Section 14011.2 shall be eligible for the full scope of Medi-Cal benefits, if they are otherwise eligible for benefits under this chapter.~~

~~(2) (A) An individual under 19 years of age enrolled in Medi-Cal pursuant to subdivision (d) of Section 14007.5 at the time the director makes the determination described in paragraph (1)~~

14007.8. (a) (1) Effective January 1, 2022, an individual who does not have satisfactory immigration status or is unable to establish satisfactory immigration status, as required by Section 14011.2, shall be eligible for the full scope of Medi-Cal benefits, if they are otherwise eligible for benefits under this chapter.

(2) An individual enrolled in Medi-Cal pursuant to subdivision (d) of Section 14007.5 shall be enrolled in the full scope of Medi-Cal benefits, if otherwise eligible, pursuant to an eligibility and enrollment plan. This plan shall include outreach strategies developed by the department in consultation with interested stakeholders, including, but not limited to, counties, health care service plans, consumer advocates, and the Legislature. An individual subject to this subparagraph ~~shall not be~~ *is not* required to file a new application for Medi-Cal.

~~(B) The effective date of enrollment into Medi-Cal for an individual described in subparagraph (A) shall be on the same day on which the systems are operational to begin processing new applications pursuant to the director's determination described in paragraph (1).~~

~~(C) Beginning January 31, 2016, and until the director makes the determination described in paragraph (1), the department shall provide monthly updates to the appropriate policy and fiscal~~

~~committees of the Legislature on the status of the implementation of this section.~~

~~(b) After the director determines, and communicates that determination in writing to the Department of Finance, that systems have been programmed for implementation of this subdivision, but no sooner than July 1, 2019, an individual who is 19 to 25 years of age, inclusive, and who does not have satisfactory immigration status or is unable to establish satisfactory immigration status as required by Section 14011.2 shall be eligible for the full scope of Medi-Cal benefits, if they are otherwise eligible for benefits under this chapter.~~

~~(c) If in determining the projected budget condition for the upcoming fiscal year, the Department of Finance projects a positive ending balance in the Special Fund for Economic Uncertainties for the upcoming fiscal year and each of the ensuing three fiscal years that exceeds the cost of providing individuals who are 65 years of age or older, and who do not have satisfactory immigration statuses or are unable to establish satisfactory immigration statuses as required by Section 14011.2 for the full scope of Medi-Cal benefits, if they are otherwise eligible for benefits under this chapter, such benefits to such individuals shall be prioritized for inclusion in the budget for the upcoming fiscal year.~~

(b) (1) The eligibility and enrollment plan shall ensure, to the maximum extent possible, and for purposes of the Medi-Cal managed care delivery system, that an individual may maintain their primary care provider as their assigned primary care provider in the Medi-Cal managed care health plan's provider network without disruption if their primary care provider is a contracted in-network provider within that Medi-Cal managed care health plan. For county health care access programs that assign individuals to a medical home or a primary care provider, the department shall work with counties, Medi-Cal managed care health plans, health care providers, consumer advocates, and other interested stakeholders, to ensure that an individual may maintain their primary care provider as their assigned primary care provider upon their enrollment into the Medi-Cal program if their primary care provider is a contracted in-network provider within the applicable Medi-Cal managed care health plan.

(2) This paragraph does not limit the ability of an individual enrolled in Medi-Cal pursuant to this section to select a different

health care provider or, if there is more than one Medi-Cal managed care health plan available in the county where they reside, a different Medi-Cal managed care health plan, consistent with subdivision (g) of Section 14087.305 and paragraph (7) of subdivision (d) of Section 14089.

~~(d)~~

(c) To the extent permitted by state and federal law, an individual eligible under this section shall be required to enroll in a Medi-Cal managed care health plan. Enrollment in a Medi-Cal managed care health plan shall not preclude a beneficiary from being enrolled in any other children's Medi-Cal specialty program ~~that~~ *for which* they would otherwise be ~~eligible for.~~ *eligible.*

~~(e)~~

(d) (1) The department shall maximize federal financial participation in implementing this section to the extent allowable, and, for purposes of implementing this section, the department shall claim federal financial participation to the extent that the department determines it is available.

(2) To the extent that federal financial participation is not available, the department shall implement this section using state funds appropriated for this purpose.

~~(f)~~

(e) This section shall be implemented only to the extent it is in compliance with Section 1621(d) of Title 8 of the United States Code.

~~(g)~~

(f) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time any necessary regulations are adopted. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(2) Commencing six months after the effective date of this section, and notwithstanding Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

1 ~~(h)~~
2 *(g)* In implementing this section, the department may contract,
3 as necessary, on a bid or nonbid basis. This subdivision establishes
4 an accelerated process for issuing contracts pursuant to this section.
5 Those contracts, and any other contracts entered into pursuant to
6 this subdivision, may be on a noncompetitive bid basis and shall
7 be exempt from the following:
8 (1) Part 2 (commencing with Section 10100) of Division 2 of
9 the Public Contract Code and any policies, procedures, or
10 regulations authorized by that part.
11 (2) Article 4 (commencing with Section 19130) of Chapter 5
12 of Part 2 of Division 5 of Title 2 of the Government Code.
13 (3) Review or approval of contracts by the Department of
14 General Services.
15 *(h) The department shall provide monthly updates to the*
16 *appropriate policy and fiscal committees of the Legislature on the*
17 *status of the implementation of this section.*
18 SEC. 2. If the Commission on State Mandates determines that
19 this act contains costs mandated by the state, reimbursement to
20 local agencies and school districts for those costs shall be made
21 pursuant to Part 7 (commencing with Section 17500) of Division
22 4 of Title 2 of the Government Code.

O

ASSEMBLY BILL No. 32

Introduced by Assembly Member Aguiar-Curry
(Coauthors: Assembly Members Arambula, Bauer-Kahan, Burke, Cunningham, Cristina Garcia, Petrie-Norris, Quirk-Silva, Blanca Rubio, and Santiago)

December 7, 2020

An act to amend Section 1374.14 of the Health and Safety Code, to amend Section 10123.855 of the Insurance Code, and to amend Section 14087.95 of, and to add Sections 14092.4 and 14132.722 to, the Welfare and Institutions Code, relating to telehealth.

legislative counsel's digest

AB 32, as introduced, Aguiar-Curry. Telehealth.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, Medi-Cal services may be provided pursuant to contracts with various types of managed care health plans, including through a county organized health system. Under existing law, in-person contact between a health care provider and a patient is not required under the Medi-Cal program for services appropriately provided through telehealth. Existing law provides that neither face-to-face contact nor a patient's physical presence on the premises of an enrolled community clinic is required for services provided by the clinic to a Medi-Cal beneficiary during or immediately following a proclamation declaring a state of emergency. Existing law defines "immediately following" for this purpose to mean up to 90 days

following the termination of the proclaimed state of emergency, unless there are extraordinary circumstances.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a contract issued, amended, or renewed on or after January 1, 2021, between a health care service plan or health insurer and a health care provider to require the plan or insurer to reimburse the provider for the diagnosis, consultation, or treatment of an enrollee, subscriber, insured, or policyholder appropriately delivered through telehealth services on the same basis and to the same extent as the same service through in-person diagnosis, consultation, or treatment. Existing law requires a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2021, to specify that coverage is provided for health care services appropriately delivered through telehealth on the same basis and to the same extent as in-person diagnosis, consultation, or treatment. Existing law exempts Medi-Cal managed care plans that contract with the State Department of Health Care Services under the Medi-Cal program from these provisions, and generally exempts county organized health systems that provide services under the Medi-Cal program from Knox-Keene.

This bill would delete the above-described references to contracts issued, amended, or renewed on or after January 1, 2021, would require these provisions to apply to the plan or insurer's contracted entity, as specified, and would delete the exemption for Medi-Cal managed care plans. The bill would subject county organized health systems, and their subcontractors, that provide services under the Medi-Cal program to the above-described Knox-Keene requirements relative to telehealth. The bill would authorize a provider to enroll or recertify an individual in Medi-Cal programs through telehealth and other forms of virtual communication, as specified.

This bill would require the State Department of Health Care Services to indefinitely continue the telehealth flexibilities in place during the COVID-19 pandemic state of emergency. The bill would require the department, by January 2022, to convene an advisory group with specified membership to provide input to the department on the development of a revised Medi-Cal telehealth policy that promotes specified principles. The bill would require the department, by December 2024, to complete an evaluation to assess the benefits of telehealth in

Medi-Cal, including an analysis of improved access for patients, changes in health quality outcomes and utilization, and best practices for the right mix of in-person visits and telehealth. The bill would require the department to report its findings and recommendations from the evaluation to the appropriate policy and fiscal committees of the Legislature no later than July 1, 2025.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. (a) The Legislature finds and declares all of the
2 following:
3 (1) The Legislature has recognized the practice of telehealth as
4 a legitimate means by which an individual may receive health care
5 services from a health care provider without in-person contact with
6 the provider, and enacted protections in Section 14132.72 of the
7 Welfare and Institutions Code to prevent the State Department of
8 Health Care Services from restricting or limiting telehealth
9 services.
10 (2) The use of telehealth was expanded during the COVID-19
11 pandemic public health emergency and has proven to be an
12 important modality for patients to stay connected to their health
13 care providers. Telehealth has been especially critical for
14 California's Medi-Cal patients.
15 (3) Patients have reported high satisfaction with telehealth,
16 noting how easy it is to connect with their care teams without
17 having to take time off work, find childcare, or find transportation
18 to an in-person appointment.
19 (4) In addition to video access, audio-only care is essential
20 because many patients have reported challenges accessing video
21 technology due to limitations with data plans and internet access.
22 (5) Primary care and specialty care providers have found
23 telehealth to be a critical access point to address a variety of health
24 care needs, including helping patients manage chronic disease,
25 adjust pain medications, and for followup visits after a procedure,
26 among others.
27 (6) Behavioral health providers have found that offering
28 telehealth has engaged patients in necessary care they would never
29 have received if required to walk into a clinic.

(7) Health care providers have reported significant decreases in the number of missed appointments since telehealth became available, helping to ensure that patients receive high-quality care in a timely manner.

(8) Telehealth is widely available to individuals with health insurance in the commercial market, and existing law in Section 1374.14 of the Health and Safety Code and Section 10123.855 of the Insurance Code requires commercial health care service plans and health insurers to pay for services delivered through telehealth services on the same basis as equivalent services furnished in person. Medi-Cal must evolve with the rest of the health care industry to achieve health equity for low-income Californians.

(9) The expanded telehealth options that patients and providers have relied on during the COVID-19 pandemic should continue to be available to Medi-Cal recipients after the public health emergency is over.

(b) It is the intent of the Legislature to continue the provision of telehealth in Medi-Cal, including video and audio-only technology, for the purposes of expanding access and enhancing delivery of health care services for beneficiaries.

SEC. 2. Section 1374.14 of the Health and Safety Code is amended to read:

1374.14. (a) (1) A contract ~~issued, amended, or renewed on or after January 1, 2021,~~ between a health care service plan and a health care provider for the provision of health care services to an enrollee or subscriber shall specify that the health care service plan shall reimburse the treating or consulting health care provider for the diagnosis, consultation, or treatment of an enrollee or subscriber appropriately delivered through telehealth services on the same basis and to the same extent that the health care service plan is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment.

(2) This section does not limit the ability of a health care service plan and a health care provider to negotiate the rate of reimbursement for a health care service provided pursuant to a contract subject to this section. Services that are the same, as determined by the provider’s description of the service on the claim, shall be reimbursed at the same rate whether provided in person or through telehealth. When negotiating a rate of reimbursement for telehealth services for which no in-person

equivalent exists, a health care service plan and the provider shall ensure the rate is consistent with subdivision (h) of Section 1367.

(3) This section does not require telehealth reimbursement to be unbundled from other capitated or bundled, risk-based payments.

(4) If a health care service plan delegates responsibility for the performance of the duties described in this section to a contracted entity, including a medical group or independent practice association, then the delegated entity shall comply with this section.

(5) The obligation of a health care service plan to comply with this section shall not be waived if the plan delegates services or activities that the plan is required to perform to its provider or another contracting entity. A plan's implementation of this section shall be consistent with the requirements of the Health Care Providers' Bill of Rights, and a material change in the obligations of a plan's contracting network providers shall be considered a material change to the provider contract, within the meaning of subdivision (b) Section 1375.7.

(b) (1) A health care service plan contract ~~issued, amended, or renewed on or after January 1, 2021,~~ shall specify that the health care service plan shall provide coverage for health care services appropriately delivered through telehealth services on the same basis and to the same extent that the health care service plan is responsible for coverage for the same service through in-person diagnosis, consultation, or treatment. Coverage shall not be limited only to services delivered by select third-party corporate telehealth providers.

(2) This section does not alter the obligation of a health care service plan to ensure that enrollees have access to all covered services through an adequate network of contracted providers, as required under Sections 1367, 1367.03, and 1367.035, and the regulations promulgated thereunder.

(3) This section does not require a health care service plan to cover telehealth services provided by an out-of-network provider, unless coverage is required under other ~~provisions of~~ law.

(c) A health care service plan may offer a contract containing a copayment or coinsurance requirement for a health care service delivered through telehealth services, provided that the copayment or coinsurance does not exceed the copayment or coinsurance applicable if the same services were delivered through in-person

diagnosis, consultation, or treatment. This subdivision does not require cost sharing for services provided through telehealth.

(d) Services provided through telehealth and covered pursuant to this chapter shall be subject to the same deductible and annual or lifetime dollar maximum as equivalent services that are not provided through telehealth.

(e) The definitions in subdivision (a) of Section 2290.5 of the Business and Professions Code apply to this section.

~~(f) This section shall not apply to Medi-Cal managed care plans that contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) of, Chapter 8 (commencing with Section 14200) of, or Chapter 8.75 (commencing with Section 14591) of, Part 3 of Division 9 of the Welfare and Institutions Code.~~

SEC. 3. Section 10123.855 of the Insurance Code is amended to read:

10123.855. (a) (1) A contract ~~issued, amended, or renewed on or after January 1, 2021,~~ between a health insurer and a health care provider for an alternative rate of payment pursuant to Section 10133 shall specify that the health insurer shall reimburse the treating or consulting health care provider for the diagnosis, consultation, or treatment of an insured or policyholder appropriately delivered through telehealth services on the same basis and to the same extent that the health insurer is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment.

(2) This section does not limit the ability of a health insurer and a health care provider to negotiate the rate of reimbursement for a health care service provided pursuant to a contract subject to this section. Services that are the same, as determined by the provider's description of the service on the claim, shall be reimbursed at the same rate whether provided in person or through telehealth. When negotiating a rate of reimbursement for telehealth services for which no in-person equivalent exists, a health insurer and the provider shall ensure the rate is consistent with subdivision (a) of Section 10123.137.

(3) If a health insurer delegates responsibility for the performance of the duties described in this section to a contracted entity, including a medical group or independent practice association, then the delegated entity shall comply with this section.

(4) The obligation of a health insurer to comply with this section shall not be waived if the insurer delegates services or activities that the insurer is required to perform to its provider or another contracting entity. An insurer's implementation of this section shall be consistent with the requirements of the Health Care Providers' Bill of Rights, and a material change in the obligations of an insurer's contracting network providers shall be considered a material change to the provider contract, within the meaning of subdivision (b) Section 10133.65.

(b) (1) A policy of health insurance ~~issued, amended, or renewed on or after January 1, 2021,~~ that provides benefits through contracts with providers at alternative rates of payment shall specify that the health insurer shall provide coverage for health care services appropriately delivered through telehealth services on the same basis and to the same extent that the health insurer is responsible for coverage for the same service through in-person diagnosis, consultation, or treatment. Coverage shall not be limited only to services delivered by select third-party corporate telehealth providers.

(2) This section does not alter the existing statutory or regulatory obligations of a health insurer to ensure that insureds have access to all covered services through an adequate network of contracted providers, as required by Sections 10133 and 10133.5 and the regulations promulgated thereunder.

(3) This section does not require a health insurer to deliver health care services through telehealth services.

(4) This section does not require a health insurer to cover telehealth services provided by an out-of-network provider, unless coverage is required under other ~~provisions of~~ law.

(c) A health insurer may offer a policy containing a copayment or coinsurance requirement for a health care service delivered through telehealth services, provided that the copayment or coinsurance does not exceed the copayment or coinsurance applicable if the same services were delivered through in-person diagnosis, consultation, or treatment. This subdivision does not require cost sharing for services provided through telehealth.

(d) Services provided through telehealth and covered pursuant to this chapter shall be subject to the same deductible and annual or lifetime dollar maximum as equivalent services that are not provided through telehealth.

(e) The definitions in subdivision (a) of Section 2290.5 of the Business and Professions Code apply to this section.

SEC. 4. Section 14087.95 of the Welfare and Institutions Code is amended to read:

14087.95. ~~Counties~~ *(a) A county* contracting with the department pursuant to this article shall be exempt from ~~the provisions of~~ Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code for purposes of carrying out the contracts.

(b) (1) Notwithstanding subdivision (a), a county contracting with the department pursuant to this article shall comply with Section 1374.14 of the Health and Safety Code.

(2) If a county subcontracts for the provision of services pursuant to this article, as authorized under Section 14087.6, the subcontractor shall comply with Section 1374.14 of the Health and Safety Code.

SEC. 5. Section 14092.4 is added to the Welfare and Institutions Code, immediately following Section 14092.35, to read:

14092.4. For the purposes of enrolling patients in programs administered through Medi-Cal, including the Family Planning, Access, Care, and Treatment (Family PACT), presumptive eligibility Programs, accelerated enrollment programs, and the Medi-Cal Minor Consent program, a provider may determine program eligibility, enroll, and recertify patients remotely through telehealth and other virtual communication modalities, including telephone, based on the current Medi-Cal program criteria. The department may develop program policies and systems to support implementation of offsite eligibility determination, enrollment, and recertification.

SEC. 6. Section 14132.722 is added to the Welfare and Institutions Code, immediately following Section 14132.72, to read:

14132.722. (a) The department shall indefinitely continue the telehealth flexibilities in place during the COVID-19 pandemic, including those implemented pursuant to Section 14132.723.

(b) (1) By January 2022, the department shall convene an advisory group that includes representatives from community health centers, designated public hospitals, Medi-Cal managed

1 care plans, consumer groups, labor organizations, behavioral health
2 providers, counties, and other Medi-Cal providers.
3 (2) The advisory group shall provide input to the department
4 on the development of a revised Medi-Cal telehealth policy that
5 promotes all of the following principles:
6 (A) Telehealth shall be used as a means to promote timely and
7 patient-centered access to health care.
8 (B) Patients, in conjunction with their providers, shall be offered
9 their choice of service delivery mode. Patients shall retain the right
10 to receive health care in person.
11 (C) Confidentiality and security of patient information shall be
12 protected.
13 (D) Usual standard of care requirements shall apply to services
14 provided via telehealth, including quality, safety, and clinical
15 effectiveness.
16 (E) The department shall consider disparities in the utilization
17 of, and access to, telehealth, and shall support patients and
18 providers in increasing access to the technologies needed to use
19 telehealth.
20 (F) When the care provided during a telehealth visit is
21 commensurate with what would have been provided in person,
22 payment shall also be commensurate.
23 (c) (1) By December 2024, the department shall complete an
24 evaluation to assess the benefits of telehealth in Medi-Cal. The
25 evaluation shall analyze improved access for patients, changes in
26 health quality outcomes and utilization, and best practices for the
27 right mix of in-person visits and telehealth.
28 (2) The department shall report its findings and
29 recommendations on the evaluation to the appropriate policy and
30 fiscal committees of the Legislature no later than July 1, 2025.

O

SENATE BILL No. 17

Introduced by Senator Pan
(Principal coauthors: Assembly Members Arambula and Chiu)
(Coauthor: Senator Durazo)
(Coauthors: Assembly Members Robert Rivas and Weber)

December 7, 2020

An act relating to public health.

LEGISLATIVE COUNSEL'S DIGEST

SB 17, as introduced, Pan. Public health crisis: racism.

Existing law establishes an Office of Health Equity in the State Department of Public Health for purposes of aligning state resources, decisionmaking, and programs to accomplish certain goals related to health equity and protecting vulnerable communities. Existing law requires the office to develop department-wide plans to close the gaps in health status and access to care among the state's diverse racial and ethnic communities, women, persons with disabilities, and the lesbian, gay, bisexual, transgender, queer, and questioning communities, as specified. Existing law requires the office to work with the Health in All Policies Task Force to assist state agencies and departments in developing policies, systems, programs, and environmental change strategies that have population health impacts by, among other things, prioritizing building cross-sectoral partnerships within and across departments and agencies to change policies and practices to advance health equity.

This bill would state the intent of the Legislature to enact legislation to require the department, in collaboration with the Health in All Policies Program, the Office of Health Equity, and other relevant departments, agencies, and stakeholders, to address racism as a public health crisis.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. The Legislature finds and declares all of the
2 following:
3 (a) Racism is the systemic subordination of members of targeted
4 racial groups who have historically had relatively little social power
5 in the United States by members of the racial groups who have
6 more social power. Racism in the United States is informed by
7 over 400 years of Black slavery, settler colonialism, and American
8 neoimperialism.
9 (b) Racism, as a negative social system, is supported by the
10 actions of individuals, cultural norms and values, institutional
11 structures, practices of society, and laws and regulations imposed
12 by government.
13 (c) Through the "Three-Fifths Compromise," racism was
14 embedded as a founding principle in the United States Constitution.
15 It is an ugly stain that continues to haunt our nation and that we
16 must confront and actively dismantle.
17 (d) Public health is the science of protecting and improving the
18 health of people and their communities by promoting healthy
19 lifestyles, researching disease and injury prevention, and detecting,
20 preventing, and responding to infectious diseases.
21 (e) Many government policies, institutional practices, and
22 individual actions continue to be imbued, both consciously and
23 unconsciously, with racist assumptions and practices that have
24 created unhealthy physical and social conditions for Black,
25 Indigenous, and people of color (BIPOC) and thereby prevent
26 BIPOC communities from achieving good public health.
27 (f) For instance, the legacy of slavery, Jim Crow, and
28 discriminatory housing policies against Black people have
29 restricted the ability of Black families to build generational wealth,
30 in comparison to White families, leading to income inequality.
31 Income inequality and poverty have been well researched to be
32 negative social determinants of health. Children who grow up in
33 poverty, and especially those who are BIPOC, are more likely to
34 be exposed to risk factors for obesity, elevated blood lead levels,
35 and experience more adverse childhood experiences (ACEs).

1 (g) Racism in government policies, institutional practices, and
2 income inequality also results in BIPOC communities being more
3 likely to live near polluters, breathe polluted air, and be impacted
4 disproportionately by the effects of climate change. Breathing in
5 dangerous substances in the air has been linked to asthma, other
6 chronic respiratory illnesses, and some cancers. In California,
7 Black and Native American individuals have a significantly higher
8 prevalence of asthma and are more likely to experience an
9 avoidable hospitalization due to asthma.
10 (h) BIPOC communities experience racial disparities in
11 accessing health care and receiving quality care. For example,
12 Black women are three to four times more likely to die from
13 pregnancy-related causes than White women. Research indicates
14 these disparities persist in spite of income differences and can
15 often be attributed to Black women receiving discriminatory care,
16 such as health care providers dismissing symptoms raised by Black
17 women or racist assumptions about pain thresholds experienced
18 by Black people.
19 (i) Black transwomen suffer from employment, housing, and
20 educational discrimination and police brutality that result in the
21 most acute health disparities. Government policies, such as recent
22 federal actions that encourage homeless shelters, social services,
23 educational institutions, and health care providers to discriminate
24 against transgender people and overlook the deleterious impacts
25 of racism, actively prevent Black transwomen from accessing
26 services critical to achieving optimal health.
27 (j) On an individual physiological level, studies show that
28 chronic stress from individual and systemic acts of racism and
29 discrimination trigger high blood pressure, heart disease,
30 immunodeficiency, and result in accelerated aging.
31 (k) The COVID-19 pandemic, the ensuing economic crisis, and
32 recent protests against institutional violence committed against
33 Black communities again highlight the racial injustices and health
34 disparities that have long threatened BIPOC communities.
35 (*l*) In California, Black and Latino individuals are more likely
36 to have existing health conditions that make them more susceptible
37 to contracting COVID-19, experience more severe symptoms, and
38 suffer from higher mortality rates. BIPOC tend to work in essential
39 jobs that may lead to a higher likelihood of being exposed to

1 COVID-19, or in jobs that have an inability to work remotely and,
2 therefore, are more severely impacted by the economic crisis.
3 (m) Racism results in the underinvestment of social, health, and
4 educational services in BIPOC communities and an overinvestment
5 of disproportionate and inappropriate policing by law enforcement.
6 Racism threatens to endanger the health of individuals, the
7 community, and public health.
8 (n) Accordingly, California, joining a growing list of cities and
9 counties across the state and country to acknowledge the
10 long-standing impacts of systemic racism, declares racism as a
11 public health crisis. In order to advance and improve public health
12 for all Californians, the state must approach laws and regulations
13 with an antiracist, Health in All policy equity-driven focus that
14 interrogates whether policies play a role in upholding or
15 dismantling racist systems, and must secure adequate resources to
16 address the crisis.
17 SEC. 2. It is the intent of the Legislature to enact legislation
18 to require the State Department of Public Health, in collaboration
19 with the Health in All Policies Program, the Office of Health
20 Equity, and other relevant departments, agencies, and stakeholders,
21 to address racism as a public health crisis.

O

SENATE BILL No. 56

Introduced by Senator Durazo
(Principal coauthor: Assembly Member Arambula)

December 7, 2020

An act to amend Section 14007.8 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

SB 56, as introduced, Durazo. Medi-Cal: eligibility.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. The federal Medicaid program provisions prohibit payment to a state for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.

Existing law requires individuals under 19 years of age enrolled in restricted-scope Medi-Cal at the time the Director of Health Care Services makes a determination that systems have been programmed for implementation of these provisions to be enrolled in the full scope of Medi-Cal benefits, if otherwise eligible, and extends eligibility for full-scope Medi-Cal benefits to individuals under 25 years of age, and who are otherwise eligible for those benefits but for their immigration status. Existing law makes the effective date of enrollment for those individuals the same day that systems are operational to begin processing new applications pursuant to the director's determination, and requires the department to maximize federal financial participation for purposes of implementing the requirements. Existing law provides that Medi-Cal benefits for individuals who are 65 years of age or older, and who do

not have satisfactory immigration statuses or are unable to establish satisfactory immigration statuses, will be prioritized in the Budget Act for the upcoming fiscal year if the Department of Finance projects a positive ending balance in the Special Fund for Economic Uncertainties for the upcoming fiscal year and each of the ensuing 3 fiscal years that exceeds the cost of providing those individuals full scope Medi-Cal benefits.

This bill would, subject to an appropriation by the Legislature, and effective July 1, 2022, extend eligibility for full-scope Medi-Cal benefits to individuals who are 65 years of age or older, and who are otherwise eligible for those benefits but for their immigration status. The bill would delete provisions delaying implementation until the director makes the determination described above. The bill would require the department to seek federal approvals to obtain federal financial participation to implement these requirements. Because counties are required to make Medi-Cal eligibility determinations and this bill would expand Medi-Cal eligibility, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 14007.8 of the Welfare and Institutions Code is amended to read:

14007.8. (a) (1) ~~After the director determines, and communicates that determination in writing to the Department of Finance, that systems have been programmed for implementation of this section, but no sooner than May 1, 2016, an~~ *An* individual who is under 19 years of age and who does not have satisfactory immigration status or is unable to establish satisfactory immigration status as required by Section 14011.2 shall be eligible for the full

scope of Medi-Cal benefits, if they are otherwise eligible for benefits under this chapter.

(2) No sooner than July 1, 2021, an individual who is 19 to 25 years of age, inclusive, and who does not have satisfactory immigration status or is unable to establish satisfactory immigration status as required by Section 14011.2 shall be eligible for the full scope of Medi-Cal benefits, if they are otherwise eligible for benefits under this chapter.

(3) (A) Effective July 1, 2022, an individual who is 65 years of age or older, and who does not have satisfactory immigrant status or is unable to establish satisfactory immigration status as required by Section 14011.2, shall be eligible for the full scope of Medi-Cal benefits, if they are otherwise eligible for benefits under this chapter.

(B) Implementation of this paragraph shall be subject to an appropriation in the annual Budget Act or any other act approved by the Legislature for the express purpose of this paragraph.

(4) (A) An individual enrolled in the Medi-Cal program pursuant to this section and subdivision (d) of Section 14007.5 shall not be required to file a new application for the Medi-Cal program.

~~(2) (A) An individual under 19 years of age enrolled in Medi-Cal pursuant to subdivision (d) of Section 14007.5 at the time the director makes the determination described in paragraph (1) shall be enrolled in the full scope of Medi-Cal benefits, if otherwise eligible,~~

(B) The enrollment specified in subparagraph (A) shall be complete pursuant to an eligibility and enrollment ~~plan. This plan~~ *plan, and* shall include outreach strategies developed by the department in consultation with interested stakeholders, including, but not limited to, counties, health care service plans, *health care providers,* consumer advocates, and the Legislature. ~~An individual subject to this subparagraph shall not be required to file a new application for Medi-Cal.~~

~~(B) The effective date of enrollment into Medi-Cal for an individual described in subparagraph (A) shall be on the same day on which the systems are operational to begin processing new applications pursuant to the director's determination described in paragraph (1).~~

(C) ~~Beginning January 31, 2016, and until the director makes the determination described in paragraph (1), the~~*The* department shall provide monthly updates to the appropriate policy and fiscal committees of the Legislature on the status of the implementation of this section.

~~(b) After the director determines, and communicates that determination in writing to the Department of Finance, that systems have been programmed for implementation of this subdivision, but no sooner than July 1, 2019, an individual who is 19 to 25 years of age, inclusive, and who does not have satisfactory immigration status or is unable to establish satisfactory immigration status as required by Section 14011.2 shall be eligible for the full scope of Medi-Cal benefits, if they are otherwise eligible for benefits under this chapter.~~

~~(c)~~

(b) If in determining the projected budget condition for the upcoming fiscal year, the Department of Finance projects a positive ending balance in the Special Fund for Economic Uncertainties for the upcoming fiscal year and each of the ensuing three fiscal years that exceeds the cost of providing individuals who are 65 years of age or older, and who do not have satisfactory immigration statuses or are unable to establish satisfactory immigration statuses as required by Section 14011.2 for the full scope of Medi-Cal benefits, if they are otherwise eligible for benefits under this chapter, such benefits to such individuals shall be prioritized for inclusion in the budget for the upcoming fiscal year.

~~(d)~~

(c) To the extent permitted by state and federal law, an individual eligible under this section shall be required to enroll in a Medi-Cal managed care health plan. Enrollment in a Medi-Cal managed care health plan shall not preclude a beneficiary from being enrolled in any other children's Medi-Cal specialty program that they would otherwise be eligible for.

~~(e) (1)~~

(d) The department shall ~~maximize~~ *seek any necessary federal approvals to obtain* federal financial participation in implementing this ~~section to the extent allowable, and, for purposes of implementing this section, the department shall claim federal financial participation to the extent that the department determines it is available.~~ *section. Benefits for services under this section shall*

be provided with state-only funds if federal financial participation is unavailable for those services.

~~(2) To the extent that federal financial participation is not available, the department shall implement this section using state funds appropriated for this purpose.~~

~~(f)~~

(e) This section shall be implemented only to the extent it is in compliance with Section 1621(d) of Title 8 of the United States Code.

~~(g)~~

(f) (1) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, without taking any further regulatory action, shall implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions until the time any necessary regulations are adopted. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(2) ~~Commencing six months after the effective date of this section, and notwithstanding~~ *Notwithstanding* Section 10231.5 of the Government Code, the department shall provide a status report to the Legislature on a semiannual basis, in compliance with Section 9795 of the Government Code, until regulations have been adopted.

~~(h)~~

(g) In implementing this section, the department may contract, as necessary, on a bid or nonbid basis. This subdivision establishes an accelerated process for issuing contracts pursuant to this section. Those contracts, and any other contracts entered into pursuant to this subdivision, may be on a noncompetitive bid basis and shall be exempt from the following:

(1) Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code and any policies, procedures, or regulations authorized by that part.

(2) Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code.

(3) Review or approval of contracts by the Department of General Services.

1 SEC. 2. If the Commission on State Mandates determines that
2 this act contains costs mandated by the state, reimbursement to
3 local agencies and school districts for those costs shall be made
4 pursuant to Part 7 (commencing with Section 17500) of Division
5 4 of Title 2 of the Government Code.

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SENATE BILL No. 57

Introduced by Senator Wiener
(Principal coauthors: Assembly Members Chiu, Friedman, and Kamlager)
(Coauthor: Senator Eggman)
(Coauthors: Assembly Members Bonta, Carrillo, Ting, and Wicks)

December 7, 2020

An act to add and repeal Section 11376.6 of the Health and Safety Code, relating to controlled substances.

LEGISLATIVE COUNSEL'S DIGEST

SB 57, as introduced, Wiener. Controlled substances: overdose prevention program.

Existing law makes it a crime to possess specified controlled substances or paraphernalia. Existing law makes it a crime to use or be under the influence of specified controlled substances. Existing law additionally makes it a crime to visit or be in any room where specified controlled substances are being unlawfully used with knowledge that the activity is occurring, or to open or maintain a place for the purpose of giving away or using specified controlled substances. Existing law makes it a crime for a person to rent, lease, or make available for use any building or room for the purpose of storing or distributing any controlled substance. Existing law authorizes forfeiture of property used for specified crimes involving controlled substances.

This bill would, until January 1, 2027, authorize the City and County of San Francisco, the County of Los Angeles, and the City of Oakland to approve entities to operate overdose prevention programs for persons that satisfy specified requirements, including, among other things, providing a hygienic space supervised by trained staff where people who use drugs can consume preobtained drugs, providing sterile

consumption supplies, and providing access or referrals to substance use disorder treatment. The bill would require the City and County of San Francisco, the County of Los Angeles, and the City of Oakland, prior to authorizing an overdose prevention program in its jurisdiction, to provide local law enforcement officials, local public health officials, and the public with an opportunity to comment in a public meeting. The bill would require an entity operating a program to provide an annual report to the city or the city and county, as specified. The bill would exempt a person from, among other things, civil liability, professional discipline, or existing criminal sanctions, solely for actions, conduct, or omissions in compliance with an overdose prevention program authorized by the city or the city and county.

This bill would make legislative findings and declarations as to the necessity of a special statute for the City and County of San Francisco, the County of Los Angeles, and the City of Oakland.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. The Legislature finds and declares all of the
2 following:
3 (a) Overdose deaths in California are an urgent public health
4 crisis. Overdose has been the leading cause of accidental death in
5 the United States and in California each year since 2011.
6 (b) The COVID-19 pandemic has been associated with a rapid
7 increase in drug overdose deaths. According to data published in
8 the article "Drug overdoses are soaring during the coronavirus
9 pandemic" by the Washington Post, overdoses increased every
10 month in fall of 2020 compared to the prior year. In May 2020,
11 the increase was 42 percent compared to the prior year.
12 (c) Overdose prevention programs (OPPs) are an evidence-based
13 harm reduction strategy that allows individuals to consume drugs
14 in a hygienic environment under the supervision of staff trained
15 to intervene if the individual overdoses. OPPs also provide sterile
16 consumption equipment and offer general medical advice and
17 referrals to substance use disorder treatment, housing, medical
18 care, and other community social services.
19 (d) There are approximately 165 overdose prevention programs
20 operating in 10 countries around the world. Numerous

1 peer-reviewed studies have confirmed that OPPs are effective in
2 reducing overdose deaths and HIV transmission, and in increasing
3 access to counseling, treatment, and other risk reduction services.
4 Research has also demonstrated that OPPs decrease use of
5 emergency medical services, reduce public drug use, reduce syringe
6 debris, and do not increase crime or drug use.
7 (e) In July 2020, the American Medical Association (AMA)
8 joined several associations representing health officials and public
9 health, drug policy, and substance use disorder treatment
10 specialists, in an amicus brief supporting an OPP in Philadelphia,
11 Pennsylvania. The AMA and others wrote that, "Supervised
12 consumption sites are an evidence-based medical and public health
13 intervention with the potential to improve individual and
14 community health."
15 (f) On July 8, 2020, the New England Journal of Medicine
16 published a study on the outcomes of an unsanctioned OPP
17 operating in the United States from 2014 to 2019, inclusive. The
18 study and supplemental material show that not only were there no
19 deaths resulting from over 10,000 injections, but that it was not
20 once necessary in five years to call for paramedic services or use
21 an outside medical facility. The authors conclude that, "sanctioned
22 safe consumption sites in the United States could reduce mortality
23 from opioid-involved overdose. Sanctioning sites could allow
24 persons to link to other medical and social services, including
25 treatment for substance use, and facilitate rigorous evaluation of
26 their implementation and effect on reducing problems such as
27 public injection of drugs and improperly discarded syringes."
28 (g) An analysis published in the Journal of Drug Issues in 2016
29 found that, based on the experience of an OPP in Vancouver, a
30 proposed program in San Francisco would reduce government
31 expenses associated with health care, emergency services, and
32 crime, saving $2.33 for every dollar spent. It is estimated that one
33 OPP would save the City and County of San Francisco $3,500,000
34 in other costs.
35 (h) As demands for reform of the criminal justice and legal
36 system reverberate around the country, OPPs offer an alternative
37 framework for addressing both drug use as well as the enforcement
38 of drug laws that disproportionately injures communities of color.
39 OPPs bring people inside to a safe and therapeutic space, instead

of leaving them vulnerable to police intervention, arrest, and incarceration.

(i) In July 2020, California law enforcement leadership, including district attorneys of the Counties of Los Angeles, San Francisco, Santa Clara, and Contra Costa, signed onto an amicus brief in support of an OPP in Philadelphia, Pennsylvania, writing, "The issues are particularly acute at this current moment, with a global pandemic and fractured relations between law enforcement and communities. There is an urgent need to fortify trust in the justice system. Failing to address the loss of life resulting from drug overdose-and criminalizing a community based public health organization working to save lives-will further erode trust. If there were ever a time to demonstrate that the justice system values the dignity of human life, that time is now."

(j) Also in July 2020, California Attorney General Xavier Becerra joined an amicus brief with eight other states and the District of Columbia, in support of an OPP. In the brief, the attorneys general wrote, "After studying SIS [safe injection services] interventions in other countries, many states and cities are considering them as a means of saving lives. The studies predict that the sites will reduce deaths, the spread of bloodborne diseases, and costs. And they are a unique solution to the common problem in many urban areas of rapid, unintended overdoses of heroin or fentanyl."

(k) It is the intent of the Legislature to promote the health and safety of communities by evaluating the health impacts of OPPs in San Francisco, Los Angeles, and Oakland.

(*l*) It is the intent of the Legislature to prevent fatal and nonfatal drug overdoses, reduce drug use by providing a pathway to drug treatment, as well as medical and social services for high-risk drug users, many of whom are homeless, uninsured, or very low income, prevent the transmission of HIV and hepatitis C, reduce nuisance and public safety problems related to public use of controlled substances, and reduce emergency room use and hospital utilization related to drug use, reserving precious space, including intensive care beds for treatment of COVID-19 and other life-threatening conditions.

(m) It is the intent of the Legislature that OPPs should be evaluated in California cities that authorize them, as OPPs show great promise to save lives, enhance public safety, improve access

1 to substance use disorder treatment, medical care, and related
2 services, reduce emergency department and hospital utilization
3 related to drug overdose, and reduce the human, social, and
4 financial costs of the triple epidemics of drug misuse,
5 homelessness, and COVID-19.
6 SEC. 2. Section 11376.6 is added to the Health and Safety
7 Code, to read:
8 11376.6. (a) Notwithstanding any other law, the City and
9 County of San Francisco, the County of Los Angeles, and the City
10 of Oakland may approve entities within their jurisdictions to
11 establish and operate overdose prevention programs that satisfy
12 the requirements set forth in subdivision (c).
13 (b) Prior to approving an entity within its jurisdiction pursuant
14 to subdivision (a), the City and County of San Francisco, the
15 County of Los Angeles, or the City of Oakland shall provide local
16 law enforcement officials, local public health officials, and the
17 public with an opportunity to comment in a public meeting. The
18 notice of the meeting to the public shall be sufficient to ensure
19 adequate participation in the meeting by the public. The meeting
20 shall be noticed in accordance with all state laws and local
21 ordinances, and as local officials deem appropriate.
22 (c) In order for an entity to be approved to operate an overdose
23 prevention program pursuant to this section, the entity shall
24 demonstrate that it will, at a minimum:
25 (1) Provide a hygienic space to consume controlled substances
26 under supervision of staff trained to prevent and treat drug
27 overdoses.
28 (2) Provide sterile consumption supplies, collect used equipment,
29 and provide secure hypodermic needle and syringe disposal
30 services.
31 (3) Monitor participants for potential overdose and provide care
32 as necessary to prevent fatal overdose.
33 (4) Provide access or referrals to substance use disorder
34 treatment services, primary medical care, mental health services,
35 and social services.
36 (5) Educate participants on preventing transmission of HIV and
37 viral hepatitis.
38 (6) Provide overdose prevention education and access to or
39 referrals to obtain naloxone hydrochloride or another overdose

1 reversal medication approved by the United States Food and Drug
2 Administration.
3 (7) Educate participants regarding proper disposal of hypodermic
4 needles and syringes and provide participants with approved
5 biohazard containers for syringe disposal.
6 (8) Provide reasonable security of the program site.
7 (9) Establish operating procedures for the program including,
8 but not limited to, standard hours of operation, training standards
9 for staff, a minimum number of personnel required to be onsite
10 during those hours of operation, the maximum number of
11 individuals who can be served at one time, and an established
12 relationship with the nearest emergency department of a general
13 acute care hospital, as well as eligibility criteria for program
14 participants.
15 (10) Establish and make public a good neighbor policy that
16 facilitates communication from and to local businesses and
17 residences, to the extent they exist, to address any neighborhood
18 concerns and complaints.
19 (d) An entity operating an overdose prevention program under
20 this section shall provide an annual report to the authorizing
21 jurisdiction that shall include all of the following:
22 (1) The number of program participants.
23 (2) Aggregate information regarding the characteristics of
24 program participants.
25 (3) The number of overdoses experienced and the number of
26 overdoses reversed onsite.
27 (4) The number of persons referred to substance use disorder
28 treatment, primary medical care, and other services.
29 (e) Notwithstanding any other law, a person or entity, including,
30 but not limited to, property owners, managers, employees,
31 volunteers, clients or participants, and employees of the City and
32 County of San Francisco, the County of Los Angeles, or the City
33 of Oakland acting in the course and scope of employment, shall
34 not be arrested, charged, or prosecuted pursuant to Section 11350,
35 11364, 11365, 11366, 11366.5, or 11377, or subdivision (a) of
36 Section 11550, including for attempt, aiding and abetting, or
37 conspiracy to commit a violation of any of those sections, or be
38 subjected to any civil or administrative penalty or liability,
39 including property forfeiture or disciplinary action by a professional
40 licensing board, or otherwise be penalized solely for actions,

1 conduct, or omissions related to the operation of and on the site
2 of an overdose prevention program approved by the City and
3 County of San Francisco, the County of Los Angeles, or the City
4 of Oakland, or for conduct relating to the approval of an entity to
5 operate an overdose prevention program, or the inspection,
6 licensing, or other regulation of an overdose prevention program
7 approved by the City and County of San Francisco, the County of
8 Los Angeles, or the City of Oakland pursuant to subdivision (a).
9 (f) This section shall remain in effect only until January 1, 2027,
10 and as of that date is repealed.
11 SEC. 3. The Legislature finds and declares that a special statute
12 is necessary and that a general statute cannot be made applicable
13 within the meaning of Section 16 of Article IV of the California
14 Constitution because of the unique needs of the City and County
15 of San Francisco, the County of Los Angeles, and the City of
16 Oakland.

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LOS ANGELES COUNTY

Governor's FY 2021-22 Proposed Budget Executive Summary

January 8, 2021

OVERVIEW

Today, Governor Gavin Newsom released his Fiscal Year (FY) 2021-22 Proposed State Budget (Proposed Budget), which projects a beginning State General Fund (SGF) balance surplus of $12.2 billion from FY 2020-21, total revenues and transfers of $170.6 billion, total expenditures of $164.5 billion, and a year-end fund balance of $6.1 billion. Of the projected year-end surplus, $3.1 billion would be allocated to the Reserve for Liquidation of Encumbrances and $2.9 billion would be deposited to the Special Fund for Economic Uncertainties. The Proposed Budget also allocates $3.0 billion to the Public School System Stabilization Account and $450.0 million to the Safety Net Reserve. The Budget Stabilization Account, better known as the Rainy Day Fund, would increase to $15.6 billion by the end of FY 2021-22.

The Proposed Budget reflects the Governor's priorities, including: $2.4 billion for $600.00 payments to low-income workers; $2.0 billion for the safe reopening of schools beginning in February 2021; $1.75 billion in one-time SGF to purchase additional motels, develop short-term community mental facilities, and purchase or preserve housing dedicated for seniors; $1.5 billion for infrastructure and zero-emission vehicle goals; $1.1 billion in immediate relief for small businesses; $775.5 million to accelerate investment and job creation; an additional $575.0 million for grants to small businesses impacted by the pandemic; $500.0 million for infill structure and an additional $500.0 million in low-income housing tax credits; $400.0 million ongoing to expand early education and child care; $300.0 million for COVID-19 vaccinations; $353.0 million for workforce development; $300.0 million in one-time SGF for toxic site cleanup and investigations, including $31.4 million to assist with the cleanup of residential properties that surround the Exide facility; and $70.0 million for small business relief, among others.

MAJOR PROPOSALS OF COUNTY INTEREST

Below are items in the Governor's Proposed Budget of major interest to the County. **The Chief Executive Office – Legislative Affairs and Intergovernmental Relations Branch is currently working with affected departments to determine potential County impact.** The Proposed Budget includes:

HOMELESSNESS AND HOUSING

Emergency Rental Assistance – Proposes early action to deploy the State's Federal Emergency Rental Assistance (ERA) allocation ($1.4 billion) to assist low-income tenants stay housed and help stabilize small property owners. This ERA funding was approved as part of the recently enacted Federal Fiscal Year 2021 omnibus spending and COVID-19 relief bill (H.R. 133).

Eviction Moratorium Extension – Proposes immediate extension of the eviction protections enacted by AB 3088 (Chapter 37, Statutes of 2020). Without immediate action, the moratorium expires on January 31, 2021.

Trial Courts – $11.7 million in one-time SGF to process anticipated increase in unlawful detainer claims.

Homelessness – $750.0 million in one-time SGF for competitive grants for local governments to purchase and rehabilitate housing, including hotels, motels, vacant apartment buildings, and other buildings, and convert them into interim or permanent long-term housing. Proposes early action on $250.0 million of that funding to continue funding Project Homekey sites.

Expanded Facilities to Support Housing – $250.0 million in one-time SGF for counties to acquire and rehabilitate Adult Residential Facilities and Residential Care Facilities for the elderly, with a specific focus on preserving and expanding housing for low-income seniors.

Fair Housing Enforcement – $2.0 million SGF for the State to conduct outreach education campaigns, housing surveys, and prosecute violation of anti-housing discrimination laws.

Infill Infrastructure Grant (IIG) Program – $500.0 million for IIG grants to local governments and developers to defray the costs for things like sewers, roads and site preparation. $250.0 million of these funds are proposed for early action.

Low Income Housing Tax Credit – $500.0 million to support low-income housing development.

Excess State Land Development – Proposes statutory changes to encourage the authorization of market-rate and commercial development that will provide flexibility and financial feasibility to subsidize fair and affordable housing production on excess lands.

JUSTICE

Community Care Demonstration Project for Felony Incompetent to Stand Trial (IST) (CCDP-IST) – $233.2 million SGF in FY 2021-22 and $136.4 million SGF in FY 2022-23 and ongoing, to contract with three counties to provide a continuum of services to felony ISTs in the county as opposed to State hospitals. The proposal seeks to demonstrate the effectiveness of streamlining services to drive improved outcomes for individuals with serious mental illness. The proposal is projected to serve up to 1,252 ISTs in the county continuum of care settings in FY 2021-22.

Reappropriation and Expansion of the IST Program – $46.4 million one-time SGF, available over three years, to expand the current IST Diversion program in both current and new counties, in addition to five-year limited-term funding of $1.2 million SGF annually to support research and administration for the program. The Proposed Budget also authorizes the reappropriation of existing program funds set to expire in FY 2020-21.

Expansion of Community Based Restoration (CBR) – $9.8 million SGF in FY 2020-21, $4.5 million SGF in FY 2021-22, and $5.0 million SGF in FY 2022-23 and ongoing to expand the current Los Angeles County CBR program beginning in FY 2020-21 and establish new CBR programs in additional counties in FY 2021-22. This proposal is projected to increase capacity by up to 250 beds in FY 2021-22.

Local Jail Funding – $163.4 million estimated SGF for additional reimbursement to county sheriffs and corrections departments though June 30, 2021 due to the suspension of intake and/or transfer of inmates to State prisons to reduce the risk of COVID-19 entering the State prison system.

Police Use of Force Investigations – $13.0 million SGF, increasing to $13.5 million ongoing SGF, to establish three teams, one in the northern, central, and southern regions, to conduct investigations statewide.

Probation Reform – $122.9 million ongoing SGF to county probation departments, based on the highest payment to individual counties over the prior three fiscal years, to support efforts to reduce or maintain low revocation rates while recognizing the impacts of the COVID-19 pandemic and changes to statewide probation policy.

Juvenile Justice Realignment – $46.5 million SGF in FY 2021-22 to support the implementation of SB 823 (Chapter 337, Statutes of 2020) and the transition of wards from the Division of Juvenile Justice (DJJ) to county probation departments beginning June 30, 2021. The Proposed Budget also provides future FY allocations of $122.9 million SGF in FY 2022-23, $195.9 million SGF in FY 2023-24, and $212.7 million SGF ongoing beginning in FY 2024-25.

Post-Release Community Supervision – $19.5 million one-time SGF for county probation departments to supervise the temporary increase in the average daily population of offenders on Post-Release Community Supervision as a result of implementation of Proposition 57.

HEALTH AND BEHAVIORAL HEALTH

California Advancing and Innovating Medi-Cal (CalAIM) Initiative – $1.1 billion ($531.9 million SGF) in FY 2021-22, growing to $1.5 billion ($755.5 billion SGF) in FY 2023-23 to implement the CalAIM initiative, which includes California's Medicaid Section 1115 and 1915(b) Waivers, effective January 1, 2022. This is an increase from the amount previously proposed in the Governor's FY 2020-21 Proposed Budget. The proposal notes that CalAIM will include enhanced care management and in lieu of services, infrastructure to expand whole person care approaches statewide, and build upon dental initiatives.

Behavioral Health Continuum Infrastructure – $750.0 million in one-time SGF for competitive grants to counties, available over three years, to acquire and rehabilitate real estate assets to expand the community continuum of behavioral health treatment resources. These community resources are needed to address individuals experiencing a crisis and are a critical component of an overarching framework to solve and not just mitigate homelessness. Counties will be required to provide a match of local funds.

Proposes $250.0 million one-time SGF to the California Department of Social Services for the acquisition or rehabilitation of Adult Residential Facilities (ARF) and Residential Care Facilities for the Elderly (RCFE), commonly referred to as board and care facilities, with a focus on preserving and expanding housing for low-income seniors.

The Proposed Budget also includes the Administration's proposal to explore repurposing relinquished adult jail bond financing to invest in short-term residential mental health facilities, with approximately $202.0 million currently available for reallocation.

Mental Health Services Act (MHSA) Flexibilities – Proposes statutory changes to extend for one additional fiscal year the flexibilities in county spending of MHSA funds from the FY 2020 State Budget Act in response to the ongoing pandemic. Authorizes counties to use their existing approved MHSA spending plans, if a new plan is delayed because of COVID-19-related reasons.

Telehealth – $94.8 million ($34.0 million SGF) to expand and make permanent certain Medi-Cal telehealth flexibilities authorized during the pandemic, and to add remote patient monitoring as a new covered benefit, effective July 1, 2021.

Medi-Cal Benefits and Services – Proposes to delay the suspension of Medi-Cal covered benefits and services for 12 months until 2021, including: $27.1 million SGF to delay the suspension of Medi-Cal post-partum extended eligibility, and $47.0 million ($15.6 million SGF) to delay the suspension of audiology and speech therapy services, incontinence creams and washes, optician and optical lab services, and podiatric services.

PUBLIC HEALTH

COVID-19 Vaccination Efforts – $300.0 million as an initial estimate for vaccine distribution, including for a public awareness campaign to increase vaccine adoption.

License and Certification – $19.1 million for the third year of the County's contract with the State to conduct licensing, certification, and inspection of approximately 3,200 health care facilities in the County, and $4.5 million to support increased medical breach and caregiver investigation workload.

Health Equity – Proposes initiatives to address health inequities, including $1.7 million in SGF in FY 2021-22 and $154,000 SGF in 2022-23 and ongoing for the State to conduct an analysis of the intersection of COVID-19, health disparities, and health equity to help inform any future response.

ECONOMIC AND WORKFORCE DEVELOPMENT

Proposes an **Equitable Recovery for California's Businesses and Jobs** plan to help the State through the COVID-19 pandemic and advance an equitable, broad-based recovery.

Small Business Grants – An additional $575.0 million on top of the $500.0 million approved for the State's Small Business COVID-19 Relief Grant program to offer grant up to $25,000 to micro and small businesses, distributed across the State, with priority given to regions and industries impacted by the COVID-19 pandemic, disadvantaged

communities and underserved small business groups. $25.0 million will be set aside for small cultural institutions such as museums and art galleries.

California Jobs Initiative – $775.0 million for job creation and retention, regional development, small businesses and climate innovation, including:

- $430.0 million to incentivize businesses to locate in California, create jobs, and support job creation and investments in infrastructure;
- $100.0 million to encourage hiring new employees and rehiring former employees;
- $100.0 million in expanded sales tax exclusions to reduce the cost of manufacturing equipment and promote innovation and meet the State's climate goals;
- $100.0 million to provide small business loan and disaster loan guarantees;
- $35.0 million to seed entrepreneurship and small business creation in underserved communities;
- $12.5 million to support low-interest loans to underserved businesses; and to
- Mitigate the State and Local Tax deduction limitation for S-Corporation shareholders.

Workforce Development – $353.0 million in one-time and ongoing investments to support workforce strategies, including apprenticeships and High-Road Training Partnerships and demand-driven workforce programs in key sectors like health care and technology.

Fee Waivers – $70.6 million for individuals and businesses most impacted by the pandemic, including barbers, cosmetologists, manicurists, bars and restaurants.

California Dream Fund – $35.0 million one-time SGF to support micro-grants up to $10,000 to seed entrepreneurship and small business creation in underserved groups that are facing opportunity gaps. The Administration requests the Legislature take action in early 2021.

SOCIAL SERVICES

In-Home Supportive Services (IHSS) Hour Restoration – $449.8 million SGF in FY 2021-22 and $242.6 million SGF in FY 2022-23 to delay suspending the seven percent across-the-board reduction to IHSS service hours until December 31, 2021. The suspension may be lifted if the Administration determines through the 2022 State Budget Act process that there is sufficient SGF revenue to support all suspended programs in the subsequent two fiscal years.

State Minimum Wage – $1.2 billion ($557.6 million SGF) to support planned minimum wage increases of $14.00 per hour on January 1, 2021 and $15.00 per hour on January 1, 2022.

IHSS County Administration – $17.8 million SGF to reflect caseload and California Consumer Price Index (CCPI) adjustments.

CalWORKs Grant Increase – $50.1 million in FY 2021-22 to reflect a 1.5 percent increase to the CalWORKs Maximum Aid Payment (MAP) levels, effective October 1, 2021, funded entirely by the Child Poverty and Family Supplemental Support Subaccounts and the Local Revenue Fund.

CalWORKs Time on Aid Exemption – $46.1 million in one-time Temporary Assistance for Needy Families (TANF) block grant funding to temporarily suspend any month in which CalWORKs aid or services are received from counting towards the CalWORKs 48-month time limit based on a good cause exemption due to the COVID-19 pandemic.

Medi-Cal County Administration – $65.4 million ongoing increase ($22.9 million SGF) for county eligibility determination activities based on growth in the CCPI.

Food Banks – $30.0 million in one-time SGF above program-based funding levels to fund existing Emergency Food Assistance Program providers, food banks, tribes, and tribal organizations to mitigate increases in food needs among low-income and food-insecure populations.

Supplemental Nutrition Benefit and Transition Nutrition Benefit Program Adjustments – $22.3 million in ongoing SGF to reflect adjusted benefit amounts to mitigate the effects of the elimination of the Social Security Income (SSI) Cash-Out policy.

California Food Assistance Program (CFAP) – $11.4 million in one-time SGF for CFAP households to receive the maximum allowable allotment based on household size.

Supplemental Security Income/State Supplementary Payment (SSI/SP) – $2.69 billion SGF in FY 2021-22 which represents a 0.6 percent decrease from the revised FY 2020-21 levels. Effective January 2021, the maximum SSI/SS monthly grant levels will increase by approximately $17.00 and $26.00 for individuals and couples, respectively.

EARLY CHILDHOOD

Child Development – $3.1 billion ($1.3 billion SGF) for local assistance and to shift programs to the California Department of Social Services that include General Child Care and Alternate Payment Programs, among others.

Early Care and Education – Proposes the following investments:

- $250.0 million in one-time Proposition 98 General Funds for incentive funds for districts to expand high-quality transitional kindergarten programs;
- $200.0 million in one-time SGF to construct and retrofit transitional kindergarten and kindergarten facilities;
- $50.0 million in one-time SGF one-time Proposition 98 General Funds for professional development focused on preparing teachers for early childhood programs;
- $44.0 million ongoing Cannabis Funds for 4,500 additional child care vouchers, including $21.5 million in FY 2020-21; and
- $15.0 million SGF, of which $3.0 million is one-time, to support the Cradle-to-Career Data System.

Support for COVID-19 – $55.0 million one-time SGF to support the needs of child care providers and families resulting from COVID-19 in addition to approximately $1.0 billion the State is estimated to receive for child care and Early Start from the recently enacted Federal COVID-19 relief bill (H.R. 133).

CHILDREN AND FAMILIES

Child Welfare Services – $700.1 million SGF for family support and maltreatment prevention services, child protective services, foster care services, and adoptions including:

- $61.1 million SGF for COVID-19 related supports related to quarantine needs for foster youth and caregivers, temporary extension of assistance payments to emergency caregivers, support to Family Resource Center, assistance to families with youth who are at-risk of foster care entry, and temporary provision of assistance payments to youth turning 21 years while in extended foster care after April 17, 2020 through December 31, 2021;
- $61.1 million ($42.7 million SGF) to begin implementation of new criteria for non-foster home placement settings eligible for Federal Title IV-E reimbursement under the Family First Prevention Services Act;
- $10.1 million ($5.9 million SGF) ongoing to establish an additional child welfare social workers regional training academy in northern California to bring the statewide total to five academies; and
- $54.5 million SGF estimated to extend the temporary augmentation to programs that include the Emergency Child Care Bridge Program and Child Welfare Public Health Nursing Early Intervention Program, among others.

Foster Youth – $20.0 million increase ongoing SGF to increase Cal Grant awards for all former or current foster youth.

Child Support Services – $24.9 million ($8.5 million SGF) ongoing for local child support agencies to improve child support collections and services and $23.8 million ($8.1 million SGF) ongoing for local child support courts and State operations child support funding.

GENERAL GOVERNMENT

Golden State Stimulus – $2.4 billion to provide a $600.00 tax refund to all 2019 taxpayers who received a California Earned Income Tax Credit (CalEITC) in 2020, as well as to 2020 taxpayers with Individual Taxpayer Identification Numbers (ITINs) who are eligible for and receive the CalEITC in 2021. The State stimulus would also reach low-income taxpayers who are excluded from the Federal stimulus, such as undocumented households that file taxes with an ITIN.

California Privacy Protection Agency – $5.0 million SGF in FY 2020-21 and $10.0 million ongoing SGF in FY 2021-22 to support this new agency, which was established under Proposition 24, the California Privacy Rights Act of 2020, approved by the voters in November 2020.

Self-Help Legal Centers – $19.1 million ongoing SGF for the trial courts to continue providing self-help services for unrepresented litigants.

Equity and Inclusion – $290,000 ongoing SGF to establish the State's first ever Chief Equity Officer within the Government Operations Agency to build upon and implement the California Leads Task Force which has established actions to create a more inclusive, respectful and equitable workplace. The Chief Equity Officer would create a framework for creating equitable policies, practices and metrics for hiring and procurement.

Public Libraries – One-time increases include $5.0 million SGF to provide grants to local libraries to support early learning and after school programs; $3.0 million SGF to provide grants to underserved local libraries for the purchase of a bookmobile or community outreach vehicle; and $800,000 increase ongoing SGF for library districts to develop summer meal programs for students in low-income communities.

Cultural Institutions – $25.0 million for grants to small non-profit cultural institutions, including museums and art galleries, disproportionately impacted by the pandemic.

TRANSPORTATION

Road Repair and Accountability Act of 2017 (SB 1) – $17.4 billion programmed for FY 2020-21 through FY 2023-24 for new and ongoing state highway repair and rehabilitation projects in the State Highway Operations and Protection Program (SHOPP)

State Transportation Improvement Program – $2.4 billion for FY 2020-21 through FY 2023-24 for future multi-modal transportation improvements. An additional $1.0 billion to address traffic congestion, $900.0 million for projects that support walking and biking, and $800.0 million for partnerships with local transportation agencies.

Transit and Rail – $667.0 million, including $487.0 million for the Transit and Intercity Rail Capital Program and $107 million for the Low Carbon Transit Operations Program.

ENVIRONMENTAL AND NATURAL RESOURCES

Exide Cleanup – $31.4 million in one-time SGF for the State's existing commitment to cleanup up 3,200 contaminated residential properties that surround the Exide Facility. The Proposed Budget also includes $14.0 million in one-time SGF and $2.5 million ongoing funding from the Lead-Acid Battery Cleanup Fund to pursuing cost recovery from responsible parties for Exide.

Toxic Site Cleanup and Investigation – $300.0 million (inclusive of the funding for Exide Cleanup) for high-priority contaminated properties in impacted communities across the state (prioritized based on public health risk criteria).

Department of Toxic Substances Control (DTSC) Reform – Proposes governance and fiscal reform of DTSC to support better and more timely permit decisions, increase enforcement against those who violate hazardous waste control laws, and compel the use of safer chemicals in consumer products.

The Proposed Budget also includes statutory changes that will provide sustainable funding for DTSC's operations and oversight on an ongoing basis; $22.5 million in one-time SGF backfill for the Hazardous Waste Control Account, and $13.0 million in one-time SGF backfill for the Toxic Substances Control Account.

Circular Economy – $5.0 million from the Beverage Container Recycling Fund in both FY 2020-21 and FY 2021-22 and statutory changes to expand pilot programs to expand consumer redemption in communities underserved by recycling centers.

Zero-Emission Vehicles and Zero-Emission Vehicle Infrastructure – Proposes $1.5 billion to accelerate the pace and scale of infrastructure needed to meet the goal of requiring all new passenger vehicles to be zero-emission by 2035 and 2045. Funds will support purchases of clean trucks, buses and off-road freight equipment and Clean Cars 4 All program.

Cap and Trade Expenditure Plan – $1.37 billion to support existing programs, including $325.0 million in one-time funding to support the Community Air Protection Program (AB 617), which reduced emission in communities disproportionately impacted by air pollution, $130.0 million to maintain full implementation of the Safe and Affordable Drinking Water Program, and $635.0 million in one-time funding to reduce emission from the transportation sector.

Advancing Parks for All – $82.0 million, including $12.7 million ongoing (Cannabis Tax Fund) for the Youth Community Access Grant Program, $6.3 million one-time SGF and $6.3 million one-time federal reimbursements to provide State matching funds to leverage the recent increase in the Federal Land and Water Conservation Fund; and $585,000 ongoing State Park and Recreation Fund for community liaison programs in underserved and underrepresented communities.

WILDFIRE AND EMERGENCY MANAGEMENT

California Disaster Assistance Act (CDAA) – $256.1 million in one-time SGF to assist local governments in serving their communities during and in the wake of emergency events. This funding will be used to repair, restore, or replace public real property damaged or destroyed during disaster events or reimburse local governments for eligible costs associated with emergency activities undertaken in response to a state of emergency proclamation by the Governor.

Woolsey Fire Restoration – $10.0 million in one-time SGF and $23.4 million in one-time reimbursements from Federal Emergency Management Agency funds for the continuation of Woolsey Fire restoration projects to restore destroyed facilities and trails.

IMMIGRATION

Immigration Services – $75.0 million ongoing SGF in FY 2021-22 to fund qualified nonprofit organizations to provide immigration services to immigrants via the unaccompanied undocumented minors and Immigration Services Funding programs. The Proposed Budget also includes $5.0 million in one-time SGF for the Rapid Response Program to support entities that provide critical assistance and services to immigrants during emergency situations when Federal funding is not available.

CANNABIS

Cannabis Management – Includes $153.8 million Cannabis Control Fund to reflect the consolidation of the Bureau of Cannabis Control, the California Department of Food and Agriculture, and the California Department of Public Health into a new stand-alone State Department of Cannabis Control within the Business, Consumer Services, and Housing Agency on July 1, 2021. Under the new Department, the already existing Equity-Local Liaison Unit will be expanded to all equity applicants and licensees across all license types.

Cannabis Tax Fund – $443.1 million for the Cannabis Tax Fund in FY 2021-22, including: $265.9 million for education, prevention, and treatment of youth substance use disorders and school retention; $88.6 million for cleanup, remediation and enforcement of environmental impacts created by illegal cannabis cultivation; and $88.6 million for public safety-related activities.

Includes legislative proposal to establish permanent funding authority from the Cannabis Tax Fund for the local equity grant program that is administered by the Governor's Office of Business and Economic Development to facilitate greater equity in business ownership and employment in the cannabis industry. Includes $15.5 million ongoing Cannabis Tax Fund for this program.

As a follow up to this Executive Summary, the CEO's Legislative Affairs and Intergovernmental Relations Branch will continue to work with Departments throughout the County to analyze the Governor's Proposed Budget and will provide a detailed analysis. In addition, the Sacramento advocates will work with the Administration and key legislators to advocate on behalf of the County's funding and program priorities.

COVID-19: Considerations for People with HIV

Version: December 22, 2020

This document on COVID-19 considerations for people with HIV (PWH) is intended as a resource for clinicians and public health officials. The information is based on evolving best practices developed during the coronavirus pandemic and the available published data on COVID-19. *See the IDSA Real-Time Learning Network's HIV and COVID-19 literature review*. This document will be updated as new data and information become available.

This information is not intended to supersede existing clinical practice guidelines, nor should it be construed as a care directive. For HIV treatment, refer to the HHS *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV* and the HHS HIV/AIDS Guidelines Panel's Interim Guidance for COVID-19 and Persons with HIV. Email HIVMA with suggestions or questions and visit the IDSA RTLN. for additional resources.

Vaccines

The Centers for Disease Control and Prevention recommend that because people with HIV may be at higher risk for serious illness, they can receive the Pfizer-BioNTech and Moderna COVID-19 vaccines if they have no contraindications. They should be counseled that we do not yet know whether the level of protection for people with HIV is as strong as it is for those without HIV. Like everyone else, they should continue to protect themselves and others by wearing face coverings, practicing physical distancing and avoiding crowds because we also do not yet know whether the vaccines prevent infection entirely or just prevent infection from turning into severe disease.

Currently, in most states health care workers and individuals living in nursing homes or long-term care facilities are eligible to receive the two mRNA vaccines that have been given emergency use authorization by the U.S. Food and Drug Administration. During the next phase, essential workers and persons 75 and older will be prioritized for vaccination. People with HIV who fall into any of these groups should be eligible to receive the vaccines barring any contraindications.

Patients with HIV Hospitalized with COVID-19

- PWH on antiretroviral treatment have a normal life expectancy. Therefore, **HIV status should not be a factor in medical decision-making regarding the triaging of potentially lifesaving interventions or enrollment into clinical trials**. Since HIV is eminently treatable, *whether HIV is currently controlled or not* should also not be factor in triaging clinical care interventions, or resources for COVID-19.
- Care and treatment for COVID-19 in PWH should follow the same protocols advised for patients without HIV. See the IDSA Guidelines on the Treatment and Management of Patients with COVID-19 and the NIH COVID-19 Treatment Guidelines.

- Emerging data on COVID-19 in people with HIV suggest that they may be at higher risk for severe disease and worse outcomes. However, it is not yet known if this is due to immunodeficiencies; high rates of comorbid conditions, such as cardiovascular disease, hypertension, obesity and diabetes; or the social determinants of health, including poverty and poor health care access.
- Until more data are available **heightened awareness for severe disease should be considered for persons with HIV**, particularly those who have other comorbidities associated with worse COVID-19 outcomes or CD4+ T cells <200/ml and viral loads > 1000/ml (see Interim Guidance).
- **Consultation with an HIV or infectious diseases (ID) specialist** is strongly recommended for people with HIV who are hospitalized for the treatment of COVID-19.
- If HIV or ID expertise is not available locally, the national Clinician Consultation Center maintains an HIV management warmline Monday to Friday from 9 am ET to 8 pm ET. HIV treatment consultation is available by leaving a voicemail message at **(800) 933-3413 or submitting a** case online **(registration required).** The service responds to voicemail messages as soon as possible with the average response time being 30 to 60 minutes during their business hours. Cases submitted online are responded to within one business day.
- For providers caring for pregnant women with HIV who are also admitted with COVID-19, the Perinatal HIV/AIDS Hotline -- **(888) 448-8765** -- provides 24 hour/7 day week consultation services.
- **Antiretroviral therapy should be continued during hospitalization for COVID-19 without interruption** and changes in therapy are generally not recommended.
- For patients who have not initiated antiretroviral therapy or have been off therapy for > 2 weeks prior to hospitalization, consult with an HIV or ID specialist about a safe plan for initiating antiretroviral therapy as soon as is clinically feasible.
- If a patient is on a COVID-19 clinical trial with a drug active against HIV, an HIV or ID specialist should be consulted to ensure their HIV therapy remains appropriate and that a complete antiretroviral regimen is maintained. In addition, if a patient admitted for COVID-19 is in an HIV-related clinical trial, their ID/HIV providers should be contacted.
- Medications used for treatment of COVID-19 may interact with some HIV medications. **The Liverpool Drug Interaction Group is maintaining prescribing resources for experimental COVID-19 treatments including drug interaction information**.
- For patients who are not able to swallow medications, consult an HIV or ID specialist. Also refer to a resource like this one from the Toronto General Hospital on *Oral Antiretroviral/HCV DAA Administration: Information On Crushing And Liquid Drug Formulations*.

Diagnostic Testing

Follow the IDSA *Guidelines on the Diagnosis of COVID-19* when prioritizing diagnostic testing for COVID-19. As recommended in the guidelines for the general population, people with HIV who are symptomatic should be prioritized for diagnostic testing or who have been exposed to COVID-19 depending on the availability of testing. We have insufficient data in people living with HIV at this time to suggest what laboratory parameters comprise increased immunologic risk for severe COVID-19 disease.

Clinical Trials

People with HIV who are virally suppressed should not be excluded from COVID-19 clinical trials, including trials of therapeutics, prophylaxis, and vaccines. It is important to evaluate the response of people with HIV to COVID-19 therapies and prevention interventions, including vaccines, to ensure interventions approved by the U.S. Food and Drug Administration include an indication for people with HIV.

Issues for Ambulatory HIV Care Management

Social and Physical Distancing

All patients should be educated on the importance of following the CDC guidelines to promote physical distancing and to wear face coverings in public to reduce spread of the virus. Clinic and clinical protocols should be adjusted to support physical distancing through telehealth and home delivery of medication when possible.

HIV Treatment

Changes in antiretroviral therapy to prevent or treat COVID-19 are generally not recommended, except in the context of a clinical trial, a documented failing HIV regimen, and in consultation with an ID or HIV specialist. Please refer to the HHS Interim Guidance for COVID-19 and Persons with HIV.

HIV Viral Load Monitoring

Laboratory monitoring for HIV remains important and should follow current guidelines when possible (see *Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV* and the HHS HIV/AIDS Guidelines Panels Interim Guidance for COVID-19 and Persons with HIV). However, it is important to recognize that some of the same resources (personnel, machines, reagents) that are used for HIV RNA testing are also used for COVID-19 testing which might result in limited viral load testing capacity. In these cases, HIV viral load testing **should be prioritized for those who are on a new regimen, have had recent blips, who are pregnant, or who otherwise do not have a history of stable suppression over time**.

Routine Office Visits

For stable patients, or patients with non-urgent appointments, schedule a telephone or telehealth encounter if that is an option. Check with your patients to see if they have COVID-19 questions. For patients with non-respiratory urgent concerns, consider keeping the appointment or offering a telehealth or telephone visit. The American Society of Addiction Medicine has guidance on maintaining access to buprenorphine by leveraging telehealth.

HRSA's HIV/AIDS Bureau is encouraging the use of telehealth in Ryan White clinical settings to support social distancing and refers to PCN #16-02 in support of the policy. The Center for Connected Health Policy is a resource for updates on state telehealth policies. ACGME is maintaining a web page with guidance for residents and fellows, including for participation in telehealth visits. For protocols for telehealth and in person appointments, please see the Practice Resources/Telehealth section of the IDSA Resource Center. Also see IDSA's *Medicare Telehealth: What You Need to Know*.

Prescription Drug Refills

Patients should maintain at least a supplemental 30-day supply of their medications to prevent the possibility of treatment interruptions. A number of health insurers and state AIDS Drug Assistance

Programs are allowing early medication refills and lifting quantity limits in addition to making other changes to their coverage policies. Many health insurers require patients to have a new prescription to obtain a 90-day supply and/or switch to mail order. Please check with your patients to see if they need a new prescription.

Ryan White HIV/AIDS Program

The HIV/AIDS Bureau maintains an online Frequently Asked Questions resource that is regularly updated with questions raised by Ryan White Program grantees.