Gold Coast Health Plan℠
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Ventura County Medi-Cal Managed Care Commission (VCMMCC)
dba Gold Coast Health Plan

Provider Advisory Committee (PAC) Regular Meeting

Tuesday, September 23, 2025, 7:30 a.m.
Gold Coast Health Plan, 711 East Daily Drive, Community Room, Camarillo, CA 93010
Members of the public can participate using the Conference Call Number below.
Conference Call Number: 1-805-324-7279
Conference ID: 217 342 830 #

Telephonic Location:
3080 Bristol Street
Costa Mesa, CA 92626

Carrer de Francesc Carbonell, 31,
Sarrià-Sant Gervasi, 08034 Barcelona

5085 West Belle Circle, Depoe Bay OR 97341

AGENDA

CALL TO ORDER

ROLL CALL

PUBLIC COMMENT

The public has the opportunity to address Ventura County Medi-Cal Managed Care Commission (VCMMCC) doing business as Gold Coast Health Plan (GCHP) on the agenda.

Persons wishing to address VCMMCC are limited to three (3) minutes unless the Chair of the Commission extends time for good cause shown. Comments regarding items not on the agenda must be within the subject matter jurisdiction of the Commission.

Members of the public may call in, using the numbers above, or can submit public comments to the Committee via email by sending an email to ask@goldchp.org. If members of the public want to speak on a particular agenda item, please identify the agenda item number. Public comments submitted by email should be under 300 words.

OPENING REMARKS / WELCOME

Felix L. Nunez, M.D., Chief Executive Officer
Erik Cho, Chief Policy & Programs Officer

CONSENT

1. General Counsel Discussion on Immigration Issues

Staff: Scott Campbell, General Counsel

RECOMMENDATION: Receive and file the information.

2. Approval of Regular Meeting Minutes of June 10, 2025

Staff: Maddie Gutierrez, MMC, Clerk of the Commission

RECOMMENDATION: Approve the minutes as presented.

PRESENTATION

3. Risk Adjustment Factor (RAF) & How D-SNPs are Paid

Staff: Eve Gelb, Chief Innovation Officer
Paul VerHaar, Sr. Manager, Medicare Financial Analysis

RECOMMENDATION: Receive and file the presentation.

4. Dual Special Needs Plan (D-SNP) Provider Portal (Demonstration)

Staff: Eve Gelb, Chief Innovation Officer
Vicki Wrighster, Sr. Director of Network Operations
Maria Najar, Provider Services Representative II

RECOMMENDATION: Receive and file the presentation.

5. Stipend Policy

Staff: Marlen Torres, Chief Member Experience & External Affairs
James Cruz, M.D., Chief Medical Officer

RECOMMENDATION: Receive and file the presentation

FORMAL ACTION

6. Creation of an Ad Hoc Subcommittee for the Nomination of a Chairperson and Vice-Chairperson to Serve on the Provider Advisory Committee and search for an additional member to fill a vacant seat.

Staff: Marlen Torres, Chief Member Experience & External Affairs Officer

RECOMMENDATION: Staff recommends the PAC establish a nomination ad hoc subcommittee to commence the selection process of the Chairperson and Vice-Chairperson of the PAC and begin the search to fill a vacant seat on the committee.

ADJOURNMENT

Unless otherwise determined by the PAC, the next meeting is scheduled for December 9, 2025 and will be held at Gold Coast Health Plan located at 711 E. Daily Drive, Suite 110, Community Room, Camarillo, CA 93010.

Administrative Reports relating to this agenda are available at 711 East Daily Drive, Suite #106, Camarillo, California, during normal business hours and on http://goldcoasthealthplan.org. Materials related to an agenda item submitted to the Committee after distribution of the agenda packet are available for public review during normal business hours at the office of the Secretary of the Committee.

In compliance with the Americans with Disabilities Act, if you need assistance to participate in this meeting, please contact (805) 437-5562. Notification for accommodation must be made by the Monday prior to the meeting by 1:00 p.m. to enable GCHP to make reasonable arrangements for accessibility to this meeting.

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AGENDA ITEM NO. 1

TO: Provider Advisory Committee (PAC)

FROM: Scott Campbell, General Counsel

DATE: September 23, 2025

SUBJECT: General Counsel Discussion on Immigration Issues

VERBAL PRESENTATION

Promoting Safe and Secure Healthcare Access for All

Guidance and Model Policies to Assist California's Healthcare Facilities in Responding to Immigration Issues

Rob Bonta
California Attorney General
December 2024

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Introduction

California is home to more than 10 million immigrants, more than one in four state residents.[1] Prior federal policies led many immigrants and their families to feel deterred from using healthcare facilities because of fear that doing so would provoke immigration enforcement actions or other negative immigration consequences. It is in the State's interest to ensure access to healthcare, including a safe and secure environment in which all Californians feel comfortable seeking that care. To that end, California has embraced the immigrant population and created laws that protect their interests in accessing healthcare services.[2] The California Office of the Attorney General is committed to safeguarding these rights and access to healthcare services for all Californians.

California's healthcare facilities serve many people in need of help, regardless of circumstances. According to the California Association of Public Hospitals and Health Systems, California's public healthcare systems serve more than 3.7 million patients each year. These public facilities include just 6 percent of the State's hospitals, but provide more than 35 percent of hospital care to the State's lower income and uninsured patients. Additionally, these systems train more than half of the State's new doctors.[3]

The collective health of all Californians, immigrants and non-immigrants, benefits greatly when all have access to the State's multifaceted healthcare system, including public healthcare facilities, community health clinics, hospital systems, and emergency departments. Communicable diseases do not discriminate on the basis of immigration status and, for the health of the population as a whole, neither should the treatment of those diseases. However, fears of immigration enforcement at healthcare facilities, or other negative immigration consequences, have led many immigrants to question whether they should seek medical care and utilize those systems, even when facing health crises or medical emergencies.

Existing federal laws and regulations address the rights of all people to access medical care, including immigrants. To improve access to the healthcare system, the U.S. Congress has established various publicly funded healthcare programs, such as Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). It also created the federal subsidies available to purchase private coverage as a result of the Patient Protection and Affordable Care Act (ACA).[4] In addition, the Emergency Medical Treatment and Active Labor Act (EMTALA) guarantees medical treatment for all people who arrive at emergency departments in hospitals that accept Medicare, regardless of factors such as citizenship, legal status, or ability to pay.[5]

California laws and regulations go further and promote all individuals' rights to access healthcare. California expanded access to its state-funded, full-scope Medi-Cal program to all eligible individuals, regardless of immigration status, effective January 1, 2024.[6] As the backbone of California's healthcare safety net, the California Department of Health Care Services (DHCS) administers Medi-Cal and seeks to preserve and to improve the overall health and well-being of all Californians. Similarly, the California Department of Managed Health Care and the California Department of Insurance (oversee access to healthcare by Californians covered by managed-care and insurance contracts. California also mirrors the protections provided by EMTALA, guaranteeing medical treatment for all people who enter California emergency rooms that accept Medicare.[7]

In sum, California's healthcare facilities contribute to the overall health of the entire state population by ensuring that there are safe, accessible facilities for those who are in need of medical care.

Purpose of this Guide

The first version of this guide was published after the California Values Act, Senate Bill (SB) No. 54 (2017-2018 Regular Session), mandated that the California Attorney General publish model policies "limiting assistance with immigration enforcement to the fullest extent possible consistent with federal and state law at" several kinds of public institutions, including healthcare facilities.[8] All health facilities operated by the State or a political subdivision of the State adopt and implement the following model policies or equivalent policies.[9] Covered "health facilities" include facilities as defined in section 1250 of the Health and Safety Code, clinics as defined in sections 1200 and 1200.1 of the Health and Safety Code, and substance abuse treatment facilities.[10]

In 2018, then-California Attorney General Xavier Becerra issued an earlier version of this guide to California's healthcare facilities.

California Attorney General Rob Bonta is now issuing a new edition of this guide to assist California healthcare facilities in complying with California law and to equip personnel with the information and resources necessary to continue to provide healthcare to all California residents. This guidance implements the California Legislature's decision to limit state and local participation in immigration- enforcement activities. Such participation diverts state resources, blurs lines of accountability, and threatens trust between immigrant communities and state and local agencies that provide critical public services. The model policies laid out in this guidance are aimed at assisting healthcare facilities in focusing their resources on their distinct missions, while leaving immigration enforcement efforts to others. To that end, this guide discusses procedures for responding to immigration enforcement actions and requests for information. Specifically, the guide:

- Outlines relevant federal and state laws for the benefit of patients, healthcare facility administrators, doctors, nurses, families, and other facility staff and health professionals (including relevant volunteers);
- Provides policy recommendations that comply with federal and state laws, and that may mitigate disruptions from immigration enforcement actions at healthcare facilities; and
- Promulgates model policies that must be adopted and implemented (unless equivalent policies are adopted and implemented) by all healthcare facilities operated by the State or a political subdivision of the State, and that all other related organizations and entities are encouraged to adopt.

This guide is intended to help California healthcare facility officials form practical plans to protect the rights of patients and their families. To that end, this guide discusses procedures for responding to immigration enforcement actions and requests for immigration-related information directed at healthcare facilities. This guide is *not* intended to cover the obligations arising from employer-employee relationships at public healthcare facilities. Public healthcare facilities should be aware that other laws may apply to immigration enforcement activities and requests for information directed at facility employees as the subjects.[11]

California law enforcement agencies are prohibited under state law from performing the functions of immigration officers.[12] But healthcare facilities should be aware that, although U.S. Immigration and Customs Enforcement (ICE) and U.S. Customs and Border Protection (CBP) are the federal agencies with primary responsibility for federal immigration law enforcement, there are instances in which other law enforcement agencies may also attempt to enforce immigration laws.[13] In this guide, ICE, CBP, and other law enforcement agencies attempting to enforce immigration laws are treated the same, in terms of the advice given for how healthcare facilities should handle interactions with them. Any policy adopted to address interactions between healthcare facility personnel and immigration enforcement officers should encompass all law enforcement agencies that seek to enforce immigration law, and should handle requests from all law enforcement agencies acting with that purpose in the same way.

To the extent that any specific healthcare facility program encounters circumstances that are not addressed in this guidance, healthcare facility personnel should consult with their designated healthcare facility administrators in adapting the model policies described here.

Some healthcare facilities may have already adopted policies equivalent to, or exceeding, the protections provided with the policies set forth in this guidance. To the extent that healthcare facilities have developed policies that are aligned with or provide greater protections for immigrants, this guide is not intended to displace those policies. Nor does the exclusion of a particular policy in this guide—whether recommended by a stakeholder group or implemented by an agency—necessarily indicate the Attorney General's disapproval of that policy. Rather, this guide offers foundational elements reflecting the minimum that should be present in the policies of any covered California healthcare facility and should serve as a resource to enhance current policies as needed and to ensure alignment with state law. Healthcare facilities that have already adopted policies should use this guide as a resource to ensure alignment, providing protections at least as strong as are described here. Ultimately, the policies of healthcare facilities operated by the State or a political subdivision of the State must at minimum follow the model policies here, except where contrasting laws or circumstances require adjustments.

It is important that healthcare facilities train staff for possible interaction with immigration enforcement officers, so that staff can be prepared in the event of an immigration enforcement activity, inquiry, or request at the facility, including determining when, if at all, any potential disclosures of patient information will be necessary.

This guide is not legal advice. This guide is based on current law as of its date of December 2024, which, of course, may change. Management at healthcare facilities operated by the State or a political subdivision of the State should consult with their facility attorneys when formulating policies and practices, and in addressing any questions, regarding the issues covered in this guide.

01 Gathering and Handling Patient and Family Health Information

Purpose of this Section

Provide healthcare facility administrators with policies for collecting and retaining patient and family health information, while preventing unnecessary collection and maintenance of information on the immigration status of patients and their families.

Governing Law

1. Privacy Law and Personal Health Information

California state and federal laws and regulations give all patients, regardless of immigration status, the right to keep their medical records private in most circumstances. All healthcare facilities and other covered entities should already understand and have policies in place to protect private medical information; this guidance complements, but is not a substitute for, general privacy policies.[14]

HIPAA

The federal Health Insurance Portability and Accountability Act (HIPAA), including its Privacy Rule and its Security Rule, provides protections for the use and disclosure of information contained in medical records. Healthcare facilities should be well-versed in ensuring HIPAA compliance. Under HIPAA, personal health information may not be used or disclosed, except under certain conditions, including for treatment or payment for health care;[15] upon the consent of the patient;[16] in connection with a use or disclosure otherwise permitted, if the disclosure is the minimum necessary to accomplish the purpose of the disclosure;[17] or under limited circumstances for which neither authorization nor agreement is required.[18] Federally funded programs that provide treatment for substance-abuse disorders must take additional precautions.[19] (See Section 3 of this guidance for information about the circumstances under which personal health information may be disclosed to law enforcement.)

California Law

California state laws provide similar protections. The California Constitution includes a right to "privacy."[20] California has several laws protecting health information privacy, including the Confidentiality of Medical Information Act (CMIA), which prohibits healthcare providers, insurance plans, and contractors from disclosing medical information to third parties;[21] the Patient Access to Health Records Act, which establishes a patient's right to see and to receive copies of his or her own medical records;[22] the Insurance Information and Privacy Protection Act (IIPPA), which applies to insurance agents, brokers, and companies;[23] and the Information Practices Act (IPA), which limits California state agencies' authorization to collect, manage, and disseminate personal information.[24] Additionally, healthcare facilities are obligated to prevent unauthorized access to, or disclosure of, medical information.[25] Furthermore, for a patient involuntarily detained, a healthcare facility must abide by California Welfare and Institutions Code section 5328, governing the disclosure of all information and records obtained in the

course of providing mental health services and developmental-disability services.

Patient Privacy
The scope of private health information protected from disclosure is very broad. While immigration status and evidence of foreign birth are not expressly listed as protected personal health information, both federal and state rules allow for protections for any characteristics that could uniquely identify the individual.[26] For example, Social Security numbers and patients' addresses are considered personal health information. Immigration information that can be linked to an individual's identity should therefore also be considered protected information.

Most healthcare providers must give all patients a notice of provider privacy policies.[27] The notice tells patients how their personal information about their health care will be used, who will see that information, what the patients' rights are, and where to lodge a complaint if those rights have been violated. A patient has the right to ask his or her healthcare provider or insurer to contact the patient only in certain ways or in certain locations. For example, a patient can ask to be sent notices only at home or only at work.

2. Collection of Immigration-Related Personal Information for Public Benefits Purposes

Healthcare facilities have no general affirmative legal obligation to inquire into a patient's immigration status. In some circumstances, however, information related to immigration status may be relevant to a determination of a patient's eligibility for public benefits that assist with payment for health care, and HIPAA permits disclosure of personal health information for this purpose. County, state, and federal agencies, not healthcare facilities, make final determinations regarding immigrant eligibility for healthcare benefits, but healthcare facilities may play a role in that eligibility screening process. For example, hospitals participating in the Hospital Presumptive Eligibility (HPE) program may temporarily provide qualified individuals immediate access to Medi-Cal covered services.[28] The information collected by DHCS under HPE is provided by the patient and is not verified against any federal databases. However, for the limited purpose of ensuring that eligibility has not otherwise been established for the individual, DHCS verifies an individual's HPE information against the California Medi-Cal Eligibility Data System. Other programs or sources of healthcare payment or coverage, and the types of immigration-related information that are collected, are discussed below.

The ACA and the Medicaid Act of the Social Security Act (SSA) require that individuals seeking coverage under programs like Medicaid, CHIP, and subsidized private insurance through Covered California (California's state-based health insurance benefit exchange) provide information regarding their immigration status and some information about their household members to determine eligibility for such coverage. According to the U.S. Department of Health and Human Services, when an individual applies for coverage through the ACA, information about immigration status is only used to check qualification for marketplace coverage, not immigration enforcement.[29] According to the U.S. Department of Homeland Security (DHS) policy, ICE does not presently use information about individuals submitted to assist in determining eligibility for health coverage as the basis for pursuing civil immigration enforcement actions.[30] That policy, adopted in 2013, has not been withdrawn or superseded as of the date of this guidance.

Medi-Cal
Medicaid is a federal-state partnership to provide healthcare coverage to low-income individuals

and families. The program coverage and policies vary by state. In California, the state-only Medi-Cal program provides coverage for adults under certain income levels, even if the individuals are not U.S. citizens or U.S. nationals.[31] An immigrant, like any other beneficiary, must meet certain eligibility requirements, such as income limits and California residency. Any personal information provided to Medi-Cal is kept private and only used to determine eligibility.[32]

DHCS is required under federal law to verify citizenship or immigration status for most individuals who apply for Medi-Cal coverage and to report data, including demographic information and immigration status, to the federal government. California law provides that all types of information concerning an individual and obtained for provision of Medi-Cal services "shall be kept confidential, and shall not be open to examination other than for purposes directly connected with the administration of the Medi-Cal program."[33] DHCS obtains and maintains an individual's immigration status only for evaluating a person's eligibility for benefits. If a facility assists someone in applying for Medi-Cal, the facility may become aware of an individual's immigration status. However, California public healthcare facilities should not otherwise ask for, or, in any event, retain, citizenship or immigration information from patients in their facilities.

In California, CHIP serves low-income children under the age of 19 years and pregnant women who have incomes above the level to qualify for Medi-Cal, including immigrants, without a waiting period, throughout pregnancy until the end of the post-partum period.[34]

Medicare
Medicare is a federal health benefit program with different eligibility rules from Medi-Cal, including requirements for qualifying work history, and immigration-status restrictions. While some non-citizens are eligible for Medicare, all Medicare recipients must have satisfactory immigration status. Medicare applicants (including those dually eligible for both Medi-Cal and Medicare) have their individual information determined and verified by a federally managed data services hub, such that the federal government has the relevant information.[35] Medicare records contained within that system may be disclosed without a beneficiary's consent, but only in certain limited situations; disclosure for federal law enforcement purposes is only permitted "if the [federal law enforcement] activity is authorized by law and the request is from the head of the agency and specifies the particular record desired and the law enforcement activity for which the record is sought."[36]

Covered California
An individual must have certain types of immigration status in the United States to purchase health insurance through the health benefit exchange (Covered California, in California).[37] Lawfully present individuals (green card holders), lawful temporary residents, refugees and asylees, other humanitarian immigrants (including those with temporary protected status, and those on worker visas and student visas, are all eligible. Starting November 1, 2024, a new federal rule allows Deferred Action for Childhood Arrivals (DACA) recipients who meet all other eligibility requirements to enroll in Covered California and receive financial assistance if they qualify.[38]

An individual who applies for coverage through Covered California, and is determined to be eligible for Medi-Cal or for subsidies, will have his or her eligibility information verified through the federal data services hub, meaning that the federal government has the relevant information.

The ACA requires applicants seeking coverage through a health insurance exchange, such as Covered California, to provide information about their immigration status.[39] Applicants who attest to eligibility based on immigration status, rather than citizenship, must provide their Social Security numbers (if applicable) and "such identifying information with respect to the enrollee's immigration status as the Secretary [of Health and Human Services], after consultation with the Secretary of Homeland Security, determines appropriate."[40]

Covered California collects information regarding immigration status of only the person seeking health coverage, not of family members who are not applying for coverage. Information provided by individuals who are applying for coverage through Covered California will not be used for any purpose other than to confirm eligibility and to ensure the efficient operation of the healthcare exchange.

Emergency Services

All individuals, including immigrants regardless of status, must be screened and provided with some healthcare for an emergency medical condition. EMTALA requires hospitals to provide a medically appropriate screening exam for any patient, regardless of immigration status, who comes to the hospital's emergency department.[41] If the hospital determines that a patient has an emergency condition, then EMTALA restricts the hospital from transferring the patient until the patient has been stabilized.[42] California law likewise requires licensed healthcare facilities to provide emergency services and care to any person who requests them "for any condition in which the person is in danger of loss of life, or serious injury or illness [...] when the health facility has appropriate facilities and qualified personnel available to provide the services or care." The healthcare facility may not first question the patient's ability to pay.[43] Hospitals may not delay screening or treatment in order to resolve questions about the patient's method of payment or insurance status.[44]

3. Effect of Receipt of Health Benefits on Future Immigration Status

Under current immigration law, receiving publicly funded health benefits like regular Medi- Cal or other subsidized health services does not make someone a "public charge," a factor which negatively affects an immigrant's chances of becoming a legal permanent resident.[45] The only health benefit considered for public charge is long-term institutional care at government expense (for example, in a skilled nursing home.) Importantly, the public-charge test does not apply to many categories of immigrants, including refugees, asylum seekers, certain victims of trafficking, self-petitioners, and some other persons.[46] The previous trump administration temporarily changed the public-charge regulations to cover more types of healthcare, as of the date of this guidance, the rules remain the same as they have been for decades. Any future rule changes would not be retroactive, meaning that health services used before any rule change would not count against immigrants seeking to adjust their status.

Policy Recommendations

- Healthcare facilities should have written policies and procedures for gathering and handling confidential patient information. Staff, including any volunteers whose duties may involve responding to external information requests or healthcare delivery, should be well-trained in these policies and procedures.
- Healthcare facilities should limit collection of information about immigration status, citizenship status, and national origin to information that the facilities are required by law to collect.
  - If a health provider must collect such information for a patient, the provider should avoid including that information in the patient's medical and billing records.
  - Healthcare facilities should collect such information for only the person seeking care, not his or her family members.
- Healthcare facilities should respond promptly to requests by patients (or their parents, guardians, or caretakers, as appropriate) to remove immigration status information from their medical records, as permitted by law.
- Healthcare facilities should educate patients about their privacy rights and reassure them that their healthcare information is protected by federal and state laws. Healthcare facilities should amend standard notices of privacy practices to clarify that information about immigration status may be protected by privacy laws.
- Healthcare facilities should make information regarding privacy laws and policies accessible to individuals with limited English proficiency, in the languages commonly spoken in the community.

02 Sharing Patient and Family Health Information

Purpose of this Section

Identify categories of patient information not subject to release by healthcare facilities, and provide model policies protecting against the release of patient or family information, to the extent permitted under the law.

Governing Law

1. Citizenship and Immigration Status Information

Federal law does not impose an affirmative duty on state or local government entities to collect information about an individual's citizenship or immigration status. California law generally prohibits law enforcement agencies from "[i]nquiring into an individual's immigration status."[47]

Under federal law, hospitals with emergency rooms must screen and treat people who need emergency medical services, regardless of whether a person has health insurance, how much money the person has, or the person's immigration status. Similarly, anyone can seek primary and preventive health care at certain kinds of community clinics[48] regardless of whether they are insured, their ability to pay, or their immigration status. Neither citizenship, nor lawful immigration status, nor a Social Security number are required to receive healthcare services under federal law. But, as mentioned above, hospitals, clinics, health centers, or other medical providers may ask for this information to determine if a patient may be eligible for public health insurance, like Medicaid, or to establish the patient's method of payment for services.

The U.S. Department of Homeland Security, which oversees the actions of ICE and CBP, maintains current policy that immigration enforcement actions such as arrests, interviews, searches, and surveillance will generally not occur at "protected areas," which include medical-treatment and healthcare facilities, such as hospitals, doctors' offices, accredited health clinics, and emergent or urgent care facilities. This policy is generally referred to as the ICE Protected Area Policy (discussed in Section 3 below). These policies do not preclude immigration law enforcement actions at or focused on sensitive locations, but rather provide that these areas should generally be avoided. Therefore, immigrant employees, patients, and families may be more vulnerable to immigration law enforcement actions when in areas of healthcare facilities that are open to the public versus areas that are considered private. Some healthcare facilities have sought to adopt internal policies and procedures that limit law enforcement on their premises by designating certain spaces as "private," protected spaces into which law enforcement agents may not enter without a warrant. It is unclear if such designations will suffice as a matter of law to preclude entry into those areas by immigration enforcement officers.

Healthcare facilities seeking to protect immigrant patients' privacy may simply avoid acquiring or maintaining information about immigration and citizenship status. (See Section 1, above.) Federal law itself restricts healthcare facilities from sharing personal information without patient consent as described above, under HIPAA's Privacy Rule, and those federal restrictions apply with equal force to patient personal information, such as information regarding a patient's citizenship or immigration status, contained in medical records.

In addition, there have been successful constitutional challenges to section 1373 of title 8 of the U.S. Code, which provides that state and local government entities and officials cannot prohibit or restrict any government entity or official from maintaining information regarding a person's immigration status, exchanging information regarding a person's immigration status with federal immigration enforcement authorities or other governmental entities.[49] Specifically, the Ninth Circuit determined that this statute violates the Tenth Amendment to the U.S. Constitution.[50]

There have also been successful challenges to the federal government's expansive interpretation of section 1373. The Ninth Circuit construed section 1373 narrowly, finding that it covers only "information strictly pertaining to immigration status (i.e., what one's immigration status is)" and clarifying that this federal statute does not apply to other categories of information, such as an individual's home or work address.[51]

2. Patient Information Generally

Healthcare providers have no affirmative legal obligation to inquire into or report to federal immigration authorities information about a patient's immigration status. As discussed above, the HIPAA Privacy Rule is the primary federal law that requires healthcare facilities to protect the confidentiality of a patient's protected health information, with certain exceptions.[52] In general, protected health information is individually identifiable information that a healthcare provider receives from an individual and that relates to his or her health status, treatment, or payment, and that could be used to identify the person.[53] As mentioned above, immigration status or evidence of foreign birth is not alone considered protected health information under HIPAA, but federal guidance states that "any characteristic that could uniquely identify the individual" is protected health information. Thus, Social Security numbers and patients' addresses in combination with health information or other reasonably available information,[54] are considered protected health information.[55] Under some of the legal exceptions, including when information is requested by law enforcement officials for law enforcement purposes, protected health information may be shared, but its release is generally not required.[56] Similarly, the HIPAA Security Rule establishes national standards to protect individuals' electronic personal health information that is created, received, used, or maintained by a covered entity. The Security Rule requires appropriate administrative, physical, and technical safeguards to ensure the confidentiality, integrity, and security of electronic protected health information.

As discussed above, California has several laws governing health information privacy. Most notable is CMIA,[57] which provides some stronger privacy protections for medical information than those in HIPAA.[58]

3. Restrictions on Release of Personal Information or Patient Records

HIPAA

Under the HIPAA Privacy Rule, organizations that must comply with the rule are called "covered entities," and include health plans, healthcare clearinghouses, and some healthcare providers, such as local healthcare facilities. A covered entity may not use or disclose protected health information except (1) as permitted or required by the Privacy Rule; or (2) as authorized in writing by the individual who is the subject of the information (or the individual's personal representative). Under the Privacy Rule, anyone aged 18 years or older and emancipated minors can exercise the rights of individuals; but specific provisions address the protected health information of un-emancipated minors (younger than 18 years).[59] A minor can exercise rights under the rule in one of three circumstances:

- When the minor has the right to consent to health care and has consented, such as when a minor has consented to treatment of a sexually transmitted disease under a state minor consent law.[60]
- When the minor may legally receive the care without parental consent, and the minor or another individual or a court has consented to the care.[61]
- When a parent has assented to an agreement of confidentiality between the health care provider and the minor, which occurs most often when an adolescent is seen by a physician who knows the family.[62]

In each of these circumstances, the parent is not the personal representative of the minor and does not automatically have access to health information specific to the situation, unless the minor requests that the parent be given such access. However, under immigration law, "child" or "minor" is not uniformly defined, and the age of a child for purposes of certain immigration benefits may vary from 18 years old to 21 years old.[63] Therefore, a healthcare facility should determine who is entitled to make decisions about access to a young person's health information before seeking parent/guardian approval of any disclosures relevant to immigration enforcement. The adolescent may be entitled to maintain the privacy of his or her medical records under state law even from the adolescent's parents, and seeking consent from parents or guardians would deprive the minor of this protection.

As noted above, healthcare providers must give each patient a notice of privacy policies.[64] The notice tells patients how their personal health information will be used, who will see that information, what their rights are, and where to file a complaint if their privacy has been compromised.

Under HIPAA, a healthcare facility has an obligation to provide, upon a patient's request, an "accounting of disclosures" whenever it has disclosed any patient's protected health information.[65] However a healthcare facility is not required to account for disclosures that were made for treatment, payment, or healthcare operations, and disclosures authorized by the individual.[66] Disclosures that are subject to the accounting-for-disclosures requirement include those made by a healthcare facility that is not a party to a related litigation matter or proceeding yet compelled thereby to take some action;[67] made in proceedings before a healthcare oversight agency,[68] or made in response to a subpoena, discovery request, or other lawful process (discussed below).[69]

CMIA

Like HIPAA, the primary purpose of CMIA, a state law, is to protect an individual's medical information, in electronic or paper format, from unauthorized disclosure. However, instead of "protected health information," CMIA applies to "medical information," which it defines as "individually identifiable" information about a patient's medical history, mental or physical condition, or treatment.[70] Under CMIA, individually identifiable information is medical information that includes a data element that identifies a person, such as a name, address, e-mail address, telephone number, or Social Security number, and includes information that can be combined with other publicly available information to reveal a person's identity.[71] Like HIPAA, CMIA applies to healthcare providers, health insurers, and individuals or businesses they contract with that have access to medical information. However, CMIA's definition of "provider of health care" is much broader than HIPAA's, and includes, for example, any business that offers software or products to maintain such medical information.[72] Finally, unlike HIPAA, CMIA provides an individual private right of action.[73] These broader protections and remedies offered under CMIA provide reassurances about these rights for immigrant families and other people of the confidentiality of patient information in California. Establishing policies and practices that both disseminate information and enforce these protections will encourage many immigrant families to continue enrolling and seeking available healthcare services.

4. Exceptions Requiring or Permitting Disclosure of Information Without Consent

HIPAA

The HIPAA Privacy Rule allows covered entities to disclose protected health information in certain circumstances. Generally, protected health information includes demographic data and information that identifies the individual and that relates to the individual's past, present, or future physical or mental health or condition; the provision of health care to the individual; or the past, present, or future payment for the provision of health care to the individual.[74] Protected health information includes many common identifiers, such as a patient's name, address, birth date, Social Security Number, etc., so long as the identifiers are created/included in a medical record.[75] Therefore, identifiers could potentially include information pertaining to a patient's immigration status.

Required Disclosures

Pursuant to the Privacy Rule, a healthcare facility must disclose protected health information (1) when an individual (or his or her personal representative) specifically requests access, and (2) to the U.S. Department of Health and Human Services (HHS) when it is undertaking a compliance investigation, review, or enforcement action.[76] In special circumstances dealing with public health concerns and disease outbreaks, health providers may be required to disclose protected health information under title 17 of the California Code of Regulations.[77] State laws and regulations mandate that specified diseases and conditions be reported by healthcare providers and laboratories to the public health authorities.[78]

Permissive Disclosures

Healthcare facilities covered under HIPAA are permitted, but not required, to disclose protected health information, without an individual's consent, in a number of circumstances: (1) to the individual (unless required for access or accounting of disclosures); (2) for treatment, payment,

and healthcare operations;[79] (3) to provide an individual an opportunity to agree or object to disclosure;[80] (4) incident to an otherwise permitted use and disclosure;[81] (5) for public interest and benefit activities;[82] and (6) as a limited data set for the purposes of research, public health, or healthcare operations.[83] Any sharing of protected health information data sets for the purpose of research is limited to de-identified information.[84]

Some of the most important permissible disclosures relevant to public interest and benefit activities are when disclosures are required by law, or for public health, public safety, or in accordance with court orders. Healthcare facilities may be required to report protected health information to a law enforcement official when required under certain laws, including those requiring the reporting of certain types of wounds or other physical injuries.[85] State laws commonly require healthcare providers to report incidents of gunshot or stab wounds, or other violent injuries. Additionally, healthcare providers are commonly required to report child abuse or neglect or adult abuse, neglect, or domestic violence.[86] Healthcare facilities may also be required to provide protected health information to a law enforcement official, but only to the extent that such disclosure is required by law, such as when complying with a properly issued court order, warrant, subpoena, or summons.[87] Any such written request for PHI must show that the PHI request is relevant and material, specific and limited in scope, and that the de-identified data cannot be used.[88] Therefore, while HIPAA will not require disclosure under these circumstances, disclosure without patient authorization may nevertheless be required by other laws in these instances.

With respect to immigration enforcement, HIPAA-protected information must be withheld unless limited exceptions apply. One such exception is found at 45 Code of Federal Regulations section 164.512, subdivision (k)(5)(I), which applies when an immigration enforcement official demonstrates that there is "lawful custody" of the patient. Therefore, unless the immigration enforcement official provides evidence of lawful custody, the HIPAA-protected information should not be released. Furthermore, this regulatory exception is permissive. The healthcare facility is not required to provide the HIPAA-protected information to the requesting immigration enforcement official invoking that exception.

Policy Recommendations

In addition to the model policies below, healthcare facilities should consider adopting the following policy recommendations.

1. Policies and Procedures Regarding Information Sharing

Healthcare facilities and their providers are required to protect patient information, and in most circumstances a healthcare facility must obtain consent from the patient before any patient information is disclosed. Still, healthcare facilities should have policies and procedures in place regarding disclosures of protected health information in response to court orders, warrants, subpoenas, summonses, and administrative requests. Obviously, the procedure should provide sufficient details to help employees determine how to respond. (See model policies in Section 3.)

To guarantee protected health information is safeguarded, each healthcare facility should designate a healthcare facility administrator to handle immigration issues, ensuring staff members and relevant volunteers are adequately dealing with immigration enforcement inquiries and requests, dissemination of information to patients, and compliance with internal procedures.

2. General Information Policies

Most healthcare providers must give all patients a notice of privacy policies, which alerts patients of their privacy rights, how their personal health information will be used, who will see that information, and where to file a complaint if those rights have been violated. Healthcare providers should:

- ✓ Provide assurances that the healthcare facility will not release information to third parties for immigration law enforcement purposes, except as required by law or court order.
- ✓ Provide access to privacy notices in multiple languages to reach immigrants whose primary languages are not English.
- ✓ Provide annual updates of any changes to the healthcare facilities' privacy policies.

3. Requirements for Written Consent for Release of Patient Information

- ✓ The patients or eligible representatives, in their preferred language (or after adequate translation), must sign and date the consent forms before disclosure of the information.
- ✓ The consent form must include the following:
  - Description of the records to be disclosed;
  - Reason for disclosure;
  - Party or class of parties to whom disclosure may be made; and
  - If desired by the patient, a copy of the records to be released.
- ✓ The consent notice must be permanently kept in the patient's record file.

Model Policies

All healthcare facilities operated by the State or a political subdivision of the State shall adopt the following model policies or equivalent policies, and all other California healthcare facilities are encouraged to adopt the following model policies, or equivalent policies.[89] The text below should be adapted by inserting the information sought in the bracketed portions.

Model Policies and Procedures Regarding Information Sharing

- [Healthcare facility] should develop and post its model policies, if at all possible in the languages commonly spoken in the local community, and make these policies accessible on the [healthcare facility's] website. Staff, including any relevant volunteers, should be well-trained in these policies and procedures.
- [Healthcare facility] shall designate a healthcare facility administrator to handle immigration issues, ensuring staff members and relevant volunteers are adequately dealing with immigration enforcement inquiries and requests, dissemination of information to patients, and compliance with internal procedures.
- [Healthcare facility] should implement a policy that is protective of patient information, under which [healthcare facility] staff members and volunteers disclose patient information only when required or expressly authorized to do so by law.
- [Healthcare facility] and [designated healthcare facility administrator] should consult legal counsel to help [healthcare facility] determine when and to what extent [healthcare facility] is required to comply with administrative requests.
- [Healthcare facility] shall require that an immigration enforcement official provide his/her badge or identification card to be photocopied by [healthcare facility] personnel.
- For responding to requests issued by immigration enforcement officers, [healthcare facility] should develop a verification procedure to determine and document:
    - The specific agency the requester is from
    - Whether the requester has law enforcement power
    - The specific types of protected health information the requester seeks
    - The reason the requester wants the information, including any legal authority claimed.
- [Healthcare facility] should develop procedures for handling information requests by telephone, such as requiring a call-back process through publicly listed agency phone numbers. Staff members and volunteers receiving immigration inquiries and requests shall first consult with the [designated healthcare facility administrator] to ensure that correct protocols are followed.
- [Healthcare facility] should establish policies that provide guidance on determining whether a document labeled "subpoena," "warrant," or "summons" has been issued by a court or judicial officer, and whether the request for the PHI is narrowly tailored as required by HIPAA. Often such requests are handled by the [healthcare facility's] privacy officer or medical records department, to assure that information is disclosed appropriately. If possible, [healthcare facility] should consult with competent legal counsel each time on such matters.

Model Policies and Procedures Regarding Information Sharing Continued

- If [healthcare facility] is required to make a disclosure of patient information to immigration enforcement authorities without the patient's authorization in compliance with a court order or judicial warrant, then the [healthcare facility] should document the disclosure in compliance with facility policies and procedures. Such documentation should include information that supported the decision to disclose the information. Disclosures to law enforcement are subject to the accounting-of-disclosures requirement under the HIPAA Privacy Rule.

Model Policies for Information Notice to Patients or Representatives

- [Healthcare facility] should post and issue general information policies telling patients of their privacy rights and remedies.
  - [Healthcare facility] should give assurances that [healthcare facility] will not release information to third parties for immigration enforcement purposes, except as required or expressly authorized by law or court order.
  - [Healthcare facility] should provide a comprehensive list of privacy protections, under both federal law and California law (including a patient's right of action for disclosures in violation of CMIA).
- Healthcare facility should post information guides regarding immigrant patient rights, including the right to remain silent. While immigration enforcement at [healthcare facility] is limited by the "protected area" guidance described previously, immigration agents may enter a public area of [healthcare facility] without a warrant or the facility's consent and may question any person present (with that person's consent).

03 Responding to Requests for Physical Access to Healthcare Facilities for Immigration Enforcement Purposes

Purpose of this Section

Explain what to do when an immigration enforcement official requests physical access to a healthcare facility, including pointing out applicable law and suggesting steps for healthcare facility employees to follow in responding to access requests.

Governing Law

1. Substantive Federal Law and Policy

The Fourth Amendment to the U.S. Constitution protects individuals against unreasonable searches and seizures. What is required for law enforcement officers to access different areas of a healthcare facility depends on whether an individual has an expectation of privacy in the place to be entered. Where a reasonable expectation of privacy exists, the U.S. Constitution prohibits access without consent, a judicial warrant, or the types of exigent circumstances that excuse the warrant requirement. This guide does not address all of the factual circumstances that may arise relating to an individual's Fourth Amendment protections in different areas of a facility.

Federal Policies Regarding Immigration Enforcement at "Protected Areas"
All hospitals and other healthcare facilities have been designated by DHS as "protected areas" at which immigration enforcement actions should not generally occur.[90] These policies do not preclude enforcement actions at such locations. Rather, the policies provide that enforcement actions at or focused on protected areas should generally be avoided.

Such actions may take place at protected areas only when either: (1) prior approval was obtained from an appropriate supervisory official; or (2) there are "exigent circumstances" necessitating immediate action without prior approval.

According to the ICE memorandum, exigent circumstances exist when there is:

- an enforcement action involving a national security or terrorism matter;
- imminent risk of death, violence, or physical harm to a person or property;
- an enforcement action involving the immediate arrest or pursuit of a dangerous felon, terrorist suspect, or other individual posing an imminent danger to public safety; or
- an imminent risk of destruction of evidence material to an ongoing criminal case.

When proceeding with an enforcement action under exigent circumstances, ICE officers and agents must conduct themselves as discretely as possible, consistent with officer and public safety, and make every effort to limit the time at or focused on the protected areas.

The protected-area policies cover any actions taken by ICE or CBP to apprehend, arrest, interview, or search an individual, or to conduct surveillance for immigration enforcement purposes. These policies do not extend to actions such as obtaining records, documents, and similar materials from officials or employees; providing notice to officials or employees; serving

subpoenas; or participating in official functions or community meetings. CBP's protected-area policy does not apply to CBP operations conducted at or near the international border, or that bear a "nexus" to the border.

Although the protected-area policies remain in effect, they may be modified, superseded, or withdrawn at any time with little notice. Because of this possible transience of the policies, and because exceptions to the memos exist, healthcare facilities should have plans in place in the event that a law enforcement officer requests information about or physical access to a healthcare facility or a patient for immigration enforcement purposes.

Relevant Statutes
HIPAA established federal standards for the confidentiality, security, and transmissibility of healthcare information. Healthcare facilities should be well-versed in ensuring HIPAA compliance.

As mentioned above, with respect to immigration enforcement, HIPAA-protected information must be withheld unless limited exceptions apply. An immigration official may attempt to obtain such information by relying on a HIPAA exception, 45 Code of Federal Regulations section 164.512, subdivision (k)(5)(i). However, this regulatory exception is permissive. Therefore, the healthcare facility need not provide the HIPAA-protected information to the requesting immigration enforcement official invoking that exception. Also, the exception is available only when an immigration enforcement official demonstrates that there is "lawful custody" of the patient, and only to the extent that disclosure of the HIPAA-protected information is necessary for the provision of healthcare or specific purposes such as the health and safety of the custodial institution. Therefore, unless immigration enforcement officials provide evidence of lawful custody, the HIPAA-protected information should not be released and only to the extent allowed by HIPAA.

Different Types of Documents Requesting Information
The type of entity issuing the request determines a covered entity's response:

ICE Administrative "Warrant"
An ICE administrative "warrant" is the most typical type used by immigration enforcement officers. Such a document authorizes an immigration enforcement officer to arrest a person suspected of violating immigration laws. An ICE warrant can be issued by any authorized immigration enforcement officer. An ICE administrative warrant is not a warrant within the meaning of the Fourth Amendment to the U.S. Constitution, because an ICE warrant is not supported by a showing of probable cause of a criminal offense. An ICE warrant is not issued by a court judge or magistrate.

An ICE warrant does not grant an immigration enforcement officer any special power to compel facility personnel to cooperate with his or her requests. For example, an ICE warrant does not authorize access to non-public areas of a healthcare facility. An ICE warrant alone does not allow an immigration enforcement officer to search facility records. (See Appendix A for a sample ICE administrative "arrest warrant" (Form I-200), and Appendix B for a sample ICE "removal warrant" (Form I-205).)

Facility personnel should not physically interfere with an immigration enforcement officer in the performance of his or her duties. However, a facility employee is not required to assist with the apprehension of a person identified in an ICE administrative warrant, nor is a facility employee required to consent to an immigration enforcement officer's search of the facility. In fact, a healthcare facility that is a public employer may not provide voluntary consent to an immigration enforcement officer seeking access to a nonpublic area when presented with an ICE warrant.[91]

Federal Court Warrant
A federal court warrant is issued by a district judge or a magistrate judge of a U.S. District Court, based on a finding of probable cause authorizing the search or seizure of property, the entry into a nonpublic place to arrest a person named in an arrest warrant, or the arrest of a named person.

There are two types of federal court warrants, a search-and-seizure warrant and an arrest warrant.

- A federal search-and-seizure warrant allows an officer to conduct a search authorized by the warrant. (See Appendix C for a sample federal search and seizure warrant (Form AO 93).)
- A federal arrest warrant allows an officer to arrest the individual named in the warrant. (See Appendix D for a sample federal arrest warrant (Form AO 442).)

Prompt compliance with a federal court warrant is usually required. Where feasible, however, healthcare facility personnel should consult with a designated healthcare facility official or legal counsel before responding.

Administrative Subpoena
An administrative subpoena is a document that requests production of documents or other evidence, and (in the immigration enforcement context) is issued by an immigration enforcement officer. The administrative subpoena will contain the following information: file number, subpoena number, mailing address to which to mail the requested information, a list of the regulations that apply, the request for information, and the signature(s) of the officer(s). (See Appendix E for a sample administrative subpoena (Form I-138).)

A healthcare facility generally does not need to immediately comply with an administrative subpoena. If an immigration enforcement officer arrives with an administrative subpoena, the facility may decline to produce the information sought and may choose to challenge the administrative subpoena before a judge. Therefore, facility personnel should immediately contact a designated administrator or the facility's legal counsel upon receipt of a subpoena.

Federal Judicial Subpoena
A federal judicial subpoena is a document that asks for the production of documents or other evidence. The federal judicial subpoena will identify a federal court and the name of the judge

or judicial magistrate issuing the subpoena, and may require attendance at a specific time and location and the production of prescribed records. (See Appendix F for a sample federal judicial subpoena.)

As with an administrative subpoena, noted above, a healthcare facility generally does not need to immediately comply with a federal judicial subpoena, and can challenge it before a federal judge in a U.S. District Court. Facility personnel should therefore immediately contact a designated facility administrator or legal counsel upon receipt of a federal judicial subpoena.

Court Order
If an immigration enforcement officer arrives with a court order, a designated healthcare facility administrator shall review the order with legal counsel or other designated person, and then respond accordingly.

Notice to Appear
A notice to appear (NTA) is a charging document issued by ICE, CBP, or U.S. Citizenship and Immigration Services (USCIS) seeking to commence formal removal proceedings against an individual before an immigration court. An NTA contains allegations made about a particular person's immigration status. An NTA notifies an individual that he or she is expected to appear before an immigration judge on a certain date. An NTA does not authorize an individual's arrest by immigration enforcement authorities or local law enforcement authorities.[92] (See Appendix G for a sample notice to appear form (Form I-862).)

An NTA does not require health facility staff to take any action, and also does not grant an officer engaged in immigration enforcement any special power to compel the facility to cooperate with the officer. An NTA does not authorize access to nonpublic areas of the facility. An NTA does not legally require facility staff to allow authorities to search facility records.

Medical Code of Ethics
The American Medical Association's Code of Medical Ethics sets forth a number of principles which relate to a doctor's obligation to provide care, even in the face of immigration enforcement activities. For example, physicians must provide competent medical care; they must respect the rights of patients, and "safeguard patient confidences and privacy within the constraints of the law"; and, while caring for a patient, they must "regard responsibility to the patient as paramount." Therefore, doctors may have ethical obligations to their patients that require restricting immigration enforcement officers' access to a patient.

Substance Abuse Disorder Treatment Facilities
A facility that is subject to 42 CFR Part 2 cannot release information about a patient, event in response to a subpoena or other lawful order, unless a court order that satisfies 42 C.F.R. 2.61-2.67, as applicable, is also allowed. Facility staff should review any request for access with legal counsel or other designed persons in light of Part 2's specific requirements.

Additional Resources
In the event that a patient is detained, the healthcare facility should refer the patient or his or her family members to other resources for assistance, including, but not limited to the following.

ICE Detainee Locator
The ICE detainee locator (https://locator.ice.gov/odls/homePage.do) can help people determine if their family member has been detained and where the family member is being held. In using the ICE detainee locator, it is helpful to know the family member's date of birth and 'A-Number' (Alien Registration Number), if there is one. The ICE detainee locator is intended only for locating individuals who are already detained. If an individual has general questions about his or her immigration status, he or she should be referred to the list of legal service providers.
Legal Assistance
Immigration lawyers in private practice, accredited representatives (who assist immigrants in immigration proceedings), or legal-aid organizations may be able to provide legal assistance to secure the release of a patient or his or her family member or to help arrange for the patient to visit the family member.

An individual can determine whether lawyers are licensed by and in good standing with the State Bar of California, by checking online at http://www.calbar.ca.gov/Attorneys.

Individuals should not hire a "notario" or an immigration consultant if they are seeking advice and assistance regarding their immigration status. Notarios and immigration consultants are not attorneys or experts in immigration. In fact, they are not legally required to know anything about immigration law because they are only allowed to help with non-legal tasks like translating information. They cannot—and should not—provide advice or direction about an individual's immigration forms or speak to the government on their behalf.

A list of California organizations accredited by the Board of Immigration Appeals (BIA) to represent immigrants before the DHS and Executive Office of Immigration Review (EOIR) can be found here: https://www.justice.gov/eoir/page/file/942306/download#CALIFORNIA.

California courts operate Self-Help Centers that may also be able to provide family-law assistance of relevance. A list of these centers across the State is available at https://selfhelp.courts.ca.gov/self-help/find-self-help
A patient or his or her family member may be able to find legal assistance from legal-aid offices and lawyer-referral services at the California Department of Social Services website, https://www.cdss.ca.gov/benefits-services/more-services/immigration-services/immigration-services-contractors, or at the California Courts website, http://www.courts.ca.gov/1001.htm.

Consulate or Embassy
The consulate or embassy of the patient's country of origin may be able to offer additional information and assistance.

Policy Recommendations

1. Establish Procedures for Monitoring and Receiving Visitors to Healthcare Facilities and Designating Restricted-access Areas

Healthcare facilities should have in place policies for receiving visitors to their facilities, and those policies should apply to immigration enforcement officers. Immigration enforcement

officers may be in civilian clothing without displaying a badge or other insignia. Model policies for receiving and registering outsiders, including immigration enforcement officers, are included below. Healthcare facilities may post a "notice to authorities" at facility entrances. (See sample below.)

Healthcare facilities should develop policies to enhance the privacy available to facility users while being consistent with their healthcare mission. Healthcare facilities should consider which areas of their facilities can benefit from restricted access and clearly designate those areas through mapping, signage, key-entry, or a combination thereof. Healthcare facilities can have, and indeed do have, different policies in place regarding restricted areas, for instance, areas designated for staff or patients only. Designating restricted areas and policies limiting access to outsiders can promote the need for a safe environment conducive to the facility's mission. Healthcare facilities should also acknowledge that immigration enforcement activities, and threats of such activities, interfere with healthcare facility activities and should adopt policies on restricted areas and similar policies regarding access to facilities that promote the facility's mission. While restricted areas protect facility users and staff in other ways and promote the need for a safe environment conducive to the institution's mission, such restrictions on access will not always equate to Fourth Amendment protection.

The Immigrant Worker Protection Act (Assembly Bill No. 450; 2017-2018 Regular Session), imposes obligations on public employers and persons acting on their behalf, in the event an officer engaged in immigration enforcement seeks to enter an employer's place of business, subject to certain exceptions.[93]

Public employers, or persons acting on behalf of the public employer, are prohibited from providing "voluntary consent" for an immigration enforcement officer to enter "any nonpublic areas of a place of labor."[94] This provision does not apply if the immigration officer provides a judicial warrant.[95] (Additional information about how to identify judicial warrants can be found below.) This provision also does not preclude an employer from bringing an immigration enforcement officer into a nonpublic area of the workplace for the purpose of determining whether the agent has a judicial warrant, "provided no consent to search nonpublic areas is given in the process."[96]

Whether voluntary consent has been provided by an employer, or a person working on behalf of an employer, is a fact-based determination that depends upon the specific circumstances of the interaction between the employer and the officer conducting immigration enforcement, including the conduct of, and words used by, the employer or person working on behalf of the employer. In general, for consent to be voluntary, it cannot be the result of duress or coercion, whether express or implied.

2. Develop Policies for Responding to Immigration Enforcement Officer's Physical Presence at Healthcare Facility

When the circumstances allow, healthcare facility personnel should immediately notify healthcare facility management or a designated healthcare facility administrator of any request by an immigration enforcement officer for healthcare facility physical access or patient access, or any requests for review of healthcare facility documents (including via the service of a lawful subpoena, a petition, a complaint, a warrant, or a court order). Also, healthcare facility personnel shall direct the immigration enforcement officer to the designated healthcare facility administrator when the immigration enforcement officer requests access to a healthcare facility site or patient, including to obtain information about a patient or his or her family. The healthcare facility administrator should, in turn, contact the healthcare facility's legal counsel and inform the immigration enforcement officer to direct requests and questions to the healthcare facility's legal office.

Healthcare facility personnel should identify circumstances in which granting immigration enforcement officers access to patients may interfere with physicians' duty to provide competent medical care, to safeguard patient confidences and privacy, and to otherwise prioritize their obligations to their patients. If a provider determines that granting a request for access would interfere with their ethical obligations to the patient, they should consult with the healthcare facility's ethics official and legal counsel.

The policy language below provides specific steps that healthcare facility personnel should follow in responding to an officer present at the healthcare facility specifically for immigration-enforcement purposes.

3. Develop Policies Regarding Parental Notification of Immigration Enforcement Actions

Healthcare facility personnel should require consent from a minor patient's parent or guardian before a minor can be interviewed or searched by any officer seeking to enforce immigration laws at a healthcare facility, unless the officer presents a valid, effective warrant signed by a judge (see, e.g., sample federal search and seizure warrant [Form AO 93], attached as Appendix C; see also sample federal arrest warrant [Form AO 442], attached as Appendix D), or presents a valid, effective court order. Healthcare facility personnel should immediately notify the minor's parents or guardians if a law enforcement officer requests or gains access to a minor for immigration enforcement purposes, unless such access was in compliance with a judicial warrant or subpoena that restricts the disclosure of the information to the parent or guardian. Health facilities are encouraged to consult with their attorneys if situations involving the parental notification of information enforcement actions arise.

4. Develop Training Programs for Healthcare Facility Staff

Healthcare facilities shall establish training regarding immigration issues for healthcare facility staff and relevant volunteers, including information on responding to requests from officers enforcing immigration law to visit facility sites or to have access to patients. If feasible, the healthcare facility should also designate an immigrant-affairs liaison to facilitate training programs for staff and relevant volunteers, to help provide non-legal advice to families, and to

assist in communications with the healthcare facility and other stakeholders in local and state government.

5. Encourage Patient Preparedness

Healthcare facilities should encourage patients to attend community "Know Your Rights" trainings and update their emergency contacts. Healthcare facilities should provide patients with contact information for legal-assistance organizations, to help patients make family preparedness plans (e.g., designating a standby legal guardian for minor children), in the event that a parent is taken into immigration custody.[97]

Model Policies

All healthcare facilities operated by the State or a political subdivision of the State shall adopt the following model policies, or equivalent policies, and all other California healthcare facilities are encouraged to adopt the following model policies, or equivalent policies. The text below should be adapted by inserting the information sought in the bracketed portions.

Model Policies for Monitoring and Receiving Visitors into Healthcare Facilities

- No visitor—which would include immigration enforcement officers—shall enter or remain on [healthcare facility] grounds without having registered with [healthcare facility]'s designee. If there are no exigent circumstances necessitating immediate action, and if the visitor does not possess a judicial warrant or court order that provides a basis for the visit, the visitor must provide the following information to [healthcare facility]'s designee:
  - ✓ Name, address, occupation;
  - ✓ Age, if less than 21 years;
  - ✓ Purpose in entering [healthcare facility];
  - ✓ Proof of identity.

  (Try to obtain this information even from a visitor or officer with a court order.)
- [Healthcare facility] shall post signs at the entrances of the facility to notify outsiders of the hours of operation and requirements for registration.
- [Healthcare facility] personnel shall report entry by immigration enforcement officers to the [designated healthcare facility administrator], as would be required for any unexpected or unscheduled outside visitor coming into the facility.

Model Policies for Responding to Immigration Law Enforcement at Healthcare Facilities

- As soon as possible, [healthcare facility] personnel shall notify the [designated healthcare facility administrator] of any request (including subpoenas, petitions, complaints, warrants, or court orders) by an immigration law enforcement officer to access a healthcare facility or a patient, or any request for the review of [healthcare facility] documents.
- In addition to notifying the [designated healthcare facility administrator], [healthcare facility] personnel shall take the following steps in response to an officer present at the healthcare facility for immigration enforcement purposes:
  1. Advise the officer that before proceeding with his or her request, [healthcare facility] staff must first notify and receive direction from the [designated healthcare facility administrator].
  2. Ask to see, and make a copy of or note, the officer's credentials (name and badge number). Also ask for and copy or note the telephone number of the officer's supervisor.
  3. Ask the officer to explain the purpose of the officer's visit, and note the response.
  4. Ask the officer to produce any documentation that authorizes healthcare facility access.
  5. Make copies of all documents provided by the officer.
  6. Decline to answer questions posed by the officer and direct him or her to speak to the [designated healthcare facility administrator].
  7. State that [healthcare facility] does not consent to entry of [healthcare facility] or portions thereof.
  8. Without expressing consent, respond according to the requirements of the officer's documentation. If the officer has:
     - An ICE administrative "warrant" (see Appendices A and B): Immediate compliance is not required. Inform the officer that [healthcare facility] cannot respond to the warrant until after it has been reviewed by a designated administrator. Provide a copy of the warrant to the designated administrator as soon as possible.
     - A federal judicial warrant (either a search-and-seizure warrant or an arrest warrant; see Appendices C and D): Prompt compliance usually is required, but, where feasible, staff should consult with legal counsel before responding.
     - A subpoena for production of documents or other evidence (see Appendices E and F): Immediate compliance is not required. Inform the officer that [healthcare facility] cannot respond to the subpoena until after it has been reviewed by a designated administrator. Give your copy of the subpoena to the designated administrator or legal counsel as soon as possible.
     - A notice to appear (see Appendix G): This document is not directed at the healthcare facility. Healthcare facility staff is under no obligation to deliver or facilitate service of this document to the person named in the document. If you get a copy of the document, give it to your designated healthcare facility

administrator as soon as possible.

Model Policies for Responding to Immigration Law Enforcement at Healthcare Facilities (Continued)

9. Document the officer's actions in as much detail as possible when he or she enters [healthcare facility] premises, but without interfering with the officer's movements.
10. If the officer orders staff to provide immediate access to facilities, [healthcare facility] staff should comply with the officer's order and also immediately contact a designated administrator. Personnel also should not attempt to physically interfere with the officer, even if the officer appears to be acting without consent or appears to be exceeding the purported authority given by a warrant or other document. If an officer enters the premises without authority, [healthcare facility] personnel shall simply document the officer's actions while at the facility.

12. [Healthcare facility] staff should complete an incident report that includes the information gathered as described above and the officer's statements and actions.

Model Policies for Parental Notification of Immigration Law Enforcement Actions

1. [Healthcare facility] personnel must receive consent from a minor patient's parent or guardian (provided the child is not legally regarded as his or her own personal representative of his or her medical records) before a minor patient can be interviewed or searched by any officer seeking to enforce the civil immigration laws at [healthcare facility], unless the officer presents a valid, effective warrant signed by a judge, or presents a valid, effective court order.
2. [Healthcare facility] personnel shall immediately notify the minor patient's parent or guardian if a law enforcement officer requests or gains access to a patient for immigration enforcement purposes, unless such access was in compliance with a judicial warrant or subpoena that restricts the disclosure of the information to the parent or guardian.

Endnotes

[1] Marisol Cuellar Mejia et al., Public Policy Institute of California, *Immigrants in California* (Jan. 2024), available online at https://www.ppic.org/publication/immigrants-in-california/ (last visited Dec. 2, 2024).

[2] Gov. Code, § 7284.2, subd. (c).

[3] California Association of Public Hospitals and Health Systems, *Reducing Health Disparities at California's Public Health Care Systems* (May 2018), pp. 1-2, available online at https://www.dhcs.ca.gov/services/Documents/CAPH_SNI_DisparityReductionBrief.pdf (last visited Dec. 2, 2024).

[4] See The Commonwealth Fund, *The U.S. Healthcare System*, available online at https://www.commonwealthfund.org/international-health-policy-center/countries/united-states (last visited Dec. 2, 2024).

[5] 42 U.S.C. § 1395dd; 42 C.F.R. § 440.255; see also Centers for Medicare & Medicaid Services (CMS), *Emergency Medical Treatment and Labor Act* (EMTALA) (Mar. 2012), available online at https://www.cms.gov/medicare/regulations-guidance/legislation/emergency-medical-treatment-labor-act (last visited Dec. 2, 2024); Fact Sheet: Emergency Health Servs. For Undocumented Aliens (May 9, 2005), https://www.cms.gov/newsroom/fact-sheets/emergency-health-services-undocumented-aliens (last visited Nov. 22, 2024).

[6] Welf. & Inst. Code, § 14007.8(a)(2); see also DHCS, Coverage for All, https://www.dhcs.ca.gov/Get-Medi-Cal/Pages/coverage-for-all.aspx (last visited Nov. 22, 2024).

[7] Health & Saf. Code, § 1317.

[8] Covered public healthcare facilities are those operated by the State or a political subdivision of the State, and all other organizations and entities that provide services related to physical or mental health and wellness. Gov. Code, § 7284.8, subd. (a). SB 54 defines "immigration enforcement" to include "any and all efforts to investigate, enforce, or assist in the investigation or enforcement of any federal civil immigration law, and also includes any and all efforts to investigate, enforce, or assist in the investigation or enforcement of any federal criminal immigration law that penalizes a person's presence in, entry, or reentry to, or employment in, the United States." Gov. Code, § 7284.4, subd. (f). This guide adopts that definition.

[9] Gov. Code, § 7284.8, subd. (a).

[10] Gov. Code, § 7284.4, subd. (d). The statute defines "health facility" by reference to parts of the Health and Safety Code, under which health facilities include general acute care hospitals; acute psychiatric hospitals; skilled nursing facilities; intermediate care facilities; special hospitals (dentistry or maternity); intermediate care facilities for the developmentally disabled; congregate living healthcare facilities; correctional treatment centers (i.e., healthcare facilities operated by the California Department of Corrections and Rehabilitation); and hospice facilities. Health & Saf. Code, §§ 1200, 1200.1, and 1250.

[11] Public employers have federal and state obligations based on their statuses as employers, and this guide does not address those obligations. For example, state law prohibits an employer, or a person acting on the employer's behalf, from providing voluntary consent to an immigration enforcement officer to access, review, or obtain the employer's employee records without a subpoena or judicial warrant, unless certain exceptions apply. Gov. Code, § 7285.1, subd. (a). Employers should ensure that all their policies are consistent with applicable federal and state law.

[12] Gov. Code § 7284.6, subd. (a)(1)(G)

[13] Examples of law enforcement agents and officers include (city) police chiefs, police officers, (county) sheriffs, deputy sheriffs, healthcare facility police officers or security agents, and virtually any agent of the U.S. Department of Homeland Security (DHS).

[14] For more general guidance about how to protect patient privacy, healthcare facilities should consult with the California Center for Data Insights and Innovation's *Statewide Health Information Policy Manual* (SHIPM), available online at https://www.cdii.ca.gov/compliance-and-policy/statewide-health-information-policy-manual-shipm/ (last visited Nov. 22, 2024). The California Hospital Association also publishes guidance for the association's members regarding privacy; see California Health Information Privacy Manual, available online at https://calhospital.org/publications/california-health-information-privacy-manual/ (last visited Nov. 22, 2024). Patients seeking general information about their privacy rights and remedies should consult the California Attorney General's guide, *Your Patient Privacy Rights: A Consumer Guide to Health Information Privacy in California*, available online at https://oag.ca.gov/privacy/facts/medical-privacy/patient-rights (last visited Nov. 22, 2024).

[15] 45 C.F.R. § 164.506.

[16] 45 C.F.R. § 164.508.

[17] 45 C.F.R. §§ 164.502, subd. (b); 164.514, subd. (d); 164.530, subd. (c).

[18] 45 C.F.R. §§ 164.502, subd. (a); 164.512; 164.514, subds. (e),(f), or (g).

[19] 42 C.F.R. pt. 2.

[20] Cal. Const., art. I, § 1

[21] Civ. Code, §§ 56 et seq.

[22] Health & Saf. Code, §§ 123110 et seq.

[23] Ins. Code, §§ 791 et seq.

[24] Civ. Code, §§ 1798 et seq. A government agency may not disclose an individual's personal information without his or her consent, other than to a guardian or conservator of the individual, to officers or employees of the agency that holds the information for the performance of their official duties, or where authorized by state or federal law. *Id.*, § 1798.24, subds. (c-e).

[25] Health & Saf. Code, §§ 1280.15, 1280.18.

[26] 45 C.F.R. §§ 160.103; 164.514, subd. (b)(2)(I)(R) (listing as items to be removed to ensure de-identification: "[a]ny. . .unique identifying number, characteristic, or code [...]"); Civ. Code, § 56.05, subd.(j) ("'Individually identifiable' means that the medical information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the individual's identity").

[27] 45 C.F.R. § 164.520 (federal Health Insurance Portability and Accountability Act [HIPAA] regulation requiring provision of notice of privacy practices); Civ. Code, § 1798.17; Gov. Code, § 11019.9; California Department of General Services, *State Administrative Manual* (2014), § 5310.1, available online at https://www.dgs.ca.gov/Resources/SAM/TOC/5300/5310-1 (last visited Nov. 22, 2024).

[28] See California Department of Health Care Services (DHCS), *Hospital Presumptive Eligibility (HPE) Program Frequently Asked Questions*, available online at https://mcweb.apps.prd.cammis.medi-cal.ca.gov/faq/hpe-faq (last visited Nov. 22, 2024). According to DHCS, an applicant does not need to provide a Social Security number, although doing so is "highly recommended." *(Ibid.)*

[29] U.S. Dep't of Health and Human Services, Immigration Status to Qualify for the Marketplace, available at https://www.healthcare.gov/immigrants/immigration-status/ (last checked Nov. 22, 2024).

[30] U.S. Immigrations and Customs Enforcement (ICE), *Clarification of Existing Practices Related to Certain Health Care Information* (Oct. 25, 2013), available online at https://www.ice.gov/doclib/ero-outreach/pdf/ice-aca-memo.pdf (last visited Nov. 22, 2024).

[31] DHCS, *Coverage for All*, available online at https://www.dhcs.ca.gov/Get-Medi-Cal/Pages/coverage-for-all.aspx (last visited Nov. 22, 2024).

[32] Ibid.

[33] Welf. & Inst. Code, § 14100.2, subd. (a); see also Centers for Medicare & Medicaid Services (CMS), *Eligibility for Non-Citizens in Medicaid and CHIP* (Nov. 2014), available online at https://www.medicaid.gov/medicaid/outreach-and-enrollment/downloads/overview-of-eligibility-for-non-citizens-in-medicaid-and-chip.pdf (last visited Nov. 27, 2024) (noting that collection of Social Security number must be consented to and used only to determine eligibility for applicant/beneficiary, or for purpose directly connected to Medicaid).

[34] Welf. & Inst. Code, §§ 14005.64(c)(3)(A); 14013.3(d)(1); Cal. Code Regs., tit. 22, §§ 50260, 50262.3, subd. (a); see also DHCS, *Medi-Cal Access Program*, available online at http://mcap.dhcs.ca.gov/MCAP_Program/ (last visited Nov. 27, 2024).

[35] See, e.g., CMS, SORN 09-70-0526 ("Common Working File"), available online at https://www.hhs.gov/foia/privacy/sorns/09700526/index.html (last visited Nov. 27, 2024); CMS, SORN 09-70-0536 ("Medicare Beneficiary Database"), available online at https://www.hhs.gov/foia/privacy/sorns/09700536/index.html (last visited Nov. 22, 2024).

[36] See generally CMS, *Chapter 6 – Disclosure of Information*, Medicare Eligibility Manual (May 17, 2019), available online at https://www.hhs.gov/guidance/document/medicare-manual-chapter-6-disclosure-information (last visited Nov. 22, 2024). Information about individuals that is under the control of federal agencies is generally subject to the federal Privacy Act, 5 U.S.C. § 552a.

[37] For more details about immigrants' eligibility to apply for healthcare coverage through Covered California, and to receive financial assistance, see Covered California, *Immigration for Immigrants*, available online at https://www.coveredca.com/learning-center/information-for-immigrants/ (last visited Nov. 22, 2024).

[38] CMA, Final Rule Clarifying the Eligibility of Deferred Action for Childhood Arrivals (DACA) Studnets and Certain Other Noncitizens (May 3, 2024), available at https://www.cms.gov/newsroom/fact-sheets/hhs-final-rule-clarifying-eligibility-deferred-action-childhood-arrivals-daca-recipients-and-certain (last visited Nov. 22, 2024).

[39] 42 U.S.C. § 18081, subd. (b)(2).

[40] 42 U.S.C. § 1395dd(a).

[41] Ibid.

[42] 42 U.S.C. § 1395dd(b), (c).

[43] Health & Saf. Code, § 1317 (a), (d).

[44] 42 U.S.C. § 1395dd(h).

[45] The California Health & Human Services Agency's Public Charge Guide, last updated in September, 2022, is available online here: https://www.chhs.ca.gov/wp-content/uploads/2022/09/CalHHSPublicChargeGuideUPDATED_Sep22.pdf and also in Spanish here: https://www.chhs.ca.gov/wp-content/uploads/2022/09/CalHHS-GUIA-SOBRE-LA-CARGA-PUBLICA_Sep22.pdf (last visited Nov. 22, 2024).

[46] 8 U.S.C. 1182, subd. (a)(4)(E)(i)-(iii).

[47] Gov. Code, § 7284.6, subd. (a)(1)(A). See also Gardner, California Department of Justice, Division of Law Enforcement, DLE Information Bulletin No. DLE-2018-01, *Responsibilities of Law Enforcement Agencies Under the California Values Act, California TRUST Act, and the California TRUTH Act* (Mar. 28, 2018), available online at https://oag.ca.gov/sites/all/files/agweb/pdfs/law_enforcement/dle-18-01.pdf (last visited Nov. 27, 2024).

[48] Community clinics include federally qualified healthcare centers, and family planning clinics, including Ryan White funded clinics (which provide HIV/AIDS treatment and related services), all of which provide healthcare services regardless of insurance coverage or immigration status.

[49] 8 U.S.C. § 1373(a), (b).

[50] United States v. California (9th Cir. 2019) 921 F.3d 865, 888; see also, e.g., Cnty. of Ocean v. Grewal 475 F. Supp. 3d 355, 378 n.20 (D.N.J. 2020); Ocean County Board of Commissioners v. Attorney General of State of New Jersey (3d Cir. 2021) 8 F.4th 176, 182; Steinle v. City and County of San Francisco (9th Cir. 2019) 919 F.3d 1154, 1163; City of Chicago v. Sessions (N.D. Ill. 2018) 321 F.Supp.3d 855, 871, aff'd and remanded sub nom. City of Chicago v. Barr (7th Cir. 2020) 961 F.3d 882; City of Philadelphia v. Sessions, 309 F.Supp.3d 289, 331.

[51] Ibid.

[52] 45 C.F.R. § 160.103.

[53] Protected health information, also sometimes called "PHI," is individually identifiable health information. PHI excludes education records covered by the Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. § 1232g, and employment records held by a covered entity. (45 C.F.R. §§ 160.103, 164.512, subd . (f)(1).)

[54] PHI's relationship with health information is fundamental. Identifying information alone, such as personal names, residential addresses, or phone numbers, would not necessarily be designated as PHI. U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR), *Guidance Regarding Methods for De-identification of Protected Health Information in Accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule* (Nov. 2015), available online at https://www.hhs.gov/hipaa/for-professionals/special-topics/de-identification/index.html (last visited Nov. 27, 2024).

[55] 45 C.F.R. §§ 160.103; 164.514, subd. (b)(2)(i)(R) (listing as items to be removed to ensure deidentification "[a]ny other unique identifying number, characteristic, or code [...]").

[56] 45 C.F.R. § 164.512, subd. (f). State laws vary, however, as to whether healthcare facilities are required to report undocumented status.

[57] Civ. Code, §§ 56.10-56.37.

[58] *Id.*; see also Health & Saf. Code, § 1280.15.

[59] 45 C.F.R., § 164.502, subd. (g)(3).

[60] 45 C.F.R., § 164.502, subd. (g)(3)(A).

[61] 45 C.F.R., § 164.502, subd. (g)(3)(B).

[62] 45 C.F.R., § 164.502, subd. (g)(3)(C).

[63] An "unaccompanied alien child" is defined as a child who has not attained 18 years of age. (6 U.S.C. § 279(g)(2).) An "unaccompanied refugee minor" is defined as a child who has not yet attained 18 years of age. (45 C.F.R. § 400.111.) Whereas, a "child" is defined as an unmarried person under 21 years of age, for purposes of applying for an immigration benefits such as naturalization and approvals of visa petitions, issuance of visas, including special immigrant juvenile status. (8 U.S.C. § 1101(b-c).)

[64] 45 C.F.R. §164.520, subd. (a)(1).

[65] 45 C.F.R. §164.528.

[66] *Ibid*.

[67] 45 C.F.R. § 164.512, subds. (a) and (e)(1)(I).

[68] 45 C.F.R. § 164.512, subd. (d)

[69] 45 C.F.R. § 164.512, subd. (e).

[70] Civ. Code, § 56.05, subd. (j).

[71] Ibid.

[72] Civ. Code, § 56.05, subd. (m).

[73] Civ. Code, §§ 56.35-56.37.

[74] 45 C.F.R. § 160.103.

[75] HHS, OCR, Guidance Regarding Methods for De-identification of Protected Health Information in Accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (Nov. 2015), available online at https://www.hhs.gov/hipaa/for-professionals/special-topics/de-identification/index.html (last visited Nov. 27, 2024).

[76] 45 C.F.R. § 164.502(a)(2).

[77] Cal. Code Regs., tit. 17, §§ 2500 (reportable communicable diseases), 2593, 2641.5-2643.20 (Human Immunodeficiency Virus (HIV) infection reporting), 2800-2812 (reportable non-communicable diseases and conditions). For complete HIV-specific reporting requirements, see Cal. Code Regs., tit. 17, §§ 2641.30-2643.20, and California Department of Public Health (CDPH), Office of AIDS, *HIV Surveillance and Case Reporting Resources*, available online at https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OAsre.aspx (last visited Nov. 27, 2024).

[78] See CDPH, Division of Communicable Diseases, *Reportable Diseases and Conditions*, available online at https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Reportable-Disease-and-Conditions.aspx (last visited Nov. 27, 2024).

[79] 45 C.F.R. § 164.506, subd. (c).

[80] 45 C.F.R. § 164.510.

[81] 45 C.F.R. § 164.502(a)(1)(iii).

[82] 45 C.F.R. § 164.512.

[83] 45 C.F.R. § 164.514(e).

[84] *Ibid*.

[85] 45 C.F.R. § 164.512, subd. (f)(1).

[86] 45 C.F.R. § 164.512, subd. (c)(1). Where a covered entity makes a disclosure permitted or required by law, the entity must promptly inform the individual that such a report has been or will be made, except if there is reason to believe that this information will place the individual at risk.

[87] 45 C.F.R. § 164.512, subd. (f)(1)(ii)(A).

[88] 45 CFR 164.512(f)(1)(ii)(C).

[89] Healthcare facilities include general acute care hospitals; acute psychiatric hospitals; skilled nursing facilities; intermediate care facilities; special hospitals (dentistry or maternity); intermediate care facilities for the developmentally disabled; congregate living healthcare facilities; correctional treatment centers (i.e., healthcare facilities operated by the California Department of Corrections and Rehabilitation); and hospice facilities. Health & Saf. Code, §§ 1200, 1200.1, and 1250.

[90] See Morton, ICE, *Enforcement Actions at or Focused on Sensitive Locations* (Oct. 24, 2011) (available online at https://www.ice.gov/doclib/ero-outreach/pdf/10029.2-policy.pdf [last visited Nov. 27. 2024]); CBP, *DHS Protected Areas FAQs* (available online at https://www.cbp.gov/border-security/dhs-protected-areas-faqs [last visited Nov. 27, 2024]).

[91] Gov. Code, § 7285.1.

[92] *Arizona v. United States* (2012) 567 U.S. 387, 407.

[93] The Immigrant Worker Protection Act contains other terms limiting cooperation with immigration enforcement officers by public employers and persons acting on their behalf, including, for example, when responding to requests by immigration enforcement officers for employee records. (Gov. Code, § 7285.2.) These terms, and other legal requirements running between employers and their employees, fall outside the scope of this guide.

[94] Gov. Code, § 7285.1, subd. (a).

[95] *Ibid*.

[96] Gov. Code, § 7285.1, subd. (c).

[97] Instructions on how to develop a family preparedness plan, affidavits, and sample emergency cards for minors can be found online at https://www.ilrc.org/resources/family-preparedness-plan (last visited Nov. 27. 2024).

Appendix A
Immigrations and Customs Enforcement "Arrest Warrant" (Form I-200)

U.S. DEPARTMENT OF HOMELAND SECURITY **Warrant for Arrest of Alien**

File No. _____

Date: _____

To: **Any immigration officer authorized pursuant to sections 236 and 287 of the Immigration and Nationality Act and part 287 of title 8, Code of Federal Regulations, to serve warrants of arrest for immigration violations**

I have determined that there is probable cause to believe that _____ is removable from the United States. This determination is based upon:

☐ the execution of a charging document to initiate removal proceedings against the subject;

☐ the pendency of ongoing removal proceedings against the subject;

☐ the failure to establish admissibility subsequent to deferred inspection;

☐ biometric confirmation of the subject's identity and a records check of federal databases that affirmatively indicate, by themselves or in addition to other reliable information, that the subject either lacks immigration status or notwithstanding such status is removable under U.S. immigration law; and/or

☐ statements made voluntarily by the subject to an immigration officer and/or other reliable evidence that affirmatively indicate the subject either lacks immigration status or notwithstanding such status is removable under U.S. immigration law.

YOU ARE COMMANDED to arrest and take into custody for removal proceedings under the Immigration and Nationality Act, the above-named alien.

_____
(Signature of Authorized Immigration Officer)

_____
(Printed Name and Title of Authorized Immigration Officer)

Certificate of Service

I hereby certify that the Warrant for Arrest of Alien was served by me at _____ (Location)

on _____ (Name of Alien) on _____ (Date of Service), and the contents of this notice were read to him or her in the _____ (Language) language.

_____ Name and Signature of Officer

_____ Name or Number of Interpreter (if applicable)

Form I-200 (Rev. 08/10)

Appendix B
Immigrations and Customs Enforcement "Removal Warrant" (Form I-205)

DEPARTMENT OF HOMELAND SECURITY
U.S. Immigration and Customs Enforcement

WARRANT OF REMOVAL/DEPORTATION

File No: _____

Date: _____

To any immigration officer of the United States Department of Homeland Security:

_____
(Full name of alien)

who entered the United States at _____ on _____
(Place of entry) (Date of entry)

is subject to removal/deportation from the United States, based upon a final order by:

- ☐ an immigration judge in exclusion, deportation, or removal proceedings
- ☐ a designated official
- ☐ the Board of Immigration Appeals
- ☐ a United States District or Magistrate Court Judge

and pursuant to the following provisions of the Immigration and Nationality Act:

I, the undersigned officer of the United States, by virtue of the power and authority vested in the Secretary of Homeland Security under the laws of the United States and by his or her direction, command you to take into custody and remove from the United States the above-named alien pursuant to law, at the expense of:

_____
(Signature of immigration officer)

_____
(Title of immigration officer)

_____
(Date and office location)

Appendix C
Federal Search and Seizure Warrant (Form AO 93)

AO 93 (Rev. 11/13) Search and Seizure Warrant

UNITED STATES DISTRICT COURT

for the

In the Matter of the Search of
(Briefly describe the property to be searched or identify the person by name and address)

) Case No.

SEARCH AND SEIZURE WARRANT

To: Any authorized law enforcement officer

An application by a federal law enforcement officer or an attorney for the government requests the search of the following person or property located in the _____ District of _____
(identify the person or describe the property to be searched and give its location):

I find that the affidavit(s), or any recorded testimony, establishes probable cause to search and seize the person or property described above, and that such search will reveal *(identify the person or describe the property to be seized)*:

YOU ARE COMMANDED to execute this warrant on or before _____ *(not to exceed 14 days)*
☐ in the daytime 6:00 a.m. to 10:00 p.m. ☐ at any time in the day or night because good cause has been established.

Unless delayed notice is authorized below, you must give a copy of the warrant and a receipt for the property taken to the person from whom, or from whose premises, the property was taken, or leave the copy and receipt at the place where the property was taken.

The officer executing this warrant, or an officer present during the execution of the warrant, must prepare an inventory as required by law and promptly return this warrant and inventory to _____.
(United States Magistrate Judge)

☐ Pursuant to 18 U.S.C. § 3103a(b), I find that immediate notification may have an adverse result listed in 18 U.S.C. § 2705 (except for delay of trial), and authorize the officer executing this warrant to delay notice to the person who, or whose property, will be searched or seized *(check the appropriate box)*
☐ for _____ days *(not to exceed 30)* ☐ until, the facts justifying, the later specific date of _____.

Date and time issued: _____ _____
Judge's signature

City and state: _____ _____
Printed name and title

Appendix D
Federal Arrest Warrant (Form AO 442)

AO 442 (Rev. 11/11) Arrest Warrant

UNITED STATES DISTRICT COURT

for the

United States of America
v.
) Case No.
)
)
)
)
)

Defendant

ARREST WARRANT

To: Any authorized law enforcement officer

YOU ARE COMMANDED to arrest and bring before a United States magistrate judge without unnecessary delay
(name of person to be arrested) _____,
who is accused of an offense or violation based on the following document filed with the court:

☐ Indictment ☐ Superseding Indictment ☐ Information ☐ Superseding Information ☐ Complaint
☐ Probation Violation Petition ☐ Supervised Release Violation Petition ☐ Violation Notice ☐ Order of the Court

This offense is briefly described as follows:

Date: _____
Issuing officer's signature

City and state: _____
Printed name and title

Return

This warrant was received on *(date)* _____, and the person was arrested on *(date)* _____
at *(city and state)* _____.

Date: _____
Arresting officer's signature

Printed name and title

Appendix E
Department of Homeland Security Immigration Enforcement Subpoena (Form I-138)

1. To (Name, Address, City, State, Zip Code)	DEPARTMENT OF HOMELAND SECURITY **IMMIGRATION ENFORCEMENT SUBPOENA** **to Appear and/or Produce Records** 8 U.S.C. § 1225(d), 8 C.F.R. § 287.4
Subpoena Number	
2. In Reference To (Title of Proceeding) (File Number, if Applicable)	

By the service of this subpoena upon you, **YOU ARE HEREBY SUMMONED AND REQUIRED TO:**

(A) ☐ **APPEAR** before the U.S. Customs and Border Protection (CBP), U.S. Immigration and Customs Enforcement (ICE), or U.S. Citizenship and Immigration Services (USCIS) Official named in Block 3 at the place, date, and time specified, to testify and give information relating to the matter indicated in Block 2.

(B) ☒ **PRODUCE** the records (books, papers, or other documents) indicated in Block 4, to the CBP, ICE, or USCIS Official named in Block 3 at the place, date, and time specified.

Your testimony and/or production of the indicated records is required in connection with an investigation or inquiry relating to the enforcement of U.S. Immigration laws. Failure to comply with this subpoena may subject you to an order of contempt by a federal District Court, as provided by 8 U.S.C. § 1225(d)(4)(B).

3. (A) CBP, ICE or USCIS Official before whom you are required to appear Name Title Address Telephone Number	(B) Date (C) Time ☒ a.m. ☐ p.m.
4. Records required to be produced for inspection	

If you have any questions regarding this subpoena, contact the CBP, ICE, or USCIS Official identified in Block 3.

5. Authorized Official

(Signature)

(Printed Name)

(Title)

(Date)

DHS Form I-138 (6/09)

Appendix F
Federal Judicial Subpoena

AO 888 (Rev. 02/14) Subpoena to Produce Documents, Information, or Objects or to Permit Inspection of Premises in a Civil Action

UNITED STATES DISTRICT COURT

for the

_____)
Plaintiff)
v.) Civil Action No.
_____)
Defendant)

SUBPOENA TO PRODUCE DOCUMENTS, INFORMATION, OR OBJECTS OR TO PERMIT INSPECTION OF PREMISES IN A CIVIL ACTION

To:

_____
(Name of person to whom this subpoena is directed)

☐ *Production:* **YOU ARE COMMANDED** to produce at the time, date, and place set forth below the following documents, electronically stored information, or objects, and to permit inspection, copying, testing, or sampling of the material:

Place:	Date and Time:

☐ *Inspection of Premises:* **YOU ARE COMMANDED** to permit entry onto the designated premises, land, or other property possessed or controlled by you at the time, date, and location set forth below, so that the requesting party may inspect, measure, survey, photograph, test, or sample the property or any designated object or operation on it.

Place:	Date and Time:

The following provisions of Fed. R. Civ. P. 45 are attached – Rule 45(c), relating to the place of compliance; Rule 45(d), relating to your protection as a person subject to a subpoena; and Rule 45(e) and (g), relating to your duty to respond to this subpoena and the potential consequences of not doing so.

Date: _____

CLERK OF COURT

OR

_____ _____
Signature of Clerk or Deputy Clerk *Attorney's signature*

The name, address, e-mail address, and telephone number of the attorney representing *(name of party)* _____
_____, who issues or requests this subpoena, are:

Notice to the person who issues or requests this subpoena

If this subpoena commands the production of documents, electronically stored information, or tangible things or the inspection of premises before trial, a notice and a copy of the subpoena must be served on each party in this case before it is served on the person to whom it is directed. Fed. R. Civ. P. 45(a)(4).

Appendix G
Notice to Appear Form (Form I-862)

U.S. Department of Homeland Security **Notice to Appear**

In removal proceedings under section 240 of the Immigration and Nationality Act

File No: _____

In the Matter of:

Respondent: _____ currently residing at:

_____ _____
(Number, street, city, state and ZIP code) (Area code and phone number)

☐ 1. You are an arriving alien.
☐ 2. You are an alien present in the United States who has not been admitted or paroled.
☐ 3. You have been admitted to the United States, but are deportable for the reasons stated below:

The Department of Homeland Security alleges that you:

On the basis of the foregoing, it is charged that you are subject to removal from the United States pursuant to the following provision(s) of law:

☐ This notice is being issued after an asylum officer has found that the respondent has demonstrated a credible fear of persecution.

☐ Section 235(b)(1) order was vacated pursuant to : ☐ 8 CFR208.30(f)(2) ☐ 8CFR235.3(b)(5)(iv)

YOU ARE ORDERED to appear before an immigration judge of the United States Department of Justice at: _____

_____
(Complete Address of Immigration Court, Including Room Number, if any)

on _____ at _____ to show why you should not be removed from the United States based on the charge(s) set forth above.
(Date) (Time)

_____
(Signature and Title of Issuing Officer)

Date: _____ _____
(City and State)

See reverse for important information

Form I-862 (Rev. 08/01/07)

Return to Agenda

Appendix H
Quick Reference Guide for Healthcare Facility Personnel

What Should You Do if an Immigration Enforcement Officer Comes to Your Healthcare Facility?

1. As soon as possible, notify the designated healthcare facility administrator (the person tasked with responding to immigration enforcement actions at the healthcare facility) of any request (including subpoenas, petitions, complaints, warrants, or court orders) by an immigration enforcement officer to access a healthcare facility or a patient, or any request for the review of [healthcare facility] documents.
2. Advise the officer that before proceeding with his or her request, you must first notify and receive direction from a designated healthcare facility administrator.
3. Ask to see, and make a copy of or note, the officer's credentials (name and badge number). Also ask for and copy or note the telephone number of the officer's supervisor.
4. Ask the officer to explain the purpose of the officer's visit, and note the response.
5. Ask the officer to produce any documentation that authorizes healthcare facility access.
6. Make copies of all documents provided by the officer.
7. Decline to answer questions posed by the officer and direct him or her to speak to the designated healthcare facility administrator.
8. State that the healthcare facility does not consent to entry of the healthcare facilities or portions thereof.
9. Without expressing consent, respond according to the requirements of the documentation. If the officer has:
   - ✓ An ICE administrative "warrant" (see samples in Appendix, items A & B): Immediate compliance is not required. Inform the officer that the healthcare facility cannot respond to the warrant until after it has been reviewed by a designated administrator. Provide a copy of the warrant to the designated administrator as soon as possible.
   - ✓ A federal judicial warrant (either a search-and-seizure warrant or an arrest warrant; see samples in Appendix, items C & D): Prompt compliance usually is required, but where feasible, consult with legal counsel before responding.
   - ✓ A subpoena for the production of documents or other evidence (see samples in Appendix, items E & F): Immediate compliance is not required. Inform the officer that the healthcare facility cannot respond to the subpoena until after it has been reviewed by a designated administrator. Give your copy of the subpoena to the designated administrator or legal counsel as soon as possible.
   - ✓ A notice to appear (see sample in Appendix, item G): This document is not directed at the healthcare facility. There is no obligation to deliver this document or facilitate service to the person named in the document. If you get a copy of the document, give it to your designated healthcare facility administrator as soon as possible.
10. Document the officer's actions in as much detail as possible after he or she enters healthcare facility premises, but without interfering with the officer's movements.
11. If the officer orders staff to provide immediate access to facilities, comply with the officer's order and also immediately contact a designated administrator. Do not attempt to physically interfere with the officer, even if the officer appears to be acting without consent or appears to be exceeding the purported authority given by a warrant or other document. If an officer enters the premises without authority, [healthcare facility] personnel shall simply document the officer's actions while at the facility.

12. [Healthcare facility] staff should document the officer's actions while in [healthcare facility] premises in as much detail as possible, but without interfering with the officer's movements.
13. [Healthcare facility] staff should complete an incident report that includes the information gathered as described above and the officer's statements and actions.

AGENDA ITEM NO. 2

TO: Provider Advisory Committee (PAC)

FROM: Maddie Gutierrez, MMC, Sr. Clerk of the Commission

DATE: September 23, 2025

SUBJECT: Approval of the regular Provider Advisory Committee Meeting minutes of June 10, 2025

RECOMMENDATION:

Approve the minutes.

ATTACHMENTS:

Copy of the June 10, 2025 Provider Advisory Committee meeting minutes.

Ventura County Medi-Cal Managed Care Commission (VCMMCC)
dba Gold Coast Health Plan (GCHP)
Provider Advisory Committee (PAC)
Regular Meeting
June 10, 2025

CALL TO ORDER

The Dr. Pablo Velez, Vice Chair called the meeting to order at 7:32 a.m., in the Community Room located at Gold Coast Health Plan, 711 E. Daily Drive, Camarillo, California.

ROLL CALL

Present: Committee members: Masood Babaeian, Amelia Breckenridge, M.D., Molly Corbett, Claudia Gallard, Katy Krul, Amanda Larson, Josie Roemhild, Kristine Supple, and Dr. Pablo Velez.

Absent: Committee member: Sim Mandelbaum, Vince Pillard.

Gold Coast Health Plan Staff in attendance: Felix Nunez, M.D., Chief Executive Officer, Marlen Torres, Chief of Member Experience & External Affairs, Erik Cho, Chief Policy & Program Officer, Robert Franco, Chief Compliance Officer, Acting Chief Medical Officer, James Cruz, M.D., Chief Diversity Officer Ted Bagley, Vicki Wrighster, David Tovar, Michelle Espinoza, Brenda Gomez-Garcia, Kim Marquez-Johnson, and Valli Coakley.

Guests: Anastasia Dodson, and Cassidy Acosta from DHCS

PUBLIC COMMENT

None.

OPENING REMARKS

CEO Felix L. Nunez, M.D. thanked everyone for their participation on the committee. He stated times are currently challenging for access to care in our communities. During these stressful times, our communities rely on us to be available to help. We are facing many changes, but GCHP wants to continue to be a resource and remains dedicated to the work we are doing, and our strategic vision has not changed. CEO Nunez stated that he will be available for committee members and not to hesitate to contact him if they have questions or concerns.

PRESENTATION

4. D-SNP from the State Perspective

Staff: Eve Gelb, Chief Innovation Officer
Anastasia Dodson – DHCS

RECOMMENDATION: Receive and file the presentation

Eve Gelb, Chief Innovation Officer introduced Anastasia Dodson, Deputy Director of the Office of Medicare, Innovation, and Integration at DHCS. Ms. Dodson's work is about supporting those members who have both Medicare and Medi-Cal. Ms. Dodson presented her slides which provided an overview of people who are dually eligible for Medicare and Medi-Cal, Med-Medi plans, and what providers and partners can expect in 2026.

Ms. Dodson stated the Medicare covers doctor visits, hospital stays, labs, prescription drugs, etc. Medi-Cal covers the member's Part B premiums and co-pays, adult day care, skilled nursing facilities that are not otherwise covered by Medicare. She noted that Medicare and Medi-Cal are two separate programs and there are people who have both. She also noted that people who are dually eligible are a diverse group, 25% statewide are under the age of sixty-five. The most prevalent chronic condition for that population is serious behavioral health/mental illness and substance use disorders. Ms. Dodson stated that one-third of this group have limited English proficiency. 75%of people with IHSS statewide are dually eligible, for long-term skilled facility residents 80% are dually eligible. There are approximately 1.7 million dually eligible members in California. Ms. Dodson stated that all dually eligible are enrolled in a Medi-Cal Managed Care Plan. For the Medicare portion there are options such as Medicare Advantage, original Medicare, and other types of D-SNPs special needs plans, as well as PACE.

Ms. Dodson stated that Medicare and Medi-Cal are two programs, they operate separately and independently and have different funding streams; one is a federal program and there is a stated federal partnership, with different benefits and different rules. It can be hard to navigate across the two sets of benefits. Medi-Medi plans are not new, there are available in twelve counties within the state of California, and starting January 1, 2026, additional counties will be launching Medi-Medi plans.

Ms. Dodson stated that there are two different plans that work together seamlessly and are presented as one plan to the member – one is the Medi-Cal plan, and they partner with a companion Dual Special Needs Plan (D-SNP). Together they make up the Medi-Medi plan. She noted that enrollment in Med-Medi plans is voluntary, as is enrollment in any type of Medicare option.

Gold Coast will have its own marketing name for its Medi-Medi plan. For members, one of the important aspects is that the member experience is a single plan in all the member materials. They will get one card, one welcome packet, they will have one phone number to call for member services and care coordination. Care coordination is a fundamental requirement for Medi-Medi plans. There must be strong care coordination across all Medicare and all Medi-Cal benefits. Ms. Dodson stated that there is an expectation of coordination and communication with IHSS, but the health plan joining a Medi-Medi plan does not impact someone's IHSS benefits.

Joining a Medi-Medi plan does not impact someone's ability to receive community supports because of the structure where it is the Medi-Cal Managed Care Plan plus the D-SNP.

Provider network is important to members, many plans have Medicare requirements to the Medicare provider network. She noted that the member can choose from among the network, but if they do not choose, they get assigned to a primary care provider. If the provider is not in the plan network, they can make a temporary agreement for continuity of care and the provider can then see if they like being in the network – they do not have to fully join the network. Ms. Dodson also stated there new for 2025 is that dual eligibles on the Medicare side can make changes and join a Medi-Medi plan any month of the year, and they can also leave a Medi-Medi plan any month of the year. They are not locked into an annual enrollment cycle. She noted that there is also crossover billing now. For dually eligible members there is the primary payment that goes to the Medicare process and then goes secondarily to Medi-Cal which will pay a portion of the remainder. Dual eligibles are not required to have to pay any balance.

Ms. Dodson stated that it is anticipated that Medi-Medi plans will be available from GCHP and Kaiser in Ventura County in 2026. October 15 through December 7 is the Medicare open enrollment period where people can choose a plan that will start January 1.

A Medi-Medi plan is a single plan across both sets of benefits. It has care coordination, one card, one phone number, one care coordinator for both and the care coordinator is required to actively help a member find doctors, make appointments, and help with prescription drug access, as well as setting up transportation, follow up services and connections with home and community-based services.

CIO Gelb stated that she will send out the link to the stakeholder statewide meetings to our providers.

Committee member Amanda Larson asked if someone gets a Medicare plan and then gets a secondary, do they look at your medical history even if you decide to switch to another plan or are you a blank slate. You are "market value." Ms. Dodson stated that if for people who are above the income level for Medi-Cal. Medi-Medi plans are for people who have an income that is low enough to get Medi-Cal.

CIO Gelb stated that we cannot pick and choose members we accept all who qualify for Medi-Cal. All marketing must be across the board for all beneficiaries. We will launch our product name as soon as we are allowed to launch our product name. With the new plan it is an integrated plan that is going to be fully integrated.

CMO James Cruz, M.D. asked if a Medi-Medi member misses an appointment some providers will bill a member for that missed appointment, he wanted clarification that issue will not be allowed. Ms. Dodson stated that she believed that is correct, billing for a missed appointment is not allowed and will not be paid and the member will not be responsible. She stated that she will confirm on specific rules around missed appointments. It is also not legal to charge Medi-Medi patients extra fees to complete forms.

FORMAL ACTION

5. Reinstituting PAC AdHoc Committee - Review of Applicants/ Selection of new PAC members

Staff: Marlen Torres, Chief of Member Experience & External Affairs

RECOMMENDATION: Staff recommends the PAC reinstitute a nomination ad hoc subcommittee to commence the selection process of new members.

Marlen Torres, Chief of Member Experience & External Affairs stated that under the Pac Charter it is required to assemble a subcommittee to review applications. This subcommittee would review applications, work through them, and then present their recommendations. We are currently looking for three volunteers to be part of that committee.

The committee members who volunteered are Amanda Larson, Amelia Breckenridge, M.D., and Masood Babeian.

Committee member Amelia Breckenridge, M.D., motioned to approve the three volunteers. Committee member Claudia Gallard seconded.

AYES: Committee members: Masood Babaeian, Amelia Breckenridge, M.D., Molly Corbett, Claudia Gallard, Katy Krul, Amanda Larsen, Josie Roemhild, and Dr. Pablo Velez.

NOES: None.

ABSENT: Committee members Sim Mandelbaum, Vince Pillard, and Kristine Supple

The motion carried.

CONSENT

1. Approval of Regular Meeting Minutes of March 11, 2025

Staff: Maddie Gutierrez, MMC, Clerk of the Commission

RECOMMENDATION: Approve the minutes as presented.

Committee member Amanda Larson motioned to approve Agenda item 1 as presented. Committee member Masood Babaeian seconded.

AYES: Committee members: Masood Babaeian, Amelia Breckenridge, M.D., Molly Corbett, Claudia Gallard, Katy Krul, Amanda Larsen, Josie Roemhild, and Dr. Pablo Velez.

NOES: None.

ABSENT: Committee members Sim Mandelbaum, Vince Pillard and Kristine Supple

The motion carried.

UPDATES

2. Federal and State Updates

Staff: Marlen Torres, Chief Member Experience & External Affairs Officer

RECOMMENDATION: Receive and file the update.

Marlen Torres, Chief Member Experience & External Affairs Officer started by thanking the AdHoc committee members for being available to meet and securing approval from their respective organizations for us to send the coalition letter. The

House moved quickly once we met on May 19th. The Rules Committee had an overnighter, and they called the members for a vote, which was strategic. They then passed the Big, Beautiful Bill over to the Senate side. The Senate does not need to entertain a markup bill like the Energy and Commerce Finance Committee and can continue negotiations within themselves without a markup or the opportunity of public comment, which is most likely what they will do, so they will have a vote ahead of the July 4th recess. The letter we drafted went straight to senators, and now it is up to the senators to go advocate.

From a process timeline, the legislature needs to have the budget passed by June 15th and that is under a statute for them to be able to continue to get paid. The governor will need to sign this budget by June 27th. They will reconvene for a special session. In August/September, normally they are in recess, but will be reconvening to rework the budget that they are passing now, aware of proposed federal changes. Ms. Torres reviewed some of the proposals. One of the proposals is maintain freezing enrollment and Medicare for individuals with unsatisfactory immigration status ages nineteen and older – this would begin January 1, 2026. They would cap any new enrollment for individuals nineteen and older. They would include a six-month enrollment grace period. There is also a lot of discussion around the governor proposing $100 monthly premium for individuals 19 to 59. The legislature is proposing a $30 monthly premium. This would be effective July 1, 2027, which allows time for discussion on how this would be implemented. There is also a proposal to eliminate the acupuncture benefit, they are rejecting that elimination, and the acupuncture benefit would be maintained. They are also rejecting the proposal to eliminate long-term care benefits for Medi-Cal enrollees with unsatisfactory immigration status. They are still working through what the MCO tax would look like under a different trailer bill language. They have also proposed to reinstate the medical asset limit of 130,000 for individuals and 195,000 for couples. Once the legislature passes final vote, then negotiations take place with the governor. By the end of June, we should be able to see what this looks like, keeping in mind that we still must see what Congress does. We will have another session in the Fall to revisit the budget.

Committee member Amanda Larson thanks Ms. Torres for all the work done on the AdHoc Committee and being able to participate in the draft of the letter.

3. RISE Grant Update

Staff: Erik Cho, Chief Policy & Programs Officer
Ellen Rudy, Director of Grants Administration & Oversight

RECOMMENDATION: Receive and file the update

Erik Cho, Chief Policy & Programs Officer stated there is quite a bit of current instability in the health care system. We want to continue to be supportive of all our providers as much as possible. CPPO Cho announced we awarded our first set of RISE grants. The RISE Grants program is intended to be a three-year program for Gold Coast Health Plan. We have clear goals and believe we are meeting those goals in the first set of grants. We are excited about the projects that will be underway. The goals are to increase and improve access to care, to bring care to where members live, work, and go to school to improve member outcomes. We want to offer alternative healthcare solutions and remove structural barriers to care. CPPO Cho stated that applications closed on March 31st, and we had a robust response from the Community. We received thirty-five applications which we reviewed, scored, and managed. Sixteen organizations were selected to fund thirteen grants for a twelve-month period and three grants were requested and received awards for longer periods of time for the full three years. Award letters were sent June 2nd, and the grantees have all officially accepted the award. The total funding is currently $11.3million for year one and the three grants that have commitments for a longer period will receive $6.4 million in year two, and $4.1 million in year three. We will reopen the process for next year and we hope to introduce some more streamlined focuses. CPPO Cho stated that for small organizations we want to be there to provide support and guidance. CPPO Cho reviewed the list of grantees and stated it was a great mix of services. David Tovar, Incentive Strategy Manager stated that at a future meeting staff can provide a breakdown of each of the grantees and their goals.

Committee member Amanda Larson motioned to approve the updates as presented. Committee member Molly Corbett seconded.

AYES: Committee members: Masood Babaeian, Amelia Breckenridge, M.D., Molly Corbett, Claudia Gallard, Katy Krul, Amanda Larsen, Josie Roemhild, and Dr. Pablo Velez.

NOES: None.

ABSENT: Committee members Sim Mandelbaum, Vince Pillard and Kristine Supple

The motion carried.

The Clerk stated that the next meeting is scheduled for September 9, 2025, with a start time of 7:30AM.

ADJOURNMENT

With no further items to be addressed, the Clerk adjourned the meeting at 9:01 a.m.

Approved:

_____
Maddie Gutierrez, MMC
Clerk to the Commission

AGENDA ITEM NO. 3

TO: Provider Advisory Committee (PAC)

FROM: Eve Gelb, Chief Innovation Officer
Paul VerHaar, Sr. Manager, Medicare Financial Analysis

DATE: September 23, 2025

SUBJECT: Risk Adjustment Factor (RAF) & How D-SNPs are Paid

PowerPoint with Verbal Presentation

ATTACHMENTS:

RAF PowerPoint

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Gold Coast Health Plan

Integrity

Accountability

Collaboration

Trust

Respect

September 23, 2025

Paul VerHaar, Senior Manager, Medicare Financial Analysis

Return to Agenda

Traditional Medicare vs Medicare Advantage (MA)

Traditional Medicare

Offers

- (Part A) Hospital Insurance
- (Part B) Outpatient Medical including doctor visits, medical supplies, and preventive services
- The member may see any doctor in the country but must pay a 20% coinsurance with no annual out of pocket maximum

Medicare Advantage (MA)

Offers

- (Part C) is a private plan that bundles Parts A&B
- (Part D) is a Pharmacy benefit
- Supplemental benefits which can include vision, hearing and dental benefits, but restricted to in-network providers

Return to Agenda

How Does Traditional Medicare Pay Providers?

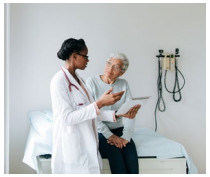
Participating **physicians** agree to accept Medicare's reimbursement as payment in full (also known as accepting "**assignment**"). Some physicians opt out of Medicare, but this represents only 1% of non-pediatric providers.

Physicians and other providers are paid based on the physician fee schedule which covers payments for thousands of services including office visits. The **fee schedule** is adjusted for several factors including geography and changes in the laws relating to Medicare payments.

Medicare pays **skilled nursing facilities** using a prospective payment system (PPS). It is also adjusted for case mix, wage index and other factors.

Medicare pays **hospitals** through the Inpatient Prospective Payment System (IPPS). Under IPPS, hospitals are paid a predetermined amount for each patient discharge based on **Medicare Severity Diagnosis Related Groups (MS-DRG)**.

The MS-DRG is adjusted for things like the wage index, facilities that are teaching hospitals, Disproportionate Share Hospitals (that serve low-income individuals), and outlier cases that are particularly expensive.



Medicare's system for paying hospitals for outpatient services like clinic visits, minor surgeries, and ER care is the Outpatient Prospective Payment System (OPPS).

Under OPPS services are grouped into APCs (Ambulatory Payment Classifications). Each APC has a fixed payment rate. CMS updates OPPS every year to reflect changes in costs and policies.

Return to Agenda

How Does Medicare Advantage Pay Providers?

For Managed Care Organizations offering a Medicare Advantage Plan, Medicare pays the health plan a **per member per month (PMPM)** premium, or capitation amount. A **risk adjustment factor** is then applied to account for member-specific acuity.

The health plan then pays providers according to its contracts with each provider. This can include paying providers fee-for-service or capitation. The health plan may also pay providers **quality incentives**.

Return to Agenda

Components of the MA Payment

Each year, MA Plans submit a bid (projected cost of providing care to a beneficiary for an entire year) to CMS. This projected cost is compared to CMS' own cost projection ("**benchmark**") of care in the MA Plan's county. If the MA Plan's bid is lower than CMS projection, and if CMS approves of the benefits, the bid is accepted. The difference ("**rebate**") between the bid and the CMS county benchmark is shared between CMS and the MA Plan, with the MA Plan using its share to enrich benefits.

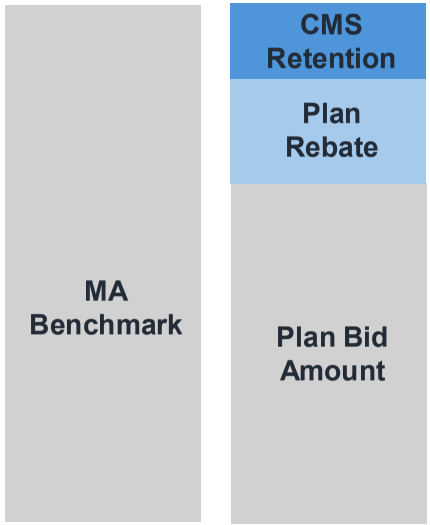
The MA Plan will receive monthly premium payments from CMS based on the bid amount and acuity ("**risk score**") of members. A Plan's Star (quality) rating also impacts final payments to plans.

Bid Amount
- Claims expense, gain/margin, and admin costs for providing Medicare benefits
- Excludes ESRD and hospice members

MA Benchmark
- A county level projection of the average cost for original Medicare benefits
- Developed by CMS using Medicare FFS member experience

Rebate
- Plan retained savings used by plan to offer non-Medicare covered services, reduced cost sharing, and/or buy down the Part D premium
- Rebate percentage determined by plan's Star Rating (MA's quality rating system)

Risk Score
- A measure of a member's morbidity and its impact on expected costs
- Used to adjust plan payment



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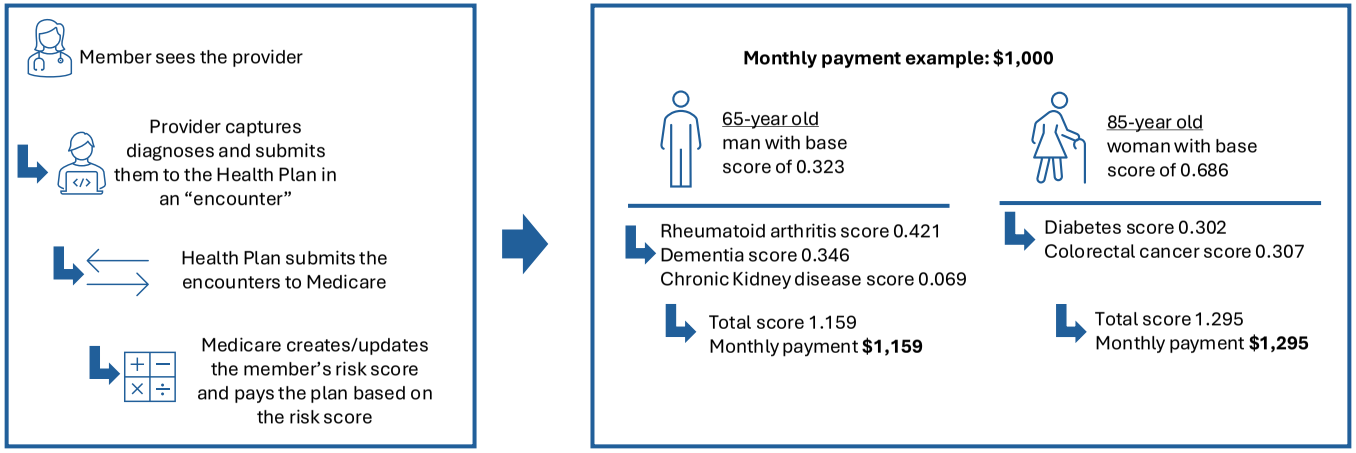
Risk Score Explained

- The Risk Score (also known as Risk Adjustment Factor – RAF) is a multiplier that CMS uses to adjust what it pays MA plans for each member using that member's demographic and medical profile (acuity as evidenced through medical charts and **diagnoses on claims and encounters**). The higher the risk score, the higher the premium paid by CMS.
- For example, an older person with multiple chronic conditions needs more care — and costs more for providers to treat — than a younger person with no health issues. Risk adjustment factor helps to ensure that MA plans are paid enough to care for the sicker members.



Base monthly premium payment is adjusted for each member's risk factors each year, so visits to the provider are vital to capture accurate revenue amount.

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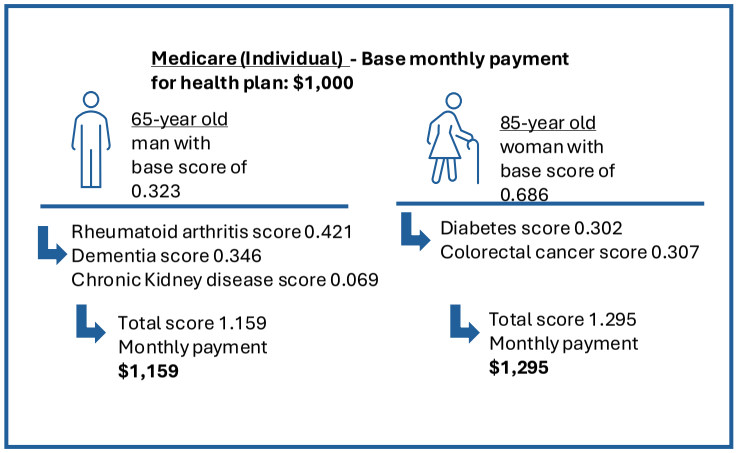
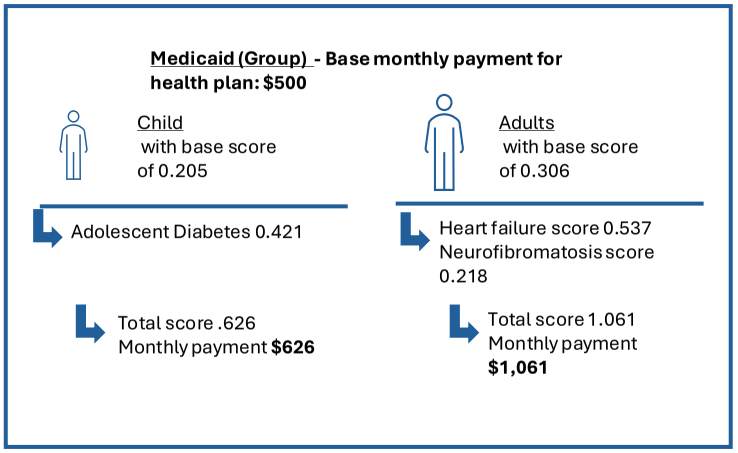
Risk Adjustment Factor is coming to Medi-Cal

- Medicaid has a RAF model like Medicare to adjust payments to health plans the patient's acuity; however, use of the model has not begun will be phased based on the individual states.
- Key difference between Medicaid and Medicare RAF: Medicaid RAF will be based on the combined acuity of an entire Group such as "Child" or "Adult". Medicare RAF is based on the acuity of each individual member.





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AGENDA ITEM NO. 4

TO: Provider Advisory Committee (PAC)

FROM: Eve Gelb, Chief Innovation Officer
Vicki Wrighster, Sr. Director of Network Operations
Maria Najar, Provider Services Representative II

DATE: September 23, 2025

SUBJECT: Dual Special Needs Plan (D-SNP) Provider Portal (Demonstration)

PowerPoint with Verbal Presentation

ATTACHMENTS:

GCHP NTT Provider Portal
DSNP Updates

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Gold Coast Health Plan

Provider Advisory Committee

GCHP NTT Provider Portal
DSNP Updates

September 23, 2025

Vicki Wrighster, Sr. Director, Network Operations
Maria Najar, Provider Relations Representative II

Integrity
Accountability
Collaboration
Trust
Respect

GCHP NTT Data Provider Portal Updates - DSNP

- **DSNP Integration**:

The provider portal has been enhanced to support the addition of Dual Special Needs Plan (DSNP) information. New fields have been introduced to capture and display DSNP data for provider use.

- **Improved Access to Critical Information**:

Providers now have access to essential healthcare details that support informed decision-making and care coordination.

- **Streamlined Care Management**:

These updates empower providers to more effectively guide members to appropriate care management resources, improving outcomes and ensuring timely support.

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PROVIDER PORTAL (DSNP) – Updated Screens & Functionalities

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Tools and Resources

Authorizations

Claims Search

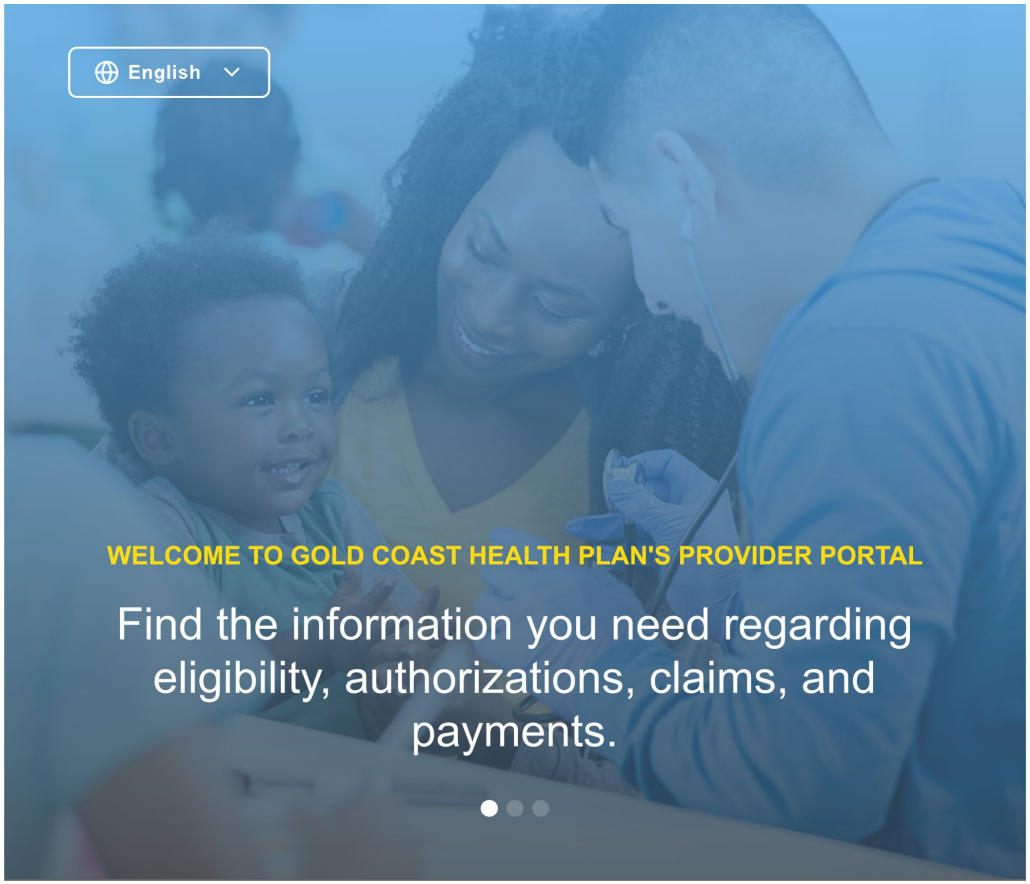
My Practice – Provider Information

Provider Locations

Patient Eligibility

Patient Eligibility – Care Management

PROVIDER PORTAL (DSNP) –Sign On Screen



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Username*
abc@zxy.com

Password*
••••••

Forgot Username or Password

Login

Not a Provider? Register here

Privacy Policy Conditions of Use Notice of Nondiscrimination

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PROVIDER PORTAL (DSNP)– Tools and Resources

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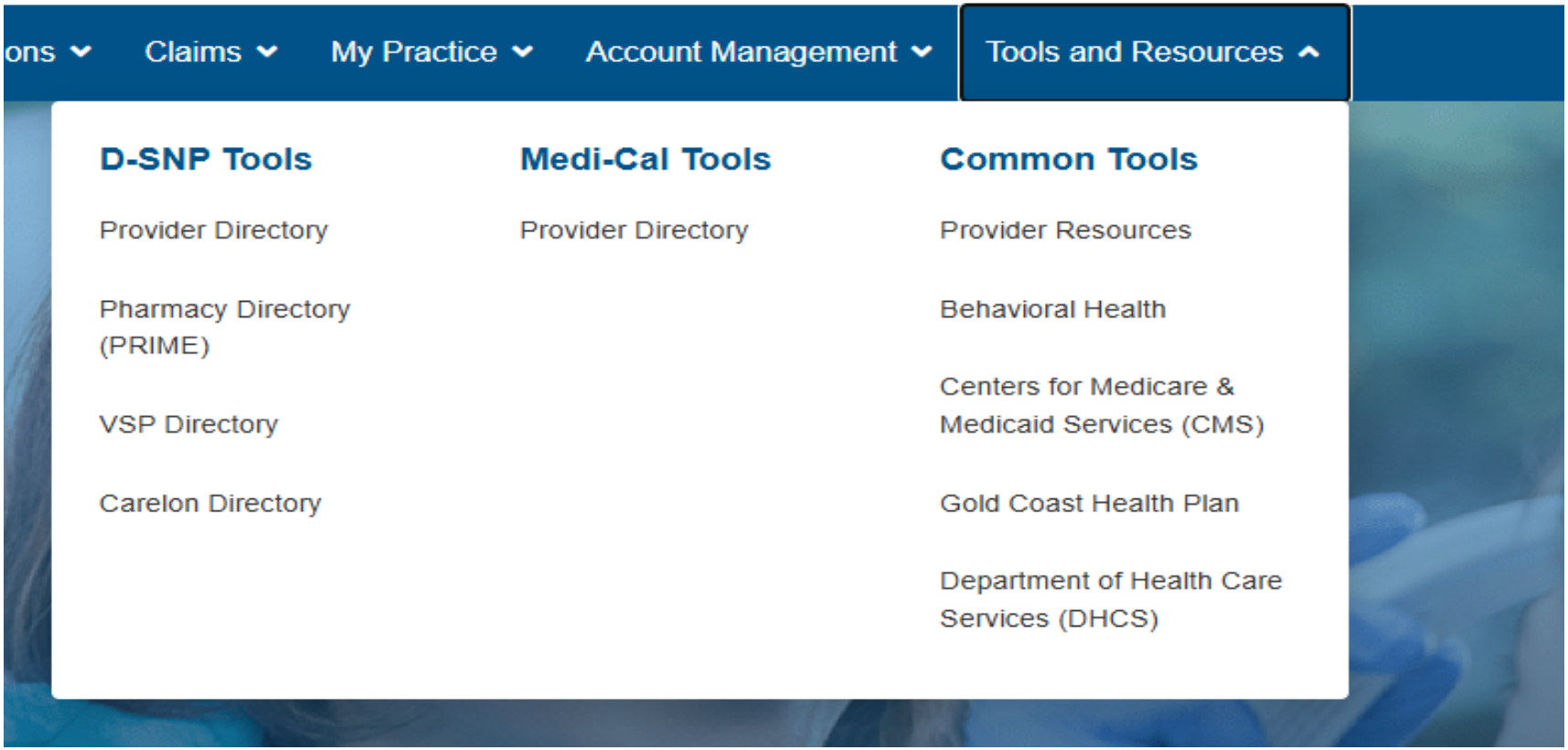

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PROVIDER PORTAL (DSNP)- Authorizations

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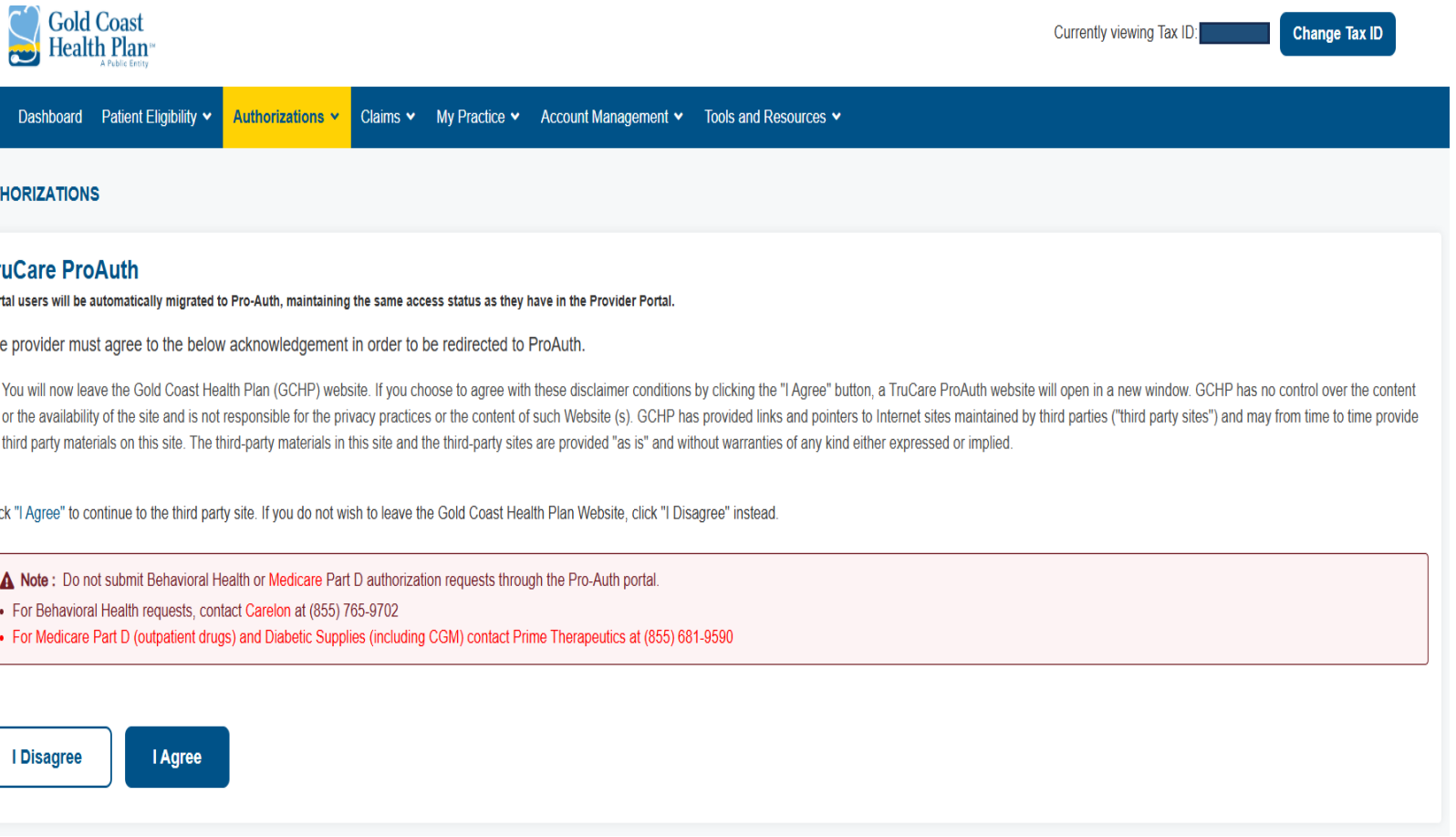

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PROVIDER PORTAL (DSNP) –Claims Search

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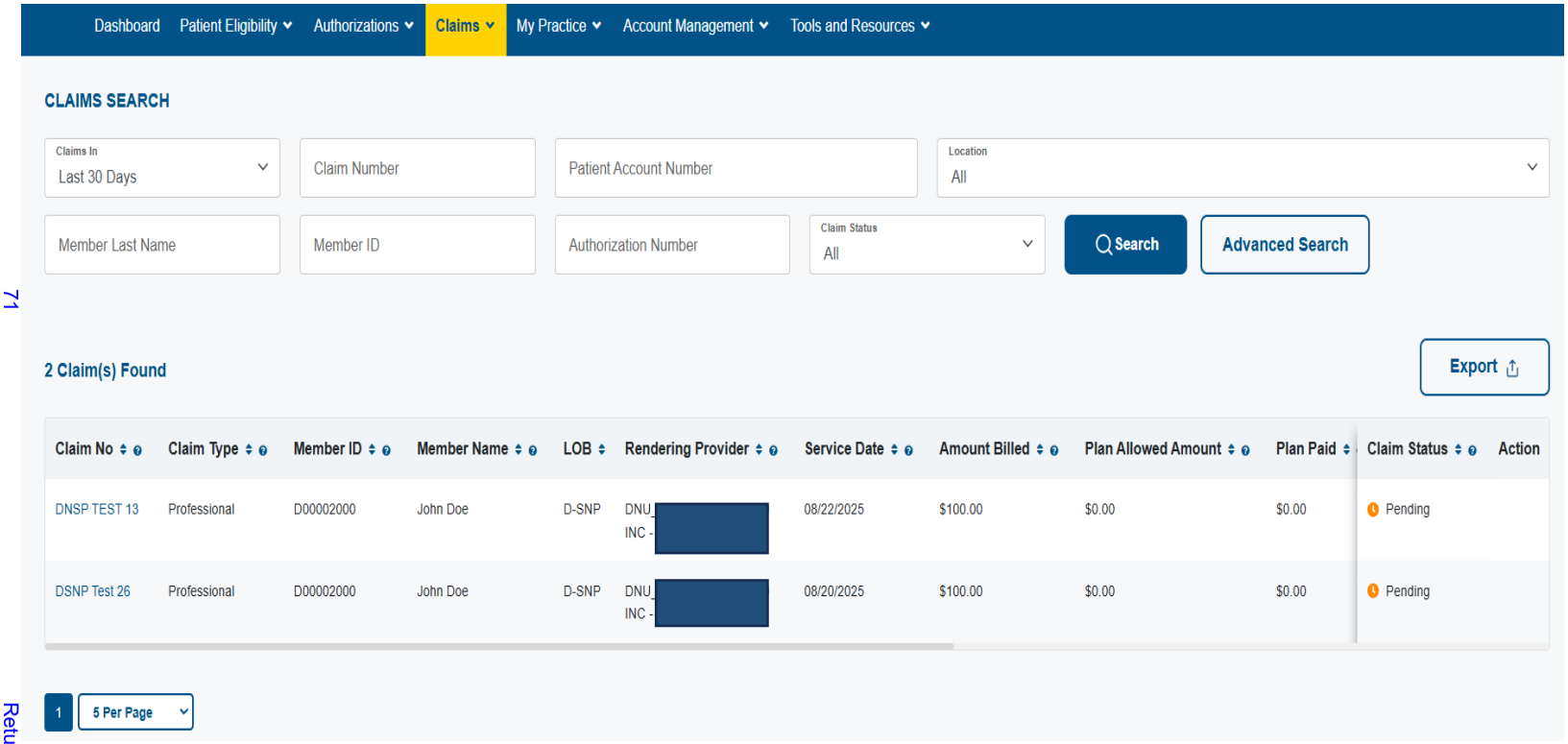

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PROVIDER PORTAL (DSNP) – Provider Information

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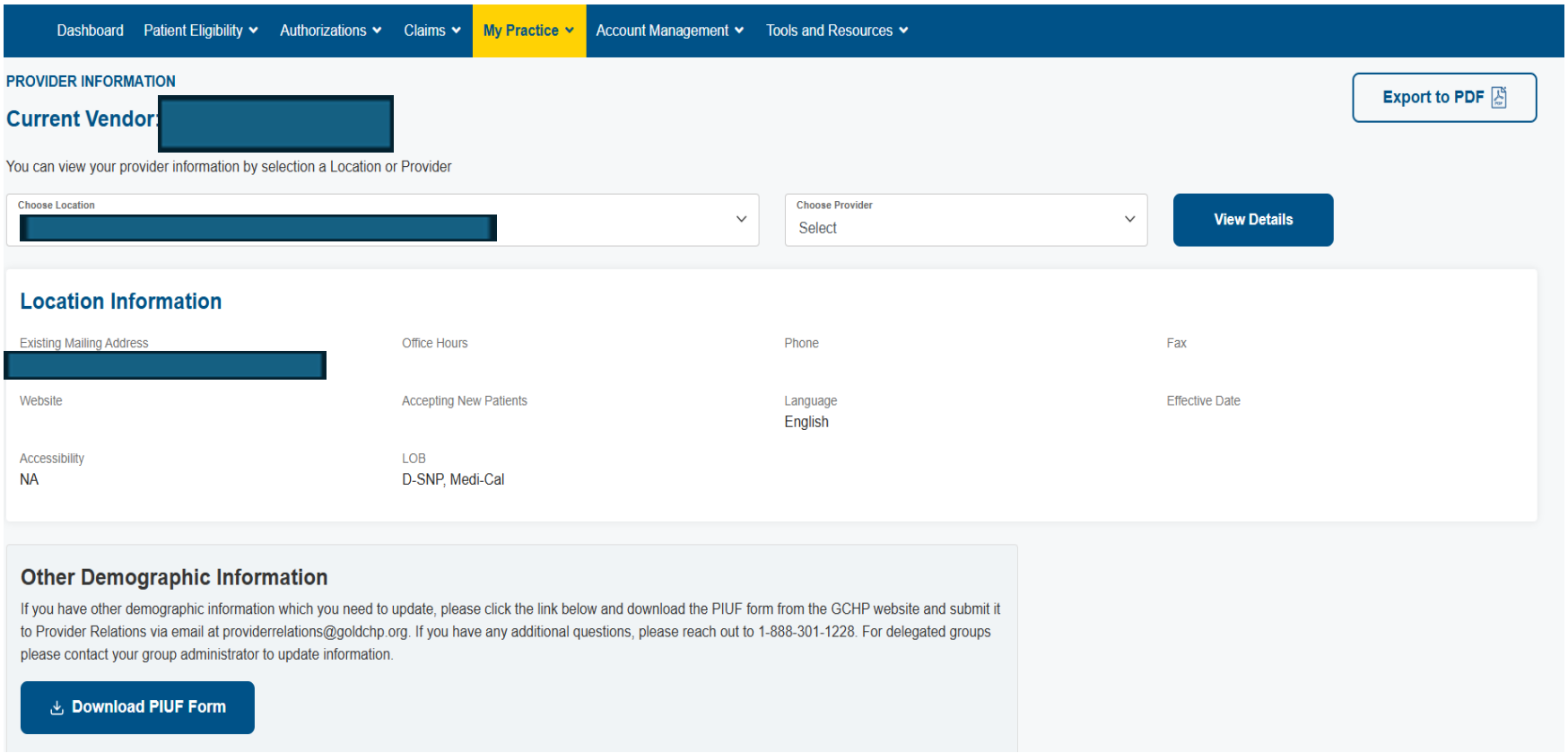

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PROVIDER PORTAL (DSNP)- Provider Locations

Provider Location Details

Paul [redacted]
Provider ID: [redacted]

Export

Location	Effective Date	Term Date	Accepting New Patients	LOB
[redacted]	07/01/2021			Medi-Cal
[redacted]	07/01/2021			Medi-Cal
[redacted]	07/01/2021			Medi-Cal

Close

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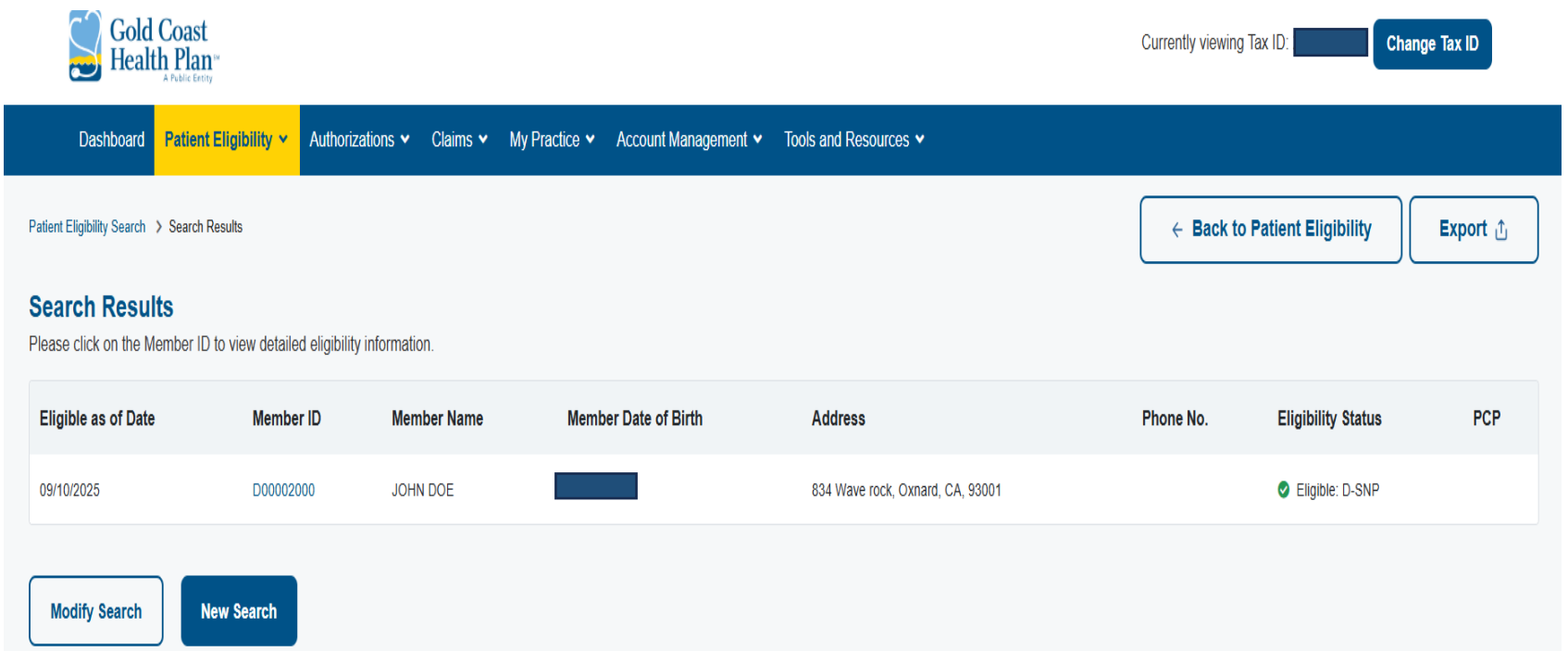
PROVIDER PORTAL (DSNP) - Eligibility



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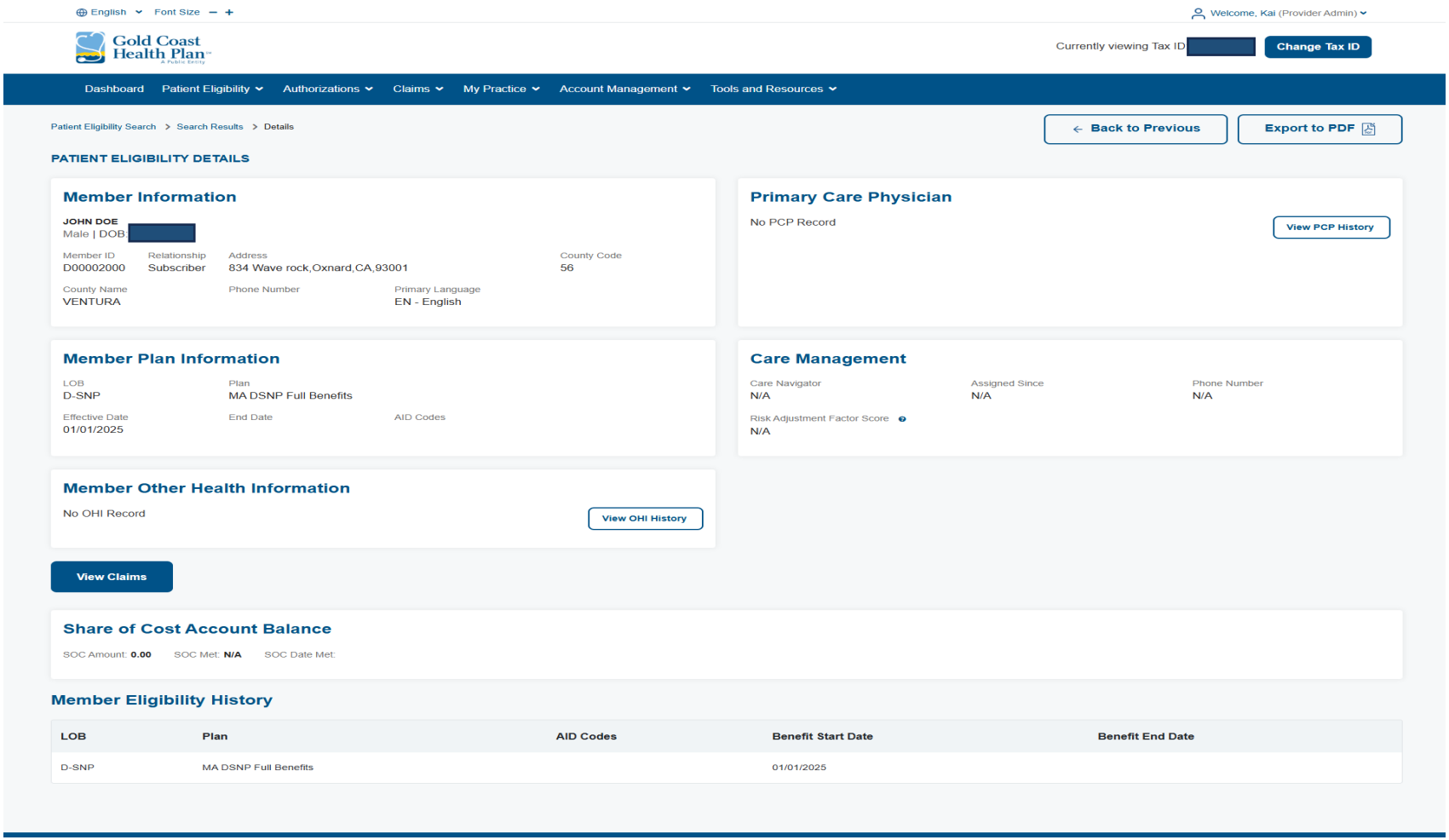
PROVIDER PORTAL (DSNP) – Eligibility 2



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PROVIDER PORTAL (DSNP) – Questions/Comments

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AGENDA ITEM NO. 5

TO: Provider Advisory Committee (PAC)

FROM: James Cruz, MD, Chief Medical Officer
Marlen Torres, Chief Member Experience & External Affairs Officer

DATE: September 23, 2025

SUBJECT: Stipend Policy Approval

Summary and Background

Gold Coast Health Plan (GCHP) proposes a formal policy that outlines the terms and conditions to issue a stipend to community member representatives and external provider representatives who sit on GCHP Brown Act committee meetings and specific GCHP quality committee meetings. The specific committees that are eligible for a stipend include the following: Provider Advisory Committee (PAC), Community Advisory Committee (CAC), Member Advisory Committee (MAC), Credentialing/Peer Review Committee (C/PRC), Quality Improvement and Health Equity Committee (QIHEC), and Pharmacy and Therapeutic Committee (P&T). The proposed policy outlines the amount to be paid ($200) for attending a committee meeting, and the frequency of stipend payment (no more often than monthly).

ATTACHMENTS:

Stipend Policy

POLICY AND PROCEDURE	
TITLE: Committee Stipend and Reimbursement Policy	
DEPARTMENT:	**POLICY #:**
EFFECTIVE DATE:	**REVIEW/REVISION DATE:**
COMMITTEE APPROVAL DATE:	**RETIRE DATE:**
PRODUCT TYPE: Medi-Cal	**REPLACES:**

I. Purpose

A. To establish the terms and conditions for members of Gold Coast Health Plan (GCHP) legislative bodies composed of community members and/or providers to receive stipends and expense reimbursement when performing their official duties on behalf of GCHP.

II. Policy

A. This policy (Policy) is adopted pursuant to Government Code Section 53232 et seq. and must be adopted or amended by resolution.

III. Definitions

A. N/A

IV. Procedure

A. Meeting Stipends
   i. Stipends and Eligible Meetings.
      1. Members of all GCHP legislative bodies (as defined in Government Code Section 54952) that are composed of community members and/or providers (Committees) shall be entitled to receive meeting stipends under this Policy.
      2. Committee members shall be entitled to receive stipends of $200 per day for attending meetings of the Committee.
   ii. Limitations
      1. Committee members shall not receive more than one (1) stipend payment in any calendar month.

2. Committee members may decline to receive a stipend under this Policy. The Committee member must notify relevant GCHP staff if they decline to receive a stipend on a one-time or ongoing basis.

B. Reimbursement of Reasonable and Necessary Expenses
   i. Travel to/from Committee Meetings of GCHP
      1. Committee members may receive reimbursement for mileage or public transportation expenses to and from meetings of a Committee within Ventura County. Such expenses shall be subject to GCHP's travel and expense reimbursement policy criteria.
   ii. Rates of Reimbursement
      1. Mileage and public transportation expenses as authorized under this Policy shall be reimbursed at the rates established under GCHP travel and expense reimbursement policy. If such rates are not provided, the reimbursement shall be at rates established under Internal Revenue Service Publication 463 or any successor publication.
   iii. Claim Forms
      1. All expense reimbursement claims must be submitted in accordance with GCHP travel and expense reimbursement policy.

C. Training Requirements
   i. Committee members eligible to receive stipends or reimbursement of expenses under this Policy shall receive ethics training and sexual harassment prevention training in accordance with Government Code sections 53234 et seq. and 53237 et seq.

V. Attachments

A. N/A

VI. References

A. Government Code section 53232 et seq.
B. Government Code section 53234 et seq.
C. Government Code section 53237 et seq.
D. Government Code section 54952
E. Internal Revenue Service Publication 463 (or its successor)

Gold Coast Health Plan℠
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AGENDA ITEM NO. 6

TO: Provider Advisory Committee (PAC)

FROM: Marlen Torres, Chief Member Experience & External Affairs Officer

DATE: September 23, 2025

SUBJECT: Creation of an Ad Hoc Subcommittee for the Nomination of a Chairperson and Vice-Chairperson to Serve on the Ventura County Medi-Cal Managed Care Commission's Provider Advisory Committee and search for an additional member to fill a vacant seat.

SUMMARY:

Pursuant to the Charter of the Ventura County Medi-Cal Managed Care Commission's ("Commission") Provider Advisory Committee ("PAC"), a nomination ad hoc subcommittee must be created for the nomination of a Chairperson and Vice-Chairperson of the PAC. Accordingly, staff recommends the PAC establish a nomination ad hoc subcommittee to commence the selection process of the Chairperson and Vice-Chairperson of the PAC and seek an additional member to the committee.

BACKGROUND/DISCUSSION:

Pursuant to its bylaws, the Commission shall establish a Provider Advisory Committee ("PAC") Pursuant to the PAC's Charter, which is attached, the PAC's purpose includes providing feedback and recommendations on the Commission's membership needs with a focus Model of Care and enhancing access to care and the relationships and interactions between providers and the Plan to enhance member care. The Commission may utilize information gained from the PAC to make recommendations or address issues brought forth by the Committee.

The PAC consists of thirteen (13) providers or practitioners. Each appointed member can serve up to three (3) two-year terms and individuals can apply for reappointment if they haven't met their term limits. Two of the PAC's thirteen members shall serve as Chairperson and Vice-Chairperson. The Chairperson and Vice-Chairperson may serve one-year terms with two term extensions, or a total of three years in each position. As the PAC membership has been selected, it is time to select a Chair and Vice-Chair. Due to a resignation, we will also be seeking an additional member to add to the committee.

Pursuant to the PAC's Charter, a nomination ad hoc subcommittee must be created for the nomination of a Chairperson and Vice-Chairperson of the PAC. Accordingly, staff recommends the PAC establish a nomination ad hoc subcommittee to commence the selection process of the Chairperson and Vice-Chairperson of the PAC.

To establish a nomination ad hoc subcommittee, the PAC shall select three to four PAC members to serve on the ad hoc subcommittee. PAC members who are being considered for reappointment of Chair or Vice-Chair should not participate in the nomination of the ad hoc subcommittee and should not serve on the ad hoc committee. It is suggested that Committee members interested in serving as Chair and Vice-Chair do not serve on the ad hoc committee. The ad hoc committee shall meet and make a recommendation for Chair and Vice-Chair and the PAC shall determine who to recommend to the Commission for Chair and Vice-Chair. The Commission votes on the appointments of Chair and Vice-Chair.

FISCAL IMPACT:

None.

RECOMMENDATION:

Staff recommends the PAC establish a nomination ad hoc subcommittee to commence the selection process of the Chairperson and Vice-Chairperson of the PAC, and begin the search for an additional member to fill a vacant seat on the committee.