L.A. Care
HEALTH PLAN
For All of L.A.

BOARD OF GOVERNORS MEETING

May 2, 2024 • 1:00 PM

L.A. Care Health Plan

1055 W. 7th Street, Los Angeles, CA 90017

About L.A. Care Health Plan

Statement

L.A. Care's mission is to provide access to quality health care for Los Angeles County's vulnerable and low-income communities and residents and to support the safety net required to achieve that purpose.

Overview

Committed to the promotion of accessible, affordable and high quality health care, L.A. Care Health Plan (Local Initiative Health Authority of Los Angeles County) is an independent local public agency created by the State of California to provide health coverage to low-income Los Angeles County residents. Serving more than 2.6 million members in four product lines, L.A. Care is the nation's largest publicly operated health plan.

L.A. Care Health Plan is governed by 13 board members representing specific stakeholder groups, including consumer members, physicians, federally qualified health centers, children's health care providers, local hospitals and the Los Angeles County Department of Health Services.

L.A. Care advances individual and community health through a variety of targeted activities including a Community Health Investment Fund and sponsorships program that have awarded more than $180 million throughout the years to support the health care safety net and expand health coverage. The patient-centered health plan has a robust system of consumer advisory groups, including 11 Regional Community Advisory Committees (governed by an Executive Community Advisory Committee), 35 health promoters and nine Resource Centers that offer free health education and exercise classes to the community, and has made significant investments in Health Information Technology for the benefit of the more than 10,000 doctors and other health care professionals who serve L.A. Care members.

Programs

- **Medi-Cal** – In addition to offering a direct Medi-Cal line of business, L.A. Care works with three subcontracted health plans to provide coverage to Medi-Cal members. These partners are Anthem Blue Cross, Blue Shield of California Promise Health Plan and Kaiser Permanente. Medi-Cal beneficiaries represent a vast majority of L.A. Care members.

- **L.A. Care Covered™** – As a state selected Qualified Health Plan, L.A. Care provides the opportunity for all members of a family to receive health coverage under one health plan in the Covered California state exchange.

- **L.A. Care Medicare Plus** – L.A. Care Medicare Plus provides complete care that coordinates Medicare and Medi-Cal benefits for Los Angeles County seniors and people with disabilities, helps with access to resources like housing and food, and offers benefits and services like care managers and 24/7 customer service at no cost.

- **PASC-SEIU Homecare Workers Health Care Plan** – L.A. Care provides health coverage to Los Angeles County's In-Home Supportive Services (IHSS) workers, who enable our most vulnerable community members to remain safely in their homes by providing services such as meal preparation and personal care services.

L.A. Care Membership by Product Line – As of April 2024	
Medi-Cal	**2,349,431**
L.A. Care Covered	**188,106**
D-SNP	**19,423**
PASC-SEIU	**48,721**
Total membership	**2,605,681**
L.A. Care Providers – As of April 2022	
Physicians	**5,709**
Specialists	**13,534**
Both	**364**
Hospitals, clinics and other health care professionals	**14,276**
Financial Performance (FY 2023-2024 budget)	
Revenue	**$11B**
Fund Equity	**$1,779,445**
Net Operating Surplus	**$103.9M**
Administrative cost ratio	**5.1%**
Staffing highlights	
Full-time employees (Actual as of September 2023)	**2,269**
Projected full-time employees (FY 2023-2024 budget)	**2,407**

AGENDA
BOARD OF GOVERNORS MEETING
L.A. Care Health Plan
Thursday, May 2, 2024, 1:00 P.M.

L.A. Care Health Plan, 1055 W. 7th Street, Conference Room 100, 1st Floor
Los Angeles, CA 90017

DRAFT

Members of the Board of Governors, staff and the public can attend the meeting in person at the address listed above. Public comment can be made live and in person at the meeting. A form will be available at the meeting to submit public comment.

To listen to the meeting via videoconference please register by using the link below:
https://lacare.webex.com/lacare/j.php?MTID=mb694f941171bbfa62fb1e63f250667d1

To listen to the meeting via teleconference please dial: +1-213-306-3065
English Meeting Access Number 2493 175 9286 Password: lacare
Spanish Meeting Access Number: 2486 221 0068 Password: lacare

Supervisor Hilda L. Solis
500 West Temple Street, Room 856
Los Angeles, CA 90012

For those not attending the meeting in person, public comments on Agenda items can be submitted prior to the start of the meeting in writing by e-mail to BoardServices@lacare.org, or by sending a text or voicemail to (213) 628-6420. Due to time constraints, we are not able to transcribe and read public comment received by voice mail during the meeting. Public comment submitted by voice messages after the start of the meeting will be included in writing at the end of the meeting minutes.

The purpose of public comment is an opportunity for members of the public to inform the governing body about their views. The Board of Governors appreciates hearing the input as it considers the business on the Agenda. All public comments submitted will be read for up to 3 minutes during the meeting. The process for public comment is evolving and may change at future meetings. We thank you for your patience.

All votes in a teleconferenced meeting shall be conducted by roll call.

If you are an individual with a disability and need a reasonable modification or accommodation pursuant to the Americans with Disabilities Act (ADA) please contact L.A. Care Board Services staff prior to the meeting for assistance by text to 213 628-6420 or by email to BoardServices@lacare.org.

Welcome — Alvaro Ballesteros, MBA, *Chair*

1. Approve today's agenda — *Chair*
2. Public Comment *(Please read instructions above.)* — *Chair*

ADJOURN TO CLOSED SESSION (Estimated time: 60 minutes) — *Chair*

3. REPORT INVOLVING TRADE SECRET
   Pursuant to Welfare and Institutions Code Section 14087.38(n)
   Discussion Concerning new Service, Program, Marketing Strategy, Business Plan or Technology
   Estimated date of public disclosure: *May 2026*
4. CONTRACT RATES
   Pursuant to Welfare and Institutions Code Section 14087.38(m)
   - Plan Partner Rates
   - Provider Rates
   - DHCS Rates

5. THREAT TO PUBLIC SERVICES OR FACILITIES
Government Code Section 54957
Consultation with: Tom MacDougall, *Chief Information & Technology Officer* and Gene Magerr, *Chief Information Security Officer*

6. CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION
Significant exposure to litigation pursuant to Section 54956.9(d)(2) of Ralph M. Brown Act:
Four Potential Cases

7. CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION
Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act
L.A. Care Health Plan's Notice of Contract Dispute under Contract No. 04-36069
Department of Health Care Services (Case No. Unavailable)

8. CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION
Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act
   - Local Initiative Health Authority for Los Angeles County (L.A. Care Health Plan) v. U.S., Case No. 1:22-CV-01515 CNL (U.S. Court of Federal Claims)
   - Local Initiative Health Authority for Los Angeles County (L.A. Care Health Plan) v. U.S., Case No. 20-1393, (U.S. Court of Appeals for the Federal Circuit)

9. CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION
Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act
   - Department of Managed Health Care Enforcement Matter Numbers: 18-799, 20-063, 21-428, 21-509, 21-680
   - Department of Health Care Services, Office of Administrative Hearings and Appeals, In the matter of: L.A. Care Health Care Plan Appeal No. MCP22-0322-559-MF

10. PUBLIC EMPLOYEE PERFORMANCE EVALUATION, PUBLIC EMPLOYMENT and CONFERENCE WITH LABOR NEGOTIATOR
Sections 54957 and 54957.6 of the Ralph M. Brown Act
Title: CEO
Agency Designated Representative: Alvaro Ballesteros, MBA
Unrepresented Employee: John Baackes

11. CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION
Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act
CommonSpirit Health Dignity Community Care dba California Hospital Medical Center, Glendale Memorial Hospital and Health Center, Northridge Hospital Medical Center, St. Mary Medical Center v. L.A. Care Health Plan, JAMS 5220002620 (filed Feb. 23, 2023)

RECONVENE IN OPEN SESSION *Chair*

12. Public Comment *(Please read instructions above.)* *Chair*

13. Approve Consent Agenda Items — *Chair*

(A consent agenda is a way the Board of Governors can approve many motions at the same time to improve efficiency at the meeting. Most motions on a consent agenda have already been discussed at a previous Board Committee meeting. According to the Brown Act [California Government Code Section 54954.3(a)], the agenda need not provide an opportunity for public comment on any item that has already been considered by a committee. Sometimes routine motions are placed on the consent agenda by staff, and those have motion numbers that start with "BOG".)

- April 4, 2024 meeting minutes p.19
- To authorize a Letter of Credit from a financial institution for tenant improvements according the existing lease for 1200 W. 7th Street, Los Angeles **(EXE 100)** p.47
- Contract with the Department of Health Services Housing for Health in partnership with Brilliant Corners to provide support on accessibility improvements in Interim Housing facilities throughout Los Angeles County **(EXE 101)** p.49
- Technical Advisory Committee Revised Charter **(TAC 100)** p.51

14. Chairperson's Report — *Chair*

15. Chief Executive Officer Report p.56 — John Baackes, *Chief Executive Officer*
- Vision 2024 Progress 2nd Quarter Report p.62
- Monthly Grants & Sponsorship Reports p.61
- Government Affairs Update p.87 — Cherie Compartore, *Senior Director, Government Affairs*

16. Chief Medical Officer Report p.262 — Sameer Amin, MD, *Chief Medical Officer*

17. Keck Graduate Institute Grant **(BOG 100)** p.284 — John Baackes, Wendy Schiffer, *Senior Director, Strategic Planning*

Public Advisory Committee Reports

18. Temporary Transitional Executive Community Advisory Committee — Fatima Vazquez / Layla Gonzalez, *Consumer member and Advocate member*

- To request the Board of Governors' to consider returning the BOG monthly meetings to the first Thursday 1 pm – 4 PM BOG "public" session meetings which would cause the BOG "closed" sessions to begin before or after the "public" session meetings designated hours. **(TTECA 100)** p.287 — Ana Rodriguez, *TTECAC Chairperson*

- L.A. Care Board of Governors to consider the placement of push door buttons on any door accessible to the public at any site used by L.A. Care for public meetings. **(TTECA 101)** p.288 — Ana Rodriguez

19. Technical Advisory Committee — Alex Li, MD, *Committee Chair*

Board Committee Reports

20. Executive Committee — *Chair*

- Chief Financial Officer Report p.323 — Afzal Shah, *Chief Financial Officer*
  - Financial Report – February 2024 **(EXE 102)** p.333

- Monthly Investment Transactions Reports – February 2024 p.342 — Jeffrey Ingram, *Deputy Chief Financial Officer*

21. Compliance & Quality Committee — Stephanie Booth, MD, *Committee Chair*

ADJOURN TO CLOSED SESSION (if needed) — *Chair*

Please see items 3. through 11. on pages 1 and 2 of this Agenda

RECONVENE IN OPEN SESSION — *Chair*

Adjournment — *Chair*

The next meeting is scheduled on June 6, 2024 at 1 PM, it may be conducted as a teleconference meeting.
The order of items appearing on the agenda may change during the meeting.

THE PUBLIC MAY SUBMIT COMMENTS TO THE BOARD OF GOVERNORS BEFORE DISCUSSION OF EACH ITEM LISTED ON THE AGENDA BY SUBMITTING THE COMMENT IN WRITING BY TEXT MESSAGE TO 213 628 6420, OR IN WRITING BY EMAIL TO BoardServices@lacare.org. Please follow additional instructions on the first page of this Agenda.
ACTION MAY NOT BE TAKEN ON ANY MATTER RAISED DURING THE PUBLIC COMMENT PERIODS UNTIL THE MATTER IS SPECIFICALLY LISTED ON A FUTURE AGENDA, according to California Govt Code Section 54954.2 (a)(3) and Section 54954.3.
AGENDA and PRINTED MEETING MATERIALS ARE AVAILABLE FOR INSPECTION 72 HOURS BEFORE THE MEETING:

1. **At L.A. CARE'S Website:** http://www.lacare.org/about-us/public-meetings/board-meetings
2. **L.A. Care's Offices at 1055 W. 7th Street, Los Angeles, CA 90017 through the Reception Area in the Building Lobby, or**
3. **by email request to BoardServices@lacare.org**

Any documents distributed to a majority of the Board Members regarding any agenda item for an open session after the agenda and meeting materials have been posted will be available for public inspection by email request to BoardServices@lacare.org

An audio recording of the meeting is made to assist in writing the minutes and is retained for 30 days.

Meetings are accessible to people with disabilities. Individuals who may require any accommodations (alternative formats - i.e., large print, audio, translation of meeting materials, interpretation, etc.) to participate in this meeting and wish to request an alternative format for the agenda, meeting notice, and meeting packet may contact L.A. Care's Board Services Department at (213) 628 6420. Notification at least one week before the meeting will enable us to make reasonable arrangements to ensure accessibility to the meetings and to the related materials.

SCHEDULE OF MEETINGS

L.A. Care HEALTH PLAN

Schedule of Meetings
May 2024

Monday	Tuesday	Wednesday	Thursday	Friday
		1	2 ***Board of Governors Meeting*** ***1 pm*** *(for approx. 6 hours)*	3
6	7	8 ***TTECAC Meeting*** *10 AM* *(for approx. 3 hours)*	9	10
13	14	15 ***Provider Relations Advisory Committee Meeting*** *9:30 AM* *(for approx. 2 hours)*	16 ***Compliance & Quality Committee Meeting*** *2 PM* *(for approx. 2 hours)*	17
20	21	22 ***Finance & Budget Committee Meeting*** *1 PM* *(for approx. 1 hour)* ***Executive Committee Meeting*** *2 PM* *(for approx. 2 hours)*	23	24
27	28	29	30	31

For information on the current month's meetings, check calendar of events at www.lacare.org. Meetings may be cancelled or rescheduled at the last moment. To check on a particular meeting, please call (213) 694-1250 or send email to boardservices@lacare.org.

Prepared by mhbalones/printed on 04/26/24

L.A. Care HEALTH PLAN
1055 W. 7th Street, 1st Floor, Los Angeles, **CA 90017**
Tel. (213) 694-1250 / Fax (213) 438-5728

BOARD OF GOVERNORS & PUBLIC ADVISORY COMMITTEES
2024 MEETING SCHEDULE / MEMBER LISTING

	MEETING DAY, TIME & LOCATION	MEETING DATES	BOARD MEMBERS / STAFF CONTACT
BOARD OF GOVERNORS	**1st Thursday** 1:00 PM *(for approximately 3 hours)* L.A. Care Health Plan 1055 W. 7th Street Los Angeles, CA 90017 (213) 694-1250 ** Meeting 4th Thursday due to summer holiday schedule* ***All Day Retreat. Location TBD* ****Placeholder meeting*	May 2 June 6 July 25 * *No meeting in August* September 5 ** October 3 *** November 7 December 5	Alvaro Ballesteros, MBA, *Chairperson* Ilan Shapiro, MD, *Vice Chairperson* Stephanie Booth, MD, *Treasurer* John G. Raffoul, *Secretary* Jackie Contreras, PhD Hector De La Torre Christina R. Ghaly, MD Layla Gonzalez, George W. Greene, Esq. G. Michael Roybal, MD, MPH Supervisor Hilda L. Solis Nina Vaccaro, MPH Fatima Vazquez **Staff Contact:** John Baackes *Chief Executive Officer, x4102* Linda Merkens *Senior Manager, Board Services, x4050*
BOARD COMMITTEES			
EXECUTIVE COMMITTEE	**4th Wednesday of the month** 2:00 PM *(for approximately 2 hours)* L.A. Care Health Plan 1055 W. 7th Street Los Angeles, CA 90017 (213) 694-1250 **3rd Wednesday due to Thanksgiving holiday*	May 22 June 26 *No meeting in July* August 28 September 25 October 23 November 20 * *No meeting in December*	Alvaro Ballesteros, MBA, *Chairperson* Ilan Shapiro, MD, *Vice Chairperson* Stephanie Booth, MD, *Treasurer* John G. Raffoul, *Secretary* *Governance Committee Chair* *Compliance & Quality Committee Chair* **Staff Contact:** Linda Merkens *Senior Manager, Board Services, x4050* Malou Balones *Board Specialist III, Board Services x4183*

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BOARD OF GOVERNORS, BOARD COMMITTEES, PUBLIC ADVISORY COMMITTEES AND REGIONAL COMMUNITY ADVISORY COMMITTEES
2024 MEETING SCHEDULE / MEMBER LISTING

	MEETING DAY, TIME & LOCATION	MEETING DATES	BOARD MEMBERS / STAFF CONTACT
COMPLIANCE & QUALITY COMMITTEE	**3rd Thursday of the month** 2:00 PM *(for approximately 2 hours)* L.A. Care Health Plan 1055 W. 7th Street Los Angeles, CA 90017 (213) 694-1250	May 16 June 20 *No meeting in July* August 15 September 19 October 17 November 21 *No meeting in December*	Stephanie Booth, MD, *Chairperson* Alvaro Ballesteros, MBA G. Michael Roybal, MD, MPH Fatima Vazquez **Staff Contact:** Victor Rodriguez *Board Specialist II, Board Services x 5214*
FINANCE & BUDGET COMMITTEE	**4th Wednesday of the month** 1:00 PM *(for approximately 1 hour)* L.A. Care Health Plan 1055 W. 7th Street Los Angeles, CA 90017 (213) 694-1250 **3rd Wednesday due to Thanksgiving holiday*	May 22 June 26 *No meeting in July* August 28 September 25 October 23 November 20 * *No meeting in December*	Stephanie Booth, MD, *Treasurer* Al Ballesteros, MBA G. Michael Roybal, MD, MPH Nina Vaccaro **Staff Contact:** Malou Balones *Board Specialist III, Board Services x4183*
PROVIDER RELATIONS ADVISORY COMMITTEE	**Meets Quarterly** **3rd Wednesday of meeting month** 9:30 AM *(for approximately 2 hours)* L.A. Care Health Plan 1055 W. 7th Street Los Angeles, CA 90017 (213) 694-1250	May 15 August 21 November 20	George Greene, Esq., *Chairperson* **Staff Contact:** Linda Merkens *Senior Manager, Board Services, x4050*
AUDIT COMMITTEE	L.A. Care Health Plan 1055 W. 7th Street Los Angeles, CA 90017 (213) 694-1250 **MEETS AS NEEDED**		Hector De La Torre, *Chairperson* Layla Gonzalez George Greene **Staff Contact** Malou Balones *Board Specialist III, Board Services, x 4183*

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BOARD OF GOVERNORS, BOARD COMMITTEES, PUBLIC ADVISORY COMMITTEES AND REGIONAL COMMUNITY ADVISORY COMMITTEES
2024 MEETING SCHEDULE / MEMBER LISTING

	MEETING DAY, TIME & LOCATION	MEETING DATES	BOARD MEMBERS / STAFF CONTACT
GOVERNANCE COMMITTEE	L.A. Care Health Plan 1055 W. 7th Street Los Angeles, CA 90017 (213) 694-1250 **MEETS AS NEEDED**		Chairperson - **VACANT** Stephanie Booth, MD Layla Gonzalez Nina Vaccaro, MPH **Staff Contact:** Malou Balones *Board Specialist III, Board Services/x 4183*
SERVICE AGREEMENT COMMITTEE	L.A. Care Health Plan 1055 W. 7th Street Los Angeles, CA 90017 (213) 694-1250 **MEETS AS NEEDED**		Layla Gonzalez, *Chairperson* George W. Greene **Staff Contact** Malou Balones *Board Specialist III, Board Services/x 4183*

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L.A. CARE COMMUNITY HEALTH PLAN	**Meets Annually or as needed** L.A. Care Health Plan 1055 W. 7th Street Los Angeles, CA 90017 (213) 694-1250		Alvaro Ballesteros, MBA, *Chairperson* Ilan Shapiro, MD, *Vice Chairperson* Stephanie Booth, MD, *Treasurer* John G. Raffoul, *Secretary* Jackie Contreras, PhD Hector De La Torre Christina R. Ghaly, MD Layla Gonzalez, George W. Greene, Esq. G. Michael Roybal, MD, MPH Supervisor Hilda Solis Nina Vaccaro, MPH Fatima Vazquez **Staff Contact:** John Baackes, *Chief Executive Officer, x4102* Linda Merkens, *Senior Manager, Board Services, x4050*
L.A. CARE JOINT POWERS AUTHORITY	L.A. Care Health Plan 1055 W. 7th Street Los Angeles, CA 90017 (213) 694-1250 ** Offsite meeting. Location TBD* *** Meeting 4th Thursday due to summer holiday schedule* ****All Day Retreat. Location TBD* *****Placeholder meeting*	May 2 June 6 * July 25 ** *No meeting in August* September 5 *** October 3 **** November 7 December 5	Alvaro Ballesteros, MBA, *Chairperson* Ilan Shapiro, MD, *Vice Chairperson* Stephanie Booth, MD, *Treasurer* John G. Raffoul, *Secretary* Jackie Contreras, PhD Hector De La Torre Christina R. Ghaly, MD Layla Gonzalez, George W. Greene, Esq. G. Michael Roybal, MD, MPH Supervisor Hilda Solis Nina Vaccaro, MPH Fatima Vazquez **Staff Contact:** John Baackes, *Chief Executive Officer, x4102* Linda Merkens, *Senior Manager, Board Services, x4050*

BOARD OF GOVERNORS, BOARD COMMITTEES, PUBLIC ADVISORY COMMITTEES AND REGIONAL COMMUNITY ADVISORY COMMITTEES
2024 MEETING SCHEDULE / MEMBER LISTING

PUBLIC ADVISORY COMMITTEES			
CHILDREN'S HEALTH CONSULTANT ADVISORY COMMITTEE GENERAL MEETING	**3rd Tuesday of every other month** 8:30 AM *(for approximately 2 hours)* L.A. Care Health Plan 1055 W. 7th Street Los Angeles, CA 90017 (213) 694-1250	May 21 August 20 October 15	**Tara Ficek, MPH,** *Chairperson* **Staff Contact:** Victor Rodriguez *Board Specialist II, Board Services/x 5214*
EXECUTIVE COMMUNITY ADVISORY COMMITTEE	**2nd Wednesday of the month** 10:00 AM *(for approximately 3 hours)* L.A. Care Health Plan 1055 W. 7th Street Los Angeles, CA 90017 (213) 694-1250	May 8 June 12 July 10 *No meeting in August* September 11 October 9 November 13 December 11	**Ana Rodriguez,** *Chairperson* **Staff Contact:** Idalia Chitica**,** *Community Outreach & Education, Ext. 4420*
TECHNICAL ADVISORY COMMITTEE	**Meets Quarterly** **2nd Thursday of meeting month** 2:00 PM *(for approximately 2 hours)* L.A. Care Health Plan 1055 W. 7th Street Los Angeles, CA 90017 (213) 694-1250	August 8 October 10	Alex Li, MD, *Chairperson* **Staff Contact:** Victor Rodriguez *Board Specialist II, Board Services/x 5214*

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BOARD OF GOVERNORS, BOARD COMMITTEES, PUBLIC ADVISORY COMMITTEES AND REGIONAL COMMUNITY ADVISORY COMMITTEES
2024 MEETING SCHEDULE / MEMBER LISTING

REGIONAL COMMUNITY ADVISORY COMMITTEES			
REGION 1 **ANTELOPE VALLEY**	**3rd Friday of every other month** 10:30 AM *(for approximately 2-1/2 hours)* L.A. Care Family Resource Center 2072 E. Palmdale Blvd. Palmdale, CA 93550 (213) 438-5580		**Roger Rabaja,** *Chairperson* **Staff Contact:** Kristina Chung, Field Specialist Cell Phone (213) 905-8502 *Community Outreach & Education*
REGION 2 **SAN FERNANDO VALLEY**	**3rd Monday of every other month** 10:00 *(for approximately 2-1/2 hours)* L.A. Care Family Resource Center 10807 San Fernando Rd. Pacoima, CA 91331 (844) 858-9942		**Ana Rodriguez,** *Chairperson* **Staff Contact:** Martin Vicente, Field Specialist Cell Phone (213) 503-6199 *Community Outreach & Education*
REGION 3 **ALHAMBRA, PASADENA AND FOOTHILL**	**3rd Tuesday of every other month** 10:00 AM *(for approximately 2-1/2 hours)* Robinson Park Recreation Center 1081 N. Fair Oaks Ave. Pasadena, CA 91103 (626) 744-7330		**Lidia Parra,** *Chairperson* **Staff Contact:** Frank Meza, Field Specialist Cell phone (323) 541-7900 *Community Outreach & Education*
REGION 4 **HOLLYWOOD-WILSHIRE, CENTRAL L.A. AND GLENDALE**	**3rd Wednesday of every other month** 10:00 AM *(for approximately 2-1/2 hours)* Community Resource Center Metro LA 1233 S. Western Ave. Los Angeles, CA 90006 (213) 428-1457		**Sylvia Poz,** *Chairperson* **Staff Contact:** Kristina Chung, Field Specialist Cell Phone (213) 905-8502 *Community Outreach & Education*

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REGION 5 **CULVER CITY, VENICE, SANTA MONICA, MALIBU, WESTCHESTER**	**3rd Monday of every other month** 10:00 AM *(for approximately 2-1/2 hours)* Veterans Memorial Bldg Multipurpose Room 4117 Overland Avenue Culver City, CA 90230 (310) 253-6625		**Maria Sanchez,** *Chairperson* **Staff Contact:** Cindy Pozos, Field Specialist Cell phone (213) 545-4649 *Community Outreach & Education*
REGION 6 **COMPTON, INGLEWOOD, WATTS, GARDENA, HAWTHORNE**	**3rd Thursday of every other month** 10:00 AM *(for approximately 2-1/2 hours)* Community Resource Center Inglewood 2864 W. Imperial Highway Inglewood, CA 90303 (310) 330-3130		**Joyce Sales,** *Chairperson* **Staff Contact:** Frank Meza, Field Specialist Cell phone (323) 541-7900 *Community Outreach & Education*
REGION 7 **HUNTINGTON PARK, BELLFLOWER, NORWALK, CUDAHY**	**3rd Thursday of every other month** 10:00 AM *(for approximately 2-1/2 hours)* Community Resource Center Norwalk 11721 Rosecrans Ave. Norwalk, CA 90650 (562) 651-6060		**Maritza LeBron,** *Chairperson* **Staff Contact:** Martin Vicente, Field Specialist Cell Phone (213) 503-6199 *Community Outreach & Education*
REGION 8 **CARSON, TORRANCE, SAN PEDRO, WILMINGTON**	**3rd Friday of every other month** 10:30 AM *(for approximately 2-1/2 hours)* Community Resource Center Wilmington 911 N. Avalon Ave. Wilmington, CA 90744 (213) 428-1490		**Ana Romo – *Chairperson*** **Staff Contact:** Hilda Herrera, *Field Specialist* Cell phone (213) 605-4197 *Community Outreach & Education*

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REGION 9 **LONG BEACH**	**3rd Monday of every other month** 11:00 AM *(for approximately 2-1/2 hours)* Community Resource Center Long Beach 5599 Atlantic Ave. Long Beach, CA 90805 (213) 905-8502		**Tonya Byrd**, *Chairperson* **Staff Contact:** Kristina Chung, Field Specialist Cell Phone (213) 905-8502 *Community Outreach & Education*
REGION 10 **EAST LOS ANGELES, WHITTIER AND HIGHLAND PARK**	**3rd Thursday of every other month** 2:00 PM *(for approximately 2-1/2 hours)* L.A. Care East L.A. Family Resource Center 4801 Whittier Blvd Los Angeles, CA 90022 (213) 438-5570		**Damares Hernández de Cordero,** *Chairperson* **Staff Contact:** Hilda Herrera, *Field Specialist* Cell phone (213) 605-4197 *Community Outreach & Education*
REGION 11 **POMONA AND EL MONTE**	**3rd Thursday of every other Month** 10:00 AM *(for approximately 2-1/2 hours)* Pomona Community Resource Center 696 W. Holt Street Pomona, CA 91768 (909) 620-1661		**Maria Angel Refugio,** *Chairperson* **Staff Contact:** Frank Meza, Field Specialist Cell phone (323) 541-7900 *Community Outreach & Education*

CONSENT AGENDA

Board of Governors
Regular Meeting Minutes #326
April 4, 2024

L.A. Care Health Plan, 1055 W. 7th Street, Los Angeles, CA 90017

Members

Alvaro Ballesteros, MBA, *Chairperson*
Ilan Shapiro, MD, *Vice Chairperson**
Stephanie Booth, MD, *Treasurer*
John G. Raffoul, *Secretary*
Jackie Contreras, PhD
Hector De La Torre
Christina R. Ghaly, MD *
Layla Gonzalez
George W. Greene, Esq.*
Supervisor Hilda Solis **
G. Michael Roybal, MD, MPH
Nina Vaccaro, MPH
Fatima Vazquez

**Absent*
*** Via teleconference*

Management

John Baackes, *Chief Executive Officer*
Sameer Amin, MD, *Chief Medical Officer*
Terry Brown, *Chief of Human Resources*
Linda Greenfeld, *Chief Product Officer*
Todd Gower, *Chief Compliance Officer*
Augustavia Haydel, Esq., *General Counsel*
Alex Li, MD, *Chief Health Equity Officer*
Tom MacDougall, *Chief Technology & Information Officer*
Noah Paley, *Chief of Staff*
Afzal Shah, *Chief Financial Officer*

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
WELCOME	Alvaro Ballesteros, *Board Chairperson,* called to order at 1:08 pm the regular and special meetings of L.A. Care Health Plan Board of Governors and the L.A. Care Health Plan Joint Powers Authority Board of Directors. The meetings were held simultaneously. Board Chairperson Ballesteros welcomed everyone. • Everyone's time is valuable. Recently, a few meetings have lasted more than three hours so L.A. Care will make some changes to improve meeting efficiency. • The public comment time may be adjusted to a shorter time limit during the meeting to keep the meeting on schedule and allow more people to comment. • Please be respectful of everyone at the meeting. Comments should end at 3 minutes. That's a lot of time – more time than is given for public comment at other meetings. Commenters do not have to use the full three minutes if their views can be expressed in less time. There is no need to wait for the clock to countdown the full 3 minutes. Get your points across quickly and step away from the microphone even if there is still time on the clock so others can be heard. Those attending the meeting in person who wish to submit a public comment should use the form provided. For those with access to the internet, the materials for today's meeting are available on the L.A. Care website. He thanked those who have submitted public comment by voice mail, text or email. He informed participants that for those using the video software during the meetings; the "chat"	

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	function will be available to provide live and direct public comment to everyone participating in the virtual meeting. The Chat feature will be open throughout the meeting for public comment. All are welcome to provide input.	
APPROVAL OF MEETING AGENDA	**PUBLIC COMMENT** *Andria McFerson commented that the TTECAC minutes are very important for Board members to overlook and actually see the conversation and how the community is affected by the decisions made by the Board and the Department of Health Care Services, the comments having to do with the Senate, and just all kinds of different things, provisions having to do with that. On page12 of the TTECAC minutes, it is stated that Ms. McFerson asserted her authority and dictated staff actions, including the establishment of continuation of the advisory committee. In summary, her comments were about the rights and role of stakeholders in the decisions made that would affect staff's operation to better the communication and the overall committee in itself. She wants to take the time to say the Board is very important. She would love to have this meeting definitely with more comments and not less comments and with that, she just wanted to make sure that the Board seems proper and not a summary of what she's saying, and if one is going to look at it, she just wants to be clear on that with the agenda in itself. She doesn't know if that has anything to do with it, but she really thinks that the Board members are important, your decisions are important as your overview is important. The staff is important as well. And with that, her comment was just to better our intercommunication and that's it.* Chairperson Ballesteros asked that Motion EXE 100 be considered during the CEO Report item instead of the Executive Committee report. There was no objection from Board Members. **The meeting Agendas were approved as amended.**	**Unanimously approved by roll call. 10 AYES (Ballesteros, Booth, Contreras, De La Torre, Gonzalez, Raffoul, Roybal, Solis, Vaccaro and Vazquez)**
ADJOURN TO CLOSED SESSION	**PUBLIC COMMENT** *Andria McFerson thinks that their rights should be available as far as the meeting proper protocol, having to do with the disabled. And that's all she wanted to say because as far as the agenda goes, the closed session is first, and there are disabled people here, there are seniors here, and there are people who definitely would love to comment on closed items. But with that, they don't know how long the closed session is going to be. As far as provisions having to do with medical appointments, family, just all kinds of different things like that, and they don't know how long they're going to be here. So this public comment is towards making sure that the Board knows that it's important for them to comment on closed session items like item number 9, due to the fact that the public employee performance evaluation. Like that should be heard and decided accordingly towards the stakeholders who are affected by all of the different actions that the staff has, according the Board, the quality and compliance, and the Department of Health Care Services and the Senate. All of these items are important when it comes to the staff's input, the staff's actions. So, with that, if the Board is going to evaluate the staff, that would be important to for the Board to know exactly how the staff has affected them. And with that, if the Board is going to make that decision, then the Board would need to know how they feel about what*	

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	has happened throughout the month. If the Board is going to evaluate the staff in itself. She will talk about that later, the RCAC meetings have not had an opportunity to have the Brown Act or Robert's Rules of Order or anything else since they met the last time. They've had RCAC meetings and had no motions on the Board. They just had things dictated to us that the staff wants to change and state recommendations, things like that. They have not had the opportunity to have a.RCAC meeting to discuss these things. They should have been able to have that right to have those comments made before the Board evaluated the staff in itself. It's inappropriate to have a closed session first without having those comments. Of course, they have those comments, but it's hard to even state because she has a clock and she has to go upstairs. The Board has the closed session for three hours and she doesn't know when she is able to talk to her doctor, because the closed session is, they don't know how long, and she does need to speak. Chairperson Ballesteros noted that the time is on the Agenda, it's 60 minutes. *Ms. McFerson asked where people are supposed to sit?* Chairperson Ballesteros responded that he will announce it, it's on the second floor. There is a space for public to wait on the second floor. *Ms. McFerson apologized that she sounds kind of perturbed, but she just feels that they should just have the regular agenda with the agenda first, and then the closed items second.* Chairperson Ballesteros noted that it was difficult for the Board to keep it that way, because they were not able to get to the items in closed session because of the length of meetings. The Board decided to hold the close session at the beginning of the meeting. To alleviate the concerns, it is posted on the agenda that the closed session will be an hour, so the public knows when the meeting will reconvene in open session. There is a space on the second floor for individuals. Ms. McFerson apologized and said she appreciates the provisions, but the Board still needs to change it. Board Member Booth noted that the reason the Board has to do it this way is that the meeting could lose quorum. There are closed session items the Board may need to vote on. At the end of the meeting, there are reports. The Board can lose quorum and still receive those reports, the Board can vote only if there is a quorum. Board Member De La Torre commented that is why the Board is doing this. Secondly, under the Brown Act, cities and other public entities are allowed to structure their meeting however they like. There are cities who leave public comment to the very end of the meeting. The Board is not doing that, it is taking an hour for some closed session items that may require a vote, and then conducting regular business in public session. Under the Brown Act, there's flexibility, as long as it's clear how the meeting is structured and time is allowed for public comment. *Ms. McFerson (speaking over Board Member De La Torre) said, "That's great,", and she commented that stakeholders need that right as well. They absolutely have no RCAC meetings at all.*	

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	Board Member De La Torre continued his comment that the Board is conducting the business for L.A. Care and that, first and foremost, is the Board's obligation. *Ms. McFerson commented, "much appreciated. Definitely."* Public comment submitted via voicemail today at 12:21 PM. by Elizabeth Cooper RCAC 2 member *Good afternoon members of the Board of Governors and the Chairperson. She would like to speak on today's agenda for the Board of Governors, particularly when it comes to public and closed session items, public performance evaluation for public employment. She would like to ask the Board Chairperson to please consider having a member of the RCACs present when it comes to public employee evaluation for the CEO. At present, she thinks Mr. Baackes is doing a good job, but she feels that the performance evaluation should consider how well the RCAC issues are addressed. She thinks he's doing a good job. She thinks that would be a good thing for the RCACs to have someone from the RCACs present during the conversation. She feels they may not have a voice, and are not being heard on some of these issues that they are addressing.* The Joint Powers Authority Board of Directors meeting temporarily adjourned at 1:24 pm. Augustavia J. Haydel, Esq., *General Counsel*, announced the following items to be discussed in closed session. The L.A. Care Board of Governors adjourned to closed session at 1:24 pm. No report was anticipated from the closed session. REPORT INVOLVING TRADE SECRET Pursuant to Welfare and Institutions Code Section 14087.38(n) Discussion Concerning New Service, Program, Business Plan Estimated date of public disclosure: *April 2026* THREAT TO PUBLIC SERVICES OR FACILITIES Government Code Section 54957 Consultation with: Tom MacDougall, *Chief Technology and Information* CONTRACT RATES Pursuant to Welfare and Institutions Code Section 14087.38(m) • Plan Partner Rates • Provider Rates • DHCS Rates THREAT TO PUBLIC SERVICES OR FACILITIES Government Code Section 54957 Consultation with: Tom MacDougall, *Chief Information & Technology Officer* CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION Significant exposure to litigation pursuant to Section 54956.9(d)(2) of Ralph M. Brown Act:	

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	Four Potential Cases CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act L.A. Care Health Plan's Notice of Contract Dispute under Contract No. 04-36069 Department of Health Care Services (Case No. Unavailable) CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act • Department of Managed Health Care Enforcement Matter Numbers: 18-799, 20-063, 21-428, 21-509, 21-680 • Department of Health Care Services, Office of Administrative Hearings and Appeals, In the matter of: L.A. Care Health Care Plan Appeal No. MCP22-0322-559-MF PUBLIC EMPLOYEE PERFORMANCE EVALUATION, PUBLIC EMPLOYMENT and CONFERENCE WITH LABOR NEGOTIATOR Sections 54957 and 54957.6 of the Ralph M. Brown Act Title: CEO Agency Designated Representative: Alvaro Ballesteros, MBA Unrepresented Employee: John Baackes	
RECONVENE IN OPEN SESSION	The L.A. Care Board of Governors and the L.A. Care Health Plan Joint Powers Authority Board of Directors reconvened in open session at 2:28 pm. There was no report from closed session. Chairperson Ballesteros welcomed members of the public back to the meeting. He hoped the accommodations were comfortable for them during the one hour closed session. He provided information about submitting public comment.	
PUBLIC COMMENTS	Submitted via voicemail at 12:29 PM by Elizabeth Cooper RCAC 2 member *Board members, Elizabeth Cooper again, please take notice of her comments. It is very challenging now to read the agenda not being physically present. Please take notice that the phone service needs to be updated because they need to be more consumer friendly. It is very hard and challenging. She asked the two Board of Governors Consumer representatives to please take notice of the comments of the members of the RCACs and the public. There are a number of issues that she would like to address, but due to the fact that she is physically not present, she would like to have the Board and the Chairperson of the Board to please take notice of the board book and see whether it's friendly for the consumers, and ask those who are not physically present. The month of April should be a challenge for so many as it has been for her. She would like the Board book to be more consumer friendly. Please take notice Board of Governors consumer members they hope that you represent the interests of all of them in these issues when they have been brought up to the Board, the board book sometimes is not user friendly. Please read and take notice of her comments.*	

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	Andria McFerson commented she wants to take the time out to apologize to the Board, I had an episode, dizzy episode, her medication wasn't proper. The brain specialist didn't approve the new medication that her PCP and her specialist told me to take. Today was the first time taking it on an empty stomach. She wants to completely apologize to the Board and to the staff for that. But, with that, her neurologist called her and told her of a need to see her at a certain time and she committed to this meeting, and did not know what time she was leaving. That's why she feels it's so important that the closed session is held last. She just wants to take the time out to say thank you for listening. And with that her whole story, she hates saying I, I, I. But with the RCACs, they would have that opportunity to say "I", and being that they did have RCAC meetings, they did, but not with the Brown Act and Robert's Rules of Order. The new provisions that they want to make with the stakeholder committees; unfortunately, they don't have a motion on the floor on the agenda with the RCACs. So they can't vote yay or nay. They do say we can take recommendations and things like that, but the RCAC members, unfortunately, the ones who she spoke with, they feel as though decisions are already made and they don't have word and any sort of changes having to do with the stakeholder committees. She asked if there are any other RCAC meetings to please allow them to use the Brown Act and Robert's Rules of Order, and let them know whether they have a right to vote on any changes, provisions towards the stakeholders, towards the RCACs, towards the ECAC, and just all kinds of different things like that. And if the state has recommendations or requirements, and things like that, specifically with quotations, present that as well with the new request that the staff is making with every single meeting. And give them the opportunity on the agenda to have open conversation. An open form of conversation with the stakeholders and how those things would affect them would benefit them and it would benefit the Board on the decisions that you make according to the stakeholder requests.	
Consideration of Chief Executive Officer's Compensation and Employment Agreement	*This item was discussed later in the meeting.*	
APPROVE CONSENT AGENDA ITEMS	• March 7, 2024 meeting minutes • Contract with Microsoft (via SHI International) to provide product support services for Information Technology staff supporting critical virtual production infrastructure **Motion FIN 100.0424** **To authorize staff to execute a contract in the amount of $9,500,000 with Microsoft to provide product support services for the period of May 2024 to May 2027.**	

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	• Faneuil, Inc. Contract Extension and Funding for Customer Service Center **Motion FIN 101.0424** **To authorize the staff to enter into Amendment 2 for SOW 2 with Faneuil, Inc., increasing the overall contract amount from $22,000,000 to $64,287,729, an incremental increase of $42,287,729, and increasing the contract terms from January 14, 2022 - March 31, 2025, to April 1, 2025 - March 31, 2027, an incremental term of 2 years. This amendment will allow Faneuil, Inc. to continue to support L.A. Care with 24/7 call center operations through March 31, 2027.**	**Unanimously approved by roll call. 11 AYES (Ballesteros, Booth, Contreras, De La Torre, Gonzalez, Raffoul, Roybal, Shapiro, Solis, Vaccaro and Vazquez)**
CHAIRPERSON'S REPORT	Chairperson Ballesteros reported that Board member Vazquez was appointed to the Compliance & Quality Committee.	
CHIEF EXECUTIVE OFFICER REPORT • Catalina Island Health Grant to support safety net access to health care for L.A. Care members living on Catalina Island	**PUBLIC COMMENT** Public comments submitted via voicemail at 12:25 PM by Elizabeth Cooper, RCAC 2 member *Good morning Members of the Board, she received a Board book a short time ago. She is calling regarding today's board meeting item for a Catalina Island Health grant supporting the safety net and the L.A Care members who live on Catalina island. Board members, she would like to be allowed the opportunity to visit Catalina Island on behalf of the members and the RCACs. It is on the agenda, she would like to support this, and she would like to speak to the RCAC members on Catalina Island.* John Baackes, *Chief Executive Officer,* reported that the CEO of Catalina Island Medical Center came to visit him. The hospital is the only medical service available on the island and faces closure by the middle of this year without intervention. The CEO asked that we give Catalina Island Health an increase in the Medi-Cal reimbursement, and asked for a grant. L.A. Care has 733 members on Catalina Island, which has a total population of 4,200. Board Members may recall that in December 31, 2022, Madera Hospital in California closed without notice and left no services available within 50 miles of that facility. Afterward, there was considerable discussion about how Madera's closure could have been avoided. L.A. Care has the opportunity to step in and support Catalina Island. Mr. Baackes has made clear to the hospital, and to the representatives of the California Assembly, Senate, and Los Angeles County Board of Supervisors, that L.A. Care cannot singlehandedly save Catalina Island Health, but L.A. Care can extend a lifeline. L.A. Care will increase in the Medi-Cal reimbursement for Catalina Island Health. However, with so few L.A. Care members residing on Catalina Island, that will not be enough to save Catalina Island Health.	

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	Mr. Baackes recommends providing a $2 million dollar grant, which will keep the medical center open through the end of 2024. During that time, Catalina Island Health would have an opportunity to negotiate an affiliation arrangement with a larger organization so it can continue providing health services. He noted that if the hospital were to close and because it serves on an island, the Los Angeles County Fire Department (LACoFD) essentially would be the provider of last resort. LACoFD would be called upon to use helicopter transportation off the island in an emergency, which would be an unbudgeted expense for the County. L.A. Care is working with providers and with other health plans to garner additional support. Mr. Baackes asked the Board to consider a motion to grant $2 million to Catalina Island Health, to support the hospital, to provide time for it to arrange for a sustainable future. Supervisor and Board Member Solis thanked Mr. Baackes for his report on this very important facility on Catalina Island on behalf of her colleague, Supervisor Hahn. Catalina Island is in Supervisor Hahn's jurisdiction, and she has been sharing information about Catalina Island Health with the Supervisors. They realize how significant this is. She understands the grant will be helpful as a lifeline, but it is not permanent. Mr. Baackes is correct that the impact to the County would be even more costly and untenable. Supervisor Solis supports the grant and she thanked Mr. Baackes, the Board of Governors, and the individuals that you have been working with on this issue for their cooperation. She hopes the State will come up with some remedies in the future to prevent these types of situations. This is not the first and unfortunately she knows it would not be the last time. Board Member De La Torre commented that beside the obvious that Catalina Island Health is on an island, for state purposes the area is considered "urban" because it is part of Los Angeles County. Catalina Island is more rural than any place he can think of, as there's no other place in Los Angeles County that is 26 miles away from anything. It is a weird situation and affects how the local area is treated in state law. One cannot get there except by boat or a plane. He hopes there will be changes in legislation to remedy that they are treated as rural just because they are in Los Angeles County. He thanked Supervisor Solis for sharing Supervisor Hahn's interest in this. He noted that if it was any other location, L.A. Care probably wouldn't provide a grant. Ms. Balones noted a correction in the votes she announced for the Consent Agenda, which should be 11 Ayes. **<u>Motion EXE 100.0424</u>** **To approve delegated authority to Chief Executive Officer, John Baackes, to issue up to a $2 million award to Catalina Island Health to support safety net access to health care for L.A. Care members living on Catalina Island.**	**Unanimously approved by roll call. 11 AYES (Ballesteros, Booth, Contreras, De La Torre, Gonzalez, Raffoul, Roybal, Shapiro, Solis, Vaccaro and Vazquez)**

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	Mr. Baackes continued his report with an update on the Change Healthcare cyber-attack reported at the last board meeting. L.A. Care has secured an alternate electronic claims clearing house on March 12 through a division of United Health called Optum. This interim solution was very helpful for many providers, but was not as helpful for some of the smaller community-based organizations. L.A. Care has reengaged a former clearinghouse vendor, Office Ally, and is negotiating a contract to continue with Office Ally permanently. While that is being negotiated, providers are connected to the Optum site and providers who prefer or have access can submit claims to Office Ally and those will be processed through the Optum portal. L.A. Care is also working with another cloud based organization called Availity, and considering working with them even after Change Healthcare is back online. L.A. Care's security team will be evaluating the new platform that Change Healthcare developed as a result of the cyber-attack. The cyber-attack is of great concern nation-wide. Mr. Baackes is on the Board of America's Health Insurance Plans (AHIP), a national trade association, and AHIP has been in the lead, and is being called on by the Department of Health and Human Services and by Congress, to explain what the industry is doing to protect data from this kind of attack. There is going to be further inquiry. Part of the problem with the cyber-attack is that it left some of the smaller community-based organizations and hospitals without a way to submit claims. L.A. Care informed all providers that they could use paper but some found that more difficult. L.A. Care offered to make cash advances to providers who are having cash flow issues. Since that was announced, L.A. Care has approved 91 cash advances, totaling about $31 million to a variety of organizations. Most notably, 27 skilled nursing facilities, seven community based adult services (CBAS) organizations and a variety of others, have received cash advances. Only three hospitals have received cash advances. In prior months, most of the major hospitals that contract with L.A. Care had asked for cash advances on the Hospital Quality Assurance Fee (HQAF) payments, which L.A. Care facilitated. The HQAF payments were paid to health plans in March, and L.A. Care has been reimbursed for the advances it made. Based on observing the hospital industry, L.A. Care will probably be asked for advances on the HQAF payment in October. Mr. Baackes invited Board Member Raffoul to comment. This is a cycle that is not sustainable. L.A. Care can make cash advances using its reserves, but the health plan is becoming a bank for the California Department of Health Care Services (DHCS), L.A. Care collects no interest or administrative charges for advancing substantial sums. L.A. Care is bringing the situation of repetitive cash advances to the attention of DHCS. The advances to the 91 provider organizations were made against future claims to L.A. Care, and the payback period will average less than 90 days and so these are temporary cash advances. Making the advances has brought L.A. Care some good will. The trade association for skilled nursing facilities called Mr. Baackes	

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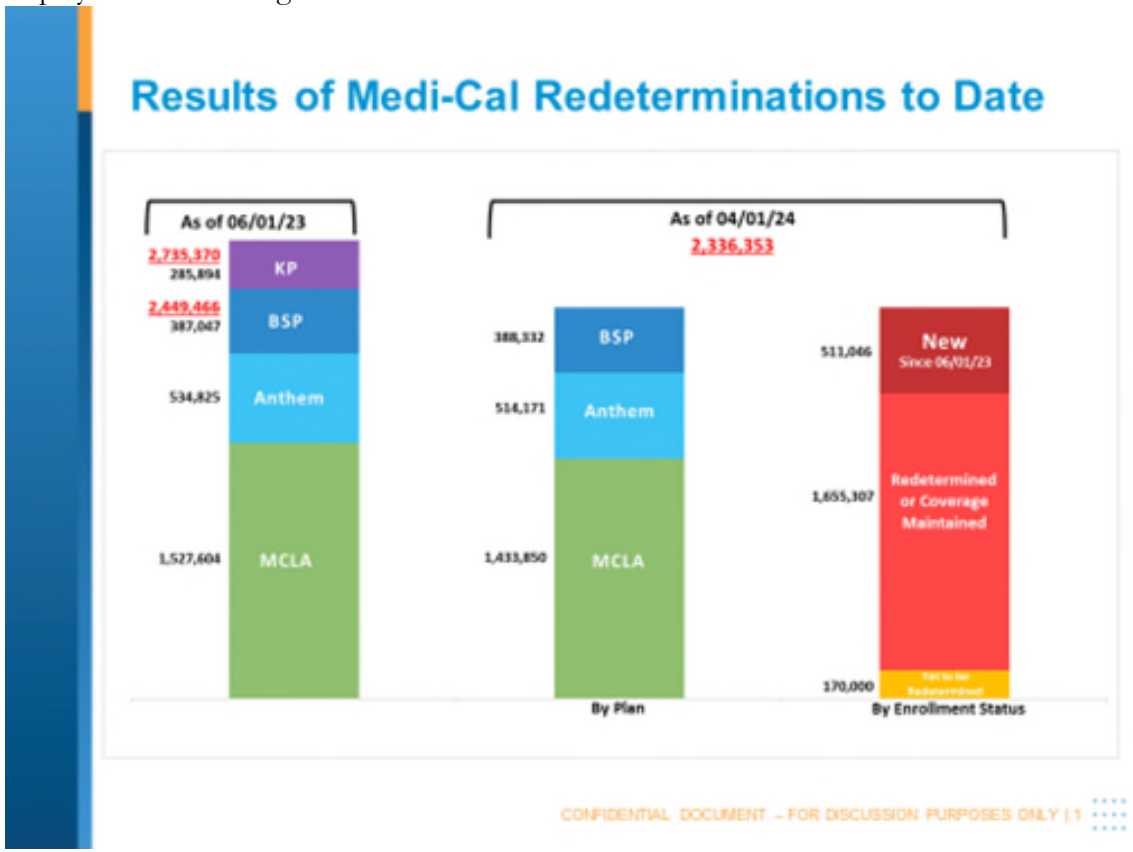
to thank L.A. Care, and he is informed that DHCS has received messages about L.A. Care stepping up and helping out these organizations, and L.A. Care received a "thank you" note from DHCS.

Mr. Baackes also updated Board members on the Medi-Cal redetermination process and he displayed the following information:



- The far left bar is L.A. Care's Medi-Cal enrollment before the redetermination process started last June. It includes the Kaiser enrollment, which L.A. Care knew would be dropping off on January 1, 2024. L.A. Care started (without the Kaiser enrollment) with 2.4+ million Medi-Cal members enrolled. As of April. 1, 2024, L.A. Care has 2,336,000, so there is a net loss in members generating revenue of only about 113,000 lives. The second bar from the left shows the distribution of L.A. Care Medi-Cal members with the two plan partners, Anthem and Blue Shield Promise.

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	• The bar on the far right shows current enrollment, with 511,000 new members enrolled since last June, including 165,000 undocumented residents between the ages of 26 and 49. • 1,655,000 Medi-Cal members have completed the redetermination process, and there are 170,000 still to go. • About 500,000 members enrolled in Medi-Cal through L.A. Care last June are no longer enrolled, but were replaced by new enrollees. L.A. Care is trying to discern, and Mr. Baackes has discussed this with Board Member Contreras, how many of those people didn't go through a redetermination process but completed a new Medi-Cal application. L.A. Care continues to research this interesting phenomenon. There is a 90-day period from the renewal date for Medi-Cal members to submit the redetermination packet. Over 100,000 people are in the "on hold" category, which means the process was not yet completed. During that 90 day grace period, if the process is completed, coverage will resume retroactive to the original renewal date. In summary, this had far less impact on total enrollment and revenue than was originally thought. The churn in membership can disrupt continuity of care. L.A. Care is following up and has been very closely monitoring the customer service department contacts with members who went to the pharmacy and discovered coverage was declined or went to the doctor and was told they don't have coverage. L.A. Care has had very few of those calls. The members that dis-enrolled may have changed their county of residence or signed up again with a new application. Mr. Baackes reported that L.A. Care received Health Equity accreditation from the National Committee on Quality Assurance (NCQA), which is the accreditation agency for health plans. It is impressive that L.A. Care received a 98% score, and staff is very proud of that. The accreditation is for three years. He congratulated staff who worked on that. Under California Advancing and Innovating Medi-Cal (CalAIM) there is funding for an equity and practice transformation program, which is to support development of infrastructure and technologies in the practice and improve access to care. L.A. Care nominated a number of practices in Los Angeles County, 46 of the practices were approved and their provider transformation programs are being launched. L.A. Care supports AB4, which is a state legislative bill that will allow undocumented Californians to purchase health care coverage through the health benefit exchange. The Medi-Cal expansion was for people whose income is below 138% of the federal poverty level (FPL). There are undocumented residents who may not qualify because their income is higher than 138% of FPL. Those people are currently prohibited from buying insurance on the exchange because the federal government supplements the funding for premium assistance. Advisory	

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	committee members raised this when discussing eligibility for Medi-Cal in the expansion. L.A. Care is not sponsoring it, but is supporting the legislation, and has sent letters to the two state legislative leaders. AB4 would help reduce health care disparities and L.A. Care's position aligns with the commitment to health equity, which means everyone has a fair and just opportunity to access health care coverage. Mr. Baackes thanked L.A. Care's ECAC members for pointing out this glaring hole and hopefully this bill will help solve it. Board Member Gonzalez noted that Lluvia Salazar is the advisory committee member who brought it up. The Deferred Action for Childhood Arrivals (DACA) program recipients are unable to get health insurance that is federally funded, so this bill would allow them to be able to purchase health coverage through the state health benefit exchange rather than using federal funds. Mr. Baackes noted that whatever state premium subsidy applies would be available to them, which is important. The state subsidy is not quite as generous as the federal premium subsidy, and L.A. Care will determine AB4 calls for the state subsidy to match the federal. L.A. Care's marketing department developed a guide for new members. Previously, a package was sent to new members joining L.A. Care, which included a folder with a lot of different pieces of paper in it. The information has been put together in a bound booklet that is available in 17 languages. At the very back pages, it has information about language assistance. If L.A. Care is informed about the preferred language of the beneficiary, the booklet will be sent in their preferred language. But if the member gets a booklet that is not in their preferred language, this is a way to find out how to get one. The booklets are made for each of the coverage programs offered by L.A. Care. Mr. Baackes thanked Linda Greenfield and her department staff that came up with this booklet. It is a great step forward and is easier for members to use. *(Board Member Raffoul left the meeting.)*	
• Monthly Grants and Sponsorships Reports	*Mr. Baackes referred Board Members to the written reports included in the meeting materials.*	
• Government Affairs Update	Joanne Campbell, *Health Care Policy Specialist III, Government Affairs,* reported: • Governor Newsom and the leaders of the California Assembly and Senate have announced that an agreement was reached on early budget actions. The detail on those early budget actions will be released this month. A non-specific shortfall reduction is estimated between $12 to $18 billion. One piece of the budget proposal that has moved forward is SB136, the Managed Care Organization (MCO) tax bill. SB136 increases a portion of the MCO tax that	

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	will generate an additional $1.5 billion for the general fund, and was signed by the Governor at the end of last month. It requires review at the federal level to approve the retroactive effective date of January 2024. • Tyler Sadwith was appointed State Medicaid Director at the California Department of Health Care Services (DHCS). He previously was the deputy director of behavioral health at DHCS. • California voters have approved Proposition 1 by a very narrow margin. This is Governor Newsom's $6.4 billion plan to build treatment beds and housing for people experiencing serious mental health illness. • To follow up on the previous question regarding AB4, the bill language includes coverage for the undocumented with subsidies for premiums and cost sharing if funds are available, either from the state or federal government.	
Consideration of Chief Executive Officer's Compensation and Employment Agreement	*The Agenda position of this report was adjusted due to a timing issue.* Augustavia Haydel, *General Counsel,* read a motion for consideration of compensation and employment agreement for the Chief Executive Officer. **MOTION BOG 100.0424** **To approve the payment of the following compensation amounts for Chief Executive Officer, John Baackes, as follows:** **1. Provide a performance based incentive for the performance period of March 23, 2023 thru March 22, 2024 of 44% of base salary;** **2. Increase base salary of 4.5% for a total base salary of approximately $850,722.59 effective March 23, 2024.** **To authorize and direct the Chair of the Board to execute appropriate amendments to Mr. Baackes' employment agreement as necessary to accomplish the actions discussed herein.**	**10 AYES (Ballesteros, Booth, Contreras, De La Torre, Gonzalez, Roybal, Shapiro, Solis, Vaccaro and Vazquez)** *Board Member Raffoul was not in the meeting at the time of this vote.*
CHIEF MEDICAL OFFICER	Sameer Amin, MD, *Chief Medical Officer,* reported: • The 2022-2023 DHCS Medical Audit had a review period from July 1, 2021 through January 31, 2023 for the Medi-Cal line of business. From a Health Services perspective, there were seven Utilization Management, three Care Management, and one Quality Improvement findings. Health Services staff have been very aggressive in creating durable fixes for the findings. A dedicated Health Services manager created a Strategic Roadmap with deliverables, responsible parties, and next steps. The goal is to correct the underlying issue, test the solution, and then audit the process to ensure we are on the right track. If there is ambiguity, we are reaching out to DHCS and regulatory consultants. Each department is working closely with Compliance on tracking and reporting. Across the	

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	company, steps have been broken down into 147 total actions in extraordinary detail and each step is being accounted for so that we don't have a fix in name only, but a fix that actually will sustainably change how we practice here at the health plan, so we do not have repeat findings. During each Monthly Departmental Review, the Roadmap is reviewed, aligning the finding with the corrective action and status so we are fully aware of where we are progressing. Utilization Management (UM) findings can be briefly summarized as: 1) Medical Director Oversight of Post-Stabilization Authorizations 2) Referral Tracking 3) Over and Under-Utilization 4) Written Consent for Appeals 5) Delegation Oversight of Utilization Management 6) Delegation and Subcontractor Ownership and Control Information 7) Notification to Contract Manager for the Subcontractor Ownership and Control Disclosure Requirements A majority of these issues were correctable by instituting new policies and creating new process documents. Some required more intensive corrective actions such as L.A. Care's work with Los Angeles County Department of Health Services (DHS) on EConsult, the establishment of a new Over and Under Utilization frameworks, and hiring a clinical data analyst to institute more robust referral tracking. For all seven findings, L.A. Care is confident that the underlying issues have been corrected and has reported as such through the Utilization Management Committee. Care Management (CM) findings can be summarized as: 1) Initial Health Assessment Completion 2) Anticipatory Guidance for Lead Exposure 3) Blood Lead Screening Tests The issues associated with the findings were corrected by refashioning the initial health assessment (IHA) annual audit, building IHA Monitoring Tools, creating monthly gap reports, updating policies, and writing new processes. The Quality Improvement finding was associated with Provider Training and has been remedied through on-demand training at L.A. Care University and improved monitoring and escalation processes for non-compliant providers. In total, we are very confident that all of the DHS findings have been addressed and that we have a corrective action that is in flight and completed and should be ready to go the next time that we have a DHCS audit.	

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	• The 2021 California Department of Managed Health Care (DMHC) Routine Survey was for all lines of business with a review period from September 2019 to August 2021. The review cited overlapping findings between our two entities, Local Initiative Health Authority (LIHA) and Joint Powers Authority (JPA). For Health Services, there are 11 separate findings for Utilization Management, five for Quality, one for Access and Availability, and four for Prescription Drug Coverage. Considering how long ago the review period was, a majority of the findings in Health Services were formally corrected some time ago. Regardless, we are tracking the findings and corrective actions in a similar fashion to the DHCS audit, with over 200 individual steps taken to correct the issues. To help focus, comments center on the UM findings and group findings where they overlap: 1) Written notification to enrollees of denials or modifications 2) Documentation of licensed physicians making decisions 3) Decisions to deny or modify requests within required timeframes and timely notification of providers and enrollees 4) Delegation oversight of Los Angeles Department of Health Services' (DHS) Specialty Referral Process 5) UM approval process for terminal ill members requiring experimental therapies 6) Standing referrals 7) Notification letter language The corrective action plans (CAP) for most findings were formally completed. Though the underlying issues related to item 3) have been fixed and the performance of the UM team has been excellent, we have included development of a Provider Portal for electronic authorization submission within our formal CAP to DMHC. L.A. Care's performance on written notifications as well as decisions to deny or modify requests within the required timeframes has been phenomenal. We have now been consistently in the green and are over 99% in compliance across the board, and that's been a major accomplishment for the team. It is important to say that we included in our CAP to DMHC all the way back in 2021 that L.A. Care would have a provider portal up and going. It was the intention to have that provider portal up and going. Unfortunately, the Provider Portal was delayed due to poor performance by the vendor and the eventual bankruptcy of UpHealth. L.A. Care is on track to implement the Provider Portal by the end of July for hospitals, and by the end of October for the remainder of providers. It will allow electronic submissions to occur for tracking of authorizations. Completion will perhaps not be in time for the CAP, and L.A.	

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	Care is frequently communicating with DMHC about the provider portal and the delay that occurred. The solution for issue 4) has actually moved along quite well with great collaboration with DHS. L.A. Care and DHS have agreed upon the steps to be taken and they are now in an implementation phase. There are regular meetings between Dr. Amin, Todd Gower, *Chief Compliance Officer*, with the DHS team, and they are tracking. The corrective action for 6) is awaiting a pending update to the Direct Network Contracted Provider Reference Guide, which should be completed shortly. In total, all of the issues that were associated with the DMHC audit should be completed. And I'm very confident that we are in a good place with all of them. • There is another audit in June of 2024. Dr. Amin is confident that L.A. Care is going to do an excellent job and he confident in the approach and the work that has been done, and he is excited to show the progress that the health plan has made. He has great confidence in L.A. Care's ability to be compliant with the new contract. Chairperson Ballesteros commented that it is great that L.A. Care has made great strides to implement the CAPs and that Dr. Amin has such positive anticipation for the next audit. The reporting to the Compliance & Quality Committee has become much more clear. The Board appreciates the work by Dr. Amin and the Health Services team. Dr. Amin thanked him and he commended the Health Services team that has worked very hard. L.A. Care is working toward maintaining the strategic plan and helping members, rather than responding to audits. He hopes to continue to cut down on the findings and not have any repeat findings. The individual process points are key to the successful implementation. From a few findings, hundreds of individual steps were created and the team went back and made sure that all of them happened. Afterward, an audit was conducted to make sure that the system was working well.	
ADVISORY COMMITTEE REPORT		
Children's Health Consultant Advisory Committee	*The Agenda position of this report was adjusted due to a timing issue.* Tara Ficek, MPH, *Chairperson,* reported The members of the Children's Health Consultant Advisory Committee met on March 26 (*approved minutes can be obtained by contacting Board Services).* • In February a survey of CHCAC members was conducted on what was working well, where there were opportunities for improvement with the committee, with the meetings, et cetera. The feedback received from members was shared at the March meeting, and positive remarks were that the meetings are informative, there's clear and consistent communication	

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	between L.A. Care staff and the committee members, along with suggestions for discussing pressing issues, like pediatric specialist shortages, enhancing engagement in meetings through more interactive presentations. We also heard recommendations including partner presentations, so not just hearing from staff, but also from partner organizations that are working closely with L.A. Care, revisiting our meeting times for better attendance and expanding our group membership to include more regional center representation. We encourage further input from members who had not participated in the surveys and will continue to collect that feedback, and additional comments or thoughts on the feedback received are welcome. • Dr. Amin provided a Chief Medical Officer update to the Committee. • Matthew Pirritano, PhD, MPH, addressed a request from the January meeting to furnish descriptive statistics and a foundational understanding concerning children and women of childbearing age within the Medi-Cal member population. Dr. Pirritano delineated the demographic composition of children in various age brackets, such as infants, young children, and adolescents. He highlighted the distribution of these age groups across gender, race, and geographical regions, showcasing areas with significant concentrations of children. Dr. Pirritano provided insights into the healthcare preferences of these demographic segments, and noted the top healthcare providers utilized. • Elaine Sadocchi-Smith gave an Initial Health Appointment (IHA) Update. She explained that the IHA is a medical requirement for all newly enrolled members, to be completed within 120 days of enrollment, covering various components such as physical, environmental, and medical history. She emphasized that while there isn't a single assessment form, the IHA must be comprehensive and include identification of risks, needs for preventative screenings or services, health education, diagnosis, and treatment plans. Ms. Sadocchi-Smith also mentioned that the Stay Healthy Assessment (SHA), a part of the IHA, has been retired since January 1, 2023. Despite no specific form being required, documentation of the IHA components is crucial, and all screenings and assessments must be culturally and linguistically appropriate. She provided examples of age-appropriate screenings and discussed efforts to monitor and ensure compliance with the IHA requirements including the development of tools, monthly compliance reports, provider outreach, and member interventions. Additionally, there were discussions about challenges in data exchange, variations in risk assessment, and the need for standardization and system improvements to ensure appropriate reporting and compliance.	
Transitional Temporary Executive Community Advisory	**PUBLIC COMMENT** *Andria McFerson commented that she looked at the schedule of the meetings for the RCACs and on the calendar it states that there is no meeting for RCAC 3 on April 16. Members were sent information that the meeting would be held April 16. She attended*	

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Committee (TTECAC)	*RCAC 4 meeting. Unfortunately, they were not able to have the Robert's Rules of Order or the Brown Act to discuss the new provisions that the staff is proposing. Throughout the meeting, they had to listen to staff and had a limited amount of time to speak. She thinks that affected an individual at the meeting. During the meeting, he stood up because he did not have an opportunity to speak and it wasn't an open forum concerning his medical condition. He said that was one of the reasons he came to the RCAC. So he threatened to kill himself during the meeting. He said that he did not have the opportunity to actually speak about not having the PCP access and not having a specialist access, not having therapy for what he was going through. He was having issues with that being covered with L.A. Care, and he wanted to focus more on those type of topics during the RCAC meeting. But the agenda just basically focused on the new plan that they had and not the actual intercommunication that would better the decisions made by L.A. Care, the BoG, and a lot of different other committees. And with that, he walked out he said he didn't want a stipend, and he stood in the hallway for 45 minutes. Actually longer than that, and he stood at a wall. He looked at the wall, and just was crying the whole time. Scott is a nice person, and he's been with the RCACs for a long time. He felt defeated that day and unfortunately, he did not receive assistance from staff. When someone threatens to kill himself or herself and has a mental disorder, you need to call 911 or the department or something like that, that deals with that directly. Maybe with the county, whatever the case may be, but we definitely need better intercommunication with the staff, empathy training, or something. The staff needs to know that if someone has a mental breakdown like that, they have a responsibility to make sure that they don't leave the building and threaten to kill themselves and actually follow through with that. That's important. And then also, like she said, the RCACs are an important factor and we need to have that open communication during the RCACs with the Board of Governors as well to give advice.* Mr. Baackes asked Acacia Reed to get the member information and follow up directly with the member. *Russel Mahler commented that the comment that Andria made, this guy was a member of his RCAC 4 in L. A. and he wanted to say, he was a witness as to how he was feeling that day. They don't know if he's going to be back at the RCAC. They haven't heard anything or not. But he was very distraught when he wasn't getting heard, his questions answered, anything. And he thinks staff or whoever can come to these meetings and see what's going on. How they see things in the meeting. It probably wake up the staff members around L.A. Care as well as give them a chance to see what they go through.* Public comments submitted by voicemail at 12:42 PM by Elizabeth Cooper RCAC 2 member. *Elizabeth Cooper RCAC 2 member, L. A. Care Board meeting regarding public advisory committee report, the two board representatives, She is concerned as a RCAC member and concerned as a public person with some of the issues that were brought up, and also there*	

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	seems to be concern about what is happening to the RCACs, and no motion is being brought up by the two representatives to the ECAC meeting. It is very important for the two representatives like the other members that bring their concerns about their agencies, that they bring up some of these issues. Because right now the RCACs will be going through reorganization or recertification, et cetera. It is important to let the Board members know what the members concerns are that affect members. But she certainly would like to see more input rather than just a report from the Board representatives on the Board. She listened to the public, who they represent, and appreciates all the Board members. She hopes her comments are read today because it is really challenging to read the board book not being physically there. She thanked all of those who will listen to her comments and please take notice. Chairperson Ballesteros commented to members that have joined the meeting and those that have made some comments, the Board hears you. He had a brief conversation about this. He will be talking to Mr. Baackes after the meeting. We appreciate members and appreciate member participation. Members will be hearing more information about the Board's desires for addressing member concerns. He wants members to know, from his position and all board members here, they appreciate members and thank members very, very much. It is not falling on deaf ears. Mr. Baackes noted he would be talking to the Chair and the rest of the board. He has been meeting with the RCACs in their traditional configurations to go over the proposed DHCS contract changes. He has been listening. There are three more RCAC meetings to go, and after those, a recommendation will be made that to the ECAC. There is a lot t going on. L.A. Care is very conscious of this, and there is a regulatory deadline to be in compliance with the new state contract. Board Member Gonzalez reported that TTECAC met on March 13, 2024. She thanked members that attended the TTECAC in person and those present today: 1. Roger Rabaja (R3) 2. Ana Rodriguez (R2) 3. Joyce Sales (R6) 4. Maritza Lebron (R7) 5. Deaka McClain (R9) 6. Damares O Hernandez de Cordero (R10) • Dr. Amin gave an update on the RCAC restructuring. He described modifications to enhance diversity, engagement, and alignment with contractual requirements, stressing a grassroots approach and thorough deliberation among the RCAC members before implementation.	

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	• Dr. Li gave a Health Equity Steering Committee update. He spoke about operationalizing health equity at L.A. Care through new structure and engaging members in decision-making. He outlined the structure of equity committees and emphasized the importance of seeking feedback on initiatives to enhance inclusivity. Dr. Li encouraged transparent collaboration and invited input, highlighting a commitment to inclusive engagement strategies. • Shavonda Webber-Christmas presented information about the Community Health Investment Fund (CHIF) and Accessible Equipment Fund in 2023-24. CHIF was established in 2000, and financially supports community health care programs, investing over $138 million in nearly 1000 projects. The Accessible Equipment Fund was created to increase access for differently-abled individuals, and this fiscal year up to $450,000 is allocated to provide accessible exam tables and scales to L.A. Care contracted clinics. Applications will be accepted online through August 31, 2024, and awards announced within 60 days of the month an application was received. Board Member Vazquez reported (*Board Member Vazquez gave her report in the Spanish language and the following English translation is from the interpreter)*: • Henock Solomon presented information on the Clinician & Group-Consumer Assessment of Health Care Providers & Systems (CG-CAHPS) member survey, highlighting the importance in gauging patient experiences with L.A. Care and its providers. The survey focuses on things valued by patients, such as timely appointments, access to information, and communication with healthcare providers. The results affect L.A. Care's National Committee on Quality Assurance (NCQA) accreditation and health plan ratings. Unlike regular CAHPS, CG-CAHPS is for the physician, clinic, and IPA levels, with a larger sample size, aiming for more actionable measurement at the provider level, particularly for Medi-Cal patients. Board Member Vazquez informed the Board that L.A. Care community resource centers provide training and workshops for our community. The RCAC meetings are being held in March, and April. They are grateful to the individuals that are here today and were also present at the RCAC meetings. Board Member Gonzalez invited everybody to attend the next ECAC meeting on April 10. It is a Zoom meeting, so one does not have to fight traffic. Board Members can get an idea of what happens at TTECAC. The Board Chair participated in an TTECAC meeting, and she thanked him. She thanked Ms. Vaccaro for attending TTECAC recently. She invited Board Members to attend and get an idea of what goes on in those meetings as well as topics the members are discussing, and the issues in contention with the new contract.	
BOARD COMMITTEE REPORTS		

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Executive Committee	Chairperson Ballesteros reported that the Executive committee met on March 27, 2024 (*approved minutes can be obtained by contacting Board Services and will be available on the L.A. Care website).*	
Finance & Budget Committee	*(Member Raffoul rejoined the meeting.)* Committee Chairperson Stephanie Booth, MD, reported that the Committee met on March 27. *(Contact Board Services to obtain a copy of approved meeting minutes.)* • The Committee reviewed and approved a motion for a contract amendment with Cloud Technology Innovations, LLC (Healthcare Fraud Shield) to provide Special Investigations Unit (SIU) Case Management and Data Analytics tool. This motion does not require full Board approval. • The Committee reviewed and approved motions at that meeting that were approved earlier today on the Consent Agenda.	
Chief Financial Officer Report • Financial Report – January 2024 • FY 2023-24 4+8 Forecast	*Supervisor Solis left the meeting.* Afzal Shah, *Chief Financial Officer,* summarized the highlights of the January 2024 Financial Reports and the updated FY 2023-24 4+8 Forecast (*a copy of his presentation can be obtained by contacting Board Services*): <u>Membership</u> January 2024 total membership was 2.49 million members, around 56,000 unfavorable to the budget. The large drop between December 2023 and January 2024 for both the budget and actuals was the loss of Kaiser (approximately 266,000 members). L.A. Care Covered (LACC) was 22,000 favorable to budget. At the time of budget completion, the final pricing position for LACC was unknown. The favorable price position drove the higher enrollment. Medi-Cal membership was 79,000 unfavorable to budget. The budget assumed roughly 150,000 new members associated with the expansion of coverage to undocumented adults aged 26-49 years old, split equally over January and February. Actual January 2024 enrollment was closer to 10,000, with a majority of those assumed members enrolling in February 2024. <u>Financial Performance for January Month to date (MTD)</u> January 2024 net surplus was $55 million, which is $48 million favorable to the budget when Housing and Homelessness Incentive Program/ Incentive Payment Program (HHIP/IPP) funds are excluded. Revenue was $113 million behind budget, driven by an $81 million retroactive acuity adjustment for CY 2023 that was recognized in the January 2024 financial reports.	

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	Healthcare costs (HCC) were $146 million favorable to budget driven by lower than anticipated Fee-for service (FFS) expenses. Administrative expenses were unfavorable $8 million for the month. The drivers include higher headcount than included in the budget, timing on contract spend for annual mailers, and an update to Government Accounting Standards Board Statement No. 96 (GASB96) that affects depreciation and amortization. <u>Financial Performance YTD</u> YTD net surplus was $267 million, $201 million favorable to the budget when HHIP and IPP funds are excluded. We have reported previously that rates were favorable in 2023 but that has changed and in 2024 there is a potential for rate decreases. Prior period adjustments are reflected in January. Cost pressures and decreasing margins are expected for the 2023-24 fiscal year. <u>Operating Margin by Segment</u> • Overall Medical Care Ratio (MCR) was 88.8% vs the budgeted 93.3% excluding HHIP/IPP funds. • Medi-Cal is performing closer to 90% due to lower FFS claims than anticipated. • Duals Special Needs Plan (DSNP) was 81.8% vs 89.5%, which was up from last month's 77.4%. • LACC was at 70.0% vs the 83.7%. Increased enrollment drove higher revenue paired with prior period Incurred but not Reported (IBNR) adjustments. February 2024 will see some Risk Adjustment Factor (RAF) adjustments that bring the MCR above 80%. <u>Key Financial Ratios</u> • MCR was 88.8% • Administrative ratio was 5.7% vs 5.1%, higher than budget driven by headcount • All balance sheet metrics are healthy again this month with no caveats for pass-through payments. <u>Tangible Net Equity (TNE)</u> TNE was at 861% with days of cash on-hand at 117. Jeff Ingram, *Deputy Chief Financial Officer,* reported that in terms of overall administrative expenses increases, staff updated the forecast to take inflation into account, which increased the employee benefits burden from 23.5% to about 31%. In calendar year 2024, L.A. Care will absorb the overall medical benefit premium increase and has waived the one-year lockout, period for retirement matching, both were approved by the Executive Committee. GASB96 changes financial accounting for software license subscriptions and for leases. Purchased	

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	services have increased from the original fiscal year budget as L.A. Care used an outside staff augmentation service to help address the high inventory of claims. Expenses for UM related activity also increased as L.A. Care addressed the disruption in claims authorizations. There is additional staff augmentation expense for the Call Center. The additional costs are targeted investments to address core needs and are not permanent expenses. Mr. Shah continued the report. **4+8 Forecast Update** Highlights • Updated the timing of the Medi-Cal expansion member enrollment, original budget assumed 150,000 members in January and February, which is very close to the actual enrollment for those two months combined • Assuming an 8% membership growth rate for DSNP • LACC surpassed expectations for enrollment • Projecting a slight deterioration in medical care ratio from 93.2% in the original budget to 94.1% • Projecting revenue to be lower than originally budgeted based on current rate information; final rates and adjustments are expected later this year. • Projecting overall decreased operating margin by $126 million. • Administrative expense increase of $75 million from budget was discussed by Mr. Ingram earlier. • Overall net surplus expected to lower from $207 million to $147 million, a drop of nearly $60 million. **Motion FIN 102.0424** **To accept the Financial Reports for January 2024, as submitted.**	**Unanimously approved by roll call. 10 AYES (Ballesteros, Booth, Contreras, De La Torre, Gonzalez, Raffoul, Roybal, Shapiro, Vaccaro and Vazquez)**
• Monthly Investments Transactions Report	Mr. Shah referred to the investment transactions reports included in the meeting materials (a *copy of the reports can be obtained by contacting Board Services).* This report is provided to comply with the California Government Code and is presented as an informational item. L.A. Care's total investment market value as of January 31, 2024, was $3.5 billion: • $35 million invested with the statewide Local Agency Investment Fund (LAIF) • $80 million invested with the Los Angeles County Pooled Investment Fund (LACPIF) • $3.4 billion is managed by 1) Payden & Rygel and 2) New England Asset Management (NEAM)	

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Compliance & Quality Committee	**PUBLIC COMMENT** *Andria McFerson asked that the committee talk about virtual assistance for seniors and for developmentally delayed, perhaps just having the advisory committee actually talk to the staff and let them know how best to communicate and make it so that the technical virtual world is more accessible to seniors and to the disabled. Perhaps working with CBOs or different resources out there that give classes for seniors and making it much easier, so that they're not left behind with emails and just different things like that. Because we've lost that communication from our PCPs and different offices because they have a lack of communication with calling and just making sure that people follow up with their appointments, medication and all those types of things. People first and foremost before anything else, they send emails. And she knows a lot of seniors and a lot of disabled people that do not have emails, or they don't check their emails on a regular basis. And that would adhere to the necessities of people who are legally blind and just all kinds of different things having to do with that. It would make it so that a lot of different people just have a better form of communication with their doctors, and just all kinds of things like that. If we made some sort of provisions and taught people how to better access the virtual world in itself. She doesn't know if that's compliance and quality committee, but the Board talked about designing compliance officers and compliance committees, conducting effective training and education, develop effective lines of communication, conducting internal monitoring. She doesn't know if that had any relativity to the compliance committee, she just wanted to make that comment and thought that it was a great option for people. We can work directly with the PCPs and different people like that, they can refer their patients over to a program that L.A. Care provides for the members to have better access to the virtual world, and so they can have virtual doctor's appointments as well.* Committee Chairperson Stephanie Booth, MD, reported that there was a backlog in processing of appeals and grievances. Most of the potential quality issues come from appeals and grievances, and as the backlog was addressed, cases in for potential quality issues were received. Additional staff was hired for processing. There were 7,336 cases screened for potential quality issues in FY 22-23. Of those, about 2100 had no potential quality issues and did not require review. Of the remaining 5,169, 3352 had no quality issues that were identified, close to 1,500 (or about 29% of 5,169) had some quality of service issues identified, and 346 (6.7% of 5,169) had quality of care issues identified. Those with quality of service issues identified are addressed by sending notices or additional action up to writing a CAP, and follow it of course. Timeliness of closure rates are also very important. The overall closure rate was 85% in FY 22-23. The quality issue is to be closed in 6 months from receipt, although a one-month extension may be provided in certain cases, usually it involves not getting the proper records from the provider. The backlog was cleared by March 2023. The compliance rate for timely closure has averaged over 99% since then. This means that 0 to 5 were closed untimely among about 2500 and 3500 cases closed per month. She thanked all who worked on processing the backlog.	

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	L.A. Care delegates some potential quality issues and conducts oversight audits. All of the plan partners passed the 2023 oversight audit. She thought that was really important for Board Members to hear about. Committee Chairperson Booth continued her report on the Compliance & Quality Committee meeting held March 21. (*Approved meeting minutes can be obtained by contacting Board Services.*) Todd Gower, Chief Compliance Officer, and the Compliance Department presented the Chief Compliance Officer report: • Michael Devine, reported on the significant successes in Special Investigations. Recoveries total over $2 million for January and February, reaching $2.8 million for the fiscal year, along with $2.7 million in savings, totaling $5.5 million year-to-date. He emphasized the importance of preventing losses in addition to recovering lost funds, highlighting successful efforts in both areas. He mentioned 47 active criminal cases involving law enforcement, resulting in arrests, pending prosecutions, and recent convictions. • Michael Sobetzko's Issues Inventory report described past issues that have been remediated, administratively closed, and documented for mediation efforts. He spoke on two open issues: one regarding alternative format selection for visually impaired members, where there's a concern about consistent collection and reporting of preferences, and another concerning noncompliance with timely termination of providers, specifically regarding three providers who remained active despite administrative termination. • Audit services presented the internal audit plan. • Dr. Amin presented the Chief Medical Officer report. • Alex Li, MD, Chief Health Equity Officer, reported achieving a 98% health equity accreditation score on March 11from the National Committee for Quality Assurance. The NCQA's Health Equity Accreditation focuses on the foundation of health equity work, including building an internal culture and infrastructure that supports the organization's external health equity work; collecting data that helps the organization create and offer language services and provider networks mindful of individuals' cultural and linguistic needs; and identifying opportunities to reduce health inequities and improve care. Participants at the kick-off for the Equity Practice Transformation Program showed great enthusiasm and engagement. Negotiations with DHCS and Health Net continue regarding operational aspects of L.A. Care's Health Equity and Disparities Mitigation program. • Edward Sheen, MD, Senior Quality, Population Health and Informatics Executive, provided updates about the Quality Oversight Committee meeting and the 2023 health equity annual evaluation, the 2024 health equity program and work plan, and the provider quality review annual update. He will provide detailed reports on these items at a future meeting. He	

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	highlighted the health education program's accomplishments, challenges, and next steps, including improvements in member engagement strategies and addressing data quality issues. • Bettsy Santana, Senior Manager, Quality Improvement Initiatives, presented information on L.A. Care's Medi-Cal Managed Care Accountability Measure Sets (MCAS) for measurement year (MY)2023 and MY2024. She presented a motion for approval of the 2023 Quality Improvement Evaluation (for all lines of business) and the 2024 Quality Improvement Program documents. • Rhonda Reyes, Quality Improvement Program Manager, and Christine Chueh, RN MS HCM, CPHQ Director, Provider Quality, Quality Improvement, presented information about the Provider Quality Review Annual Update. She described managing potential quality of care issues by evaluating clinical care standards, holding providers accountable, and assigning actions based on severity levels. The update highlighted an increase in total processed cases due to backlog closure and increased staffing, as well as a detailed approach by nurses resulting in a higher percentage of quality of care issues identified and addressed. Internal audit programs, provider monitoring based on points thresholds, and actions against providers for quality of care issues were discussed, with a focus on timeliness and ongoing collaboration. Chairperson Ballesteros commented that he has been a member of the Compliance & Quality Committee for most of his time on the Board, and he wanted to acknowledge that the level of reports that are coming forward now are much more expansive. The Committee hears reports from various components the Compliance and Health Services divisions. The Committee hears directly from the staff about their work. He likes going to the committee because there is so much helpful information. The level of reporting has substantially increased, and he appreciates the efforts from Dr. Amin and Mr. Baackes for directing that. He thinks it would be helpful to have some of those reports at the board meetings. Board Member Booth noted that staff is doing more as well, as new staff joined there is a new perspective.	
Provider Relations Advisory Committee	The Committee met on February 21 *(contact Board Services to obtain a copy of approved meeting minutes)*. • The Committee received an update on Provider Awareness for Enhanced Care Management/CalAIM ○ In the last calendar quarter of 2023, L.A. Care, its Plan Partners, Health Net and Molina partnered to develop a comprehensive CalAIM Enhanced Care Management (ECM) and Community Supports (CS) training for the entire contracted provider network in Los Angeles County, which included:	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	✓ An overview of ECM and Community Supports; ✓ Which populations of focus are eligible to receive ECM; ✓ Information about which Community Supports are provided by L.A. Care and Plan Partners; ✓ How Providers can refer Members to ECM and Community Supports; and ✓ The process L.A. Care and Plan Partners follow to authorize ECM and Community Supports. • There was discussion about o Progress on issues affecting network providers. o Joint advocacy at the state level regarding low reimbursement, the changing regulatory environment, sanctions and potential effects on providers and health plans related to quality measures, and new programs in Medi-Cal which contribute to physician/provider burnout. Board Member Vaccaro asked about representation for health centers on the Committee. Mr. Baackes noted that an interim replacement will be added to the committee.	
ADJOURN TO CLOSED SESSION	The Joint Powers Authority Board of Directors meeting adjourned at 4:22 pm. Augustavia J. Haydel, Esq., General Counsel, announced the following items to be discussed in closed session. The L.A. Care Board of Governors adjourned to closed session at 4:35 pm. No report was anticipated from the closed session. REPORT INVOLVING TRADE SECRET Pursuant to Welfare and Institutions Code Section 14087.38(n) Discussion Concerning New Service, Program, Business Plan Estimated date of public disclosure: April 2026 THREAT TO PUBLIC SERVICES OR FACILITIES Government Code Section 54957 Consultation with: Tom MacDougall, Chief Technology and Information CONTRACT RATES Pursuant to Welfare and Institutions Code Section 14087.38(m) • Plan Partner Rates • Provider Rates • DHCS Rates CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION Significant exposure to litigation pursuant to Section 54956.9(d)(2) of Ralph M. Brown Act: Four Potential Cases	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act L.A. Care Health Plan's Notice of Contract Dispute under Contract No. 04-36069 Department of Health Care Services (Case No. Unavailable) CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act • Department of Managed Health Care Enforcement Matter Numbers: 18-799, 20-063, 21-428, 21-509, 21-680 • Department of Health Care Services, Office of Administrative Hearings and Appeals, In the matter of: L.A. Care Health Care Plan Appeal No. MCP22-0322-559-MF PUBLIC EMPLOYEE PERFORMANCE EVALUATION, PUBLIC EMPLOYMENT and CONFERENCE WITH LABOR NEGOTIATOR Sections 54957 and 54957.6 of the Ralph M. Brown Act Title: CEO Agency Designated Representative: Alvaro Ballesteros, MBA Unrepresented Employee: John Baackes	
RECONVENE IN OPEN SESSION	The L.A. Care Board of Governors and the L.A. Care Health Plan Joint Powers Authority Board of Directors reconvened in open session at 5:24 pm. There was no report from closed session.	
ADJOURNMENT	The meeting was adjourned at 5:25 pm.	

Respectfully submitted by:
Linda Merkens, *Senior Manager, Board Services*
Malou Balones, *Board Specialist III*
Victor Rodriguez, *Board Specialist II*

APPROVED BY:

_____
John G. Raffoul, *Board Secretary*
Date Signed _____

L.A. Care
HEALTH PLAN

Board of Governors
MOTION SUMMARY

Date: April 24, 2024 **Motion No. EXE 100.0524**

Committee: Executive **Chairperson:** Alvaro Ballesteros

Issue: Approval of delegated authority to secure a letter of credit (LC) from a financial institution that is cash collateralized to access the Tenant Improvement (TI) Allowance as part of the 1200 W. 7th Street (Garland) Building lease.

☒ **New Contract** ☐ **Amendment** ☐ **Sole Source** ☐ **RFP/RFQ was conducted**

Background: L.A. Care previously presented FIN 104.0324 requesting delegated authority to contract with professional services to perform capital improvement construction as part of the hybrid workspace build-out in the 1200 W. 7th Street (Garland) Building. The overall construction cost, with contingency, was estimated to be $47,027,791.00. The lease provides TI Allowance of $24,300,401.00 but requires L.A. Care's portion to be delivered as an unconditional, clean, irrevocable LC.

L.A. Care is seeking authority to obtain an irrevocable LC from a financial institution (such as Wells Fargo Bank, N.A.) in the principal amount of $22,727,390 which will create access to the TI Allowance of $24,300,401. The LC shall be cash collateralized by pledging $22,727,390 in unrestricted cash to said financial institution by depositing said cash to a public funds interest bearing account with said financial institution. This will support the existing plan, previously approved, to perform capital improvements to build-out floors 1, 5, 6 and 7 in the 1700 W. 7th Street Building in an amount not to exceed $47,027,791.

Member Impact: N/A

Budget Impact: The fee for the LC is approximately 1% per year which will be offset by higher than anticipated interest income generated from L.A. Care's investment portfolio.

Motion:

To approve L.A. Care (a) obtaining a letter of credit from a financial institution (such as Wells Fargo Bank, N.A.) to be delivered to the landlord of the Garland building for tenant improvements, as required per L.A. Care's lease contract and (b) cash collateralizing the letter of credit by pledging $22,727,390 in unrestricted cash to said financial institution in exchange for the letter of credit and depositing said cash with said financial institution.

The Board of Governors have determined that pursuant to California Welfare & Institutions Code § 14087.9605 (b)(2)(d) and (c), L.A. Care is permitted to "contract for services required to meet its obligations" and to "acquire, possess, and dispose of real or personal property" and obtaining and securing the letter of credit in order to facilitate the Tenant Improvements will allow L.A. Care to meet its obligations.

Additionally the Board of Governors have determined that it may "dispose" of its personal property by cash collateralizing the letter of credit. Further, pursuant to California Welfare & Institutions Code § 14087.9665 (a) L.A. Care may borrow or receive funds from any person or entity as necessary to cover development costs and other actual or projected obligations of the local initiative and the Board of Governors have determined that obtaining and securing the letter of credit in order to facilitate the Tenant Improvements is necessary to cover actual or projected obligations of L.A. Care. The Board of Governors have identified $22,727,390 in unrestricted cash which may be used to cash collateralize the letter of credit by depositing said cash to a public funds interest bearing account with said financial institution providing such letter of credit.

The Chief Financial Officer, the Deputy Chief Financial Officer, or person duly appointed in writing to act in the stead of such officer (collectively, the "Responsible Officers"), is hereby authorized and directed for and in the name of and on behalf of L.A. Care to further negotiate the terms of the letter of credit and fees and security relating thereto and execute and deliver documents and instruments relating to the letter of credit and cash collateralizing and pledging funds to secure the letter of credit with such changes therein, deletions therefrom and additions thereto as may be approved (i) by any Responsible Officer, in such person's discretion, as being in the best interests of L.A. Care, and (ii) by L.A. Care's General Counsel, such approval to be conclusively evidenced by the execution and delivery thereof by the person executing the same on behalf of L.A. Care (the "LC Documents").

Further Actions. The Responsible Officers are, and each of them acting alone is, hereby authorized and directed to take such actions and to execute such documents and certificates as may be necessary to effectuate the purposes of this resolution, including the execution and delivery of the LC Documents, and execution and delivery of any and all memorandums of agreement or understanding, assignments, certificates, requisitions, agreements, notices, consents, instruments of conveyance, warrants and other documents, which they, or any of them, deem necessary or advisable in order to consummate the transactions and requirements as described herein.

All actions heretofore taken by any officer of L.A. Care with respect to the execution and delivery of LC Documents, and the cash collateralizing and pledging funds to secure the letter of credit described therein are hereby approved, confirmed and ratified.

Board of Governors
MOTION SUMMARY

Date: April 24, 2024 **Motion No. EXE 101.0524**

Committee: Executive **Chairperson:** Alvaro Ballesteros, MBA

Requesting Department: Housing and Homelessness Incentive Program (HHIP)

Issue: Execute a contract with the Department of Health Services (DHS) Housing for Health in partnership with Brilliant Corners to provide support on accessibility improvements in Interim Housing facilities throughout Los Angeles County to ensure residents with disabilities are able to be safely housed in interim facilities, preventing returns to homelessness.

☒ **New Contract** ☐ **Amendment** ☐ **Sole Source** ☐ **RFP/RFQ was conducted in** <<year>>

Background: As of 2022, L.A. Care opted to participate in the Department of Health Care Services (DHCS) Housing and Homelessness Incentive Program (HHIP), which has two (2) overarching goals:

1) Ensuring that Managed Care Plans (MCPs) have the necessary capacity and partnerships to connect their members to needed housing services; and
2) Reducing and preventing homelessness.

HHIP is a MCP incentive program through which MCPs may earn incentive funds for improving health outcomes and access to whole person care services by addressing homelessness and housing insecurity as social drivers of health and health disparities. The HHIP rewards MCPs for developing the necessary capacity and partnerships to connect their members to needed housing services and taking active steps to reduce and prevent homelessness.

In order to align with HHIP goals, L.A. Care staff requests approval to execute a contract with DHS Housing for Health in partnership with Brilliant Corners from September 1, 2024 to September 30, 2027 in the amount of $3,500,000. The investment will fund the delivery of accessibility improvements in Interim Housing facilities throughout Los Angeles County to ensure residents with disabilities are able to be safely housed in the facilities, preventing return to homelessness. Some of the types of improvements include installing or fixing/updating ramps, widening doorways for wheelchair access, elevator repairs, member closets/personal storage renovations, food service/dining area upgrades and laundry area/machine upgrades that meet ADA standard requirements.

L.A. Care selected the DHS Housing for Health in partnership with Brilliant Corners because of their experience providing and coordinating housing and homeless services, including physical plant improvements for interim housing facilities, for the County of Los Angeles, and position to quickly build capacity and coordinate the required services for vulnerable communities.

Member Impact: L.A Care members will benefit from this motion as it will help increase access to homelessness prevention services, including improving members experience and care in during the interim housing phase of their pursuit of permanent supportive housing and providing housing related community support services to support successfully maintaining members housed.

Budget Impact: The cost was anticipated and included in the approved budget for the Housing and Homeless Incentive Program and will use HHIP funds already received by L.A. Care.

Motion: **To authorize staff to execute an Housing and Homelessness Incentive Program (HHIP) investment agreement in the amount of up to $3,500,000 with the Los Angeles County Department of Health Services in partnership with Brilliant Corners, to provide accessibility improvements in Interim Housing facilities throughout Los Angeles County to ensure residents with disabilities are able to be safely housed in the facilities from September 1, 2024 to September 30, 2027.**

Board of Governors
MOTION SUMMARY

Date: May 2, 2024 **Motion No. TAC 100.0524**

Committee: Technical Advisory Committee **Chairperson:** Alex Li, MD

Issue: Approval of the revised Technical Advisory Committee (TAC) Charter.

☐ **New Contract** ☐ **Amendment** ☐ **Sole Source** ☐ **RFP/RFQ was conducted**

Background: None.

Member Impact: None.

Budget Impact: Not applicable

Motion: **To approve the revised Technical Advisory Committee (TAC) charter, as presented.**

Board of Governors
Technical Advisory Committee
CHARTER

General Information

The Technical Advisory Committee (TAC) is a legislatively mandated, broad-based public advisory committee, reporting to the L.A. Care Board of Governors. The TAC assists the L.A. Care Board of Governors in formulating broad public policy directives, through the provision of expertise, the identification of issues in the community related to health equity, quality of care, and the review of health care delivery models and innovations offered by L.A. Care Health Plan. Its membership shall include, but not be limited to, individuals representing the following disciplines, expertise or professions e.g.: epidemiology, health services research, public health, health equity, quality, delivery systems and policy. Each member of the committee shall be selected by an appropriate nominating entity(ies) in the discipline/profession the person is representing. If an appropriate nominating entity does not exist, staff and TAC membership shall make recommendations and elect those individuals based on a vote of the entire committee membership.

The scope and nature of the issues considered by TAC relate most closely, though not exclusively, to activities and functions under the purview of the Chief Health Equity Officer. As such, the Chief Health Equity Officer serves as the primary conduit for information exchange between TAC, L.A. Care Health Plan management, including all organizational areas, and the L.A. Care Board of Governors, and also serves as a permanent, voting member of the Committee.

Committee Roles

The primary roles of the committee are:

A. To review program development, reports and other considerations presented by L.A. Care Health Plan staff regarding L.A. Care Health Plan's health care services, program delivery models, and provider community, offering advisory feedback and recommendations as appropriate.

B. To develop and present recommendations to the Chief Health Equity Officer and L.A. Care Board of Governors about issues relating to L.A. Care Health Plan's provision of health care services, health equity and social determinants of health initiatives, program delivery models, and provider community.

C. The committee

Technical Advisory Committee (TAC) Charter

Committee Responsibilities

The responsibilities of the Committee, on behalf of the L.A. Care Board of Governors, shall include:

A. Review of policies related to the service models used by L.A. Care Health Plan in order to recommend related public policy.

B. "Provision of expert advice to the Chief Health Equity Officer, other LA Care senior leaders and managers, and L.A. Care Board of Governors concerning L.A. Care Health Plan proposals or activities impacting the provider community.Creation of an annual workplan with periodic status reports to the Board on the implementation of the workplan.

C. As appropriate**,** regular communication with the nominating entity (ies) to identify their issues and represent these issues to the committee and to share committee actions.

Committee Operations and Organizational Interface

Key aspects of committee operations and organizational interface include:

A. The committee will be informed of key L.A. Care Health Plan initiatives and develop recommendations for the organization and the Board of Governors.

B. The committee shall meet at least every other month when possible.

C. The committee shall maintain minutes of all its meetings to document its activities and recommendations.

D. Each committee member shall be selected by an appropriate nominating entity/ies in the particular discipline or profession, or by the committee as a whole, if such an entity does not exist.

E. The committee will consist of a minimum of 8 members and no more than 12.

F. The appointed member shall be limited to serving two consecutive four year terms or a maximum of eight years cumulatively. Appointment or reappointment is contingent upon approval of L.A. Care Board of Governors.

G. Board Services staffs the committee, in consultation and collaboration with the Chief Health Equity Officer.

H. The committee shall make recommendations to the L.A. Care Board of Governors on those findings and matters within its scope of responsibility. Such recommendations are brought to the L.A. Care Board of Governors via the Board's Executive Committee and/or other Board committees, as appropriate, and are presented to the L.A. Care Board of Governors.

Signed:

Secretary, Board of Governors

Date:

CHIEF EXECUTIVE OFFICER REPORT

April 22, 2024

TO: Board of Governors

FROM: John Baackes, *Chief Executive Officer*

SUBJECT: CEO Report – May 2024

Prior to the announcement of my retirement this month, I shared all that we have accomplished in the past nine years that I have been with L.A. Care. In the very fast-paced health care environment we are in coming out of the COVID-19 pandemic, the handoff to the next CEO has to be like runners in a relay race with no break in pace to keep our many transformational projects on track. I have also assessed that our management team is at its highest level of talent, competency, and experience since I arrived. That was not by accident, since every hire I have made in the C-Suite has been with this day in mind, that there would be a time I would leave and would only do so knowing that I had the strongest team possible in place to continue our important work in support of our mission.

This year we decided to create a report on L.A. Care's remarkable history of community investment instead of an annual report that most entities produce. On April 10, we released the 2024 Community Impact Report. It chronicles that since 2001, L.A. Care has invested $509 million into the Los Angeles County safety net of medical and social service providers for the benefit of our members and the community at large. We recognizes that it takes more than health coverage to build healthy communities. Starting in 2024, for the first time, all managed care plans in California will be required to allocate 5 to 7.5 percent of their profits to local community activities that support Medi-Cal members. We are proud to say that we have been investing in the community long before the new mandate. L.A. Care adds value for our members, our providers, and the community at large.

Following are the cumulative totals for some of our community- and provider-focused work.

	Since Last CEO Report	As of 04/22/24
Provider Recruitment Program Physicians hired under PRP[1]	1	186
Provider Loan Repayment Program Active grants for medical school loan repayment[1]	—	192
Medical School Scholarships Grants for medical school scholarships[2]	—	48
Elevating Community Health Home care worker graduates from CCA's IHSS training program	—	6,677

Notes:
1. Effective January 2024, this table will provide cumulative (since program inception) award counts, and will no longer provide "active" award counts.
2. The count includes scholarships that have been awarded and announced, not prospective scholar seats.

Below please find organizational updates for April.

L.A. Care Commits a $2 Million Lifeline to Catalina Island Health
L.A. Care awarded Catalina Island's only hospital, Catalina Island Health, a $2 million grant to help sustain the hospital until the end of the year. We are deeply committed to supporting the health care safety net that serves our members and all of Los Angeles County. In addition to the grant, we are boosting the hospital's Medi-Cal reimbursement rates and urging other health plans to step up and do the same. The grant is just a lifeline and not a long-term solution, but it will give Catalina Island Health the time needed to make an affiliation arrangement with a larger organization, so it can continue to provide services to this isolated population.

Los Angeles County Medical Association, L.A. Care Health Plan and Los Angeles County Department of Public Health, Launch Gun Safety Billboard Campaign
L.A. Care and the Los Angeles County Medical Association funded a campaign in response to the public health crisis of gun violence. We collaborated with the Los Angeles County Department of Public Health's Office of Violence Prevention on a digital billboard campaign that emphasizes the importance of gun safety, promotes the use of gun locks to keep children and youth safe from accidental gun violence inside the home, and directs viewers where to obtain a free gun lock, no questions asked. As the largest health plan in Los Angeles County with nearly 2.6 million members, we feel a deep responsibility to take a community leadership role in advocating for responsible gun safety laws.

Speaking Events
April 3 – UCLA FSPH Paul Torrens Health Forum; *Housing and Health Care: CalAIM's Funding Opportunity for Health Care and Affordable Housing Providers.*

Attachments
Becker's Hospital CFO Report
My News LA

BECKER'S
Hospital CFO Report

Isolated California hospital gets $2M from payer to stave off closure

Andrew Cass - Wednesday, April 10th, 2024

L.A. Care Health Plan is giving Avalon, Calif-based Catalina Island Health hospital a $2 million grant to help stay afloat as the hospital looks to make an affiliation arrangement.

Jason Paret, CEO of Catalina Island Health, told the Avalon City Council in January that the hospital was running out of money and might not be able to stay open past June, according to a Jan. 12 report from the *Catalina Islander.* Mr. Paret said the best option for the hospital was to become part of the University of California system.

L.A. Care, the largest publicly operated health plan in the U.S., said in an April 10 news release that it is also boosting Catalina Island Health's Medi-Cal reimbursement rates and urging other payers to do the same.

The hospital is isolated because it is on an island, but because it is part of Los Angeles County, it is considered an urban facility, making it ineligible for some state funding offered to rural facilities, according to the release. The island is home to 4,200 residents and 733 are L.A. Care Health Plan beneficiaries.

The grant will allow the hospital to stay open through December, according to an April 5 news release from Los Angeles County Supervisor Janice Hahn.

Billboards Promote Gun Safety, Free Locks In Los Angeles County

by **Contributing Editor** April 8, 2024

A countywide billboard campaign designed to promote gun safety and encourage the use of free gun locks to keep children safe from accidents was announced Monday by county officials.

“A significant portion of the gun violence that plagues our communities — especially unintentional deaths or injuries and gun suicides — can be prevented if firearms in the home are kept locked and unloaded,” Barbara Ferrer, director of the Department of Public Health, said in a statement. “The billboard campaign and the free gun lock distribution program are critically important steps in the effort to reduce gun violence, especially gun violence involving children.”

The digital billboard advertising campaign is a collaboration with the Los Angeles County Medical Association, L.A. Care Health Plan and the Los Angeles County Department of Public Health’s Office of Violence Prevention. The initiative is funded by the Los Angeles County Medical Association and L.A. Care Health Plan.

As of this month, the digital billboards are on display on heavily traveled portions of the Santa Monica (10) Freeway and Long Beach (710) Freeway. They depict a young person next to the statistic that in Los Angeles County a child is either injured or killed by gun violence every 30 hours. Another 150 poster billboards with the same message are located at bus benches across the county.

The advertisements direct viewers to visit lockedandunloaded.org to obtain a free gun lock. The website features an interactive map where residents can find distribution locations for more than 60,000 available cable gun locks.

“Gun violence exacts a devastating toll on our communities, especially our youth,” county Medical Association CEO Gustavo Friederichsen said. “By advocating for responsible gun safety measures, such as the use of gun locks, we can prevent tragic accidents and save lives. We invite our healthcare community to help spread the word and we urge every member of our community to take advantage of this opportunity to make our homes safer and protect our loved ones. Together, we can make a meaningful difference in the fight against gun violence.”

According to a report from the U.S. Centers for Disease Control and Prevention, between 2003 and 2021, accidental gun deaths of children ages 17 and younger were most likely to occur in a house or apartment. Eight in 10 such incidents took place in a home, and 56% happened in the child’s own home. The report also stated that in 2022, more than 800 deaths in Los Angeles County involved a firearm and 313 of those deaths were due to gun suicide.

March 2024
Grants & Sponsorships Report
May 2024 Board of Governors Meeting

#	Organization Name	Project Description	Grant/ Sponsorship Aproval Date	Grant Category/ Sponsorship	Grant Amount	Sponsorship Amount	FY CHIF & Sponsorships Cummulative Total
1	**Health Consortium of Greater San Gabriel Valley, a program of Public Health Foundation Enterprises, Inc DBA Heluna Health**	2024 San Gabriel Valley Health Summit	3/5/2024	Sponsorship	$ -	$ 2,500	$ 2,500
2	**National Alliance on Mental Illness Greater Los Angeles County**	NAMIWalks Greater LA County & Mental Health Fest	3/7/2024	Sponsorship	$ -	$ 5,000	$ 5,000
3	**Nick and Normas No Child Left Behind Fund DBA Meals in Motion**	Meals in Motion - Food Distributions	3/7/2024	Sponsorship	$ -	$ 10,000	$ 10,000
4	**Discovery Science Center of Los Angeles**	Star Gala - 10-Year-Anniversary of Discovery Cube Los Angeles	3/7/2024	Sponsorship	$ -	$ 2,500	$ 2,500
5	**Los Angeles County Department of Health Services - Rancho Los Amigos**	Rancho Los Amigos Foundation's Annual Amistad Gala - 2024	3/14/2024	Sponsorship	$ -	$ 10,000	$ 10,000
6	**LA Family Housing**	LAFH Awards 2024	3/14/2024	Sponsorship	$ -	$ 10,000	$ 10,000
7	**Community Partners FBO Maternal Mental Health NOW**	2024 Sex and Perinatal Mental Health Conference	3/18/2024	Sponsorship	$ -	$ 5,000	$ 5,000
8	**California Black Freedom Fund**	CBFF proposes a unique approach to supporting BPOs: a combination of unrestricted grantmaking, technical assistance, communications and narrative change, engaging movement-based networks and coalitions, and the creation of shared learning spaces	3/27/2024	Grant	$ 200,000	$ -	$ 200,000
9	**California Community Foundation**	Support community-based organizations that are implementing California Advancing and Innovating Medi-Cal (CalAIM) housing-related Community Supports and explore additional funding mechanisms to scale housing-based services supported by Medi-Cal in Los Angeles County (LA).	3/27/2024	Grant	$ 75,000	$ -	$ 75,000
10	**STEM to the Future**	STEM to the Future's program, Theory and Practice (TxP), consists of afterschool initiatives in which elementary and middle school youth combine Youth Participatory Action Research (YPAR) and STEAM as they work together to reimagine and create the communities they want and deserve	3/27/2024	Grant	$ 150,000	$ -	$ 150,000
		Total of grants and sponsorships approved in March 2024			**$ 425,000**	**$ 45,000**	**$ 470,000**

Introduction

Vision 2024

L.A. Care's strategic plan, Vision 2024, outlines our major goals for 2021-2024. Vision 2024 guides us towards continued growth and success using the framework offered by the four strategic directions that remain our guideposts—Operational Excellence, High Quality Network, Member Centric Care, and Health Leader. The Vision 2024 document is available upon request.

Progress Reports

L.A. Care reports to the Board of Governors regarding the progress made towards the goals in Vision 2024 on a quarterly basis. Each quarterly report is retrospective, and captures a high-level summary of activities from the previous quarter. **The following report covers the second quarter of our fiscal year, from January 1 through March 31.**

A more detailed report is available in the Appendix of this document.

Operational Excellence

Achieve operational excellence by improving health plan functionality.

Goals	Q2: January – March 2024 Highlights
Build out information technology systems that support improved health plan functionality.	• L.A. Care initiated additional plans to enhance the interactive voice response (IVR) for the VOICE program that would elevate the customer experience and upgrade the call quality monitoring system. • Implementation for Callidus, the SAP cloud-based commission software solution for managing incentives and compensation programs for brokers, began in FY Q2 and is in the preliminary phase. • Collaborative workshops were held with Infosys to capture business, integration, and security requirements in accordance with L.A. Care's specifications for the configuration of Helix, a cloud-based platform to help teams perform provider enrollment and maintenance tasks efficiently.
Support and sustain a diverse and skilled workforce and plan for future needs.	• A succession planning pilot for one L.A. Care department was completed, yielding a development plan for potential successors. • Cohort One has completed the Management Certificate Program; one graduate has already been selected for a supervisor role.
Ensure long-term financial sustainability.	• FY 23-24 Q1 administrative expenses were over budget and the initial budget targets are being updated to reflect our new estimates. Targeted investments across various departments have been made to address key, time-sensitive needs. In addition to expanding headcount, there has been additional spend in purchased services relating to claims processing, call center, and IT projects.
Mature L.A. Care's family of product lines, taking an "all products" approach whenever possible.	• L.A. Care Covered Open Enrollment finished strong with January and February Effective Enrollments significantly exceeding our 183% forecast. • A high volume of SB 260 auto-assigned members continuing from Medi-Cal Redetermination, and are effectuated at a rate of approximately 22%.

High Quality Network

Support a robust provider network that offers access to high-quality, cost-efficient care.

Goals	Q2: January – March 2024 Highlights
Mature and grow our Direct Network.	• Care Management implemented a pilot program aimed at reducing hospital readmissions and enabling follow-up to optimize care post-discharge. • L.A. Care is undertaking an initiative to increase primary care provider (PCP) utilization by assessing distance between members and their assigned PCPs, as well as evaluating member demographics and the age limits of their assigned PCPs to ensure members are appropriately assigned.
Improve our quality across products and providers.	• The Direct Network Pay-for-Performance (P4P) Program for Measurement Year 2024 is being changed to mirror the Medi-Cal Value Initiative for IPA Performance (VIIP) program. • We deployed text message campaigns to encourage members to schedule their cervical cancer screenings and their children's well-child visits. • L.A. Care achieved Health Equity Accreditation status in March 2024 with the score of 98/100 from the National Committee for Quality Assurance (NCQA).
Invest in providers and practices serving our members and the L.A. County safety net.	• L.A. Care launched the start of the DHCS Equity and Practice Transformation Program (EPT) for the 46 primary care practices they have partnered. Practices have begun working on their first deliverable for the EPT Provider Directed Payment Program, the Population Health Management Capabilities Assessment Tool (PhmCAT). • In the Help Me Grow LA effort, both cohorts of practices have exceed the program goal of 15% improvement in screenings over the baseline measurement. • The In-Home Supportive Services Training Program Center for Caregiver Advancement (CCA) had a total of 328 students graduate from the Trimester 20th cohort. • L.A. Care released request for applications for four Community Health Investment Fund (CHIF) grant initiatives: The Tranquada XV initiative; Oral Health XV; Accessible Equipment Fund; and GAAINS III (Black infant and nurturers' outcomes).

Member Centric Care

Provide services and care that meet the broad health and social needs of our members.

Goals	Q2: January – March 2024 Highlights
Operate all components of California Advancing and Innovating Medi-Cal (CalAIM) as they are launched.	• In January, we initiated the launch of the new Enhanced Care Management (ECM) Population of Focus – Birth Equity. • Among other LA County plans, we took the lead in updating the ECM assessment tool to comply with the latest regulatory requirements and incorporate valuable feedback from our ECM providers. • The Care Management team is developing a Transitional Care Services (TCS) central call line and piloting a field TCS Community Health Worker (CHW) home visiting program for high-risk members.
Establish and implement a strategy for a high-touch care management approach.	• Care Managers increased the rate of members who successfully met their care plan goals by 9%, as compared to Q2 2023. • Care Management Community Health Workers (CHWs) began CHW certification training to improve the use of best practices when providing support to members. • Palliative care referrals increased by 8% in Q1 & Q2 of FY 23-24 compared to Q3 & Q4 of FY 22-23.
Ensure that the services we provide to members promote equity and are free of implicit and explicit bias.	• Community Benefits convened 13 grantee partners from Generating African American Infant and Nurturers' Survival (GAAINS) to work on creating and sustaining supportive, just systems that reduce disparities in Black births and maternal health. • Community Benefits approved Ad Hoc 2023-2024 grants for STEM to the Future (STTF) and the California Black Freedom Fund (CBFF). • We continue to expand our doula provider network; contracts are being finalized with Birthworkers of Color Collective, LA County Department of Public Health, and one independent doula. • L.A. Care's Doula Benefit has recommended 115 members and serviced 90 members since its inception on January 1, 2023.

Health Leader

Serve as a national leader in promoting equitable healthcare to our members and the community and act as a catalyst for community change.

Goals	Q2: January – March 2024 Highlights
Drive improvements to the Affordable Care Act by serving as a model of a successful public option.	• L.A. Care held preliminary conversations with a plan from another county interested in participating in Covered California.
Optimize members' use of Community Resource Centers and expand our member and community offerings.	• Total visits to the CRCs in 2023 were over 308,000. • Nearly 5,000 CRC visitors received assistance with Medi-Cal redetermination and enrollment services.
Drive change to advance health and social services for our members and the community.	• L.A. Care enrolled in the DHCS Child Health Equity Collaborative. • We launched a one-time Health Information Exchange (HIE) Adoption incentive for hospitals and Skilled Nursing Facilities with the aim of enhancing HIE adoption and supporting their participation in California's Health and Human Services (CalHHS) Data Exchange Framework (DxF). • Homeless & Housing Support Services (HHSS) Community Supports has seen a significant increase in referrals starting in January. The increase in referrals is projected to continue throughout the remainder of FY 23-24, leading to a higher number of members being served by HHSS Community Supports.

APPENDIX

Detailed Vision 2024 Progress Report
Fiscal Year Quarter 2
January – March 2024

Operational Excellence

Achieve operational excellence by improving health plan functionality.

Build out information technology systems that support improved health plan functionality.	
Tactics	**Update**
Improve customer service through the Voice of the Customer (VOICE) initiative, our customer service information technology system.	L.A. Care completed the reprioritization of the roadmap for the VOICE program and has moved into the discovery phase to solidify detailed requirements from business units. Engagement of an outside consulting firm continues in order to support timely delivery of scheduled deployments. Initial system build demonstrations were scheduled and are targeted to be rolled out to business units in Q3. Additional plans were initiated to enhance the interactive voice response (IVR) in order to support strategies that elevate the customer experience; and exploratory plans began to upgrade the call quality monitoring system to provide specific, targeted feedback and coaching to agents. Both functionalities are targeted to deploy in Q4.
Improve efficiency and effectiveness of financial management functions with the implementation of the additional phases of the SAP Enterprise Resource Planning (ERP).	Implementation for Callidus, the SAP cloud-based commission software solution for managing incentives and compensation programs for Brokers, began during FY Q2 and is currently in the preliminary phase of the project. The Request for Proposal process will be completed in Q3 to select an implementation partner for Ariba Procurement system. Implementation for Ariba is projected to start in FY Q3 and will replace the current SciQuest Procurement system. SAP Analytics Cloud for Reporting (SAC) is now live.
Modernize provider data management by defining and creating a roadmap for achieving our target state for our provider data ecosystem.	L.A. Care continued work towards implementing the Provider Target State by: • Conducting collaborative workshops with Infosys to capture business, integration, and security requirements for configuring Helix – a cloud-based SaaS platform that will streamline the Provider Network Management and Provider Data Management team's performance of all provider enrollment and provider maintenance tasks – in accordance with L.A. Care's unique specifications. • Developing requirements to streamline business processes and automate task performance using the advanced technology and artificial intelligence capabilities integrated into the Helix platform to maximize efficiency and enhance operational effectiveness.

Build out information technology systems that support improved health plan functionality.	
Tactics	**Update**
	• Finalizing L.A. Care's functional and nonfunctional requirements for suitable Helix configuration; • Designing and testing protocols for data migration; • Ensuring adherence to project plan milestones for on-time implementation scheduled for Q2 2025.
Refine and implement our three-year technology roadmap and ensure that the reference architecture serves as a blueprint that evolves with L.A. Care's needs.	Deloitte worked on design and began the delivery phase of the VOICE program; the initial deliverable will be a Pilot of the Provider Portal scheduled for completion in Q3. We also completed an Upgrade of the QNXT platform and all surround systems utilized for Health Services Care Management and Operations Claims Adjudication. The QNXT upgrade also sets the stage for our Health Services Utilization Management (UM) system implementation later in Q3. We have begun the development phase of our Potential Quality of Care Issues (PQI) and Appeals and Grievances (A&G) Systems, due for delivery in Q3 as well. Overall substantial progress against the roadmap.
Develop real-time interoperability capabilities to share data with providers and members.	This tactic has been completed.

Support and sustain a diverse and skilled workforce and plan for future needs.	
Tactics	**Update**
Conduct succession planning, particularly at the leadership level.	A succession planning pilot for one L.A. Care department was completed, yielding a development plan for potential successors. The Pilot review informed areas of revision and the ability to solidify the tools and resources (including new tools from our vendor, Korn Ferry) to continue to expand the pilot into another department.
Maintain a diverse and inclusive workforce, validated by data analysis, to model L.A. Care's commitment to Diversity, Equity, and Inclusion.	We continue to monitor current employee demographics, and remain an ethnically diverse organization with only minor variations in demographics over the last quarter. Our employees are: 36.8% Hispanic or Latino; 21.9% Asian; 15.3% Black or African American; 11.2% White; 4.9% Native Hawaiian or Other Pacific Islander; .26% American Indian/Alaskan Native; 3% two or more races; 6.8% non-applicable. Additionally, our employees are 69.7% Female and 30.3% Male.

Support and sustain a diverse and skilled workforce and plan for future needs.	
Tactics	**Update**
Improve managed care and Management Services Organization (MSO) acumen among staff.	L.A. Care has partnered with Local Health Plans of California (LHPC) to help educate our employees on Managed Care services. In Q2, employees attended the following educational sessions: • Medi-Cal Managed Care 101 (attended by 72 employees) • Medi-Cal Managed Care Finance 101 (attended by 60 employees) Classes are already scheduled for Q3 and employees are currently getting registered.
Promote retention of staff in an evolving work environment.	Cohort One has completed the Management Certificate Program; one graduate has already been selected for a supervisor role. Cohort Two is currently in progress and will graduate in July 2024. As of March 29, 2024, the selection process for Cohort Three is in its final phase. Employee Engagement results roll-out is complete; focus groups and action planning are in process. Our overall engagement score increased from 4.04 in 2022 to 4.09 in 2023 (24th percentile to 33rd percentile of our peers).

Ensure long-term financial sustainability.	
Tactics	**Update**
Implement recommendations from the administrative expense benchmarking study and update the administrative expense target in the revised forecasts.	FY 23-24 Q1 administrative expenses were over budget by $9.8M. The initial budget targets for FY 23-24 had to be updated as part of the 4+8 forecast. Targeted investments across various departments have been made to address key, time-sensitive needs. In addition to expanding headcount, there has been additional spend in purchased services relating to claims processing, call center, and IT projects.

Mature L.A. Care's family of product lines, taking an "all products" approach whenever possible.	
Tactics	**Update**
Launch a D-SNP to serve the dually-eligible Medicare and Medi-Cal population and transition members from Cal MediConnect (CMC) to the D-SNP.	This tactic has been completed.

Increase membership across all products by implementing member recruitment and retention strategies.	**Sales**
	• L.A. Care Covered (LACC): The Plan Year 2024 Open Enrollment Period (OEP) finished strong with January 2024 and February 2024 Effective Enrollments significantly exceeding (183%+) forecast. FY Q2 also saw:
	  ○ A high volume of SB 260 auto-assigned members continuing from Medi-Cal Redetermination effectuating at a rate of approximately 22%.
	  ○ Price positioning, an active broker channel, and SB 260 are currently contributing to Special Election Period (March 2024 through December 2024) growth.
	• Medicare Plus D-SNP: The Special Election Period (February 2024 through December 2024) net membership growth continues on a monthly basis, with current net membership just under 19,500 members.
	  ○ Plan Year-to-Date Enrollments are currently just under 4,100 versus a recent forecast of 3,930 and original budget goal of 3,780.
	  ○ Initiatives to drive higher growth include contract efforts with LexisNexis to secure improved dual-eligible contact data to increase contact rates and conversions to D-SNP.
	
	Marketing
	• L.A. Care Covered (LACC): In Q2, our focus remained on engaging our target audience through strategic outreach efforts. In February, we extended our campaign to support the Open Enrollment extension, allocating funds to high-performing digital tactics. Additionally, we capitalized on our Rams partnership to promote LACC with co-branded outdoor billboards. Transitioning to a lean digital marketing campaign for the Special Enrollment

Mature L.A. Care's family of product lines, taking an "all products" approach whenever possible.	
Tactics	**Update**
	Period (SEP), we tailored messaging and creative to effectively address audience needs while staying aligned with our overarching product objectives. • Medicare Plus D-SNP: We've begun collaborating with product partners to lay the groundwork for the FY25 campaign, leveraging past performance data to inform marketing recommendations, goals and objectives. Our strategy for D-SNP members prioritizes targeted, personalized, and accessible campaigns tailored to their unique needs. Through a multi-channel approach emphasizing education and engagement, we aim to forge a strong connection, fostering improved health outcomes and member satisfaction. • Medi-Cal (MCLA): We supported the older adult expansion with a targeted awareness campaign, emphasizing visibility in key public spaces and leveraging high-performance digital marketing tactics. The Plan Partner campaign has concluded and is undergoing data analyzation to generate insights and recommendations that further empower our partners and enhance collaboration. Concurrently, we've sustained support for redetermination efforts through continuous digital marketing tactics and content.
Engage in a provider network strategy that meets distinct business and competitive needs of all products and ensures that members receive high-value care.	L.A. Care continued to host monthly Provider Engagement Events at Community Resource Centers (CRCs) and quarterly Physician Advisory Collaborative events to gather valuable insights from network providers. These insights are then utilized to address pain points, enhance and streamline operations, and improve the overall provider experience. To enhance access to care, L.A. Care is amending its contracts with directly contracted specialists to enable them to render services to both Medi-Cal and PASC-SEIU members assigned to DHS.

High Quality Network

Support a robust provider network that offers access to high-quality, cost-efficient care.

Mature and grow our Direct Network.	
Tactics	**Update**
Insource delegation functions that are currently outsourced, as appropriate and cost effective.	This tactic has been completed.
Improve the operations of all L.A. Care functions necessary to support and scale up the Direct Network.	To create efficiencies and improve prior authorization processing times, L.A. Care undertook the following initiatives: • Automated the translation of member notifications conveying utilization management (UM) decisions; • Implemented a Direct Network Service Request Form, which will streamline specialty referrals and authorizations for participating direct network providers and will trigger notifications to both referring and rendering physicians; • Worked on expanding the range of service codes that do not require prior authorization. To reduce hospital readmissions, Care Management implemented a pilot program that notifies directly contracted primary care providers (PCPs) whenever one of their assigned members is discharged from a facility, enabling suitable follow-up to optimize care post-discharge. L.A. Care also developed an integrated and filterable performance scorecard to measure service delivery at the practice level. This scorecard will be shared with directly contracted PCPs to facilitate performance improvements.
Strategically address gaps in the Direct Network to meet all member needs countywide.	To increase primary care provider (PCP) utilization, L.A. Care undertook the following initiatives: • Assessed the distance between members and their assigned PCPs, identified members assigned to a PCP outside required time-and-distance standards, and developed protocols to facilitate reassignment to more geographically accessible PCPs; • Evaluated member demographics and the age limits of their assigned PCPs, identified members needing to be reassigned, and developed protocols to facilitate suitable reassignments.

Mature and grow our Direct Network.	
Tactics	**Update**
	L.A. Care collaborated with regulators to develop the required filing for approval to increase membership in the Direct Network. L.A. Care continues to maintain 100% network adequacy.
Increase access to virtual care by implementing L.A. Care's Virtual Specialty Care Program (V-SCP).	Since the V-SCP program started last July: • We have received a total of 104 eConsults submitted and five telehealth visits; • The eConsult specialists have responded back to the primary care provider in 24 hours or less and around 70% of the eConsults needed an in-person visit. Eight eConsults were submitted in Q2 of FY 23-24. The top five eConsult specialties continue to be for Neurology, Gastroenterology, Ophthalmology, Dermatology, and OB/GYN. In Q3, we plan to re-assess where we are with this pilot and determine our next steps.

Improve our quality across products and providers.	
Tactics	**Update**

Achieve quality scores for the Direct Network that are commensurate with the median IPA network scores.	• Q3 2023 Capitated Claims Reports and Practice-level Provider Opportunity Reports for January through November 2023 data were distributed. These reports support quality improvement efforts for the Direct Network and allow practices to track progress toward incentive performance targets and act upon lower performing measures.
	• The Measurement Year 2024 Direct Network Pay-for-Performance Program Description review is underway. Major changes for 2024 mirror changes made for the Medi-Cal Value Initiative for IPA Performance (VIIP) Program, which includes:
	  ○ Using National Committee for Quality Assurance's (NCQA) Quality Compass National Medicaid HMO thresholds (50th percentile) and benchmarks (95th percentile) instead of internal targets in order to better meet the Minimum Performance Level (National Medicaid HMO 50th percentile) required by DHCS for the Medi-Cal Accountability Set (MCAS) measures;
	  ○ Increasing the HEDIS domain weight from 30% to 50% in order for the incentive to align more deeply with HEDIS performance.

Improve our quality across products and providers.	
Tactics	**Update**
Exceed the DHCS Minimum Performance Level for all measures for Medi-Cal, achieve a four-star quality rating for L.A. Care Covered, and build the infrastructure to achieve a four-star quality rating for our D-SNP.	L.A. Care deployed text message campaigns to encourage members to schedule their cervical cancer screenings and their children's well-child visits. Quality Improvement Nurses started reaching out to parents/guardians of children due for vaccines to provide vaccine education and to facilitate the scheduling of a visit. A social media video campaign for Colorectal Cancer Awareness Month was launched in March, emphasizing the importance of colorectal cancer screenings. We are working with the DHCS Data Exchange and Integration Section (DEIS) to confirm L.A. Care is receiving carved-out and bi-directional data that impacts Medi-Cal Accountability Set (MCAS) performance.
Improve clinical data integration and data governance, starting with race, ethnicity, language, sexual orientation, and gender identity data, in order to achieve the NCQA Health Equity Accreditation.	This tactic is completed, as we have updated our systems to help L.A. Care achieve NCQA Health Equity Accreditation. We have entered the next phase of the Race and Ethnicity Program which will include the creation of outbound files and continued oversight from the Data Governance Team. Additionally, we are modernizing our overall data eco system.
Improve clinical performance for children's care.	We launched social media campaigns that focused on Children's Dental Health and Preteen Vaccine Week in Q2 of FY 23-24. These campaigns encouraged parents/guardians to keep up-to-date with their children's appointments and vaccinations. We also conducted a Well Care Visit text messaging campaign in February. The campaign served as a reminder for parent/guardians to take their children (ages 3-17 years old) for their annual check-up.

Invest in providers and practices serving our members and the L.A. County safety net.	
Tactics	**Update**
Assist our providers in adopting and using Health Information Technology (HIT) resources.	**Transform L.A.:** The team completed data validation work with eMed, an electronic health record (EHR) software, to correct data mapping errors and to begin reporting Child Immunization Status. The team is continuing to encourage practices to use health information exchanges (HIE) and other resources to improve care delivery. Three practices have been

Invest in providers and practices serving our members and the L.A. County safety net.	
Tactics	**Update**
	approved for the one-time HIE Incentive program. Transform L.A. is also supporting practice use of Provider Opportunity Reports (POR) and Cozeva as alternative data sources for their monthly measure progress reports. **Help Me Grow LA:** Practices continued to work on incorporating developmental screening tools into their electronic medical records and to improve their referral processes. First 5 LA has agreed to distribute remaining grant funds to support screening tool subscriptions, to streamline current workflows and reduce administrative burden on practices. Practice coaches are working to strengthen connections between practices and Regional Centers. **EQuIP-LA:** Three of the four enrolled Direct Network practices are continuing to transition their patient record data from paper to their newly installed or upgraded Electronic Health Record (HER) software programs. The development of HEDIS reporting capabilities from the EHR to include race and ethnicity data is also underway. The team has worked with Quality Performance Management team to provide interim practice data reports and eliminated the backlog of report submissions to the program office. **Equity & Practice Transformation:** The 46 primary care practices that L.A. Care partnered with for DHCS's Equity and Practice Transformation Program (EPT) have begun working on their first deliverable for the EPT Provider Directed Payment Program; the Population Health Management Capabilities Assessment Tool (phmCAT). This is a multi-domain assessment that practices will utilize to understand their current population health management capabilities (due by April 30th). Practice payments are expected from L.A. Care by October 2024.
Provide practice coaching to support patient-centered care.	**Transform L.A.:** One new practice was enrolled for a new total number of Direct Network practices of 21, 112 providers and 33% of Direct Network members. Five practices are reporting an average 17% improvement from baseline for Glycemic Assessment in Patients with Diabetes (>9%). The Well-Child Visit measure has been added for practices to report on, and baseline measurements are in process. In collaboration with the Clinical Initiatives team, work is being done to improve Childhood Immunization Status and Well-Child Visit performance rates. Central Medical Business Management is on track to complete Phase Five of Transform L.A.'s transformation process in April. **Help Me Grow LA:** Both cohorts of practices have exceeded the program goal of 15% improvement in screenings over the baseline measurement. Cohorts One and Two have achieved increases of 37% and 18% respectively over their baselines. Practices are developing their sustainability plans for this final program year.

Invest in providers and practices serving our members and the L.A. County safety net.	
Tactics	**Update**
	EQuIP-LA: Quality improvement work is currently underway with practices working on their Plan, Do, Study, Act cycles (conducting small tests of change) to improve selected HEDIS measures. **Equity & Practice Transformation:** L.A. Care hosted two webinars launching the start of the DHCS Equity and Practice Transformation Program (EPT) for the 46 primary care practices they are partnering with (24 private practices and 22 FQHCs). Participating practices are required to commit to four categories of activities for the Provider Directed Payment Program (PDPP) that align with the Population Health Capabilities Assessment Tool (phmCAT) and the Population Health Management Implementation (PHMI) Model. L.A. Care's role is to support these practices achieve program goals, manage the Directed Payments process, and contribute to the curriculum development and practice coaching pool. Population Health Learning Center has been contracted by DHCS to provide the Learning Collaborative and serve as the Program Office for the Provider Directed Payment Program. Practices will complete and submit the phmCAT as their first program deliverable by April 30th.
Implement innovative programs to train, recruit, and retain highly qualified providers through the Elevating the Safety Net initiative.	**Provider Recruitment Program:** We continue to grow this program, with 163 active providers totaling slightly more than $21.9 million in investment. There are currently 22 vacancies. **Provider Loan Repayment Program:** Of the 192 physicians awarded, we have 135 active awards, including 113 new awardees and 22 award extensions. **Medical School Scholarship Program:** L.A. Care has awarded a total of 48 scholars, 24 at CDU and 24 at UCLA, with full-tuition scholarships. In December 2023, we executed the grants to award four new scholars at CDU and four at UCLA, to be selected later in 2024 (they are not included in the total, as they are not yet awarded). **In-Home Supportive Services Training Program Center for Caregiver Advancement (CCA):** Three hundred twenty-eight students graduated from the Trimester 20th cohort. CCA is wrapping up the Trimester 21st cohort and will be hosting graduation ceremonies starting April 16th. Overall, 6,677 students have completed the L.A. Care training course as of December 2023.

Invest in providers and practices serving our members and the L.A. County safety net.	
Tactics	**Update**
Utilize the Community Health Investment Fund (CHIF) to leverage opportunities for providers to increase quality and access to care.	Community Benefits released request for applications (RFA) for four Community Health Investment Fund (CHIF) initiatives for providers to increase quality and access to care. The Tranquada XV initiative is purposed to prevent, reduce and manage disease through multi-disciplinary approaches that address patients' social determinants of health as well as physical health issues; Oral Health XV will prevent disease and reduce dental disparities by addressing social barriers to dental care; the 2023-24 Accessible Equipment Fund will improve access and more accurate medical assessments for seniors and people with disabilities (SPD); and GAAINS III, aimed to repair systems' ability to meet needs related to and eliminate disparities in Black infants' and nurturers' morbidity and mortality rates. Funding approvals will be announced next quarter. An Ad Hoc grant was approved for the California Community Foundation to develop advocacy priorities related to CalAIM Community Supports, partnering with 11 housing services organizations and obtaining guidance from the Corporation for Supportive Housing and other key stakeholders.

Member Centric Care

Provide services and care that meet the broad health and social needs of our members.

Operate all components of California Advancing and Innovating Medi-Cal (CalAIM) as they are launched.	
Tactics	**Update**
Maximize care for L.A. Care members, within funding constraints, through successful implementation of Enhanced Care Management (ECM) and Community Supports (CS) for specified populations of focus.	**Enhanced Care Management:** In January, we initiated the launch of the new Enhanced Care Management (ECM) Population of Focus - Birth Equity. In tandem with the introduction of the new Population of Focus and our expanding ECM enrollment, we have expanded our ECM provider network to include 81 providers and are continuing to grow. L.A. Care took the lead among the other LA County plans in updating the ECM assessment tool to comply with the latest regulatory requirements, and incorporated valuable feedback from our ECM providers into this revised tool. To expedite the process of our members receiving ECM care, L.A. Care

Operate all components of California Advancing and Innovating Medi-Cal (CalAIM) as they are launched.	
Tactics	**Update**
	has implemented a presumptive authorization process for our ECM providers who utilize the e-form for authorization requests. **Community Supports:** L.A. Care is on track to launch the remaining two of the 14 CalAIM Community Supports services by July 1, 2024 (Day Habilitation and Short Term Post Hospitalization Housing).
Ensure CalAIM Population Health Management (PHM) requirements are met.	• The Population Health Management department continues to lead the community partnership meetings that involve the three L.A. County Local Health Departments and all health plans that serve L.A. County to fulfill the collaborative/meaningful SMART goals of improving infant and maternal health and reducing social isolation for older adults (55+). • Care Management team continues to work on operationalizing Transitional Care Services (TCS) requirements by developing a TCS central call line, piloting field TCS Community Health Worker (CHW) home visiting program for high-risk members, adding post-partum population, and continually doing outreach and monitoring of members at all risk levels (high and low) internally as defined in the DHCS PHM requirements. • Continuing to develop delegation oversight monitoring for Participating Physician Groups (PPGs) on TCS PHM requirements based on DHCS feedback. Amendments have been added to contracts with PPGs, Skilled Nursing Facilities (SNFs), and hospitals to define and clarify TCS responsibility. • Operational report to monitor Health Risk Assessment (HRA) requirements for MCLA is now available. • The Initial Health Appointment (IHA) will become a platform for additional care coordination, preventive health measures, and holistic member care. IHA updates include: ○ IHA Data Enhancements: Monthly IHA compliance reports are complete and will be posted in the provider portal (along with the existing IHA Due Reports). The Compliance Reports have been shared with Care Management (CM), Pharmacy, California Children's Services (CCS), and Risk Adjustment teams for the purpose of encouraging members to make an appointment with their providers. Additionally these reports will be shared in the QI Joint Operations Meetings and utilized by the monitoring team to prioritize monitoring.

Operate all components of California Advancing and Innovating Medi-Cal (CalAIM) as they are launched.	
Tactics	**Update**
	○ Enterprise Performance Optimization revised the monitoring tool and is utilizing it for quarterly updates. ○ Pay-for-Performance will start incentive payments for completed IHAs in May 2024. ○ The IHA Provider Training is live on the Learning Management System (LMS)
Monitor and establish infrastructure for longer-term CalAIM initiatives.	Effective January 1, 2024, all Managed Care Plans (MCP) became responsible for full Long Term Care (LTC), Intermediate Care Facility – Developmental Disabled (ICF-DD), and Pediatric Sub-Acute Care benefits. The Carve-In for these benefits were implemented successfully. In Q2 (Jan-March), we have authorized services for 314 ICF-DD members and 22 Pediatric Sub-Acute Care members. Managed Long Term Services and Supports (MLTSS) along with internal stakeholders are meeting regularly to ensure all are aligned with program requirements. MLTSS is working closely with Provider Network Management to resolve some challenges and ensure network readiness. The teams conducted multiple trainings for ICF-DD providers and Skilled Nursing Facilities and continue to provide ongoing support with the transition. MLTSS continues to facilitate meetings with other L.A. County Managed Care Plans for alignment and to share best practices on ICF-DD.

Establish and implement a strategy for a high-touch care management approach.	
Tactics	**Update**
Maximize use of care managers and community health workers within our care management model.	Care Managers increased the rate of members who successfully met their care plan goals in Q2 by 9%, as compared to Q2 2023. Care Management also continued to provide Transitional Care Services (TCS) support to DHCS High Risk members, and began offering post-discharge TCS support to low risk TCS members. Care Management also increased the overall number of members supported under TCS in Q2 compared to Q1 2024. Care Management Community Health Workers (CHWs) began training for CHW Certification with El Sol Neighborhood Community Center to improve the use of best practices when providing support to members.

Establish and implement a strategy for a high-touch care management approach.	
Tactics	**Update**
Expand upon our progress with palliative care and add other end-of-life services.	Palliative care referrals increased by 8% in Q1 & Q2 of FY 23-24 compared to Q3 & Q4 of FY 22-23. Since January 1, 2024 the program eligibility has expanded to include D-SNP members. The Managed Long Term Services and Supports team continues with ongoing educational webinars and partnerships with internal and external stakeholders to increase awareness of the program. Palliative Care Providers also started participating in Care Management (CM) Interdisciplinary Care Team (ICT).

Ensure that the services we provide to members promote equity and are free of implicit and explicit bias.	
Tactics	**Update**
Leverage external partnerships, grantmaking, and sponsorships to implement programs that address the root causes of inequity, including racism and poverty.	Community Benefits convened 13 grantee partners from Generating African American Infant and Nurturers' Survival (GAAINS) to work on creating and sustaining supportive, just systems that reduce disparities in Black births and maternal health. Partners reported the following accomplishments: decreasing maternal anxiety, expanding their geographic reach, and collectively building the birth equity workforce. They also identified program barriers like anti-blackness among desired partners, and low wages, compensation, and reimbursement rates for birth workers and/or doulas as primary. Partners recommended increased messaging about the specialized care needs of Black mothers/birthers and expressed a need for safe information sharing and learning spaces for progressive leaders. Ad Hoc 2023-24 grants were approved for STEM to the Future (STTF) and the California Black Freedom Fund (CBFF). STTF's grant increases early exposure to, self-efficacy in, and community health solutions through STEM-based Youth-Participatory Action Research projects led by up to 430 youth through its partnership with LAUSD. CBFF's grant expands support for anchor networks comprised of 90 Black powerbuilding organizations (BPOs) across Los Angeles County that mobilize community members to shape policy decisions in effort to realize healthy and equitable communities.

Ensure that the services we provide to members promote equity and are free of implicit and explicit bias.	
Tactics	**Update**
	L.A. Care continues to host the L.A. County Health Equity Officers meeting. In the February meeting, the DHCS Chief Health Equity Officer provided their vision for DHCS to continue to improve health equity. Charter is still being reviewed. Project collaboration will focus on L.A. Care's Continuing Medical Education Equity Training. Member Equity Council finalized metrics for FY 23-24. The Council's goals will align with L.A. Care's Health Disparities & Mitigation plan. There are 16 goals that focus on four key areas, including: Addressing Key Health Disparities, Leading Change, Moving Toward Equitable Care with Data Improvement, and Embracing Diversity, Equity, and Inclusion. One objective in the Leading Change key area is partnering with external stakeholders to host at L.A. Care's Health Equity Conference. Draft topics include Black maternal health, screening, and addressing social determinants of health, as well as addressing burnout. The conference is proposed for early fall.
Identify and reduce health disparities among our members by implementing targeted quality improvement programs.	L.A. Care focuses on disparities in prenatal and postpartum care, diabetes, and hypertension: • L.A. Care is expanding the number of languages available for many of the text message campaigns. Well-child visit and cervical cancer screening campaigns will include messages in Chinese. • Community Health Workers (CHW) are calling parents/guardians of Black/African American infants in South Los Angeles to support them in scheduling their child's well-care visit(s). CHWs are also able to connect the parent/guardian to additional L.A. Care resources such as transportation. • Cumulative text messaging campaign enrollment in 2024 (for January and February) are the following: 37.5% of outreached members enrolled in the postpartum campaign, and 55.6% reported completing their postpartum exam, while 22.3% of Black/African American outreached members enrolled in the prenatal campaign program. • We continue to expand the doula provider network. Contracts are being finalized with Birthworkers of Color Collective, LA County Department of Public Health, and one independent doula. L.A. Care is currently contracted with one doula organization called The Doula Network and working under a Letter of Agreement (LOA) with two independent doulas. L.A. Care and DHCS have both implemented standing orders for members and

Ensure that the services we provide to members promote equity and are free of implicit and explicit bias.	
Tactics	**Update**
	can now be directly connected to services via the provider directory. L.A. Care has recommended 115 members and serviced 90 members since the Doula Benefit program inception on January 1, 2023. • 1,067 prenatal member educational mailings were distributed in January and February 2024. 1,504 Healthy Mom (Postpartum) Outreach Calls were conducted within the same timeframe. • Educational mailings were distributed to 1,067 prenatal members in January and February. Within the same timeframe, 1,504 Healthy Mom (Postpartum) Outreach Calls were conducted. • L.A. Care social media channels shared a post on Maternal Health Awareness Day in January and hosted a live event focusing on Navigating Maternal Health in February.
Implement initiatives to promote diversity among providers, vendors, and purchased services.	We have begun the diversity data enrichment effort with the small business vendor that we have contracted with. This effort will allow L.A. Care to establish a baseline of our current diversity spends. As part of the contract with this vendor, we have also received access to their proprietary diverse business database. L.A. Care can source from this database to identify applicable diverse entities when business opportunities arise. The Health Equity Award (previously known as Provider Equity Award) will award five organizations in April during the Provider Recognition Awards. The four Health Equity categories are: Roland Palencia Safety Net Awardees, School-Based Health Center Awardee, Maternal and Child Health Awardee, and Community Health Investment Fund (CHIF) Awardee. The Provider Directory enhancements to include primary care provider (PCP) photos in our online provider directory continues to be underway. The council will pilot this project with one participating physician group (PPG) across LACC, MCLA, and D-SNP lines of business. The business case has been completed and we have engaged our IT business partners on these efforts. The workgroup aims to have the provider directory enhancement in place for the next Open Enrollment Period for 2025.

Ensure that the services we provide to members promote equity and are free of implicit and explicit bias.	
Tactics	**Update**
Offer providers Diversity, Equity, and Inclusion resources to promote bias-free care.	L.A. Care remains focused on implementing the DHCS all plan letter (APL), 23-025, Diversity Equity and Inclusion Training Plan. L.A. Care is leading efforts to implement a memorandum of understanding between L.A. Care, our Plan Partners, and other local health plans. L.A. Care also launched a monthly meeting with other Local Initiatives across the state to discuss and share updates and information on the APL.

Health Leader

Serve as a national leader in promoting equitable healthcare to our members and the community and act as a catalyst for community change.

Drive improvements to the Affordable Care Act by serving as a model of a successful public option.	
Tactics	**Update**
Play a leading role in advocating for a public option at the state and national levels.	No new action this quarter.
Provide expertise and assistance to other public plans interested in participating in state exchanges.	Held preliminary conversations with a plan from another county interested in participating in Covered California.

Optimize members' use of Community Resource Centers and expand our member and community offerings.	
Tactics	**Update**
Increase the number of Community Resource Centers to 14, in partnership with Blue Shield of California Promise Health Plan, and increase number of annual visits to 70,000 by Q2 2024.	The official grand opening ceremonies of the West L.A. and Panorama City Community Resource Centers (CRCs) are scheduled for April and May respectively. Total visits to CRCs in 2023 were over 308,000. Construction continues on South L.A. and Lincoln Heights sites.
Partner with community-based organizations to offer a range of services onsite.	Contracts for eight community partners that provide assistance for Medi-Cal redetermination and enrollment services are being extended into 2025. From March to December 2023, nearly 5,000 visitors received assistance with Medi-Cal redetermination and enrollment services at the CRCs.

Drive change to advance health and social services for our members and the community.	
Tactics	**Update**
Identify and prioritize actions, interventions, and programs to promote equity and social justice.	L.A. Care achieved Health Equity Accreditation status in March 2024 with the score of 98/100 from the National Committee for Quality Assurance (NCQA). L.A. Care enrolled in the DHCS Child Health Equity Collaborative. This one-year project will partner with a clinic to improve well-child visits for populations experiencing disparities.
Support regional Health Information Exchanges (HIE).	L.A. Care actively promotes regional Health Information Exchanges (HIEs) by utilizing federal and state interoperability regulations. We are in the process of requiring contracted hospitals and Skilled Nursing Facilities (SNFs) to participate in the HIEs. Additionally, we introduced an HIE Participation Measure beginning in 2024 within Hospital and SNF Pay for Performance (P4P) programs. In March 2024, we launched a one-time HIE Adoption incentive for hospitals and SNFs, aimed at further enhancing HIE adoption and supporting their participation in California's Health and Human Services (CalHHS) Data Exchange Framework (DxF). We have allocated $2.2M towards this effort.

Drive change to advance health and social services for our members and the community.	
Tactics	**Update**
Create a deliberate and tailored strategy to address homelessness among our members.	The Housing Initiatives Unit has made significant strides in priority strategic areas during Q2. Homeless & Housing Support Services (HHSS) Community Supports has seen a significant increase in referrals starting in January, largely due to several new low-income units coming online as a result of development funded by Measure H. The increase in referrals is projected to continue throughout the remainder of FY 23-24, leading to a higher number of members being served by HHSS Community Supports. Housing and Homeless Incentive Program (HHIP) received notification of Measurement Period II earnings. The award fell within the range we had projected and will allow us to invest in identified priority areas, such as Field Medicine. Work for our Field Medicine program continues to move toward launch. We submitted and received provider surveys, Field Medicine Letters of Interest (LOIs), and we will be releasing the Field Medicine applications for providers toward the end of this month. Lastly, we are on track with our preparations to launch the new Community Support program, Day Habilitation, on July 1, 2024.

Legislative Matrix 4.22.2024

Last Updated: April 22, 2024

Bills by Issue

2024 Legislation (185)

Bill Number	Last Action	Status	Position
AB 4	**Read Second Time And Amended Re Referred To Com On Appr 2023 07 13**	**In Senate**	**Support**

Title
Covered California: expansion.

Introduction Date: 2022-12-05

Description
AB 4, as amended, Arambula. Covered California: expansion. Existing federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. Existing state law creates the California Health Benefit Exchange, also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Existing law requires the Exchange to apply for a federal waiver to allow persons otherwise not able to obtain coverage through the Exchange because of their immigration status to obtain coverage from the Exchange.This bill would delete that requirement and would instead require the Exchange to administer a program to allow persons otherwise not able to obtain coverage by reason of immigration status to enroll in health insurance coverage in a manner as substantially similar to other Californians as feasible given existing federal law and rules. The bill would require the Exchange to undertake outreach, marketing, and other efforts to ensure enrollment. The bill would also require the Exchange to adopt an annual program design for each coverage year to implement the program, and would require the Exchange to provide appropriate opportunities for stakeholders, including the Legislature, and the public to consult on the design of the program.

Primary Sponsors
Joaquin Arambula, Sabrina Cervantes, Maria Durazo

Organizational Notes

Last edited by Joanne Campbell at May 12, 2023, 9:13 PM
L.A. Care, Health Access California (co-sponsor), California Immigrant Policy Center (co-sponsor): Support

Bill Number	Last Action	Status	Position
AB 106	**Chaptered By Secretary Of State Chapter 9 Statutes Of 2024 2024 04 15**	**Enacted**	**None**

Title
Budget Acts of 2022 and 2023.

Introduction Date: 2023-01-09

Description
AB 106, Gabriel. Budget Acts of 2022 and 2023. The Budget Act of 2022 and the Budget Act of 2023 made appropriations for the support of state government for the 2022–23 and 2023–24 fiscal years.This bill would amend the Budget Act of 2022 and the Budget Act of 2023 by amending, adding, and repealing items of appropriation and making other changes.This bill would declare that it is to take effect immediately as a Budget Bill.

Primary Sponsors
Jesse Gabriel

Bill Number	Last Action	Status	Position
AB 136	**Re Referred To Com On B F R 2024 04 15**	**In Senate**	**Monitor**

Title
Medi-Cal: managed care organization provider tax.

Introduction Date: 2023-01-09

Description
AB 136, as amended, Committee on Budget. Medi-Cal: managed care organization provider tax. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, one of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care plans.Existing law imposes a managed care organization (MCO) provider tax, administered and assessed by the department, on licensed health care service plans and managed care plans contracted with the department. Under existing law, all revenues, less refunds, derived from the taxes are deposited into the Managed Care Enrollment Fund, to be available to the department, upon appropriation, for the purpose of funding specified subcomponents to support the Medi-Cal program.Existing law sets forth certain taxing tiers and tax amounts for purposes of the tax periods of April 1, 2023, to December 31, 2023, inclusive, and the 2024, 2025, and 2026 calendar years. Under existing law, the Medi-Cal per enrollee tax amount for Medi-Cal taxing tier II, as defined, is $182.50 for the 2024 calendar year, $187.50 for the 2025 calendar year, and $192.50 for the 2026 calendar year.This bill would raise that tax amount for that tier to $205 for all 3 of those calendar years.This bill would declare that it is to take effect immediately as an urgency statute.

Primary Sponsors
House Budget Committee

Organizational Notes

Last edited by Joanne Campbell at Mar 22, 2024, 6:22 PM
California Association of Health Plans - Support

Bill Number	Last Action	Status	Position
AB 236	**In Senate Read First Time To Com On Rls For Assignment 2024 01 30**	**In Senate**	**Monitor**

Title
Health care coverage: provider directories.

Introduction Date: 2023-01-13

Description
AB 236, as amended, Holden. Health care coverage: provider directories. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan and a health insurer that contracts with providers for alternative rates of payment to publish and maintain a provider directory or directories with information on contracting providers that deliver health care services enrollees or insureds, and requires a health care service plan and health insurer to regularly update its printed and online provider directory or directories, as specified. Existing law authorizes the departments to require a plan or insurer to provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on materially inaccurate, incomplete, or misleading information contained in a health plan’s provider directory or directories.This bill would require a plan or insurer to annually verify and delete inaccurate listings from its provider directories, and would require a provider directory to be 60% accurate on July 1, 2025, with increasing required percentage accuracy benchmarks to be met each year until the directories are 95% accurate on or before July 1, 2028. The bill would subject a plan or insurer to administrative penalties for failure to meet the prescribed benchmarks. If a plan or insurer has not financially compensated a provider in the prior year, the bill would require the plan or insurer to delete the provider from its directory beginning July 1, 2025, unless specified criteria applies. The bill would require a plan or insurer to arrange care and provide coverage for all covered health care services provided to an enrollee or insured who reasonably relied on inaccurate, incomplete, or misleading information contained in a health plan or policy’s provider directory or directories and to reimburse the provider the contracted amount for those services. The bill would prohibit a provider from collecting an additional amount from an enrollee or insured other than the applicable in-network cost sharing. The bill would require a plan or insurer to provide information about in-network providers to enrollees and insureds upon request, and would limit the cost-sharing amounts an enrollee or insured is required to pay for services from those providers under specified circumstances.This bill would authorize the Department of Managed Health Care and the Department of Insurance to develop uniform formats for pl... (click bill link to see more).

Primary Sponsors
Chris Holden

Organizational Notes

Last edited by Joanne Campbell at Apr 17, 2023, 3:55 PM
California Association of Health Plans: Opposed

Bill Number	Last Action	Status	Position
AB 365	**Ordered To Inactive File At The Request Of Senator Limon 2023 09 12**	**In Senate**	**Monitor**

Title
Medi-Cal: diabetes management.

Introduction Date: 2023-02-01

Description
AB 365, as amended, Aguiar-Curry. Medi-Cal: diabetes management. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law sets forth a schedule of benefits under the Medi-Cal program. This bill would add continuous glucose monitors and related supplies required for use with those monitors as a covered benefit under the Medi-Cal program for the treatment of diabetes when medically necessary, subject to utilization controls. The bill would require the department, by July 1, 2024, to review, and update as appropriate, coverage policies for continuous glucose monitors, as specified. The bill would authorize the department to require a manufacturer of a continuous glucose monitor to enter into a rebate agreement with the department. The bill would limit its implementation to the extent that any necessary federal approvals are obtained and federal financial participation is available. The bill would make related findings and declarations.

Primary Sponsors
Cecilia Aguiar-Curry

Bill Number	Last Action	Status	Position
AB 412	**Referred To Com On Health 2023 06 14**	**In Senate**	**Monitor**

Title
Distressed Hospital Loan Program.

Introduction Date: 2023-02-02

Description
AB 412, as amended, Soria. Distressed Hospital Loan Program. The California Health Facilities Financing Authority Act authorizes the California Health Facilities Financing Authority to, among other things, make loans from the continuously appropriated California Health Facilities Financing Authority Fund to participating health institutions, as defined, for financing or refinancing the acquisition, construction, or remodeling of health facilities.This bill would create the Distressed Hospital Loan Program, until January 1, 2032, for the purpose of providing loans to not-for-profit hospitals and public hospitals, as defined, in significant financial distress, or to governmental entities representing a closed hospital to prevent the closure or facilitate the reopening of a closed hospital. The bill would require, subject to an appropriation by the Legislature, the Department of Health Care Access and Information to administer the program and would require the department to enter into an interagency agreement with the authority to implement the program. The bill would require the department, in collaboration with the State Department of Health Care Services, the Department of Managed Health Care, and the State Department of Public Health, to develop a methodology to evaluate an at-risk hospital’s potential eligibility for state assistance from the program, as specified. Notwithstanding that methodology, the bill would deem a hospital applying for aid to be immediately eligible for state assistance from the program if the hospital has 90 or fewer days cash on hand and has experienced a negative operating margin over the preceding 12 months. The bill would require a hospital or a closed hospital to provide the authority and the department with financial information, in a format determined by the authority, demonstrating the hospital’s need for assistance due to financial hardship. The bill would additionally require that the department, in consultation with the authority, develop a loan forgiveness application and approval process, as specified. The bill would specify that the authority and the department may implement these provisions by information notices or other similar instructions, without taking any further regulatory action.This bill would create the Distressed Hospital Loan Program Fund, a continuously appropriated fund, for use by the department and the authority to administer the loan program, as specified. The bill would authorize both the authority and the department to recover administrative costs from the fund, as specified. By creating a continuously appropriated fund, the bill would make an appropriation.Existing law generally requires a health care facility to report specified data to the department, i... (click bill link to see more).

Primary Sponsors
Esmeralda Soria, Eduardo Garcia, Jim Wood, Anna Caballero

Bill Number	Last Action	Status	Position
AB 492	**Referred To Com On Health 2023 06 14**	**In Senate**	**Monitor**

Title
Medi-Cal: reproductive and behavioral health integration pilot programs.

Introduction Date: 2023-02-07

Description
AB 492, as amended, Pellerin. Medi-Cal: reproductive and behavioral health integration pilot programs. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including comprehensive perinatal services, among other reproductive health services, and specialty or nonspecialty mental health services and substance use disorder services, among other behavioral health services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Existing law establishes the Family Planning, Access, Care, and Treatment (Family PACT) Program pursuant to a federal waiver, as part of the schedule of Medi-Cal benefits. Under existing law, the Family PACT Program provides comprehensive clinical family planning services to a person who has a family income at or below 200% of the federal poverty level and who is eligible to receive those services pursuant to the waiver. Under the Family PACT Program, comprehensive clinical family planning services include, among other things, contraception and general reproductive health care, and exclude abortion. Abortion services are covered under the Medi-Cal program.This bill would, on or before July 1, 2024, subject to an appropriation, require the department to make grants, incentive payments, or other financial support available to Medi-Cal managed care plans to develop and implement reproductive and behavioral health integration pilot programs in partnership with identified qualified providers, in order to improve access to behavioral health services for beneficiaries with mild-to-moderate behavioral health conditions.The bill would define “qualified provider” as a Medi-Cal provider that is enrolled in the Family PACT Program and that provides abortion- and contraception-related services. For funding eligibility, the bill would require a Medi-Cal managed care plan to identify the qualified providers and the services that will be provided through the pilot program, as specified.The bill would, on or before July 1, 2024, subject to an appropriation, require the department to make grants or other financial support available to qualified providers for reproductive and behavioral health integration pilot programs, in order to support development and expansion of services, infrastructure, and capacity for the integration of behavioral health services for beneficiaries with mild-to-moderate behavioral health conditions.For funding eligibility, the bill would require a qualified provider to identify both the patient population or gap in access to care and the types of services provided, as specified.The bill would require the department to... (click bill link to see more).

Primary Sponsors
Gail Pellerin

Bill Number	Last Action	Status	Position
AB 551	**From Committee Do Pass And Re Refer To Com On Appr With Recommendation To Consent Calendar Ayes 5 Noes 0 July 3 Re Referred To Com On Appr 2023 07 05**	**In Senate**	**Monitor**

Title
Medi-Cal: specialty mental health services: foster children.

Introduction Date: 2023-02-08

Description
AB 551, as amended, Bennett. Medi-Cal: specialty mental health services: foster children. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services (department), under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, specialty mental health services include federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services provided to eligible Medi-Cal beneficiaries under 21 years of age. Existing law requires each local mental health plan to establish a procedure to ensure access to outpatient specialty mental health services, as required by the EPSDT program standards, for youth in foster care who have been placed outside their county of adjudication, as described.Existing law requires the department to issue policy guidance on the conditions for, and exceptions to, presumptive transfer of responsibility for providing or arranging for specialty mental health services to a foster youth from the county of original jurisdiction to the county in which the foster youth resides, as prescribed. On a case-by-case basis, and when consistent with the medical rights of children in foster care, existing law authorizes the waiver of presumptive transfer, with the responsibility for the provision of specialty mental health services remaining with the county of original jurisdiction if certain exceptions exist. Under existing law, the county probation agency or the child welfare services agency is responsible for determining whether waiver of the presumptive transfer is appropriate, with notice provided to the person requesting the exception.Under existing law, commencing July 1, 2023, in the case of placement of foster children in short-term residential therapeutic programs, community treatment facilities, or group homes, or in the case of admission of foster children to children’s crisis residential programs, the county of original jurisdiction is required to retain responsibility and presumptive transfer provisions apply only if certain circumstances exist.This bill, for purposes of foster children placed or admitted in those specific settings, would delay, until July 1, 2024, the requirement on the county of original jurisdiction to retain responsibility and the limitation on the presumptive transfer provisions. By extending the period during which a county agency is responsible for making determinations about presumptive transfer waivers and making certain notifications, the bill would impose a state-mandated local program.Existing law conditions implementation of the above-described provisions on the availability of fede... (click bill link to see more).

Primary Sponsors
Steve Bennett

Bill Number	Last Action	Status	Position
AB 564	**Referred To Com On Health 2023 06 14**	**In Senate**	**Monitor**

Title
Medi-Cal: claim or remittance forms: signature.

Introduction Date: 2023-02-08

Description
AB 564, as amended, Villapudua. Medi-Cal: claim or remittance forms: signature. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Existing law requires the Director of Health Care Services to develop and implement standards for the timely processing and payment of each claim type. Existing law requires that the standards be sufficient to meet minimal federal requirements for the timely processing of claims. Existing law states the intent of the Legislature that claim forms for use by physicians and hospitals be the same as claim forms in general use by other payors, as specified.This bill would require the department to allow a provider to submit an electronic signature for a claim or remittance form under the Medi-Cal program, to the extent not in conflict with federal law.

Primary Sponsors
Carlos Villapudua

Bill Number	Last Action	Status	Position
AB 815	**Referred To Com On Health 2023 06 07**	**In Senate**	**Monitor**

Title
Health care coverage: provider credentials.

Introduction Date: 2023-02-13

Description
AB 815, as amended, Wood. Health care coverage: provider credentials. Existing law establishes the California Health and Human Services Agency, which includes departments charged with the administration of health, social, and other human services. Existing law provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and the regulation of health insurers by the Department of Insurance. Existing law sets forth requirements for provider credentialing by a health care service plan or health insurer.This bill would require the California Health and Human Services Agency to create and maintain a provider credentialing board, with specified membership, to certify private and public entities for purposes of credentialing physicians and surgeons in lieu of a health care service plan’s or health insurer’s credentialing process. The bill would require the board to convene by July 1, 2024, develop criteria for the certification of public and private credentialing entities by January 1, 2025, and develop an application process for certification by July 1, 2025.This bill would require a health care service plan or health insurer, or its delegated entity, to accept a valid credential from a board-certified entity without imposing additional criteria requirements and to pay a fee to a board-certified entity based on the number of contracted providers credentialed through the board-certified entity.

Primary Sponsors
Jim Wood

Organizational Notes

Last edited by Joanne Campbell at Jun 5, 2023, 8:56 PM
Local Health Plans of California: Oppose Unless Amended

Bill Number	Last Action	Status	Position
AB 817	**In Senate Read First Time To Com On Rls For Assignment 2024 01 25**	**In Senate**	**Monitor**

Title
Open meetings: teleconferencing: subsidiary body.

Introduction Date: 2023-02-13

Description
AB 817, as amended, Pacheco. Open meetings: teleconferencing: subsidiary body. Existing law, the Ralph M. Brown Act, requires, with specified exceptions, each legislative body of a local agency to provide notice of the time and place for its regular meetings and an agenda containing a brief general description of each item of business to be transacted. The act also requires that all meetings of a legislative body be open and public, and that all persons be permitted to attend unless a closed session is authorized. The act generally requires for teleconferencing that the legislative body of a local agency that elects to use teleconferencing post agendas at all teleconference locations, identify each teleconference location in the notice and agenda of the meeting or proceeding, and have each teleconference location be accessible to the public. Existing law also requires that, during the teleconference, at least a quorum of the members of the legislative body participate from locations within the boundaries of the territory over which the local agency exercises jurisdiction.Existing law authorizes the legislative body of a local agency to use alternate teleconferencing provisions during a proclaimed state of emergency (emergency provisions) and, until January 1, 2026, in certain circumstances related to the particular member if at least a quorum of its members participate from a singular physical location that is open to the public and situated within the agency’s jurisdiction and other requirements are met (nonemergency provisions). Existing law imposes different requirements for notice, agenda, and public participation, as prescribed, when a legislative body is using alternate teleconferencing provisions. The nonemergency provisions impose restrictions on remote participation by a member of the legislative body and require the legislative body to specific means by which the public may remotely hear and visually observe the meeting. This bill, until January 1, 2026, would authorize a subsidiary body, as defined, to use similar alternative teleconferencing provisions and would impose requirements for notice, agenda, and public participation, as prescribed. In order to use teleconferencing pursuant to this act, the bill would require the legislative body that established the subsidiary body by charter, ordinance, resolution, or other formal action to make specified findings by majority vote, before the subsidiary body uses teleconferencing for the first time and every 12 months thereafter.Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest... (click bill link to see more).

Primary Sponsors
Blanca Pacheco

Bill Number	Last Action	Status	Position
AB 869	**In Committee Set Second Hearing Hearing Canceled At The Request Of Author 2023 07 10**	**In Senate**	**Monitor**

Title
Hospitals: seismic safety compliance.

Introduction Date: 2023-02-14

Description
AB 869, as amended, Wood. Hospitals: seismic safety compliance. Existing law requires, no later than January 1, 2030, owners of all acute care inpatient hospitals to either demolish, replace, or change to nonacute care use all hospital buildings not in substantial compliance with specified seismic safety standards or to seismically retrofit all acute care inpatient hospital buildings so that they are in substantial compliance with those seismic safety standards. Existing law requires the Department of Health Care Access and Information to issue a written notice upon compliance with those requirements.Existing law establishes the Small and Rural Hospital Relief Program under the administration of the Department of Health Care Access and Information for the purpose of funding seismic safety compliance with respect to small hospitals, rural hospitals, and critical access hospitals in the state. Existing law requires the department to provide grants to small, rural, and critical access hospital applicants that meet certain criteria, including that seismic safety compliance, as defined, imposes a financial burden on the applicant that may result in hospital closure. Existing law also creates the Small and Rural Hospital Relief Fund and continuously appropriates the moneys in the fund for purposes of administering and funding the grant program.Existing law provides for the formation and administration of health care districts.This bill would require the department to give first priority to grants for single- and 2-story general acute care hospitals located in remote or rural areas with less than 80 general acute care beds and general acute care hospital revenue of $75 million or less. The bill would require grants under the program to provide general acute care hospitals with funds to secure an SPC-4D assessment for purposes of planning for, and estimating the costs of, compliance with certain seismic safety standards, as specified. The bill would authorize specified general acute care hospitals to apply for a grant for purposes of complying with those seismic safety standards.The bill would delay the requirement to meet those and other building standards for specified general acute care hospitals until January 1, 2035, and would exempt a general acute care hospital with an SPC-4D assessment and with a certain estimated cost from those seismic safety standards if the department determines that the cost of design and construction for compliance results in a financial hardship for the hospital and certain funds are not available to assist with the cost of compliance.The bill would also authorize a health care district that meets certain criteria to submit financial information to the department, on a form required by the dep... (click bill link to see more).

Primary Sponsors
Jim Wood, Eduardo Garcia

Bill Number	Last Action	Status	Position
AB 892	**Ordered To Inactive File At The Request Of Senator Caballero 2023 09 07**	**In Senate**	**Monitor**

Title
Kern County Hospital Authority.

Introduction Date: 2023-02-14

Description
AB 892, as introduced, Bains. Kern County Hospital Authority. Existing law, the Kern County Hospital Authority Act, establishes the Kern County Hospital Authority, which maintains and operates the Kern Medical Center and is governed by a board of governors that is appointed, both initially and continually, by the board of supervisors. Existing law requires the authority to provide management, administration, and other controls as needed to operate the medical center, and maintain its status as a designated public hospital. The Meyers-Milias-Brown Act contains various provisions that govern collective bargaining of local represented employees, and requires the governing body of a public agency to meet and confer in good faith regarding wages, hours, and other terms and conditions of employment with representatives of recognized employee organizations. Existing law, the Ralph M. Brown Act, requires each legislative body of a local agency to provide notice of the time and place for its regular meetings and also requires that all meetings of a legislative body be open and public, and that all persons be permitted to attend unless a closed session is authorized. The California Public Records Act requires state and local agencies to make their records available for public inspection, unless an exemption from disclosure applies.This bill would require that all entities controlled, owned, administered, or funded by the authority be subject to the Meyer-Milias-Brown Act, the Ralph M. Brown Act, and the California Public Records Act. By imposing new duties on the authority, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Primary Sponsors
Jasmeet Bains

Bill Number	Last Action	Status	Position
AB 1011	**In Committee Held Under Submission 2023 09 01**	**In Senate**	**Monitor**

Title
Social care: data privacy.

Introduction Date: 2023-02-15

Description
AB 1011, as amended, Weber. Social care: data privacy. Existing federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), establishes certain requirements relating to the provision of health insurance, including provisions relating to the confidentiality of health records. Existing state law, the Confidentiality of Medical Information Act, prohibits a provider of health care, a health care service plan, a contractor, a corporation and its subsidiaries and affiliates, or any business that offers software or hardware to consumers, including a mobile application or other related device, as defined, from intentionally sharing, selling, using for marketing, or otherwise using any medical information, as defined, for any purpose not necessary to provide health care services to a patient, except as provided.This bill would prohibit a participating entity of a closed-loop referral system (CLRS) from selling, renting, releasing, disclosing, disseminating, making available, transferring, or otherwise communicating orally, in writing, or by electronic or other means, social care information stored in or transmitted through a CLRS in exchange for monetary or other valuable consideration, except as specified. The bill would further prohibit a participating entity from using social care information stored in, or transmitted through, a CLRS for any purpose or purposes other than the social care purpose or purposes for which that social care information was collected or generated, except as specified. The bill would define “social care” to mean any care, services, goods, or supplies related to an individual’s social needs, including, but not limited to, support and assistance for an individual’s food stability and nutritional needs, housing, transportation, economic stability, employment, education access and quality, childcare and family relationship needs, and environmental and physical safety. The bill would also define “social care information” to mean any information, in any form, that relates to the need for, payment for, or provision of, social care, and the individual’s personal information, as specified.

Primary Sponsors
Akilah Weber

Bill Number	Last Action	Status	Position
AB 1092	**In Committee Held Under Submission 2023 09 01**	**In Senate**	**Monitor**

Title
Health care service plans: consolidation.

Introduction Date: 2023-02-15

Description
AB 1092, as amended, Wood. Health care service plans: consolidation. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law requires a health care service plan that intends to merge with, consolidate with, or enter into an agreement resulting in its purchase, acquisition, or control by, an entity, to give notice to, and secure prior approval from, the Director of the Department of Managed Health Care. Existing law authorizes the director to disapprove the transaction or agreement if the director finds it would substantially lessen competition in health care service plan products or create a monopoly in this state. Existing law authorizes the director to conditionally approve the transaction or agreement, contingent upon the health care service plan’s agreement to fulfill one or more conditions to benefit subscribers and enrollees of the health care service plan, provide for a stable health care delivery system, and impose other conditions specific to the transaction or agreement, as specified.This bill would additionally require a health care service plan that intends to acquire or obtain control of an entity, as specified, to give notice to, and secure prior approval from, the director. Because a willful violation of this provision would be a crime, the bill would impose a state-mandated local program. The bill would also authorize the director to disapprove a transaction or agreement if it would substantially lessen competition in the health system or among a particular category of health care providers, and would require the director to provide information related to competition to the Attorney General. The bill would revise the director’s authority to conditionally approve a transaction or agreement, including authorizing the director to review information from federal agencies and other state agencies, including agencies in other states, that is relevant to any of the parties to the transaction, as specified. With respect to a conditional approval, the bill would also authorize the director to contract with an independent entity to monitor compliance with the established conditions and report to the department. The bill would prohibit the director from waiving, or delaying implementation of, certain requirements imposed under existing law and the bill, notwithstanding a specified provision.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that ... (click bill link to see more).

Primary Sponsors
Jim Wood

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 6:12 PM
California Association of Health Plans: Oppose

Bill Number	Last Action	Status	Position
AB 1110	**In Committee Held Under Submission 2023 09 01**	**In Senate**	**Monitor**

Title
Public health: adverse childhood experiences.

Introduction Date: 2023-02-15

Description
AB 1110, as amended, Arambula. Public health: adverse childhood experiences. Existing law requires the Office of the Surgeon General to, among other things, raise public awareness and coordinate policies governing scientific screening and treatment for toxic stress and adverse childhood experiences (ACEs).This bill would, subject to an appropriation and until January 1, 2027, require the office and the State Department of Health Care Services, while administering the ACEs Aware initiative and in collaboration with subject matter experts, to review available literature on ACEs, as defined, and ancestry or ethnicity-based data disaggregation practices in ACEs screenings, develop guidance for culturally and linguistically competent ACEs screenings through improved data collection methods, post the guidance on the department’s internet website and the ACEs Aware internet website, and make the guidance accessible, as specified. The bill would make legislative findings and declarations.

Primary Sponsors
Joaquin Arambula

Bill Number	Last Action	Status	Position
AB 1117	**Referred To Com On Health 2023 06 07**	**In Senate**	**Monitor**

Title
Hospice agency licensure.

Introduction Date: 2023-02-15

Description
AB 1117, as introduced, Irwin. Hospice agency licensure. The California Hospice Licensure Act of 1990 requires a person, political subdivision of the state, or other governmental agency to obtain a license from the State Department of Public Health to provide hospice services to an individual who is experiencing the last phase of life due to a terminal disease, as defined, and their family, except as provided. The act also provides for the renewal of a license. Existing law prohibits any person, political subdivision of the state, or other governmental agency from establishing, conducting, maintaining, or representing itself as a hospice agency unless a license has been issued under the act. Existing law requires that the department issue a license to a hospice agency that applies to the department for a hospice agency license and meets specified requirements, including accreditation as a hospice by an entity approved the federal Centers for Medicare and Medicaid Services as a national accreditation organization, and the national accreditation organization forwards copies to the department of all initial and subsequent survey and other accreditation reports or findings.This bill would require any hospice agency obtaining a license to obtain certification to participate in the federal Medicare program within 12 months of licensure and continuously serve patients as validated by data submission to the Department of Health Care Access and Information, or forfeit its license.

Primary Sponsors
Jacqui Irwin

Bill Number	Last Action	Status	Position
AB 1157	**In Committee Held Under Submission 2023 09 01**	**In Senate**	**Monitor**

Title
Rehabilitative and habilitative services: durable medical equipment and services.

Introduction Date: 2023-02-16

Description
AB 1157, as amended, Ortega. Rehabilitative and habilitative services: durable medical equipment and services. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service plans and makes a willful violation of the act a crime. Other existing law requires the Department of Insurance to regulate health insurers. Existing law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, to include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act. Under existing law, essential health benefits includes, among other things, rehabilitative and habilitative services. Existing law requires habilitative services and devices to be covered under the same terms and conditions applied to rehabilitative services and devices under the plan contract or policy, and defines habilitative services to mean health care services and devices that help a person keep, learn, or improve skills and functioning for daily living.This bill would specify that coverage of rehabilitative and habilitative services and devices under a health care service plan or health insurance policy includes durable medical equipment, services, and repairs, if the equipment, services, or repairs are prescribed or ordered by a physician, surgeon, or other health professional acting within the scope of their license. The bill would define “durable medical equipment” to mean devices, including replacement devices, that are designed for repeated use, and that are used for the treatment or monitoring of a medical condition or injury in order to help a person to partially or fully acquire, improve, keep, or learn, or minimize the loss of, skills and functioning of daily living. The bill would prohibit coverage of durable medical equipment and services from being subject to financial or treatment limitations, as specified.The bill would require the Secretary of California Health and Human Services to communicate to the federal Center for Consumer Information and Insurance Oversight that the coverage of durable medical equipment is necessary to comply with federal requirements for purposes of being considered essential health benefits not subject to defrayal payments. If the center overrules the state’s determination that the additional coverage subjects the state to defrayal payments, the bill would require the secretary to reevaluate California’s essential health benefits benchmark plan to incorporate the coverage without triggering the defrayal requirement. The bill would require the secretary, no later than one year... (click bill link to see more).

Primary Sponsors
Liz Ortega, Lori Wilson

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 5:55 PM
California Association of Health Plans: Oppose

Bill Number	Last Action	Status	Position
AB 1282	**Ordered To Inactive File At The Request Of Senator Menjivar 2023 09 11**	**In Senate**	**Monitor**

Title
Mental health: impacts of social media.

Description
AB 1282, as amended, Lowenthal. Mental health: impacts of social media. Existing law, the Mental Health Services Act, an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the Mental Health Services Oversight and Accountability Commission, and authorizes the commission to take specified actions, including advising the Governor or the Legislature regarding actions the state may take to improve care and services for people with mental illness.This bill would require the commission to report to specified policy committees of the Legislature, on or before July 1, 2025, a statewide strategy to understand, communicate, and mitigate mental health risks associated with the use of social media by children and youth. The bill would require the report to include, among other things, (1) the degree to which individuals negatively impacted by social media are accessing and receiving mental health services and (2) recommendations to strengthen children and youth resiliency strategies and California’s use of mental health services to reduce the negative outcomes that may result from untreated mental illness, as specified. The bill would require the commission to explore, among other things, the persons and populations that use social media and the negative mental health risks associated with social media and artificial intelligence, as defined. The bill would repeal these provisions on January 1, 2029.

Primary Sponsors
Josh Lowenthal

Introduction Date: 2023-02-16

Bill Number	Last Action	Status	Position
AB 1316	**In Senate Read First Time To Com On Rls For Assignment 2024 01 25**	**In Senate**	**Monitor**

Title
Emergency services: psychiatric emergency medical conditions.

Introduction Date: 2023-02-16

Description
AB 1316, as amended, Irwin. Emergency services: psychiatric emergency medical conditions. Existing law, the Lanterman-Petris-Short Act, provides for the involuntary commitment and treatment of a person who is a danger to themselves or others or who is gravely disabled, as defined. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Pursuant to a schedule of covered benefits, existing law requires Medi-Cal coverage for inpatient hospital services, subject to utilization controls, and with respect to fee-for service beneficiaries, coverage for emergency services and care necessary for the treatment of an emergency medical condition and medical care directly related to the emergency medical condition, as specified.Existing law provides for the licensing and regulation of health facilities by the State Department of Public Health and makes a violation of those provisions a crime. Existing law defines “psychiatric emergency medical condition,” for purposes of providing treatment for emergency conditions, as a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either an immediate danger to the patient or to others, or immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder. Existing law includes various circumstances under which a patient is required to be treated by, or may be transferred to, specified health facilities for treatment that is solely necessary to relieve or eliminate a psychiatric emergency medical condition.This bill would revise the definition of “psychiatric emergency medical condition” to make that definition applicable regardless of whether the patient is voluntary, or is involuntarily detained for evaluation and treatment, under prescribed circumstances. The bill would make conforming changes to provisions requiring facilities to provide that treatment. By expanding the definition of a crime with respect to those facilities, the bill would impose a state-mandated local program.The bill would require the Medi-Cal program to cover emergency services and care necessary to treat an emergency medical condition, as defined, including all professional physical, mental, and substance use treatment services, including screening examinations necessary to determine the presence or absence of an emergency medical condition and, if an emergency medical condition exists, all services medically necessary to stabilize the beneficiary. The bill would require coverage, inclu... (click bill link to see more).

Primary Sponsors
Jacqui Irwin, Chris Ward

Bill Number	Last Action	Status	Position
AB 1331	**In Committee Held Under Submission 2023 09 01**	**In Senate**	**Monitor**

Title
California Health and Human Services Data Exchange Framework.

Introduction Date: 2023-02-16

Description
AB 1331, as amended, Wood. California Health and Human Services Data Exchange Framework. Existing law establishes the Center for Data Insights and Innovation within the California Health and Human Services Agency to ensure the enforcement of state law mandating the confidentiality of medical information. Existing law, subject to an appropriation in the annual Budget Act, requires the California Health and Human Services Agency to establish the California Health and Human Services Data Exchange Framework on or before July 1, 2022, to govern and require the exchange of health information among health care entities and government agencies.This bill would require the Center for Data Insights and Innovation to take over establishment, implementation, and all the functions related to the California Health and Human Services Data Exchange Framework on or before January 1, 2024, subject to an appropriation in the annual Budget Act. The bill would require the center to establish the CalHHS Data Exchange Board, with specified membership, to develop recommendations and to review, modify, and approve any modifications to the Data Exchange Framework data sharing agreement, among other things. The bill would require the center to submit an annual report to the Legislature that includes required signatory compliance with the data sharing agreement, assessment of consumer experiences with health information exchange, and evaluation of technical assistance and other grant programs. The bill would require the center, by July 1, 2024, to establish a process to designate qualified health information organizations according to specified criteria.

Primary Sponsors
Jim Wood

Bill Number	Last Action	Status	Position
AB 1359	**Ordered To Inactive File At The Request Of Senator Stern 2023 09 11**	**In Senate**	**Monitor**

Title
Paid sick days: health care employees.

Introduction Date: 2023-02-17

Description
AB 1359, as amended, Schiavo. Paid sick days: health care employees. Existing law, the Healthy Workplaces, Healthy Families Act of 2014, entitles employees who satisfy specified requirements to sick leave. The act generally entitles an employee who, on or after July 1, 2015, works in California for the same employer for 30 or more days within a year to paid sick leave, subject to various use and accrual limits. The act also authorizes an employer to limit an employee’s use of accrued paid sick days to 24 hours or 3 days in each year of employment, calendar year, or 12-month period.This bill would grant an employee of a covered health care facility health care worker sick leave, as those terms are defined. The bill would permit accrued leave, and would prescribe for the use and carryover of that leave, including permitting health care worker sick leave to carry over to the following year of employment for those employees, subject to certain conditions. The bill would prohibit a covered health care facility from limiting an employee’s use of health care worker sick leave. The bill would exempt those employees from certain existing limits on the use of accrued paid sick days. The bill would authorize an employee of a covered health care facility to bring a civil action against an employer that violates this provision and would entitle the employee to collect specified legal and equitable relief to remedy a violation.

Primary Sponsors
Pilar Schiavo

Bill Number	Last Action	Status	Position
AB 1470	**In Senate Held At Desk 2023 09 13**	**Passed Senate**	**Monitor**

Title
Medi-Cal: behavioral health services: documentation standards.

Introduction Date: 2023-02-17

Description
AB 1470, as amended, Quirk-Silva. Medi-Cal: behavioral health services: documentation standards. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including behavioral health services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes the California Advancing and Innovating Medi-Cal (CalAIM) initiative, subject to receipt of any necessary federal approvals and the availability of federal financial participation, in order to, among other things, improve quality outcomes and reduce health disparities.The bill, as part of CalAIM, and with respect to behavioral health services provided under the Medi-Cal program, would require the department to standardize data elements relating to documentation requirements, including, but not limited to, medically necessary criteria, and would require the department to develop standard forms containing information necessary to properly adjudicate claims pursuant to CalAIM Terms and Conditions. The bill would require the department to consult with representatives of specified associations and programs for purposes of implementing these provisions.The bill would require the department to conduct, on or before July 1, 2025, regional trainings for personnel and provider networks of applicable entities, including county mental health plans, Medi-Cal managed care plans, and entities within the fee-for-service delivery system, on proper completion of the standard forms. The bill would require each applicable entity to distribute the training material and standard forms to its provider networks, and to commence, no later than July 1, 2025, using the standard forms. The bill would require providers of applicable entities to use those forms, as specified. The bill would authorize the department to restrict the imposition of additional documentation requirements beyond those included on standard forms, as specified.The bill would require the department to conduct an analysis on the status of utilization of the standard forms by applicable entities, and on the status of the trainings and training material, in order to determine the effectiveness of implementation of the above-described provisions. The bill would require the department to prepare a report containing findings from the analysis no later than July 1, 2026, and a followup report no later than July 1, 2028, and to submit each report to the Legislature and post it on the department’s internet website.

Primary Sponsors
Sharon Quirk-Silva

Bill Number	Last Action	Status	Position
AB 1537	**Ordered To Inactive File At The Request Of Senator Stern 2023 09 07**	**In Senate**	**Monitor**

Title
Skilled nursing facilities: direct care spending requirement.

Introduction Date: 2023-02-17

Description
AB 1537, as introduced, Wood. Skilled nursing facilities: direct care spending requirement. Existing law provides for the licensure and regulation of health facilities, including skilled nursing facilities, by the State Department of Public Health. A violation of those provisions is a crime. Existing law requires health facilities to submit specified financial reports to the Department of Health Care Access and Information. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services.This bill would require, no later than July 1, 2024, the establishment of a direct patient-related services spending, reporting, and rebate requirement for skilled nursing facilities, with exceptions. Under the direct patient-related services spending requirement, the bill would require that a minimum of 85% of a facility’s total non-Medicare health revenues from all payer sources in each fiscal year be expended on residents’ direct patient-related services, as defined.The bill would require a facility to report total revenues collected from all revenue sources, along with the portion of revenues that are expended on all direct patient-related services and nondirect patient-related services, to the State Department of Health Care Services by June 30 of each calendar year, with certification signed by a duly authorized official, as specified.The bill would require the State Department of Health Care Services to conduct an audit of the financial information reported by the facilities, to ensure its accuracy and to identify and recover any payments that exceed the allowed limit, as specified. The bill would require the department to conduct the audit every 3 years, at the same time as the facility’s Medi-Cal audit.If a skilled nursing facility fails to comply with the direct patient-related services spending requirement, the bill would require the facility to issue a pro rata dividend or credit to the state and to all individuals and entities making non-Medicare payments to the facility for resident services, as specified. The bill would require the State Department of Health Care Services to ensure that those payments are made and to impose sanctions, as specified. The bill would also authorize the department to withhold certain payments from a skilled nursing facility licensee for failure to fully disclose information, as specified.Because a violation of these requirements would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish pro... (click bill link to see more).

Primary Sponsors
Jim Wood

Bill Number	Last Action	Status	Position
AB 1783	**From Printer May Be Heard In Committee February 3 2024 01 04**	**In Assembly**	**Monitor**

Title
Health care: immigration.

Introduction Date: 2024-01-03

Description
AB 1783, as introduced, Essayli. Health care: immigration. Existing federal law provides for the Medicare Program, which is a public health insurance program for persons 65 years of age and older and specified persons with disabilities who are under 65 years of age. Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance.This bill would state the intent of the Legislature to enact legislation to remove all taxpayer funding for health care for illegal immigrants from the California State Budget.

Primary Sponsors
Bill Essayli

Bill Number	Last Action	Status	Position
AB 1842	**Read Second Time Ordered To Third Reading 2024 04 11**	**In Assembly**	**Monitor**

Title
Health care coverage: Medication-assisted treatment.

Introduction Date: 2024-01-16

Description
AB 1842, as introduced, Reyes. Health care coverage: Medication-assisted treatment. Existing law, the Knox–Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law authorizes health care service plans and health insurers that cover prescription drugs to utilize reasonable medical management practices, including prior authorization and step therapy, consistent with applicable law. This bill would prohibit a medical service plan and a health insurer from subjecting a naloxone product or another opioid antagonist approved by the United States Food and Drug Administration, or a buprenorphine product or long-acting injectable naltrexone for detoxification or maintenance treatment of a substance use disorder, to prior authorization or step therapy. Because a willful violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Eloise Reyes

Organizational Notes

Last edited by Joanne Campbell at Mar 22, 2024, 6:00 PM
California Association of Health Plans - Oppose America’s Health Insurance Plans - Oppose Association of California Life and Health Insurance Companies - Oppose Support: California Academy of Child and Adolescent Psychiatry - Support California Black Health Network - Support California Hospital Association - Support California State Association of Psychiatrists (CSAP) - Support County Behavioral Health Directors Association of California - Support Ella Baker Center for Human Rights - Support Health Access California - Support Steinberg Institute - Support

Bill Number	Last Action	Status	Position
AB 1876	**From Committee Do Pass And Re Refer To Com On Appr With Recommendation To Consent Calendar Ayes 12 Noes 0 April 9 Re Referred To Com On Appr 2024 04 09**	**In Assembly**	**Monitor**

Title
Developmental services: individual program plans and individual family service plans: remote meetings.

Introduction Date: 2024-01-22

Description
AB 1876, as introduced, Jackson. Developmental services: individual program plans and individual family service plans: remote meetings. Existing law, the Lanterman Developmental Disabilities Services Act, requires the State Department of Developmental Services to contract with regional centers for the provision of community services and supports for persons with developmental disabilities and their families. Existing law, until June 30, 2024, requires a meeting regarding the provision of services and supports by the regional center, including a meeting to develop or revise a consumer's individual program plan (IPP), to be held by remote electronic communications if requested by the consumer or, if appropriate, if requested by the consumer's parents, legal guardian, conservator, or authorized representative. Existing law, the California Early Intervention Services Act, provides a statewide system of coordinated, comprehensive, family-centered, multidisciplinary, and interagency programs that are responsible for providing appropriate early intervention services and supports to all eligible infants and toddlers and their families. Under the act, direct services for eligible infants and toddlers and their families are provided by regional centers and local educational agencies. The act requires an eligible infant or toddler receiving services under the act to have an individualized family service plan (IFSP), as specified. Existing law, until June 30, 2024, requires, at the request of the parent or legal guardian, an IFSP meeting to be held by remote electronic communications. This bill, beginning January 1, 2025, would indefinitely extend the requirements that, if requested, IPP and IFSP meetings be held by remote electronic communications. By extending a requirement for local educational agencies, this bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Primary Sponsors
Corey Jackson

Bill Number	Last Action	Status	Position
AB 1895	**From Committee Do Pass And Re Refer To Com On Appr Ayes 13 Noes 1 April 16 Re Referred To Com On Appr 2024 04 17**	**In Assembly**	**Monitor**

Title
Public health: maternity ward closures.

Introduction Date: 2024-01-23

Description
AB 1895, as amended, Weber. Public health: maternity ward closures. Existing law establishes the licensure and regulation of health facilities by the State Department of Public Health, including, among others, general acute care hospitals. A violation of these provisions is a crime. Under existing law, a general acute care hospital is required to provide certain basic services, including medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services. Existing law authorizes a general acute care hospital to provide various special or supplemental services if certain conditions are met. Existing regulations define a supplemental service as an organized inpatient or outpatient service that is not required to be provided by law or regulation. Existing law requires a health facility to provide 90 days of public notice, with specified requirements, of the proposed closure or elimination of a supplemental service, such as maternity services.This bill would require an acute care hospital that offers maternity services, when those services are at risk of closure, as defined, in the next 12 months to provide specified information to the Department of Health Care Access and Information as well as the State Department of Public Health, including, but not limited to, the number of medical staff and employees working in the maternity ward and the hospital’s prior and projected performance on financial metrics. The bill would require this information be kept confidential to the extent permitted by law. The bill would require, within 6 months of receiving this notice from the hospital, the Department of Health Care Access and Information, in conjunction with the State Department of Public Health, to conduct a community impact assessment to determine the 3 closest hospitals offering maternity services in the geographic area and their distance from the at-risk facility. The bill would require the hospital to provide public notice of the potential closure, including the results of the community impact assessment, and other specified information on the hospital’s internet website 90 days in advance of the proposed closure. The bill would require the public to be permitted to comment on the potential closure for 60 days after the notice is given, and would require at least one noticed public hearing be conducted by the hospital. The bill would also require the hospital to accept written public comment. By creating a new crime, this bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provid... (click bill link to see more).

Primary Sponsors
Akilah Weber

Organizational Notes

Last edited by Joanne Campbell at Apr 22, 2024, 6:00 PM
Local Health Plans of California- Support

Bill Number	Last Action	Status	Position
AB 1926	**In Committee Set First Hearing Referred To Suspense File 2024 04 17**	**In Assembly**	**Monitor**

Title
Health care coverage: regional enteritis.

Introduction Date: 2024-01-25

Description
AB 1926, as amended, Connolly. Health care coverage: regional enteritis. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of disability insurers, including health insurers, by the Department of Insurance. Existing law requires a health care service plan contract and disability insurance policy that provides coverage for hospital, medical, or surgical expenses and is issued, amended, delivered, or renewed on and after July 1, 2000, to provide coverage for the testing and treatment of phenylketonuria, including coverage for the formulas and special food products that are part of a prescribed diet, as specified.This bill would require a health care service plan contract or disability insurance policy that provides coverage for hospital, medical, or surgical expenses and is issued, amended, delivered, or renewed on and after July 1, 2025, to provide coverage for dietary enteral formulas, as defined, for the treatment of regional enteritis, as specified. The bill would specify that these provisions do not apply to Medi-Cal managed care plans to the extent that the services are excluded from coverage under the contract between the Medi-Cal managed care plan and the State Department of Health Care Services. Because a violation of the bill’s requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Damon Connolly

Organizational Notes

Last edited by Joanne Campbell at Mar 7, 2024, 9:15 PM
California Association of Health Plans - Oppose

Bill Number	Last Action	Status	Position
AB 1936	**From Committee Do Pass And Re Refer To Com On Appr With Recommendation To Consent Calendar Ayes 16 Noes 0 April 16 Re Referred To Com On Appr 2024 04 17**	**In Assembly**	**Monitor**

Title
Maternal mental health screenings.

Introduction Date: 2024-01-25

Description
AB 1936, as amended, Cervantes. Maternal mental health screenings. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan or health insurer to develop a maternal mental health program designed to promote quality and cost-effective outcomes, as specified.This bill would require the program to consist of at least one maternal mental health screening during pregnancy, and at least one additional screening during the first 6 months of the postpartum period, if determined medically necessary and clinically appropriate in the judgment of the treating provider. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Sabrina Cervantes

Bill Number	Last Action	Status	Position
AB 1943	**Re Referred To Com On Appr Pursuant To Assembly Rule 96 2024 04 11**	**In Assembly**	**Monitor**

Title
Medi-Cal: telehealth.

Introduction Date: 2024-01-29

Description
AB 1943, as amended, Weber. Medi-Cal: telehealth. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Under existing law, in-person, face-to-face contact is not required under the Medi-Cal program when covered health care services are provided by video synchronous interaction, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual communication modalities, when those services and settings meet certain criteria.This bill would require the department to produce a public report on telehealth in the Medi-Cal program that includes analyses of, among other things, (1) telehealth access and utilization, (2) the effect of telehealth on timeliness of, access to, and quality of care, and (3) the effect of telehealth on clinical outcomes, as specified. The bill would authorize the department, in collaboration with the California Health and Human Services Agency, to issue policy recommendations based on the report’s findings.

Primary Sponsors
Akilah Weber

Organizational Notes

Last edited by Joanne Campbell at Mar 18, 2024, 5:28 PM
California Association of Health Plans - Oppose

Bill Number	Last Action	Status	Position
AB 1944	**Referred To Coms On Health And B P 2024 02 20**	**In Assembly**	**Monitor**

Title
Individualized investigational treatment.

Introduction Date: 2024-01-29

Description
AB 1944, as introduced, Waldron. Individualized investigational treatment. Existing law, the federal Food, Drug, and Cosmetic Act, prohibits a person from introducing into interstate commerce any new drug unless the drug has been approved by the United States Food and Drug Administration (FDA). Existing law requires the sponsor of a new drug to submit to the FDA an investigational new drug application and to then conduct a series of clinical trials to establish the safety and efficacy of the drug in human populations and submit the results to the FDA in a new drug application. Existing federal law also regulates biomedical and behavioral research involving human subjects. Existing law, the Sherman Food, Drug, and Cosmetic Law, regulates the packaging, labeling, and advertising of drugs and devices and is administered by the State Department of Public Health. A violation of that law is a crime. The Sherman Food, Drug, and Cosmetic Law prohibits, among other things, the sale, delivery, or giving away of a new drug or new device unless either the department has approved a new drug or device application for that new drug or new device and that approval has not been withdrawn, terminated, or suspended or the drug or device has been approved pursuant to specified provisions of federal law, including the federal Food, Drug, and Cosmetic Act.Existing law provides for the licensure and regulation of various healing arts professions and vocations by boards within the Department of Consumer Affairs. For instance, the Medical Practice Act provides for the licensure and regulation of physicians and surgeons by the Medical Board of California and the Osteopathic Act provides for the licensure and regulation of osteopathic physicians and surgeons by the Osteopathic Medical Board of California, among others.This bill, the Right to Try Individualized Investigational Treatments Act, would permit a manufacturer of an individualized investigational treatment, as defined, to make the product available to eligible patients with life-threatening or severely debilitating illness, as specified. The bill would authorize, but not require, a health benefit plan, as defined, to provide coverage for any individualized investigational treatment made available pursuant to these provisions.The bill would prohibit a state regulatory board from taking any action against a health care provider’s license solely on a provider’s recommendation of or providing access to an individualized investigational treatment.The bill would prohibit a state agency from altering any recommendation made to the federal Centers for Medicare and Medicaid Services regarding a health care provider's certification to participate in the Medicare or Medicaid program based solely on ... (click bill link to see more).

Primary Sponsors
Marie Waldron

Bill Number	Last Action	Status	Position
AB 1970	**From Committee Do Pass And Re Refer To Com On Appr Ayes 13 Noes 0 April 9 Re Referred To Com On Appr 2024 04 10**	**In Assembly**	**Monitor**

Title
Mental Health: Black Mental Health Navigator Certification.

Description
AB 1970, as amended, Jackson. Mental Health: Black Mental Health Navigator Certification. Existing law establishes, within the Health and Welfare Agency, the Department of Health Care Access and Information, which is responsible for, among other things, administering various health professions training and development programs. Existing law requires the department to develop and approve statewide requirements for community health worker certificate programs. Existing law defines “community health worker” to mean a liaison, link, or intermediary between health and social services and the community to facilitate access to services and to improve the access and cultural competence of service delivery.This bill would require the department to develop criteria for a specialty certificate program and specialized training requirements for a Black Mental Health Navigator Certification, as specified. The bill would require the department to collect and regularly publish data, not less than annually, including, but not limited to, the number of individuals certified, including those who complete a specialty certificate program, as specified, and the number of individuals who are actively employed in a community health worker role.

Primary Sponsors
Corey Jackson

Introduction Date: 2024-01-30

Bill Number	Last Action	Status	Position
AB 1975	**From Committee Do Pass And Re Refer To Com On Appr Ayes 14 Noes 1 April 16 Re Referred To Com On Appr 2024 04 17**	**In Assembly**	**Monitor**

Title
Medi-Cal: medically supportive food and nutrition interventions.

Introduction Date: 2024-01-30

Description
AB 1975, as introduced, Bonta. Medi-Cal: medically supportive food and nutrition interventions. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Existing law requires the department to establish the Medically Tailored Meals Pilot Program and the Short-Term Medically Tailored Meals Intervention Services Program, to operate in specified counties and during limited periods for the purpose of providing medically tailored meal intervention services to eligible Medi-Cal beneficiaries with certain health conditions, including congestive heart failure, cancer, diabetes, chronic obstructive pulmonary disease, or renal disease.Existing law, subject to implementation of the California Advancing and Innovating Medi-Cal (CalAIM) initiative, authorizes a Medi-Cal managed care plan to elect to cover community supports approved by the department as cost effective and medically appropriate in a comprehensive risk contract that are in lieu of applicable Medi-Cal state plan services. Under existing law, community supports that the department is authorized to approve include, among other things, medically supportive food and nutrition services, including medically tailored meals.This bill would make medically supportive food and nutrition interventions, as defined, a covered benefit under the Medi-Cal program, through both the fee-for-service and managed care delivery systems, effective July 1, 2026, subject to federal approval and the issuance of final guidance by the department. The bill would require those interventions to be covered if determined to be medically necessary by a health care provider or health care plan, as specified. The bill would require the provision of interventions for 12 weeks, or longer if deemed medically necessary. The bill would require a Medi-Cal managed care plan to offer at least 3 of 6 listed interventions, with certain conditions for a 7th intervention.The bill would require the department to define the qualifying medical conditions for purposes of the covered interventions. The bill would require a health care provider, to the extent possible, to match the acuity of a patient’s condition to the intensity and duration of the covered intervention and to include culturally appropriate foods.The bill would require the department to establish a medically supportive food and nutrition benefit stakeholder group, with a specified composition, to advise the department on certain related items. The bill would require the workgroup to issue final guidance on or before July 1, 2026.

Primary Sponsors
Mia Bonta

Organizational Notes

Last edited by Joanne Campbell at Apr 22, 2024, 5:41 PM
Local Health Plans of California - Support

Bill Number	Last Action	Status	Position
AB 1977	**From Committee Do Pass And Re Refer To Com On Appr Ayes 16 Noes 0 April 9 Re Referred To Com On Appr 2024 04 10**	**In Assembly**	**Monitor**

Title
Health care coverage: behavioral diagnoses.

Introduction Date: 2024-01-30

Description
AB 1977, as amended, Ta. Health care coverage: behavioral diagnoses. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or health insurance policy to provide coverage for behavioral health treatment for pervasive developmental disorder or autism.This bill would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, from requiring an enrollee or insured previously diagnosed with pervasive developmental disorder or autism to be reevaluated or receive a new behavioral diagnosis to maintain coverage for behavioral health treatment for their condition. Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Tri Ta

Bill Number	Last Action	Status	Position
AB 1995	**From Printer May Be Heard In Committee March 1 2024 01 31**	**In Assembly**	**Monitor**

Title
Health care facilities: small and rural hospitals.

Introduction Date: 2024-01-30

Description
AB 1995, as introduced, Essayli. Health care facilities: small and rural hospitals. Under existing law, the State Department of Public Health issues licenses for and regulates health facilities, including small and rural hospitals, as defined. Under existing law, a hospital that meets the definition of a small and rural hospital may be eligible for special programs, including business assistance, regulatory relief, and increased Medi-Cal reimbursement.This bill would make technical, nonsubstantive changes to the definition of small and rural hospital.

Primary Sponsors
Bill Essayli

Bill Number	Last Action	Status	Position
AB 2013	**Referred To Com On P C P 2024 02 12**	**In Assembly**	**Monitor**

Title
Artificial intelligence: training data transparency.

Introduction Date: 2024-01-31

Description
AB 2013, as introduced, Irwin. Artificial intelligence: training data transparency. Existing law requires the Department of Technology, in coordination with other interagency bodies, to conduct, on or before September 1, 2024, a comprehensive inventory of all high-risk automated decision systems, as defined, that have been proposed for use, development, or procurement by, or are being used, developed, or procured by, state agencies, as defined.This bill would require, on or before January 1, 2026, a developer, as defined, of an artificial intelligence system or service, as defined, made available to Californians for use, regardless of whether the terms of that use include compensation, to post on the developer’s internet website documentation regarding the data used to train the artificial intelligence system or service, as specified.

Primary Sponsors
Jacqui Irwin

Bill Number	Last Action	Status	Position
AB 2028	**In Committee Set First Hearing Hearing Canceled At The Request Of Author 2024 04 18**	**In Assembly**	**Monitor**

Title
Medical loss ratios.

Introduction Date: 2024-02-01

Description
AB 2028, as introduced, Ortega. Medical loss ratios. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. The federal Patient Protection and Affordable Care Act requires a health insurance issuer to comply with minimum medical loss ratios (MLRs) and to provide an annual rebate to each insured if the MLR of the amount of the revenue expended by the issuer on costs to the total amount of premium revenue is less than a certain percentage, as specified. Existing law requires health care service plans and health insurers that issue, sell, renew, or offer a contract or policy, excluding specialized dental and vision contracts and policies, to comply with a minimum MLR of 85% and provide specified rebates. Existing law requires a health care service plan or health insurer that issues, sells, renews, or offers a contract or policy covering dental services to annually report MLR information to the appropriate department.This bill would require a health care service plan or health insurer that issues, sells, renews, or offers a specialized dental health care service plan contract or specialized dental health insurance policy to comply with a minimum MLR of 85% and to provide a specified rebate to an enrollee or insured. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Liz Ortega

Organizational Notes

Last edited by Joanne Campbell at Apr 19, 2024, 8:05 PM
California Association of Health Plans - Opposed

Bill Number	Last Action	Status	Position
AB 2043	**From Committee Do Pass And Re Refer To Com On Appr With Recommendation To Consent Calendar Ayes 16 Noes 0 April 9 Re Referred To Com On Appr 2024 04 10**	**In Assembly**	**Monitor**

Title
Medi-Cal: nonmedical and nonemergency medical transportation.

Introduction Date: 2024-02-01

Description
AB 2043, as amended, Boerner. Medi-Cal: nonmedical and nonemergency medical transportation. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, through managed care or fee-for-service delivery systems. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law covers emergency or nonemergency medical transportation, and nonmedical transportation, under the Medi-Cal program, as specified.This bill would require the department to ensure that the fiscal burden of nonemergency medical transportation or nonmedical transportation is not unfairly placed on public paratransit service operators and would authorize the department to direct Medi-Cal managed care plans to reimburse public paratransit service operators who are enrolled as Medi-Cal providers at the fee-for-service rates for conducting that transportation, as described. The bill would require the department to engage with public paratransit service operators to understand the challenges as public operators of nonemergency medical transportation or nonmedical transportation services and would require the department to issue new guidance to ensure the fiscal burden is not unfairly placed on public operators on or before June 1, 2026.The bill would condition implementation of these provisions on receipt of any necessary federal approvals and the availability of federal financial participation.

Primary Sponsors
Tasha Boerner

Organizational Notes

Last edited by Joanne Campbell at Apr 22, 2024, 6:01 PM
Local Health Plans of California - Oppose

Bill Number	Last Action	Status	Position
AB 2063	**From Committee Do Pass And Re Refer To Com On Appr Ayes 15 Noes 0 April 16 Re Referred To Com On Appr 2024 04 17**	**In Assembly**	**Monitor**

Title
Health care coverage.

Introduction Date: 2024-02-01

Description
AB 2063, as introduced, Maienschein. Health care coverage. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law exempts a health care service plan from the requirements of the act if the plan is operated by a city, county, city and county, public entity, political subdivision, or public joint labor management trust that satisfies certain criteria, including that the plan requires providers to be reimbursed solely on a fee-for-service basis. Existing law authorizes the Director of the Department of Managed Health Care, no later than May 1, 2021, to authorize 2 pilot programs, one in northern California and one in southern California, under which providers approved by the department may undertake risk-bearing arrangements with a voluntary employees' beneficiary association with enrollment of more than 100,000 lives, notwithstanding the fee-for-service requirement described above, or a trust fund that is a welfare plan and a multiemployer plan with enrollment of more than 25,000 lives, for independent periods of time beginning no earlier than January 1, 2022, to December 31, 2025, inclusive, if certain criteria are met. Existing law requires the association or trust fund and each health care provider participating in each pilot program to report to the department information regarding cost savings and clinical patient outcomes compared to a fee-for-service payment model, and requires the department to report those findings to the Legislature no later than January 1, 2027. Existing law repeals these provisions on January 1, 2028. This bill would extend that repeal date to January 1, 2030. The bill would extend the period of time authorized for those pilot programs to operate from December 31, 2025, to December 31, 2027. The bill would extend the deadline for the department to report the findings to the Legislature from January 1, 2027, to January 1, 2029.

Primary Sponsors
Brian Maienschein

Bill Number	Last Action	Status	Position
AB 2072	**Read Second Time And Amended 2024 04 18**	**In Assembly**	**Monitor**

Title
Group health care coverage: biomedical industry.

Introduction Date: 2024-02-05

Description
AB 2072, as amended, Weber. Group health care coverage: biomedical industry. Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law provides for the regulation of individual, small employer, grandfathered small employer, and nongrandfathered small employer health care service plan contracts and health insurance policies, as defined.Existing federal law, the federal Employee Retirement Income Security Act of 1974 (ERISA), authorizes multiple employer welfare arrangements (MEWAs) in which 2 or more employers join together to provide health care coverage for employees or to their beneficiaries. Under existing state law, the status of each distinct member of an association determines whether that member’s association coverage is individual, small group, or large group health coverage.Existing law, until January 1, 2026, authorizes an association of employers to offer a large group health care service plan contract or large group health insurance policy to small group employer members of the association consistent with ERISA if certain requirements are met, including that the association is the sponsor of a MEWA that has offered a large group health care service plan contract since January 1, 2012, in connection with an employee welfare benefit plan under ERISA, provides a specified level of coverage, and includes coverage for common law employees, and their dependents, who are employed by an association member in the biomedical industry with operations in California. Existing law also requires an association and MEWA to annually file evidence of ongoing compliance with these requirements in a manner specified by the departments.This bill would require the departments, on or before June 30, 2032, to provide the health policy committees of the Legislature the most recent annual filings and would require the departments to recommend to the Legislature whether any of those MEWAs should remain operative based on compliance with the above-described requirements. This bill would extend the sunset date of January 1, 2026, to January 1, 2033, for the authorization of this type of health care service plan and insurance policy. By extending the authorization for a specific type of health care service plan, this bill would correspondingly extend the applicability of the crime for a violation of Knox-Keene, thereby imposing a state-mandated local program.The California Constitution requires the state to reimburse local agencies and sc... (click bill link to see more).

Primary Sponsors
Akilah Weber

Bill Number	Last Action	Status	Position
AB 2101	**Re Referred To Com On Health 2024 04 16**	**In Assembly**	**Monitor**

Title
Statewide strategic stockpile.

Introduction Date: 2024-02-05

Description
AB 2101, as amended, Rodriguez. Statewide strategic stockpile. Existing law establishes the State Department of Public Health to implement various programs throughout the state relating to public health.This bill would require the State Department of Public Health, in coordination with the Office of Emergency Services, medical health operational area coordinators, regional disaster and medical health coordinators and specialists, and other state agencies, to establish a statewide strategic stockpile. The bill would require the department, in coordination with the Office of Emergency Services, to establish guidelines for the procurement, management, and distribution of medicine, vaccines, and dental and medical supplies, taking into account, among other things, the amount of each type of item required for a sustained health emergency. The bill would authorize the department to enter into contracts with private entities for the procurement or reservation of supplies and for management and distribution of the stockpile. The bill would require the department to report annually to the Legislature, and others, the amount of items in the stockpile, the amount of items from the stockpile that have been used, the amount of anticipated future usage, the status of existing contracts with private entities that fulfill the procurement guidelines, and information regarding items reserved through those private entities. By creating new duties for medical health operational area coordinators and regional disaster and medical health coordinators and specialists, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Primary Sponsors
Freddie Rodriguez

Bill Number	Last Action	Status	Position
AB 2105	**Read Second Time And Amended 2024 04 18**	**In Assembly**	**Monitor**

Title
Coverage for PANDAS and PANS.

Introduction Date: 2024-02-05

Description
AB 2105, as amended, Lowenthal. Coverage for PANDAS and PANS. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law sets forth specified coverage requirements for health care service plan contracts and health insurance policies, and limits the copayment, coinsurance, deductible, and other cost sharing that may be imposed for specified health care services.This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to provide coverage for the prophylaxis, diagnosis, and treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) that is prescribed or ordered by the treating physician and surgeon and is medically necessary, as specified. The bill would prohibit coverage for PANDAS and PANS from being subject to a copayment, coinsurance, deductible, or other cost sharing that is greater than that applied to other benefits. The bill would prohibit a plan or insurer from denying or delaying coverage for PANDAS or PANS therapies because the enrollee or insured previously received treatment for PANDAS or PANS or was diagnosed with or received treatment for the condition under a different diagnostic name. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Josh Lowenthal

Organizational Notes

Last edited by Joanne Campbell at Mar 18, 2024, 5:29 PM
California Association of Health Plans - Oppose

Bill Number	Last Action	Status	Position
AB 2110	**From Committee Do Pass And Re Refer To Com On Appr Ayes 16 Noes 0 April 9 Re Referred To Com On Appr 2024 04 10**	**In Assembly**	**Monitor**

Title
Medi-Cal: Adverse Childhood Experiences trauma screenings: providers.

Introduction Date: 2024-02-05

Description
AB 2110, as introduced, Arambula. Medi-Cal: Adverse Childhood Experiences trauma screenings: providers. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Existing law requires that Medi-Cal provider payments and payments for specified non-Medi-Cal programs be reduced by 10% for dates of service on and after June 1, 2011, and conditions implementation of those payment reductions on receipt of any necessary federal approvals. Existing law, for dates of service on and after July 1, 2022, authorizes the maintenance of the reimbursement rates or payments for specified services, including, among others, Adverse Childhood Experiences (ACEs) trauma screenings and specified providers, using General Fund or other state funds appropriated to the State Department of Health Care Services as the state share, at the payment levels in effect on December 31, 2021, as specified, under the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 that were implemented with funds from the Healthcare Treatment Fund, as specified. Existing law requires the department to develop the eligibility criteria, methodologies, and parameters for the payments and rate increases maintained, and would authorize revisions, as specified.This bill would require the department, as part of its above-described duties, to include (1) community-based organizations and local health jurisdictions that provide health services through community health workers and (2) doulas, that are enrolled Medi-Cal providers, as providers qualified to provide, and eligible to receive payments for, ACEs trauma screenings pursuant to the provisions described above. The bill would require the department to file a state plan amendment and seek any federal approvals it deems necessary to implement these provisions and condition implementation on receipt of any necessary federal approvals and the availability of federal financial participation. The bill would also require the department to update its internet website and the ACEs Aware internet website to reflect the addition of the Medi-Cal providers described above as authorized to provide ACEs screenings.

Primary Sponsors
Joaquin Arambula

Organizational Notes

Last edited by Joanne Campbell at Apr 22, 2024, 6:02 PM
Local Health Plans of California - Support

Bill Number	Last Action	Status	Position
AB 2115	**From Committee Do Pass And Re Refer To Com On Health Ayes 17 Noes 0 April 16 Re Referred To Com On Health 2024 04 16**	**In Assembly**	**Monitor**

Title
Controlled substances: clinics.

Introduction Date: 2024-02-05

Description
AB 2115, as amended, Haney. Controlled substances: clinics. Existing law, the Pharmacy Law, provides for the licensure and regulation of pharmacists by the California State Board of Pharmacy and makes a violation of the act a crime. Under existing law, specified clinics, including surgical clinics, may purchase drugs at wholesale for administration or dispensing to the clinic’s patients. Existing law requires these clinics to maintain certain records and to obtain a license from the board. Existing law prohibits specified substances from being dispensed by a nonprofit or free clinic, as defined.This bill would authorize a nonprofit or free clinic to dispense a narcotic drug for the purpose of relieving acute withdrawal symptoms while arrangements are being made for referral for treatment, as described, and would require the clinic dispensing the narcotic to be subject to specified labeling and recordkeeping requirements. Because the bill would specify additional requirements under the Pharmacy Law, a violation of which would be a crime, it would impose a state-mandated local program.Existing law requires the State Department of Health Care Services to regulate and license narcotic treatment programs, including in the use of narcotic replacement therapy and medication-assisted treatment. Existing regulation specifies certain requirements and considerations for a patient to be eligible for treatment at a licensed narcotic treatment program, such as a medical evaluation conducted by the program, laboratory tests for disease, and minimum monthly participation in counseling, among others. Existing regulation also imposes specified criteria to be considered before a patient is eligible for take-home doses of medication, requires revocation of those privileges if a patient tests positive for illicit substances on 2 consecutive monthly samples, and prescribes criteria for the restoration of those privileges, including test results that are negative for illicit substances. Existing regulation requires a patient who is absent from a program for 2 weeks without contacting the program be terminated from the program.This bill would specify that medical evaluation may be conducted by any health care provider, if it is verified by a narcotic treatment program practitioner, would authorize a program to allow patients to refuse or delay laboratory tests for disease, and would state that a patient receiving maintenance treatment is not precluded from receiving medication by a refusal to participate in counseling. The bill would revise the criteria to be considered prior to providing a patient with take-home medication privileges to include the absence of active substance use disorders and known recent diversion activity and the re... (click bill link to see more).

Primary Sponsors
Matt Haney

Bill Number	Last Action	Status	Position
AB 2129	**Re Referred To Com On Appr 2024 04 15**	**In Assembly**	**Monitor**

Title
Immediate postpartum contraception.

Introduction Date: 2024-02-06

Description
AB 2129, as amended, Petrie-Norris. Immediate postpartum contraception. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally regulates contractual provisions between health care service plans and health insurers and their contracting health care providers.This bill would require a contract between a health care service plan or health insurer and a health care provider issued, amended, or renewed on or after January 1, 2025, to authorize a provider to separately bill for devices, implants, or professional services, or a combination thereof, associated with immediate postpartum contraception if the birth takes place in a general acute care hospital or accredited birthing center. The bill would prohibit that provider contract from considering those devices, implants, or services to be part of a payment for a general obstetric procedure. Because a violation of the bill’s requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Cottie Petrie-Norris

Bill Number	Last Action	Status	Position
AB 2132	**In Committee Set First Hearing Referred To Suspense File 2024 04 10**	**In Assembly**	**Monitor**

Title
Health care services.

Introduction Date: 2024-02-06

Description
AB 2132, as amended, Low. Health care services. Existing law provides for the licensure and regulation of health facilities and clinics, including primary care clinics, by the State Department of Public Health. A violation of these provisions is a crime. Existing law requires an adult patient receiving primary care services in certain health care settings to be offered a screening test for hepatitis B and hepatitis C, as specified.This bill would require an adult patient receiving primary care services in a facility, clinic, unlicensed clinic, center, office, or other setting, as specified, to be offered a tuberculosis (TB) risk assessment and TB screening test, if TB risk factors are identified, to the extent these services are covered under the patient’s health insurance, unless the health care provider reasonably believes certain conditions apply. The bill would also require the health care provider to offer the patient followup health care or refer the patient to a health care provider who can provide followup health care if a screening test is positive, as specified. The bill would prohibit a health care provider who fails to comply with these provisions from being subject to any disciplinary action related to their licensure or certification, or to any civil or criminal liability for that failure. The bill would make related findings and declarations.

Primary Sponsors
Evan Low

Bill Number	Last Action	Status	Position
AB 2161	**Re Referred To Com On Appr 2024 04 15**	**In Assembly**	**Monitor**

Title
The Early Psychosis Intervention Plus Program.

Introduction Date: 2024-02-06

Description
AB 2161, as amended, Arambula. The Early Psychosis Intervention Plus Program. Existing law establishes the Early Psychosis Intervention Plus (EPI Plus) Program to encompass early psychosis and mood disorder detection and intervention. Existing law establishes the Early Psychosis and Mood Disorder Detection and Intervention Fund and makes the moneys in the fund available, upon appropriation, to the Behavioral Health Services Oversight and Accountability Commission. Existing law authorizes the commission to allocate moneys from that fund to provide grants to create or expand existing capacity for early psychosis and mood disorder detection and intervention services and supports.This bill would require the Behavioral Health Services Oversight and Accountability Commission to consult with the State Department of Health Care Services and related state departments and entities, create a strategic plan to achieve specific goals, including improving the understanding of psychosis, as specified, and, no later than July 1, 2025, submit that strategic plan to the relevant policy and fiscal committees of the Legislature. The bill would require the State Department of Health Care Services to seek to partner with the University of California to develop a plan to establish the Center for Mental Health Wellness and Innovations to, among other things, promote the widespread availability of evidence-based practices to improve behavioral health services. If the center is established, the bill would require the State Department of Health Care Services, no later than July 1, 2025, to submit the plan to create the center to the relevant policy and fiscal committees of the Legislature.

Primary Sponsors
Joaquin Arambula

Bill Number	Last Action	Status	Position
AB 2169	**From Committee Do Pass And Re Refer To Com On Appr Ayes 14 Noes 0 April 9 Re Referred To Com On Appr 2024 04 10**	**In Assembly**	**Monitor**

Title
Prescription drug coverage: dose adjustments.

Introduction Date: 2024-02-07

Description
AB 2169, as amended, Bauer-Kahan. Prescription drug coverage: dose adjustments. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or health insurer to use utilization review, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Existing law also prohibits a health care service plan that covers prescription drug benefits from limiting or excluding coverage for a drug that was previously approved for coverage if an enrollee continues to be prescribed that drug, as specified.The bill would authorize a licensed health care professional to request, and would require that they be granted, the authority to adjust the dose or frequency of a drug to meet the specific medical needs of the enrollee or insured without prior authorization if specified conditions are met. Under the bill, if the enrollee or insured has been continuously using a prescription drug selected by their prescribing provider for the medical condition under consideration while covered by their current or previous health coverage, the health care service plan or health insurance policy would be prohibited from limiting or excluding coverage of that prescription. With respect to health care service plans, the bill would specify that its provisions do not apply to Medi-Cal managed care plan contracts. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Rebecca Bauer-Kahan

Organizational Notes

Last edited by Joanne Campbell at Mar 7, 2024, 9:17 PM
California Association of Health Plans - Oppose

Bill Number	Last Action	Status	Position
AB 2180	**Re Referred To Com On Health 2024 04 11**	**In Assembly**	**Monitor**

Title
Health care coverage: cost sharing.

Introduction Date: 2024-02-07

Description
AB 2180, as amended, Weber. Health care coverage: cost sharing. Existing law generally prohibits a person who manufactures a prescription drug from offering in California any discount, repayment, product voucher, or other reduction in an individual’s out-of-pocket expenses associated with the individual’s health insurance, health care service plan, or other health coverage, including, but not limited to, a copayment, coinsurance, or deductible, for any prescription drug if a lower cost generic drug is covered under the individual’s health insurance, health care service plan, or other health coverage on a lower cost-sharing tier that is designated as therapeutically equivalent to the prescription drug manufactured by that person or if the active ingredients of the drug are contained in products regulated by the federal Food and Drug Administration, are available without prescription at a lower cost, and are not otherwise contraindicated for the condition for which the prescription drug is approved.Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance.This bill would require a health care service plan, health insurance policy, or pharmacy benefit manager that administers pharmacy benefits for a health care service plan or health insurer to apply any amounts paid by the enrollee, insured, or a third-party patient assistance program, as defined, toward the enrollee’s or insured’s cost-sharing requirement, and would only apply those requirements with respect to enrollees or insureds who have a chronic disease or terminal illness. The bill would limit the application of the section to health care service plans and health insurance policies issued, amended, delivered, or renewed on or after January 1, 2025. Because a willful violation of these requirements by a health care service plan would be a crime, this bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Akilah Weber

Organizational Notes

Last edited by Joanne Campbell at Apr 19, 2024, 8:06 PM
California Association of Health Plans - Opposed

Bill Number	Last Action	Status	Position
AB 2198	**In Committee Hearing Postponed By Committee 2024 04 11**	**In Assembly**	**Monitor**

Title
Health information.

Introduction Date: 2024-02-07

Description
AB 2198, as introduced, Flora. Health information. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plans and health insurers to establish and maintain specified application programming interfaces (API), including patient access API, for the benefit of enrollees, insureds, and contracted providers.This bill would exclude dental or vision benefits from the above-described API requirements.

Primary Sponsors
Heath Flora

Bill Number	Last Action	Status	Position
AB 2200	**Re Referred To Com On Health 2024 04 10**	**In Assembly**	**Monitor**

Title
Guaranteed Health Care for All.

Introduction Date: 2024-02-07

Description
AB 2200, as amended, Kalra. Guaranteed Health Care for All. Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. PPACA defines a “qualified health plan” as a plan that, among other requirements, provides an essential health benefits package. Existing state law creates the California Health Benefit Exchange, also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA.Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.This bill, the California Guaranteed Health Care for All Act, would create the California Guaranteed Health Care for All program, or CalCare, to provide comprehensive universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state. The bill, among other things, would provide that CalCare cover a wide range of medical benefits and other services and would incorporate the health care benefits and standards of other existing federal and state provisions, including the federal Children’s Health Insurance Program, Medi-Cal, ancillary health care or social services covered by regional centers for persons with developmental disabilities, Knox-Keene, and the federal Medicare Program. The bill would make specified persons eligible to enroll as CalCare members during the implementation period, and would provide for automatic enrollment. The bill would require the board to seek all necessary waivers, approvals, and agreements to allow various existing federal health care payments to be paid to CalCare, which would then assume responsibility for all benefits and services previously paid for with those funds.This bill would create the CalCare Board to govern CalCare, made up of 9 voting members with demonstrated and acknowledged expertise in health care, and appointed as provided, plus the Secretary of California Health and Human Services or their designee as a nonvoting, ex officio member. The bill would provide the board with all ... (click bill link to see more).

Primary Sponsors
Ash Kalra, Isaac Bryan, Wendy Carrillo, Damon Connolly, Dave Cortese, Lena Gonzalez, Alex Lee

Bill Number	Last Action	Status	Position
AB 2237	**Re Referred To Com On Appr Pursuant To Assembly Rule 96 2024 04 15**	**In Assembly**	**Monitor**

Title
Children and youth: transfer of specialty mental health services.

Introduction Date: 2024-02-08

Description
AB 2237, as amended, Aguiar-Curry. Children and youth: transfer of specialty mental health services. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services (department), under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, specialty mental health services include federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services provided to eligible Medi-Cal beneficiaries under 21 years of age.This bill would require, when a child or youth 21 years of age or younger who is receiving Medi-Cal specialty mental health services changes residence from one county to another, the receiving county to provide specialty mental health services to the child or youth, if the transfer of those services from one county to another is not otherwise governed by a process established in statute. The bill also would require the State Department of Health Care Services to collect specified data related to the receipt of specialty mental health services by children and youth who move outside of the county where they originally received specialty mental health services, and to include the data in the department’s Medi-Cal specialty mental health services performance dashboard. The bill would require the department to issue guidance, as specified, to define the requirements on a receiving county for the continued provision of specialty mental health services, to coordinate and expedite the transfer of services from one county to another, and reduce the burden on children and youth and their caregivers to reestablish services in the receiving county. The bill would authorize the department to implement, interpret, or make specific its provisions by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, until regulations are adopted, as specified. By increasing duties of counties administering the Medi-Cal program, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Cecilia Aguiar-Curry

Bill Number	Last Action	Status	Position
AB 2250	**From Committee Do Pass And Re Refer To Com On Appr Ayes 15 Noes 0 April 2 Re Referred To Com On Appr 2024 04 03**	**In Assembly**	**Monitor**

Title
Social determinants of health: screening and outreach.

Introduction Date: 2024-02-08

Description
AB 2250, as introduced, Weber. Social determinants of health: screening and outreach. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plans and health insurers to include coverage for screening for various conditions and circumstances, including adverse childhood experiences. Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2027, to include coverage for screenings for social determinants of health, as defined. The bill would require providers to use specified tools or protocols when documenting patient responses to questions asked in these screenings. The bill would require a health care service plan or health insurer to provide physicians who provide primary care services with adequate access to peer support specialists, lay health workers, social workers, or community health workers in counties where the plan or insurer has enrollees or insureds, as specified. The bill would authorize the respective departments to adopt guidance to implement its provisions. Because a violation of the bill’s requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.This bill would make social determinants of health screenings a covered benefit for Medi-Cal beneficiaries and would require the State Department of Health Care Services or a Medi-Cal managed care plan to provide reimbursement for those screenings, as specified.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Akilah Weber

Organizational Notes

Last edited by Joanne Campbell at Apr 22, 2024, 6:05 PM
Local Health Plans of California, California Academy of Family Physicians (sponsor) - Support

Bill Number	Last Action	Status	Position
AB 2258	**From Committee Do Pass And Re Refer To Com On Appr Ayes 13 Noes 0 April 9 Re Referred To Com On Appr 2024 04 10**	**In Assembly**	**Monitor**

Title
Health care coverage: cost sharing.

Introduction Date: 2024-02-08

Description
AB 2258, as amended, Zbur. Health care coverage: cost sharing. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a group or individual nongrandfathered health care service plan contract or health insurance policy to provide coverage for, and prohibits a contract or policy from imposing cost-sharing requirements for, specified preventive care services and screenings.This bill would prohibit a group or individual nongrandfathered health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, from imposing a cost-sharing requirement for items or services that are integral to the provision of the above-described preventive care services and screenings. The bill would require those contracts and policies to cover items and services for those preventive care services and screenings, including home test kits for sexually transmitted diseases and specified cancer screenings. Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Rick Zbur

Organizational Notes

Last edited by Joanne Campbell at Mar 7, 2024, 9:18 PM
California Association of Health Plans - Oppose

Bill Number	Last Action	Status	Position
AB 2271	**From Committee Chair With Authors Amendments Amend And Re Refer To Com On Health Read Second Time And Amended 2024 04 18**	**In Assembly**	**Monitor**

Title
St. Rose Hospital.

Introduction Date: 2024-02-08

Description
AB 2271, as amended, Ortega. St. Rose Hospital. Existing law, the California Health Facility Construction Loan Insurance Law, establishes, without cost to the state, an insurance program for health facility construction, improvement, and expansion loans in order to stimulate the flow of private capital into health facilities construction, improvement, and expansion and in order to rationally meet the need for new, expanded, and modernized public and nonprofit health facilities necessary to protect the health of all the people of this state. Existing law creates the Distressed Hospital Loan Program, until January 1, 2032, for the purpose of providing loans to not-for-profit hospitals and public hospitals, as defined, in significant financial distress or to governmental entities representing a closed hospital to prevent the closure or facilitate the reopening of a closed hospital. Existing law requires the Department of Health Care Access and Information to administer both of these programs.This bill would require the department to approve the forgiveness of both of these loans for the St. Rose Hospital in the City of Hayward. The bill would require the department to forgive the full amounts of the principal, interests, fees, and any other outstanding balances of the loan.This bill would make legislative findings and declarations as to the necessity of a special statute for the City of Hayward.

Primary Sponsors
Liz Ortega

Bill Number	Last Action	Status	Position
AB 2293	**Referred To Com On L Gov 2024 02 26**	**In Assembly**	**Monitor**

Title
Joint powers agreements: health care services.

Introduction Date: 2024-02-12

Description
AB 2293, as introduced, Mathis. Joint powers agreements: health care services. Existing law, the Joint Exercise of Powers Act, authorizes 2 or more public agencies by agreement to exercise any power common to the contracting parties, subject to meeting certain conditions with respect to that agreement. Existing law authorizes a private, nonprofit corporation, until January 1, 2023, formed for the purposes of providing services to zero-emission transportation systems or facilities, to join a joint powers authority or enter into a joint powers agreement with a public agency to facilitate the development, construction, and operation of zero-emission transportation systems or facilities that lower greenhouse gases, reduce vehicle congestion and vehicle miles traveled, and improve public transit connections. This bill would authorize one or more private, nonprofit mutual benefit corporations formed for purposes of providing health care services to join a joint powers authority or enter into a joint powers agreement with one or more public entities established under the act. The bill would deem any joint powers authority formed pursuant to this provision to be a public entity, except that the authority would not have the power to incur debt.

Primary Sponsors
Devon Mathis

Bill Number	Last Action	Status	Position
AB 2297	**Re Referred To Com On Jud 2024 04 15**	**In Assembly**	**Monitor**

Title
Hospital and Emergency Physician Fair Pricing Policies.

Introduction Date: 2024-02-12

Description
AB 2297, as amended, Friedman. Hospital and Emergency Physician Fair Pricing Policies. Existing law requires a hospital to maintain a written charity care policy and a discount payment policy for uninsured patients or patients with high medical costs who are at or below 400 percent of the federal poverty level. Existing law requires the written policy regarding discount payments to also include a statement that an emergency physician who provides emergency medical services in a hospital that provides emergency care is also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 400 percent of the federal poverty level. Existing law authorizes an emergency physician to choose to grant eligibility for a discount payment policy to patients with incomes over 350% of the federal poverty level. Existing law defines “high medical costs” for these purposes to mean, among other things, specified annual out-of-pocket costs incurred by the individual at the hospital or a hospital that provided emergency care.This bill would authorize an emergency physician to choose to grant eligibility for a discount payment policy to patients with incomes over 400% of the federal poverty level. The bill would also clarify that out-of-pocket costs for the above-described definition of “high medical costs” means any expenses for medical care that are not reimbursed by insurance or a health coverage program, such as Medicare copays or Medi-Cal cost sharing.Existing law requires a hospital’s discount payment policy to clearly state the eligibility criteria based upon income, and authorizes a hospital to consider the income and monetary assets of the patient in determining eligibility under its charity care policy.This bill would prohibit a hospital from considering the monetary assets of the patient in determining eligibility for both the charity care and the discount payment policies, but would authorize the hospital to consider a health savings account, as specified. The bill would instead require that the eligibility for charity care or discounted payments be determined at any time the hospital is in receipt of recent pay stubs or income tax returns. The bill would prohibit a hospital from imposing time limits for eligibility. The bill would authorize a hospital to waive Medi-Cal and Medicare cost-sharing amounts as part of its charity care program or discount payment program.Existing law requires a hospital or an emergency physician to establish a written policy defining standards and practices for the collection of debt. Existing law authorizes a hospital or emergency physician to consider only income and monetary assets, as specified, in determining the amount of debt a hospital or ... (click bill link to see more).

Primary Sponsors
Laura Friedman

Bill Number	Last Action	Status	Position
AB 2302	**Read Second Time Ordered To Third Reading 2024 04 15**	**In Assembly**	**Monitor**

Title
Open meetings: local agencies: teleconferences.

Introduction Date: 2024-02-12

Description
AB 2302, as introduced, Addis. Open meetings: local agencies: teleconferences. Existing law, the Ralph M. Brown Act, requires, with specified exceptions, that all meetings of a legislative body, as defined, of a local agency be open and public and that all persons be permitted to attend and participate. The act generally requires for teleconferencing that the legislative body of a local agency that elects to use teleconferencing post agendas at all teleconference locations, identify each teleconference location in the notice and agenda of the meeting or proceeding, and have each teleconference location be accessible to the public. Existing law also requires that, during the teleconference, at least a quorum of the members of the legislative body participate from locations within the boundaries of the territory over which the local agency exercises jurisdiction. The act provides an exemption to the jurisdictional requirement for health authorities, as defined.Existing law, until January 1, 2026, authorizes the legislative body of a local agency to use alternative teleconferencing in specified circumstances if, during the teleconference meeting, at least a quorum of the members of the legislative body participates in person from a singular physical location clearly identified on the agenda that is open to the public and situated within the boundaries of the territory over which the local agency exercises jurisdiction, and the legislative body complies with prescribed requirements. Existing law imposes prescribed restrictions on remote participation by a member under these alternative teleconferencing provisions, including establishing limits on the number of meetings a member may participate in solely by teleconference from a remote location, prohibiting such participation for a period of more than 3 consecutive months or 20% of the regular meetings for the local agency within a calendar year, or more than 2 meetings if the legislative body regularly meets fewer than 10 times per calendar year.This bill would revise those limits, instead prohibiting such participation for more than a specified number of meetings per year, based on how frequently the legislative body regularly meets. The bill, for the purpose of counting meetings attended by teleconference, would define a “meeting” as any number of meetings of the legislative body of a local agency that begin on the same calendar day.The California Constitution requires local agencies, for the purpose of ensuring public access to the meetings of public bodies and the writings of public officials and agencies, to comply with a statutory enactment that amends or enacts laws relating to public records or open meetings and contains findings demonstrating that the enactment furthe... (click bill link to see more).

Primary Sponsors
Dawn Addis

Bill Number	Last Action	Status	Position
AB 2303	**In Committee Set Second Hearing Hearing Canceled At The Request Of Author 2024 04 11**	**In Assembly**	**Monitor**

Title
Health and care facilities: prospective payment system rate increase.

Introduction Date: 2024-02-12

Description
AB 2303, as amended, Juan Carrillo. Health and care facilities: prospective payment system rate increase. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law provides that federally qualified health center services and rural health clinic services, as defined, are covered benefits under the Medi-Cal program, to be reimbursed, to the extent that federal financial participation is obtained, to providers on a per-visit basis and at a per-visit prospective payment system rate, as defined.Existing law establishes 5 separate minimum wage schedules for covered health care employees, as defined, depending on the nature of the employer and includes increases beginning on June 1, 2024. Existing law generally requires the State Department of Public Health to license, regulate, and inspect health and care facilities.This bill would, upon appropriation, require the State Department of Health Care Services to develop a minimum wage add-on as an alternative payment methodology to increase rates of payment for specified health care facilities to account for the costs of complying with the minimum wage schedules described above. The bill would require that the alternative methodology be applied retroactively to January 1, 2025, until those costs are included in the prospective payment system rate. The bill would require the department to seek all necessary federal approvals or amendments to the state Medi-Cal plan to implement these provisions and would require the department to make any state plan amendments or waiver requests public 45 days prior to submitting them to the federal Centers for Medicare and Medicaid Services.

Primary Sponsors
Juan Carrillo

Bill Number	Last Action	Status	Position
AB 2315	**From Printer May Be Heard In Committee March 14 2024 02 13**	**In Assembly**	**Monitor**

Title
Mental health: programs for seriously emotionally disturbed children and court wards and dependents.

Description
AB 2315, as introduced, Lowenthal. Mental health: programs for seriously emotionally disturbed children and court wards and dependents. Existing law generally provides for the placement of foster youth in various placement settings and governs the provision of child welfare services, as specified. Existing law, the California Community Care Facilities Act, provides for the licensure and regulation of community care facilities, including community treatment facilities (CTFs) by the State Department of Social Services.Existing law requires the State Department of Health Care Services to adopt certain regulations for CTFs, including, among others, that only seriously emotionally disturbed children, as defined, either (1) for whom other less restrictive mental health interventions have been tried, as specified, or (2) who are currently placed in an acute psychiatric hospital or state hospital or in a facility outside the state for mental health treatment, and who may require periods of containment to participate in, and benefit from, mental health treatment, shall be placed in a CTF.This bill would make technical, nonsubstantive changes to these provisions.

Primary Sponsors
Josh Lowenthal

Introduction Date: 2024-02-12

Bill Number	Last Action	Status	Position
AB 2319	**From Committee Do Pass And Re Refer To Com On Appr Ayes 12 Noes 2 April 2 Re Referred To Com On Appr 2024 04 03**	**In Assembly**	**Monitor**

Title
California Dignity in Pregnancy and Childbirth Act.

Introduction Date: 2024-02-12

Description
AB 2319, as amended, Wilson. California Dignity in Pregnancy and Childbirth Act. Existing law requires the State Department of Public Health to maintain a program of maternal and child health, which may include, among other things, facilitating services directed toward reducing infant mortality and improving the health of mothers and children. Existing law requires the Office of Health Equity within the department to serve as a resource for ensuring that programs collect and keep data and information regarding ethnic and racial health statistics, and strategies and programs that address multicultural health issues, including, but not limited to, infant and maternal mortality. Existing law makes legislative findings relating to implicit bias and racial disparities in maternal mortality rates. Existing law requires a hospital that provides perinatal care, and an alternative birth center or a primary clinic that provides services as an alternative birth center, to implement an evidence-based implicit bias program, as specified, for all health care providers involved in perinatal care of patients within those facilities. Existing law requires the health care provider to complete initial basic training through the program and a refresher course every 2 years thereafter, or on a more frequent basis if deemed necessary by the facility. Existing law requires the facility to provide a certificate of training completion upon request, to accept certificates of completion from other facilities, and to offer training to physicians not directly employed by the facility. Existing law requires the department to track and publish data on pregnancy-related death and severe maternal morbidity, as specified.This bill would make a legislative finding that the Legislature recognizes all birthing people, including nonbinary persons and persons of transgender experience. The bill would extend the evidence-based implicit bias training requirements to also include hospitals that provide perinatal care, as defined. The bill would require an implicit bias program to include recognition of intersecting identities and the potential associated biases. The bill would require initial basic training for the implicit bias program to be completed by June 1, 2025, for current health care providers, and within 6 months of their start date for new health care providers, unless exempted. The bill would require specified facilities to document each employee’s implicit bias training in accordance with regulations adopted by the department for documenting staff development programs. The bill would require the department to assess each hospital’s compliance with this requirement during periodic inspections. The bill would authorize the department to issue ... (click bill link to see more).

Primary Sponsors
Lori Wilson, Akilah Weber, Mia Bonta, Steve Bradford, Isaac Bryan, Mike Gipson, Chris Holden

Bill Number	Last Action	Status	Position
AB 2327	**Read Second Time Ordered To Consent Calendar 2024 04 18**	**In Assembly**	**Monitor**

Title
Optometry: mobile optometric offices: regulations.

Introduction Date: 2024-02-12

Description
AB 2327, as amended, Wendy Carrillo. Optometry: mobile optometric offices: regulations. Existing law, the Optometry Practice Act, establishes the State Board of Optometry within the Department of Consumer Affairs and sets forth the powers and duties of the board relating to the licensure and regulation of the practice of optometry. Existing law requires the board, by January 1, 2023, to adopt regulations establishing a registry for the owners and operators of mobile optometric offices, as specified. Existing law prohibits the board, before January 1, 2023, from bringing an enforcement action against an owner and operator of a mobile optometric office based solely on its affiliation status with an approved optometry school in California for remotely providing optometric service. Existing law makes these and other provisions related to the permitting and regulation of mobile optometric offices effective only until July 1, 2025, and repeals them as of that date.This bill would require the board to adopt the above-described regulations by January 1, 2026. The bill would prohibit the board from bringing the above-described enforcement action before January 1, 2026, or before the board adopts those regulations, whichever is earlier. The bill would extend the repeal date of the provisions related to the permitting and regulation of mobile optometric clinics to July 1, 2035.

Primary Sponsors
Wendy Carrillo

Bill Number	Last Action	Status	Position
AB 2332	**From Committee Do Pass And Re Refer To Com On Appr With Recommendation To Consent Calendar Ayes 8 Noes 0 April 16 Re Referred To Com On Appr 2024 04 17**	**In Assembly**	**Monitor**

Title
Corrections: health care.

Introduction Date: 2024-02-12

Description
AB 2332, as amended, Connolly. Corrections: health care. Existing law establishes the Division of Health Care Operations and the Division of Health Care Policy and Administration within the Department of Corrections and Rehabilitation (CDCR) under the supervision of the Undersecretary of Health Care Services. Existing law requires the department to expand substance abuse treatment services in prisons to accommodate at least 4,000 additional inmates who have histories of substance abuse. Existing law requires the department to establish a 3-year pilot program to provide a medically assisted substance use disorder treatment model for the treatment of inmates, as specified.This bill would require the CDCR to take specific actions in the provision of substance use treatment, such as ensuring uniform application of the California Correctional Health Care Services Care Guide and retaining at least one full-time addiction medicine physician and surgeon at each facility to be assigned medication-assisted treatment patients exclusively. The bill would require the CDCR to provide physicians and surgeons clear guidance on interpretation of certain toxicology tests, the misuse, abuse, and illegal distribution of substances, and access to alternative medication. The bill would require the CDCR to provide physicians and surgeons training consisting of at least 8 hours of integrated substance use disorder treatment didactic training, 3 days of shadowing an integrated substance use disorder treatment practice, and an annual training of at least 8 hours covering specified topics.The bill would require the CDCR to form a working group consisting of 6 members of the Union of American Physicians and Dentists and integrated substance use disorder treatment program departmental representation with the authority to make decisions for the purpose of identifying program areas for improvement or additional training that could be offered to certain employees, in order to enhance program success.Existing regulations establish a process for the CDCR to verify licenses and credentials of newly hired health care providers.This bill would require that process to include addiction medicine as an additional qualification.

Primary Sponsors
Damon Connolly

Bill Number	Last Action	Status	Position
AB 2339	**In Committee Set First Hearing Referred To Suspense File 2024 04 17**	**In Assembly**	**Monitor**

Title
Medi-Cal: telehealth.

Introduction Date: 2024-02-12

Description
AB 2339, as introduced, Aguiar-Curry. Medi-Cal: telehealth. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Under existing law, subject to federal approval, in-person, face-to-face contact is not required under Medi-Cal when covered health care services are provided by video synchronous interaction, asynchronous store and forward, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual communication modalities, when those services and settings meet certain criteria. Existing law defines “asynchronous store and forward” as the transmission of a patient’s medical information from an originating site to the health care provider at a distant site.This bill would expand that definition, for purposes of the above-described Medi-Cal provisions, to include asynchronous electronic transmission initiated directly by patients, including through mobile telephone applications.Existing law prohibits a health care provider from establishing a new patient relationship with a Medi-Cal beneficiary via asynchronous store and forward, telephonic (audio-only) synchronous interaction, remote patient monitoring, or other virtual communication modalities, except as specified. Among those exceptions, existing law authorizes a health care provider to establish a new patient relationship using an audio-only synchronous interaction when the visit is related to sensitive services, as defined, and when established in accordance with department-specific requirements and consistent with federal and state law, regulations, and guidance.This bill would expand that exception to include asynchronous store and forward when the visit is related to sensitive services, as specified. The bill would also authorize a health care provider to establish a new patient relationship using asynchronous store and forward when the patient requests an asynchronous store and forward modality, as specified.Existing law authorizes a health care provider to establish a new patient relationship using an audio-only synchronous interaction when the patient requests an audio-only modality or attests that they do not have access to video, as specified.This bill would remove, from that exception, the option of the patient attesting that they do not have access to video.

Primary Sponsors
Cecilia Aguiar-Curry

Bill Number	Last Action	Status	Position
AB 2340	**From Committee Do Pass And Re Refer To Com On Appr With Recommendation To Consent Calendar Ayes 16 Noes 0 April 16 Re Referred To Com On Appr 2024 04 17**	**In Assembly**	**Monitor**

Title
Medi-Cal: EPSDT services: informational materials.

Introduction Date: 2024-02-12

Description
AB 2340, as amended, Bonta. Medi-Cal: EPSDT services: informational materials. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive medically necessary health care services, through fee-for-service or managed care delivery systems. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, early and periodic screening, diagnostic, and treatment (EPSDT) services are covered under Medi-Cal for an individual under 21 years of age in accordance with certain federal provisions.Existing federal regulations require the state to provide for a combination of written and oral methods designed to inform individuals eligible for EPSDT services, or their families, about the EPSDT program, within 60 days of the individual’s initial Medicaid eligibility determination and, in the case of families that have not utilized EPSDT services, annually thereafter, as specified. Under those regulations, required information includes, among other components, the benefits of preventive health care and the services available under the EPSDT program and where and how to obtain those services.This bill would require the department to prepare written informational materials that effectively explain and clarify the scope and nature of EPSDT services, as defined, that are available under the Medi-Cal program. Under the bill, the materials would include, but would not be limited to, the information required in the above-described federal regulations or their successor. Under the bill, the informational materials would also include content designed for youth, for purposes of delivery of that content to a beneficiary who is 12 years of age or older but under 21 years of age.The bill would authorize the department to standardize the materials, as specified, and would require the department to regularly review the materials to ensure that they are up to date. The bill would require the department to test the quality, clarity, and cultural concordance of translations of the informational materials with Medi-Cal beneficiaries, in order to ensure that the materials use clear and nontechnical language that effectively informs beneficiaries.The bill would require the department or a Medi-Cal managed care plan, depending on the delivery system, to provide to a beneficiary who is eligible for EPSDT services, or to the parent or other authorized representative of that beneficiary, as applicable, the informational materials within 60 calendar days after that beneficiary’s initial Medi-Cal eligibility determination and annually thereafter.

Primary Sponsors
Mia Bonta

Bill Number	Last Action	Status	Position
AB 2342	**Referred To Com On Health 2024 02 26**	**In Assembly**	**Monitor**

Title
Medi-Cal: critical access hospitals: islands.

Introduction Date: 2024-02-12

Description
AB 2342, as introduced, Lowenthal. Medi-Cal: critical access hospitals: islands. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Under existing law, a hospital designated by the department as a critical access hospital, and certified as such by the Secretary of the United States Department of Health and Human Services under the federal Medicare rural hospital flexibility program, is eligible for supplemental payments for Medi-Cal covered outpatient services rendered to Medi-Cal eligible persons. Existing law conditions those payments on receipt of federal financial participation and an appropriation in the annual Budget Act for the nonfederal share of those payments, with supplemental payments being apportioned among critical access hospitals based on their number of Medi-Cal outpatient visits.This bill, subject to appropriation and the availability of federal funding, would require the department to provide an annual supplemental payment, for services covered under Medi-Cal, to each critical access hospital that operates on an island that is located more than 10 miles offshore of the mainland coast of the state but is still within the jurisdiction of the state. The bill would specify the formula of the payment amount, which would be in addition to any supplemental payment described above.This bill would make legislative findings and declarations as to the necessity of a special statute for critical access hospitals operating on those islands.

Primary Sponsors
Josh Lowenthal

Bill Number	Last Action	Status	Position
AB 2352	**Re Referred To Com On Health 2024 04 11**	**In Assembly**	**Monitor**

Title
Behavioral health and psychiatric advance directives.

Introduction Date: 2024-02-12

Description
AB 2352, as amended, Irwin. Behavioral health and psychiatric advance directives. (1) Existing law establishes the requirements for executing a written advance health care directive that is legally sufficient to direct health care decisions. Existing law provides a form that an individual may use or modify to create an advance health care directive. Under existing law, a written advance health care directive is legally sufficient if specified requirements are satisfied, may be revoked by a patient having capacity at any time, and is revoked to the extent of a conflict with a later executed directive. Existing law requires a supervising health care provider who knows of the existence of an advance health care directive or its revocation to record that fact in the patient's health record. Existing law sets forth requirements of witnesses to a written advance health care directive. A written advance health care directive or similar instrument executed in another jurisdiction is valid and enforceable in this state under existing law. A person who intentionally falsifies, forges, conceals, defaces, or obliterates an individual's advance health care directive or its revocation without the individual's consent is subject to liability of up to $10,000 or actual damages, whichever is greater, plus reasonable attorney's fees.Existing law authorizes an appeal of specified orders relating to an advance health care directive. Existing law generally prohibits involuntary civil placement of a ward, conservatee, or person with capacity in a mental health treatment facility, subject to a valid and effective advance health care directive. Existing law prohibits specified entities, including a provider, health care service plan, or insurer, from requiring or prohibiting the execution or revocation of an advance health care directive as a condition for providing health care, admission to a facility, or furnishing insurance. Existing law requires the Secretary of State to establish a registry system for written advance health care directives, but failure to register does not affect the directive's validity and registration does not affect a registrant's ability to revoke the directive.Under existing law, an advance psychiatric directive is a legal document, executed on a voluntary basis by a person who has the capacity to make medical decisions and in accordance with the requirements for an advance health care directive, that allows a person with mental illness to protect their autonomy and ability to direct their own care by documenting their preferences for treatment in advance of a mental health crisis. An individual may execute both an advance health care directive and a voluntary standalone psychiatric advance directive.This bill wo... (click bill link to see more).

Primary Sponsors
Jacqui Irwin

Organizational Notes

Last edited by Joanne Campbell at Apr 19, 2024, 8:06 PM
California Association of Health Plans - Opposed

Bill Number	Last Action	Status	Position
AB 2356	**From Committee Do Pass And Re Refer To Com On Appr With Recommendation To Consent Calendar Ayes 16 Noes 0 April 9 Re Referred To Com On Appr 2024 04 10**	**In Assembly**	**Monitor**

Title
Medi-Cal: monthly maintenance amount: personal and incidental needs.

Introduction Date: 2024-02-12

Description
AB 2356, as introduced, Wallis. Medi-Cal: monthly maintenance amount: personal and incidental needs. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions. Qualified individuals under the Medi-Cal program include medically needy persons and medically needy family persons who meet the required eligibility criteria, including applicable income requirements.Existing law requires the department to establish income levels for maintenance need at the lowest levels that reasonably permit a medically needy person to meet their basic needs for food, clothing, and shelter, and for which federal financial participation will still be provided under applicable federal law. In calculating the income of a medically needy person in a medical institution or nursing facility, or a person receiving institutional or noninstitutional services from a Program of All-Inclusive Care for the Elderly organization, the required monthly maintenance amount includes an amount providing for personal and incidental needs in the amount of not less than $35 per month while a patient. Existing law authorizes the department to increase, by regulation, this amount as necessitated by increasing costs of personal and incidental needs.This bill would increase the monthly maintenance amount for personal and incidental needs from $35 to $50, and would require that the amount be increased annually, as specified. The bill would make these changes subject to receipt of necessary federal approvals.

Primary Sponsors
Greg Wallis

Bill Number	Last Action	Status	Position
AB 2411	**From Committee Do Pass And Re Refer To Com On Appr Ayes 15 Noes 0 April 9 Re Referred To Com On Appr 2024 04 10**	**In Assembly**	**Monitor**

Title
Local Youth Mental Health Boards.

Introduction Date: 2024-02-12

Description
AB 2411, as amended, Wendy Carrillo. Local Youth Mental Health Boards. Existing law, the Bronzan-McCorquodale Act, contains provisions governing the operation and financing of community mental health services for the mentally disordered in every county through locally administered and locally controlled community mental health programs. This bill would require each community mental health service to have a local youth mental health board (board), appointed as specified, consisting of members between 15 and 23 years of age, inclusive, at least 1/2 of whom are, to the extent possible, mental health consumers who are receiving, or have received, mental health services, or siblings or close family members of mental health consumers and 1/2 of whom are, to the extent possible, enrolled in schools in the county. The bill would require the board, among other duties, to review and evaluate the local public mental health system and advise the governing body and school district governing bodies on mental health services related to youth that are delivered by the local mental health agency or local behavioral health agency, school districts, or others, as applicable. The bill would require the governing body to include the board in the county planning process and provide a budget for the board sufficient to facilitate the purposes, duties, and responsibilities of the board. By increasing the duties of local governments, this bill would impose a state-mandated local program.Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, among other things, establishes the Mental Health Services Oversight and Accountability Commission. Existing law, the Behavioral Health Services Act (BHSA), approved by the voters as Proposition 1 at the March 5, 2024, statewide primary election, commencing January 1, 2025, revises and recasts the MHSA by, among other things, renaming the commission the Behavioral Health Services Oversight and Accountability Commission and changing the duties of the commission to include promoting transformational change in California’s behavioral health system through research, evaluation and tracking outcomes, and other strategies to assess and report progress. This bill would require the commission, on or before December 30, 2027, and once every 5 years thereafter, to assess the extent to which the local youth mental health boards have been established and to make recommendations on ways to strengthen the youth voice to support appropriate behavioral health services. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statut... (click bill link to see more).

Primary Sponsors
Wendy Carrillo, Dave Cortese

Bill Number	Last Action	Status	Position
AB 2428	**From Committee Do Pass And Re Refer To Com On Appr Ayes 16 Noes 0 April 9 Re Referred To Com On Appr 2024 04 10**	**In Assembly**	**Monitor**

Title
Medi-Cal: Community-Based Adult Services.

Introduction Date: 2024-02-13

Description
AB 2428, as introduced, Calderon. Medi-Cal: Community-Based Adult Services. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires the department to standardize applicable covered Medi-Cal benefits provided by Medi-Cal managed care plans under comprehensive risk contracts with the department on a statewide basis and across all models of Medi-Cal managed care, in accordance with the Terms and Conditions of the California Advancing and Innovating Medi-Cal (CalAIM) initiative.Existing law requires, commencing January 1, 2022, that Community-Based Adult Services (CBAS) continue to be available as a capitated benefit for a qualified Medi-Cal beneficiary under a comprehensive risk contract with an applicable Medi-Cal managed care plan. For contract periods during which that provision is implemented, existing law requires each applicable plan to reimburse a network provider furnishing CBAS to a Medi-Cal beneficiary enrolled in that plan, and requires each network provider of CBAS to accept the payment amount that the network provider of CBAS would be paid for the service in the Medi-Cal fee-for-service delivery system, as specified, unless the plan and network provider mutually agree to reimbursement in a different amount.This bill, for purposes of the mutual agreement between a Medi-Cal managed care plan and a network provider, would require that the reimbursement be in an amount equal to or greater than the amount paid for the service in the Medi-Cal fee-for-service delivery system. Under the bill, no later than January 1, 2025, for payments commencing on July 1, 2019, a Medi-Cal managed care plan that has not reimbursed a network provider furnishing CBAS according to those provisions would be required to reimburse the network provider the difference between the amount required and the amount that has been paid.Existing law requires that capitation rates paid by the department to an applicable Medi-Cal managed care plan be actuarially sound and account for the payment levels in the above-described provisions as applicable.This bill would prohibit the changes made by the bill to the above-described reimbursement from being construed as requiring the department to retroactively recalculate the capitation rates for purposes of any reimbursement of the difference between the amount required and the amount that has been paid.

Primary Sponsors
Lisa Calderon, Bill Dodd

Bill Number	Last Action	Status	Position
AB 2434	**Read Second Time And Amended 2024 04 18**	**In Assembly**	**Monitor**

Title
Health care coverage: multiple employer welfare arrangements.

Introduction Date: 2024-02-13

Description
AB 2434, as amended, Grayson. Health care coverage: multiple employer welfare arrangements. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance.Existing federal law, the federal Employee Retirement Income Security Act of 1974 (ERISA), authorizes multiple employer welfare arrangements (MEWAs) in which 2 or more employers join together to provide health care coverage for employees or to their beneficiaries. Existing law authorizes an association of employers to offer a large group health care service plan contract or large group health insurance policy, consistent with ERISA, if certain requirements are met. Until January 1, 2026, existing law also authorizes an association of employers to offer a large group health care service plan contract or large group health insurance policy to small group employer members of the association, consistent with ERISA, if certain requirements are met, including that the association is headquartered in this state, was established before March 23, 2010, and is the sponsor of a MEWA, and that the contract or policy includes coverage of employees of an association member in the biomedical industry.This bill would authorize an association of employers to offer a large group health care service plan contract or large group health insurance policy to small group employer members of the association, consistent with ERISA, if certain requirements are met, including that the association was established before January 1, 1966, and is the sponsor of a MEWA, and that the contract or policy includes coverage of employees of an association member in the engineering, surveying, or design industry. The bill would require an association and MEWA to annually file evidence of ongoing compliance with those requirements in a manner specified by the departments. This bill would require the departments, on or before June 30, 2028, to provide the health policy committees of the Legislature the most recent filings and would require the departments to recommend to the Legislature whether those MEWAs should remain operative based on that compliance. The bill, on or after June 1, 2025, would prohibit a plan or insurer from marketing, issuing, amending, renewing, or delivering large employer coverage to an association or MEWA that provides a benefit to a resident in this state unless the association and MEWA have registered and are in compliance with the requirements described above, or have filed applications for registration, as specified, that are pen... (click bill link to see more).

Primary Sponsors
Tim Grayson

Bill Number	Last Action	Status	Position
AB 2435	**Read Second Time Ordered To Third Reading 2024 04 11**	**In Assembly**	**Monitor**

Title
California Health Benefit Exchange.

Introduction Date: 2024-02-13

Description
AB 2435, as introduced, Maienschein. California Health Benefit Exchange. Existing federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. Existing state law creates the California Health Benefit Exchange, also known as Covered California, governed by an executive board, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Existing law specifies the powers of the executive board. Existing law authorizes the executive board to adopt necessary rules and regulations by emergency regulations until January 1, 2025, with the exception of regulations implementing prescribed provisions relating to criminal background history checks for persons with access to confidential, personal, or financial information. Existing law authorizes the Office of Administrative Law to approve more than 2 readoptions of emergency regulations until January 1, 2030. Existing law provides that these extensions apply to a regulation adopted before January 1, 2022.This bill would extend the authority of the executive board to adopt necessary rules and regulations by emergency regulations until January 1, 2030, and would extend the authority of the Office of Administrative Law to approve more than 2 readoptions of emergency regulations until January 1, 2035. The bill would provide that these prescribed time extensions apply to a regulation adopted before January 1, 2025.

Primary Sponsors
Brian Maienschein

Bill Number	Last Action	Status	Position
AB 2442	**Re Referred To Com On Appr 2024 04 11**	**In Assembly**	**Monitor**

Title
Healing arts: expedited licensure process: gender-affirming health care and gender-affirming mental health care.

Introduction Date: 2024-02-13

Description
AB 2442, as amended, Zbur. Healing arts: expedited licensure process: gender-affirming health care and gender-affirming mental health care. Existing law requires the Medical Board of California, the Osteopathic Medical Board of California, the Board of Registered Nursing, and the Physician Assistant Board to expedite the licensure process for an applicant who demonstrates that they intend to provide abortions within the scope of practice of their license, and specifies the manner in which the applicant is required to demonstrate their intent. This bill would also require those boards to expedite the licensure process for an applicant who demonstrates that they intend to provide gender-affirming health care and gender-affirming mental health care, as defined, within the scope of practice of their license, and would specify the manner in which the applicant would be required to demonstrate their intent. The bill would repeal its provisions on January 1, 2029.

Primary Sponsors
Rick Zbur

Bill Number	Last Action	Status	Position
AB 2445	**In Committee Set First Hearing Hearing Canceled At The Request Of Author 2024 04 12**	**In Assembly**	**Monitor**

Title
Prescriptions: personal use pharmaceutical disposal system.

Introduction Date: 2024-02-13

Description
AB 2445, as introduced, Wallis. Prescriptions: personal use pharmaceutical disposal system. Existing law, the Pharmacy Law, provides for the licensing and regulation of pharmacists by the California State Board of Pharmacy in the Department of Consumer Affairs. Existing law prohibits a pharmacist from dispensing a prescription unless the prescription is in a container that meets the requirements of state and federal law and is correctly labeled with certain information. Existing law requires a pharmacy or practitioner that dispenses a prescription drug containing an opioid to a patient for outpatient use to prominently display a specified notice on the label or container of the prescription drug containing an opioid. Existing law, when no other penalty is provided, makes a knowing violation of the Pharmacy Law a misdemeanor and, in all other instances, makes a violation punishable as an infraction.This bill would prohibit a dispenser from dispensing a prescription drug containing an opioid to a patient for outpatient use unless the dispenser also provides a personal use pharmaceutical disposal system, as defined, to the patient. The bill would provide that its provisions become operative only upon the Legislature enacting a framework for the governing of a personal use pharmaceutical disposal system program. By expanding the scope of a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Greg Wallis

Bill Number	Last Action	Status	Position
AB 2446	**In Committee Set First Hearing Referred To Suspense File 2024 04 17**	**In Assembly**	**Monitor**

Title
Medi-Cal: diapers.

Introduction Date: 2024-02-13

Description
AB 2446, as amended, Ortega. Medi-Cal: diapers. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed by, and funded pursuant to, federal Medicaid program provisions. Existing law establishes a schedule of covered benefits under the Medi-Cal program, including incontinence supplies.This bill would add to the schedule of Medi-Cal benefits diapers for infants or toddlers with certain conditions, such as a urinary tract infection and colic, among others. The bill would establish diapers as a covered benefit for a child greater than 3 years of age who has been diagnosed with a condition that contributes to incontinence and would establish diapers as a covered benefit for individuals under 21 years of age, if necessary to correct or ameliorate a condition pursuant to specified standards. The bill would require the department to seek any necessary federal approval to implement this section.

Primary Sponsors
Liz Ortega

Bill Number	Last Action	Status	Position
AB 2449	**Ordered To Second Reading 2024 04 18**	**In Assembly**	**Monitor**

Title
Health care coverage: qualified autism service providers.

Introduction Date: 2024-02-13

Description
AB 2449, as introduced, Ta. Health care coverage: qualified autism service providers. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or health insurance policy to provide coverage for behavioral health treatment provided for pervasive developmental disorder or autism and requires a plan or policy to maintain an adequate network of qualified autism service providers. Under existing law, a “qualified autism service provider” means, among other things, a person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies.This bill would clarify that the Qualified Applied Behavior Analysis Credentialing Board is also a national entity that may certify a qualified autism service provider, and would authorize the certification to be accredited by the American National Standards Institute.

Primary Sponsors
Tri Ta

Bill Number	Last Action	Status	Position
AB 2466	**Read Second Time And Amended 2024 04 18**	**In Assembly**	**Monitor**

Title
Medi-Cal managed care: network adequacy standards.

Introduction Date: 2024-02-13

Description
AB 2466, as amended, Wendy Carrillo. Medi-Cal managed care: network adequacy standards. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law authorizes the Director of Health Care Services to terminate a contract or impose sanctions if the director finds that a Medi-Cal managed care plan fails to comply with contract requirements, state or federal law or regulations, or the state plan or approved waivers, or for other good cause.Existing law establishes, until January 1, 2026, certain time and distance and appointment time standards for specified Medi-Cal managed care covered services, consistent with federal regulations relating to network adequacy standards, to ensure that those services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner, as specified.Under this bill, a Medi-Cal managed care plan would be deemed to be not in compliance with the appointment time standards if either (1) fewer than 85% of the network providers had an appointment available within the standards or (2) the department receives information establishing that the plan was unable to deliver timely, available, or accessible health care services to enrollees, as specified. Under the bill, failure to comply with the appointment time standard may result in contract termination or the issuance of sanctions as described above.Existing law requires a Medi-Cal managed care plan to submit a request for alternative access standards if the plan cannot meet the time or distance standards. Under existing law, a plan is not required to submit a previously approved request on an annual basis, unless the plan requires modifications to its request. Existing law requires the plan to submit this previously approved request at least every 3 years for review and approval when the plan is required to demonstrate compliance with time or distance standards.This bill would instead require a plan that has a previously approved alternative access standard to submit a renewal request on an annual basis, explaining which efforts the plan has made in the previous 12 months to mitigate or eliminate circumstances that justify the use of an alternative access standard, as specified. The bill would require the department to consider the reasonableness and effectiveness of the mitigating efforts as part of the renewal decision.Existing law requires a Medi-Cal managed care plan to demonstrate, annually and upon request by the department, how the plan arranged for the delivery of Medi-Cal cove... (click bill link to see more).

Primary Sponsors
Wendy Carrillo

Organizational Notes

Last edited by Joanne Campbell at Apr 22, 2024, 5:14 PM
Local Health Plans of California, California Association of Health Plans - Oppose

Bill Number	Last Action	Status	Position
AB 2467	**Re Referred To Com On Health 2024 03 06**	**In Assembly**	**Monitor**

Title
Health care coverage for menopause.

Introduction Date: 2024-02-13

Description
AB 2467, as amended, Bauer-Kahan. Health care coverage for menopause. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law sets forth specified coverage requirements for health care service plan contracts and health insurance policies.This bill would require a health care service plan contract or health insurance policy, except for a specialized contract or policy, that is issued, amended, or renewed on or after January 1, 2025, to include coverage for treatment of perimenopause and menopause. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Rebecca Bauer-Kahan

Organizational Notes

Last edited by Joanne Campbell at Mar 18, 2024, 5:16 PM
California Association of Health Plans - Oppose

Bill Number	Last Action	Status	Position
AB 2478	**From Committee Do Pass And Re Refer To Com On Appr With Recommendation To Consent Calendar Ayes 8 Noes 0 April 16 Re Referred To Com On Appr 2024 04 17**	**In Assembly**	**Monitor**

Title
Incarcerated persons: health records.

Introduction Date: 2024-02-13

Description
AB 2478, as introduced, Ramos. Incarcerated persons: health records. Existing law, the Confidentiality of Medical Information Act, prohibits a health care provider, a contractor, or a health care service plan from disclosing medical information, as defined, regarding a patient of the provider or an enrollee or subscriber of the health care service plan without first obtaining an authorization, except as specified. Existing law authorizes, among other things, mental health records to be disclosed by a county correctional facility, county medical facility, state correctional facility, or state hospital, as specified.Existing law requires, when jurisdiction of an inmate is transferred from or between the Department of Corrections and Rehabilitation, the State Department of State Hospitals, and county agencies caring for inmates, those agencies to disclose, by electronic transmission when possible, mental health records, as defined, regarding each transferred inmate who received mental health services while in custody of the transferring facility, as specified. Existing law requires mental health records to be disclosed to ensure sufficient mental health history is available for the purpose of satisfying specified requirements relating to parole and to ensure the continuity of mental health treatment of an inmate being transferred between those facilities. Existing law requires all transmissions made pursuant to those provisions to comply with specified provisions of state and federal law, including the Confidentiality of Medical Information Act.This bill would require, when jurisdiction of an inmate is transferred from or between a county correctional facility, a county medical facility, the State Department of State Hospitals, and a county agency caring for inmates, those agencies to disclose, by electronic transmission if possible, mental health records, as defined, regarding each transferred inmate who received mental health services while in custody of the transferring facility, as specified. The bill would require mental health records to be disclosed to ensure sufficient mental health history is available to ensure the continuity of mental health treatment of an inmate being transferred between those facilities.This bill would require all county behavioral health departments and contractors to establish and maintain a secure and standardized system for sharing inmate mental health records, as specified. The bill would require each county to prepare a report containing information about the effectiveness of the data sharing, the continuity of care measures, and an evaluation on the impact of inmate well-being, safety, and recidivism rates. The bill would require the report to be submitted to the Legislature on or befor... (click bill link to see more).

Primary Sponsors
James Ramos

Bill Number	Last Action	Status	Position
AB 2494	**From Committee Do Pass And Re Refer To Com On Appr Ayes 7 Noes 0 April 3 Re Referred To Com On Appr 2024 04 04**	**In Assembly**	**Monitor**

Title
Employer notification: continuation coverage.

Introduction Date: 2024-02-13

Description
AB 2494, as amended, Calderon. Employer notification: continuation coverage. Existing federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, and known as COBRA, requires that certain employers provide former employees with continuation of benefits. COBRA requires that an employee be notified of the continuation of coverage for which the employee may be eligible upon certain qualifying events, including termination. Existing law requires all employers, whether public or private, to provide employees, upon termination, notification of all continuation, disability extension, and conversion coverage options under any employer-sponsored coverage for which the employee may remain eligible.This bill would require all employers, whether public or private, to provide employees with a written, hardcopy notice of coverage under COBRA, to be provided in-person and via email, following termination or reduction in hours, as specified.

Primary Sponsors
Lisa Calderon

Bill Number	Last Action	Status	Position
AB 2526	**Re Referred To Com On Appr 2024 04 18**	**In Assembly**	**Monitor**

Title
Nurse anesthetists: general anesthesia or deep sedation.

Introduction Date: 2024-02-13

Description
AB 2526, as amended, Gipson. Nurse anesthetists: general anesthesia or deep sedation. Existing law, the Dental Practice Act, provides for the licensure and regulation of dentists by the Dental Board of California within the Department of Consumer Affairs. Existing law authorizes a licensed physician and surgeon to administer deep sedation or general anesthesia in the office of a licensed dentist for dental patients if specified conditions are met, including that they hold a valid general anesthesia permit issued by the board as prescribed.Existing law, the Nurse Anesthetists Act, provides for the certification and regulation of nurse anesthetists by the Board of Registered Nursing within the Department of Consumer Affairs. Existing law requires the utilization of a nurse anesthetist to provide anesthesia services in an acute care facility to be approved by the acute care facility administration and the appropriate committee, and at the discretion of the physician, dentist, or podiatrist.This bill would authorize a certified registered nurse anesthetist to administer general anesthesia or deep sedation in the office of a licensed dentist for dental patients if specified conditions are met, including that they hold a valid general anesthesia permit issued by the board as prescribed. To obtain that permit, the bill would require a nurse anesthetist to apply to the board on an application form prescribed by the board and to submit, among other things, payment of an application fee. Prior to issuance or renewal of a permit pursuant to these provisions, the bill authorizes the board to require an onsite inspection and evaluation of the facility, equipment, and personnel, as specified. If a nurse anesthetist fails an onsite inspection and evaluation, the bill would require their permit be automatically suspended for 30 days, as specified. The bill would authorize a nurse anesthetist who additionally meets certain requirements to apply to the board for a pediatric endorsement to provide general anesthesia or deep sedation to a child under 7 years of age.The bill would require the administration of general anesthesia or deep sedation in a dental office by a nurse anesthetist at the request of a dentist to be in accordance with prescribed requirements, including, among other things, registering with the federal Drug Enforcement Administration and ensuring that the facilities, equipment, personnel, and procedures utilized meet the Dental Board of California’s onsite inspection requirements, as specified. The bill would provide that failure of an onsite inspection constitutes unprofessional conduct and is grounds for disciplinary action by the Board of Registered Nursing.By expanding the scope of existing crimes under the Nu... (click bill link to see more).

Primary Sponsors
Mike Gipson

Bill Number	Last Action	Status	Position
AB 2556	**Re Referred To Com On Appr 2024 04 08**	**In Assembly**	**Monitor**

Title
Behavioral health and wellness screenings: notice.

Introduction Date: 2024-02-14

Description
AB 2556, as amended, Jackson. Behavioral health and wellness screenings: notice. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. This bill would require a health care service plan or insurer to provide to each legal guardian of a patient, enrollee, or insured, 10 to 18 years of age, a written or electronic notice regarding the benefits of a behavioral health and wellness screening, as defined. The bill would require a health care service plan or insurer to provide the notice on an annual basis. Because a violation of the bill’s requirements relative to a health care service plan would be crimes, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Corey Jackson

Organizational Notes

Last edited by Joanne Campbell at Mar 18, 2024, 5:29 PM
California Association of Health Plans - Oppose

Bill Number	Last Action	Status	Position
AB 2563	**In Committee Hearing Postponed By Committee 2024 03 25**	**In Assembly**	**Monitor**

Title
Newborn screening program.

Introduction Date: 2024-02-14

Description
AB 2563, as introduced, Essayli. Newborn screening program. Existing law requires the State Department of Public Health to establish a program for the development, provision, and evaluation of genetic disease testing. Existing law establishes the continuously appropriated Genetic Disease Testing Fund (GDTF), consisting of fees paid for newborn screening tests, and states the intent of the Legislature that all costs of the genetic disease testing program be fully supported by fees paid for newborn screening tests, which are deposited in the GDTF. Existing law also authorizes moneys in the GDTF to be used for the expansion of the Genetic Disease Branch Screening Information System to include cystic fibrosis, biotinidase, severe combined immunodeficiency (SCID), and adrenoleukodystrophy (ALD) and exempts the expansion of contracts for this purpose from certain provisions of the Public Contract Code, the Government Code, and the State Administrative Manual, as specified.This bill would require the department to expand statewide screening of newborns to include screening for Duchenne Muscular Dystrophy. By expanding the purposes for which moneys from the fund may be expended, this bill would make an appropriation.

Primary Sponsors
Bill Essayli

Bill Number	Last Action	Status	Position
AB 2578	**From Committee Do Pass And Re Refer To Com On Appr Ayes 18 Noes 0 April 16 Re Referred To Com On Appr 2024 04 16**	**In Assembly**	**Monitor**

Title
Nursing: students in out-of-state nursing programs.

Description
AB 2578, as amended, Flora. Nursing: students in out-of-state nursing programs. Existing law, the Nursing Practice Act, establishes the Board of Registered Nursing to license and regulate the practice of nursing. The act prohibits a person from engaging in the practice of nursing without an active license but authorizes a student to render nursing services incidental to the student's course of study, as specified.This bill would additionally authorize a student to render nursing services if the student is a resident of the state and enrolled in a prelicensure distance education nursing program based at an out-of-state private postsecondary educational institution, as defined, for the purpose of gaining clinical experience in a clinical setting that meets certain criteria, including that the program is accredited by a programmatic accreditation entity recognized by the United States Department of Education and that the program maintains minimum faculty to student ratios required of board-approved programs for in-person clinical experiences. The bill would require the student to be supervised in person by a registered nurse licensed by the board while rendering nursing services. The bill would prohibit a clinical agency or facility from offering clinical experience placements to an out-of-state private postsecondary educational institution if the placements are needed to fulfill the clinical experience requirements of in-state students enrolled in a board-approved nursing program.

Primary Sponsors
Heath Flora

Introduction Date: 2024-02-14

Bill Number	Last Action	Status	Position
AB 2636	**From Committee Do Pass And Re Refer To Com On Appr Ayes 5 Noes 0 April 16 Re Referred To Com On Appr 2024 04 17**	**In Assembly**	**Monitor**

Title
Mello-Granlund Older Californians Act.

Introduction Date: 2024-02-14

Description
AB 2636, as amended, Bains. Mello-Granlund Older Californians Act. Existing law requires the California Department of Aging to administer the Mello-Granlund Older Californians Act (act), which establishes various programs that serve older individuals, defined as persons 60 years of age or older, except as specified. The act requires the department to designate various private nonprofit or public agencies as area agencies on aging to work within a planning and service area and provide a broad array of social and nutritional services. Under the act, the department's mission is to provide leadership to those agencies in developing systems of home- and community-based services that maintain individuals in their own homes or least restrictive homelike environments.This bill would recast and revise various provisions of the act, including updating findings and declarations relating to statistics and issues of concern to the older adult population, and replacing references throughout the act from "senior," and similar terminology to "older adult." The bill would increase flexibility for area agencies on aging to develop and manage community-based program based on local need, as specified. The bill would repeal obsolete provisions, such as the Senior Center Bond Act of 1984.Existing law requires the California Department of Aging to maintain a clearinghouse of information related to the interests and needs of older individuals and provide referral services, if appropriate. Existing law establishes the Senior Housing Information and Support Center within the deparment to serve as a clearinghouse for information for seniors and their families regarding available innovative resources and senior services, subject to appropriation for these purposes.This bill, instead, would require the department to partner with other state departments, the area agencies on aging, and other stakeholders in developing and maintaining an electronic clearinghouse of information of available statewide services and supports for older adults and people with disabilities and providing referral services, if appropriate, and would repeal the provisions establishing the Senior Housing Information and Support Center.

Primary Sponsors
Jasmeet Bains

Bill Number	Last Action	Status	Position
AB 2668	**Referred To Com On Health 2024 03 04**	**In Assembly**	**Monitor**

Title
Coverage for cranial prostheses.

Introduction Date: 2024-02-14

Description
AB 2668, as introduced, Berman. Coverage for cranial prostheses. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plans and health insurers to provide coverage for prosthetic devices in connection with specified health conditions and procedures.This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to cover cranial prostheses, as defined, for individuals experiencing permanent or temporary medical hair loss. The bill would require a licensed provider to prescribe the cranial prosthesis for an individual’s course of treatment for a diagnosed health condition, chronic illness, or injury, as specified. The bill would limit coverage to once every 12 months and $750 for each instance of coverage. The bill would not apply these provisions to a specialized health care service plan or specialized health insurance policy. Because a violation of these requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.Existing law also establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Commencing January 1, 2025, this bill would require coverage for cranial prostheses for individuals experiencing permanent or temporary medical hair loss. or treatment for those conditions as a Medi-Cal benefit, subject to the same requirements with respect to provider prescription, coverage frequency, and amount. The bill would not apply these provisions to a specialized health care service plan.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Marc Berman

Organizational Notes

Last edited by Joanne Campbell at Apr 19, 2024, 8:08 PM
California Association of Health Plans - Opposed

Bill Number	Last Action	Status	Position
AB 2688	**Referred To Com On B P 2024 03 04**	**In Assembly**	**Monitor**

Title
Medical Board of California: appointments: removal.

Introduction Date: 2024-02-14

Description
AB 2688, as introduced, Berman. Medical Board of California: appointments: removal. Existing law, the Medical Practice Act, establishes the Medical Board of California within the Department of Consumer Affairs and sets forth its powers and duties relating to the licensure and regulation of the practice of medicine by physicians and surgeons. Under the act, the board consists of 15 members, including 13 members appointed by the Governor, one appointed by the Senate Committee on Rules, and one appointed by the Speaker of the Assembly, as prescribed. The act authorizes the appointing power to remove any member of the board for neglect of duty, incompetency, or unprofessional conduct.Under other existing law with respect to the department and its constituent boards, an appointing authority has power to remove from office at any time a member of any board appointed by the appointing authority for continued neglect of duties required by law, or for incompetence, or unprofessional or dishonorable conduct. Existing law prohibits this provision from being construed as a limitation or restriction on the power of the appointing authority conferred on the appointing authority by any other provision of law to remove any member of any board.This bill would revise the removal authority of an appointing power of the Medical Board of California granted by the Medical Practice Act to instead authorize the removal of a member of the board appointed by that authority for continued neglect of duties required by law, or for incompetence, or unprofessional or dishonorable conduct.

Primary Sponsors
Marc Berman

Bill Number	Last Action	Status	Position
AB 2701	**From Committee Do Pass And Re Refer To Com On Appr Ayes 16 Noes 0 April 9 Re Referred To Com On Appr 2024 04 10**	**In Assembly**	**Monitor**

Title
Medi-Cal: dental cleanings and examinations.

Description
AB 2701, as introduced, Villapudua. Medi-Cal: dental cleanings and examinations. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including certain dental services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Under existing law, one dental prophylaxis cleaning per year and one initial dental examination by a dentist are covered Medi-Cal benefits for beneficiaries 21 years of age or older. Under existing law, 2 dental prophylaxis cleanings per year and 2 periodic dental examinations per year are covered Medi-Cal benefits for beneficiaries under 21 years of age. Existing law conditions implementation of those provisions on receipt of any necessary federal approvals and the availability of federal financial participation and funding in the annual Budget Act.This bill would restructure those provisions so that 2 cleanings and 2 examinations per year, as specified, would be covered Medi-Cal benefits for all beneficiaries, regardless of age.

Primary Sponsors
Carlos Villapudua

Introduction Date: 2024-02-14

Bill Number	Last Action	Status	Position
AB 2703	**In Committee Set First Hearing Referred To Suspense File 2024 04 17**	**In Assembly**	**Monitor**

Title
Federally qualified health centers and rural health clinics: psychological associates.

Introduction Date: 2024-02-14

Description
AB 2703, as introduced, Aguiar-Curry. Federally qualified health centers and rural health clinics: psychological associates. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including federally qualified health center (FQHC) services and rural health clinic (RHC) services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Existing law requires the department to seek any necessary federal approvals and issue appropriate guidance to allow an FQHC or RHC to bill, under a supervising licensed behavioral health practitioner, for an encounter between an FQHC or RHC patient and an associate clinical social worker or associate marriage and family therapist when certain conditions are met, including, among others, that the FQHC or RHC is otherwise authorized to bill for services provided by the supervising practitioner as a separate visit.This bill would add a psychological associate to those provisions, requiring the department to seek any necessary federal approvals and issue appropriate guidance to allow an FQHC or RHC to bill for an encounter between a patient and a psychological associate under those conditions. The bill would make conforming changes with regard to supervision by a licensed psychologist as required by the Board of Psychology.

Primary Sponsors
Cecilia Aguiar-Curry

Bill Number	Last Action	Status	Position
AB 2715	**In Committee Set First Hearing Hearing Canceled At The Request Of Author 2024 04 09**	**In Assembly**	**Monitor**

Title
Ralph M. Brown Act: closed sessions.

Introduction Date: 2024-02-14

Description
AB 2715, as introduced, Boerner. Ralph M. Brown Act: closed sessions. Existing law, the Ralph M. Brown Act, generally requires that all meetings of a legislative body of a local agency be open and public and that all persons be permitted to attend and participate. Existing law authorizes a legislative body to hold a closed session on, among other things, matters posing a threat to the security of essential public services, as specified.This bill would additionally authorize a closed session to consider or evaluate matters related to cybersecurity, as specified, provided that any action taken on those matters is done in open session.Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.This bill would make legislative findings to that effect.The California Constitution requires local agencies, for the purpose of ensuring public access to the meetings of public bodies and the writings of public officials and agencies, to comply with a statutory enactment that amends or enacts laws relating to public records or open meetings and contains findings demonstrating that the enactment furthers the constitutional requirements relating to this purpose.This bill would make legislative findings to that effect.

Primary Sponsors
Tasha Boerner

Bill Number	Last Action	Status	Position
AB 2726	**In Committee Hearing Postponed By Committee 2024 04 11**	**In Assembly**	**Monitor**

Title
Specialty care network: telehealth and other virtual services.

Introduction Date: 2024-02-14

Description
AB 2726, as amended, Flora. Specialty care network: telehealth and other virtual services. Existing law establishes, under the Medi-Cal program, certain time and distance standards for specified Medi-Cal managed care covered services, consistent with federal regulations relating to network adequacy standards, to ensure that those services, including certain specialty care, are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner. Existing law sets forth other timely access requirements for health care service plans and health insurers, including with regard to referrals to a specialist.Existing law establishes various health professions development programs, within the Department of Health Care Access and Information, for the promotion of education, training, and recruitment of health professionals to address workforce shortage and distribution needs. Existing law sets forth various provisions for the authorized use of telehealth in the delivery of health care services.This bill would, subject to an appropriation, require the California Health and Human Services Agency, in collaboration with the Department of Health Care Access and Information and the State Department of Health Care Services, to establish a demonstration project for a telehealth and other virtual services specialty care network that is designed to serve patients of safety-net providers consisting of qualifying providers, defined to include, among others, rural health clinics and community health centers. The bill would authorize the focus of the project to include increasing access to behavioral and maternal health services and additional specialties prioritized by the agency. The bill would state the intent of the Legislature that implementation of the demonstration project would facilitate compliance with any applicable network adequacy standards.The bill would require the demonstration project to include a grant program to award funding to grantees, as defined, that meet specified conditions relating to specialist networks and health information technology. Under the bill, the purpose of the grant program would be to achieve certain objectives, including, among others, reducing structural barriers to access experienced by patients, improving cost-effectiveness, and optimizing utilization. The bill would require a grantee to evaluate its performance on the objectives and to submit a report of its findings to the agency.

Primary Sponsors
Heath Flora

Bill Number	Last Action	Status	Position
AB 2749	**Re Referred To Com On Appr 2024 04 15**	**In Assembly**	**Monitor**

Title
California Health Benefit Exchange: financial assistance.

Introduction Date: 2024-02-15

Description
AB 2749, as amended, Wood. California Health Benefit Exchange: financial assistance. Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. PPACA authorizes a state to apply to the United States Department of Health and Human Services for a state innovation waiver of any or all PPACA requirements, if certain criteria are met, including that the state has enacted a law that provides for state actions under a waiver. Existing state law creates the California Health Benefit Exchange (Exchange), also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Existing law requires the Exchange, upon appropriation by the Legislature, to administer a program of financial assistance beginning July 1, 2023, to help Californians obtain and maintain health benefits through the Exchange if they lose employer-provided health care coverage as a result of a labor dispute, as specified. Under existing law, if specified eligibility requirements are met, an individual who has lost minimum essential coverage from an employer or joint labor management trust fund as a result of a strike, lockout, or other labor dispute receives the same premium assistance and cost-sharing reductions as an individual with a household income of 138.1% of the federal poverty level, and is also not required to pay a deductible for any covered benefit if the standard benefit design for a household income of 138.1% of the federal poverty level has zero deductibles. Existing law excludes from gross income any subsidy amount received pursuant to that program of financial assistance.This bill would revise various provisions of the financial assistance program, including deleting the exclusion of financial assistance received under the program from gross income, and specifying the criteria required for an individual to be qualified to receive coverage under the program. The bill would specify that an individual would no longer be eligible for financial assistance under the program when the Exchange verifies that employer-provided minimum essential coverage from the employer has been reinstated for the individual and dependents, as specified. The bill would require an employer or labor organization to notify the Exchange before employer-provided coverage is affected by a strike, lockout, or labor dispute, and would authorize the Exchange to contact the employer, labor organization, or other appropriate representative to determine information necessa... (click bill link to see more).

Primary Sponsors
Jim Wood

Bill Number	Last Action	Status	Position
AB 2753	**In Committee Set First Hearing Referred To Suspense File 2024 04 17**	**In Assembly**	**Monitor**

Title
Rehabilitative and habilitative services: durable medical equipment and services.

Introduction Date: 2024-02-15

Description
AB 2753, as introduced, Ortega. Rehabilitative and habilitative services: durable medical equipment and services. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service plans and makes a willful violation of the act a crime. Other existing law requires the Department of Insurance to regulate health insurers. Existing law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, to include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act. Under existing law, essential health benefits include, among other things, rehabilitative and habilitative services. Existing law requires habilitative services and devices to be covered under the same terms and conditions applied to rehabilitative services and devices under the plan contract or policy, and defines habilitative services to mean health care services and devices that help a person keep, learn, or improve skills and functioning for daily living.This bill would specify that coverage of rehabilitative and habilitative services and devices under a health care service plan or health insurance policy includes durable medical equipment, services, and repairs, if the equipment, services, or repairs are prescribed or ordered by a physician, surgeon, or other health professional acting within the scope of their license. The bill would define “durable medical equipment” to mean devices, including replacement devices, that are designed for repeated use, and that are used for the treatment or monitoring of a medical condition or injury in order to help a person to partially or fully acquire, improve, keep, or learn, or minimize the loss of, skills and functioning of daily living. The bill would prohibit coverage of durable medical equipment and services from being subject to financial or treatment limitations, as specified.The bill would make related findings and declarations, including that coverage of durable medical equipment is necessary to comply with federal requirements for purposes of being considered essential health benefits not subject to defrayal payments. Because a violation of the bill’s provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Liz Ortega

Organizational Notes

Last edited by Joanne Campbell at Mar 29, 2024, 2:16 PM
California Association of Health Plans - Oppose

Bill Number	Last Action	Status	Position
AB 2756	**In Committee Hearing Postponed By Committee 2024 04 11**	**In Assembly**	**Monitor**

Title
Pelvic Floor and Core Conditioning Pilot Program.

Introduction Date: 2024-02-15

Description
AB 2756, as amended, Boerner. Pelvic Floor and Core Conditioning Pilot Program. Existing law finds and declares that postpartum care, among other things, is an essential service necessary to ensure maternal health. Existing law establishes the State Department of Health Care Services, and requires the department to, among other things, maintain programs relating to maternal health.This bill would, commencing January 1, 2026, until January 1, 2029, authorize the County of San Diego to establish a pilot program for pelvic floor and core conditioning group classes that would be provided to people twice a week between their 6 to 12 week postpartum window to help people rebuild their pelvic floor after pregnancy. The bill would require the program to record specified information to directly assess pelvic floor changes, and would require the program to annually report all the information and outcomes to the department. The bill would require the department to provide a final report on the program to the Legislature by June 1, 2029.This bill would make legislative findings and declarations as to the necessity of a special statute for the County of San Diego.

Primary Sponsors
Tasha Boerner

Bill Number	Last Action	Status	Position
AB 2767	**In Committee Set First Hearing Hearing Canceled At The Request Of Author 2024 03 18**	**In Assembly**	**Monitor**

Title
Financial Solvency Standards Board: membership.

Introduction Date: 2024-02-15

Description
AB 2767, as introduced, Santiago. Financial Solvency Standards Board: membership. Existing law establishes the Department of Managed Health Care, which, among other duties, ensures the financial stability of managed care plans. Existing law establishes within the department the Financial Solvency Standards Board for the purpose of, among other things, developing and recommending to the director of the department financial solvency requirements and standards relating to health care service plan operations. Existing law requires the board to be composed of the director, or their designee, and 7 members appointed by the director, and authorizes the director to appoint individuals with training and experience in specified subject areas or fields.This bill would instead require the director to appoint 10 members to the board, and would additionally authorize the director to appoint health care consumer advocates, representatives of organized labor unions representing health care workers, and individuals with training and experience in large group health insurance purchasing.

Primary Sponsors
Miguel Santiago

Bill Number	Last Action	Status	Position
AB 2775	**From Committee Do Pass And Re Refer To Com On Appr Ayes 16 Noes 0 April 16 Re Referred To Com On Appr 2024 04 17**	**In Assembly**	**Monitor**

Title
Emergency medical services.

Introduction Date: 2024-02-15

Description
AB 2775, as amended, Gipson. Emergency medical services. Existing law, the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, governs local emergency medical services (EMS) systems. The act establishes the Emergency Medical Services Authority (authority), which is responsible for the coordination and integration of all emergency medical services. Existing law requires the authority to develop planning and implementation guidelines for EMS systems that address specified components, including the assessment of hospital and critical care centers and data collection and evaluation.This bill would authorize the authority to develop planning and implementation guidelines for the use of telehealth, within existing authority, in EMS systems. The bill would also authorize the authority to develop guidelines for the collection of data regarding the use of telehealth in EMS systems, as specified.Existing law establishes within the act, until January 1, 2031, the Community Paramedicine or Triage to Alternate Destination Act of 2020. Existing law states that it is the intent of the Legislature, among other things, that local EMS agencies be authorized to develop a community paramedicine or triage to alternate destination program to improve patient care and community health. Existing law states that it is the intent of the Legislature to monitor and evaluate implementation of community paramedicine and triage to alternate destination programs by local EMS agencies in California and determine whether these programs should be modified or extended before the program ends.This bill would make a technical conforming change to these provisions.

Primary Sponsors
Mike Gipson

Bill Number	Last Action	Status	Position
AB 2806	**From Printer May Be Heard In Committee March 17 2024 02 16**	**In Assembly**	**Monitor**

Title
Mental health.

Introduction Date: 2024-02-15

Description
AB 2806, as introduced, Santiago. Mental health. Existing law, the Bronzan-McCorquodale Act, governs the organization and financing of community mental health services for persons with mental health disorders in every county through locally administered and locally controlled community mental health programs.This bill would make technical, nonsubstantive changes to that provision.

Primary Sponsors
Miguel Santiago

Bill Number	Last Action	Status	Position
AB 2843	**Referred To Com On Health 2024 03 04**	**In Assembly**	**Monitor**

Title
Health care coverage: rape and sexual assault.

Introduction Date: 2024-02-15

Description
AB 2843, as introduced, Petrie-Norris. Health care coverage: rape and sexual assault. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance.Existing law requires a victim of sexual assault who seeks a medical evidentiary examination to be provided with one, as specified. Existing law prohibits costs incurred by a qualified health care professional, hospital, clinic, sexual assault forensic examination team, or other emergency medical facility for the medical evidentiary examination portion of the examination of the victim of a sexual assault, as described in a specified protocol, when the examination is performed as specified, from being charged directly or indirectly to the victim of the assault. This bill would require a health care service plan or health insurance policy that is issued, amended, renewed, or delivered on or after January 1, 2025, to provide coverage without cost sharing for emergency room medical care and follow-up health care treatment for an enrollee or insured who is treated following a rape or sexual assault. The bill would prohibit a health care service plan or health insurer from requiring, as a condition of providing coverage, (1) an enrollee or insured to file a police report, (2) charges to be brought against an assailant, (3) or an assailant to be convicted of rape or sexual assault. Because a violation of the bill by a health care service plan would be a crime, the bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Cottie Petrie-Norris

Bill Number	Last Action	Status	Position
AB 2859	**Read Second Time And Amended 2024 04 18**	**In Assembly**	**Monitor**

Title
Emergency medical technicians: peer support.

Introduction Date: 2024-02-15

Description
AB 2859, as amended, Jim Patterson. Emergency medical technicians: peer support. Existing law establishes a statewide system for emergency medical services (EMS) and establishes the Emergency Medical Services Authority, which is responsible for establishing training, scope of practice, and continuing education for emergency medical technicians and other prehospital personnel.Existing law authorizes a public fire agency or law enforcement agency to establish a peer support and crisis referral program, to provide a network of peer representatives who are available to come to the aid of their fellow employees on a broad range of emotional or professional issues. This bill would authorize an EMS provider to establish a peer support and crisis referral program to provide a network of peer representatives available to aid fellow employees on emotional or professional issues. The bill would provide that EMS personnel, whether or not a party to an action, have a right to refuse to disclose, and to prevent another from disclosing, a confidential communication between the EMS personnel and a peer support team member, crisis hotline, or crisis referral service, except under limited circumstances, including, among others, if disclosure is reasonably believed to be necessary to prevent death, substantial bodily harm, or commission of a crime, or in a criminal proceeding. The bill would also provide that, except for an action for medical malpractice, a peer support team member and the EMS provider that employs them are not liable for damages, as specified, relating to an act, error, or omission in performing peer support services, unless the act, error, or omission constitutes gross negligence or intentional misconduct. To be eligible for these confidentiality protections, the bill would require a peer support team member to complete a training course or courses on peer support approved by the local EMS agency. By imposing a higher level of service on a local agency, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Primary Sponsors
Jim Patterson

Bill Number	Last Action	Status	Position
AB 2860	**Read Second Time Ordered To Consent Calendar 2024 04 18**	**In Assembly**	**Monitor**

Title
Licensed Physicians and Dentists from Mexico programs.

Introduction Date: 2024-02-15

Description
AB 2860, as amended, Garcia. Licensed Physicians and Dentists from Mexico programs. Existing law, the Licensed Physicians and Dentists from Mexico Pilot Program, allows up to 30 licensed physicians and up to 30 licensed dentists from Mexico to practice medicine or dentistry in California for a period not to exceed 3 years, in accordance with certain requirements. Existing law requires the Medical Board of California and the Dental Board of California to provide oversight pursuant to these provisions. Existing law requires appropriate funding to be secured from nonprofit philanthropic entities before implementation of the pilot program may proceed.Existing law requires physicians participating in the Licensed Physicians and Dentists from Mexico Pilot Program to be enrolled in English as a second language classes, to have satisfactorily completed a 6-month orientation program, and to have satisfactorily completed a 6-month externship at the applicant’s place of employment, among various other requirements.This bill would repeal the provisions regarding the Licensed Physicians and Dentists from Mexico Pilot Program, and would instead establish two bifurcated programs, the Licensed Physicians from Mexico Program and the Licensed Dentists from Mexico Pilot Program. Within these 2 programs, the bill would generally revise and recast certain requirements pertaining to the Licensed Physicians and Dentists from Mexico Pilot Program, including deleting the above-described requirement that Mexican physicians participating in the program enroll in adult English as a second language classes. The bill would instead require those physicians to have satisfactorily completed the Test of English as a Foreign Language or the Occupational English Test, as specified. The bill would remove the requirement that the orientation program be 6 months, and would further require the orientation program to include electronic medical records systems utilized by federally qualified health centers and standards for medical chart notations. The bill would also delete the requirement that the physicians participate in a 6-month externship. The bill would further delete provisions requiring an evaluation of the pilot program to be undertaken with funds provided from philanthropic foundations, and would make various other related changes to the program.Commencing January 1, 2025, the bill would require the Medical Board of California to permit each of the no more than 30 licensed physicians who were issued a 3-year license to practice medicine pursuant to the program to extend their license for 3 years on a one-time basis. Commencing January 1, 2025, and every 3 years thereafter, until January 1, 2041, the bill would require the board to permit no more ... (click bill link to see more).

Primary Sponsors
Eduardo Garcia

Organizational Notes

Last edited by Joanne Campbell at Apr 22, 2024, 6:09 PM
Local Health Plans of California, California Primary Care Association (Co-Sponsor), Clinica De Salud Del Valle De Salinas (Co-Sponsor) - Support

Bill Number	Last Action	Status	Position
AB 2885	**Read Second Time And Amended 2024 04 18**	**In Assembly**	**Monitor**

Title
Artificial intelligence.

Introduction Date: 2024-02-15

Description
AB 2885, as amended, Bauer-Kahan. Artificial intelligence. Existing law establishes the Government Operations Agency, which is governed by the Secretary of Government Operations. Existing law requires the Secretary of Government Operations to develop a coordinated plan to, among other things, evaluate the impact of the proliferation of deepfakes, defined to mean audio or visual content that has been generated or manipulated by artificial intelligence that would falsely appear to be authentic or truthful and that features depictions of people appearing to say or do things they did not say or do without their consent, on state government, California-based businesses, and residents of the state.Existing law establishes within the Government Operations Agency the Department of Technology, which is supervised by the Director of Technology. Existing law requires the Department of Technology to conduct, in coordination with other interagency bodies as it deems appropriate, a comprehensive inventory of all high-risk automated decision systems that have been proposed for use, development, or procurement by, or are being used, developed, or procured by, any state agency. Existing law defines an “automated decision system” as a computational process derived from machine learning, statistical modeling, data analytics, or artificial intelligence that issues simplified output, including a score, classification, or recommendation, that is used to assist or replace human discretionary decisionmaking and materially impacts natural persons.Existing law requires each local agency, as defined, to provide specified information to the public before approving an economic development subsidy, as defined, within its jurisdiction, and to, among other things, hold hearings and issue annual reports on those subsidies, as provided. Existing law requires those reports to contain, among other things, information about any net job loss or replacement due to the use of automation, artificial intelligence, or other technologies, if known.Existing law establishes the California Online Community College, under the administration of the Board of Governors of the California Community Colleges, for purposes of creating an organized system of accessible, flexible, and high-quality online content, courses, and programs focused on providing industry-valued credentials compatible with the vocational and educational needs of Californians who are not currently accessing higher education. Existing law requires the California Online Community College to develop a Research and Development Unit to, among other things, focus on using technology, data science, behavioral science, machine learning, and artificial intelligence to build out student supports, as provided... (click bill link to see more).

Primary Sponsors
Rebecca Bauer-Kahan, Tom Umberg

Bill Number	Last Action	Status	Position
AB 2893	**Re Referred To Com On Health 2024 04 18**	**In Assembly**	**Monitor**

Title
The Shared Recovery Housing Residency Program.

Introduction Date: 2024-02-15

Description
AB 2893, as amended, Ward. The Shared Recovery Housing Residency Program. Existing law establishes the California Interagency Council on Homelessness to oversee the implementation of Housing First guidelines and regulations, and, among other things, identify resources, benefits, and services that can be accessed to prevent and end homelessness in California. Existing law requires a state agency or department that funds, implements, or administers a state program that provides housing or housing-related services to people experiencing homelessness or who are at risk of homelessness to revise or adopt guidelines and regulations to include enumerated Housing First policies. Existing law specifies the core components of Housing First, including services that are informed by a harm-reduction philosophy that recognizes drug and alcohol use and addiction as a part of tenants' lives and where tenants are engaged in nonjudgmental communication regarding drug and alcohol use.This bill would authorize state programs to fund recovery housing, as defined, that emphasize abstinence under these provisions as long as the state program meets specified criteria, including using at least 75% of its funds in each county for housing or housing-based services using a harm-reduction model. The bill would specify requirements for applicants seeking funds under these programs and would require the state to perform periodic monitoring of select recovery housing programs to ensure that the recovery housing meets certain requirements, including that core outcomes of the recovery housing emphasize long-term housing stability and minimize returns to homelessness. The bill would also prohibit eviction on the basis of relapse, as specified. Existing law requires the State Department of Health Care Services to license and regulate facilities that provide residential nonmedical services to adults who are recovering from problems related to alcohol, drug, or alcohol and drug misuse or abuse, and who need alcohol, drug, or alcohol and drug recovery treatment or detoxification services. Existing law also requires the department to certify alcohol and other drug treatment recovery services, as specified.This bill would require the department to oversee certification of recovery houses that serve individuals experiencing, or who are at risk of experiencing, homelessness or who are experiencing serious mental illness or substance use disorders with a housing first model, as defined. The bill would require the department to establish criteria for certification of recovery houses in order to allow a recovery house to receive referrals from the department as available housing for persons experiencing, or at risk of experiencing, homelessness or mental... (click bill link to see more).

Primary Sponsors
Chris Ward

Bill Number	Last Action	Status	Position
AB 2914	**Re Referred To Com On Health 2024 04 11**	**In Assembly**	**Monitor**

Title
Health care coverage: essential health benefits.

Introduction Date: 2024-02-15

Description
AB 2914, as amended, Bonta. Health care coverage: essential health benefits. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service plans. Existing law requires the Department of Insurance to regulate health insurers. Existing law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, to include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act. Existing law requires a health care service plan contract or health insurance policy to cover the same health benefits that the benchmark plan, the Kaiser Foundation Health Plan Small Group HMO 30 plan, offered during the first quarter of 2014, as specified.This bill would express the intent of the Legislature to review California’s essential health benefits benchmark plan and establish a new benchmark plan for the 2027 plan year. The bill would limit the applicability of the current benchmark plan benefits to plan years on or before the 2027 plan year.

Primary Sponsors
Mia Bonta

Organizational Notes

Last edited by Joanne Campbell at Apr 19, 2024, 8:09 PM
California Association of Health Plans - Support in Concept

Bill Number	Last Action	Status	Position
AB 2930	**From Committee Amend And Do Pass As Amended And Re Refer To Com On Jud Ayes 8 Noes 3 April 16 2024 04 18**	**In Assembly**	**Monitor**

Title
Automated decision tools.

Introduction Date: 2024-02-15

Description
AB 2930, as amended, Bauer-Kahan. Automated decision tools. The Unruh Civil Rights Act provides that all persons within the jurisdiction of this state are free and equal and, regardless of their sex, race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, sexual orientation, citizenship, primary language, or immigration status, are entitled to the full and equal accommodations, advantages, facilities, privileges, or services in all business establishments of every kind whatsoever.The California Fair Employment and Housing Act establishes the Civil Rights Department within the Business, Consumer Services, and Housing Agency and requires the department to, among other things, bring civil actions to enforce the act.This bill would, among other things, require a deployer, as defined, and a developer of an automated decision tool, as defined, to perform an impact assessment on any automated decision tool before first using it and annually thereafter, and with respect to an automated decision tool that a deployer first used before January 1, 2025, the bill would require the deployer to perform an impact assessment on that automated decision tool before January 1, 2026, and annually thereafter, that includes, among other things, a statement of the purpose of the automated decision tool and its intended benefits, uses, and deployment contexts. The bill would require a deployer or developer to provide the impact assessment to the Civil Rights Department within 7 days of a request by the department and would punish a violation of that provision with an administrative fine of not more than $10,000 to be recovered in an administrative enforcement action brought by the Civil Rights Department. The bill would, in complying with a request for public records, require the Civil Rights Department, or an entity with which an impact assessment was shared, to redact any trade secret from the impact assessment.This bill would require a deployer to, at or before the time an automated decision tool is used to make a consequential decision, as defined, notify any natural person that is the subject of the consequential decision that an automated decision tool is being used and to provide that person with, among other things, a statement of the purpose of the automated decision tool. The bill would, if a consequential decision is made solely based on the output of an automated decision tool, require a deployer to, if technically feasible, accommodate a natural person’s request to not be subject to the automated decision tool and to be subject to an alternative selection process or accommodation, as prescribed.This bill would prohibit a deployer from using an automated decision t... (click bill link to see more).

Primary Sponsors
Rebecca Bauer-Kahan

Bill Number	Last Action	Status	Position
AB 2956	**Read Second Time And Amended 2024 04 18**	**In Assembly**	**Monitor**

Title
Medi-Cal eligibility: redetermination.

Introduction Date: 2024-02-16

Description
AB 2956, as amended, Boerner. Medi-Cal eligibility: redetermination. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Existing law generally requires a county to redetermine a Medi-Cal beneficiary's eligibility to receive Medi-Cal benefits every 12 months and whenever the county receives information about changes in a beneficiary's circumstances that may affect their Medi-Cal eligibility. Existing law conditions implementation of the redetermination provisions on the availability of federal financial participation and receipt of any necessary federal approvals. Under existing law, if a county has facts clearly demonstrating that a Medi-Cal beneficiary cannot be eligible for Medi-Cal due to an event, such as death or change of state residency, Medi-Cal benefits are terminated without a redetermination.Existing law requires the department, subject to federal funding, to extend continuous eligibility to children 19 years of age or younger for a 12-month period, as specified. Under existing law, operative on January 1, 2025, or the date that the department certifies that certain conditions have been met, a child is continuously eligible for Medi-Cal up to 5 years of age. Under those provisions, a redetermination is prohibited during this time, unless certain circumstances apply, including, voluntary disenrollment, death, or change of state residency.This bill would require the department to seek federal approval to extend continuous eligibility to individuals over 19 years of age. Under the bill, subject to federal funding, and except as described above with regard to death, change of state residency, or other events, an individual would remain eligible from the date of a Medi-Cal eligibility determination until the end of a 12-month period, as specified.The bill would make various changes to the above-described redetermination procedures. The bill would, among other things, require the county, in the event of a loss of contact, to attempt communication with the intended recipient through all additionally available channels before completing a prompt redetermination. The bill would require the county to make another review of certain obtained information in an attempt to renew eligibility without needing a response from a beneficiary.The bill would require the county to complete a determination at renewal without requesting additional information or documentation if specified conditions are met, relating to, among other things, prior income verification and no contradictory information on... (click bill link to see more).

Primary Sponsors
Tasha Boerner

Organizational Notes

Last edited by Joanne Campbell at Apr 22, 2024, 6:11 PM
Local Health Plans of California - Support

Bill Number	Last Action	Status	Position
AB 2976	**From Printer May Be Heard In Committee March 18 2024 02 17**	**In Assembly**	**Monitor**

Title
Mental health care.

Description
AB 2976, as introduced, Jackson. Mental health care. Existing law establishes various state and local programs for the provision of mental health services within the jurisdiction of the State Department of Health Care Services, the State Department of Public Health, the California Behavioral Health Planning Council, the Department of Health Care Access and Information, and county public health or behavioral health departments, among other entities. Under existing law, those programs, services, and provisions include, among others, the Mental Health Services Act, the Lanterman-Petris-Short Act, the Children and Youth Behavioral Health Initiative, the Behavioral Health Continuum Infrastructure Program, the Licensed Mental Health Service Provider Education Program, and Medi-Cal specialty mental health services.This bill would state the intent of the Legislature to enact legislation relating to access to mental health care.

Primary Sponsors
Corey Jackson

Introduction Date: 2024-02-16

Bill Number	Last Action	Status	Position
AB 2998	**Re Referred To Com On Ed Pursuant To Assembly Rule 96 2024 04 18**	**In Assembly**	**Monitor**

Title
Opioid overdose reversal medications: pupil administration.

Introduction Date: 2024-02-16

Description
AB 2998, as amended, McKinnor. Opioid overdose reversal medications: pupil administration. Existing law authorizes a public or private elementary or secondary school to determine whether or not to make emergency naloxone hydrochloride or another opioid antagonist and trained personnel available at its school, and to designate one or more volunteers to receive related training to address an opioid overdose, as specified. Existing law prohibits a person who has completed that training and who administers naloxone hydrochloride or another opioid antagonist, in good faith and not for compensation, to a person who appears to be experiencing an opioid overdose from being subject to professional review, liable in a civil action, or subject to criminal prosecution for the person’s acts or omissions in administering the naloxone hydrochloride or another opioid antagonist, unless the person’s acts or omissions constituted gross negligence or willful and wanton misconduct, as provided.This bill would prohibit a school district, county office of education, or charter school from prohibiting a pupil, while on a schoolsite or participating in school activities, from carrying or administering, for the purposes of providing emergency treatment to persons who are suffering, or reasonably believed to be suffering, from an opioid overdose, specified opioid overdose reversal medications that are federally approved for over-the-counter, nonprescription use, as provided. The bill would prohibit a pupil of those local educational agencies who administers naloxone hydrochloride or another opioid antagonist on a schoolsite or while participating in school activities, in good faith and not for compensation, to a person who appears to be experiencing an opioid overdose, from being held liable in a civil action or being subject to criminal prosecution for their acts or omissions, unless the pupil’s acts or omissions constitute gross negligence or willful and wanton misconduct, as provided. The bill would also prohibit those local educational agencies, or an employee of those local educational agencies, from being subject to professional review, liable in a civil action, or subject to criminal prosecution for a pupil’s acts or omissions in administering naloxone hydrochloride or another opioid antagonist, unless an act or omission of the local educational agency, or the employee of the local educational agency, constitutes gross negligence or willful and wanton misconduct connected to the administration of the naloxone hydrochloride or another opioid antagonist.

Primary Sponsors
Tina McKinnor

Bill Number	Last Action	Status	Position
AB 3030	**Re Referred To Com On P C P 2024 04 15**	**In Assembly**	**Monitor**

Title
Health care services: artificial intelligence.

Introduction Date: 2024-02-16

Description
AB 3030, as amended, Calderon. Health care services: artificial intelligence. Existing law provides for the licensure and regulation of health facilities and clinics by the State Department of Public Health. A violation of these provisions is a crime.This bill would require an entity, including a health facility, clinic, physician’s office, or office of a group practice that uses a generative artificial intelligence tool to generate responses for health care providers to communicate with patients to ensure that those communications include both (1) a disclaimer that indicates to the patient that a communication was generated by artificial intelligence and (2) clear instructions for the patient to access direct communications with a health care provider, as specified. The bill would prohibit an entity or health care provider from being subject to any disciplinary action related to licensure or certification solely because of the entity’s or health care provider’s failure to comply with these provisions.

Primary Sponsors
Lisa Calderon

Bill Number	Last Action	Status	Position
AB 3050	**Referred To Coms On P C P And Jud 2024 03 21**	**In Assembly**	**Monitor**

Title
Artificial intelligence.

Introduction Date: 2024-02-16

Description
AB 3050, as introduced, Low. Artificial intelligence. Existing law requires the Secretary of Government Operations to develop a coordinated plan to, among other things, investigate the feasibility of, and obstacles to, developing standards and technologies for state departments to determine digital content provenance. For the purpose of informing that coordinated plan, existing law requires the secretary to evaluate, among other things, the impact of the proliferation of deepfakes, as defined.This bill would require the Department of Technology to issue regulations to establish standards for watermarks to be included in covered AI-generated material, as defined. The bill would require the department’s standard to, at minimum, require an AI-generating entity to include digital content provenance in the watermarks. The bill would prohibit an AI-generating entity from creating covered AI-generated material unless the material includes a watermark that meets the standards established by the department. The bill would provide that the prohibition becomes operative on the date that is one year after the date on which the department issues the regulations to establish standards for watermarks.Under existing law, a person who knowingly uses another’s name, voice, signature, photograph, or likeness, in any manner, on or in products, merchandise, or goods, or for the purposes of advertising or selling, or soliciting purchases of, products, merchandise, goods, or services, without that person’s prior consent is liable for any damages sustained by the person or persons injured as a result thereof and for the payment to the injured party of any profits attributable to that unauthorized use.This bill would provide that an AI-generating entity or individual that creates a deepfake using a person’s name, voice, signature, photograph, or likeness, in any manner, without permission from the person being depicted in the deepfake, is liable for the actual damages suffered by the person or persons as a result of the unauthorized use.This bill would provide that an AI-generating entity that violates the provisions of this act is subject to a civil penalty assessed by the department in an amount, as determined by the department, not less than $250 or more than $500.

Primary Sponsors
Evan Low

Bill Number	Last Action	Status	Position
AB 3059	**Re Referred To Com On Health 2024 03 12**	**In Assembly**	**Monitor**

Title
Human milk.

Introduction Date: 2024-02-16

Description
AB 3059, as amended, Weber. Human milk. Existing law licenses and regulates tissue banks and generally makes a violation of the requirements applicable to tissue banks a crime. Existing law exempts a “mothers’ milk bank,” as defined, from paying a licensing fee to be a tissue bank.This bill would specify that a general acute care hospital is not required to have a license to operate a tissue bank to store or distribute pasteurized human milk that was obtained from a mothers’ milk bank.Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service plans and makes a willful violation of the act a crime. Other existing law requires the Department of Insurance to regulate health insurers. Existing law requires health care service plans and health insurers, as specified, to provide certain health benefits and services, including, among others, maternity hospital stays, inpatient hospital and ambulatory maternity services, and maternal mental health programs. This bill would require a health care service plan contract or health insurance policy that is issued, amended, delivered, or renewed on or after January 1, 2025, to cover the same health benefits for human milk and human milk derivatives covered under the Medi-Cal program as of 1988.Because a violation of the bill’s provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Akilah Weber

Organizational Notes

Last edited by Joanne Campbell at Apr 19, 2024, 8:10 PM
California Association of Health Plans - Opposed

Bill Number	Last Action	Status	Position
AB 3063	**From Committee Do Pass And Re Refer To Com On Appr Ayes 17 Noes 0 April 2 Re Referred To Com On Appr 2024 04 02**	**In Assembly**	**Monitor**

Title
Pharmacies: compounding.

Introduction Date: 2024-02-16

Description
AB 3063, as introduced, McKinnor. Pharmacies: compounding. Existing law, the Pharmacy Law, requires the California State Board of Pharmacy to license and regulate the practice of pharmacy by pharmacists and pharmacy corporations in this state. Existing law prohibits a pharmacy from compounding sterile drug products unless the pharmacy has obtained a sterile compounding pharmacy license from the board. Existing law requires the compounding of drug preparations by a pharmacy for furnishing, distribution, or use to be consistent with standards established in the pharmacy compounding chapters of the current version of the United States Pharmacopeia-National Formulary, including relevant testing and quality assurance. Existing law authorizes the board to adopt regulations to impose additional standards for compounding drug preparations.This bill would, notwithstanding those provisions, specify that compounding does not include reconstitution of a drug pursuant to a manufacturer’s directions, the sole act of tablet splitting or crushing, capsule opening, or the addition of a flavoring agent to enhance palatability. The bill would require a pharmacy to retain documentation that a flavoring agent was added to a prescription and to make that documentation available to the board or its agent upon request. The bill would make those provisions operative until January 1, 2030.This bill would declare that it is to take effect immediately as an urgency statute.

Primary Sponsors
Tina McKinnor

Bill Number	Last Action	Status	Position
AB 3129	**In Committee Hearing Postponed By Committee 2024 04 15**	**In Assembly**	**Monitor**

Title
Health care system consolidation.

Introduction Date: 2024-02-16

Description
AB 3129, as amended, Wood. Health care system consolidation. Existing law requires a nonprofit corporation that operates or controls a health facility or other facility that provides similar health care to provide written notice to, and to obtain the written consent of, the Attorney General prior to entering into any agreement or transaction to sell, transfer, lease, exchange, option, convey, or otherwise dispose of the asset, or to transfer control, responsibility, or governance of the asset or operation, to a for-profit corporation or entity, to a mutual benefit corporation or entity, or to a nonprofit corporation, as specified.This bill would require a private equity group or a hedge fund, as defined, to provide written notice to, and obtain the written consent of, the Attorney General prior to a change of control or an acquisition between the private equity group or hedge fund and a health care facility or provider group, as those terms are defined, except as specified. The bill would require the notice to be submitted at the same time that any other state or federal agency is notified pursuant to state or federal law, and otherwise at least 90 days before the change in control or acquisition. The bill would authorize the Attorney General to extend that 90-day period under certain circumstances. The bill would additionally require a private equity group or hedge fund to provide advance written notice to the Attorney General prior to a change of control or acquisition between a private equity group or hedge fund and a nonphysician provider, or a provider with specified annual revenue.The bill would authorize the Attorney General to give the private equity group or hedge fund a written waiver or the notice and consent requirements if specified conditions apply, including, but not limited to, that the party makes a written waiver request, the party’s operating costs have exceeded its operating revenue in the relevant market for 3 or more years and the party cannot meet its debts, and the acquisition or change of control will ensure continued health care access in the relevant markets. The bill would require the Attorney General to grant or deny the waiver within 60 days, as prescribed.The bill would authorize the Attorney General to grant, deny, or impose conditions to a change of control or an acquisition between a private equity group or hedge fund and a health care facility, provider group, or both, if the change of control or acquisition may have a substantial likelihood of anticompetitive effects or may create a significant effect on the access or availability of health care services to the affected community, applying a public interest standard, as defined. The bill would authorize any party to the acquisition or ... (click bill link to see more).

Primary Sponsors
Jim Wood

Bill Number	Last Action	Status	Position
AB 3130	**Re Referred To Com On L Gov Pursuant To Assembly Rule 96 2024 04 04**	**In Assembly**	**Monitor**

Title
County board of supervisors: disclosure.

Introduction Date: 2024-02-16

Description
AB 3130, as amended, Quirk-Silva. County board of supervisors: disclosure. Existing law prohibits certain public officials, including, but not limited to, state, county, or district officers or employees, from being financially interested in any contract made by them in their official capacity, or by any body or board of which they are members, except as provided. A willful violation of these provisions is a crime.Existing law excepts from the above conflict-of-interest provisions certain remote interests, as described, including those of officers or employees of a nonprofit entity exempt from taxation or a nonprofit corporation, except as prescribed. Existing law requires a remote interest to be disclosed to the body or board of which the officer is a member and noted in its official records, and thereafter the body or board to authorize, approve, or ratify the contract in good faith by a vote of its membership sufficient for the purpose without counting the vote or votes of the officer or member with the remote interest.This bill would require a member of the board of supervisors to disclose a known family relationship with an officer or employee of a nonprofit entity before the board of supervisors appropriates money to that nonprofit entity.

Primary Sponsors
Sharon Quirk-Silva

Bill Number	Last Action	Status	Position
AB 3149	**Read Second Time And Amended 2024 04 18**	**In Assembly**	**Support**

Title
Promotores and Promotoras Advisory and Oversight Workgroup.

Introduction Date: 2024-02-16

Description
AB 3149, as amended, Garcia. Promotores and Promotoras Advisory and Oversight Workgroup. Existing law establishes the California Health and Human Services Agency, which includes the State Department of Health Care Services, among other state departments charged with the administration of health, social, and other human services.Existing law establishes the Medi-Cal program under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law sets forth a schedule of covered benefits under the Medi-Cal program, which includes community health worker services.Existing law defines “community health worker” as a liaison, link, or intermediary between health and social services and the community to facilitate access to services and to improve the access and cultural competence of service delivery and who is a frontline health worker either trusted by, or who has a close understanding of, the community served. Existing law includes in the definition of community health worker Promotores, Promotores de Salud, Community Health Representatives, navigators, and other nonlicensed health workers with specified qualifications.This bill would require the department, by no later than January 1, 2025, and until December 31, 2026, to convene the Promotores and Promotoras Advisory and Oversight Workgroup to provide perspective and guidance to changes in the health and human services delivery system, including, but not limited to, the Medi-Cal program. The bill would require the secretary to appoint no fewer than 9 individuals to the workgroup who have at least ten years experience working in California as, or with, Promotores or Promotoras. The bill would require the workgroup to be comprised of no less than 51% Promotores or Promotoras, as specified, and require the appointees to be from geographically diverse areas of the state. The bill would require the workgroup to advise the departments under the agency to ensure that services provided by Promotores or Promotoras are available and accessible to all eligible populations. The bill would also require the workgroup to advise the agency to ensure that Promotores and Promotoras training and outreach materials are culturally and linguistically appropriate, to make recommendations on outreach efforts, as specified, and to provide input on issues that should be informed by community representatives who have lived experience with using and navigating Promotores or Promotoras services and the Medi-Cal program.The bill would also make findings and declarations related to the inclusion of Promotoras.

Primary Sponsors
Eduardo Garcia, Eloise Reyes

Bill Number	Last Action	Status	Position
AB 3156	**Re Referred To Com On Health 2024 04 01**	**In Assembly**	**Monitor**

Title
Medi-Cal managed care plans: exemption from mandatory enrollment.

Introduction Date: 2024-02-16

Description
AB 3156, as amended, Joe Patterson. Medi-Cal managed care plans: exemption from mandatory enrollment. Existing law, the Lanterman Developmental Disabilities Services Act, requires the State Department of Developmental Services to contract with regional centers to provide community services and supports for persons with developmental disabilities and their families. The act generally requires a regional center to identify and pursue all possible sources of funding, including the Medi-Cal program, for consumers receiving regional center services.Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes the California Advancing and Innovating Medi-Cal (CalAIM) initiative, subject to receipt of any necessary federal approvals and the availability of federal financial participation, in order to, among other things, improve quality outcomes, reduce health disparities, and increase flexibility.Existing law authorizes the department to standardize those populations that are subject to mandatory enrollment in a Medi-Cal managed care plan across all aid code groups and Medi-Cal managed care models statewide, as specified, in accordance with the CalAIM Terms and Conditions. Existing law, if the department standardizes those populations subject to mandatory enrollment, exempts certain dual eligible and non-dual-eligible beneficiary groups from that mandatory enrollment. Under existing law, a dual eligible beneficiary is an individual 21 years of age or older who is enrolled for benefits under the federal Medicare Program and is eligible for medical assistance under the Medi-Cal program.This bill would exempt, from mandatory enrollment in a Medi-Cal managed care plan, dual eligible and non-dual-eligible beneficiaries who receive services from a regional center and use a Medi-Cal fee-for-service delivery system as a secondary form of health coverage. For purposes of this exemption, the bill would require the beneficiary to complete and submit an exemption form every 5 years.

Primary Sponsors
Joe Patterson, Stephanie Nguyen

Bill Number	Last Action	Status	Position
AB 3161	**From Committee Do Pass And Re Refer To Com On Appr Ayes 11 Noes 0 April 16 Re Referred To Com On Appr 2024 04 16**	**In Assembly**	**Monitor**

Title
Health and care facilities: patient safety and antidiscrimination.

Introduction Date: 2024-02-16

Description
AB 3161, as amended, Bonta. Health and care facilities: patient safety and antidiscrimination. (1) Existing law provides for the licensure and regulation of health facilities by the State Department of Public Health. A violation of these provisions is a crime.Existing law allows for patients to submit complaints to the department regarding health facilities. Existing law also requires the department to establish a centralized consumer response unit within the Licensing and Certification Division of the department to respond to consumer inquiries and complaints.This bill would require the department to include a section for complaints involving specified health facilities to collect information about outlined demographic factors of affected patients. The bill would require the department to include a section on the Complaint Against a Health Care Facility/Provider form on the department’s internet website, and provide means for complaints submitted via mail, fax, or by telephone, for complaints involving specified health facilities. The bill would require the department to inform complainants that the information collected is voluntary, is to ensure patients receive the best care possible, and will not affect the department’s investigation. The bill would require that complainants shall be provided the option to refer the complaint to the Civil Rights Department, and the department will provide the complaint to the Civil Rights Department only when requested to do so by the complainant. The bill would require the department to develop an outreach program to provide patients, consumers, and members of the public with specified information regarding the complaint process.
(2) Existing law requires the department to prepare a staffing and systems analysis to ensure efficient and effective utilization of fees collected, proper allocation of departmental resources to licensing and certification activities, survey schedules, complaint investigations, enforcement and appeal activities, data collection and dissemination, surveyor training, and policy development. Existing law requires the analysis be made available to interested persons and include specified information.This bill would require the department, in preparing this report, to include demographic data from adverse events reported by health facilities and include the demographic data collected from complaints submitted, as specified.(3) Existing law requires a health facility to develop, implement, and comply with a patient safety plan to improve the health and safety of patients and to reduce preventable patient safety events. The patient safety plan requires specified elements, including, but not limited to, a reporting system for patient safety events that all... (click bill link to see more).

Primary Sponsors
Mia Bonta

Bill Number	Last Action	Status	Position
AB 3175	**From Printer May Be Heard In Committee March 18 2024 02 17**	**In Assembly**	**Monitor**

Title
Health care coverage: dental services.

Introduction Date: 2024-02-16

Description
AB 3175, as introduced, Villapudua. Health care coverage: dental services. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act’s requirements a crime. Existing law imposes specified coverage and disclosure requirements on health care service plans, including specialized plans, that cover dental services. Existing law, on and after January 1, 2025, prohibits a health care service plan from issuing, amending, renewing, or offering a plan contract that imposes a dental waiting period provision in a large group plan or preexisting condition provision for any plan.This bill would make technical, nonsubstantive changes to those provisions.

Primary Sponsors
Carlos Villapudua

Bill Number	Last Action	Status	Position
AB 3204	**From Committee Chair With Authors Amendments Amend And Re Refer To Com On P C P Read Second Time And Amended 2024 04 18**	**In Assembly**	**Monitor**

Title
Data Digesters Registration Act.

Introduction Date: 2024-02-16

Description
AB 3204, as amended, Bauer-Kahan. Data Digesters Registration Act. The California Consumer Privacy Act of 2018 (CCPA) grants a consumer various rights with respect to personal information that is collected or sold by a business. The CCPA defines various terms for these purposes. The California Privacy Rights Act of 2020 (CPRA), approved by the voters as Proposition 24 at the November 3, 2020, statewide general election, amended, added to, and reenacted the CCPA and establishes the California Privacy Protection Agency (agency) and vests the agency with full administrative power, authority, and jurisdiction to enforce the CCPA.Existing law requires data brokers to register with the agency, pay a registration fee, and provide certain information, prescribes penalties for failure to register as required by these provisions, requires the agency to create a page on its internet website where this registration information is accessible to the public, and creates a fund known as the “Data Brokers’ Registry Fund” that may be used by the agency, upon appropriation, to, among other things, offset the reasonable costs of establishing and maintaining the informational website and the costs incurred by the state courts and the agency in connection with enforcing these provisions, as specified. Existing law defines various terms for these purposes, including by incorporating specified definitions provided in the CPRA.This bill would require data digesters to register with the agency, pay a registration fee, and provide specified information, prescribe penalties for a failure to register as required by these provisions, require the agency to create a page on its internet website where this registration information is accessible to the public, and create a fund known as the “Data Digester Registry Fund” to be administered by the agency to be available for expenditure by the agency, upon appropriation, to offset the reasonable costs of establishing and maintaining the informational website and the costs incurred by the state courts and the agency in connection with enforcing these provisions, as specified. The bill would define various terms and incorporate specified definitions provided in the CPRA for these purposes.

Primary Sponsors
Rebecca Bauer-Kahan

Bill Number	Last Action	Status	Position
AB 3215	**From Printer May Be Heard In Committee March 18 2024 02 17**	**In Assembly**	**Monitor**

Title
Medi-Cal: mental health services for children.

Description
AB 3215, as introduced, Soria. Medi-Cal: mental health services for children. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, specialty mental health services include federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services provided to eligible Medi-Cal beneficiaries under 21 years of age.This bill would express the intent of the Legislature to enact legislation to expand access to behavioral mental health services to children receiving Medi-Cal benefits.

Primary Sponsors
Esmeralda Soria

Introduction Date: 2024-02-16

Bill Number	Last Action	Status	Position
AB 3221	**From Committee Do Pass And Re Refer To Com On Appr With Recommendation To Consent Calendar Ayes 16 Noes 0 April 16 Re Referred To Com On Appr 2024 04 17**	**In Assembly**	**Monitor**

Title
Department of Managed Health Care: review of records.

Introduction Date: 2024-02-16

Description
AB 3221, as amended, Pellerin. Department of Managed Health Care: review of records. Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (hereafter the act), provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law requires the records, books, and papers of a health care service plan and other specified entities to be open to inspection by the director of the department during normal business hours.This bill would instead require the records, books, and papers of a health care service plan and other specified entities to be open to inspection by the director, including through electronic means. The bill would require a plan and other specified entities to furnish in electronic media records, books, and papers that are possessed in electronic media and to conduct a diligent review of records, books, and papers and make every effort to furnish those responsive to the director’s request. The bill would require records, books, and papers to be furnished in a format that is digitally searchable, to the greatest extent feasible. The bill would require records, books, and papers to be preserved until furnished, if requested by the department. The bill would authorize the director to inspect and copy these records, books, and papers, and to seek relief in an administrative law proceeding if, in the director’s determination, a plan or other specified entity fails to fully or timely respond to a duly authorized request for production of records, books, and papers. Because a willful violation of these requirements would be a crime, the bill would impose a state-mandated local program.Existing law requires the department to conduct periodically an onsite medical survey of the health delivery system of each plan. Existing law requires the director to publicly report survey results no later than 180 days following the completion of the survey, and requires a final report to be issued after public review of the survey. Existing law requires the department to conduct a followup review to determine and report on the status of the plan’s efforts to correct deficiencies no later than 18 months following release of the final report.This bill would state that nothing in those provisions prohibits the director from taking any action permitted or required under the act in response to the survey results before the followup review is initiated or completed, including, but not limited to, taking enforcement actions and opening further investigations.Existing law enumerates acts or omissions by a health care service plan that constitute grounds for disciplinary action by the director.This bill would add to tho... (click bill link to see more).

Primary Sponsors
Gail Pellerin

Organizational Notes

Last edited by Joanne Campbell at Feb 28, 2024, 9:06 PM
National Union of Healthcare Workers, Sponsor

Bill Number	Last Action	Status	Position
AB 3245	**Referred To Com On Health 2024 03 11**	**In Assembly**	**Monitor**

Title
Coverage for colorectal cancer screening.

Introduction Date: 2024-02-16

Description
AB 3245, as introduced, Joe Patterson. Coverage for colorectal cancer screening. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally requires a health care service plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2022, to provide coverage without cost sharing for a colorectal cancer screening test, and for a colorectal cancer screening examination in specified circumstances, assigned either a grade of A or a grade of B by the United States Preventive Services Task Force.This bill would additionally require that coverage if the test or screening examination is assigned either a grade of A or a grade of B by another accredited or certified guideline agency.

Primary Sponsors
Joe Patterson

Organizational Notes

Last edited by Joanne Campbell at Apr 22, 2024, 5:03 PM
California Association of Health Plans - Opposed (removed)

Bill Number	Last Action	Status	Position
AB 3260	**From Committee Do Pass And Re Refer To Com On Appr Ayes 13 Noes 1 April 16 Re Referred To Com On Appr 2024 04 17**	**In Assembly**	**Monitor**

Title
Health care coverage: reviews and grievances.

Introduction Date: 2024-02-16

Description
AB 3260, as amended, Pellerin. Health care coverage: reviews and grievances. (1) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law generally authorizes a health care service plan or disability insurer to use utilization review, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Existing law requires these decisions to be made within 30 days, or less than 72 hours when the enrollee faces an imminent and serious threat to their health. Existing law requires a health care service plan to establish a grievance system to resolve grievances within 30 days, but limits that timeframe to 3 days when the enrollee faces an imminent and serious threat to their health. Existing law requires a plan to provide a written explanation for its grievance decisions, as specified.This bill would require that utilization review decisions be made within 72 hours from the health care service plan’s receipt of the clinical information reasonably necessary to make the determination when the enrollee’s condition is urgent, and would make a determination of urgency by the enrollee’s health care provider binding on the health care service plan. If the plan lacks the information reasonably necessary to make a decision regarding an urgent request, the bill would require the plan to notify the enrollee and provider about the information necessary to complete the request within 24 hours of receiving the request. The bill would require the plan to notify the enrollee and the provider of the decision within a reasonable amount of time, but not later than 48 hours after specified circumstances occur. If a health care service plan fails to make a utilization review decision, or provide notice of a decision, within the specified timelines, the bill would require the health care service plan to treat the request for authorization as a grievance and provide notice with specified information to the enrollee that a grievance has commenced.This bill would require a plan’s grievance system to include expedited review of urgent grievances, as specified, and would make a determination of urgency by the enrollee’s health care provider binding on the health care service plan. The bill would require a plan to communicate its final grievance determination within 72 hours of receipt if urgent and 30 days if nonurgent, except as specified. If a plan fails to make a utilization review decision within the... (click bill link to see more).

Primary Sponsors
Gail Pellerin

Organizational Notes

Last edited by Joanne Campbell at Apr 22, 2024, 5:31 PM
California Association of Health Plans, Local Health Plans of California, America's Health Insurance Plans - Oppose National Union of Healthcare Workers (NUHW) (sponsor) - Support

Bill Number	Last Action	Status	Position
AB 3275	**Read Second Time And Amended 2024 04 18**	**In Assembly**	**Monitor**

Title
Health care coverage: claim reimbursement.

Introduction Date: 2024-02-16

Description
AB 3275, as amended, Soria. Health care coverage: claim reimbursement. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health insurer or health care service plan, including a specialized health care service plan, to reimburse a claim or portion of a claim no later than 30 working days after receipt of the claim, unless the plan contests or denies the claim, in which case the plan is required to notify the claimant within 30 working days that the claim is contested or denied. Under existing law, if a claim or portion thereof is contested on the basis that a health insurer or health care service plan has not received all information necessary to determine payer liability for the claim or portion thereof and notice has been provided, the health insurer or health care service plan has 30 working days after receipt of the additional information to complete reconsideration of the claim. Existing law extends these timelines to 45 working days for a health care service plan that is a health maintenance organization. Under existing law, if a claim is not reimbursed, contested, or denied pursuant to these timelines, as specified, interest accrues at a rate of 15% per annum for a health care service plan and 10% per annum for a health insurer. This bill would increase that interest accrual rate for a health insurer to 15% per annum. The bill, notwithstanding the above-described timelines, would require a health care service plan or health insurer to reimburse a claim for a small and rural provider, critical access provider, or distressed provider within 10 business days after receipt of the claim, or, if the health care service plan or health insurer contests or denies the claim, to notify the claimant within 5 business days that the claim is contested or denied. Under the bill, if a claim for reimbursement to a small and rural provider, critical access provider, or distressed provider is contested on the basis that the health care service plan or health insurer has not received all information necessary to determine payer liability for the claim and notice has been provided, the health care service plan or health insurer would have 15 business days after receipt of the additional information to complete reconsideration of the claim. Under the bill, if a claim is not reimbursed, contested, or denied pursuant to these timelines, as specified, interest would accrue at a rate of 15% per annum for health care service plans and health insure... (click bill link to see more).

Primary Sponsors
Esmeralda Soria, Robert Rivas

Organizational Notes

Last edited by Joanne Campbell at Apr 22, 2024, 5:11 PM
Local Health Plans of California, California Association of Health Plans - Oppose

Bill Number	Last Action	Status	Position
SB 70	**September 1 Hearing Held In Committee And Under Submission 2023 09 01**	**In Assembly**	**Monitor**

Title
Prescription drug coverage.

Introduction Date: 2023-01-09

Description
SB 70, as amended, Wiener. Prescription drug coverage. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or health insurer to use utilization review, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Existing law prohibits a health care service plan contract that covers prescription drug benefits or a specified health insurance policy from limiting or excluding coverage for a drug on the basis that the drug is prescribed for a use that is different from the use for which it was approved by the federal Food and Drug Administration if specified conditions are met. Existing law also prohibits a health care service plan that covers prescription drug benefits from limiting or excluding coverage for a drug that was previously approved for coverage if an enrollee continues to be prescribed that drug, as specified.This bill would additionally prohibit limiting or excluding coverage of a drug, dose of a drug, or dosage form of a drug that is prescribed for off-label use if the drug has been previously covered for a chronic condition or cancer, as specified, regardless of whether or not the drug, dose, or dosage form is on the plan’s or insurer’s formulary. The bill would prohibit a health care service plan contract or health insurance policy from requiring additional cost sharing not already imposed for a drug that was previously approved for coverage. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Scott Wiener

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 5:57 PM
California Association of Health Plans: Oppose

Bill Number	Last Action	Status	Position
SB 106	**Re Referred To Com On Budget 2024 04 15**	**In Assembly**	**None**

Title
Budget Acts of 2022 and 2023.

Introduction Date: 2023-01-18

Description
SB 106, as amended, Wiener. Budget Acts of 2022 and 2023. The Budget Act of 2022 and the Budget Act of 2023 made appropriations for the support of state government for the 2022–23 and 2023–24 fiscal years.This bill would amend the Budget Act of 2022 and the Budget Act of 2023 by amending, adding, and repealing items of appropriation and making other changes.This bill would declare that it is to take effect immediately as a Budget Bill.

Primary Sponsors
Scott Wiener

Bill Number	Last Action	Status	Position
SB 136	**Chaptered By Secretary Of State Chapter 6 Statutes Of 2024 2024 03 25**	**Enacted**	**Monitor**

Title
Medi-Cal: managed care organization provider tax.

Introduction Date: 2023-01-18

Description
SB 136, Committee on Budget and Fiscal Review. Medi-Cal: managed care organization provider tax. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, one of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care plans.Existing law imposes a managed care organization (MCO) provider tax, administered and assessed by the department, on licensed health care service plans and managed care plans contracted with the department. Under existing law, all revenues, less refunds, derived from the taxes are deposited into the Managed Care Enrollment Fund, to be available to the department, upon appropriation, for the purpose of funding specified subcomponents to support the Medi-Cal program.Existing law sets forth certain taxing tiers and tax amounts for purposes of the tax periods of April 1, 2023, to December 31, 2023, inclusive, and the 2024, 2025, and 2026 calendar years. Under existing law, the Medi-Cal per enrollee tax amount for Medi-Cal taxing tier II, as defined, is $182.50 for the 2024 calendar year, $187.50 for the 2025 calendar year, and $192.50 for the 2026 calendar year.This bill would raise that tax amount for that tier to $205 for all 3 of those calendar years.This bill would declare that it is to take effect immediately as an urgency statute.

Primary Sponsors
Senate Budget and Fiscal Review Committee

Organizational Notes

Last edited by Joanne Campbell at Mar 18, 2024, 5:17 PM
California Association of Health Plans - Support

Bill Number	Last Action	Status	Position
SB 238	**September 1 Hearing Held In Committee And Under Submission 2023 09 01**	**In Assembly**	**Monitor**

Title
Health care coverage: independent medical review.

Introduction Date: 2023-01-24

Description
SB 238, as amended, Wiener. Health care coverage: independent medical review. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of disability insurers by the Department of Insurance. Existing law establishes the Independent Medical Review System within each department, under which an enrollee or insured may seek review if a health care service has been denied, modified, or delayed by a health care service plan or disability insurer and the enrollee or insured has previously filed a grievance that remains unresolved after 30 days.This bill, commencing July 1, 2024, would require a health care service plan or a disability insurer that modifies, delays, or denies a health care service, based in whole or in part on medical necessity, to automatically submit within 24 hours a decision regarding a disputed health care service to the Independent Medical Review System, as well as the information that informed its decision, without requiring an enrollee or insured to submit a grievance, if the decision is to deny, modify, or delay specified services relating to mental health or substance use disorder conditions for an enrollee or insured up to 26 years of age. The bill would require a health care service plan or disability insurer, within 24 hours after submitting its decision to the Independent Medical Review System to provide notice to the appropriate department, the enrollee or insured or their representative, if any, and the enrollee’s or insured’s provider. The bill would require the notice to include notification to the enrollee or insured that they or their representative may cancel the independent medical review at any time before a determination, as specified.The bill would apply specified existing provisions relating to mental health and substance use disorders for purposes of its provisions, and would be subject to relevant provisions relating to the Independent Medical Review System that do not otherwise conflict with the express requirements of the bill. With respect to health care service plans, the bill would specify that its provisions do not apply to Medi-Cal managed care plan contracts. The bill would authorize the Insurance Commissioner to promulgate regulations subject to the Administrative Procedure Act to implement and enforce the bill, and to issue interim guidance, as specified. Because a willful violation of this provision by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse... (click bill link to see more).

Primary Sponsors
Scott Wiener

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 6:11 PM
Local Health Plans of California: Oppose California Association of Health Plans: Oppose

Bill Number	Last Action	Status	Position
SB 242	**Referred To Com On Hum S 2023 06 08**	**In Assembly**	**Monitor**

Title
California Hope, Opportunity, Perseverance, and Empowerment (HOPE) for Children Trust Account Program.

Introduction Date: 2023-01-25

Description
SB 242, as amended, Skinner. California Hope, Opportunity, Perseverance, and Empowerment (HOPE) for Children Trust Account Program. Existing law establishes the California Hope, Opportunity, Perseverance, and Empowerment (HOPE) for Children Trust Account Program to provide a trust fund account to an eligible child, defined to include minor California residents who are specified dependents or wards under the jurisdiction of juvenile court in foster care with reunification services terminated by court order, or who have a parent, Indian custodian, or legal guardian who died due to COVID-19 during the federally declared COVID-19 public health emergency and meet the specified family household income limit. Under the program, all assets of the fund and moneys allocated to individual HOPE trust accounts shall be considered to be owned by the state until an eligible youth withdraws or transfers money from their HOPE trust account.Existing law establishes various means-tested public social services programs administered by counties to provide eligible recipients with certain benefits, including, but not limited to, cash assistance under the California Work Opportunity and Responsibility to Kids (CalWORKs) program, nutrition assistance under the CalFresh program, and health care services under the Medi-Cal program.This bill would, to the extent permitted by federal law, prohibit funds deposited and investment returns accrued in a HOPE trust fund account from being considered as income or assets when determining eligibility and benefit amount for any means-tested program until an eligible youth withdraws or transfers the funds from the HOPE trust fund account, as specified. The bill would make these provisions operative on July 1, 2024, or on the date that the State Department of Social Services notifies the Legislature that the Statewide Automated Welfare System can perform the necessary automation to implement these provisions or no automation is necessary, whichever date is later. To the extent this bill would expand county duties, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Primary Sponsors
Nancy Skinner

Bill Number	Last Action	Status	Position
SB 282	**September 1 Hearing Held In Committee And Under Submission 2023 09 01**	**In Assembly**	**Support**

Title
Medi-Cal: federally qualified health centers and rural health clinics.

Introduction Date: 2023-02-01

Description
SB 282, as amended, Eggman. Medi-Cal: federally qualified health centers and rural health clinics. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including federally qualified health center (FQHC) services and rural health clinic (RHC) services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, to the extent that federal financial participation is available, FQHC and RHC services are reimbursed on a per-visit basis, as specified. “Visit” is defined as a face-to-face encounter between a patient of an FQHC or RHC and a physician or other specified health care professionals. Under existing law, “visit” also includes an encounter using video or audio-only synchronous interaction or an asynchronous store and forward modality, as specified.This bill would authorize reimbursement for a maximum of 2 visits that take place on the same day at a single site, whether through a face-to-face or telehealth-based encounter, if after the first visit the patient suffers illness or injury that requires additional diagnosis or treatment, or if the patient has a medical visit and either a mental health visit or a dental visit, as defined. The bill would require the department, by July 1, 2024, to submit a state plan amendment to the federal Centers for Medicare and Medicaid Services reflecting those provisions.The bill would include a licensed acupuncturist within those health care professionals covered under the definition of a “visit.” The bill would also make a change to the provision relating to physicians and would make other technical changes.

Primary Sponsors
Susan Eggman, Mike McGuire, Cecilia Aguiar-Curry, Jim Wood

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 7:27 PM
Local Health Plans of California: Support L.A. Care: Support

Bill Number	Last Action	Status	Position
SB 294	**In Assembly Read First Time Held At Desk 2024 01 29**	**In Assembly**	**Monitor**

Title
Health care coverage: independent medical review.

Introduction Date: 2023-02-02

Description
SB 294, as amended, Wiener. Health care coverage: independent medical review. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of disability insurers by the Department of Insurance. Existing law establishes the Independent Medical Review System within each department, under which an enrollee or insured may seek review if a health care service has been denied, modified, or delayed by a health care service plan or disability insurer and the enrollee or insured has previously filed a grievance that remains unresolved after 30 days.This bill, commencing July 1, 2025, would require a health care service plan or a disability insurer that upholds its decision to modify, delay, or deny a health care service in response to a grievance or has a grievance that is otherwise pending or unresolved upon expiration of the relevant timeframe to automatically submit within 24 hours a decision regarding a disputed health care service to the Independent Medical Review System, as well as the information that informed its decision, if the decision is to deny, modify, or delay specified services relating to mental health or substance use disorder conditions for an enrollee or insured up to 26 years of age. The bill would require a health care service plan or disability insurer, within 24 hours after submitting its decision to the Independent Medical Review System to provide notice to the appropriate department, the enrollee or insured or their representative, if any, and the enrollee’s or insured’s provider. The bill would require the notice to include notification to the enrollee or insured that they or their representative may cancel the independent medical review at any time before a determination, as specified.This bill, commencing July 1, 2025, would require a health care service plan or disability insurer that provides coverage for mental health or substance use disorders to treat a modification, delay, or denial issued in response to an authorization request for coverage of treatment for a mental health or substance use disorder for an insured up to 26 years of age as if the modification, delay, or denial is also a grievance submitted by the enrollee or insured. The bill would require a plan or insurer to provide a written acknowledgment of a grievance that is automatically generated and would specify the circumstances under which that grievance is required to be submitted automatically to independent medical review.The bill would apply specified existing provisions relating to mental health and substance use disor... (click bill link to see more).

Primary Sponsors
Scott Wiener

Bill Number	Last Action	Status	Position
SB 324	**September 1 Hearing Held In Committee And Under Submission 2023 09 01**	**In Assembly**	**Monitor**

Title
Health care coverage: endometriosis.

Introduction Date: 2023-02-06

Description
SB 324, as amended, Limón. Health care coverage: endometriosis. (1) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or health insurer to use prior authorization and other utilization review functions, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity.This bill would prohibit a health care service plan contract or health insurance policy issued, amended, delivered, or renewed on or after January 1, 2024, from requiring prior authorization or other utilization review for any clinically indicated treatment for endometriosis, as determined by the treating physician and consistent with nationally recognized evidence-based clinical guidelines. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.(2) Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law sets forth a schedule of benefits under the Medi-Cal program.This bill would add any clinically indicated treatment for endometriosis, as determined by the treating physician and consistent with nationally recognized evidence-based clinical guidelines, as a covered benefit under Medi-Cal without prior authorization or other utilization review.(3) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Monique Limon

Organizational Notes

Last edited by Joanne Campbell at Apr 17, 2023, 4:45 PM
California Association of Health Plans: Oppose

Bill Number	Last Action	Status	Position
SB 339	**Chaptered By Secretary Of State Chapter 1 Statutes Of 2024 2024 02 06**	**Enacted**	**Monitor**

Title
HIV preexposure prophylaxis and postexposure prophylaxis.

Introduction Date: 2023-02-07

Description
SB 339, Wiener. HIV preexposure prophylaxis and postexposure prophylaxis. Existing law, the Pharmacy Law, provides for the licensure and regulation of pharmacists by the California State Board of Pharmacy. Existing law authorizes a pharmacist to furnish at least a 30-day supply of HIV preexposure prophylaxis, and up to a 60-day supply of those drugs if certain conditions are met. Existing law also authorizes a pharmacist to furnish postexposure prophylaxis to a patient if certain conditions are met.This bill would authorize a pharmacist to furnish up to a 90-day course of preexposure prophylaxis, or preexposure prophylaxis beyond a 90-day course, if specified conditions are met. The bill would require the California State Board of Pharmacy to adopt emergency regulations to implement these provisions by October 31, 2024.Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law prohibits a health care service plan or health insurer from covering preexposure prophylaxis that has been furnished by a pharmacist in excess of a 60-day supply once every 2 years, except as specified.Existing law provides for the Medi-Cal program administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services pursuant to a schedule of benefits. The existing schedule of benefits includes coverage for preexposure prophylaxis as pharmacist services, limited to no more than a 60-day supply furnished by a pharmacist once every 2 years, and includes coverage for postexposure prophylaxis, subject to approval by the federal Centers for Medicare and Medicaid Services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.This bill would require a health care service plan and health insurer to cover preexposure prophylaxis and postexposure prophylaxis furnished by a pharmacist, including the pharmacist’s services and related testing ordered by the pharmacist, and to pay or reimburse for the service performed by a pharmacist at an in-network pharmacy or a pharmacist at an out-of-network pharmacy if the health care service plan or health insurer has an out-of-network pharmacy benefit, except as specified. The bill would include preexposure prophylaxis furnished by a pharmacist as pharmacist services on the Medi-Cal schedule of benefits. Because a willful violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated l... (click bill link to see more).

Primary Sponsors
Scott Wiener, Mike Gipson

Organizational Notes

Last edited by Joanne Campbell at Jan 11, 2024, 5:48 PM
California Association of Health Plans: Oppose Unless Amended

Bill Number	Last Action	Status	Position
SB 340	**June 27 Set For First Hearing Canceled At The Request Of Author 2023 06 27**	**In Assembly**	**Monitor**

Title
Medi-Cal: eyeglasses: Prison Industry Authority.

Introduction Date: 2023-02-07

Description
SB 340, as introduced, Eggman. Medi-Cal: eyeglasses: Prison Industry Authority. Existing law establishes the Prison Industry Authority within the Department of Corrections and Rehabilitation and authorizes it to operate industrial, agricultural, and service enterprises that provide products and services needed by the state, or any political subdivision of the state, or by the federal government, or any department, agency, or corporation of the federal government, or for any other public use. Existing law requires state agencies to purchase these products and services at the prices fixed by the authority. Existing law also requires state agencies to make maximum utilization of these products and consult with the staff of the authority to develop new products and adapt existing products to meet their needs.Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including certain optometric services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.This bill, for purposes of Medi-Cal reimbursement for covered optometric services, would authorize a provider to obtain eyeglasses from a private entity, as an alternative to a purchase of eyeglasses from the Prison Industry Authority. The bill would condition implementation of this provision on the availability of federal financial participation.The bill, notwithstanding the above-described requirements, would authorize a provider participating in the Medi-Cal program to obtain eyeglasses from the authority or private entities, based on the optometrist’s needs and assessment of quality and value.

Primary Sponsors
Susan Eggman, Scott Wilk

Bill Number	Last Action	Status	Position
SB 363	**September 1 Hearing Held In Committee And Under Submission 2023 09 01**	**In Assembly**	**Monitor**

Title
Facilities for inpatient and residential mental health and substance use disorder: database.

Introduction Date: 2023-02-08

Description
SB 363, as amended, Eggman. Facilities for inpatient and residential mental health and substance use disorder: database. Existing law generally requires the State Department of Public Health to license, inspect, and regulate health facilities, defined to include, among other types of health facilities, an acute psychiatric hospital. Existing law generally requires the State Department of Social Services to license, inspect, and regulate various types of care facilities, including, among others, a community crisis home. Existing law requires the State Department of Health Care Services to license and regulate facilities that provide residential nonmedical services to adults who are recovering from problems related to alcohol, drug, or alcohol and drug misuse or abuse, and who need alcohol, drug, or alcohol and drug recovery treatment or detoxification services.This bill would require, by January 1, 2026, the State Department of Health Care Services, in consultation with the State Department of Public Health and the State Department of Social Services, and by conferring with specified stakeholders, to develop a real-time, internet-based database to collect, aggregate, and display information about beds in specified types of facilities, such as chemical dependency recovery hospitals, acute psychiatric hospitals, and mental health rehabilitation centers, among others, to identify the availability of inpatient and residential mental health or substance use disorder treatment. The bill would require the database to include a minimum of specific information, including the contact information for a facility’s designated employee, the types of diagnoses or treatments for which the bed is appropriate, and the target populations served at the facility, and have the capacity to, among other things, enable searches to identify beds that are appropriate for individuals in need of inpatient or residential mental health or substance use disorder treatment.This bill would authorize the department to impose a plan of correction or assess penalties against a facility that fails to submit data accurately, timely, or as otherwise required and would establish a process for facilities to appeal these penalties. The bill would create the Available Care for Inpatient and Residential Mental Health or Substance Use Disorder Treatment Database Maintenance and Oversight Fund for the receipt of any penalties. Because the bill would continuously appropriate moneys in the fund for administrative costs of implementing the database, it would create an appropriation.

Primary Sponsors
Susan Eggman

Bill Number	Last Action	Status	Position
SB 424	**Referred To Com On Health 2023 06 08**	**In Assembly**	**Monitor**

Title
Medi-Cal: Whole Child Model program.

Introduction Date: 2023-02-13

Description
SB 424, as amended, Durazo. Medi-Cal: Whole Child Model program. Existing law establishes the California Children's Services (CCS) Program, administered by the State Department of Health Care Services and a designated agency of each county, to provide medically necessary services for persons under 21 years of age who have any of specified medical conditions and who meet certain financial eligibility requirements.Existing law establishes the Medi-Cal program, which is administered by the department and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires the department to establish a statewide Whole Child Model program stakeholder advisory group that includes specified persons, including CCS case managers, and to consult with that advisory group on prescribed matters. Existing law terminates the advisory group on December 31, 2023.This bill would extend the operation of the advisory group until December 31, 2026.

Primary Sponsors
Maria Durazo

Organizational Notes

Last edited by Joanne Campbell at Jul 17, 2023, 9:27 PM
Local Health Plans of California: Oppose Unless Amended (Removed)

Bill Number	Last Action	Status	Position
SB 427	**In Senate Concurrence In Assembly Amendments Pending 2024 04 11**	**Passed Assembly**	**Monitor**

Title
Health care coverage: antiretroviral drugs, drug devices, and drug products.

Introduction Date: 2023-02-13

Description
SB 427, as amended, Portantino. Health care coverage: antiretroviral drugs, drug devices, and drug products. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally prohibits a health care service plan, excluding a Medi-Cal managed care plan, or health insurer from subjecting antiretroviral drugs that are medically necessary for the prevention of HIV/AIDS, including preexposure prophylaxis or postexposure prophylaxis, to prior authorization or step therapy. Under existing law, a health care service plan or health insurer is not required to cover all the therapeutically equivalent versions of those drugs without prior authorization or step therapy if at least one is covered without prior authorization or step therapy.This bill would prohibit a health care service plan, excluding a Medi-Cal managed care plan, or health insurer from subjecting antiretroviral drugs, drug devices, or drug products that are either approved by the United States Food and Drug Administration (FDA) or recommended by the federal Centers for Disease Control and Prevention (CDC) for the prevention of HIV/AIDS, to prior authorization or step therapy, but would authorize prior authorization or step therapy if at least one therapeutically equivalent version is covered without prior authorization or step therapy and the plan or insurer provides coverage for a noncovered therapeutic equivalent antiretroviral drug, drug device, or drug product without cost sharing pursuant to an exception request. The bill would require a plan or insurer to provide coverage under the outpatient prescription drug benefit for those drugs, drug devices, or drug products, including by supplying participating providers directly with a drug, drug device, or drug product, as specified.This bill would require a nongrandfathered or grandfathered health care service plan contract or health insurance policy to provide coverage for antiretroviral drugs, drug devices, or drug products that are either approved by the FDA or recommended by the CDC for the prevention of HIV/AIDS, and would prohibit a nongrandfathered or grandfathered health care service plan contract or health insurance policy from imposing any cost-sharing or utilization review requirements for those drugs, drug devices, or drug products. The bill would exempt Medi-Cal managed care plans from these provisions and would delay the application of these provisions for an individual and small group health care service plan contract or ... (click bill link to see more).

Primary Sponsors
Anthony Portantino

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 6:00 PM
California Association of Health Plans: Oppose

Bill Number	Last Action	Status	Position
SB 516	**Re Referred To Com On Appr Pursuant To Assembly Rule 96 2023 09 14**	**Passed Assembly**	**Monitor**

Title
Health care coverage: prior authorization.

Introduction Date: 2023-02-14

Description
SB 516, as amended, Skinner. Health care coverage: prior authorization. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or health insurer to use prior authorization and other utilization review or utilization management functions, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Existing law requires a health care service plan or health insurer, including those plans or insurers that delegate utilization review or utilization management functions to medical groups, independent practice associations, or to other contracting providers, to comply with specified requirements and limitations on their utilization review or utilization management functions. Existing law requires the criteria or guidelines used to determine whether or not to authorize, modify, or deny health care services to be developed with involvement from actively practicing health care providers.On or after January 1, 2026, this bill would prohibit a health care service plan or health insurer from requiring a contracted health professional to complete or obtain a prior authorization for any covered health care services if the plan or insurer approved or would have approved not less than 90% of the prior authorization requests they submitted in the most recent completed one-year contracted period. The bill would set standards for this exemption and its denial, rescission, and appeal. The bill would authorize a plan or insurer to evaluate the continuation of an exemption not more than once every 12 months, and would authorize a plan or insurer to rescind an exemption only at the end of the 12-month period and only if specified criteria are met. The bill would require a plan or insurer to provide an electronic prior authorization process. The bill would also require a plan or insurer to have a process for annually monitoring prior authorization approval, modification, appeal, and denial rates to identify services, items, and supplies that are regularly approved, and to discontinue prior authorization on those services, items, and supplies that are approved 95% of the time. Because a willful violation of the bill’s requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.The California Constit... (click bill link to see more).

Primary Sponsors
Nancy Skinner

Organizational Notes

Last edited by Joanne Campbell at Apr 22, 2024, 6:16 PM
Local Health Plan of California - Oppose

Bill Number	Last Action	Status	Position
SB 537	**Ordered To Inactive File On Request Of Assembly Member Bryan 2023 09 14**	**In Assembly**	**Monitor**

Title
Open meetings: multijurisdictional, cross-county agencies: teleconferences.

Introduction Date: 2023-02-14

Description
SB 537, as amended, Becker. Open meetings: multijurisdictional, cross-county agencies: teleconferences. Existing law, the Ralph M. Brown Act, requires, with specified exceptions, that all meetings of a legislative body, as defined, of a local agency be open and public and that all persons be permitted to attend and participate. The act generally requires for teleconferencing that the legislative body of a local agency that elects to use teleconferencing post agendas at all teleconference locations, identify each teleconference location in the notice and agenda of the meeting or proceeding, and have each teleconference location be accessible to the public. Existing law also requires that, during the teleconference, at least a quorum of the members of the legislative body participate from locations within the boundaries of the territory over which the local agency exercises jurisdiction. The act provides an exemption to the jurisdictional requirement for health authorities, as defined.Existing law, until January 1, 2024, authorizes the legislative body of a local agency to use alternate teleconferencing provisions during a proclaimed state of emergency or in other situations related to public health that exempt a legislative body from the general requirements (emergency provisions) and impose different requirements for notice, agenda, and public participation, as prescribed. The emergency provisions specify that they do not require a legislative body to provide a physical location from which the public may attend or comment.Existing law, until January 1, 2026, authorizes the legislative body of a local agency to use alternative teleconferencing in certain circumstances related to the particular member if at least a quorum of its members participate from a singular physical location that is open to the public and situated within the agency’s jurisdiction and other requirements are met, including restrictions on remote participation by a member of the legislative body. These circumstances include if a member shows “just cause,” including for a childcare or caregiving need of a relative that requires the member to participate remotely. This bill would expand the circumstances of “just cause” to apply to the situation in which an immunocompromised child, parent, grandparent, or other specified relative requires the member to participate remotely. The bill would authorize the legislative body of a multijurisdictional, cross-county agency, as specified, to use alternate teleconferencing provisions if the eligible legislative body has adopted an authorizing resolution, as specified. The bill would also require the legislative body to provide a record of attendance of the members of the legislative body, the number of community me... (click bill link to see more).

Primary Sponsors
Josh Becker

Bill Number	Last Action	Status	Position
SB 598	**September 1 Hearing Held In Committee And Under Submission 2023 09 01**	**In Assembly**	**Monitor**

Title
Health care coverage: prior authorization.

Introduction Date: 2023-02-15

Description
SB 598, as amended, Skinner. Health care coverage: prior authorization. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or health insurer to use prior authorization and other utilization review or utilization management functions, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Existing law requires a health care service plan or health insurer, including those plans or insurers that delegate utilization review or utilization management functions to medical groups, independent practice associations, or to other contracting providers, to comply with specified requirements and limitations on their utilization review or utilization management functions. Existing law requires the criteria or guidelines used to determine whether or not to authorize, modify, or deny health care services to be developed with involvement from actively practicing health care providers.On or after January 1, 2026, this bill would prohibit a health care service plan or health insurer from requiring a contracted health professional to complete or obtain a prior authorization for any covered health care services if the plan or insurer approved or would have approved not less than 90% of the prior authorization requests they submitted in the most recent completed one-year contracted period. The bill would set standards for this exemption and its denial, rescission, and appeal. The bill would authorize a plan or insurer to evaluate the continuation of an exemption not more than once every 12 months, and would authorize a plan or insurer to rescind an exemption only at the end of the 12-month period and only if specified criteria are met. The bill would require a plan or insurer to provide an electronic prior authorization process. The bill would also require a plan or insurer to have a process for annually monitoring prior authorization approval, modification, appeal, and denial rates to identify services, items, and supplies that are regularly approved, and to discontinue prior authorization on those services, items, and supplies that are approved 95% of the time. Because a willful violation of the bill’s requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.The California Constitut... (click bill link to see more).

Primary Sponsors
Nancy Skinner

Organizational Notes

Last edited by Joanne Campbell at Jun 5, 2023, 8:59 PM
Local Health Plans of California: Oppose Unless Amended

Last edited by Joanne Campbell at Apr 17, 2023, 4:46 PM
California Association of Health Plans: Oppose

Bill Number	Last Action	Status	Position
SB 607	**In Assembly Read First Time Held At Desk 2024 01 22**	**In Assembly**	**Monitor**

Title
Controlled substances.

Introduction Date: 2023-02-15

Description
SB 607, as amended, Portantino. Controlled substances. Existing law requires a prescriber, with certain exceptions, before directly dispensing or issuing for a minor the first prescription for a controlled substance containing an opioid in a single course of treatment, to discuss specified information with the minor, the minor’s parent or guardian, or another adult authorized to consent to the minor’s medical treatment.This bill would extend that requirement for the prescriber by applying it to any patient, not only a minor, under those circumstances.

Primary Sponsors
Anthony Portantino

Bill Number	Last Action	Status	Position
SB 729	**September 1 Hearing Postponed By Committee 2023 09 01**	**In Assembly**	**Monitor**

Title
Health care coverage: treatment for infertility and fertility services.

Introduction Date: 2023-02-17

Description
SB 729, as amended, Menjivar. Health care coverage: treatment for infertility and fertility services. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of disability insurers by the Department of Insurance. Existing law imposes various requirements and restrictions on health care service plans and disability insurers, including, among other things, a requirement that every group health care service plan contract or disability insurance policy that is issued, amended, or renewed on or after January 1, 1990, offer coverage for the treatment of infertility, except in vitro fertilization.This bill would require large and small group health care service plan contracts and disability insurance policies issued, amended, or renewed on or after January 1, 2024, to provide coverage for the diagnosis and treatment of infertility and fertility services. With respect to large group health care service plan contracts and disability insurance policies, the bill would require coverage for a maximum of 3 completed oocyte retrievals, as specified. The bill would revise the definition of infertility, and would remove the exclusion of in vitro fertilization from coverage. The bill would also delete a requirement that a health care service plan contract and disability insurance policy provide infertility treatment under agreed-upon terms that are communicated to all group contractholders and policyholders. The bill would prohibit a health care service plan or disability insurer from placing different conditions or coverage limitations on fertility medications or services, or the diagnosis and treatment of infertility and fertility services, than would apply to other conditions, as specified. The bill would make these requirements inapplicable to a religious employer, as defined, and specified contracts and policies.Because the violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Caroline Menjivar, Buffy Wicks

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 6:01 PM
California Association of Health Plans: Oppose

Bill Number	Last Action	Status	Position
SB 819	**Ordered To Inactive File On Request Of Assembly Member Bryan 2023 08 28**	**In Assembly**	**Monitor**

Title
Medi-Cal: certification.

Introduction Date: 2023-02-17

Description
SB 819, as amended, Eggman. Medi-Cal: certification. Existing law requires the State Department of Public Health to license and regulate clinics. Existing law exempts from those licensing provisions certain clinics that are directly conducted, maintained, or operated by federal, state, or local governmental entities, as specified. Existing law also exempts from those licensing provisions a clinic that is operated by a primary care community or free clinic, that is operated on separate premises from the licensed clinic, and that is only open for limited services of no more than 40 hours per week.Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services (department) and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Existing law sets forth various procedures, including the submission of an application package, for providers to enroll in the Medi-Cal program. Under existing law, an applicant or provider that is a government-run license-exempt clinic as described above is required to comply with those Medi-Cal enrollment procedures.Under existing law, an applicant or provider that is operated on separate premises and is license exempt, including an intermittent site or mobile health care unit that is operated by a licensed primary care clinic that provides all staffing, protocols, equipment, supplies, and billing services, is not required to enroll in the Medi-Cal program as a separate provider or comply with the above-described enrollment procedures, if the licensed primary care clinic has notified the department of its separate locations, premises, intermittent sites, or mobile health care units.This bill would additionally exempt from the Medi-Cal enrollment procedures an intermittent site or mobile health care unit that is operated by the above-described government-run license-exempt clinic if that clinic has notified the department of its separate locations, premises, sites, or units.The bill would make legislative findings stating that this bill is declaratory of existing law, as specified.

Primary Sponsors
Susan Eggman

Bill Number	Last Action	Status	Position
SB 873	**September 1 Hearing Held In Committee And Under Submission 2023 09 01**	**In Assembly**	**Monitor**

Title
Prescription drugs: cost sharing.

Introduction Date: 2023-02-17

Description
SB 873, as introduced, Bradford. Prescription drugs: cost sharing. (1) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care under authority of the Director of the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance under the authority of the Insurance Commissioner. Existing law limits the maximum amount an enrollee or insured may be required to pay at the point of sale for a covered prescription drug to the lesser of the applicable cost-sharing amount or the retail price.This bill, commencing no later than January 1, 2025, would require an enrollee’s or insured’s defined cost sharing for each prescription drug to be calculated at the point of sale based on a price that is reduced by an amount equal to 90% of all rebates received, or to be received, in connection with the dispensing or administration of the drug. The bill would require a health care service plan or health insurer to, among other things, pass through to each enrollee or insured at the point of sale a good faith estimate of the enrollee’s or insured’s decrease in cost sharing. The bill would require a health care service plan or health insurer to calculate an enrollee’s or insured’s defined cost sharing and provide that information to the dispensing pharmacy, as specified. The bill would require the department and the commissioner to submit an annual report on the impact of these provisions to the appropriate policy committees of the Legislature, as specified. The bill would make these provisions inoperative on January 1, 2027.(2) Existing law requires a health care service plan or health insurer that files certain rate information to report to the appropriate department specified cost information regarding covered prescription drugs, including generic drugs, brand name drugs, and specialty drugs, dispensed as provided.This bill, until January 1, 2027, would require a health care service plan or health insurer to report additional information on the above-described point of sale provision.(3) Because a willful violation of the bill’s provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Steve Bradford

Organizational Notes

Last edited by Joanne Campbell at Apr 17, 2023, 4:06 PM
California Association of Health Plans: Oppose

Bill Number	Last Action	Status	Position
SB 895	**Set For Hearing April 24 2024 04 11**	**In Senate**	**Monitor**

Title
Community colleges: Baccalaureate Degree in Nursing Pilot Program.

Introduction Date: 2024-01-03

Description
SB 895, as amended, Roth. Community colleges: Baccalaureate Degree in Nursing Pilot Program. Existing law establishes the California Community Colleges, under the administration of the Board of Governors of the California Community Colleges. Existing law establishes community college districts throughout the state, under the administration of community college district governing boards, and authorizes these districts to provide instruction at the community college campuses they operate. Existing law establishes a statewide baccalaureate degree program that authorizes up to a total of 30 baccalaureate degree programs at community college districts to be approved per academic year, as provided.This bill would require the Chancellor of the California Community Colleges to develop a Baccalaureate Degree in Nursing Pilot Program that authorizes select community college districts to offer a Bachelor of Science in Nursing degree. The bill would limit the pilot program to 15 community college districts statewide and would require the chancellor to identify eligible community college districts based on specified criteria. The bill would require the Legislative Analyst’s Office to conduct an evaluation of the pilot program to determine the effectiveness of the program and the need to continue or expand the program. The bill would repeal these provisions as of January 1, 2031.

Primary Sponsors
Richard Roth, Anna Caballero

Bill Number	Last Action	Status	Position
SB 942	**From Committee Do Pass And Re Refer To Com On G O Ayes 10 Noes 1 April 16 Re Referred To Com On G O 2024 04 17**	**In Senate**	**Monitor**

Title
California AI Transparency Act.

Introduction Date: 2024-01-17

Description
SB 942, as amended, Becker. California AI Transparency Act. Existing law requires the Secretary of Government Operations to develop a coordinated plan to, among other things, investigate the feasibility of, and obstacles to, developing standards and technologies for state departments to determine digital content provenance. For the purpose of informing that coordinated plan, existing law requires the secretary to evaluate, among other things, the impact of the proliferation of deepfakes, defined to mean audio or visual content that has been generated or manipulated by artificial intelligence that would falsely appear to be authentic or truthful and that features depictions of people appearing to say or do things they did not say or do without their consent, on state government, California-based businesses, and residents of the state.This bill, the California AI Transparency Act, would, among other things, require a covered provider, as defined, to create an AI detection tool by which a person can query the covered provider as to the extent to which text, image, video, audio, or multimedia content was created, in whole or in part, by a generative AI system, as defined, provided by the covered provider that meets certain criteria, including that the AI detection tool is publicly accessible and available via a uniform resource locator (URL) on the covered provider’s internet website and through its mobile application, as applicable. The act would also require a covered provider to include in AI-generated image, text, video, or multimedia content created by a generative AI system it provides a visible disclosure that, among other things, includes a clear and conspicuous notice, as appropriate for the medium of the content, that identifies the content as generated by AI, such that the disclosure is not avoidable, is understandable to a reasonable person, and is not contradicted, mitigated by, or inconsistent with anything else in the communication.The act would create the Generative AI Registry Fund and would require moneys in the fund to be made available, only upon appropriation by the Legislature, to the Department of Technology for the purposes of the act.The act would require a covered provider to register with the department and provide to the department a URL to any AI detection tool it has created. The act would authorize the department to charge a registration fee, which shall be deposited into the Generative AI Registry Fund, to a covered provider, as specified. The act would require the department to create and display on its internet website the Generative AI Registry that displays the name of any covered provider registered with the department and a link to the covered provider’s AI detection tool. The act wo... (click bill link to see more).

Primary Sponsors
Josh Becker

Bill Number	Last Action	Status	Position
SB 953	**April 8 Hearing Placed On Appr Suspense File 2024 04 08**	**In Senate**	**Monitor**

Title
Medi-Cal: menstrual products.

Introduction Date: 2024-01-22

Description
SB 953, as amended, Menjivar. Medi-Cal: menstrual products. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes a schedule of covered benefits under the Medi-Cal program.This bill would add menstrual products, as defined, to that schedule of covered benefits. The bill would require the department to seek any necessary federal approvals to implement this coverage. The bill would require the department to seek, and would authorize the department to use, any and all available federal funding, as specified, to implement this coverage.

Primary Sponsors
Caroline Menjivar

Bill Number	Last Action	Status	Position
SB 957	**April 15 Hearing Placed On Appr Suspense File 2024 04 15**	**In Senate**	**Monitor**

Title
Data collection: sexual orientation and gender identity.

Introduction Date: 2024-01-22

Description
SB 957, as introduced, Wiener. Data collection: sexual orientation and gender identity. (1) Existing law, the Lesbian, Gay, Bisexual, and Transgender Disparities Reduction Act, requires the State Department of Public Health, among other specified state entities, in the course of collecting demographic data directly or by contract as to the ancestry or ethnic origin of Californians, to collect voluntary self-identification information pertaining to sexual orientation, gender identity, and intersexuality.Existing law, as an exception to the provision above, authorizes those state entities, instead of requiring them, to collect the demographic data under either of the following circumstances: (a) pursuant to federal programs or surveys, whereby the guidelines for demographic data collection categories are defined by the federal program or survey; or (b) demographic data are collected by other entities, including other state agencies, surveys administered by third-party entities and the state department is not the sole funder, or third-party entities that provide aggregated data to a state department.This bill, notwithstanding the exception above, would require the State Department of Public Health to collect the demographic data from third parties, including, but not limited to, local health jurisdictions, on any forms or electronic data systems, unless prohibited by federal or state law. To the extent that the bill would create new duties for local officials in facilitating the department’s data collection, the bill would impose a state-mandated local program. Existing law requires the above-described state entities to report to the Legislature the data collected and the method used to collect the data, and to make the data available to the public, except for personally identifiable information. Existing law deems that personally identifiable information confidential and prohibits it disclosure. Existing law sets forth different deadlines, depending on the specified state entity, for complying with those requirements.This bill would require the State Department of Public Health, for purposes of the data collected by the department on sexual orientation, gender identity, and intersexuality, to comply with the above-described requirements by July 1, 2026.(2) Existing law authorizes local health officers and the State Department of Public Health to operate immunization information systems. Existing law requires health care providers and other certain agencies, including schools and county human services agencies, to disclose specified immunization and other information about the patient or client to local health departments and the State Department of Public Health. Existing law authorizes local health departments and the S... (click bill link to see more).

Primary Sponsors
Scott Wiener

Bill Number	Last Action	Status	Position
SB 966	**From Committee With Authors Amendments Read Second Time And Amended Re Referred To Com On Health 2024 04 18**	**In Senate**	**Monitor**

Title
Pharmacy benefits.

Introduction Date: 2024-01-24

Description
SB 966, as amended, Wiener. Pharmacy benefits. Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (the Knox-Keene Act), a violation of which is a crime, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. The Knox-Keene Act requires a pharmacy benefit manager under contract with a health care service plan to, among other things, register with the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance.This bill would additionally require a pharmacy benefit manager, as defined by the bill, to apply for and obtain a license from the Department of Insurance to operate as a pharmacy benefit manager. The bill would establish application qualifications and requirements, and would establish an unspecified fee for initial licensure and renewal.This bill would require a pharmacy benefit manager, on or before April 1, 2027, and annually thereafter, to file with the department a report containing specified information. The bill would specify that the contents of the report shall not be disclosed to the public. The bill would require the department, on or before August 1, 2027, and annually thereafter, to submit a report to the Legislature based on the reports submitted by licensees, and would require the department to post the report on the department’s internet website.This bill would impose specified duties on pharmacy benefit managers and requirements for pharmacy benefit manager services and pharmacy benefit manager contracts, including prohibiting a pharmacy benefit manager from deriving income from pharmacy benefit management services, except as specified. The bill would make a violation of the above-specified provisions subject to specified civil penalties. Existing law requires a health care service plan contract or health insurance policy that provides coverage for outpatient prescription drugs to cover medically necessary prescription drugs and subjects those policies to certain limitations on cost sharing and the placement of drugs on formularies. Existing law limits the maximum amount an enrollee or insured may be required to pay at the point of sale for a covered prescription drug to the lesser of the applicable cost-sharing amount or the retail price, and requires that payment apply to the applicable deductible.This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, that provides prescription drug coverage to calculate an enrollee or insured’s cost sharing amount, including deductible and coinsurance, based exclusively on its negotiated rate for the prescription drug. The ... (click bill link to see more).

Primary Sponsors
Scott Wiener

Organizational Notes

Last edited by Joanne Campbell at Apr 19, 2024, 8:12 PM
California Association of Health Plans - Oppose

Bill Number	Last Action	Status	Position
SB 975	**Referred To Com On Rls 2024 02 14**	**In Senate**	**Monitor**

Title
Emergency medical services: community paramedicine.

Introduction Date: 2024-01-29

Description
SB 975, as introduced, Ashby. Emergency medical services: community paramedicine. Existing law, the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, governs local emergency medical services (EMS) systems.This bill would state the intent of the Legislature to enact legislation relating to the payment and reimbursement for mobile integrated health and community paramedicine programs.

Primary Sponsors
Angelique Ashby

Bill Number	Last Action	Status	Position
SB 980	**April 8 Hearing Placed On Appr Suspense File 2024 04 08**	**In Senate**	**Monitor**

Title
Medi-Cal: dental crowns and implants.

Introduction Date: 2024-01-29

Description
SB 980, as amended, Wahab. Medi-Cal: dental crowns and implants. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including certain dental services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, early and periodic screening, diagnostic, and treatment (EPSDT) services are covered under Medi-Cal for an individual under 21 years of age in accordance with certain federal provisions.Under existing law, for persons 21 years of age or older, laboratory-processed crowns on posterior teeth are a covered benefit when medically necessary to restore a posterior tooth back to normal function based on the criteria specified in the Medi-Cal Dental Manual of Criteria.This bill, for purposes of the above-described Medi-Cal coverage for laboratory-processed crowns, would remove the condition that the tooth be posterior and would apply the coverage to persons 13 years of age or older. Under the bill, this provision would not be construed to exclude Medi-Cal coverage for laboratory-processed crowns on teeth if otherwise required under EPSDT services. The bill would also add, as a covered Medi-Cal benefit for persons of any age, a dental implant if tooth extraction or removal is medically necessary or if the corresponding tooth is missing.

Primary Sponsors
Aisha Wahab

Organizational Notes

Last edited by Joanne Campbell at Mar 22, 2024, 6:07 PM
California Alliance for Retired Americans (sponsor) - Support

Bill Number	Last Action	Status	Position
SB 999	**From Committee With Authors Amendments Read Second Time And Amended Re Referred To Com On Health 2024 04 08**	**In Senate**	**Monitor**

Title
Health coverage: mental health and substance use disorders.

Introduction Date: 2024-02-01

Description
SB 999, as amended, Cortese. Health coverage: mental health and substance use disorders. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service plans and makes a willful violation of the act a crime. Existing law also requires the Department of Insurance to regulate health insurers. Existing law requires a health care service plan or disability insurer, as specified, to base medical necessity determinations and the utilization review criteria the plan or insurer, and any entity acting on the plan's or insurer's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders, on current generally accepted standards of mental health and substance use disorder care.This bill would require a health care service plan and a disability insurer, and an entity acting on a plan's or insurer's behalf, to ensure compliance with specific requirements for utilization review, including maintaining telephone access and other direct communication access during California business hours for a health care provider to request authorization for mental health and substance use disorder care and conducting peer-to-peer discussions regarding specific patient issues related to treatment. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Dave Cortese

Organizational Notes

Last edited by Joanne Campbell at Mar 7, 2024, 9:19 PM
California Association of Health Plans - Oppose

Bill Number	Last Action	Status	Position
SB 1008	**Set For Hearing April 24 2024 04 05**	**In Senate**	**Monitor**

Title
Obesity Treatment Parity Act.

Introduction Date: 2024-02-01

Description
SB 1008, as amended, Bradford. Obesity Treatment Parity Act. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act’s requirements a crime. Existing law provides for the regulation of disability and health insurers by the Department of Insurance. Existing law sets forth specified coverage requirements for plan contracts and insurance policies, and limits the copayment, coinsurance, deductible, and other cost sharing that may be imposed for specified health care services.This bill would require an individual or group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to include comprehensive coverage for the treatment of obesity, including coverage for intensive behavioral therapy, bariatric surgery, and at least one FDA-approved antiobesity medication.Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Steve Bradford

Organizational Notes

Last edited by Joanne Campbell at Apr 19, 2024, 8:13 PM
California Association of Health Plans - Oppose

Bill Number	Last Action	Status	Position
SB 1017	**April 15 Hearing Placed On Appr Suspense File 2024 04 15**	**In Senate**	**Monitor**

Title
Available facilities for inpatient and residential mental health or substance use disorder treatment.

Introduction Date: 2024-02-05

Description
SB 1017, as introduced, Eggman. Available facilities for inpatient and residential mental health or substance use disorder treatment. Existing law generally requires the State Department of Public Health to license, inspect, and regulate health facilities, defined to include, among other types of health facilities, an acute psychiatric hospital. Existing law generally requires the State Department of Social Services to license, inspect, and regulate various types of care facilities, including, among others, a community crisis home. Existing law requires the State Department of Health Care Services to license and regulate facilities that provide residential nonmedical services to adults who are recovering from problems related to alcohol, drug, or alcohol and drug misuse or abuse, and who need alcohol, drug, or alcohol and drug recovery treatment or detoxification services.This bill would require the State Department of Health Care Services, in consultation with the State Department of Public Health and the State Department of Social Services, and by conferring with specified stakeholders, to develop a solution to collect, aggregate, and display information about beds in specified types of facilities, including licensed community care facilities and licensed residential alcoholism or drug abuse recovery or treatment facilities, to identify the availability of inpatient and residential mental health or substance use disorder treatment. The bill would require the solution to be operational by January 1, 2026, or the date the State Department of Health Care Services communicates to the Department of Finance in writing that the solution has been implemented to meet these provisions, whichever date is later.The bill would require the facilities subject to these provisions to submit accurate and timely data to the solution that includes, among other information, the facility’s license type, whether a bed is available, and the target population served at the facility. The bill would require the solution and information contained in the solution to be maintained in compliance with state and federal confidentiality laws. The bill would also prohibit the solution and information contained in the solution from being publically available.The bill would authorize the State Department of Health Care Services to impose a plan of correction against a facility that failed to comply with the requirements of the solution, and if a facility fails to complete a plan of correction, would further authorize the department to impose civil penalties, subject to an appeal and hearing process. The bill would create the Available Care for Inpatient and Residential Mental Health or Substance Use Disorder Treatment Solution Maintenance and Oversight Fu... (click bill link to see more).

Primary Sponsors
Susan Eggman

Organizational Notes

Last edited by Joanne Campbell at Mar 22, 2024, 6:09 PM
Psychiatric Physicians Alliance of California (sponsor) - Support Steinberg Institute - Support California Association of Alcohol and Drug Program Executives, Inc. - Oppose County Behavioral Health Directors Association of California - Oppose (unless amended)

Bill Number	Last Action	Status	Position
SB 1042	**From Committee With Authors Amendments Read Second Time And Amended Re Referred To Com On B P E D 2024 04 17**	**In Senate**	**Monitor**

Title
Health facilities and clinics: clinical placements: nursing.

Introduction Date: 2024-02-07

Description
SB 1042, as amended, Roth. Health facilities and clinics: clinical placements: nursing. Existing law establishes the Department of Health Care Access and Information (HCAI) to oversee health planning and health policy research, including the health care workforce research and data center. Existing law, the Nursing Practice Act, establishes the Board of Registered Nursing within the Department of Consumer Affairs for the licensure and regulation of nurses. Existing law provides for the licensure and regulation of health facilities and clinics, as defined, by the State Department of Public Health.Existing law requires an organization that operates, conducts, owns, or maintains a health facility, and the officers thereof, to make and file with HCAI certain reports, including balance sheets and other financial statements. Existing law sets forth related reporting provisions for clinics.This bill would require a health facility or a clinic, whether or not it currently offers prelicensure clinical placement slots, to meet with representatives from an approved school of nursing or approved nursing program, upon request by the school or program, to discuss the clinical placement needs of the school or program. The bill would require a nursing school or program to report to the board the beginning and end dates of the academic term for each clinical slot needed by a clinical group with content area and education level, and the number of clinical slots that the school or program has been unable to fill. The bill would require the board to submit that information to HCAI.The bill would require a health facility or a clinic, whether or not it currently offers prelicensure clinical placement slots, to prepare and submit to HCAI a report, with updates, on clinical placements for nursing students. Under the bill, the report would include, among other things, the estimated number of days and shifts available for student use for each type of licensed bed or unit. The bill would require HCAI to post the report on its internet website in a manner that allows for the information in the report to be cross-referenced against the above-described information from the nursing school or program.The bill would authorize the board, upon request by a nursing school or program, to assist in finding and securing clinical placement slots to meet the clinical placement needs of that school or program, by conferring with health facilities or clinics within the appropriate geographic region of each school or program in an attempt to match available clinical placement slots with needed slots and to encourage the creation of new clinical placement slots at additional clinical training sites to meet school or program demands. If the board attempts to meet cl... (click bill link to see more).

Primary Sponsors
Richard Roth

Bill Number	Last Action	Status	Position
SB 1099	**Set For Hearing April 22 2024 04 18**	**In Senate**	**Monitor**

Title
Newborn screening: genetic diseases: blood samples collected.

Introduction Date: 2024-02-13

Description
SB 1099, as amended, Nguyen. Newborn screening: genetic diseases: blood samples collected. Existing law requires the State Department of Public Health to administer a statewide program for prenatal testing for genetic disorders and birth defects, including, but not limited to, ultrasound, amniocentesis, chorionic villus sampling, and blood testing. Existing law requires the department to expand prenatal screening to include all tests that meet or exceed the current standard of care as recommended by national recognized medical or genetic organizations. Existing law requires the department to set guidelines for invoicing, charging, and collecting fee amounts from approved researchers in order to cover the costs of, among other things, data linkage, retrieval, and data processing. Existing law establishes the continuously appropriated Birth Defects Monitoring Program Fund, consisting of fees paid for prenatal screening, and states the intent of the Legislature that all costs of the genetic disease testing program be fully supported by fees paid for prenatal screening tests, which are deposited in the fund. Existing law requires funds to be available, upon appropriation by the Legislature, in order to support pregnancy blood sample storage, testing, and research activities of the Birth Defects Monitoring Program.This bill would require the department, commencing July 1, 2026, and each July 1 thereafter, as part of its research activities, to report various data to the Legislature, including the number of research projects utilizing residual screening samples from the program and the number of inheritable conditions identified by the original screening tests the previous calendar year. The bill would require the department to additionally set fee guidelines to cover the costs of reporting. The bill would also require the annual report to be made available to the public on the department’s internet website.This bill would make other conforming changes.

Primary Sponsors
Janet Nguyen

Bill Number	Last Action	Status	Position
SB 1112	**From Committee Do Pass And Re Refer To Com On Appr With Recommendation To Consent Calendar Ayes 5 Noes 0 April 15 Re Referred To Com On Appr 2024 04 16**	**In Senate**	**Monitor**

Title
Medi-Cal: families with subsidized childcare.

Introduction Date: 2024-02-13

Description
SB 1112, as amended, Menjivar. Medi-Cal: families with subsidized childcare. Existing law establishes a system of childcare and development services, administered by the State Department of Social Services, for children from infancy to 13 years of age. Existing law authorizes, upon departmental approval, the use of appropriated funds for alternative payment programs to allow for maximum parental choice. Existing law authorizes those programs to include, among other things, a subsidy that follows the family from one childcare provider to another, or choices among hours of service. Existing law requires the department to contract with local contracting agencies for alternative payment programs so that services are provided throughout the state.Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, through managed care or fee-for-service delivery systems. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, early and periodic screening, diagnostic, and treatment (EPSDT) services are covered Medi-Cal benefits for individuals under 21 years of age.This bill, subject to any necessary federal approvals and the availability of federal funding, would require the State Department of Health Care Services and the State Department of Social Services to develop a model memorandum of understanding (MOU), and would require the department to require Medi-Cal managed care plans and alternative payment agencies to enter an MOU that includes, at a minimum, the provisions included in the model.For purposes of children of families receiving subsidized childcare services through an alternative payment program, and upon the consent of the parent or guardian, the bill would require the plans and agencies to collaborate on assisting the family with the Medi-Cal enrollment of a child who is eligible but not a beneficiary, and on referring a Medi-Cal beneficiary to developmental screenings that are available under EPSDT services and administered through the plan. The bill would authorize the agency to perform certain related functions.

Primary Sponsors
Caroline Menjivar

Organizational Notes

Last edited by Joanne Campbell at Mar 22, 2024, 6:14 PM
Child Care Resource Center (sponsor) - Support Child Care Alliance Los Angeles - Support Thriving Families California (formerly California Alternative Payment Program Association) - Support

Bill Number	Last Action	Status	Position
SB 1119	**April 15 Hearing Placed On Appr Suspense File 2024 04 15**	**In Senate**	**Monitor**

Title
Hospitals: seismic compliance.

Introduction Date: 2024-02-13

Description
SB 1119, as introduced, Newman. Hospitals: seismic compliance. Existing law, the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983, establishes a program of seismic safety building standards for certain hospitals. Existing law requires hospitals that are seeking an extension for their buildings to submit an application to the Department of Health Care Access and Information by April 1, 2019, subject to certain exceptions. Existing law requires that final seismic compliance be achieved by July 1, 2022, if the compliance is based on a replacement or retrofit plan, or by January 1, 2025, if the compliance is based on a rebuild plan. Notwithstanding the above provisions, existing law authorizes the department to waive the requirements of the act for the O'Connor Hospital and Santa Clara Valley Medical Center in the City of San Jose if the hospital or medical center submits a plan for compliance by a specified date, and the department accepts the plan based on it being feasible to complete and promoting public safety. Existing law requires, if the department accepts the plan, the hospital or medical center to report to the department on its progress to timely complete the plan by specified dates. Existing law imposes penalties to a hospital that fails to meet its deadline.This bill would add Providence St. Joseph Hospital and Providence Eureka General Hospital in the City of Eureka, Providence St. Jude Medical Center in the City of Fullerton, and Providence Cedars-Sinai Tarzana Medical Center in the City of Tarzana to the hospitals for which the department may waive the requirements of the act. The bill would add additional dates for the hospital or medical center to report to the department on its progress.This bill would declare that it is to take effect immediately as an urgency statute.

Primary Sponsors
Josh Newman

Bill Number	Last Action	Status	Position
SB 1120	**Set For Hearing April 22 2024 04 16**	**In Senate**	**Monitor**

Title
Health care coverage: utilization review.

Introduction Date: 2024-02-13

Description
SB 1120, as amended, Becker. Health care coverage: utilization review. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or health insurer to use prior authorization and other utilization review or utilization management functions, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Existing law requires a health care service plan or health insurer, including those plans or insurers that delegate utilization review or utilization management functions to medical groups, independent practice associations, or to other contracting providers, to comply with specified requirements and limitations on their utilization review or utilization management functions. Existing law authorizes the Director of the Department of Managed Health Care or the Insurance Commissioner to assess an administrative penalty to a health care service plan or health insurer, as applicable, for failure to comply with those requirements. This bill would require algorithms, artificial intelligence, and other software tools used for utilization review or utilization management decisions to comply with specified requirements, including that they be fairly and equitably applied. Because a willful violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Josh Becker

Bill Number	Last Action	Status	Position
SB 1131	**April 15 Hearing Placed On Appr Suspense File 2024 04 15**	**In Senate**	**Monitor**

Title
Medi-Cal providers.

Introduction Date: 2024-02-13

Description
SB 1131, as amended, Gonzalez. Medi-Cal providers. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, services provided by a certified nurse practitioner are covered under the Medi-Cal program to the extent authorized by federal law, and existing law requires the department to permit a certified nurse practitioner to bill Medi-Cal independently for their services.This bill would similarly make services provided by a licensed physician assistant covered under the Medi-Cal program and would require the department to permit a certified nurse practitioner to bill Medi-Cal independently for their services. Existing law establishes the Family Planning, Access, Care, and Treatment (Family PACT) Program, administered by the Office of Family Planning, under which comprehensive clinical family planning services are provided as a benefit under the Medi-Cal program. Existing law also creates the State-Only Family Planning Program, under which family planning services are provided to eligible individuals. Existing law requires enrolled providers in each program to attend a specific orientation approved by the department and requires providers who conduct specified services to have prior training in those services.This bill would, for both of the above-described programs, require the department to allow a provider 6 months from the date of enrollment to complete the orientation. The bill would, for the Family PACT Program, require a site certifier of a primary care clinic or affiliate primary care clinic, as those terms are defined, to be a clinician who oversees the provision of Family PACT services and would authorize certain clinic corporations to enroll multiple service addresses under a single site certifier. The bill would require any orientation or training that the department requires of a site certifier to comply with specified requirements, such as being offered through a virtual platform and being offered at least once per month, among others.

Primary Sponsors
Lena Gonzalez

Bill Number	Last Action	Status	Position
SB 1180	**Set For Hearing April 24 2024 04 05**	**In Senate**	**Monitor**

Title
Health care coverage: emergency medical services.

Introduction Date: 2024-02-14

Description
SB 1180, as introduced, Ashby. Health care coverage: emergency medical services. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plan contracts and health insurance policies to provide coverage for certain services and treatments, including medical transportation services. Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including emergency medical transport. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Existing law, until January 1, 2031, authorizes a local emergency medical services (EMS) agency to develop a community paramedicine or triage to alternate destination program that, among other things, provides case management services to frequent EMS users and triage paramedic assessments.This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to include coverage for services provided by a community paramedicine program, a triage to alternate destination program, and a mobile integrated health program. The bill would require those plans and policies to require an enrollee or insured who receives covered services from a noncontracting program to pay no more than the same cost-sharing amount they would pay for the same covered services received from a contracting program. The bill would specify the reimbursement process and amount for a noncontracting program. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. The bill would also make services provided by these programs covered benefits under the Medi-Cal program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Angelique Ashby

Organizational Notes

Last edited by Joanne Campbell at Apr 19, 2024, 8:14 PM
California Association of Health Plans - Oppose

Bill Number	Last Action	Status	Position
SB 1184	**Set For Hearing April 30 2024 04 12**	**In Senate**	**Monitor**

Title
Mental health: involuntary treatment: antipsychotic medication.

Introduction Date: 2024-02-14

Description
SB 1184, as amended, Eggman. Mental health: involuntary treatment: antipsychotic medication. Existing law, the Lanterman-Petris-Short Act, provides for the involuntary commitment of persons who are a danger to themselves or others, or who are gravely disabled, due to a mental disorder or chronic alcoholism or drug abuse for 72 hours for evaluation and treatment, as specified. If certain conditions are met after the 72-hour detention, the act authorizes the certification of the person for a 14-day maximum period of intensive treatment and then another 14-day or 30-day maximum period of intensive treatment after the initial 14-day period of intensive treatment. Existing law, during the 30-day period of intensive treatment, as specified, also authorizes up to an additional 30 days of intensive treatment if certain conditions are met. Existing law authorizes the administration of antipsychotic medication to a person who is detained for evaluation and treatment for any of those detention periods, and establishes a process for hearings to determine the person’s capacity to refuse the treatment. Existing law requires a determination of a person’s incapacity to refuse treatment with antipsychotic medication to remain in effect only for the duration of the 72-hour period or initial 14-day intensive treatment period, or both, until capacity is restored, or by court determination.This bill would additionally require the determination of a person’s incapacity to refuse treatment with antipsychotic medication to remain in effect for the duration of the additional 14-day period or the additional 30-day period after the 14-day intensive treatment period, or the additional period of up to 30 days if certain conditions are met during the first 30-day period.

Primary Sponsors
Susan Eggman

Organizational Notes

Last edited by Joanne Campbell at Mar 22, 2024, 6:11 PM
California State Association of Psychiatrists (sponsor) - Support Psychiatric Physicians Alliance of California - Support Disability Rights California - Oppose

Bill Number	Last Action	Status	Position
SB 1213	**April 15 Hearing Placed On Appr Suspense File 2024 04 15**	**In Senate**	**Monitor**

Title
Health care programs: cancer.

Introduction Date: 2024-02-15

Description
SB 1213, as amended, Atkins. Health care programs: cancer. Existing law requires the State Department of Health Care Services to perform various health functions, including providing breast and cervical cancer screening and treatment for low-income individuals. Existing law provides that an individual is eligible to receive treatment services if, among other things, the individual has a family income at or below 200% of the federal poverty level as determined by the provider performing the screening and diagnosis.This bill would provide that an individual is eligible to receive treatment services if the individual has a family income at or below 300% of the federal poverty level as determined by the provider performing the screening and diagnosis.

Primary Sponsors
Toni Atkins, Anthony Portantino

Bill Number	Last Action	Status	Position
SB 1236	**Set For Hearing April 24 2024 04 05**	**In Senate**	**Monitor**

Title
Medicare supplement coverage: open enrollment periods.

Introduction Date: 2024-02-15

Description
SB 1236, as introduced, Blakespear. Medicare supplement coverage: open enrollment periods. Existing federal law provides for the Medicare Program, which is a public health insurance program for persons 65 years of age and older and specified persons with disabilities who are under 65 years of age. Existing federal law specifies different parts of Medicare that cover specific services, such as Medicare Part B, which generally covers medically necessary services and supplies and preventive services. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance.Existing federal law additionally provides for the issuance of Medicare supplement policies or certificates, also known as Medigap coverage, which are advertised, marketed, or designed primarily as a supplement to reimbursements under the Medicare Program for the hospital, medical, or surgical expenses of persons eligible for the Medicare Program, including coverage of Medicare deductible, copayment, or coinsurance amounts, as specified. Existing law, among other provisions, requires supplement benefit plans to be uniform in structure, language, designation, and format with the standard benefit plans, as prescribed. Existing law prohibits an issuer from denying or conditioning the offering or effectiveness of any Medicare supplement contract, policy, or certificate available for sale in this state, or discriminating in the pricing of a contract, policy, or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application that is submitted prior to or during the 6-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B.This bill, on and after January 1, 2025, would prohibit an issuer of Medicare supplement coverage in this state from denying or conditioning the issuance or effectiveness of any Medicare supplement coverage available for sale in the state, or discriminate in the pricing of that coverage because of the health status, claims experience, receipt of health care, medical condition, or age of an applicant, if an application for coverage is submitted during an open enrollment period, as specified in the bill. The bill would entitle an individual enrolled in Medicare Part B to a 90-day annual open enrollment period beginning on January 1 of each year, as specified, during which period the bill would require appli... (click bill link to see more).

Primary Sponsors
Catherine Blakespear

Organizational Notes

Last edited by Joanne Campbell at Apr 19, 2024, 8:15 PM
California Association of Health Plans - Oppose

Bill Number	Last Action	Status	Position
SB 1238	**Read Second Time And Amended Re Referred To Com On Appr 2024 04 18**	**In Senate**	**Monitor**

Title
Lanterman-Petris-Short Act: designated facilities.

Introduction Date: 2024-02-15

Description
SB 1238, as amended, Eggman. Lanterman-Petris-Short Act: designated facilities. Under existing law, the Lanterman-Petris-Short Act (act), when a person, as a result of a mental health disorder, is a danger to others or to themselves, or gravely disabled, as defined, the person may, upon probable cause, be taken into custody for a period of up to 72 hours for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment in a facility designated by the county for evaluation and treatment and approved by the State Department of Health Care Services.Existing law defines the above-described designated facility as a facility that is licensed or certified as a mental health treatment facility or a hospital by the State Department of Public Health, and may include, but is not limited to, a licensed psychiatric hospital, a licensed psychiatric health facility, and a certified crisis stabilization unit.This bill would expand the definition of a “facility designated by the county for evaluation and treatment” or “designated facility” by specifying that it may also include a facility that both (1) has appropriate services, personnel, and security to safely treat individuals being held involuntarily and (2) is licensed or certified as a skilled nursing facility, mental health rehabilitation center, social rehabilitation facility, or as a facility capable of providing treatment at American Society of Addiction Medicine levels of care 3.7 to 4.0, inclusive. The bill would authorize a county to designate a facility for the purpose of providing one or more specified treatments required by the act. Existing regulations prohibit a licensed psychiatric health facility or licensed mental health rehabilitation center from admitting an individual who is diagnosed only with a substance use disorder.This bill would require the State Department of Health Care Services to authorize licensed psychiatric health facilities and licensed mental health rehabilitation centers to admit an individual who is diagnosed only with a severe substance use disorder, as defined.Existing law requires a person admitted to a facility for 72-hour treatment and evaluation to receive an evaluation as soon as possible after the person is admitted and to receive whatever treatment and care the person’s condition requires for the full period that they are held, as specified.This bill would require the State Department of Health Care Services to ensure that designated facilities are reimbursed for evaluation and treatment of stand-alone substance use disorders at reimbursement rates equivalent to those provided for evaluation and treatment of mental health disorders.This bill would authorize the State Department of Health Care Services to implem... (click bill link to see more).

Primary Sponsors
Susan Eggman

Bill Number	Last Action	Status	Position
SB 1249	**Re Referred To Com On Appr 2024 04 17**	**In Senate**	**Monitor**

Title
Mello-Granlund Older Californians Act.

Introduction Date: 2024-02-15

Description
SB 1249, as amended, Roth. Mello-Granlund Older Californians Act. Existing law, the Mello-Granlund Older Californians Act, establishes the California Department of Aging in the California Health and Human Services Agency and sets forth its mission to provide leadership to the area agencies on aging in developing systems of home- and community-based services that maintain individuals in their own homes or the least restrictive homelike environments. Existing law requires the department to designate various private nonprofit or public agencies as area agencies on aging to work within a planning and service area and provide a broad array of social and nutritional services. Existing law includes various findings and declarations relating to the purposes of the act.This bill would update and revise those legislative findings and declarations, including recognizing the state’s major demographic shift towards an older, more diverse population and declaring the intent to reform provisions of the act related to various functions of the area agencies on aging. The bill, within specified time periods, would require the department to take various actions to reform the act, including giving counties the option to petition the department to be considered for designation as the area agency on aging that serves its local jurisdiction, developing core programs and services and developing a statewide public awareness engagement strategy.

Primary Sponsors
Richard Roth

Bill Number	Last Action	Status	Position
SB 1257	**Set For Hearing April 22 2024 04 16**	**In Senate**	**Monitor**

Title
Geographic Managed Care Pilot Project: County of San Diego: advisory board.

Introduction Date: 2024-02-15

Description
SB 1257, as amended, Blakespear. Geographic Managed Care Pilot Project: County of San Diego: advisory board. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Existing law authorizes the department, upon approval by the board of supervisors of the County of San Diego, to implement a multiplan managed care pilot project for the provision of Medi-Cal services. Existing law authorizes the County of San Diego to establish 2 advisory boards, with certain compositions, to advise the Department of Health Services of the County of San Diego and review and comment on the implementation of the multiplan project. Existing law requires that at least one member of each board be appointed by the board of supervisors and requires the board of supervisors to establish the number of members on each board.This bill would instead authorize the County of San Diego to establish one board, as specified, and would require the board to advise the Health and Human Services Agency of the County of San Diego on the implementation of the state Medi-Cal policy as it pertains to Medi-Cal managed care plans in the county. The bill would require each supervisor of the board to appoint at least one member to the advisory board, with each supervisor appointing an equal number of members.Existing law prohibits the compensation of the advisory board members for activities relating to their duties, but requires that members who are Medi-Cal recipients be reimbursed an appropriate amount by the county for travel and child care expenses incurred in performing their duties in the pilot project.This bill would also authorize advisory board members who are Medi-Cal recipients to be reimbursed by the county for their time in performing their duties in the pilot project, at the discretion of the county.

Primary Sponsors
Catherine Blakespear

Bill Number	Last Action	Status	Position
SB 1258	**April 15 Hearing Placed On Appr Suspense File 2024 04 15**	**In Senate**	**Monitor**

Title
Medi-Cal: unrecovered payments: interest rate.

Introduction Date: 2024-02-15

Description
SB 1258, as amended, Dahle. Medi-Cal: unrecovered payments: interest rate. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Existing law requires the Director of Health Care Services to establish administrative appeal processes to review grievances or complaints arising from the findings of an audit or examination. Under existing law, if recovery of a disallowed payment has been made by the department, a provider who prevails in an appeal of that payment is entitled to interest at the rate equal to the monthly average received on investments in the Surplus Money Investment Fund, or simple interest at the rate of 7% per annum, whichever is higher. Under existing law, with exceptions, interest at that same rate is assessed against any unrecovered overpayment due to the department.In the case of an assessment against any unrecovered overpayment due to the department, this bill would authorize the department to waive the interest, as part of a repayment agreement entered into with the provider, if the unrecovered overpayment occurred 4 or more years before the issuance of the first statement of account status or demand for repayment, after taking into account specified factors, including the impact of the repayment amounts on the fiscal solvency of the provider, and whether the overpayment was caused by a policy change or departmental error that was not the fault of the billing provider.

Primary Sponsors
Brian Dahle

Bill Number	Last Action	Status	Position
SB 1268	**From Committee With Authors Amendments Read Second Time And Amended Re Referred To Com On Health 2024 04 15**	**In Senate**	**Monitor**

Title
Medi-Cal managed care plans: contracts with safety net providers.

Introduction Date: 2024-02-15

Description
SB 1268, as amended, Nguyen. Medi-Cal managed care plans: contracts with safety net providers. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, one of the methods by which Medi-Cal services are provided is pursuant to contracts between the department and various types of managed care plans and between those plans and providers of those services.This bill would require a Medi-Cal managed care plan to offer a network provider contract to, and maintain a network provider contract with, each safety net provider, as defined, operating within the plan’s contracted geographic service areas if the safety net provider agrees to provide its applicable scope of services in accordance with the same terms and conditions that the Medi-Cal managed care plan requires of other similar providers.The bill would set forth exceptions to that requirement in the case of a safety net provider no longer being willing to accept those terms and conditions, its license being revoked or suspended, or the department determining that the health or welfare of a Medi-Cal enrollee is threatened by the provider. The bill would require the plan to follow certain notification procedures if it terminates the network provider contract.The bill would condition implementation of these provisions on receipt of any necessary federal approvals and the availability of federal financial participation.

Primary Sponsors
Janet Nguyen

Organizational Notes

Last edited by Joanne Campbell at Apr 19, 2024, 8:16 PM
Local Health Plans of California, California Association of Health Plans, Cal Optima - Oppose

Bill Number	Last Action	Status	Position
SB 1269	**April 24 Set For Second Hearing Canceled At The Request Of Author 2024 04 15**	**In Senate**	**Monitor**

Title
Safety net hospitals.

Introduction Date: 2024-02-15

Description
SB 1269, as introduced, Padilla. Safety net hospitals. Existing law provides for the licensure and regulation of various types of health facilities, including hospitals, by the State Department of Public Health. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Existing law sets forth various provisions relating to disproportionate share hospitals (DSH), which are hospitals providing acute inpatient services to Medi-Cal beneficiaries that meet the criteria for disproportionate share status, as specified; small and rural hospitals; and critical access hospitals, as certified by the Secretary of the United States Department of Health and Human Services under the federal Medicare rural hospital flexibility program.Existing law sets forth other provisions relating to safety net hospitals in different contexts, including among others, special health authorities and Medi-Cal reimbursement.This bill would establish a definition for “safety net hospital” and would state the intent of the Legislature that this definition serve as a recommended definition for policymakers to elect to utilize when crafting policy aimed at focusing on or supporting those hospitals. Under the bill, the definition would not be construed as affecting existing or new references to safety net hospitals, unless future legislation or other action expressly makes reference to this definition, as specified.Under the bill, “safety net hospital” would mean a Medicaid DSH-eligible hospital; a rural hospital, including a small and rural hospital and a critical access hospital, as specified; or a sole community hospital, as classified by the federal Centers for Medicare and Medicaid Services and in accordance with certain federal provisions.

Primary Sponsors
Steve Padilla

Bill Number	Last Action	Status	Position
SB 1278	**Set For Hearing April 23 2024 04 09**	**In Senate**	**Monitor**

Title
World AIDS Day.

Introduction Date: 2024-02-15

Description
SB 1278, as amended, Laird. World AIDS Day. Existing law requires the Governor to proclaim various days as holidays and days of remembrance.This bill would require the Governor to annually proclaim December 1 as World AIDS Day.

Primary Sponsors
John Laird

Bill Number	Last Action	Status	Position
SB 1289	**From Committee With Authors Amendments Read Second Time And Amended Re Referred To Com On Health 2024 04 08**	**In Senate**	**Monitor**

Title
Medi-Cal: county call centers: data.

Introduction Date: 2024-02-15

Description
SB 1289, as amended, Roth. Medi-Cal: county call centers: data. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law sets forth various responsibilities for counties relating to eligibility determinations and enrollment functions under the Medi-Cal program.Existing federal law sets forth Medicaid reporting requirements for each state during the period between April 1, 2023, and June 30, 2024, inclusive, relating to eligibility redeterminations, including, among other information, the total call-center volume, average wait times, and average abandonment rate for each call center of the state agency responsible for administering the state plan, as specified.This bill would require the department to establish statewide minimum standards for assistance provided by county call centers to applicants or beneficiaries applying for, renewing, or requesting help in obtaining or maintaining Medi-Cal coverage. The bill would require promulgation of the standards in regulation by July 1, 2026, as specified. The bill would authorize the department to develop alternate standards for a county that does not operate a call center for Medi-Cal applicants and beneficiaries.The bill would require a county to collect and submit to the department on April 1, 2025 and each quarter thereafter call-center data metrics, including, among other information, call volume, average call wait times by language, and callbacks. Commencing on July 1, 2025, and each quarter thereafter, the bill would require a county that does not operate a call center for Medi-Cal applicants and beneficiaries to collect and submit to the department approved alternative metrics. By creating new duties for counties relating to call data, the bill would impose a state-mandated local program.The bill would require the department to prepare a report, excluding any personally identifiable information, on county call data, identifying challenges and targets or standards for improvement. The bill would require the department to post the report on its internet website on a quarterly basis no later than 45 calendar days after the conclusion of each quarter. The bill would require the initial report on county call-center data from counties operating call centers to be due on May 15, 2025.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that, if the Co... (click bill link to see more).

Primary Sponsors
Richard Roth

Bill Number	Last Action	Status	Position
SB 1290	**Set For Hearing April 22 2024 04 12**	**In Senate**	**Monitor**

Title
Health care coverage: essential health benefits.

Introduction Date: 2024-02-15

Description
SB 1290, as introduced, Roth. Health care coverage: essential health benefits. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service plans and makes a willful violation of the act a crime. Other existing law requires the Department of Insurance to regulate health insurers. Existing law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, to include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act. Existing law requires a health care service plan contract or health insurance policy to cover the same health benefits that the benchmark plan, the Kaiser Foundation Health Plan Small Group HMO 30 plan, offered during the first quarter of 2014, as specified.This bill would express the intent of the Legislature to review California’s essential health benefits benchmark plan and establish a new benchmark plan for the 2027 plan year. The bill would limit the applicability of the current benchmark plan benefits to plan years on or before the 2027 plan year.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Richard Roth

Bill Number	Last Action	Status	Position
SB 1300	**Read Second Time Ordered To Third Reading 2024 04 16**	**In Senate**	**Monitor**

Title
Health facility closure: public notice: inpatient psychiatric and maternity services.

Introduction Date: 2024-02-15

Description
SB 1300, as amended, Cortese. Health facility closure: public notice: inpatient psychiatric and maternity services. Existing law requires the State Department of Public Health to license, regulate, and inspect health facilities, as specified, including general acute care hospitals. A violation of these provisions is a crime. Under existing law, a general acute care hospital is required to provide certain basic services, including medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy, and dietary services. Existing law authorizes a general acute care hospital to provide various special or supplemental services if certain conditions are met. Existing regulations define a supplemental service as an organized inpatient or outpatient service that is not required to be provided by law or regulation. Existing law requires a health facility to provide 90 days of public notice of the proposed closure or elimination of a supplemental service, and 120 days of public notice of the proposed closure or elimination of an acute psychiatric hospital.This bill would change the notice period required before proposed closure or elimination of the supplemental service of inpatient psychiatric service or maternity service from 90 days to 120 days. By changing the definition of a crime, this bill would impose a state-mandated local program. The bill would authorize the hospital to close the inpatient psychiatric service or maternity service 90 days after providing public notice of the closure if the department determines that the use of resources to keep the inpatient psychiatric services or maternity services open for the full 120 days threatens the stability of the hospital or if the department cites the hospital for unsafe staffing practices related to these services.Before a health facility may provide notice of a proposed closure or elimination of an inpatient psychiatric service or maternity service, this bill would require the facility to provide an impact analysis report, as specified, regarding the impact on the health of the community resulting from the proposed elimination of the services. By changing the requirements on a health care facility, the violation of which is a crime, this bill would impose a state-mandated local program. The bill would require that the impact analysis report be delivered to the local county board of supervisors and to the department. The bill also would require the cost of preparing the impact analysis report to be borne by the hospital. The bill would strongly encourage the board of supervisors to hold a public hearing within 15 days of receipt of the report, as specified, and to post the impact analysis report on its internet website. The bill would require, if the loss of bed... (click bill link to see more).

Primary Sponsors
Dave Cortese

Bill Number	Last Action	Status	Position
SB 1319	**Set For Hearing April 22 2024 04 17**	**In Senate**	**Monitor**

Title
Skilled nursing facilities: approval to provide therapeutic behavioral health programs.

Introduction Date: 2024-02-16

Description
SB 1319, as amended, Wahab. Skilled nursing facilities: approval to provide therapeutic behavioral health programs. Existing law provides for the licensure and regulation of health facilities, including, but not limited to, skilled nursing facilities, by the State Department of Public Health. Existing law, the Alfred E. Alquist Hospital Facilities Seismic Safety Act of 1983, establishes, under the jurisdiction of the Department of Health Care Access and Information (HCAI), a program of seismic safety building standards for certain hospitals constructed on and after March 7, 1973. The act requires the governing board or other governing authority of a hospital, before adopting plans for the hospital building, as defined, to submit to HCAI an application for approval, accompanied by the plans, as prescribed.Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services (DHCS), and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law authorizes DHCS to adopt regulations to certify providers enrolled in the Medi-Cal program, and applicants for enrollment as providers, including providers and applicants licensed as health care facilities.This bill would require a licensed skilled nursing facility that proposes to provide therapeutic behavioral health programs in an identifiable and physically separate unit of a skilled nursing facility, and that is required to submit an application and receive approvals from multiple departments, as specified above, to apply simultaneously to those departments for review and approval of application materials. The bill, when an applicant for approval from one of the specified departments is unable to complete the approval process because the applicant has not obtained required approvals and documentation from one or both of the other departments, would authorize the applicant to submit all available forms and supporting documentation, along with a letter estimating when the remaining materials will be submitted. The bill would require the receiving department to initiate review of the application, and would require final approval of the application to be granted only when all required documentation has been submitted by the applicant to each department from which approval is required. The bill would require the departments to work jointly to develop processes to allow applications to be reviewed simultaneously and in a coordinated manner, as specified.

Primary Sponsors
Aisha Wahab

Bill Number	Last Action	Status	Position
SB 1320	**Set For Hearing April 22 2024 04 12**	**In Senate**	**Monitor**

Title
Mental health and substance use disorder treatment.

Introduction Date: 2024-02-16

Description
SB 1320, as amended, Wahab. Mental health and substance use disorder treatment. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of disability insurers by the Department of Insurance. Existing law requires a health care service plan contract or disability insurance policy issued, amended, or renewed on or after January 1, 2021, to provide coverage for medically necessary treatment of mental health and substance use disorders, as defined, under the same terms and conditions applied to other medical conditions.This bill would require a plan or insurer subject to the above-described coverage requirement, and its delegates, to establish a process to reimburse providers for mental health and substance use disorder treatment services that are integrated with primary care services and provided under a contract or policy issued, amended, or renewed on or after July 1, 2025. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Aisha Wahab

Bill Number	Last Action	Status	Position
SB 1339	**From Committee With Authors Amendments Read Second Time And Amended Re Referred To Com On Health 2024 04 15**	**In Senate**	**Monitor**

Title
Supportive community residences.

Introduction Date: 2024-02-16

Description
SB 1339, as amended, Allen. Supportive community residences. Existing law generally requires the State Department of Public Health to license, inspect, and regulate health facilities, defined to include, among other types of health facilities, an acute psychiatric hospital. Existing law requires the State Department of Health Care Services to license and establish regulations for psychiatric residential treatment facilities.Existing law requires the State Department of Health Care Services to license and regulate facilities that provide residential nonmedical services to adults who are recovering from problems related to alcohol, drug, or alcohol and drug misuse or abuse, and who need alcohol, drug, or alcohol and drug recovery treatment or detoxification services. Existing law also requires the department to implement a voluntary certification program for alcohol and other drug treatment recovery services.Existing law, the California Community Care Facilities Act, generally provides for the licensing and regulation of community care facilities by the State Department of Social Services, to provide 24-hour nonmedical care of persons in need of personal services, supervision, or assistance. Existing regulation includes an adult residential facility as a community care facility for those purposes.This bill would require the State Department of Health Care Services (department), by January 1, 2027, and in consultation with relevant public agencies and stakeholders, to establish, and provide for the administration of, a voluntary certification program for supportive community residences. The bill would define a “supportive community residence” as a residential home serving adults with a substance use disorder, mental health diagnosis, or dual diagnosis that does not provide medical care or a level of support for activities of daily living that require state licensing. The bill would require the certification program to include standards and procedures for operation, such as types of certifications needed and supportive services navigation, and procedures and penalties for enforcing laws and regulations governing supportive community residences. The bill also would require the department to create and maintain a searchable online database of certified facilities, which would include specified contact and complaint information for those residences.The bill would require the department to adopt or amend regulations to require referring entities to provide information relating to the license or certification status of community care facilities and supportive community residences to individuals with a substance use disorder, mental health diagnosis, or dual diagnosis, and to report any suspected fraudulent license or cert... (click bill link to see more).

Primary Sponsors
Ben Allen

Bill Number	Last Action	Status	Position
SB 1354	**From Committee With Authors Amendments Read Second Time And Amended Re Referred To Com On Health 2024 04 15**	**In Senate**	**Monitor**

Title
Long-term health care facilities: payment source and resident census.

Introduction Date: 2024-02-16

Description
SB 1354, as amended, Wahab. Long-term health care facilities: payment source and resident census. Existing law provides for the licensing and regulation of long-term health care facilities, including, among others, skilled nursing facilities and intermediate care facilities, by the State Department of Public Health. A violation of those provisions is generally a crime. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Existing law prohibits a long-term health care facility that participates as a provider under the Medi-Cal program from discriminating against a Medi-Cal patient on the basis of the source of payment for the facility’s services that are required to be provided to individuals entitled to services under the Medi-Cal program. Existing law prohibits that facility from seeking to evict out of the facility, or transfer within the facility, any resident as a result of the resident changing their manner of purchasing the services from private payment or Medicare to Medi-Cal, except as specified.This bill would require the facility to provide aid, care, service, or other benefits available under Medi-Cal to Medi-Cal beneficiaries in the same manner, by the same methods, and at the same scope, level, and quality as provided to the general public, regardless of payment source.Existing federal regulations require certain nursing facilities to post their resident census on a daily basis.This bill would require a long-term health care facility that participates as a provider under the Medi-Cal program to make publicly available its daily resident census, excluding any personally identifiable information. The bill would require the facility to make the information available by posting it on the facility’s internet website, if one exists, and by providing the information to a requester within 24 hours of a request, as specified. The bill would exempt these requirements from the above-described and other related criminal penalties.Existing law requires that a contract of admission to a long-term health care facility state that, except in an emergency, a resident may not be involuntarily transferred or discharged from the facility unless the resident and, if applicable, the resident’s representative, are given reasonable notice in writing and transfer or discharge planning as required by law. Existing law requires that the written notice state the reason for the transfer or discharge.This bill would require that the notice also include a specified statement relating to, among other ... (click bill link to see more).

Primary Sponsors
Aisha Wahab

Bill Number	Last Action	Status	Position
SB 1355	**Set For Hearing April 23 2024 04 16**	**In Senate**	**Monitor**

Title
Medi-Cal: in-home supportive services: redetermination.

Introduction Date: 2024-02-16

Description
SB 1355, as amended, Wahab. Medi-Cal: in-home supportive services: redetermination. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services, including in-home supportive services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law generally requires a county to redetermine a Medi-Cal beneficiary's eligibility to receive Medi-Cal benefits every 12 months and whenever the county receives information about changes in a beneficiary's circumstances that may affect their eligibility for Medi-Cal benefits.Existing law provides for the In-Home Supportive Services (IHSS) program, administered by the State Department of Social Services and counties, under which qualified aged, blind, and disabled persons are provided with supportive services in order to permit them to remain in their own homes. Existing law authorizes certain Medi-Cal beneficiaries to receive IHSS as a covered Medi-Cal benefit.This bill would, to the extent that any necessary federal approvals are obtained, and federal financial participation is available and not otherwise jeopardized, require an IHSS recipient to be continuously eligible for Medi-Cal for 3 years, if they have a fixed income, and would prohibit a redetermination of Medi-Cal eligibility before 3 years, except as specified. The bill would make the implementation of its provisions contingent upon the department obtaining all necessary federal approvals, the department determining that systems have been programmed to implement these provisions, and the Legislature has appropriated funding to implement these provisions after a determination that ongoing General Fund resources are available to support the ongoing implementation of these provisions. To the extent the bill would increase county duties in administrating the IHSS program, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Primary Sponsors
Aisha Wahab

Organizational Notes

Last edited by Joanne Campbell at Apr 22, 2024, 6:19 PM
Local Health Plans of California - Support

Bill Number	Last Action	Status	Position
SB 1369	**From Committee With Authors Amendments Read Second Time And Amended Re Referred To Com On Health 2024 04 09**	**In Senate**	**Monitor**

Title
Dental providers: fee-based payments.

Introduction Date: 2024-02-16

Description
SB 1369, as amended, Limón. Dental providers: fee-based payments. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law imposes specified coverage and disclosure requirements on health care service plans and health insurers, including specialized plans and insurers, that cover dental services.This bill would require a health care service plan contract or health insurance policy, as defined, issued, amended, or renewed on and after January 1, 2025, that provides payment directly or through a contracted vendor to a dental provider to have a non-fee-based default method of payment, as specified. The bill would require a health care service plan, health insurer, or contracted vendor to obtain a signed authorization from a dental provider opting in to a fee-based payment method before the plan or vendor provides a fee-based payment method to the provider and would authorize the dental provider to opt out of the fee-based payment method at any time by providing written notice to the health care service plan, health insurer, or contracted vendor.Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Monique Limon

Bill Number	Last Action	Status	Position
SB 1397	**Set For Hearing April 22 2024 04 16**	**In Senate**	**Monitor**

Title
Behavioral health services coverage.

Introduction Date: 2024-02-16

Description
SB 1397, as amended, Eggman. Behavioral health services coverage. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health and disability insurers by the Department of Insurance. Existing law requires a health care service plan contract or disability insurance policy to provide coverage for medically necessary treatment of mental health and substance use disorders.This bill would require a health care service plan contract or health insurance policy issued, amended, renewed, or delivered on or after July 1, 2025, that covers medically necessary mental health and substance use disorder services to comply with rate and timely reimbursement requirements for services delivered by a county behavioral health agency, as specified. The bill would require in-network cost sharing, capped at the in-network deductible and in-network out-of-pocket maximum, to apply to these services. Unless an enrollee or insured is referred or authorized by the plan or insurer, the bill would require a county behavioral health agency to contact a plan or insurer before initiating services. The bill would authorize a plan or insurer to conduct a postclaim review to determine appropriate payment of a claim, and would authorize the use of prior authorization as permitted by the regulating department. The bill would require the departments to issue guidance to plans and insurers regarding compliance with these provisions no later than April 1, 2025. Because a willful violation of these provisions by a health care service plan would be a crime, and the bill would impose a higher level of service on a county behavioral health agency, this bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that, with regard to certain mandates, no reimbursement is required by this act for a specified reason.With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Primary Sponsors
Susan Eggman

Organizational Notes

Last edited by Joanne Campbell at Mar 22, 2024, 6:17 PM
County Behavioral Health Directors Association (sponsor) - Support

Bill Number	Last Action	Status	Position
SB 1423	**From Committee With Authors Amendments Read Second Time And Amended Re Referred To Com On Health 2024 04 08**	**In Senate**	**Monitor**

Title
Medi-Cal: critical access hospitals.

Introduction Date: 2024-02-16

Description
SB 1423, as amended, Dahle. Medi-Cal: critical access hospitals. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, each hospital designated by the department as a critical access hospital, and certified as such by the Secretary of the United States Department of Health and Human Services under the federal Medicare rural hospital flexibility program, is eligible for supplemental payments for Medi-Cal covered outpatient services rendered to Medi-Cal eligible persons. Existing law conditions those payments on receipt of federal financial participation and an appropriation in the annual Budget Act for the nonfederal share of those payments, with supplemental payments being apportioned among critical access hospitals based on their number of Medi-Cal outpatient visits.This bill would require that each critical access hospital that elects to participate be reimbursed at 100% of the hospital’s projected reasonable and allowable costs for covered Medi-Cal services, as defined, furnished in the Medi-Cal fee-for-service and managed care delivery systems for each subject calendar year, effective for dates of service on or after January 1, 2026. The bill would require the department to develop and maintain one or more reimbursement methodologies, or revise one or more existing reimbursement methodologies applicable to participating critical access hospitals, or both, to implement the minimum cost-based payment levels.The bill would set forth a timeline and a procedure for the department to notify each critical access hospital of the ability to elect to participate in those methodologies, and for a critical access hospital to inform the department of its election to participate, its discontinuance, or its later participation. Under the bill, these provisions would not be construed to preclude a participating critical access hospital from receiving any other Medi-Cal payment for which it is eligible, including, but not limited to, supplemental payments, with specified exceptions.The bill would require the department to determine the projected reasonable and allowable Medi-Cal costs prior to each applicable calendar year, as specified. The bill would require the department to require each applicable Medi-Cal managed care plan to reimburse a participating hospital for covered services, and would require the department to develop and pay actuarially sound capitation rates to each applicable managed care plan, as specified.The bill would require the department to promptly seek any fe... (click bill link to see more).

Primary Sponsors
Brian Dahle

Bill Number	Last Action	Status	Position
SB 1428	**In Assembly Read First Time Held At Desk 2024 04 18**	**In Assembly**	**Monitor**

Title
Health care coverage: triggering events.

Introduction Date: 2024-02-16

Description
SB 1428, as amended, Atkins. Health care coverage: triggering events. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan or a health insurer to allow an individual to enroll in or change individual health benefit plans as a result of specified triggering events, including a loss of minimum essential coverage, as defined, gaining a dependent or becoming a dependent, or being mandated to be covered as a dependent pursuant to a valid state or federal court order. Existing law allows an individual 60 days from the date of a triggering event to apply for subsequent coverage.This bill would allow an individual 60 days before and after the date of a triggering event to apply for subsequent coverage, to the extent no conflicts with the availability and length of specified special enrollment periods exist. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Toni Atkins

Bill Number	Last Action	Status	Position
SB 1492	**From Committee With Authors Amendments Read Second Time And Amended Re Referred To Com On Health 2024 04 15**	**In Senate**	**Monitor**

Title
Medi-Cal reimbursement rates: private duty nursing.

Description
SB 1492, as amended, Menjivar. Medi-Cal reimbursement rates: private duty nursing. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, one of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care plans. Existing law sets forth requirements for private duty nursing and home health care under the Medi-Cal program.Existing law imposes a managed care organization (MCO) provider tax, administered and assessed by the department, on licensed health care service plans and managed care plans contracted with the department to provide full-scope Medi-Cal services. Under existing law, proceeds from the MCO provider tax may be used, upon appropriation by the Legislature, for the increased costs incurred as a result of reimbursement requirements, among other things.This bill would provide that private duty nursing services provided to a child under 21 years of age by a home health agency are included as an eligible category for Medi-Cal reimbursement through the above-described scheme.

Primary Sponsors
Caroline Menjivar

Introduction Date: 2024-02-16

Bill Number	Last Action	Status	Position
SB 1511	**Set For Hearing April 22 2024 04 18**	**In Senate**	**Monitor**

Title
Health omnibus.

Introduction Date: 2024-02-21

Description
SB 1511, as amended, Committee on Health. Health omnibus. (1) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Existing law defines a “group contract,” for purposes of the act, as a contract that by its terms limits the eligibility of subscribers and enrollees to a specified group.This bill would clarify that reference to a “group” in the act does not include a Medi-Cal managed care contract between a health care service plan and the State Department of Health Care Services to provide benefits to beneficiaries of the Medi-Cal program.(2) Existing law, the Compassionate Access to Medical Cannabis Act or Ryan’s Law, requires specified health care facilities to allow a terminally ill patient’s use of medicinal cannabis within the health care facility, as defined, subject to certain restrictions. Existing law requires the State Department of Public Health to enforce the act. Existing law prohibits a general acute care hospital, as specified, from permitting a patient with a chronic disease to use medicinal cannabis.This bill would authorize a general acute care hospital to allow a terminally ill patient, as defined, to use medicinal cannabis.(3) Existing law establishes the Distressed Hospital Loan Program, administered by the Department of Health Care Access and Information, in order to provide interest-free cashflow loans to not-for-profit hospitals and public hospitals in significant financial distress or to governmental entities representing a closed hospital, except as otherwise provided, to prevent the closure of, or facilitate the reopening of, those hospitals. Existing law establishes the Distressed Hospital Loan Program Fund, with moneys in the fund being continuously appropriated for the department. Existing law authorizes the Department of Finance to transfer up to $150,000,000 from the General Fund and $150,000,000 from the Medi-Cal Provider Payment Reserve Fund to the Distressed Hospital Loan Program Fund in state fiscal year 2023–24 to implement the program. Existing law requires any funds transferred to be available for encumbrance or expenditure until June 30, 2026.This bill would instead require any funds transferred to be available for encumbrance or expenditure until December 31, 2031. By extending the amount of time continuously appropriated funds are available for encumbrance and expenditure, this bill would make an appropriation.(4) Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed by, and f... (click bill link to see more).

Primary Sponsors
Senate Health Committee

CHIEF MEDICAL OFFICER'S REPORT

Chief Medical Officer Report
April 2024

Medical Management Division

Medical Directors (MDs)

With a fully staffed Medical Director (MD) team of ten physicians, we efficiently allocate personnel to cover Utilization Management (UM), Case Management (CM), Medi-Cal Managed Long-Term Services & Supports (MLTSS), claims, appeals, and grievances. Leveraging their clinical and managed care expertise, MDs lead high-priority initiatives. They rotate through various tasks such as UM and appeals queues, quality of care grievances, Interdisciplinary Care Team meetings, inpatient rounds, and office hours. Additionally, specific areas like contracts/configuration, UM/Claims rules, policy/claims integrity, discharge planning, (Transitional Care Services (TCS) expansion, and utilization are handled by designated physicians.

Transitional Care Services (TCS)

- **Expansion:** Starting January 2024, low-risk members became eligible for TCS. In January, the TCS Central Call line received 132 member calls and 54 provider/facility calls, increasing to 170 member calls and 67 provider calls in February. March saw a surge in calls due to more low-risk members receiving TCS invitation letters.
- **Outreach and Engagement**: Including the Long Term Care (LTC) population within our eligibility criteria led to record-high TCS touches, with 1,595 and 1,979 high-risk members in January and February respectively. These figures only reflect TCS activities by LAC staff, excluding Plan Partners and PPGs.
- **Teams:** As of March 2024, the CM TCS team is comprised of 44 FTEs with 13 open TCS CHW positions. The MLTSS team initiated TCS work with existing staff. Unexpectedly high hospitalization rates among LTC members (over 700 in January and over 1000 in February) prompted a staffing assessment and consideration of delegation to SNFs. Additional MLTSS staff requests are anticipated in April.
- **DHCS Meetings:** L.A. Care convened two key meetings with DHCS Leadership regarding Transitional Care Services (TCS). First, on March 5th, DHCS conducted an onsite review of our 14-month progress implementing TCS, where we showcased our models, utilization of HIE, risk stratification data, and our high engagement rates. DHCS flagged concerns about delegate performance consistency, urging close compliance monitoring.
  Secondly, on March 6th, L.A. Care hosted the DHCS Population Health Management TCS Summit, facilitating dialogue among health plans and providers. Our Senior Medical Director and MLTSS Senior Director participated, discussing transition strategies involving nursing facilities and community resources. DHCS announced forthcoming changes to TCS requirements, signaling operational adjustments ahead.

Enhanced Care Management (ECM)

- **Data Integrity:** The team is enhancing ECM enrollment tracking methods to improve regulatory reporting and provider payments. Many concerns from last year are resolved, with more solutions expected by Q2 2024. The Clinical Data Analyst is developing dashboards to track referral trends and performance indicators. We plan to use this data to identify enrollment growth opportunities.

- **Payment Model:** The ECM team is adjusting payment rates to comply with DHCS guidance. We are also considering feedback from providers and exploring alternate payment models used by other health plans.
- **Clinical Oversight:** A provider audit pilot started in Q1 2024. Initial audits showed an average score of 59%. ECM providers showed commendable efforts in outreach, engagement, care coordination, and assessments with members. However, audits revealed gaps in Transitional Care Services, updating care plans, closed-loop referrals, case conferences, and clinical oversight of non-clinical staff. Monthly reports will communicate audit results to our providers, highlighting strengths and gaps identified and enabling them to assess their performance relative to other network providers. A fuller oversight program will launch in Q2 2024.
- **Enrollment:** Our goal by the end of 2024 is 30,000 ECM members. Q4 2023 enrollment was 10,765, excluding Plan Partners. Efforts to improve enrollment include modifying eligibility criteria and improving technical reporting logic. This will enable us to effectively generate lists of ECM-eligible member for ECM providers. We began tracking leads/direct referrals in February as part of our growth strategy.
- **Network:** The ECM Network currently has 75 contracted providers. The majority (52) are considered small with 0-100 members, 17 are medium with 101-500 members and six are large with more than 501 enrolled members. In 2024, we expect the network to continue to expand as the new ECM populations of focus mature and new providers complete their onboarding.
- **Staffing:** We are shifting resources toward program management and operational oversight. Recruitment is open for seven positions with further assessment for additional resources underway to manage program growth.

Care Management for DSNP Members

- **Case Volumes:** The DSNP Care Management team saw a significant rise in case volume in Q1 2024, driven mainly by new high-risk members identified through Health Risk Assessments (HRAs).
- **New Requirements:** CM continues implementation of new DSNP requirements.
  - Case volumes are expected to increase due to targeted outreach to specific populations, aligning with new regulatory requirements for ECM-like services for DSNP members. This includes higher care coordination standards for DSNP members in palliative care.
  - A new HRA, essential for care coordination, went live on 4/1/2024, with updates to operational reports and processes to accommodate it.
  - Note templates and modules in the system are being updated to track face-to-face activities per new DSNP program expectations.
- **Data Validation Period:** In Q2 2024, the accuracy of HRA data in CMS reports will be reviewed through case audits.

<u>Utilization Management Corrective Action Plans</u>

- **Timeliness of UM decisions and notifications/Compliance Scorecard measures**
  - January and February 2024 reports are now available. The measures that were below 95% were due to a member address issue resulting in untimely notifications. We identified and remediated the root cause in mid-February.
  - **Overall performance**
    - Measures above 95%: January (44); February (45)
    - Measures 90-94%: January (2); February (1)
  - **Direct Network only (Medi-Cal subset):** 20/20 measures > 95%.

  - Measures above 95%: January 19; February 20
  - Measures 90-94%: January 1; February 0

- **Regulatory Audit Findings and CAPs**: All UM findings have been remediated. Aside from the two exceptions noted below, all UM corrective action steps are complete as of April.
  - A fully functional provider portal that allows electronic prior authorization submission, status tracking, and access to decision notifications is in the planning and building phase with anticipated launch in October 2024.
  - Completion and validation of an enhanced, dynamic dashboard/business intelligence tool to monitor scorecard measures in near-real time is expected in Q2 2024.

IT Systems

- **Syntranet**
  - *E-Forms:* SMART forms for DME, non-emergency medical transportation, and Direct Network are now available for provider authorization requests via the legacy Provider Portal. Contracting team conducted webinars to promote their use. The ECM referral form has been on the portal since December 2023.
  - *Productivity Reports Enhancement:* IT team updated Syntranet to include additional analytical data for productivity monitoring. Recent updates feature a staff average, clear time gap graphics, and the ability to pull team data.
  - *Other Enhancements:* Reporting feature added to easily identify reasons for failed transmission of member letters. Additional information has now been included in easily downloadable reports.

- ***QXNT UM***: Plans are in full swing for a conversion from Syntranet to QNXT with an anticipated go-live date of 9/16/24
  - *Conversion plans* from Syntranet to QNXT in progress, with anticipated go-live date of 9/16/24.
  - *Configuration and testing:* UM leads preparation, coordinating with ECM, MLTSS, BH, and Community Health experts.
  - *Supplemental staffing:* Contract with Toney Healthcare approved in February and executed in March for non-clinical and nurse staff. Toney staff will support training and post-go-live activities to maintain timely authorization processing. Coordination of hiring and training with permanent staff activities ensured.

Community Based Adult Services (CBAS)

As of January's end, the MLTSS CBAS team reviews new and modified requests for services exceeding four days per week. They assess the member's condition to determine appropriate visit frequency, aiming to prevent avoidable over-utilization. Preliminary February data reveals a 40% decrease in inappropriate prior authorization requests and a 40% increase in modified requests. MLTSS will continue tracking and analyzing outcomes of the new process.

CalAIM & Community Supports (CS)

CS services are increasingly promoted in Joint Operating Meetings (JOMs) and provider forums, resulting in a surge in member utilization. Since October 2023, Personal Care and Homemaking Services have risen from an average of 40 per month to 101 per month. Respite Care increased from an average of seven to 17 per

month, while Environmental Accessibility Adaptations have climbed from seven per month last fiscal year to 56 per month this fiscal year.

New Populations/Benefits Standardization

- **Intermediate Care Facility for Developmentally Disabled (ICF-DD) Long-Term Care Coverage**: Since January 1, 2024, ICF-DD long-term care became a covered service under Medi-Cal Managed Care. Contracting with nearly 200 facilities, mostly new to managed care, poses a significant challenge. By the end of March, L.A. Care successfully contracted with enough facilities to meet DHCS's minimum requirements. The ICF-DD census increased from 150 in January to 230 members in February.

- **Pediatric Sub-Acute Carve-In:** Effective January 1, 2024, the Pediatric Sub-Acute Carve-In took effect. Two out of three facilities in Los Angeles County were contracted, with the third in the contracting process. Approximately 175 members are in these facilities. In January, introductory calls were made with each facility. Updates to the prior authorization form will be distributed to facilities and posted on the public website.

Palliative Care

Our palliative care enrollment has substantially increased. From January 2023 to January 2024, the census rose by 257%. In the last three months of 2023, there was a 10% increase in referrals, likely due to the program's promotion during numerous PPG JOMs. Effective 1/1/24, the benefit expanded to full duals in DSNP (under Medi-Cal), resulting in 20 referrals in January and 9 in February.

Nursing Facilities Re-contracting

The team is finalizing contracts for Skilled Nursing Facilities (SNFs), featuring updated rate tiers and carve outs. The aim is to streamline the process for facilities to accommodate members with complex medical and social needs.

- **Rockport Health Care Services**, which had previously been admitting members under a Letter of Agreement (LOA), entered into a 12-month pilot program leveraging their 201-bed Four Seasons facility starting April 1, 2024. A mid-year evaluation will take place to assess viability of the program. The pilot is open to new admissions at the LTC Complex Level. Eligible members also have access to four other Rockport facilities through LOAs. The LAC team is collaborating with HMA consultants to establish operational processes for full implementation in May.

Quality Management Division

Chief Updates

- **NCQA Health Equity Accreditation Survey** results received, accrediting L.A. Care for Medicaid, Medicare, and Marketplace Exchange, with an impressive 98% score.
- **Provider Engagement & Outreach Workgroup's** Physician Advisory Collaborative meeting held in person on 1/10/2024.
- **Equity Practice Transformation (EPT) Program:** DHCS' EPT program assigned 46 practices to L.A. Care, including 24 small/medium practices and 22 FQHC practices, out of 211 selected out of 700+ practices.

- **New Health Equity Measures:** DMHC established HEQMS (Health Equity and Quality Measure Set) as benchmark standards for health plans, consisting of 12 HEDIS measures and 1 CAHPS measure to address health inequities and ensure equitable service delivery across all market segments.

Health Education, Cultural, and Linguistic Services (HECLS)

- **The Meals As Medicine Program** expanded eligibility criteria starting 1/1/2024, with 345 requests approved as of March 1 and contracting underway for two new meal providers offering meal kits and produce boxes.
- **The 2024 Flu Campaign** will be rebranded as Fight the Flu and Covid Campaign to emphasize vaccination for both.
- **Doula Services:** 113 L.A. Care Medi-Cal pregnant members have been recommended for doula services, with 90 members serviced so far, and data pending for others.
- **Pilot programs for Adult Weight Management and Pediatric Healthy Lifestyle** are underway at three Community Resource Centers.
- **L.A. Care registered dietitians** organized various learning events and blogs focusing on nutrition and healthier food choices, under the theme "Beyond the Table".

Initiatives

- L.A. Care submitted a **Comprehensive Quality Strategy** addressing measures below minimum performance level on 3/13, with DHCS accepting our response without further questions.
- We are initiating an amendment with mPulse to include additional texting campaigns in 2024 for pediatric flu and lead screening.
- We launched the **0-15 months (W30 6+) Clinical Performance Improvement Project (PIP)** for Well-Child Visits in the First 30 Months of Life. Community Health Workers are currently contacting 89 Black/African-American members in Service Planning Area 6, to provide well care visit reminders and coordinate appointments.
- L.A. Care to participate in the **IHI Collaborative Project** from 4/4/2024 to address health disparities in Well Care visits for Children (ages 3-21).
- Quality Improvement Department leading implementation of new **Quality Improvement/Population Health-focused Joint Operation Meetings (JOMs)** for the 10 largest participating physician groups (PPGs).
- **QI Nurse Specialist** engaging with Direct Network provider offices to ensure proper follow-up for members with high blood lead levels.

Practice Transformation Programs

- **First 5LA/HMG LA:** Cohort 1 practices (Asian Pacific Health Care Venture [APHCV] + Kids & Teens MCG) are screening 50.1% of members aged 0-5 years old, realizing a 36% increase in screenings over baseline (14%) through January 2024. Cohort 2 practices (To Health Everyone Health and Wellness Centers [T.H.E.], Bartz-Altadonna, Palmdale Pediatrics, and White Memorial Community Health Center) have generated a 16.3% increase over baseline (0%) for completed screenings through December. Completed 53 out of 60 early childhood development classes for members and the community through February.

- **Transform L.A.-Direct Network (DN):** The program has enrolled 20 practices with 112 providers, serving 12,461 DN members, accounting for 30% of total DN members. The program is preparing practices to report W30 data. For January 2024, data shows A1C Poor Control/Glycemic Status for Patients with Diabetes (>9%) at 44%, which is 86% of the MPL (38%); Controlling Blood Pressure at 58%, which is at 95% of the MPL (61%); and CIS-10 at 6%, which is at 20% of the MPL (30%).
- **EQuIP LA – Direct Network A:** Practices completed AIMs (goal statements) and initiated Plan, Do, Study, Act cycles for A1C Poor Control (>9%) and Colorectal Cancer Screening.
- **Equity & Practice Transformation Payments Program:** Accepted 46 practices (24 private + 22 FQHCs) into Cohort 1 with L.A. Care as their assigned Managed Care Plan (MCP). DHCS will release Initial Planning Incentive Payment (IPIP) guidance in March, with payments distributed to MCPs by April 30. DHCS conducted kick-off meetings for Cohort 1 practices on 2/15 and 2/21, with the MCP kick-off meeting held on 2/23/24. The first deliverable for practices to receive a Directed Payment is submission of the Population Health Management Capabilities Assessment Tool (PhmCAT) and is due April 30th.

Provider Quality Review (PQR)

- **Timely Closure Rate:** PQR team maintains a closure rate above 99% for FY2023-2024.
- **Aging PQI Cases:** Total open aging as of February 2024 was 2,549, a 29% decrease from October 2023 open aging of 3,598. Referral intake has decreased by 35% since in-service training with Grievances in October 2023.
- **Audits & Delegation Oversight:** PQR resumed oversight of A&G and CSC (member call-in line) in January 2024, reviewing cases through February. Quarterly Delegation Oversight reviews completed. Recommendations made to refine peer review policies for Blue Shield Promise. Minor reporting discrepancies with Carelon resolved.
- **Provider Engagement:** Quarterly engagement with DHS continues. DHS communicated that they plan to start sharing and discussing PQI reports with their clinics. In addition, the PQR team joined the DHS Complaints Workgroup in February to discuss improvement efforts. The workgroup invited the PQR team back to review the PQI process with participating clinics on 3/27/2024.

Accreditation

- **National Committee for Quality Assurance (NCQA): Health Plan Accreditation**
  - ***2023 NCQA Survey:*** L.A. Care accredited for Medicaid, Medicare, and Exchange (Under Corrective Action) from 10/24/2023 – 10/24/2026. Onsite CAP Survey scheduled for 5/20/2024.
  - ***Discretionary Review of DHS:***
    - UM 13 Elements C: Factors 1-6: Evidence did not meet requirements because of insufficient audit methodology. Extension granted, evidence to be included in upcoming CAP survey.
      - Update 4/3/24: Newly gathered evidence for re-submission to NCQA was reviewed by our NCQA consultants and was deemed MET for all 6 Factors. QI Accred team will now submit this evidence to NCQA by the 4/23/24 submission due date.
- **Access to Care:** Future state for MY2023 PAAS results discussed with vendor. We will now have all non-compliant providers on a live dashboard.
- **Direct Network**: Provider Engagement Events held monthly by Dr. Felix Aguilar-Henriquez, providing Direct Network Appointment Availability & After-Hours Report cards.

Stars/HEDIS

- **LACC** projected year-end performance (using February 2024 data refresh) for measurement year (MY2023) has decreased relative to the prior month's year-end projection, with the overall score of 78.06, which is 2.04 lower. Clinical Quality overall score is projected to decline to 75.826 (-3.24) while Plan Efficiency/Affordability improved to 77.269 (+.668). LACC is projected to achieve an overall rating of 3 in MY2023, which is 2.04 away from achieving an overall Star rating of 4.
- **D-SNP** MY2023 performance continues to be projected at overall Star Rating of 3.0 (rounding down). Most HEDIS measure performance is still projected to perform lower year to date this year versus last year; overall domain performance has stabilized and is holding at a 2.89. Pharmacy and Operation measure performance projections are holding with an overall domain rating of 3.08 and 2.84 respectively.
- **HEDIS Q4 recovery effort** has concluded which included 1) reconciliation between PPG performance tracking vs. LAC received encounter information; 2) review of and support for PPG Q4 improvement plans and 3) review of supplemental data submission (and potential under-submissions). Impact from reconciliation efforts will be evaluated once the March 2024 data refresh occurs.
- **For the High Touch HEDIS / Pharmacy Call Center Outreach RFP**, AdhereHealth was selected as the vendor of choice. The contract completed redline reviews and is now approved. The contract has been executed. Goal is to implement by 6/2024.

Healthcare Effectiveness Data and Information Set (HEDIS)

- **HEDIS Audits**
  - ***Advent Advisory Group LLC, Virtual Audit*** successfully completed on 03/01/2024. L.A. Care submits all documentation, including Roadmap supplemental data sections and all applicable attachments.
  - ***Health Services Advisory Group (HSAG) Virtual Audit*** successfully completed on 03/06/2024. Auditor finalized approval of all supplemental data.

Population Health Management (PHM)

- The focused **2023-2024 Population Health Management Index (PHMI)** comprises nine enterprise goals, while the full PHMI encompasses 18 goals.
- The PHM team is currently developing the **2024 PHM Program Description**, incorporating CalAIM requirements and intervention updates.
- The PHM Team continues to lead **collaborative efforts with local health departments** and all health plans serving L.A. County to achieve a SMART goal: reducing maternal and infant mortality disparities for Black and Native American individuals by 50% in LA County by December 2025. Additionally, L.A. Care collaborates with SCAN for a SMART goal focused on older populations. Next steps involve coordinating health plans' efforts to maximize impact, avoiding duplication, and collecting deliverables for 2024 Medi-Cal Contract Phase III Readiness.

Initial Health Appointment (IHA)

- The **IHA Workgroup** has submitted a corrective action plan (CAP) to address the final DHCS Audit finding on IHA:

- All components of the CAP are complete or on track including updating the monitoring tool, creating a compliance report, sending attestations to PPGs and providers, and adding payment for IHAs within the P4P program.
- All Network Providers (PPG and Direct Network) have access to monthly **IHA due reports** on the provider portal to support IHA completion for members within 120 days of enrollment. Soon they will also receive monthly reporting on members not in compliance.
- The IHA workgroup is expanding opportunities for member education including developing a text campaign and exploring a member incentive.

Facility Site Review (FSR)

- DHCS provided updated FSR and MRR tools/standards on 01/23/2024, which included minor grammatical edits implemented on 1/1/2024. Updates include:
  - Enhanced oversight of MCP provider proficiency requirements.
  - Documentation of education/training for non-licensed medical personnel.
  - Requirement for qualified/trained personnel to operate medical equipment.
  - Alignment of Pediatric and Adult Preventive Criteria with APL 22-030 and the Population Health Management Guide, outlining IHA requirements.
- **External Collaboration:** FSR leadership collaborated with the Healthy Data System (HDS) vendor to update online tools and provide additional staff and provider training. The FSR team collaborated with the LA County Collaborative to develop a combined mobile unit tool and condensed street medicine tool, currently being piloted by all MCPs, with feedback pending.

Population Health Informatics

- **Health Information Management (HIM) Analytics:** Achieved Phase 1 completion of the D-SNP Performance Report Dashboard, now serving the STARS Team until the end of MY 2023, at which point the STARS Team will take over dashboard responsibilities.
  - Medi-Cal JOM Performance Reports are consistently generated for new QI JOM meetings, with plans underway to transition these reports to Tableau for easier access.
  - Development of CalAIM KPIs is ongoing, with quarterly/monthly rates calculated by line of business and PPG, and shared with Advanced Analytics Library (AAL) for inclusion in their Utilization Management Over-Under Report.
  - Data analysis has begun for two new Incentive Programs—SNF and Hospital—with code development and report distribution to providers slated for early April.
  - Collaboration with the Initiatives Team is underway to finalize reports distributed through the provider portal, aiming to improve the Follow-Up with a PCP after an ED visit metric and incorporate FQHC reports for Direct Network providers.
  - SDOH rates are generated to aid the Health Equity Team in monitoring SDOH rates across PPGs and PCPs.
  - Ongoing collaboration with DHS and affiliated hospitals include providing encounter volume/timeliness data.

- **Health Information Ecosystem (HIEc):** Updates to the Hospital Services Agreement (HSA) now require hospital participation in Health Information Exchanges (HIEs), aligning with CMS 9115-F standards for Admission, Discharge, and Transfer (ADT) notifications and California Health and Human Services (CalHHS) Data Exchange Framework (DXF). Skilled Nursing Facility contracts are also being amended to mandate participation in CalHHS DXF and HIEs for improved information exchange efficiency.
  - Participation in HIEs is integral to the newly launched Hospital Pay-for-Performance (P4P) and SNF P4P Programs, offering incentives for meeting HIE participation milestones.
  - Implementation of the Data Exchange Framework (DXF) is progressing towards a go-live date of 3/28/2024.
  - A one-time HIE Adoption Incentive, launched on 3/15/2024 with a $2.1M budget, targeting hospitals and SNFs.
  - The HIE Adoption Incentive for FQHCs, Small Practices, and Solo Practitioners is ongoing, with three provider applications approved and additional applications under review.

Incentives

- Final 2022 P4P payments and reports have been completed for all programs. The team has been fielding inquiries and meeting with providers about the results.
- Provider Opportunity Report (POR)/Gap in Care (GIC) reports are being produced monthly for all provider types. Plans for report enhancements are under way alongside efforts towards more effective use of the Cozeva platform. A final retro 2023 POR is being produced and distributed in March/April. 2024 prospective PORs will go out in a similar timeframe.
- The next Q4 2023 encounter reports for Plan Partners, PPGs, and Direct Network providers will go out in April. We are adding a new encounter metric, "percent of accepted encounters," to the VIIP in 2024.
- The 2023 CG-CAHPS survey is fielding, expecting to complete in April. The first data/reports should be available by June.
- Member incentives for 2024 are currently being assessed among stakeholders, with potential new programs for COL, WCV, and other targets.

Community Health Division

Community Supports (CS) Operations & Reporting

- **CS Provider Network:** For the July 2024 cycle, contracting is in progress for 15 providers. This includes providers for new CS programs such as Day Habilitation and Short Term Post Hospitalization Housing.
- **CS Implementation:** Implementation in progress for new CS for July 2024 launch: Day Habilitation and Short Term Post Hospitalization Housing.
- **CS Stakeholder Training:** CS monthly webinar series for current and prospective CS providers and other stakeholders is ongoing. The 3/22/24 webinar focused on: Continuum of Support for Housing Needs.
- **CS Program Alignment:** Standardization of program operations across all CS in progress
- **CS Systems:** Work is ongoing to resolve CS data issues in SyntraNet related to member enrollment status and Homeless and Housing Support Services (HHSS), RTF updates to reflect discontinuation of services, etc. QNXT testing and training is in progress.

Behavioral Health

Quarter-over-quarter, there has been a steady rise in Sobering Center cases, reflecting increased utilization of services by members.

Housing Initiatives (Housing CS, Day Habilitation CS, Field Medicine, HHIP)

- **Housing (Housing Navigation [HN] CS, Tenancy Sustaining Services [TSS] CS, Housing Deposits [HD] CS):**
  - Financial Restructure: HHSS (HN & TSS) will transition from a pre-emptive monthly capitation structure to a 2 claims per month (paid at half the cap rate each) structure. Implementation planning in progress.
  - HD admin payment to be separated from HHSS monthly cap. Implementation planning in progress.
  - Interim Housing (IH) Support: Launching IH partnerships with County and cities to connect L.A. Care Members to HN/ECM. Planning and implementation in progress.
  - Members Enrolled (as of 3/11/2024): 10,954 (456 increase from 2/5/2024)
  - Provider Network: Currently 28 contracted for HHSS, with 19 also contracted for HD

- **Day Habilitation CS (to launch 7/1/2024):**
  - Operations planning and launch in progress, including program and payment development; system build out, and configuration process.
  - Provider Network: Application review has been completed. 5 providers in process.

Field Medicine (FM) / Street Medicine (SM): Launch and Operations

- FM launch and operations planning in progress, including: final proposal for county-wide SM program; provider identification and engagement; development of SM network contract and rates; initial draft of FM application; and preparation for county-wide geo-mapping.
  - Model of Care and operational alignment with HealthNet in progress
  - Development of capacity building and performance incentives in progress

Pharmacy Division

Star Rating Metrics

- **Medication Adherence Programs:** Preliminary CY2023 rates have been released, showing a 4-5% increase in our adherence STAR measures from CY2022. We achieved 4 stars in the diabetes medication adherence measure and 2 stars in both the hypertension and cholesterol measures.
  - ***Comprehensive Adherence Solutions Program (CASP):*** As the development of a customer relationship management (CRM) system tailored to Pharmacy's needs is not expected to commence until 2025 at the earliest, Pharmacy is exploring the option of utilizing Navitus' CRM system, RISE, as an interim solution.
  - ***Pharmacoadherence Mailers:*** L.A. Care Pharmacy team will manage pharmacoadherence mailer distribution internally for DSNP and LACC/D members and providers. Since this program was previously managed by a vendor, we anticipate a cost savings of approximately $154,000 from transitioning this program in-house. This transition began in April 2024.

- ***Vendor Collaboration – CVS Adherence Program:*** The first cohort of members was enrolled in February 2024.
- ***Quality Drug Clinical Care (QDCC):*** As of 1/1/24, L.A. Care Health Plan has transitioned its mail order pharmacy services from Ralphs Pharmacy to QDCC for DSNP, LACC/D, and PASC members. QDCC offers enhancements such as the ability to ship refrigerated medications and diabetic testing supplies. DSNP members also have the option to enroll in auto-refill and auto-ship services. As of 3/1/24, 66 DSNP members have been successfully enrolled in the new pharmacy, along with 57 LACC/D and 3 PASC members.
- ***GLP-1 Receptor Agonists:*** Effective 1/1/24, prior authorizations (PA) are required for all formulary GLP-1 receptor agonist (RA) products to ensure appropriate use for Medicare Part D covered indications. GLP-1 RA medications are included in the diabetes medication adherence measure. To support the continuity of care and improve adherence Star ratings, L.A. Care Pharmacy team conducts outreach for rejected GLP-1 claims to pharmacies and providers to assist with processing. As of 3/25/24, GLP-1 rejected claims for 757 unique members have been reviewed and outreached.

- **Medication Therapy Management (MTM) Program:** CMS requires health plans to offer MTM services to Medicare members, including an annual comprehensive medication review (CMR). The 2024 MTM program year has started and changes to the program are reflected on our website. L.A. Care Pharmacy, in collaboration with Navitus Clinical Engagement Center (MTM vendor) and Custom Health pilot program, achieved 49% completion rate of eligible members as of 3/18/24, a significant improvement from 2023 Q1 at 29%.
- **Care for Older Adults (COA) – Medication Review:** Pharmacy is continuing to submit MTM CMRs to count for this measure. Participating physician groups (PPGs) are expected to work on this measure independently for the first half of the year. We have submitted a request for pharmacy interns again in the summer to assist with completing medication reviews internally.
- **Statin Use in Persons with Diabetes (SUPD)/Statin Therapy for Patients with Cardiovascular Disease (SPC):** Pharmacy launched several new initiatives in 2023 to facilitate appropriate initiation of statin therapy. We sent statin gap lists directly to the pharmacy teams at AltaMed and Optum/AppleCare, resulting in additional 16 SUPD and 34 SPC gaps closed. Preliminary CY2023 rates have been released, showing a 1% and 2% increase in our SUPD and SPC Star measures from CY2022, respectively. We achieved 4 stars for SUPD and 3 stars for the SPC measure. For 2024, Pharmacy plans to work with AdhereHealth for additional support in these measures.

Optimizing Prior Authorization

A Strategy to Improve Utilization Management and Reduce Provider Abrasion

L.A. Care HEALTH PLAN®

For All of L.A.

April 2024

Contents

Optimizing the Prior Authorization Process

Our Philosophy

The Importance of Prior Authorizations (PA) in Utilization Management

Prior Authorization is a common utilization management tactic for a payer to determine if a specific medical service, treatment, procedure, or medication is medically necessary and eligible for coverage before it is provided to the member

By implementing prior authorization for healthcare services that are identified as posing a high risk for fraud, waste, and abuse, or for potential patient harming, we can effectively...

Manage Costs: By verifying resources are used efficiently and only for necessary services

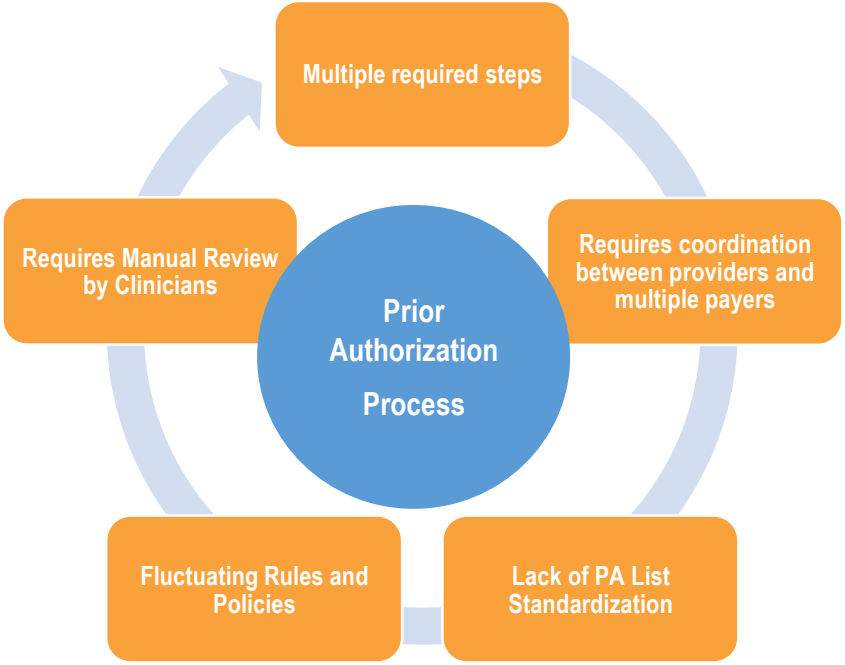
Ensure Quality: By reviewing requests against clinical guidelines, PA promotes evidence based care and patient safety

Allocate Resources and Prevent Fraud: By directing patients to the most appropriate levels of care, and requiring justification for requested treatments, procedures, equipment, and medication

Empower Members: By informing them about the necessity and appropriateness of certain treatments, they are enabled to make better healthcare decisions

Our Challenges

The Complexity of Prior Authorization and Provider Abrasion



1. **PA process requires multiple steps**, from gathering patient information and clinical documentation to submitting requests and awaiting approval. Each step introduces potential for delays and errors.

2. **The involvement of both payers and providers** makes it more challenging, as each payer and delegated provider has their own sets of rules, criteria, and workflows for reviewing and approving PA requests.

3. **Lack of standardized processes and guidelines across payers** exacerbates complexity, making it challenging for providers to navigate and comply with varying rules.

4. **Payer rules and policies (PA lists)** around prior authorization can change frequently due to changes in medical policies, clinical guidelines, formulary changes and regulatory updates.

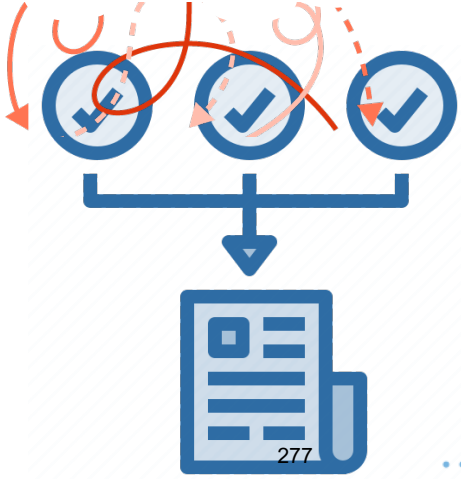
5. **Most PA requests require manual review** by the payer's clinical staff to assess medical necessity and appropriateness. Clinicians must carefully evaluate each request and supporting documentation.

Our Strategy

Goal: Streamlining Prior Authorization Processes to Reduce Provider Abrasion

Objective 1. Prior Authorization List Maintenance

Activities	Deliverables
1 Establish a structured PA governance process to appropriately manage the list and ensure its alignment with enterprise priorities, current industry standards, and regulatory requirements.	**Monthly Prior Authorization List Review meetings** involving cross-functional engagement to oversee the management of the list. These sessions focus on reviewing codes, evaluating them for inclusion, removal, and adjudication rules, and ensuring alignment with current industry standards and regulatory requirements. STATUS: COMPLETE
2 Regularly reconcile the two PA lists managed by internal UM and Claims Configuration teams, respectively, to improve consistency and accuracy in adjudication, and reducing payment delays, provider disputes, and compliance risks.	A **single source of truth Prior Authorization List** with ongoing synchronization, AND **documentation of reconciliation process** to: • Outline steps to compare and align the two lists • Keep record of discrepancies between them and decisions made to resolve them STATUS: IN PROGRESS



Our Strategy

Goal: Streamlining Prior Authorization Processes to Reduce Provider Abrasion

Objective 2. Reducing Prior Authorization Requirements

Activities

Eliminate Prior Authorization requirements for high-volume requests that pose low risk for fraud, waste, abuse, or patient harm:

- Surgical procedures
- Complex Labs & Radiology
- Medications
- Durable Medical Equipment (DME)
- Procedure codes with a >95% approval rate, examples include:
  - Mastectomy
  - Foot Reconstruction
  - Osteotomy

Deliverables: Early Results from 2024

Procedure Sets	% PA Reduced
Anesthesia	48%
Skin Surgery	38%
Musculoskeletal Surgery	89%
Respiratory Surgery	95%
Cardiac Surgery	3%
Digestive Surgery	83%
Reproductive Surgery	65%
Complex Radiology	73%
Complex Labs	34%
Medications	36%

24% **Reduction** in total CPT codes requiring prior auth

Spotlight: DME Codes

43% **Of durable medical equipment (DME) codes** no longer require PA, helping to:

- Reduce inpatient length of stay
- Free hospital bed capacity
- Facilitate hospital discharges
- Support smooth transitions to home or lower levels of care.

Our Strategy

Goal: Streamlining Prior Authorization Processes to Reduce Provider Abrasion

Objective 3. Efficient Delegation Oversight

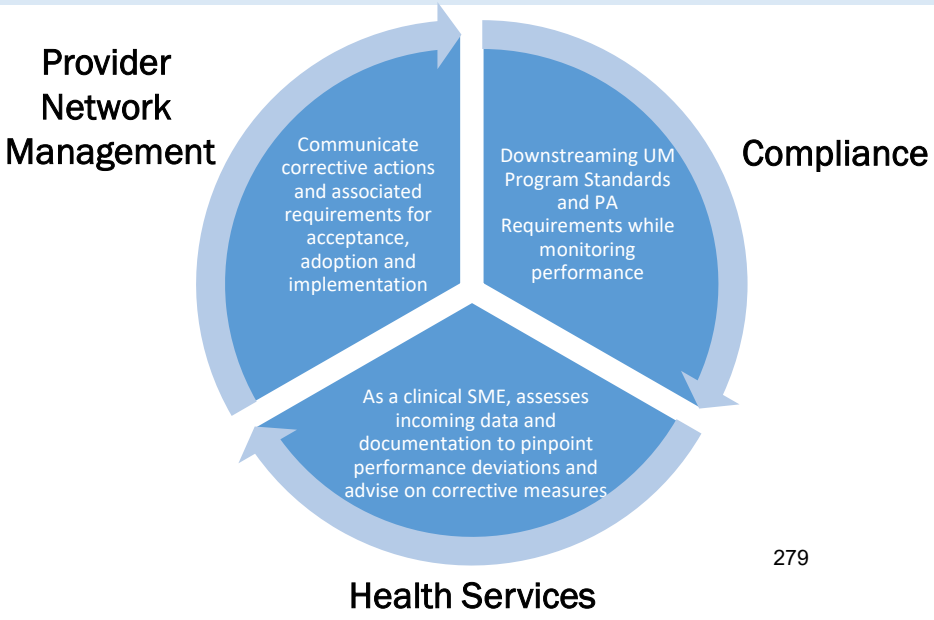
Activities

Enable efficient oversight of delegates PA responsibilities to achieve and maintain timely and accurate processing of requests to reduce delays in member care, administrative burden, and compliance risks.

Deliverables

In collaboration with Compliance, establish a streamlined PA Process for Delegates and Plan Partners featuring:

- Scheduled PA List vetting meetings
- Reporting on key metrics like approval/denial rates
- Guidelines for level setting codes and PA requirements for low-cost referrals
- Leveraging PNM to enhance communication

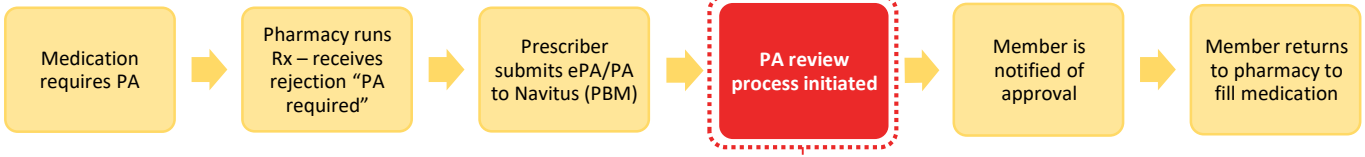


Our Strategy

Goal: Streamlining the Prior Authorization Processes to Reduce Provider Abrasion

Objective 4. Pharmacy Platform for D-SNP with *PA Accel*

Before Original PA Process: Time-Consuming and Resource Intensive



DOWNSIDE
The PA review process includes many intermediary manual steps before a decision is made:
- Eligibility checks
- Request form validation
- Claims history review
- Formulary status check

After On the Fast Track with *PA Accel*

BENEFITS
Driving improvement in:
- Compliance
- Member + Provider Abrasion
- Medication Adherence

Appendix

Our Strategy at a Glance: Executive Summary

Goal: Streamlining Prior Authorization to Reduce Provider Abrasion

Objective	Activity	Deliverable
PA List Maintenance	Establish a structured PA governance process to appropriately manage the list to ensure its alignment with enterprise priorities.	**Monthly Prior Authorization List Review meetings** involve participation from cross-functional departments to manage the list. These sessions focus on reviewing codes, evaluating them for inclusion, removal, and adjudication rules, and ensuring alignment with current industry standards and regulatory requirements
	Regularly reconcile the PA lists managed by internal UM and Claims Configuration teams, respectively, to mitigate potential issues with provider payment.	UM team has successfully synced the UM PA List with the IT configuration PA List to create a single source of truth, improving consistency and accuracy in adjudication, reducing payment delays and provider disputes, and enhanced compliance.
Delegation Oversight	Enable efficient oversight of delegates PA responsibilities to achieve and maintain timely and accurate processing of requests to mitigate delays in member care, increased administrative burden, compliance risk, and diminished effectiveness of UM efforts.	**In collaboration with Compliance, establish a streamlined PA Process for Delegates/PPs, featuring:** • Scheduled PA List vetting meetings • Reporting on key metrics, including approval/denial rates • Guidelines for level setting codes and downgrading low-cost referrals • Leveraging PNM to enhance communication effectiveness
Pharmacy Platform	The rising volume of prescriptions requiring prior authorization, along with tight turnaround times, complicates operational compliance and undermines medication adherence among members.	**PA Accelerator**, targeted for D-SNP members, bypasses the manual PA process and shifts to an automated online platform that pulls medical and pharmacy data to adjudicate requests instantly. This approach shortens turnaround times, alleviates volumes, ensures compliance, and increases medication adherence and member satisfaction.

MOTION FOR CONSIDERATION

Board of Governors
MOTION SUMMARY

Date: May 2, 2024 **Motion No. BOG 100.0524**

Committee: **Chairperson:** Alvaro Ballesteros, MBA

Issue: To approve delegated authority to the Chief Executive Officer, John Baackes, to issue up to $1,000,000 in Elevating the Safety Net funds to the Keck Graduate Institute to support the Master of Science in Community Medicine and Master of Community Health Administration programs over a two-year period.

☐ **New Contract** ☐ **Amendment** ☐ **Sole Source** ☐ **RFP/RFQ was conducted in** N/A

Background: In 2020, L.A. Care provided $5 million to Keck Graduate Institute (KGI) to establish an Integrated Master of Science in Community Medicine. This program has graduated one cohort and a second cohort will graduate in May 2024. KGI has updated the program based on experience with these cohorts and is now offering two programs: a Master of Science in Community Medicine (MSCM), geared toward preparing students to apply to medical school and a Master of Community Health Administration (MCHA) that prepares students for other health-related careers. The programs are designed to support working students, and include a community-engaged capstone project.

The goal of this program is to attract and educate a diverse healthcare workforce, with a focus on traditionally underserved communities. The program gives preference to first-generation college students and targets students from Cal State Universities who are dedicated to working in underrepresented communities. Of the 18 students who graduated in May 2023, two are currently in medical or dental school, five are awaiting results from medical school applications or are preparing to apply, and the remainder are employed or seeking employment in the health sector.

Because this program seeks to attract students from underserved communities, scholarships are essential. L.A. Care is seeking approval to establish the L.A. Care Scholars program at KGI, which would fund 22 scholarships a year and some administrative costs for two years for a total of $1 million. Students receive career advising and mentorship in addition to the curriculum.

This investment aligns with L.A. Care's Elevating the Safety Net initiative, the goal of which is to increase health access for our members and to improve equity and cultural competence among safety net providers. Pipeline and training programs are an important component of addressing workforce shortages in the health care safety net.

Member Impact: Supporting KGI is consistent with L.A. Care's mission of ensuring access and providing high quality care to vulnerable and low income populations in underserved areas. The program is designed to attract students from these communities dedicated to serving in the safety net.

Budget Impact: In October 2023, the L.A. Care Board of Governors approved adding $50 million from unassigned reserves to the Board Designated Fund for workforce development (Elevating the Safety Net) to address emerging safety net and community needs through FY 2026-27. The requested funds for KGI will come from this allocation.

Motion: **To approve delegated authority to Chief Executive Officer, John Baackes, to issue up to a $1,000,000 award to Keck Graduate Institute to support scholarships and administration for their Master of Science in Community Medicine and Master of Community Health Administration programs.**

TEMPORARY TRANSITIONAL EXECUTIVE COMMUNITY ADVISORY

Board of Governors
MOTION SUMMARY

Date: May 2, 2024

Motion No. TTECA 100.0524

Committee: Temporary Transitional Executive Community Advisory Committee (TTECAC)

Chairperson: Ana Rodriquez

Issue: Consumer input to L.A. Care's Board of Governors is essential to decisions affecting L.A. Care Medicaid members. For the last three Board meetings in 2024, closed session have been at the beginning of the Board meeting making it difficult for consumer members, who want to attend and provide public comment. Consumer members now have to wait to speak. TTECAC is asking the Board of Governors (BOG) to consider returning the "public" session to start at the beginning of monthly BOG meetings and "closed" session to occur before or after the "public" session.

This will greatly increase participation of community advisory members as well as other public members who desire to express concerns to L.A. Care's Board of Governors.

Background: During the April 2024 TTECAC meeting, it was discussed and determined that a motion be forwarded to the Board of Governors to consider returning the BOG monthly meetings for the "public" sessions to start 1:00 p.m. to 4:00 p.m. and the "closed" session to occur before or after the "public" session.

Member Impact: Reduced consumer in-person participation and lessened feedback to board members on issues affecting L.A. Care monthly BOG meetings.

Budget Impact: None

Motion: To request the Board of Governors' to consider returning the BOG monthly meetings to the first Thursday 1P-4P BOG "public" session meetings which would cause the BOG "closed" sessions to begin before or after the "public" session meetings designated hours.

Board of Governors
MOTION SUMMARY

Date: May 2, 2024

Motion No. TTECA 101.0524

Committee: Temporary Transitional Executive Community Advisory Committee (TTECAC)

Chairperson: Ana Rodriquez

Issue: Including push-door buttons in the design of all L.A. Care facilities where appropriate for persons with disabilities is essential for ensuring accessibility and independence. These buttons allow individuals with mobility impairments to easily enter and exit buildings without assistance, promoting inclusivity and equal access to public spaces. Additionally, push-door buttons can also benefit those with temporary disabilities, parents with strollers, and individuals carrying heavy loads, making them a practical and inclusive design feature for all.

Background: During the April 2024 Temporary Transitional Executive Community Advisory Committee (TTECAC) meeting, the committee discussed and determined that a motion be forwarded to the Board of Governors to consider the placement of push door buttons on any door accessible to the public on any site used by L.A. Care Health Plan for public meetings.

Member Impact:

Budget Impact: Staff will return with an estimate cost and budget impact once a response to the attached motion is developed.

Motion: **L.A. Care Board of Governors to consider the placement of push door buttons on any door accessible to the public at any site used by L.A. Care for public meetings. This action will greatly support seniors and persons with disabilities who utilize restrooms for business and access the building for public business.**

Board of Governors

Temporary Transitional Executive Community Advisory Committee (TTECAC)

Meeting Minutes – March 13, 2024

1055 W. 7th Street, Los Angeles, CA 90017

ECAC Members	RCAC Members/Public	L.A. Care Board of Governors/Senior Staff
Roger Rabaja, RCAC 1 Chair	Henry Cordero, Interpreter	Layla Gonzalez, *Advocate, Board of Governors*
Ana Rodriguez, TTECAC Chair and	Pablo De La Puente, Interpreter	Fatima Vazquez, *Member, Board of Governors*
RCAC 2 Chair	Isaac Ibarlucea, Interpreter	Sameer Amin, MD, *Chief Medical Officer, L.A. Care*
Lidia Parra, RCAC 3 Chair **	Eduardo Kogan, Interpreter	Alex Li, MD, *Chief Health Equity Officer, L.A. Care* ***
Silvia Poz, RCAC 4 Chair **	Alex Martinez, Interpreter	Francisco Oaxaca, *Chief of Communication and Community Relations*
Maria Sanchez, RCAC 5 Chair	Katelynn Mory, Captioner	Tyonna Baker, *Community Outreach Field Specialist, CO&E*
Joyce Sales, RCAC 6 Chair	Andrew Yates, Interpreter	Malou Balones, *Board Specialist, Board Services* ***
Martiza Lebron, RCAC 7 Chair		Kristina Chung, *Community Outreach Field Specialist, CO&E*
Ana Romo, RCAC 8 Chair		Idalia De La Torre, *Field Specialist Supervisor, CO&E*
Tonya Byrd, RCAC 9 Chair		Auleria Eakins, *Manager, CO&E*
Damares O Hernández de Cordero,		Erica Freed, *Executive Assistant, Health Services* ***
RCAC 10 Chair		Ramon Garcia, *Community Outreach Field Specialist, CO&E*
Maria Angel Refugio, RCAC 11 Chair	Russel Mahler, Public	Elsa Susana Greno, *Health Equity Field Specialist II, Health Equity*
Lluvia Salazar, At-Large Member	Andria McFerson, Public	Hilda Herrera, *Community Outreach Field Specialist, CO&E*
Deaka McClain, TTECAC Vice-Chair	Silvia Poz, Public ***	Christopher Maghar, *Community Outreach Field Specialist, CO&E*
and At Large Member	Demetria Saffore, Public	Rudy Martinez, *Safety & Security Program Manager III, Facilities Services*
		Linda Merkens, *Senior Manager, Board Services* ***
* Excused Absent ** Absent		Frank Meza, *Community Outreach Field Specialist, CO&E*
*** Via teleconference		Leah Elizabeth Mitchell, *Health Education Project Liaison III, Executive Services*
		Alfredo Mora, *Staff Augmentation, Facilities Services*
		Cindy Pozos, *Community Outreach Field Specialist, CO&E*
		Marissa Ramirez, *Community Benefits Grants Program Manager II, Community Benefits Program* ***
		Victor Rodriquez, *Board Specialist, Board Services*
		Henock Salomon, *Senior Manager, Incentives, Population Health* ***
		Farid Seyed, *Lead Unified Communication Mobility Engineer, IT Operations & Infrastructure*

		Prity Thanki, *Local Government Advisor, Government Affairs* *** Marvin Thompson, *Community Benefits Grant Specialist II, Community Benefit Program* *** Martin Vicente, *Community Outreach Field Specialist, CO&E* Shavonda Webber-Christmas, *Director, Community Benefits, Community Benefit Program*

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Ana Rodriguez, *TTECAC Chairperson*, explained the process for making public comments via Zoom chat and a toll-free line for WebEx bridge line listeners. She also mentioned that public members could submit comment cards and that they would be allowed time to speak during the appropriate agenda items. Ms. De La Torre welcomed L.A. Care staff and the public to the meeting and encouraged L.A. Care members with healthcare issues to contact the Member Services Department. Members of the Temporary Transitional Executive Community Advisory Committee (TTECAC), L.A. Care staff, and the public can attend the meeting in-person at the address listed above. Public comment can be made live and in-person at the meeting. A form will be available to submit public comments. Accordingly, members of the public should join this meeting via teleconference as follows: https://us06web.zoom.us/j/82628914456 Teleconference Call –In information/Site Call-in number: 1-415-655-0002 Participants Access Code: 2492 069 0481 (English) Call-in number: 1-415-655-0002 Participants Access Code: 2497 816 3798 (Spanish) For those not attending the meeting in person, public comments on Agenda items can be submitted in writing by email to COEpubliccomments@lacare.org or by calling the CO&E toll- free line at 1-888-522-2732 and leaving a voicemail. Attendees who log on to lacare.zoom using the URL above will be able to use "chat" during the meeting for public comment. You must be logged into Zoom to use the "chat" feature. The log in information is at the top of the meeting Agenda. This is a new function during the meeting so public comments can be made live and direct. 1. The "chat" will be available during the public comment periods before each item. 2. To use the "chat" during public comment periods, look at the bottom of your screen for the icon that has the word, "chat" on it. 3. Click on the chat icon. It will open a window. 4. Select "Everyone" in the to: window.	

	5. Type your public comment in the box. 6. When you hit the enter key, your message is sent and everyone can see it. 7. The chat message, text, voicemail, or email must indicate if you wish to be identified or remain anonymous, and must also include the name of the item to which your comment relates. 8. L.A. Care staff will read the chat messages for up to three minutes during public comment so people who are on the phone can hear the comment. Your comments can also be sent by voicemail or email. If we receive your comments by 10:00 a.m. on March 13, 2024, it will be provided to the members of the Temporary Transitional Executive Community Advisory Committee at the beginning of the meeting. The chat message, voicemail, or email must indicate if you wish to be identified or remain anonymous, and must also include the name of the item to which your comment relates. Once the meeting has started, public comments should be submitted prior to the time the Chair announces public comments for each agenda item and staff will read those public comments for up to three (3) minutes. Chat messages submitted during the public comment period for each agenda item will be read for up to three (3) minutes. If your public comment agenda is not related to any of the agenda item topics, your public comment will be read for up to three (3) minutes at item IX Public Comments on the agenda. Please note that there may be a delay in the digital transmittal of emails and voicemails. The Chair will announce when the public comment period is over for each item. If your public comments are not received on time for the specific agenda item you want to address, your public comments will be read at the public comment section of the agenda. The purpose of public comment is that it is an opportunity for members of the public to inform the governing body about their views. The Temporary Transitional Executive Community Advisory Committee appreciates hearing the input as it considers the business on the Agenda. The process for public comment is evolving and may change at future meetings. We thank you for your patience. All votes in a teleconferenced meeting shall be conducted by roll call. If you are an individual with a disability and need a reasonable modification or accommodation pursuant to the Americans with Disabilities Act please contact the Community Outreach & Engagement staff prior to the meeting for assistance by calling our toll-free line at 1-888-522-2732 or by email to COEpubliccomments@lacare.org. SB 1100 was signed by Governor in August 2022, and added a short section to the Brown Act as Govt Code Section 54957.95 to supplement language already part of the Brown Act :	

	(a) In addition to authority exercised pursuant to Sections 54954.3 and 54957.9, the presiding member of the legislative body conducting a meeting may remove an individual for disrupting the meeting. (b) As used in this section, "disrupting" means engaging in behavior during a meeting of a legislative body that actually disrupts, disturbs, impedes, or renders infeasible the orderly conduct of the meeting and includes, but is not limited to, both of the following: (1) A failure to comply with reasonable and lawful regulations adopted by a legislative body pursuant to Section 54954.3 or 54957.9 or any other law. (2) Engaging in behavior that includes use of force or true threats of force. (54954.3 contains provisions related to public comment time restrictions, and 54957.9 allows the presider to clear the room if the meeting can't continue.) AGENDA and PRINTED MEETING MATERIALS ARE AVAILABLE FOR INSPECTION BEFORE THE MEETING AT L.A. Care's Offices at 1055 W. 7th Street, Los Angeles, CA 90017 through the Reception Area in the Building Lobby. Chairperson Rodriguez called the meeting to order at 10:00 A.M.	
APPROVE MEETING AGENDA	**PUBLIC COMMENT** *Andria McFerson emphasized the importance of adhering to proper protocol, particularly in allowing public comments before approvals. She specifically addressed Item Number 1 and expressed concern that the public did not receive necessary information within the designated timeframe. Additionally, she questioned whether the meeting's call to order followed proper protocol.* **The Agenda for today's meeting was approved.**	**Approved Unanimously. 10 AYES (Byrd, Cordero, Lebron, McClain, Rabaja, Refugio, Rodriguez, Sales, Salazar, and Sanchez)**
APPROVE MEETING MINUTES	Member Lebron stated that on page 6 before the public comment section she said that the focus groups should not have to adhere to the Brown Act and the other meeting should continute to do so. **The January 22, 2024 Special Meeting minutes were approved with the changes mentioned above.** **The February 14, 2024 Meeting minutes were approved with the changes noted above.**	**Approved Unanimously. 10 AYES** **Approved Unanimously. 10 AYES**
STANDING ITEMS		
UPDATE FROM CHIEF MEDICAL OFFICER	*(Member Romo arrived at 10:47 A.M.)*	

	Sameer Amin, *MD*, *Chief Medical Officer*, gave the following update: Dr. Sameer Amin, the Chief Medical Officer of L.A. Care, began his report by expressing his enthusiasm for engaging with the audience regarding the restructuring of advisory committees. He emphasized that the goal is to initiate a conversation rather than dictating outcomes. Dr. Amin stressed the importance of seeking input from the community to better understand the needs of L.A. Care's members, aiming to improve the direction of the organization. He acknowledged the complexity of the subject matter but assured simplicity in presentation to facilitate understanding. Dr. Amin highlighted the grassroots approach intended for the restructuring process, seeking to build from the bottom-up rather than top-down. He acknowledged past challenges and expressed a commitment to redesigning the process for better outcomes. Dr. Amin outlined the necessity for changes in alignment with a new contract with the Department of Health Care Services, emphasizing adherence to its requirements. He discussed proposed modifications to advisory committee structures, focusing on enhancing diversity, membership, and engagement. The report delved into contractual language, detailing requirements such as community engagement, selection committees, diversity and recruitment plans, and term limits for committee members. Dr. Amin emphasized the importance of aligning advisory committees with demographic data from specific service areas (SPAs) within the county to inform decision-making effectively. He introduced the concept of community round tables as an additional avenue for engagement, alongside existing RCACs, aiming to gather more diverse input. Dr. Amin explained the proposed changes to RCAC regions and the ECAC (Executive Community Advisory Committee) while addressing concerns about the ECAC's continuity. Regarding stipends, Dr. Amin outlined increases to compensate members for their time and effort adequately. He assured continued support for logistics such as transportation and refreshments during meetings. Dr. Amin concluded by emphasizing a grassroots approach to gather feedback from RCAC members, seeking to ensure that decisions align with the community's needs and preferences. He highlighted the importance of thorough deliberation within the ECAC and eventual endorsement by the Board of Governors before final implementation. <u>PUBLIC COMMENT</u> *Ms. McFerson began by thanking the Chair for the opportunity to speak, expressing concerns about inequality. She highlighted issues regarding the timing and accessibility of information, stating that she received materials for the RCAC meeting late, preventing adequate review before the public session. She noted that the information provided was only available in Spanish, with no English translation provided. Ms. McFerson emphasized the importance of having complete and timely information, especially for individuals like herself*	

	who have undergone brain surgery. She expressed doubt regarding the proper execution of Item 4 and urged the Chairs and co-Chairs to honor public access to information. She raised questions about the necessity of proposed changes, specifically regarding the legality of making RCACs smaller and implementing term limits. Ms. McFerson questioned the selection process for committee members, particularly those with long-standing tenure, and advocated for transparency and the rights of RCACs to vote on such matters. She urged Chairs to express their opinions and sought clarification on the process moving forward, emphasizing the need for RCACs to have a say in decisions that may affect them. Ms. McFerson concluded by stressing the importance of adhering to the law and ensuring that RCACs have a voice in decision-making processes. Dr. Amin clarified that signing a contract with the Department of Health Care Services and the State of California is a requirement for providing Medi-Cal services, and there is little room for negotiation in this process. Dr. Amin explained that the changes being implemented align with the contractual obligations outlined in the signed contract. He elaborated on specific changes, noting that some directly correspond to contractual requirements, such as the establishment of a selection committee. Dr. Amin emphasized that the transition from the current RCAC structure to Service Planning Areas (SPAs) aims to facilitate actionable meetings with relevant data. He justified the introduction of term limits as a means to address diversity and turnover within RCACs. Dr. Amin acknowledged the importance of soliciting opinions from RCAC members and urged constructive feedback rather than outright rejection. He encouraged members to propose alternative solutions if they believed there was a better approach. Dr. Amin expressed openness to considering different perspectives and emphasized the need for humility in leadership. He concluded by reaffirming the sensibility of the proposed changes while remaining open to revisiting them if they did not resonate with RCAC members. Member Salazar asked for clarification about the stipends, specifically about the members that have children. Mr. Oaxaca said that a goal is to simplify stipend as all-inclusive, including child care for the meetings that members attend. Dr. Amin said that the thought is that the overall annual amount would go up in the way that it's displayed in that table. He said that staff can take that back and review. Ms. Salazar noted that the previous system included childcare provisions, which are now absent. She noted the financial strain childcare expenses can place on parents, particularly if the stipend provided is insufficient to cover these costs for those with one or two children. Member Salazar emphasized the importance of considering the needs of parent members, stressing that while their input is valuable, it may not adequately address the challenges posed by childcare expenses. Mr. Oaxaca responded by highlighting the efforts to simplify the	

	stipend structure and increase the stipend amounts, which had not been updated in years. He mentioned the availability of childcare supervision at local community resource centers during meetings, suggesting it as a solution to childcare concerns. Dr. Amin agreed with the idea, emphasizing that it aligns with the focus on the Regional Community Advisory Committee (RCAC). Mr. Oaxaca clarified that the current structure aims to provide some compensation for meeting participation expenses, further adjustments could be considered. Member Refugio inquired about who would be responsible for selecting the selection committee and choosing its members. She also expressed concern about the potential reduction of RCACs from 11 to 8, which would impact the membership, particularly the 20 members. Additionally, she questioned whether RCAC members attending Board of Governors (BOG) meetings and Executive Community Advisory Committee (ECAC) meetings would receive payment for their attendance. Mr. Oaxaca clarified that the target membership for the 11 RCACs is 20 members each, totaling 140 current members. With the reduction to 8 RCACs, there will still be 160 members, not counting the additional 65 members participating in round tables. He emphasized that they are not losing members but actually accommodating more. Attendance at board meetings or ECAC meetings is already covered in existing policy. Each RCAC will select two members monthly to attend board meetings and receive stipend, with no stipend for additional attendees. RCAC members can also attend ECAC meetings and round table meetings as observers. Similarly, round table members can attend RCAC meetings as members of the public. Member Sales raised questions regarding the development and implementation of a member diversity and recruitment strategy, the establishment of a member selection committee, maintaining a composition reflective of contractor and member populations, determining topics for round tables, and distinguishing between the RCAC structure and the proposed board advisory committee. Dr. Amin explained that the board advisory committee is essentially a name change and won't structurally differ from the RCACs. He then discussed the demographic considerations and the transition from RCACs to SPAs to ensure demographic representation. The selection committee would use demographic reports and input from the SPA to make decisions. Mr. Oaxaca explained that the committee's composition would include L.A. Care staff, health plan representatives, and community partners, with active recruitment efforts in the community to ensure diverse representation. Member Sales asked about the community partners. Mr. Oaxaca provided information about the community partners L.A. Care works with, including organizations like Neighborhood Legal Services, African American Elders, Alzheimer's Association, Mothers to Mothers, and groups focused on workforce development. He emphasized the importance of engaging these partners to ensure diversity and quality in selecting members for committees. In response to Member Sales' inquiry about suggesting possible partners, Mr. Oaxaca affirmed that suggestions are welcome and mentioned that RCACs have been asked	

	in the past to suggest partners for the annual work plan. He stressed the importance of member input in identifying organizations that are doing meaningful work in their communities. Regarding the topics for round table discussions, Mr. Oaxaca mentioned that DHCS has provided a list of topics for discussion, although it's not limited to those topics. This gives L.A. Care a starting point for discussion while allowing flexibility to address other relevant issues. Mr. Oaxaca mentioned that they have used the list of topics provided by DHCS and had discussions over the past few months with members to identify broader general topics for the round tables. Due to the limitation of having only five round tables, they created broader topics such as health access, advocacy and outreach in education, and social determinants of health. These broader topics encompass various specific issues, allowing for comprehensive discussions. Vice Chair McClain asked for clarification on whether the proposed changes are recommendations or mandates from the state and expressed confusion regarding the proposed name change to "board advisory committee." Mr. Oaxaca clarified that the proposed changes are in line with state requirements, and the name change is simply a formality with no functional change in the committee's role. Member McClain expressed frustration about the prolonged discussions and delays in finalizing the structure, suggesting that the current ECAC should be renamed "temporary RCAC" until the new structure is implemented. Dr. Amin acknowledged the frustration and emphasized the desire to expedite the process while ensuring all stakeholders' opinions are considered. He mentioned the plan to gather more feedback from RCACs before finalizing the changes, aiming to complete the process by May. Ms. Gonzalez expressed gratitude for the presentation and updates and raised concerns about the proposed changes, particularly the combining of SPAs. She mentioned the significant distance between certain areas within the combined SPAs, posing potential hardships for members, especially those without transportation. She also pointed out the difficulty in asking members to approve changes that would result in dismissing some members, suggesting a phased approach where existing members are “grandfathered in” before implementing new changes. She emphasized the importance of listening to member feedback and suggested a more gradual transition to the new structure. Mr. Oaxaca clarified that current members will start with the same terms, regardless of their previous length of service, to ensure fairness. He emphasized the importance of staggering terms to avoid sudden turnover among members. Mr. Oaxaca assures that no members will be penalized for their years of service and that all members will go through the same application and selection process. Regarding the distance issue, he acknowledged the challenge and explained that while the proposed meeting locations are ideal, they are open to alternative locations that are geographically convenient for members. Transportation options will also be available for eligible members to mitigate any burdens. Member Sales asked if the	

	disabled will also be given transportation. Mr. Oaxaca responded that is the current policy. L.A. Care has an eligibility policy and acknowledged the realities based on distance because of the structure and the location of some of resource centers will be reviewed to make sure it does not create too much of a burden for members.	
BOARD MEMBERS REPORT	Ms. Vazquez and Ms. Gonzalez gave the following Board Members Report: The Board of Governors met on March 7. Approved meeting minutes for previous Board meetings can be obtained by contacting Board Services and meeting materials are available on L.A. Care's website. • The list of motions approved at that Board meeting can be obtained from CO&E. • Thank you to the RCAC members that joined the Board meeting in person or virtually. We were happy to see members there and we appreciated hearing their public comments. Public comment gives Board Members the opportunity to hear from members and helps improve services for members. These members attended the Board Meeting in person: 1. Ana Rodriguez (R2) 2. Andria McFerson (R5) 3. Joyce Sales (R6) 4. Ana Romo (R8) 5. Deaka McClain (R9) 6. Damares O Hernandez de Cordero (R10) • In his CEO report, Mr. Baackes gave an update on a cyberattack on the claims processor, Change Healthcare, a major medical claims clearinghouse processing $15 billion annually. L.A. Care's cyber defense operations center is a team of staff working 7 days a week, 24 hours a day, looking at all incoming and outgoing traffic. He also gave an update on the managed care organization (MCO) tax. The tax was reinstated in the California State Budget and revenue will begin accruing in 2024. DHCS has announced the revenue will be allocated to providers through the health plans in a targeted rate increase or TRI, for care and services limited to primary care, behavioral health and obstetrics and gynecology (OB/GYN) • Cherie Compartore reported that the US House of Representatives passed a legislative package including health-related items as part of the continuing resolution set to expire tomorrow. The US Senate also passed the bill, securing funding through the year-end. • Dr. Amin gave a Chief Medical Officer Report. <u>PUBLIC COMMENT</u> *Andria McFerson requests that the Board of Governors (BOG) follow proper protocol regarding changes proposed for the RCAC meetings. She emphasized*	

	the need for RCAC members to have the right to vote on specific topics related to any changes. Ms. McFerson expressed concern about the lack of transparency in the agenda process, as RCAC members are not given the agenda within the required 72 hours. She highlighted that the proposed changes are staff proposals, not mandated by law, and pointed out discrepancies between the proposed changes and the requirements outlined by the Department of Health Care Services. Ms. McFerson asserted that RCAC members have the right to address these discrepancies and suggested that the state is changing its approach to committee oversight but not necessarily mandating all the proposed changes. Member Refugio thanked the Board Members for making the report available in Spanish.	
L.A. CARE EQUITY COUNCIL STEERING COMMITTEE UPDATE	Alex Li, *MD*, *Chief Health Equity Officer*, gave the following update: Dr. Li began by explaining the purpose of seeking input due to the restructuring aimed at operationalizing health equity within L.A. Care. He introduced two updates: one is a brief update, and the other an example of how engagement from members is sought. Dr. Li outlined the structure of various equity committees and councils within L.A. Care, including a large steering committee, a council for staff diversity, a member council equity steering committee, a provider equity council, and a consumer health equity council. He emphasized the importance of engaging members in decision-making processes and seeking feedback on proposed initiatives, such as enhancing the provider directory with photos and language capacity. Dr. Li also discussed the renaming of committees to reflect a focus on health equity and invited input on the best structures for engagement with community advisory committees. He encouraged open discussion and collaboration to ensure transparency and inclusivity in decision-making processes. Dr. Li elaborated on the process of seeking feedback from the consumer health equity council and other committees, emphasizing the need for consent from providers and updates to infrastructure. He also highlighted the renaming of the quality improvement committee to the quality of health equity committee and the inclusion of member voices in decision-making processes. Dr. Li expressed a willingness to work with members on structuring engagement with various committees transparently. He invited initial thoughts and suggested the possibility of forming a subcommittee to further explore engagement strategies, ensuring that conversations occur in an informed and inclusive manner. <u>PUBLIC COMMENT</u> *Andria McFerson emphasized the importance of focusing on content rather than time during the meeting to ensure members can fully express their opinions and discuss how decisions will impact public services. She questioned the equity of*	

	representation on committees, including the Board of Governors, and requested information on the members representing stakeholders in each committee. Additionally, she sought clarification on the law that grants members the right to vote on all changes. Dr. Li acknowledged Ms. McFerson's concerns about equity in committee representation and emphasized the importance of member feedback in health equity efforts and programs. He expressed a desire for guidance on how to structure communication and conversation so that ECAC members are aware of relevant discussions and feel adequately represented. Dr. Li asked for input on ensuring that ECAC members are informed and involved in decision-making processes related to health equity initiatives. Member Lebron expressed concern about the shortage of health promoters in Los Angeles, emphasizing the need to expand and support their efforts in educating the community about health topics. She acknowledges the challenges posed by the size of Los Angeles and suggested that increasing the number of health promoters could help address these issues. Ms. Gonzalez appreciated the presentation and the inclusion of pictures of doctors, noting that it makes selecting a doctor easier and friendlier. She emphasized the importance of equity in the committee's work, highlighting equal access to healthcare for all people. Ms. Gonzalez expressed concern about the lack of access to a current and active list of urgent care centers for people with Medi-Cal insurance, stressing the need for equitable access to emergency healthcare services. Vice Chair McClain expressed appreciation for Dr. Li's presentation and raised concerns about the diversity, equity, and inclusion training program outlined in the document. She questioned how this program contributes to improving healthcare access for all individuals, particularly regarding access to urgent care services for those with Medi-Cal insurance. Vice Chair McClain shared her own experience of encountering difficulties accessing urgent care despite assurances that they accept Medi-Cal. She inquired about the role of diversity, equity, and inclusion in addressing these issues and seeks clarification on the presence of a diversity, equity, and inclusion department at L.A. Care. Dr. Li expressed gratitude to Vice Chair McClain and explained that the diversity, equity, and inclusion training for staff is managed by human resources, while provider training is overseen by the health equity department. He mentioned the challenges in tracking and monitoring provider training completion and cited an example where only 20 percent of providers completed required training due to tracking difficulties. Dr. Li spoke about the role of the Quality Improvement Health Equity Committee in tracking training implementation progress and mentioned using the Consumer Health Equity Council for feedback once the training program is established. He clarified that the program is set to be implemented in January 2025.	

MEMBER ISSUES	PUBLIC COMMENT *Andria McFerson emphasized the lack of stakeholder representation in L.A. Care's committee meetings and agenda materials, including representation for actual members of L.A. Care and Board of Governors seats. She stressed the importance of having representation in decisions related to budget, quality, and compliance, citing the need for someone to advocate for patients' stories and concerns. Ms. McFerson concluded by mentioning negative Yelp reviews for L.A. Care, indicating dissatisfaction among members.* *Demetria Saffore expressed concerns regarding the continuation of issues with receiving her C-PAP supplies. She sought an update on what actions are being taken to resolve this problem, noting a cessation of communication after picking up her supplies.* Ms. De La Torre responded to Ms. Saffore and advised that staff will follow up with her in regard to her issues.	
NEW BUSINESS		
COMMUNITY HEALTH INVESTMENT FUND – ACCESSIBLE EQUIPMENT FUND 2023-2024	Shavonda Webber-Christmas, *Director, Community Benefits*, gave a presentation about Community Health Investment Fund and Accessible Equipment Fund 2023-24 (*a copy of the presentation can be obtained from CO&E*). • L.A. Care Board of Governors established the Community Health Investment Fund (CHIF) in 2000 to support specific community health care programs • Grant awards improve clinics' workforce and infrastructure, access to care, and health outcomes for members • Awards help stabilize social determinants like food, housing and income security. • As of October 1, 2023, the CHIF Program has supported nearly 1000 projects and invested more than $138 million in organizations caring for under-resourced communities • Since 2018, Community Benefits has awarded Provider Recruitment Program grants on behalf of the Elevating the Safety Net Initiative. PRP has invested $24M to hire 185 providers since 2018 • In 2023, Community Benefits began awarding capacity building investment through the Housing & Homelessness Incentive Program (HHIP) to improve equity in housing placement and health care coordination for people experiencing homelessness • The department now oversees the Strengthening Clinical Operations and Patient Experience (SCOPE) Fund which broadly impacts healthcare systems, through advocacy, policy, and training.	

	• On October 5, 2023, the L.A. Care Board of Governors approved a motion from the Temporary Transitional Executive Community Advisory Council to increase access for differently abled individuals and to make funds available for providers to obtain accessible exam tables • Community Benefits developed the Accessible Equipment Fund to meet the motion. It provides L.A. Care contracted clinics accessible exam tables and scales and increases access to care. • Allocated up to $450,000 from CHIF to fund approximately 45-50 items • Request for Applications will be released this Spring • Community clinics (FQHC/501c3) and private providers contracted with L.A. Care in good standing • Serve high proportion of Seniors and People with Disabilities (SPD) and other differently abled individuals • Have or be able to obtain a compatible EHR system to transfer blood pressure, weight, and other vitals into medical records • Strong justification why equipment is needed and how it will be used • Applications will be accepted online with continuous submissions through August 31, 2024 • Applicants may request up to $15,000 in equipment. • Awards will be announced for approved clinics within 60 days of application month • L.A. Care vendors will deliver equipment using white glove delivery service, which includes set up at the clinic site <u>PUBLIC COMMENT</u> *Andria McFerson expressed gratitude for the information shared, emphasizing its importance. She acknowledged the role of advisory committee members in publicizing healthcare additions to L.A. Care members. McFerson then raised the question of how to disseminate this information to the public effectively. She suggesed utilizing the budget of the RCACs for outreach purposes, considering it a necessity discussed during the meeting.* Ms. Webber-Christmas suggests the availability of a fact sheet that can be printed and distributed, potentially by working with the CO&E team. She noted that the fact sheet has not yet been fully reviewed and approved. It will contain essential information about criteria, application procedures, and the website. Although it cannot be interacted with like a digital document, the fact sheet will be available via email for forwarding to interested individuals.	

	Ms. De La Torre acknowledged the inquiry regarding budgetary matters but said that they are unable to address such issues at the moment due to being in a transition period. She notes that Ms. Webber-Christmas may also not be able to provide insight into their budget protocols. She assured that the question will be noted and that they will endeavor to provide an answer in a future meeting. Member Romo expressed concern about the increase in homelessness in her community and inquired about the status of the homeless program. Ms. Webber-Christmas acknowledges the inquiry but states she doesn't have detailed information at the moment, promising to follow up. Ms. De La Torre stated that Ms. Webber-Christmas is here to speak about exam tables and chairs. Ms. Sales asked for clarification on the timeline for the delivery of equipment to clinics after application approval and the process for requesting additional funds once the initial allocation is depleted. Ms. Webber-Christmas explained that within the 60-day period following application approval, orders approved by the vendor will be processed, ensuring timely delivery to clinics. She emphasized the importance of allowing adequate time for processing due to the newness of the process. She explained that if the current funds are depleted, they will request additional funding from the board during the annual budget allocation in November. She assures that if there is high demand and insufficient resources, they will request additional funding to meet the needs. Member Sales suggests spreading awareness about the application process among individuals with disabilities and encourages them to inform their L.A. Care doctors. This would help doctors become aware of the process and potentially allocate budget for promotion in the future, although currently, it relies on word of mouth. Ms. Gonzalez expressed appreciation to Ms. Webber-Christmas for her presentation and professionalism, despite technical difficulties. She asked if the availability of accessible equipment in clinics will be indicated on the website next to a primary care provider's name for easy access. Ms. Webber-Christmas appreciated the suggestion, acknowledging it as a wonderful idea. She explained that while they currently lack the ability to implement this feature directly, they can develop a list of approved clinics and the equipment they have received. She interpreted Ms. Gonzalez's suggestion as integrating this information into the clinic directory on the website, acknowledging it as a separate department's responsibility. Ms. Webber- Christmas committed to initiating the conversation and working towards integrating this feature into the website directory as the program progresses. Ms. Vazquez thanked Ms. Webber-Christmas for the presentation and shared the sentiment with members regarding accessibility for individuals with wheelchairs. She requested a link to the application process for suggesting clinics where individuals can apply for access to the equipment and suggested distributing information within the community. She asked for a	

	list of clinics that will receive the equipment once it becomes available. Ms. Webber-Christmas confirmed that they will work on publishing a list of organizations that receive the grant and have accessible equipment. She asked for clarification on whether Ms. Vazquez is asking for a link to the application process or for the list of clinics and she confirmed that she is requesting a link to the application process to share with doctors. Ms. Webber-Christmas assured that this information will be provided via email and paper flyers, with the URL included for easy access. Vice Chair McClain thanked Ms. Webber-Christmas. She mentioned a community link that provides information about accessible tables and suggested collaborating with them. She also suggested including pictures of each doctor or provider on the paper for accessibility, particularly for visually impaired individuals. She emphasized the importance of ensuring accessibility for all individuals, including those with visual impairments. Ms. Webber-Christmas acknowledged the suggestions and assured that they will consider all aspects, including providing pictures of each provider. She emphasized the importance of acting on these suggestions promptly and that they will add to the accessibility measures as they progress.	

CG-CAHPS MEMBER SURVEY	Henock Solomon, *MPH, Population Health Senior Manager, Incentives,* gave a presentation about Clinician & Group - Consumer Assessment of Health Care Providers & Systems (CG-CAHPS) member survey *(a copy of the presentation can be obtained from CO&E).*
	
	• CAHCPS is a tool used to get views on the services L.A. Care and its providers are delivering to members.
	• It looks at things that patients value highly like:
	  o Getting timely appointments
	  o Easy access to information
	  o Friendly office staff
	  o Good communication with health care providers
	• CAHPS mostly reflects experiences at the point of service
	• CAHPS scores have a significant impact on NCQA accreditation and health plan ratings
	• CAHPS allows healthcare members to make informed decisions when selecting providers and health plans
	• Survey is used by L.A. Care for provider incentive programs
	
	• How does CG-CAHPS differ from regular CAHPS?
	  o Sampled at Physician, Clinic & IPA levels, not health plan overall
	  o Samples only patients, not members that didn't have a visit
	  o Much larger sample size
	• Why conduct CG-CAHPS?	

	○ Measurement at the provider level is more actionable • Who is CG-CAHPS for? ○ Medi-Cal patients, there are other CAHPS surveys for Medicare and Covered California members. • How often is CG-CAHPS conducted? ○ Adult and Child survey versions are conducted annually! LA Care works with a vendor named "The Center for the Study of Services" • Fielding timing - Usually between December and March - Survey asks how was your visit(s) during the last year • Paper Mailing - Two survey mailings sent in English & Spanish - Reminder postcard • Website - Survey can be completed in up to 11 languages online - Mailed letter includes a QR code and link to get to the website • Phone Calls - Follow-up calls to those who did not respond to the mail survey (up to 9 attempts) • Texting (NEW FOR Measurement Year 2023!) Adult - 2022 VIIP+P4P CG-CAHPS Two Year Trending Results (All L.A. Care)	

Composite or Question	2022 Adjusted Score	2021 Adjusted Score	Change in Score from 2021*
Overall Ratings of Care			
Overall rating of provider	64.0%	64.2%	-0.2%
Overall rating of provider - Primary Care†	**62.3%**	**62.6%**	**-0.3%**
Overall rating of provider - Specialists	66.6%	66.4%	0.1%
Overall rating of all health care†	**64.9%**	**63.4%**	**1.5%**
Timely Care and Service			
Composite Score	**49.5%**	**50.4%**	**-1.0%**
Appointment for care needed right away	47.5%	48.8%	-1.3%
Appointment for routine care	51.6%	52.7%	-1.1%
Same day response to phone question	49.5%	50.2%	-0.6%
Composite Score - Primary Care††	**48.0%**	**48.0%**	**-0.1%**
Appointment for care needed right away - Primary Care	46.9%	47.0%	-0.1%
Appointment for routine care - Primary Care	49.8%	50.2%	-0.4%
Same day response to phone question - Primary Care	48.3%	48.0%	0.3%
Getting Needed Care			
Composite Score††	**54.6%**	**53.4%**	**1.2%**
Easy to get care, tests, or treatment	59.4%	58.1%	1.3%
Specialist appointment as soon as needed	48.1%	47.9%	0.3%
Doctor-Patient Interactions			
Composite Score	**68.2%**	**68.9%**	**-0.7%**
Provider explanations understandable	67.8%	68.1%	-0.3%
Provider listens carefully	70.3%	70.8%	-0.5%
Provider shows respect	75.7%	76.0%	-0.4%
Provider spends enough time	59.5%	61.0%	-1.4%
Coordination of Care			
Composite Score†	**53.4%**	**54.2%**	**-0.8%**
Provider knows medical history	61.3%	62.3%	-1.0%
Follow-up on test results provided	54.4%	54.7%	-0.3%
Discussed all prescription medicines	44.2%	45.3%	-1.1%

Adult - 2022 VIIP+P4P CG-CAHPS Two Year Trending Results (All L.A. Care)

Composite or Question	2022 Adjusted Score	2021 Adjusted Score	Change in Score from 2021*
Office Staff			
Composite Score†	**64.4%**	**65.0%**	**-0.6%**
Office staff were helpful	58.4%	58.3%	0.1%
Office staff were respectful	70.3%	71.7%	-1.4%
Health Promotion			
Composite Score	**42.1%**	**42.4%**	**-0.2%**
Provider discussed eating habits	42.9%	42.8%	0.0%
Provider discussed exercise	41.4%	42.0%	-0.5%
CG-CAHPS Supplemental Items			
Visit started within 15 minutes of appointment	31.3%	30.2%	1.1%
Discussed goals for health	57.6%	55.3%	2.3%
Discussed challenges with taking care of health	41.6%	38.8%	2.8%
Provider informed and up-to-date	49.9%	50.2%	-0.3%
L.A. Care Additional Items			
Able to get an interpreter to talk with providers	43.0%	43.2%	-0.2%
Overall rating of health plan	64.0%	63.2%	0.8%
Flu vaccinations for adults	52.6%	53.8%	-1.2%
Advising smokers and tobacco users to quit	40.5%	43.9%	-3.4%
Discussing cessation medications	20.9%	20.6%	0.3%
Discussing cessation strategies	16.9%	18.5%	-1.6%
Provider treated unfairly because of race or ethnicity	90.8%	NA	NA
Provider treated unfairly because of language barrier	91.5%	NA	NA
Overall trust in doctor	70.7%	NA	NA

Child - 2022 VIIP+P4P CG-CAHPS Two Year Trending Results (All L.A. Care)

Composite or Question	2022 Adjusted Score	2021 Adjusted Score	Change in Score from 2021*
Overall Ratings of Care			
Overall rating of provider	67.5%	70.3%	-2.7%
Overall rating of provider - Primary Care†	**67.9%**	**70.3%**	**-2.4%**
Overall rating of provider - Specialists	65.9%	69.9%	-4.0%
Overall rating of all health care†	**74.1%**	**73.7%**	**0.4%**
Timely Care and Service			
Composite Score	**53.9%**	**58.0%**	**-4.0%**
Appointment for care needed right away	52.1%	56.2%	-4.1%
Appointment for routine care	54.9%	58.7%	-3.8%
Same day response to phone question	56.8%	60.8%	-4.0%
Composite Score - Primary Care††	**54.6%**	**58.5%**	**-3.9%**
Appointment for care needed right away - Primary Care	52.4%	56.5%	-4.1%
Appointment for routine care - Primary Care	55.7%	59.2%	-3.5%
Same day response to phone question - Primary Care	57.5%	61.2%	-3.7%
Getting Needed Care			
Composite Score††	**53.5%**	**54.4%**	**-0.9%**
Easy to get care, tests, or treatment	57.0%	58.1%	-1.1%
Specialist appointment as soon as needed	47.2%	48.8%	-1.6%
Doctor-Patient Interactions			
Composite Score	**70.4%**	**72.3%**	**-1.9%**
Provider explanations understandable	70.2%	71.8%	-1.6%
Provider listens carefully	72.9%	74.6%	-1.7%
Provider shows respect	78.7%	80.4%	-1.6%
Provider spends enough time	59.9%	62.3%	-2.4%
Coordination of Care			
Composite Score	**60.7%**	**62.1%**	**-1.4%**
Provider knows medical history	64.5%	66.3%	-1.9%
Follow-up on test results provided	55.0%	54.6%	0.4%

Child - 2022 VIIP+P4P CG-CAHPS Two Year Trending Results (All L.A. Care)

Composite or Question	2022 Adjusted Score	2021 Adjusted Score	Change in Score from 2021*
Office Staff			
Composite Score†	**62.6%**	**65.3%**	**-2.7%**
Office staff were helpful	56.6%	60.1%	-3.6%
Office staff were respectful	68.6%	70.6%	-2.0%
Child Development			
Composite Score	**61.7%**	**58.1%**	**3.6%**
Provider discussed child's moods and emotions	51.6%	46.8%	4.8%
Provider discussed child's growth	71.9%	68.8%	3.1%
Provider discussed child's behavior	63.6%	59.8%	3.8%
Provider discussed child getting along with others	60.1%	57.2%	2.9%
Health Promotion			
Composite Score	**69.4%**	**67.2%**	**2.2%**
Provider discussed injury prevention	60.1%	57.1%	3.0%
Provider discussed eating habits	76.5%	73.8%	2.8%
Provider discussed exercise	71.7%	70.8%	0.9%
L.A. Care Additional Items			
Visit started within 15 minutes of appointment	29.4%	30.6%	-1.2%
Provider informed and up-to-date	50.1%	55.0%	-5.0%
Discussed all prescription medicines	52.9%	54.2%	-1.3%
Able to get an interpreter to talk with providers	54.9%	54.3%	0.6%
Overall rating of health plan	75.2%	74.9%	0.3%
Provider treated unfairly because of race or ethnicity	91.7%	NA	NA
Provider treated unfairly because of language barrier	92.1%	NA	NA
Overall trust in doctor	73.9%	NA	NA

Three Health Equity questions were added to the CG-CAHPS survey:

- In the last 12 months, how often have you been treated unfairly at the provider's office because of your race or ethnicity?
- In the last 12 months, how often were you treated unfairly at this provider's office because you did not speak English very well?
- Using any number from 0-10, where 0 means that you do not trust this provider at all and 10 means that you trust this provider completely, what number would you use to rate how much you trust this provider?

PUBLIC COMMENT

	Andria McFerson expressed gratitude for the information shared during the meeting and acknowledged the implementation of a motion she filed regarding a survey. She emphasized the importance of peer-to-peer interaction in healthcare feedback to ensure honest and accurate responses, highlighting the reluctance of individuals to speak up about their healthcare experiences due to fear of repercussions or ineffectiveness. Ms. McFerson urged the completion of the motion to enable RCAC members to directly engage with individuals receiving healthcare to foster a more comfortable environment for sharing feedback. Mr. Solomon thanked Ms. McFerson for her input. He assured her that the survey includes multiple messages to encourage members to participate and emphasizes the privacy of responses. Salomon underscores the importance of peer-to-peer encouragement in completing the surveys to gather comprehensive feedback for identifying areas of improvement in healthcare services. Ms. Sales expressed appreciation for the informative survey but expressed concern about the persistent issues in healthcare access and quality, particularly noting challenges with appointment availability, responsiveness, and bedside manner even before the pandemic. She questioned when meaningful changes will occur despite the data collected from surveys over the years. Mr. Solomon acknowledged the challenges highlighted by Ms. Sales, noting that the pandemic has exacerbated existing issues and created new challenges. He explained that efforts are being made to address these challenges through various initiatives, including engaging with providers to understand the barriers, conducting member experience surveys, and providing training sessions. Mr. Solomon emphasized that while progress may not be immediate, improvements have been observed over time, with momentum being disrupted by the pandemic. He reassured that efforts to address the issues are ongoing. Ms. Sales stated that she has had the same doctors for over 10 years and being with L.A. Care for a similar duration. She noted the ongoing challenges she faces in obtaining timely appointments and necessary care, noting that she often has to advocate for herself and request specific actions from her doctor. Ms. Sales emphasized her frustration with receiving surveys but seeing no tangible changes in the healthcare system. Ms. McClain suggested adding questions to the survey regarding the accessibility of facilities like tables and scales for members with specific needs. She inquired about how L.A. Care follows up with providers who receive low scores on the survey and if suggestions for improvement are offered. Mr. Solomon acknowledged the suggestions and mentions the possibility of incorporating questions about facility accessibility into the survey. He explained that L.A. Care conducts one-on-one meetings with select providers to discuss member experience, review survey reports, and address areas for improvement. These meetings involve discussion about what providers are doing to address lower scores, and the	

	organization endeavors to reach as many providers as possible through webinars and group trainings.	
FUTURE AGENDA ITEM SUGGESTIONS		
	Ms. Gonzalez suggested that the committee considers creating a motion at the next meeting to include information in the directory indicating which doctors have accessible tables. She proposed that, similar to the motion for funding accessible tables and chairs, another motion could be made to request the inclusion of the information in the directory. This would require the organization to figure out a way to implement it. Member Romo expressed frustration with the lengthy and inefficient process when calling for patient services. She suggested having a dedicated space where patients can listen to the steps required without having to go through a lengthy questionnaire only to be transferred to another department. Member Romo finds certain questions regarding gender discrimination unnecessary and believes the focus should be on health-related inquiries. She advocates for a streamlined process where patients can easily access the information they need without unnecessary hurdles. Ms. Sales stated that she would like to vote on changing the Board of Governors regular meeting to 1:00 P.M. Vice Chair McClain proposed adding to Ms. Gonzalez's motion by suggesting a report be provided to the committee as a benchmark to ensure that funds allocated to providers are being used appropriately. Vice Chair McClain suggests that if providers show an increase in clientele, particularly seniors and people with disabilities, they should be rewarded with incentives so they don't have to reapply for funding. She emphasizes the importance of ensuring that the funds are effectively utilized and suggests providing incentives to encourage continued improvement.	
PUBLIC COMMENTS		

	Demetria Saffore shared her observation of L.A. Care's Yelp page, noting over 160 negative reviews from both members and providers. She expressed concern about the emotional toll on team members who respond to these reviews, suggesting they may need psychological counseling due to the emotional abuse of dealing with unhappy customers regularly. She highlighted the severity of the situation, mentioning cases of individuals being injured or killed due to perceived lack of care. *Andria McFerson expressed her desire to address functional issues rather than being confrontational. She emphasized the need for discussions about homelessness within L.A. Care and requested a representative from L.A. Care who handles homeless information to address the committee. She mentioned filing motions regarding meeting frequency and budget discussions, expressing frustration that these matters haven't been properly addressed. She urged placing the budget on the agenda and providing details about fiscal year spending.* *Diana Leff suggests adding information about the languages spoken by doctors so that patients can choose a doctor who speaks their language, especially for foreign patients who prefer speaking to their doctor in their native language. She mentioned that Blue Cross was advised to implement this over 20 years ago but did not include foreign language options. She emphasized the importance of providing language accessibility, stating that patients often have to rely on nurses who speak their language and would prefer direct communication with the doctor.*	
ADJOURNMENT		
ADJOURNMENT	The meeting was adjourned at 1:34 P.M.	

RESPECTFULLY SUBMITTED BY:
Victor Rodriguez, *Board Specialist II, Board Services*
Malou Balones, *Board Specialist III, Board Services*
Linda Merkens, *Senior Manager, Board Services*

APPROVED BY

Ana Rodriguez, TTECAC Chair _____

Date 4/10/24

TECHNICAL ADVISORY COMMITTEE

BOARD OF GOVERNORS
Technical Advisory Committee
Meeting Summary – January 11, 2024

1055 W. Seventh Street, Los Angeles, CA 90017

Members

Alex Li, *MD, Chief Health Equity Officer*, *Chairperson*
Sameer Amin, *MD*, *Chief Medical Officer*
John Baackes, *Chief Executive Officer**
Elaine Batchlor, *MD, MPH**
Paul Chung, *MD, MS*
Muntu Davis, *MD, MPH*,
Rishi Manchanda, *MD, MPH*
Santiago Munoz*
Elan Shultz
Stephanie Taylor, *PhD*

Management

Noah Paley, *Chief of Staff, Executive Services*
Acacia Reed, *Chief Operating Officer, Managed Care Services*
Phinney Ahn, *Executive Director, Medi-Cal Product Management*
Todd Gower, *Chief Compliance Officer*

** Absent ***Present (Does not count towards Quorum)*

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Alex Li, *MD*, *Chief Health Equity Officer,* called the meeting to order at 2:05 p.m.	
APPROVAL OF MEETING AGENDA	The Agenda for today's meeting was approved.	**Approved Unanimously by roll call. 7 AYES (Amin, Chung, Davis, Li, Manchanda, Shultz, Taylor)**
PUBLIC COMMENT	There were no public comments.	
APPROVAL OF MEETING MINUTES	The November 9, 2023 meeting minutes were approved as submitted.	**Approved Unanimously by roll call. 7 AYES**
CHAIRPERSON'S REPORT • **Chief Health Equity Update**	*(Member Manchanda joined the meeting at 2:30pm. Committee reached a quorum.)* Member Alex Li, *MD*, Chief Health Equity Officer gave a Chief Health Equity Officer Update as part of the Chairperson's Report *(a copy of the report can be obtained from Board services).*	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Sample 2024 Initiatives and Changes • Full Scope Medi-Cal is now available for all low-income adults ages 26-49 regardless of immigration status. The estimated number of eligible undocumented and immigrant adults who qualify for Medi-Cal in Los Angeles County is around 270K individuals. As of 1st week of January, L.A. Care will now provide coverage for around 10K individuals. • Medi-Cal provider rate increase (no less than 87.5% of Medicare rate) will be effective for primary care, obstetric and non-specialty mental health services starting on January 1, 2024. L.A. Care team is actively working on this and should be able to push out the new rates and contracts to our network in the Summer or Fall of 2024. The funding for this increase comes from the revenue collected from the Managed Care Organization Provider Taxes. • Kaiser Permanente now have a direct contract with California Department of Health Care Services. Around 1.2 million Medi-Cal beneficiaries in 32 counties will transition from local plans to Kaiser. Around 244K L.A. Care Medi-Cal members have transitioned to Kaiser. • DHCS has signaled to Medi-Cal Managed Care Plans that they will be issuing monetary sanctions to Plans that fail to meet the minimum performance levels for Medi-Cal Managed Care Accountability Measures. Most managed care plans will receive a fine. • The Provider Relations Advisory Committee is a new Board of Governors approved committee. The committee is composed of representatives from hospitals, FQHC, DHS, IPAs, SNFs and ancillary service providers. The purpose of the committee is to address systemic issues and challenges between payors and providers as it relates to gaps in communication, accessing services (e.g. skilled nursing care facilities, DME, transportation etc), transitional care services, reimbursement and others. Elevating Safety Net Program (workforce investment) <table><tr><td></td><td>As of 11/27/23</td></tr><tr><td>Provider Recruitment Program</td><td>16</td></tr><tr><td>Provider Loan Repayment Program</td><td>122</td></tr><tr><td>Medical School Scholarship</td><td>48</td></tr><tr><td>Elevating Community Heatlh Home care workers who graduate from CCA's IHSS training program</td><td>6,349</td></tr></table>	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Sample Advancing Health Equity Efforts • Children's Health Disparities Roundtable – November 14, 2023 (see CHEO powerpoint) • L.A. Care committed $1.25 Million dollars in grants to support Black, Indigenous and other people of color non-profits.	
HEALTH EQUITY CONFERENCE UPDATE	Member Li spoke about the need to promote health equity within the provider space and the community space. He asked Johanna Gonzalez, Health Equity Project Manager II, to give a brief overview of a planned Health Equity Conference in L.A. County *(a copy of the presentation can be obtained from Board Services)*.. Ms. Gonzalez talked about organizing the first-ever health equity conference on May 18 to educate healthcare professionals. They gathered feedback from county health equity officers to shape the conference topics. The conference will cover health disparities, social drivers of health, and using data for change. Attendees can choose workshops like maternity health, community screening, and discussions on burnout and moving forward. The conference also addresses data collection and peer-to-peer exchanges. Ms. Gonzalez welcomes questions or feedback before proceeding with the final slides. Member Muntu Davis, *MD, MPH*, suggested and proposed a future topic: "partnering with other organizations to meet the needs of patients." He emphasized that offices or facilities don't have to do everything themselves and that there are benefits to connecting and collaborating with other organizations, which he believes could be helpful for attendees. Member Li thanked Member Davis for his suggestion. Member Rishi Manchanda, *MD, MPH*, said that the idea of the conference looks really wonderful and suggested enhancing a specific block related to navigating members to services. He noted the opportunity to connect with community partners and leverage new benefits for both members and providers. He recommended making this connection more explicit to understand community supports better and how providers can access them, aligning with Member Davis's point about leveraging benefits and community connections. Ms. Gonzalez thanked Member Manchanda for his feedback and said that this presentation was meant to gather as much feedback from the committee before the conference takes place. Member Manchanda asked about the target audience. Member Li mentioned that historically, they have primarily targeted private providers, including power practices, and also some county providers. The	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	audience also includes a range of professionals from physicians to social workers, indicating a wide reach for the conference. Member Manchanda thanked Member Li for his response and suggested two ideas for enhancing the conference experience. Firstly, he proposed using tags to identify subsets of attendees (like private practice or county providers) to facilitate targeted learning tracks. Secondly, he recommended tailoring the program content throughout the day to address specific audience needs, such as during panel discussions, to ensure meaningful insights for different subsets of attendees. He expressed willingness to discuss these ideas further offline.	
EQUITY PRACTICE TRANSFORMATION PROGRAM	Cathy Mechsner, *Manager, Practice Transformation,* gave a presentation about the 2024-2028 Equity and Practice Transformation (EPT) Program *(a copy of the presentation can be obtained from Board Services).* Equity and Practice Transformation Program Overview • Equity and Practice Transformation Program: - 5-year, $700 million Department of Health Care Services (DHCS) Initiative - Aligns with the following DHCS programs and goals: o Comprehensive Quality Strategy o Equity Roadmap o 50 by 2025 Bold Goals • Purpose: - Assist lower functioning practices to improve their capacity to deliver better care to Medi-Cal patients through: o Investments in technology, infrastructure, staffing, practice support/technical assistance, and learning collaborative • Program Funding: - DHCS flows Directed Payments through Managed Care Plans (MCPs) to practices for completed program work - Duration: January 1, 2024 – 2028 - Awaiting final list of enrolled practices from DHCS DCHS Programs & Goals Aligned with EPT Specific Measures • Infant, child and adolescent well-child visits - Childhood/Adolescent vaccinations	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	- Blood lead and developmental screening - Chlamydia screening for adolescents • Prenatal and postpartum visits & depression screening - Adolescent depression screening and follow-up • Follow-up after ED visit for SUD within 30 days - Depression screening and follow-up for adults - Initiation & engagement of alcohol and SUD treatment Impact to L.A. Care & L.A. County- Direct and Indirect ROI/Impact L.A. Care Medi-Cal Programs: • CalAim • Pay for Performance Programs • Data Exchange Framework, Health Information Exchange programs • Health Equity & Disparities Mitigation Plan • Direct Network expansion • Care delivery improvement efforts • Other care delivery programs • Telehealth/access to care Primary Care Providers and Patients/Members: • Helping providers obtain needed tools and knowledge to use them • Developing practices' quality improvement capacity to more effectively deliver better care to our members and to sustain that knowledge • Strengthening/reinforcing Medi-Cal quality improvement programs already in place • Focusing on DHCS's initiatives: - Health Equity Roadmap - 50 Bold Goals in 2025 Financial: • Impact of improved Managed Care Accountability Set (MCAS) measures and achievement of Minimum Performance Levels (MPL) - Reduced penalties from DHCS for below MPL performance levels • Higher cost of "wellness" claims vs. lower cost of chronic/high risk disease claims Reputation, Relationship and Others:	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

- Develop a positive relationship with providers *or negative relationship will if we have a poor execution* (L.A. Care)
- Ability to directly engage with providers and align our goals (L.A. Care)
- Improve access for Medi-Cal, DSNP and Covered California members (Members)
- Improve performances for MCAS measures (L.A. Care)
  - Better auto-assignment
- Address health care disparities within a practice (Members)

Potential Enrollment Results and Areas of Focus

Primary Care Practice Enrollment	Goal	Actual	DN	Medi-Cal Beneficiaries
Small/Medium, Independent	50	84	22	322,101
All others (FQHC, Large Indep.)	Unlimited	50	11	1,219,718
		134	33	1,541,819

HP QUARTILE RESULTS			
Quartile	Total	Small/Medium	FQ/Larger
1	67	43	24
2	51	29	22
3	11	9	2
4	5	2	3

HEDIS High/Low Performing			
Type of Practice	High	Low	DN
Small/Medium	5	3	9
FQHCs	2	4	5
TOTALS	**7**	**7**	**14**

Potential Enrollment Results with Crossover Opportunities
Crossover Programs:
<u>CalAIM:</u>

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

Enhanced Care Management/CalAim Cross Over				
Type of Practice	**ECM**	**CalAim**	**EPT**	**DN**
Small/Medium	2			2
FQHCs	22			4
TOTALS	**24**	**0**	**0**	**6**

Data Exchange Framework (DxF) & Health Information Exchange (HIE)

Type of Practice	No. Participating in LANES	Total Signed DSAs	No. Qualify for One-Time Incentive
Small/Medium	2	12	35
FQHCs	19	38	43
TOTALS	**21**	**50**	**78**

**Data Sharing Agreement (DSA) **One-Time HIE Incentive*

EPT Program – Program Success Goals
Support for practice success

- Develop strong engagement/trust with providers and care teams
- Ensure practices receive value add services and leverage all areas of the program to be successful:
  - Population Health Management Initiative Training (PHMI),
  - Technology support (EHR/Population Health Management tools), Learning Collaborative
  - L.A. Care Health Services/Quality Improvement resources & programs (Pay 4 Performance program, Provider/Member health education, etc.)
- Manage Directed Payments process for timely payments to practices

Determine technical assistance for small and medium-sized independent practices (<51 providers)

- Number of coaches needed to support practices
- Required qualifications for coaches:
  - Level of experience, knowledge of Population Health Management Initiative
  - Knowledge of EMR programs, PHM tools, etc.
  - Knowledge of adults vs pediatrics and/or both
  - Data analytics

Program management:

- Program success criteria and project management requirements
  - Data analytics, Legal, Finance (administer Directed Payments to practices)

EPT Program Progress To Date

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Enrollment – Concluded 10/23/24 • Received 134 applications, (84 Small/Medium Independents, 50 FQHCs/Large Independents. • Next Step: Receive final list of =practices from DHCS *(Expected soon)* Program resources – In progress • Planning and development of practice facilitation team to support Small/Medium practices to achieve program goals - Reviewed investment proposal to Leadership team - Identifying practice facilitation vendors for engagement with LAC/practices - Working with Communications to announce Program participation, notifications to practices Program launch – *Pending Cohort 1 announcement* • DHCS announced Program Office & Learning Collaborative vendor: Population Health Learning Center - Will lead Technical Assistance program including strategy development, tools & resources and evidence based models of improvement EPT Program Next Steps Timeline January 2024 • Receive final list of enrolled practices from DHCS (TBD) • Finalize financial support and plan for technical assistance/practice facilitation for Cohort 1 small/medium-sized independent practices (<51 providers) - Begin RFP process with Procurement for additional practice facilitator vendors to recruit/hire practice coaches • Launch Program! 1Q2024 • Begin practice transformation work with practices per program details: - Develop/launch action plans based upon assessments and identified program gaps - Incorporate Population Health Management Initiative (model of improvement) tools & resources • Manage staff and vendor contract(s) to achieve program deliverables • Begin administration of Directed Payments for all assigned receiving practices (develop new/leverage existing workflows to process payments)	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• 2Q2024 - 2028 • Communication of program achievements for practices and members • Ongoing program management of: - Practice transformation work - Vendor management - Administration of Directed Payments to practices	
ADJOURNMENT	The meeting was adjourned at 3:40 P.M.	

Respectfully submitted by:
Victor Rodriguez*, Board Specialist II, Board Services*
Malou Balones*, Board Specialist III, Board Services*
Linda Merkens*, Senior Manager, Board Services*

APPROVED BY: DocuSigned by: Alex Li FF33F5D33BFB4D4...
Alex Li, MD, *Chairperson*
4/24/2024 | 9:37 AM PDT
Date Signed

EXECUTIVE COMMITTEE

Financial Update

Board of Governors Meeting

May 2, 2024

Agenda

Financial Performance – February 2024 YTD

- Membership
- Consolidated Financial Performance
- Operating Margins by Segment
- Key Financial Ratios
- Tangible Net Equity & Days of Cash On-Hand Comparison

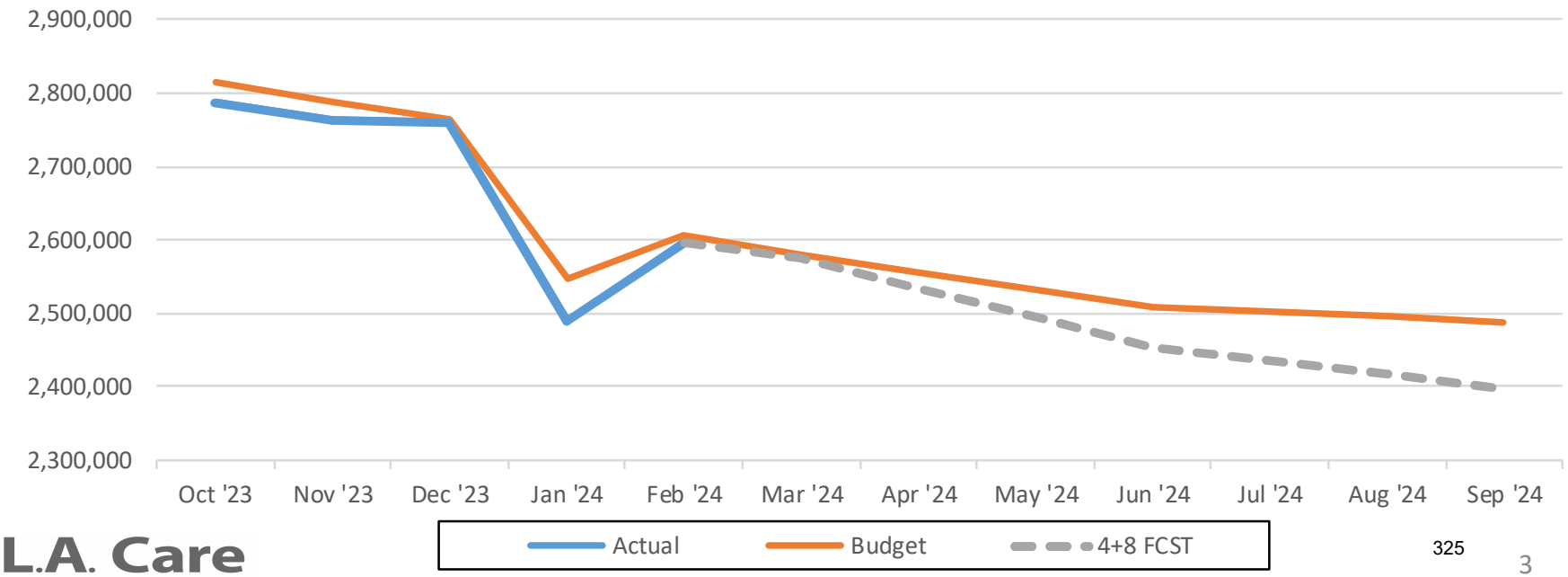
Financial Informational Updates

- Investment Transactions

Membership
for the 5 months ended February 2024

	February 2024			Year-to-Date		
Sub-Segment	**Actual**	**4+8 FCST**	**Variance**	**Actual**	**4+8 FCST**	**Variance**
Medi-Cal	2,376,585	2,377,646	(1,061)	12,420,122	12,421,183	(1,061)
D-SNP	19,392	19,261	131	93,806	93,675	131
LACC	172,948	168,879	4,069	737,450	733,381	4,069
PASC	48,580	48,258	322	241,806	241,484	322
***Elimination**	(19,392)	(19,261)	(131)	(93,806)	(93,675)	(131)
Consolidated	**2,598,113**	**2,594,783**	**3,330**	**13,399,378**	**13,396,048**	**3,330**

***D-SNP members included in MCLA membership under CCI beginning in January 2023**



Consolidated Financial Performance

for the month of February 2024

($ in Thousands)	Actual	4+8 FCST	Variance
Member Months	2,598,113	2,594,783	3,330
Total Revenues	$872,409	$882,976	($10,567)
Total Healthcare Expenses	$812,039	$836,563	$24,524
Operating Margin	$60,370	$46,413	$13,957
Operating Margin (excl HHIP/IPP)	$61,609	$38,384	$23,225
Total Admin Expenses	$47,566	$39,927	($7,639)
Income/(Loss) from Operations	$12,804	$6,487	$6,318
Non-Operating Income (Expense)	$9,253	$13,412	($4,159)
Net Surplus	**$22,057**	**$19,898**	**$2,159**
Net Surplus (excl HHIP/IPP)	***$23,480***	***$12,196***	***$11,284***

Consolidated Financial Performance

for the 5 months ended February 2024

($ in Thousands)	Actual	4+8 FCST	Variance
Member Months	13,399,378	13,396,047	3,330
Total Revenues	$4,531,693	$4,542,260	($10,567)
Total Healthcare Expenses	$4,027,732	$4,052,256	$24,524
Operating Margin	$503,961	$490,004	$13,957
Operating Margin (excl HHIP/IPP)	$466,950	$443,726	$23,225
Total Admin Expenses	$252,488	$244,849	($7,639)
Income/(Loss) from Operations	$251,473	$245,155	$6,318
Non-Operating Income (Expense)	$75,960	$80,118	($4,159)
Net Surplus	**$327,432**	**$325,273**	**$2,159**
Net Surplus (excl HHIP/IPP)	***$290,864***	***$279,580***	***$11,284***

Operating Margin by Segment

for the 5 months ended February 2024

($ in Thousands)

	Medi-Cal	D-SNP	LACC	PASC	Total	Total *(excl HHIP/IPP)*
Revenue	$4,081,053	$133,650	$200,118	$76,404	$4,531,693	$4,487,695
Healthcare Exp.	$3,668,663	$115,885	$163,741	$75,742	$4,027,732	$4,020,745
Operating Margin	$412,390	$17,765	$36,377	$662	$503,961	$466,950
MCR %	89.9%	86.7%	81.8%	99.1%	88.9%	89.6%
4+8 FCST %	90.7%	83.7%	78.4%	99.7%	89.2%	90.1%

Key Financial Ratios

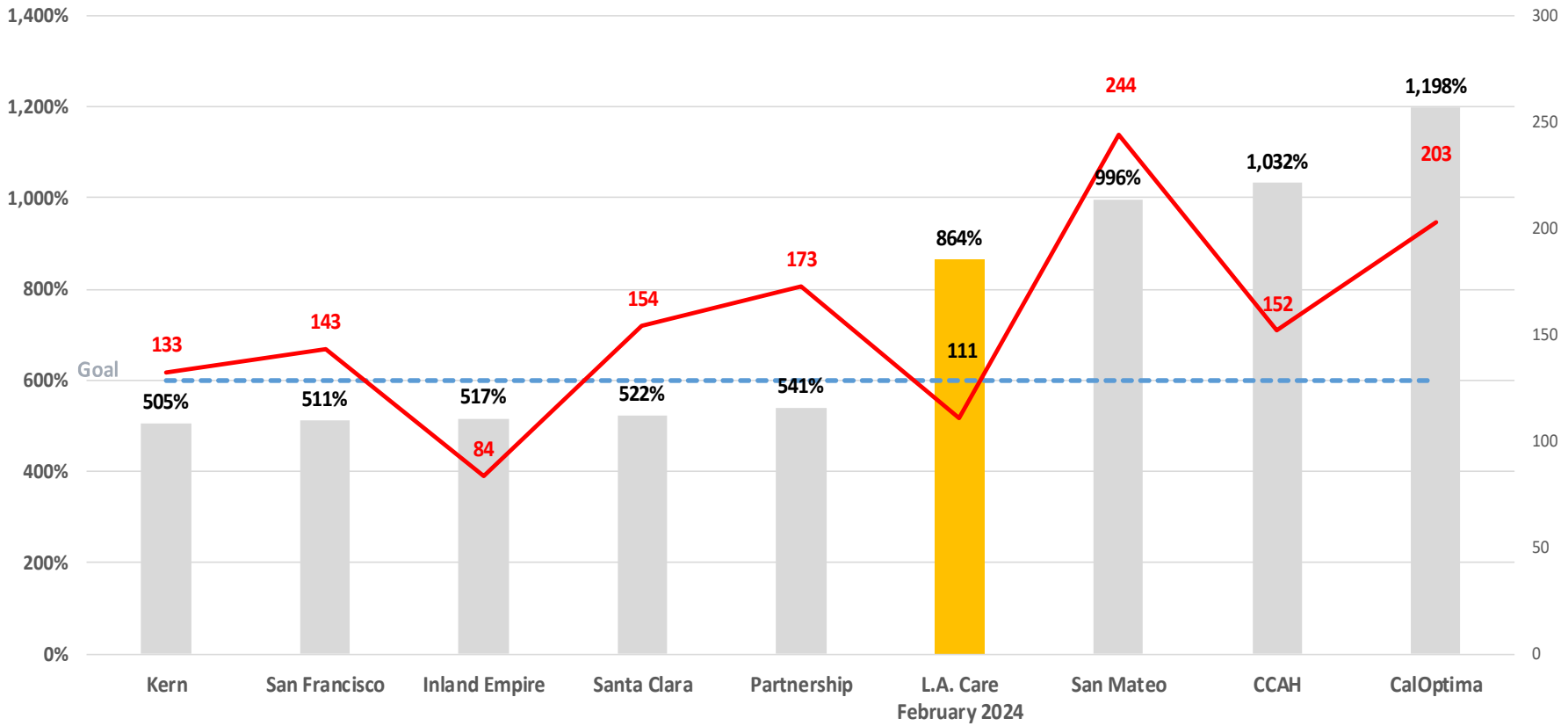
for the 5 months ended February 2024

(Excl. HHIP/IPP)	Actual		4+8 FCST	
MCR	89.6%	vs.	90.1%	✓
Admin Ratio	5.6%	vs.	5.5%	✗

	Actual		Benchmark	
Working Capital	1.35	vs.	1.00+	✓
Cash to Claims	0.98	vs.	0.75+	✓
Tangible Net Equity	8.64	vs.	1.30+	✓

Tangible Net Equity & Days of Cash On-Hand

for the 5 months ended February 2024



• As of December 2023 Quarterly filings, unless noted otherwise.

Questions & Consideration

Motion

- To accept the Financial Reports for the five months ended February 29, 2024, as submitted.

Informational Items

Investment Transactions

- As of February 29, 2024, L.A. Care's total investment market value was $4.1B
  - $3.86B managed by Payden & Rygel and New England Asset Management (NEAM)
  - $36M in Local Agency Investment Fund
  - $80M in Los Angeles County Pooled Investment Fund
  - $125M in BlackRock Liquidity T-Fund, new as of February 2024

L.A. Care
HEALTH PLAN

Board of Governors
MOTION SUMMARY

Date: April 24, 2024 **Motion No. EXE 102.0524**

Committee: Executive **Chairperson:** Alvaro Ballesteros, MBA

Requesting Department: Accounts & Finance Services

☐ **New Contract** ☐ **Amendment** ☐ **Sole Source** ☐ **RFP/RFQ was conducted**

Issue: Acceptance of the Financial Reports for February 2024.

Background: N/A

Member Impact: N/A

Budget Impact: N/A

Motion: To accept the Financial Reports for February 2024, as submitted.

Financial Performance Highlights - Year-to-Date

February 2024

Overall (incl. HHIP/IPP)

L.A. Care total YTD combined member months are 13.4M, +3K favorable to forecast. February YTD financial performance resulted in a surplus of +$327M or 7.2% margin and is +$2M/+6bps favorable to forecast. The YTD favorability is driven by lower capitation expense +$23.7M and timing of provider incentives +$8.8M and Medical Admin expense +$2.8M; partially offset by lower revenue ($10.6M), higher operating expense ($7.6M), higher skilled nursing ($4.6M), inpatient ($3.6M) and outpatient ($3.5M) claims, and higher unrealized losses ($4M).

Medi-Cal

Medi-Cal consists of members through our contracted providers and our contracted health plans ("Plan Partners"). February YTD member months are 12.4M, (1K) unfavorable to forecast. February YTD financial performance resulted in a surplus of +$308M or 7.6% margin, +$58.3M/+142bps favorable to forecast, driven by lower capitation expense +$21.6M, lower operating expenses +$20.2M, timing of provider incentives +$12.4M, higher net interest income +$7.5M, and higher revenue +$6.2M; partially offset by higher outpatient ($5.5M) and skilled nursing ($3.9M) claims, and higher unrealized losses ($3.5M).

D-SNP

Effective February 1, 2023, members enrolled in CMC have been transitioned to our D-SNP plan. February YTD member months are 94K, +131 favorable to forecast. February YTD financial performance resulted in a surplus of +$2M or 1.3% margin, ($11.1M)/(831bps) unfavorable to forecast, primarily driven by higher shared risk ($8.5M) and higher operating expenses ($7.1M); partially offset by lower inpatient +$2.8M and outpatient +$1.3M claims.

Commercial

L.A. Care Commercial consists of LACC and PASC-SEIU. February YTD member months are 979K, favorable +4K to forecast. February YTD financial performance resulted in a deficit of ($10M) or (3.5%) margin, ($25M)/(910bps) unfavorable to forecast, driven by higher operating expenses ($19M), higher inpatient claims ($7.7M), and higher shared risk ($2.4M); partially offset by higher revenue +$4M.

Incentive Programs

L.A. Care Incentive Programs consist of CalAIM Incentive Payment Program (IPP) and Housing and Homelessness Incentive Program (HHIP). February YTD financial performance resulted in a surplus of +$37M, ($9.1M) unfavorable to forecast, primarily driven by the timing of revenue ($16.6M); partially offset by the timing of healthcare expenses $7.3M.

Consolidated Operations Income Statement ($ in thousands)

February 2024

MTD Actual	PMPM	MTD 4+8 Forecast	PMPM	MTD Fav/(Unfav)	PMPM		YTD Actual	PMPM	YTD 4+8 Forecast	PMPM	YTD Fav/(Unfav)	PMPM
						Membership						
2,598,113		2,594,782		3,331		Member Months	13,399,378		13,396,047		3,331	
						Revenue						
$ 872,409	$ 335.79	$ 882,976	$ 340.29	$ (10,567)	$ (4.50)	Capitation Revenue	$ 4,531,693	$ 338.20	$ 4,542,260	$ 339.07	$ (10,567)	$ (0.87)
$ 872,409	**$ 335.79**	**$ 882,976**	**$ 340.29**	**$ (10,567)**	**$ (4.50)**	**Total Revenues**	**$ 4,531,693**	**$ 338.20**	**$ 4,542,260**	**$ 339.07**	**$ (10,567)**	**$ (0.87)**
						Healthcare Expenses						
$ 440,799	$ 169.66	$ 464,478	$ 179.00	$ 23,679	$ 9.34	Capitation	$ 2,307,681	$ 172.22	$ 2,331,360	$ 174.03	$ 23,679	$ 1.81
$ 115,322	$ 44.39	$ 111,746	$ 43.07	$ (3,575)	$ (1.32)	Inpatient Claims	$ 500,620	$ 37.36	$ 497,044	$ 37.10	$ (3,575)	$ (0.26)
$ 114,602	$ 44.11	$ 111,085	$ 42.81	$ (3,516)	$ (1.30)	Outpatient Claims	$ 531,867	$ 39.69	$ 528,351	$ 39.44	$ (3,516)	$ (0.25)
$ 98,134	$ 37.77	$ 93,554	$ 36.05	$ (4,580)	$ (1.72)	Skilled Nurse Facility	$ 489,816	$ 36.56	$ 485,236	$ 36.22	$ (4,580)	$ (0.33)
$ 12,585	$ 4.84	$ 13,520	$ 5.21	$ 935	$ 0.37	Pharmacy	$ 71,456	$ 5.33	$ 72,391	$ 5.40	$ 935	$ 0.07
$ 19,049	$ 7.33	$ 27,846	$ 10.73	$ 8,797	$ 3.40	Provider Incentive and Shared Risk	$ 70,280	$ 5.25	$ 79,078	$ 5.90	$ 8,797	$ 0.66
$ 11,549	$ 4.45	$ 14,334	$ 5.52	$ 2,784	$ 1.08	Medical Administrative Expenses	$ 56,012	$ 4.18	$ 58,796	$ 4.39	$ 2,784	$ 0.21
$ 812,039	**$ 312.55**	**$ 836,563**	**$ 322.40**	**$ 24,524**	**$ 9.85**	**Total Healthcare Expenses**	**$ 4,027,732**	**$ 300.59**	**$ 4,052,256**	**$ 302.50**	**$ 24,524**	**$ 1.91**
93.1%		*94.7%*		*166bps*		*MCR (%)*	*88.9%*		*89.2%*		*33bps*	
$ 60,370	**$ 23.24**	**$ 46,413**	**$ 17.89**	**$ 13,957**	**$ 5.35**	**Operating Margin**	**$ 503,961**	**$ 37.61**	**$ 490,004**	**$ 36.58**	**$ 13,957**	**$ 1.03**
$ 47,566	**$ 18.31**	**$ 39,927**	**$ 15.39**	**$ (7,639)**	**$ (2.92)**	**Total Operating Expenses**	**$ 252,488**	**$ 18.84**	**$ 244,849**	**$ 18.28**	**$ (7,639)**	**$ (0.57)**
5.5%		*4.5%*		*(93bps)*		*Admin Ratio (%)*	*5.6%*		*5.4%*		*(18bps)*	
$ 12,804	**$ 4.93**	**$ 6,487**	**$ 2.50**	**$ 6,318**	**$ 2.43**	**Income (Loss) from Operations**	**$ 251,473**	**$ 18.77**	**$ 245,155**	**$ 18.30**	**$ 6,318**	**$ 0.47**
1.5%		*0.7%*		*73bps*		*Margin before Non-Operating Inc/(Exp) Ratio (%)*	*5.5%*		*5.4%*		*15bps*	
$ 13,586	$ 5.23	$ 15,702	$ 6.05	$ (2,116)	$ (0.82)	Interest Income,Net	$ 72,112	$ 5.38	$ 74,229	$ 5.54	$ (2,116)	$ (0.16)
$ (234)	$ (0.09)	$ (2,291)	$ (0.88)	$ 2,057	$ 0.79	Other Income (Expense),Net	$ (5,971)	$ (0.45)	$ (8,028)	$ (0.60)	$ 2,057	$ 0.15
$ (151)	$ (0.06)	$ -	$ -	$ (151)	$ (0.06)	Realized Gain/Loss	$ (1,138)	$ (0.08)	$ (987)	$ (0.07)	$ (151)	$ (0.01)
$ (3,948)	$ (1.52)	$ -	$ -	$ (3,948)	$ (1.52)	Unrealized Gain/Loss	$ 10,956	$ 0.82	$ 14,904	$ 1.11	$ (3,948)	$ (0.29)
$ 9,253	**$ 3.56**	**$ 13,412**	**$ 5.17**	**$ (4,159)**	**(1.61)**	**Total Non-Operating Income/(Expense)**	**$ 75,960**	**$ 5.67**	**$ 80,118**	**$ 5.98**	**$ (4,159)**	**$ (0.31)**
$ 22,057	**$ 8.49**	**$ 19,898**	**$ 7.67**	**$ 2,159**	**$ 0.82**	**Net Surplus/(Deficit)**	**$ 327,432**	**$ 24.44**	**$ 325,273**	**$ 24.28**	**$ 2,159**	**$ 0.16**
2.5%		*2.3%*		*27bps*		*Margin (%)*	*7.2%*		*7.2%*		*6bps*	

L.A. Care HEALTH PLAN

Total Medi-Cal Income Statement ($ in thousands)

February 2024

MTD Actual	PMPM	MTD 4+8 Forecast	PMPM	MTD Fav/(Unfav)	PMPM		YTD Actual	PMPM	YTD 4+8 Forecast	PMPM	YTD Fav/(Unfav)	PMPM
						Membership						
2,376,585		2,377,646		(1,061)		Member Months	12,420,122		12,421,183		(1,061)	
						Revenue						
$ 808,331	$ 340.12	$ 802,138	$ 337.37	$ 6,193	$ 2.76	Capitation Revenue	$ 4,081,053	$ 328.58	$ 4,074,860	$ 328.06	$ 6,193	$ 0.53
$ 808,331	**$ 340.12**	**$ 802,138**	**$ 337.37**	**$ 6,193**	**$ 2.76**	**Total Revenues**	**$ 4,081,053**	**$ 328.58**	**$ 4,074,860**	**$ 328.06**	**$ 6,193**	**$ 0.53**
						Healthcare Expenses						
$ 421,224	$ 177.24	$ 442,784	$ 186.23	$ 21,560	$ 8.99	Capitation	$ 2,178,373	$ 175.39	$ 2,199,932	$ 177.11	$ 21,560	$ 1.72
$ 93,956	$ 39.53	$ 94,904	$ 39.92	$ 948	$ 0.38	Inpatient Claims	$ 430,845	$ 34.69	$ 431,793	$ 34.76	$ 948	$ 0.07
$ 102,092	$ 42.96	$ 96,569	$ 40.62	$ (5,523)	$ (2.34)	Outpatient Claims	$ 478,981	$ 38.56	$ 473,458	$ 38.12	$ (5,523)	$ (0.45)
$ 97,454	$ 41.01	$ 93,554	$ 39.35	$ (3,901)	$ (1.66)	Skilled Nurse Facility	$ 485,853	$ 39.12	$ 481,952	$ 38.80	$ (3,901)	$ (0.32)
$ 55	$ 0.02	$ -	$ -	$ (55)	$ (0.02)	Pharmacy	$ 195	$ 0.02	$ 141	$ 0.01	$ (55)	$ (0.00)
$ 4,178	$ 1.76	$ 16,574	$ 6.97	$ 12,396	$ 5.21	Provider Incentive and Shared Risk	$ 43,097	$ 3.47	$ 55,493	$ 4.47	$ 12,396	$ 1.00
$ 10,338	$ 4.35	$ 12,693	$ 5.34	$ 2,355	$ 0.99	Medical Administrative Expenses	$ 51,320	$ 4.13	$ 53,675	$ 4.32	$ 2,355	$ 0.19
$ 729,297	**$ 306.87**	**$ 757,077**	**$ 318.41**	**$ 27,780**	**$ 11.55**	**Total Healthcare Expenses**	**$ 3,668,663**	**$ 295.38**	**$ 3,696,444**	**$ 297.59**	**$ 27,780**	**$ 2.21**
90.2%		*94.4%*		*416bps*		*MCR (%)*	*89.9%*		*90.7%*		*82bps*	
$ 79,034	**$ 33.26**	**$ 45,061**	**$ 18.95**	**$ 33,974**	**$ 14.30**	**Operating Margin**	**$ 412,390**	**$ 33.20**	**$ 378,417**	**$ 30.47**	**$ 33,974**	**$ 2.74**
$ 33,842	**$ 14.24**	**$ 54,003**	**$ 22.71**	**$ 20,162**	**$ 8.47**	**Total Operating Expenses**	**$ 184,690**	**$ 14.87**	**$ 204,852**	**$ 16.49**	**$ 20,162**	**$ 1.62**
4.2%		*6.7%*		*255bps*		*Admin Ratio (%)*	*4.5%*		*5.0%*		*50bps*	
$ 45,193	**$ 19.02**	**$ (8,942)**	**$ (3.76)**	**$ 54,135**	**$ 22.78**	**Income (Loss) from Operations**	**$ 227,700**	**$ 18.33**	**$ 173,565**	**$ 13.97**	**$ 54,135**	**$ 4.36**
5.6%		*-1.1%*		*671bps*		*Margin before Non-Operating Inc/(Exp) Ratio (%)*	*5.6%*		*4.3%*		*132bps*	
$ 11,908	$ 5.01	$ 4,429	$ 1.86	$ 7,479	$ 3.15	Interest Income,Net	$ 67,460	$ 5.43	$ 59,982	$ 4.83	$ 7,479	$ 0.60
$ 1,795	$ 0.76	$ 1,477	$ 0.62	$ 318	$ 0.13	Other Income (Expense),Net	$ 3,186	$ 0.26	$ 2,868	$ 0.23	$ 318	$ 0.03
$ (132)	$ (0.06)	$ -	$ -	$ (132)	$ (0.06)	Realized Gain/Loss	$ (1,072)	$ (0.09)	$ (940)	$ (0.08)	$ (132)	$ (0.01)
$ (3,462)	$ (1.46)	$ -	$ -	$ (3,462)	$ (1.46)	Unrealized Gain/Loss	$ 10,999	$ 0.89	$ 14,460	$ 1.16	$ (3,462)	$ (0.28)
$ 10,109	**$ 4.25**	**$ 5,906**	**$ 2.48**	**$ 4,203**	**1.77**	**Total Non-Operating Income/(Expense)**	**$ 80,573**	**$ 6.49**	**$ 76,370**	**$ 6.15**	**$ 4,203**	**$ 0.34**
$ 55,301	**$ 23.27**	**$ (3,036)**	**$ (1.28)**	**$ 58,338**	**$ 24.55**	**Net Surplus/(Deficit)**	**$ 308,273**	**$ 24.82**	**$ 249,935**	**$ 20.12**	**$ 58,338**	**$ 4.70**
6.8%		*-0.4%*		*722bps*		*Margin (%)*	*7.6%*		*6.1%*		*142bps*	

L.A. Care HEALTH PLAN

DSNP Income Statement ($ in thousands)

February 2024

MTD Actual	PMPM	MTD 4+8 Forecast	PMPM	MTD Fav/(Unfav)	PMPM		YTD Actual	PMPM	YTD 4+8 Forecast	PMPM	YTD Fav/(Unfav)	PMPM
						Membership						
19,392		19,261		131		Member Months	93,806		93,675		131	
						Revenue						
$ 27,524	$ 1,419.33	$ 27,909	$ 1,449.00	$ (385)	$ (29.67)	Capitation Revenue	$ 133,650	$ 1,424.75	$ 134,035	$ 1,430.86	$ (385)	$ (6.11)
$ 27,524	**$ 1,419.33**	**$ 27,909**	**$ 1,449.00**	**$ (385)**	**$ (29.67)**	**Total Revenues**	**$ 133,650**	**$ 1,424.75**	**$ 134,035**	**$ 1,430.86**	**$ (385)**	**$ (6.11)**
						Healthcare Expenses						
$ 9,683	$ 499.35	$ 10,521	$ 546.21	$ 837	$ 46.86	Capitation	$ 48,660	$ 518.73	$ 49,497	$ 528.39	$ 837	$ 9.66
$ 3,978	$ 205.11	$ 6,827	$ 354.43	$ 2,849	$ 149.32	Inpatient Claims	$ 25,647	$ 273.41	$ 28,496	$ 304.20	$ 2,849	$ 30.80
$ 3,150	$ 162.44	$ 4,464	$ 231.75	$ 1,314	$ 69.31	Outpatient Claims	$ 15,330	$ 163.42	$ 16,644	$ 177.67	$ 1,314	$ 14.25
$ 596	$ 30.74	$ -	$ -	$ (596)	$ (30.74)	Skilled Nurse Facility	$ 3,405	$ 36.29	$ 2,808	$ 29.98	$ (596)	$ (6.31)
$ 539	$ 27.79	$ 1,098	$ 57.00	$ 559	$ 29.20	Pharmacy	$ 6,190	$ 65.99	$ 6,749	$ 72.04	$ 559	$ 6.06
$ 10,784	$ 556.13	$ 2,315	$ 120.18	$ (8,470)	$ (435.95)	Provider Incentive and Shared Risk	$ 15,131	$ 161.30	$ 6,661	$ 71.11	$ (8,470)	$ (90.19)
$ 383	$ 19.75	$ 214	$ 11.12	$ (169)	$ (8.64)	Medical Administrative Expenses	$ 1,523	$ 16.24	$ 1,354	$ 14.45	$ (169)	$ (1.78)
$ 29,113	**$ 1,501.31**	**$ 25,438**	**$ 1,320.68**	**$ (3,676)**	**$ (180.63)**	**Total Healthcare Expenses**	**$ 115,885**	**$ 1,235.37**	**$ 112,209**	**$ 1,197.85**	**$ (3,676)**	**$ (37.51)**
105.8%		*91.1%*		*(1,463bps)*		*MCR (%)*	*86.7%*		*83.7%*		*(299bps)*	
$ (1,590)	**$ (81.98)**	**$ 2,471**	**$ 128.32**	**$ (4,061)**	**$ (210.30)**	**Operating Margin**	**$ 17,765**	**$ 189.38**	**$ 21,826**	**$ 233.00**	**$ (4,061)**	**$ (43.62)**
$ 2,449	**$ 126.30**	**$ (4,699)**	**$ (243.94)**	**$ (7,148)**	**$ (370.24)**	**Total Operating Expenses**	**$ 17,953**	**$ 191.38**	**$ 10,805**	**$ 115.35**	**$ (7,148)**	**$ (76.04)**
8.9%		*-16.8%*		*(2,573bps)*		*Admin Ratio (%)*	*13.4%*		*8.1%*		*(537bps)*	
$ (4,039)	**$ (208.28)**	**$ 7,170**	**$ 372.26**	**$ (11,209)**	**$ (580.54)**	**Income (Loss) from Operations**	**$ (188)**	**$ (2.00)**	**$ 11,021**	**$ 117.66**	**$ (11,209)**	**$ (119.66)**
-14.7%		*25.7%*		*(4,037bps)*		*Margin before Non-Operating Inc/(Exp) Ratio (%)*	*-0.1%*		*8.2%*		*(836bps)*	
$ 315	$ 16.22	$ 154	$ 8.00	$ 160	$ 8.22	Interest Income,Net	$ 1,670	$ 17.80	$ 1,510	$ 16.12	$ 160	$ 1.69
$ 0	$ 0.02	$ -	$ -	$ 0	$ 0.02	Other Income (Expense),Net	$ 1	$ 0.01	$ 1	$ 0.01	$ 0	$ 0.01
$ (3)	$ (0.18)	$ -	$ -	$ (3)	$ (0.18)	Realized Gain/Loss	$ (26)	$ (0.28)	$ (23)	$ (0.24)	$ (3)	$ (0.04)
$ (91)	$ (4.70)	$ -	$ -	$ (91)	$ (4.70)	Unrealized Gain/Loss	$ 253	$ 2.70	$ 344	$ 3.68	$ (91)	$ (0.98)
$ 220	**$ 11.35**	**$ 154**	**$ 8.00**	**$ 66**	**3.35**	**Total Non-Operating Income/(Expense)**	**$ 1,898**	**$ 20.23**	**$ 1,832**	**$ 19.56**	**$ 66**	**$ 0.68**
$ (3,819)	**$ (196.93)**	**$ 7,324**	**$ 380.26**	**$ (11,143)**	**$ (577.18)**	**Net Surplus/(Deficit)**	**$ 1,710**	**$ 18.23**	**$ 12,853**	**$ 137.21**	**$ (11,143)**	**$ (118.97)**
-13.9%		*26.2%*		*(4,012bps)*		*Margin (%)*	*1.3%*		*9.6%*		*(831bps)*	

L.A. Care HEALTH PLAN

Commercial Income Statement ($ in thousands)

February 2024

MTD Actual	PMPM	MTD 4+8 Forecast	PMPM	MTD Fav/(Unfav)	PMPM		YTD Actual	PMPM	YTD 4+8 Forecast	PMPM	YTD Fav/(Unfav)	PMPM
						Membership						
221,528		217,137		4,391		Member Months	979,256		974,865		4,391	
						Revenue						
$ 40,416	$ 182.44	$ 36,372	$ 167.51	$ 4,043	$ 14.93	Capitation Revenue	$ 276,522	$ 282.38	$ 272,479	$ 279.50	$ 4,043	$ 2.88
$ 40,416	**$ 182.44**	**$ 36,372**	**$ 167.51**	**$ 4,043**	**$ 14.93**	**Total Revenues**	**$ 276,522**	**$ 282.38**	**$ 272,479**	**$ 279.50**	**$ 4,043**	**$ 2.88**
						Healthcare Expenses						
$ 11,777	$ 53.16	$ 11,173	$ 51.46	$ (603)	$ (1.70)	Capitation	$ 82,285	$ 84.03	$ 81,681	$ 83.79	$ (603)	$ (0.24)
$ 17,670	$ 79.76	$ 10,016	$ 46.13	$ (7,654)	$ (33.64)	Inpatient Claims	$ 45,259	$ 46.22	$ 37,605	$ 38.57	$ (7,654)	$ (7.64)
$ 9,119	$ 41.16	$ 9,220	$ 42.46	$ 101	$ 1.30	Outpatient Claims	$ 37,470	$ 38.26	$ 37,571	$ 38.54	$ 101	$ 0.28
$ 111	$ 0.50	$ -	$ -	$ (111)	$ (0.50)	Skilled Nurse Facility	$ 692	$ 0.71	$ 581	$ 0.60	$ (111)	$ (0.11)
$ 11,989	$ 54.12	$ 12,423	$ 57.21	$ 434	$ 3.09	Pharmacy	$ 64,713	$ 66.08	$ 65,147	$ 66.83	$ 434	$ 0.74
$ 3,677	$ 16.60	$ 1,263	$ 5.82	$ (2,414)	$ (10.78)	Provider Incentive and Shared Risk	$ 5,895	$ 6.02	$ 3,482	$ 3.57	$ (2,414)	$ (2.45)
$ 828	$ 3.74	$ 1,426	$ 6.57	$ 598	$ 2.83	Medical Administrative Expenses	$ 3,169	$ 3.24	$ 3,767	$ 3.86	$ 598	$ 0.63
$ 55,170	**$ 249.04**	**$ 45,520**	**$ 209.64**	**$ (9,649)**	**$ (39.40)**	**Total Healthcare Expenses**	**$ 239,483**	**$ 244.56**	**$ 229,834**	**$ 235.76**	**$ (9,649)**	**$ (8.80)**
136.5%		*125.2%*		*(1,135bps)*		*MCR (%)*	*86.6%*		*84.3%*		*(226bps)*	
$ (14,754)	**$ (66.60)**	**$ (9,148)**	**$ (42.13)**	**$ (5,606)**	**$ (24.47)**	**Operating Margin**	**$ 37,039**	**$ 37.82**	**$ 42,645**	**$ 43.74**	**$ (5,606)**	**$ (5.92)**
$ 10,505	**$ 47.42**	**$ (8,447)**	**$ (38.90)**	**$ (18,952)**	**$ (86.32)**	**Total Operating Expenses**	**$ 46,606**	**$ 47.59**	**$ 27,654**	**$ 28.37**	**$ (18,952)**	**$ (19.23)**
26.0%		*-23.2%*		*(4,922bps)*		*Admin Ratio (%)*	*16.9%*		*10.1%*		*(671bps)*	
$ (25,259)	**$ (114.02)**	**$ (701)**	**$ (3.23)**	**$ (24,558)**	**$ (110.79)**	**Income (Loss) from Operations**	**$ (9,567)**	**$ (9.77)**	**$ 14,991**	**$ 15.38**	**$ (24,558)**	**$ (25.15)**
-62.5%		*-1.9%*		*(6,057bps)*		*Margin before Non-Operating Inc/(Exp) Ratio (%)*	*-3.5%*		*5.5%*		*(896bps)*	
$ 1	$ 0.00	$ 393	$ 1.81	$ (392)	$ (1.81)	Interest Income,Net	$ 1	$ 0.00	$ 393	$ 0.40	$ (392)	$ (0.40)
$ (17)	$ (0.08)	$ (17)	$ (0.08)	$ -	$ 0.00	Other Income (Expense),Net	$ (192)	$ (0.20)	$ (192)	$ (0.20)	$ -	$ 0.00
$ -	$ -	$ -	$ -	$ -	$ -	Realized Gain/Loss	$ -	$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -	$ -	Unrealized Gain/Loss	$ -	$ -	$ -	$ -	$ -	$ -
$ (17)	**$ (0.08)**	**$ 375**	**$ 1.73**	**$ (392)**	**(1.80)**	**Total Non-Operating Income/(Expense)**	**$ (191)**	**$ (0.19)**	**$ 201**	**$ 0.21**	**$ (392)**	**$ (0.40)**
$ (25,276)	**$ (114.10)**	**$ (326)**	**$ (1.50)**	**$ (24,950)**	**$ (112.60)**	**Net Surplus/(Deficit)**	**$ (9,758)**	**$ (9.96)**	**$ 15,193**	**$ 15.58**	**$ (24,950)**	**$ (25.55)**
-62.5%		*-0.9%*		*(6,164bps)*		*Margin (%)*	*-3.5%*		*5.6%*		*(910bps)*	

L.A. Care HEALTH PLAN

Incentive Programs Income Statement ($ in thousands)

February 2024

MTD Actual	PMPM	MTD 4+8 Forecast	PMPM	MTD Fav/(Unfav)	PMPM		YTD Actual	PMPM	YTD 4+8 Forecast	PMPM	YTD Fav/(Unfav)	PMPM
						Membership						
-		-		-		Member Months	-		-		-	
						Revenue						
$ -	$ -	$ 16,556	$ -	$ (16,556)	$ -	Capitation Revenue	$ 43,998	$ -	$ 60,554	$ -	$ (16,556)	$ -
$ -	**$ -**	**$ 16,556**	**$ -**	**$ (16,556)**	**$ -**	**Total Revenues**	**$ 43,998**	**$ -**	**$ 60,554**	**$ -**	**$ (16,556)**	**$ -**
						Healthcare Expenses						
$ -	$ -	$ -	$ -	$ -	$ -	Capitation	$ -	$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -	$ -	Inpatient Claims	$ -	$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ 833	$ -	$ 833	$ -	Outpatient Claims	$ -	$ -	$ 833	$ -	$ 833	$ -
$ -	$ -	$ -	$ -	$ -	$ -	Skilled Nurse Facility	$ -	$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -	$ -	Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -
$ 1,239	$ -	$ 7,694	$ -	$ 6,455	$ -	Provider Incentive and Shared Risk	$ 6,987	$ -	$ 13,442	$ -	$ 6,455	$ -
$ -	$ -	$ -	$ -	$ -	$ -	Medical Administrative Expenses	$ -	$ -	$ -	$ -	$ -	$ -
$ 1,239	**$ -**	**$ 8,528**	**$ -**	**$ 7,289**	**$ -**	**Total Healthcare Expenses**	**$ 6,987**	**$ -**	**$ 14,275**	**$ -**	**$ 7,289**	**$ -**
0.0%		*51.5%*		*5,151bps*		*MCR (%)*	*15.9%*		*23.6%*		*770bps*	
$ (1,239)	**$ -**	**$ 8,029**	**$ -**	**$ (9,268)**	**$ -**	**Operating Margin**	**$ 37,011**	**$ -**	**$ 46,279**	**$ -**	**$ (9,268)**	**$ -**
$ 184	**$ -**	**$ 327**	**$ -**	**$ 143**	**$ -**	**Total Operating Expenses**	**$ 442**	**$ -**	**$ 585**	**$ -**	**$ 143**	**$ -**
0.0%		*2.0%*		*197bps*		*Admin Ratio (%)*	*1.0%*		*1.0%*		*(4bps)*	
$ (1,423)	**$ -**	**$ 7,702**	**$ -**	**$ (9,125)**	**$ -**	**Income (Loss) from Operations**	**$ 36,569**	**$ -**	**$ 45,694**	**$ -**	**$ (9,125)**	**$ -**
0.0%		*46.5%*		*(4,652bps)*		*Margin before Non-Operating Inc/(Exp) Ratio (%)*	*83.1%*		*75.5%*		*766bps*	
$ -	$ -	$ -	$ -	$ -	$ -	Interest Income,Net	$ -	$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -	$ -	Other Income (Expense),Net	$ -	$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -	$ -	Realized Gain/Loss	$ -	$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -	$ -	Unrealized Gain/Loss	$ -	$ -	$ -	$ -	$ -	$ -
$ -	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**Total Non-Operating Income/(Expense)**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
$ (1,423)	**$ -**	**$ 7,702**	**$ -**	**$ (9,125)**	**$ -**	**Net Surplus/(Deficit)**	**$ 36,569**	**$ -**	**$ 45,694**	**$ -**	**$ (9,125)**	**$ -**
0.0%		*46.5%*		*(4,652bps)*		*Margin (%)*	*83.1%*		*75.5%*		*766bps*	

L.A. Care HEALTH PLAN

Balance Sheet ($ in thousands)

	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Assets					
Cash and Cash Equivalents	$ 1,215,928	$ 1,164,685	$ 1,050,823	$ 1,300,559	$ 1,457,922
Short Term Investments, at fair value	$ 1,858,223	$ 2,006,373	$ 2,298,594	$ 2,203,165	$ 2,494,863
Capitation Receivable	$ 3,182,445	$ 3,233,165	$ 3,152,661	$ 2,907,187	$ 3,022,046
Interest and Non-Operating Receivables	$ 40,813	$ 6,752	$ 423,494	$ 472,216	$ 515,539
Prepaids and Other Current Assets	$ 18,325	$ 16,145	$ 27,978	$ 33,486	$ 33,847
Current Assets	**$ 6,315,735**	**$ 6,427,120**	**$ 6,953,551**	**$ 6,916,612**	**$ 7,524,217**
Capitalized Assets - net	$ 168,137	$ 166,800	$ 163,264	$ 160,379	$ 161,628
Non-Current Assets	$ 3,071	$ 2,901	$ 2,744	$ 1,744	$ 1,765
Total Assets	**$ 6,486,942**	**$ 6,596,822**	**$ 7,119,560**	**$ 7,078,735**	**$ 7,687,611**
Liabilities & Equity					
Liabilities					
Accounts Payable and Accrued Liabilities	$ 175,928	$ 187,262	$ 551,099	$ 598,049	$ 489,004
Subcapitation Payable	$ 3,110,125	$ 3,153,507	$ 3,258,876	$ 3,194,511	$ 3,214,279
Accts Receivable - PP	$ 2	$ 2	$ 1	$ 1	$ 1
Reserve for Claims	$ 819,965	$ 827,368	$ 867,307	$ 851,802	$ 809,922
Accrued Medical Expenses	$ 271,671	$ 266,999	$ 269,172	$ 211,542	$ 212,239
Deferred Revenue	$ 69,446	$ 64,958	$ 38,107	$ 76,179	$ 138,196
Reserve for Provider Incentives	$ 109,889	$ 114,474	$ 78,126	$ 67,785	$ 60,283
Non-Operating Payables	$ 33,097	$ 29,341	$ 9,667	$ (19,112)	$ 645,902
Grants Payable	$ 18,094	$ 16,769	$ 17,968	$ 17,443	$ 16,955
Deferred Rent	$ 48,456	$ 45,243	$ 43,553	$ 41,868	$ 40,104
Total Current Liabilities	**$ 4,656,673**	**$ 4,705,923**	**$ 5,133,874**	**$ 5,040,067**	**$ 5,626,885**
Equity					
Invested in Capital Assets, Net of related de	$ 99,218	$ 99,259	$ 97,349	$ 99,507	$ 103,953
Restricted Equity	$ 600	$ 600	$ 600	$ 600	$ 600
Minimum Tangible Net Equity	$ 235,945	$ 235,089	$ 238,050	$ 236,840	$ 238,550
Board Designated Funds	$ 143,902	$ 142,476	$ 147,962	$ 145,172	$ 143,248
Unrestricted Net Assets	$ 1,350,604	$ 1,413,475	$ 1,501,725	$ 1,556,550	$ 1,574,375
Total Equity	**$ 1,830,268**	**$ 1,890,899**	**$ 1,985,685**	**$ 2,038,668**	**$ 2,060,725**
Total Liabilities & Equity	**$ 6,486,942**	**$ 6,596,822**	**$ 7,119,560**	**$ 7,078,735**	**$ 7,687,611**

L.A. Care HEALTH PLAN

Cash Flows Statement ($ in thousands) — February 2024

	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	YTD
Cash Flows from Operating Activities:						
Capitation Revenue	$ 841,537	$ 878,375	$ 1,020,197	$ 1,056,193	$ 814,382	$ 4,610,684
Other Income (Expense), net	$ 19,423	$ 8,321	$ 3,604	$ 13,760	$ 11,212	$ 56,320
Healthcare Expenses	$ (846,331)	$ (796,846)	$ (739,718)	$ (808,174)	$ (835,771)	$ (4,026,840)
Operating Expenses	$ (36,472)	$ (29,715)	$ (75,466)	$ (48,204)	$ (51,472)	$ (241,329)
Net Cash Provided By Operating Activities	**$ (21,843)**	**$ 60,135**	**$ 208,617**	**$ 213,575**	**$ (61,649)**	**$ 398,835**
Cash Flows from Investing Activities						
Purchase of investments - Net	$ (67,389)	$ (137,165)	$ (285,931)	$ 96,186	$ (295,798)	$ (690,097)
Purchase of Capital Assets	$ (3,065)	$ (2,368)	$ (161)	$ (4,646)	$ (5,605)	$ (15,845)
Net Cash Provided By Investing Activities	**$ (70,454)**	**$ (139,533)**	**$ (286,092)**	**$ 91,540**	**$ (301,403)**	**$ (705,942)**
Cash Flows from Financing Activities:						
Lease Payment - Capital & ROU	$ (1,546)	$ (1,377)	$ (1,505)	$ (1,502)	$ (1,367)	$ (7,297)
SBITA Liabilty	$ -	$ -	$ -	$ -	$ 188	$ 188
Gross Premium Tax (MCO Sales Tax) - Net		$ 33,288	$ (15,208)	$ (25,099)	$ (143,420)	$ (150,439)
Pass through transactions (AB 85, IGT, etc.)	$ (269,155)	$ (3,756)	$ (19,674)	$ (28,779)	$ 665,014	$ 343,650
Net Cash Provided By Financing Activities	**$ (270,701)**	**$ 28,155**	**$ (36,387)**	**$ (55,380)**	**$ 520,415**	**$ 186,102**
Net Increase in Cash and Cash Equivalents	**$ (362,998)**	**$ (51,243)**	**$ (113,862)**	**$ 249,735**	**$ 157,363**	**$ (121,005)**
Cash and Cash Equivalents, Beginning	$ 1,578,927	$ 1,215,929	$ 1,164,686	$ 1,050,824	$ 1,300,559	$ 1,578,927
Cash and Cash Equivalents, Ending	**$ 1,215,929**	**$ 1,164,686**	**$ 1,050,824**	**$ 1,300,559**	**$ 1,457,922**	**$ 1,457,922**
Reconciliation of Income from Operations to Net Cash Provided By (Used In) Operating Activities:						
Excess of Revenues over Expenses	**$ 96,976**	**$ 60,630**	**$ 94,786**	**$ 52,983**	**$ 22,057**	**$ 327,432**
Adjustments to Excess of Revenues Over Expenses:						
Depreciation	$ 4,181	$ 3,715	$ 3,697	$ 7,531	$ 4,356	$ 23,480
Realized and Unrealized (Gain)/Loss on Investments	$ 868	$ (7,749)	$ (6,291)	$ (756)	$ 4,099	$ (9,829)
Deferred Rent	$ 50	$ (6)	$ 50	$ 50		$ 144
Gross Premium Tax provision	$ (1)	$ (2)	$ 2	$ (1,187)	$ (1,765)	$ (2,953)
Loss on Disposal of Capital Assets		$ (10)	$ -	$ -	$ -	$ (10)
Total Adjustments to Excess of Revenues over Expenses	**$ 5,098**	**$ (4,052)**	**$ (2,542)**	**$ 5,638**	**$ 6,690**	**$ 10,832**
Changes in Operating Assets and Liabilities:						
Capitation Receivable	$ (92,525)	$ (53,272)	$ (1,340,639)	$ 1,635,640	$ (120,052)	$ 29,152
Interest and Non-Operating Receivables	$ 4,753	$ (2,462)	$ (7,465)	$ 1,386	$ 321	$ (3,467)
Prepaid and Other Current Assets	$ 4,508	$ 4,901	$ (12,882)	$ (5,512)	$ 4,812	$ (4,173)
Accounts Payable and Accrued Liabilities	$ 4,634	$ 9,503	$ (12,961)	$ 4,877	$ (8,089)	$ (2,036)
Subcapitation Payable	$ (13,634)	$ 43,487	$ 105,367	$ (30,666)	$ 19,768	$ 124,322
MediCal Adult Expansion Payable		$ (104)	$ -	$ -	$ -	$ (104)
Deferred Capitation Revenue	$ (18,967)	$ (3,952)	$ 1,377,508	$ (1,366,774)	$ 62,024	$ 49,839
Accrued Medical Expenses	$ 6,124	$ (5,208)	$ 2,656	$ (57,626)	$ 690	$ (53,364)
Reserve for Claims	$ (22,643)	$ 7,403	$ 39,939	$ (15,505)	$ (41,880)	$ (32,686)
Reserve for Provider Incentives	$ 5,038	$ 4,586	$ (36,349)	$ (10,341)	$ (7,502)	$ (44,568)
Grants Payable	$ (1,205)	$ (1,325)	$ 1,199	$ (525)	$ (488)	$ (2,344)
Net Changes in Operating Assets and Liabilities	**$ (123,917)**	**$ 3,557**	**$ 116,373**	**$ 154,954**	**$ (90,396)**	**$ 60,571**
Net Cash Provided By Operating Activities	**$ (21,843)**	**$ 60,135**	**$ 208,617**	**$ 213,575**	**$ (61,649)**	**$ 398,835**

DATE: April 24, 2024

TO: Finance & Budget Committee

FROM: Afzal Shah, *Chief Financial Officer*

SUBJECT: Monthly Investment Portfolio Securities Transaction Report for February, 2024

To keep the Committee apprised of L.A. Care's investment portfolios and to comply with California Government Code Section 53607, attached are the monthly investment transaction details from February 1 to February 29, 2024.

L.A. Care's investment market value as of February 29, 2024, was $4.1 billion. This includes our funds invested with the government pooled funds. L.A. Care has approximately $36 million invested with the statewide Local Agency Investment Fund (LAIF), and approximately $80 million invested with the Los Angeles County Pooled Investment Fund (LACPIF).

In February 2024, L.A. Care began investing in the BlackRock Liquity T-Fund, which is a money market fund that invests in US Treasury obligations. This money market fund is rated AAA by the credit agencies S&P and Moody's. As of February 29, 2024, L.A. Care had $125M invested in this fund.

The remainder as of February 29, 2024, of $3.86 billion is managed by two independent asset managers, 1) Payden & Rygel and 2) New England Asset Management (NEAM) and is divided into three portfolios based on investment style,

1. Payden & Rygel - Short-term portfolio
2. Payden & Rygel - Extended term portfolio
3. New England Asset Management - Corporate notes extended term portfolio

The transactions within these three portfolios are included in the attached reports.

LA Care, as a California government entity, only makes investments in bonds/fixed income, as per the California Government Code. The entries on the Investment Securities Portfolio Transaction Report reflect transactions undertaken by financial management companies on L.A. Care's behalf. L.A. Care does not direct these individual transactions. The firms, managing investments on behalf of L.A. Care, conduct the transactions based on L.A. Care's investment guidelines.

Account Name: L.A. CARE HEALTH PLAN

02/01/2024 through 02/29/2024

Tr Date	*St Date*	*Transaction Type*	*Units*	*Description*	*Proceeds / (Cost)*	*Accrued Interest (Purch) or Sold*	*G/L < 1 Yr Amort Cost*	*G/L > 1 Yr Amort Cost*	*Total Amount*
02/01/24	02/01/24	Buy	20,000,000.000	FHLB DISCOUNT NOTE MAT 02/02/24 Cpn 313384SP5	(19,997,083.33)		0.00	0.00	(19,997,083.33)
02/01/24	02/01/24	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 02/02/24 Cpn 313384SP5	(49,992,708.33)		0.00	0.00	(49,992,708.33)
02/01/24	02/01/24	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 02/02/24 Cpn 313384SP5	(49,992,708.33)		0.00	0.00	(49,992,708.33)
02/01/24	02/01/24	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 02/02/24 Cpn 313384SP5	(49,992,708.33)		0.00	0.00	(49,992,708.33)
02/02/24	02/02/24	Buy	10,000,000.000	U.S. TREASURY BILL MAT 05/02/24 Cpn 912797HH3	(9,869,476.25)		0.00	0.00	(9,869,476.25)
02/02/24	02/02/24	Buy	50,000,000.000	U.S. TREASURY BILL MAT 05/02/24 Cpn 912797HH3	(49,347,381.25)		0.00	0.00	(49,347,381.25)
02/02/24	02/02/24	Buy	10,000,000.000	U.S. TREASURY BILL MAT 08/01/24 Cpn 912797JU2	(9,746,723.18)		0.00	0.00	(9,746,723.18)
02/02/24	02/02/24	Buy	50,000,000.000	U.S. TREASURY BILL MAT 08/01/24 Cpn 912797JU2	(48,733,615.90)		0.00	0.00	(48,733,615.90)
02/02/24	02/02/24	Buy	10,000,000.000	U.S. TREASURY BILL MAT 03/26/24 Cpn 912797JK4	(9,922,801.08)		0.00	0.00	(9,922,801.08)
02/02/24	02/02/24	Buy	50,000,000.000	U.S. TREASURY BILL MAT 03/26/24 Cpn 912797JK4	(49,614,005.42)		0.00	0.00	(49,614,005.42)
02/05/24	02/05/24	Buy	40,000,000.000	AUTOMATIC DATA CP 144A MAT 02/06/24 Cpn 0530A2B66	(39,994,111.11)		0.00	0.00	(39,994,111.11)
02/05/24	02/05/24	Buy	15,000,000.000	FHLB DISCOUNT NOTE MAT 02/06/24 Cpn 313384ST7	(14,997,812.50)		0.00	0.00	(14,997,812.50)
02/06/24	02/06/24	Buy	40,000,000.000	AUTOMATIC DATA CP 144A MAT 02/07/24 Cpn 0530A2B74	(39,994,122.22)		0.00	0.00	(39,994,122.22)

Account Name: L.A. CARE HEALTH PLAN

02/01/2024 through 02/29/2024

Tr Date	St Date	Transaction Type	Units	Description		Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/06/24	02/06/24	Buy	20,000,000.000	U.S. TREASURY BILL MAT 04/02/24 Cpn	912797JL2	(19,836,184.44)		0.00	0.00	(19,836,184.44)
02/06/24	02/06/24	Buy	50,000,000.000	U.S. TREASURY BILL MAT 04/02/24 Cpn	912797JL2	(49,590,461.11)		0.00	0.00	(49,590,461.11)
02/06/24	02/06/24	Buy	20,000,000.000	U.S. TREASURY BILL MAT 05/02/24 Cpn	912797HH3	(19,750,504.44)		0.00	0.00	(19,750,504.44)
02/06/24	02/06/24	Buy	50,000,000.000	U.S. TREASURY BILL MAT 05/02/24 Cpn	912797HH3	(49,376,261.11)		0.00	0.00	(49,376,261.11)
02/06/24	02/06/24	Buy	20,000,000.000	U.S. TREASURY BILL MAT 08/01/24 Cpn	912797JU2	(19,504,842.50)		0.00	0.00	(19,504,842.50)
02/06/24	02/06/24	Buy	50,000,000.000	U.S. TREASURY BILL MAT 08/01/24 Cpn	912797JU2	(48,762,106.25)		0.00	0.00	(48,762,106.25)
02/06/24	02/06/24	Buy	30,000,000.000	CREDIT AGRICOLE CP MAT 02/07/24 Cpn	22533TB70	(29,995,608.33)		0.00	0.00	(29,995,608.33)
02/08/24	02/08/24	Buy	25,000,000.000	U.S. TREASURY BILL MAT 04/02/24 Cpn	912797JL2	(24,802,560.63)		0.00	0.00	(24,802,560.63)
02/08/24	02/08/24	Buy	50,000,000.000	U.S. TREASURY BILL MAT 04/02/24 Cpn	912797JL2	(49,605,121.25)		0.00	0.00	(49,605,121.25)
02/08/24	02/08/24	Buy	25,000,000.000	U.S. TREASURY BILL MAT 05/09/24 Cpn	912797HQ3	(24,669,777.43)		0.00	0.00	(24,669,777.43)
02/08/24	02/08/24	Buy	50,000,000.000	U.S. TREASURY BILL MAT 05/09/24 Cpn	912797HQ3	(49,339,554.86)		0.00	0.00	(49,339,554.86)
02/08/24	02/08/24	Buy	25,000,000.000	CREDIT AGRICOLE CP MAT 02/15/24 Cpn	22533TBF2	(24,974,284.72)		0.00	0.00	(24,974,284.72)
02/08/24	02/08/24	Buy	27,500,000.000	CATERPILLAR CP 144A MAT 02/09/24 Cpn	14912PB92	(27,495,951.39)		0.00	0.00	(27,495,951.39)

Account Name: L.A. CARE HEALTH PLAN

02/01/2024 through 02/29/2024

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/08/24	02/08/24	Buy	35,000,000.000	FHLB DISCOUNT NOTE MAT 02/09/24 Cpn 313384SW0	(34,994,915.28)		0.00	0.00	(34,994,915.28)
02/08/24	02/08/24	Buy	40,000,000.000	NESTLE CAPITAL CP 144A MAT 02/09/24 Cpn 64105GB94	(39,994,133.33)		0.00	0.00	(39,994,133.33)
02/09/24	02/09/24	Buy	15,000,000.000	FHLB DISCOUNT NOTE MAT 02/12/24 Cpn 313384SZ3	(14,993,475.00)		0.00	0.00	(14,993,475.00)
02/09/24	02/09/24	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 02/12/24 Cpn 313384SZ3	(49,978,250.00)		0.00	0.00	(49,978,250.00)
02/12/24	02/12/24	Buy	30,000,000.000	NESTLE CAPITAL CP 144A MAT 02/13/24 Cpn 64105GBD5	(29,995,600.00)		0.00	0.00	(29,995,600.00)
02/13/24	02/13/24	Buy	40,000,000.000	FHLB DISCOUNT NOTE MAT 02/14/24 Cpn 313384TB5	(39,994,194.44)		0.00	0.00	(39,994,194.44)
02/06/24	02/14/24	Buy	3,000,000.000	BMWLT 2024-1 A2A LEASE MAT 07/27/26 Cpn 5.10 05611UAB9	(2,999,938.50)		0.00	0.00	(2,999,938.50)
02/06/24	02/14/24	Buy	3,000,000.000	LADAR 2024-1A A2 CAR 144A MAT 11/16/26 Cpn 5.44 501689AB9	(2,999,875.50)		0.00	0.00	(2,999,875.50)
02/15/24	02/15/24	Buy	50,000,000.000	U.S. TREASURY BILL MAT 02/20/24 Cpn 912797JE8	(49,963,850.00)		0.00	0.00	(49,963,850.00)
02/15/24	02/15/24	Buy	50,000,000.000	U.S. TREASURY BILL MAT 02/20/24 Cpn 912797JE8	(49,963,850.00)		0.00	0.00	(49,963,850.00)
02/15/24	02/15/24	Buy	50,000,000.000	U.S. TREASURY BILL MAT 02/20/24 Cpn 912797JE8	(49,963,850.00)		0.00	0.00	(49,963,850.00)
02/15/24	02/15/24	Buy	50,000,000.000	U.S. TREASURY BILL MAT 02/22/24 Cpn 912796Z28	(49,949,337.50)		0.00	0.00	(49,949,337.50)
02/15/24	02/15/24	Buy	50,000,000.000	U.S. TREASURY BILL MAT 02/22/24 Cpn 912796Z28	(49,949,337.50)		0.00	0.00	(49,949,337.50)

Account Name: L.A. CARE HEALTH PLAN

02/01/2024 through 02/29/2024

Tr Date	St Date	Transaction Type	Units	Description		Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/15/24	02/15/24	Buy	50,000,000.000	U.S. TREASURY BILL MAT 02/22/24 Cpn	912796Z28	(49,949,337.50)		0.00	0.00	(49,949,337.50)
02/15/24	02/15/24	Buy	25,000,000.000	U.S. TREASURY BILL MAT 05/16/24 Cpn	912797FH5	(24,670,320.90)		0.00	0.00	(24,670,320.90)
02/15/24	02/15/24	Buy	50,000,000.000	U.S. TREASURY BILL MAT 05/16/24 Cpn	912797FH5	(49,340,641.81)		0.00	0.00	(49,340,641.81)
02/15/24	02/15/24	Buy	50,000,000.000	U.S. TREASURY BILL MAT 05/16/24 Cpn	912797FH5	(49,340,641.81)		0.00	0.00	(49,340,641.81)
02/15/24	02/15/24	Buy	50,000,000.000	U.S. TREASURY BILL MAT 06/11/24 Cpn	912797KE6	(49,153,131.25)		0.00	0.00	(49,153,131.25)
02/15/24	02/15/24	Buy	50,000,000.000	U.S. TREASURY BILL MAT 06/11/24 Cpn	912797KE6	(49,153,131.25)		0.00	0.00	(49,153,131.25)
02/15/24	02/15/24	Buy	50,000,000.000	U.S. TREASURY BILL MAT 08/15/24 Cpn	912797KB2	(48,709,076.53)		0.00	0.00	(48,709,076.53)
02/15/24	02/15/24	Buy	50,000,000.000	U.S. TREASURY BILL MAT 08/15/24 Cpn	912797KB2	(48,709,076.53)		0.00	0.00	(48,709,076.53)
02/15/24	02/15/24	Buy	50,000,000.000	U.S. TREASURY BILL MAT 08/15/24 Cpn	912797KB2	(48,709,076.53)		0.00	0.00	(48,709,076.53)
02/15/24	02/15/24	Buy	30,000,000.000	FHLB DISCOUNT NOTE MAT 02/16/24 Cpn	313384TD1	(29,995,700.00)		0.00	0.00	(29,995,700.00)
02/15/24	02/15/24	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 02/16/24 Cpn	313384TD1	(49,992,833.33)		0.00	0.00	(49,992,833.33)
02/15/24	02/15/24	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 02/16/24 Cpn	313384TD1	(49,992,833.33)		0.00	0.00	(49,992,833.33)
02/08/24	02/15/24	Buy	2,500,000.000	GMALT 2024-1 A2A LEASE MAT 06/22/26 Cpn 5.18	36269FAB2	(2,499,736.50)		0.00	0.00	(2,499,736.50)

Account Name: L.A. CARE HEALTH PLAN

02/01/2024 through 02/29/2024

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/15/24	02/15/24	Buy	25,000,000.000	NOVARTIS FINANCE CP 144A MAT 04/01/24 Cpn 6698M4D17	(24,830,694.44)		0.00	0.00	(24,830,694.44)
02/16/24	02/16/24	Buy	50,000,000.000	U.S. TREASURY BILL MAT 02/20/24 Cpn 912797JE8	(49,971,166.67)		0.00	0.00	(49,971,166.67)
02/16/24	02/16/24	Buy	50,000,000.000	U.S. TREASURY BILL MAT 02/20/24 Cpn 912797JE8	(49,971,166.67)		0.00	0.00	(49,971,166.67)
02/16/24	02/16/24	Buy	50,000,000.000	U.S. TREASURY BILL MAT 02/22/24 Cpn 912796Z28	(49,956,572.50)		0.00	0.00	(49,956,572.50)
02/20/24	02/20/24	Buy	9,000,000.000	AUTOMATIC DATA CP 144A MAT 02/21/24 Cpn 0530A2BM1	(8,998,675.00)		0.00	0.00	(8,998,675.00)
02/20/24	02/20/24	Buy	20,000,000.000	U.S. TREASURY BILL MAT 02/22/24 Cpn 912796Z28	(19,994,183.78)		0.00	0.00	(19,994,183.78)
02/20/24	02/20/24	Buy	45,000,000.000	CREDIT AGRICOLE CP MAT 02/21/24 Cpn 22533TBM7	(44,993,412.50)		0.00	0.00	(44,993,412.50)
02/20/24	02/20/24	Buy	35,000,000.000	CATERPILLAR CP 144A MAT 02/23/24 Cpn 14912PBP6	(34,984,541.67)		0.00	0.00	(34,984,541.67)
02/20/24	02/20/24	Buy	36,500,000.000	COLGATE-PALMOLIVE CP 144A MAT 02/21/24 Cpn 19416EBM8	(36,494,656.81)		0.00	0.00	(36,494,656.81)
02/20/24	02/20/24	Buy	40,000,000.000	NORDEA BANK CP 144A MAT 02/21/24 Cpn 65558JBM8	(39,994,122.22)		0.00	0.00	(39,994,122.22)
02/20/24	02/20/24	Buy	6,400,000.000	HYDRO-QUEBEC CP 144A MAT 02/26/24 Cpn 44881LBS3	(6,394,346.67)		0.00	0.00	(6,394,346.67)
02/20/24	02/20/24	Buy	10,000,000.000	TOTALENERGIES CAPITAL CP 144 MAT 02/21/24 Cpn 89152EBM9	(9,998,525.00)		0.00	0.00	(9,998,525.00)
02/20/24	02/20/24	Buy	30,000,000.000	UNITEDHEALTH GROUP CP 144A MAT 02/27/24 Cpn 91058TBT2	(29,968,966.67)		0.00	0.00	(29,968,966.67)

Account Name: L.A. CARE HEALTH PLAN

02/01/2024 through 02/29/2024

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/21/24	02/21/24	Buy	29,000,000.000	CREDIT AGRICOLE CP MAT 02/22/24 Cpn 22533TBN5	(28,995,754.72)		0.00	0.00	(28,995,754.72)
02/20/24	02/21/24	Buy	10,300,000.000	FHLB DISCOUNT NOTE MAT 01/24/25 Cpn 313385AZ9	(9,837,263.92)		0.00	0.00	(9,837,263.92)
02/21/24	02/21/24	Buy	45,000,000.000	NORDEA BANK CP 144A MAT 02/22/24 Cpn 65558JBN6	(44,993,387.50)		0.00	0.00	(44,993,387.50)
02/21/24	02/21/24	Buy	21,000,000.000	SOUTHERN CALIF GAS CP 144A MAT 03/05/24 Cpn 84243LC51	(20,959,505.00)		0.00	0.00	(20,959,505.00)
02/21/24	02/21/24	Buy	35,000,000.000	WAL-MART STORES CP 144A MAT 02/26/24 Cpn 93114EBS5	(34,974,381.94)		0.00	0.00	(34,974,381.94)
02/21/24	02/21/24	Buy	5,000,000.000	WAL-MART STORES CP 144A MAT 02/26/24 Cpn 93114EBS5	(4,996,340.28)		0.00	0.00	(4,996,340.28)
02/22/24	02/22/24	Buy	42,000,000.000	CREDIT AGRICOLE CP MAT 02/23/24 Cpn 22533TBP0	(41,993,851.67)		0.00	0.00	(41,993,851.67)
02/22/24	02/22/24	Buy	35,000,000.000	CANADIAN IMPERIAL BANK CP 144 MAT 02/29/24 Cpn 13608ABV7	(34,963,862.50)		0.00	0.00	(34,963,862.50)
02/22/24	02/22/24	Buy	34,000,000.000	FHLB DISCOUNT NOTE MAT 02/23/24 Cpn 313384TL3	(33,995,117.22)		0.00	0.00	(33,995,117.22)
02/22/24	02/22/24	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 02/23/24 Cpn 313384TL3	(49,992,819.44)		0.00	0.00	(49,992,819.44)
02/22/24	02/22/24	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 02/23/24 Cpn 313384TL3	(49,992,819.44)		0.00	0.00	(49,992,819.44)
02/22/24	02/22/24	Buy	27,000,000.000	FHLB DISCOUNT NOTE MAT 02/23/24 Cpn 313384TL3	(26,996,122.50)		0.00	0.00	(26,996,122.50)
02/22/24	02/22/24	Buy	42,000,000.000	NORDEA BANK CP 144A MAT 02/23/24 Cpn 65558JBP1	(41,993,828.33)		0.00	0.00	(41,993,828.33)

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/22/24	02/22/24	Buy	5,000,000.000	UNITEDHEALTH GROUP CP 144A MAT 02/29/24 Cpn 91058TBV7	(4,994,827.78)		0.00	0.00	(4,994,827.78)
02/23/24	02/23/24	Buy	40,000,000.000	COMPASS GROUP CP 144A MAT 02/26/24 Cpn 20453PBS2	(39,982,333.33)		0.00	0.00	(39,982,333.33)
02/23/24	02/23/24	Buy	5,000,000.000	EMERSON ELECTRIC CP 144A MAT 02/27/24 Cpn 29101ABT0	(4,997,061.11)		0.00	0.00	(4,997,061.11)
02/15/24	02/23/24	Buy	5,000,000.000	INTL BANK RECON & DEVELOP SO MAT 02/23/27 Cpn 5.61 459058LD3	(5,000,000.00)		0.00	0.00	(5,000,000.00)
02/26/24	02/26/24	Buy	40,000,000.000	AUTOMATIC DATA CP 144A MAT 02/27/24 Cpn 0530A2BT6	(39,994,100.00)		0.00	0.00	(39,994,100.00)
02/26/24	02/26/24	Buy	10,000,000.000	TOTALENERGIES CAPITAL CP 144 MAT 02/27/24 Cpn 89152EBT4	(9,998,525.00)		0.00	0.00	(9,998,525.00)
02/27/24	02/27/24	Buy	50,000,000.000	U.S. TREASURY BILL MAT 03/05/24 Cpn 912797JG3	(49,949,006.94)		0.00	0.00	(49,949,006.94)
02/27/24	02/27/24	Buy	50,000,000.000	U.S. TREASURY BILL MAT 03/05/24 Cpn 912797JG3	(49,949,006.94)		0.00	0.00	(49,949,006.94)
02/27/24	02/27/24	Buy	50,000,000.000	U.S. TREASURY BILL MAT 03/05/24 Cpn 912797JG3	(49,949,006.94)		0.00	0.00	(49,949,006.94)
02/27/24	02/27/24	Buy	50,000,000.000	U.S. TREASURY BILL MAT 03/05/24 Cpn 912797JG3	(49,949,006.94)		0.00	0.00	(49,949,006.94)
02/27/24	02/27/24	Buy	25,000,000.000	FHLB DISCOUNT NOTE MAT 02/28/24 Cpn 313384TR0	(24,996,409.72)		0.00	0.00	(24,996,409.72)
02/27/24	02/27/24	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 02/28/24 Cpn 313384TR0	(49,992,819.44)		0.00	0.00	(49,992,819.44)
02/27/24	02/27/24	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 02/28/24 Cpn 313384TR0	(49,992,819.44)		0.00	0.00	(49,992,819.44)

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02/27/24	02/27/24	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 02/28/24 Cpn	313384TR0	(49,992,819.44)		0.00	0.00	(49,992,819.44)
02/27/24	02/27/24	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 02/28/24 Cpn	313384TR0	(49,992,819.44)		0.00	0.00	(49,992,819.44)
02/27/24	02/27/24	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 02/28/24 Cpn	313384TR0	(49,992,819.44)		0.00	0.00	(49,992,819.44)
02/27/24	02/27/24	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 02/28/24 Cpn	313384TR0	(49,992,819.44)		0.00	0.00	(49,992,819.44)
02/27/24	02/27/24	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 02/28/24 Cpn	313384TR0	(49,992,819.44)		0.00	0.00	(49,992,819.44)
02/27/24	02/27/24	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 02/28/24 Cpn	313384TR0	(49,992,819.44)		0.00	0.00	(49,992,819.44)
02/27/24	02/27/24	Buy	32,000,000.000	TVA DISCOUNT NOTE MAT 02/29/24 Cpn	880592TS9	(31,990,613.33)		0.00	0.00	(31,990,613.33)
02/27/24	02/27/24	Buy	50,000,000.000	TVA DISCOUNT NOTE MAT 02/29/24 Cpn	880592TS9	(49,985,333.33)		0.00	0.00	(49,985,333.33)
02/27/24	02/28/24	Buy	50,000,000.000	U.S. TREASURY BILL MAT 03/12/24 Cpn	912797JH1	(49,904,892.36)		0.00	0.00	(49,904,892.36)
02/27/24	02/28/24	Buy	50,000,000.000	U.S. TREASURY BILL MAT 03/12/24 Cpn	912797JH1	(49,904,892.36)		0.00	0.00	(49,904,892.36)
02/27/24	02/28/24	Buy	50,000,000.000	U.S. TREASURY BILL MAT 03/12/24 Cpn	912797JH1	(49,904,892.36)		0.00	0.00	(49,904,892.36)
02/27/24	02/28/24	Buy	50,000,000.000	U.S. TREASURY BILL MAT 03/12/24 Cpn	912797JH1	(49,904,892.36)		0.00	0.00	(49,904,892.36)
02/28/24	02/28/24	Buy	20,000,000.000	CREDIT AGRICOLE CP MAT 02/29/24 Cpn	22533TBV7	(19,997,072.22)		0.00	0.00	(19,997,072.22)

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02/27/24	02/28/24	Buy	35,000,000.000	CREDIT AGRICOLE CP MAT 03/05/24 Cpn 22533TC53	(34,969,141.67)		0.00	0.00	(34,969,141.67)
02/28/24	02/28/24	Buy	15,000,000.000	FFCB DISCOUNT NOTE MAT 03/04/24 Cpn 313312TW0	(14,989,208.33)		0.00	0.00	(14,989,208.33)
02/28/24	02/28/24	Buy	50,000,000.000	FFCB DISCOUNT NOTE MAT 03/04/24 Cpn 313312TW0	(49,964,027.78)		0.00	0.00	(49,964,027.78)
02/28/24	02/28/24	Buy	50,000,000.000	FFCB DISCOUNT NOTE MAT 03/04/24 Cpn 313312TW0	(49,964,027.78)		0.00	0.00	(49,964,027.78)
02/27/24	02/28/24	Buy	45,000,000.000	USAA CAPITAL CP MAT 03/06/24 Cpn 90328AC68	(44,953,537.50)		0.00	0.00	(44,953,537.50)
02/27/24	02/29/24	Buy	4,000,000.000	CARMX 2022-3 A3 CAR MAT 04/15/27 Cpn 3.97 14318MAD1	(3,941,875.00)	(6,175.56)	0.00	0.00	(3,948,050.56)
02/28/24	02/29/24	Buy	25,000,000.000	EMERSON ELECTRIC CP 144A MAT 03/12/24 Cpn 29101ACC6	(24,955,833.33)		0.00	0.00	(24,955,833.33)
02/29/24	02/29/24	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 03/01/24 Cpn 313384TT6	(49,992,847.22)		0.00	0.00	(49,992,847.22)
02/29/24	02/29/24	Buy	13,000,000.000	FHLB DISCOUNT NOTE MAT 03/01/24 Cpn 313384TT6	(12,998,140.28)		0.00	0.00	(12,998,140.28)
02/29/24	02/29/24	Buy	2,000,000.000	FLORIDA POWER & LIGHT CP MAT 03/06/24 Cpn 34108AC62	(1,998,226.67)		0.00	0.00	(1,998,226.67)
02/27/24	02/29/24	Buy	5,000,000.000	GALC 2022-1 A3 EQP 144A MAT 09/15/26 Cpn 5.08 39154TBW7	(4,979,296.88)	(9,877.78)	0.00	0.00	(4,989,174.66)

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
Fixed Income - cont.									
02/28/24	02/29/24	Buy	45,000,000.000	WAL-MART STORES CP 144A MAT 03/04/24 Cpn 93114EC47	(44,973,650.00)		0.00	0.00	(44,973,650.00)
			4,114,200,000.000		(4,097,064,946.05)	(16,053.34)	0.00	0.00	(4,097,080,999.39)
02/01/24	02/01/24	Coupon		FHLMC C 8/1/23 Q MAT 08/01/24 Cpn 5.05 3134GYFM9		126,250.00	0.00	0.00	126,250.00
02/07/24	02/07/24	Coupon		CCCIT 2023-A2 A2 CARD MAT 12/08/27 Cpn 5.94 17305EGX7		23,969.39	0.00	0.00	23,969.39
02/12/24	02/12/24	Coupon		INTER-AMERICAN DEV BANK FRN MAT 02/10/26 Cpn 5.54 4581X0DT2		140,253.75	0.00	0.00	140,253.75
02/12/24	02/12/24	Coupon		INTER-AMERICAN DEV BANK FRN MAT 02/10/26 Cpn 5.54 4581X0DT2		70,126.88	0.00	0.00	70,126.88
02/13/24	02/13/24	Coupon		MMAF 2023-A A1 EQP 144A MAT 08/09/24 Cpn 5.71 55317WAA9		3,271.04	0.00	0.00	3,271.04
02/13/24	02/13/24	Coupon		MMAF 2024-A A2 EQP 144A MAT 09/13/27 Cpn 5.20 55318CAB0		6,586.67	0.00	0.00	6,586.67
02/14/24	02/14/24	Coupon		CCG 2023-2 A1 EQP 144A MAT 11/14/24 Cpn 5.75 12511QAA7		19,083.96	0.00	0.00	19,083.96
02/15/24	02/15/24	Coupon		ALLYA 2022-2 A2 CAR MAT 10/15/25 Cpn 4.62 02008MAB5		3,842.86	0.00	0.00	3,842.86
02/15/24	02/15/24	Coupon		ARIFL 2023-B A1 FLEET 144A MAT 10/15/24 Cpn 5.92 04033GAA5		12,569.86	0.00	0.00	12,569.86
02/15/24	02/15/24	Coupon		BAAT 2023-1A A2 CAR 144A MAT 05/15/26 Cpn 5.83 06428AAB4		23,027.52	0.00	0.00	23,027.52

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02/15/24	02/15/24	Coupon		CARMX 2020-1 A4 CAR MAT 06/16/25 Cpn 2.03 14315XAD0		9,742.94	0.00	0.00	9,742.94
02/15/24	02/15/24	Coupon		CARMX 2020-3 A4 CAR MAT 03/16/26 Cpn 0.77 14315FAE7		2,156.47	0.00	0.00	2,156.47
02/15/24	02/15/24	Coupon		CARMX 2020-4 A3 CAR MAT 08/15/25 Cpn 0.50 14316HAC6		1,603.13	0.00	0.00	1,603.13
02/15/24	02/15/24	Coupon		CARMX 2020-4 A3 CAR MAT 08/15/25 Cpn 0.50 14316HAC6		143.14	0.00	0.00	143.14
02/15/24	02/15/24	Coupon		CARMX 2021-3 A3 CAR MAT 06/15/26 Cpn 0.55 14317DAC4		1,866.15	0.00	0.00	1,866.15
02/15/24	02/15/24	Coupon		CARMX 2023-3 A1 CAR MAT 07/15/24 Cpn 5.63 14319BAA0		2,849.37	0.00	0.00	2,849.37
02/15/24	02/15/24	Coupon		CARMX 2023-4 A1 CAR MAT 10/15/24 Cpn 5.73 14318XAA3		20,639.43	0.00	0.00	20,639.43
02/15/24	02/15/24	Coupon		CARMX 2024-A2A CAR MAT 03/15/27 Cpn 5.30 14318WAB3		3,710.00	0.00	0.00	3,710.00
02/15/24	02/15/24	Coupon		FORDL 2022-A A3 LEASE MAT 05/15/25 Cpn 3.23 34528LAD7		3,741.60	0.00	0.00	3,741.60
02/15/24	02/15/24	Coupon		FORDL 2023-B A1 LEASE MAT 10/15/24 Cpn 5.69 34529NAA8		12,788.55	0.00	0.00	12,788.55
02/15/24	02/15/24	Coupon		FORDO 2020-C A3 MAT 07/15/25 Cpn 0.41 34533YAD2		607.95	0.00	0.00	607.95
02/15/24	02/15/24	Coupon		GALC 2023-1 A1 EQP 144A MAT 06/14/24 Cpn 5.52 39154TCA4		1,458.48	0.00	0.00	1,458.48
02/15/24	02/15/24	Coupon		GALC 2024-1 A2 EQP 144A MAT 08/17/26 Cpn 5.32 39154TCH9		5,172.22	0.00	0.00	5,172.22

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02/15/24	02/15/24	Coupon		GSAR 2023-2A A1 CAR 144A MAT 10/15/24 Cpn 5.86 36269EAA7		3,872.26	0.00	0.00	3,872.26
02/15/24	02/15/24	Coupon		HALST 2024-A A2A LEASE 144A MAT 06/15/26 Cpn 5.15 448988AB1		6,008.33	0.00	0.00	6,008.33
02/15/24	02/15/24	Coupon		HAROT 2023-2 A2 CAR MAT 04/15/26 Cpn 5.41 437927AB2		27,760.97	0.00	0.00	27,760.97
02/15/24	02/15/24	Coupon		HART 2021-C A3 CAR MAT 05/15/26 Cpn 0.74 44935FAD6		1,886.49	0.00	0.00	1,886.49
02/15/24	02/15/24	Coupon		HART 2023-A A2A CAR MAT 12/15/25 Cpn 5.19 448979AB0		3,167.27	0.00	0.00	3,167.27
02/15/24	02/15/24	Coupon		HART 2023-B A2A CAR MAT 05/15/26 Cpn 5.77 44933XAB3		16,348.33	0.00	0.00	16,348.33
02/15/24	02/15/24	Coupon		HART 2023-C A1 CAR MAT 11/15/24 Cpn 5.63 44918CAA0		11,288.26	0.00	0.00	11,288.26
02/15/24	02/15/24	Coupon		HART 2023-C A2A CAR MAT 01/15/27 Cpn 5.80 44918CAB8		9,666.67	0.00	0.00	9,666.67
02/15/24	02/15/24	Coupon		JOHN DEERE 2020-B A4 EQP MAT 06/15/27 Cpn 0.72 47787NAD1		1,609.34	0.00	0.00	1,609.34
02/15/24	02/15/24	Coupon		JOHN DEERE 2021-A A3 EQP MAT 09/15/25 Cpn 0.36 47788UAC6		934.40	0.00	0.00	934.40
02/15/24	02/15/24	Coupon		KCOT 2023-2A A1 EQP 144A MAT 07/15/24 Cpn 5.62 500945AA8		2,289.44	0.00	0.00	2,289.44
02/15/24	02/15/24	Coupon		NALT 2022-A A3 LEASE MAT 05/15/25 Cpn 3.81 65480LAD7		21,689.76	0.00	0.00	21,689.76
02/15/24	02/15/24	Coupon		NAROT 2020-B A4 CAR MAT 02/16/27 Cpn 0.71 65479CAE8		1,610.89	0.00	0.00	1,610.89

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02/15/24	02/15/24	Coupon		TAOT 2022-C A2A CAR MAT 08/15/25 Cpn 3.83 89231CAB3		5,531.30	0.00	0.00	5,531.30
02/15/24	02/15/24	Coupon		TAOT 2023-D A2A CAR MAT 11/16/26 Cpn 5.80 89239FAB8		18,850.00	0.00	0.00	18,850.00
02/15/24	02/15/24	Coupon		WORLD OMNI 2020-C A4 CAR MAT 10/15/26 Cpn 0.61 98163CAF7		2,541.67	0.00	0.00	2,541.67
02/15/24	02/15/24	Coupon		WOART 2022-B A2A CAR MAT 10/15/25 Cpn 2.77 98163QAB5		1,670.24	0.00	0.00	1,670.24
02/15/24	02/15/24	Coupon		WOART 2023-A A2A CAR MAT 07/15/26 Cpn 5.18 98164JAB0		15,176.16	0.00	0.00	15,176.16
02/15/24	02/15/24	Coupon		WOART 2023-C A1 CAR MAT 08/15/24 Cpn 5.61 98164FAA0		5,100.79	0.00	0.00	5,100.79
02/16/24	02/16/24	Coupon		GMCAR 2021-4 A3 CAR MAT 09/16/26 Cpn 0.68 362554AC1		1,912.73	0.00	0.00	1,912.73
02/16/24	02/16/24	Coupon		GMCAR 2023-2 A2A CAR MAT 05/18/26 Cpn 5.10 362583AB2		3,187.40	0.00	0.00	3,187.40
02/16/24	02/16/24	Coupon		GMCAR 2023-2 A2A CAR MAT 05/18/26 Cpn 5.10 362583AB2		1,004.03	0.00	0.00	1,004.03
02/16/24	02/16/24	Coupon		GMCAR 2023-3 A2A CAR MAT 09/16/26 Cpn 5.74 36267KAB3		12,939.33	0.00	0.00	12,939.33
02/16/24	02/16/24	Coupon		GMCAR 2024-1 A2B CAR MAT 02/16/27 Cpn 5.72 36268GAC9		6,224.83	0.00	0.00	6,224.83
02/20/24	02/20/24	Coupon		DLLMT 2023-1A A1 EQP 144A MAT 05/20/24 Cpn 5.53 232989AA1		2,312.71	0.00	0.00	2,312.71
02/20/24	02/20/24	Coupon		DLLST 2024-1A A2 EQP 144A MAT 01/20/26 Cpn 5.33 23346HAB3		2,961.11	0.00	0.00	2,961.11

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02/20/24	02/20/24	Coupon		ENTERPRISE 2021-1 A2 FLEET 144 MAT 12/21/26 Cpn 0.44 29374EAB2		365.15	0.00	0.00	365.15
02/20/24	02/20/24	Coupon		ENTERPRISE 2021-1 A2 FLEET 144 MAT 12/21/26 Cpn 0.44 29374EAB2		43.03	0.00	0.00	43.03
02/20/24	02/20/24	Coupon		EFF 2023-2 A1 FLEET 144A MAT 06/20/24 Cpn 5.79 29375NAA3		3,009.19	0.00	0.00	3,009.19
02/20/24	02/20/24	Coupon		GMALT 2022-3 A3 LEASE MAT 09/22/25 Cpn 4.01 380130AD6		15,344.58	0.00	0.00	15,344.58
02/20/24	02/20/24	Coupon		GMALT 2023-1 A2A LEASE MAT 06/20/25 Cpn 5.27 362541AB0		6,124.78	0.00	0.00	6,124.78
02/20/24	02/20/24	Coupon		HONDA 2020-3 A4 CAR MAT 04/19/27 Cpn 0.46 43813KAD4		1,642.25	0.00	0.00	1,642.25
02/20/24	02/20/24	Coupon		HPEFS 2023-2A A1 EQP 144A MAT 10/18/24 Cpn 5.76 44328UAA4		24,746.06	0.00	0.00	24,746.06
02/20/24	02/20/24	Coupon		SBALT 2024-A A2 LEASE 144A MAT 01/20/26 Cpn 5.45 78414SAC8		13,927.78	0.00	0.00	13,927.78
02/20/24	02/20/24	Coupon		SFAST 2024-1A A2 CAR 144A MAT 06/21/27 Cpn 5.35 78435VAB8		15,202.92	0.00	0.00	15,202.92
02/20/24	02/20/24	Coupon		SWEDBANK NY YCD FRN SOFRRA MAT 04/12/24 Cpn 5.84 87019WNH4		53,563.89	0.00	0.00	53,563.89
02/20/24	02/20/24	Coupon		TESLA 2023-B A1 LEASE 144A MAT 09/20/24 Cpn 5.68 88167QAA4		7,404.23	0.00	0.00	7,404.23
02/20/24	02/20/24	Coupon		TEVT 2023-1 A2B CAR 144A MAT 12/21/26 Cpn 5.84 881943AC8		24,096.44	0.00	0.00	24,096.44
02/20/24	02/20/24	Coupon		TLOT 2022-A A3 LEASE 144A MAT 02/20/25 Cpn 1.96 89238LAC4		4,017.93	0.00	0.00	4,017.93

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/20/24	02/20/24	Coupon		TLOT 2022-A A3 LEASE 144A MAT 02/20/25 Cpn 1.96 89238LAC4		321.43	0.00	0.00	321.43
02/20/24	02/20/24	Coupon		VALET 2023-1 A2A CAR MAT 12/21/26 Cpn 5.50 92867WAB4		6,808.05	0.00	0.00	6,808.05
02/20/24	02/20/24	Coupon		VZMT 2024-1 A1B PHONE MAT 12/20/28 Cpn 5.97 92348KCM3		10,444.20	0.00	0.00	10,444.20
02/22/24	02/22/24	Coupon		DEFT 2023-2 A1 EQP 144A MAT 06/24/24 Cpn 5.64 24703GAA2		2,966.08	0.00	0.00	2,966.08
02/25/24	02/25/24	Coupon		BMWLT 2022-1 A3 LEASE MAT 03/25/25 Cpn 1.10 05601XAC3		1,052.70	0.00	0.00	1,052.70
02/25/24	02/25/24	Coupon		BMWOT 2023-A A2A CAR MAT 04/27/26 Cpn 5.72 05592XAB6		23,833.33	0.00	0.00	23,833.33
02/25/24	02/25/24	Coupon		FHMS KF38 A MAT 09/25/24 Cpn 5.78 3137FBUC8		1,115.97	0.00	0.00	1,115.97
02/25/24	02/25/24	Coupon		FHMS KI06 A 1MOFRN CMBS MAT 03/25/25 Cpn 5.67 3137FVNA6		496.67	0.00	0.00	496.67
02/25/24	02/25/24	Coupon		FHMS KI07 A SOFRFRN MAT 09/25/26 Cpn 5.50 3137H3KA9		33,000.18	0.00	0.00	33,000.18
02/25/24	02/25/24	Coupon		FHMS KI08 A 1MOFRN CMBS MAT 10/25/26 Cpn 5.53 3137H4RC6		10,916.42	0.00	0.00	10,916.42
02/28/24	02/28/24	Coupon		FHLB C 8/28/24 Q MAT 08/28/25 Cpn 5.55 3130AWYQ		124,875.00	0.00	0.00	124,875.00
02/28/24	02/28/24	Coupon		FHLMC C 8/28/24 Q MAT 08/28/25 Cpn 5.57 3134H1AZ6		139,250.00	0.00	0.00	139,250.00
02/28/24	02/28/24	Coupon		FHLMC C 2/28/24 Q MAT 08/28/25 Cpn 5.75 3134H1BG7		284,305.56	0.00	0.00	284,305.56

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/29/24	02/29/24	Coupon		CANADIAN IMPERIAL BANK YCD FR MAT 07/29/24 Cpn 5.97 13606KYN0		44,722.83	0.00	0.00	44,722.83
						1,536,602.72	0.00	0.00	1,536,602.72
02/01/24	02/01/24	Income	(8,134.590)	ADJ NET INT MAT Cpn USD		(8,134.59)	0.00	0.00	(8,134.59)
02/01/24	02/01/24	Income	580,284.880	stif int MAT Cpn USD		580,284.88	0.00	0.00	580,284.88
			572,150.290			572,150.29	0.00	0.00	572,150.29
02/15/24	02/15/24	Contributn	685,000,000.000	NM MAT Cpn USD	685,000,000.00		0.00	0.00	685,000,000.00
02/27/24	02/27/24	Contributn	680,000,000.000	NM MAT Cpn USD	680,000,000.00		0.00	0.00	680,000,000.00
			1,365,000,000.000		1,365,000,000.00		0.00	0.00	1,365,000,000.00
02/14/24	02/14/24	Sell Long	35,000,000.000	U.S. TREASURY BILL MAT 02/15/24 Cpn 912797GN1	34,784,487.50	210,466.67	87.50	0.00	34,994,954.17
02/18/24	02/18/24	Call	15,000,000.000	FHLMC C 8/18/23 Q MAT 06/14/24 Cpn 5.45 3134GYSH6	15,000,000.00	204,375.00	0.00	0.00	15,204,375.00
02/28/24	02/28/24	Call	10,000,000.000	FHLMC C 2/28/24 Q MAT 08/28/25 Cpn 5.75 3134H1BG7	10,000,000.00		0.00	0.00	10,000,000.00
			60,000,000.000		59,784,487.50	414,841.67	87.50	0.00	60,199,329.17

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/13/24	02/13/24	Pay Princpl	736,149.248	MMAF 2023-A A1 EQP 144A MAT 08/09/24 Cpn 5.71 55317WAA9	736,149.25		0.00	0.00	736,149.25
02/14/24	02/14/24	Pay Princpl	611,360.496	CCG 2023-2 A1 EQP 144A MAT 11/14/24 Cpn 5.75 12511QAA7	611,360.50		0.00	0.00	611,360.50
02/15/24	02/15/24	Pay Princpl	256,515.914	ALLYA 2022-2 A2 CAR MAT 10/15/25 Cpn 4.62 02008MAB5	256,515.91		0.00	4.79	256,515.91
02/15/24	02/15/24	Pay Princpl	385,312.339	ARIFL 2023-B A1 FLEET 144A MAT 10/15/24 Cpn 5.92 04033GAA5	385,312.34		0.00	0.00	385,312.34
02/15/24	02/15/24	Pay Princpl	416,185.835	BAAT 2023-1A A2 CAR 144A MAT 05/15/26 Cpn 5.83 06428AAB4	416,185.84		11.56	0.00	416,185.84
02/15/24	02/15/24	Pay Princpl	1,088,272.514	CARMX 2020-1 A4 CAR MAT 06/16/25 Cpn 2.03 14315XAD0	1,088,272.51		3,898.14	0.00	1,088,272.51
02/15/24	02/15/24	Pay Princpl	544,687.192	CARMX 2020-3 A4 CAR MAT 03/16/26 Cpn 0.77 14315FAE7	544,687.19		7,219.19	0.00	544,687.19
02/15/24	02/15/24	Pay Princpl	1,009,479.775	CARMX 2020-4 A3 CAR MAT 08/15/25 Cpn 0.50 14316HAC6	1,009,479.78		8,574.27	0.00	1,009,479.78
02/15/24	02/15/24	Pay Princpl	90,132.123	CARMX 2020-4 A3 CAR MAT 08/15/25 Cpn 0.50 14316HAC6	90,132.12		712.15	0.00	90,132.12
02/15/24	02/15/24	Pay Princpl	303,791.776	CARMX 2021-3 A3 CAR MAT 06/15/26 Cpn 0.55 14317DAC4	303,791.78		7,975.27	0.00	303,791.78
02/15/24	02/15/24	Pay Princpl	569,418.075	CARMX 2023-3 A1 CAR MAT 07/15/24 Cpn 5.63 14319BAA0	569,418.08		0.00	0.00	569,418.08
02/15/24	02/15/24	Pay Princpl	1,414,532.840	CARMX 2023-4 A1 CAR MAT 10/15/24 Cpn 5.73 14318XAA3	1,414,532.84		0.00	0.00	1,414,532.84
02/15/24	02/15/24	Pay Princpl	414,458.692	FORDL 2022-A A3 LEASE MAT 05/15/25 Cpn 3.23 34528LAD7	414,458.69		2,621.40	0.00	414,458.69

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02/15/24	02/15/24	Pay Princpl	1,219,966.997	FORDL 2023-B A1 LEASE MAT 10/15/24 Cpn 5.69 34529NAA8	1,219,967.00		0.00	0.00	1,219,967.00
02/15/24	02/15/24	Pay Princpl	489,855.946	FORDO 2020-C A3 MAT 07/15/25 Cpn 0.41 34533YAD2	489,855.95		4,127.53	0.00	489,855.95
02/15/24	02/15/24	Pay Princpl	317,117.557	GALC 2023-1 A1 EQP 144A MAT 06/14/24 Cpn 5.52 39154TCA4	317,117.56		0.00	0.00	317,117.56
02/15/24	02/15/24	Pay Princpl	793,360.655	GSAR 2023-2A A1 CAR 144A MAT 10/15/24 Cpn 5.86 36269EAA7	793,360.66		0.00	0.00	793,360.66
02/15/24	02/15/24	Pay Princpl	458,390.626	HAROT 2023-2 A2 CAR MAT 04/15/26 Cpn 5.41 437927AB2	458,390.63		17.87	0.00	458,390.63
02/15/24	02/15/24	Pay Princpl	258,329.731	HART 2021-C A3 CAR MAT 05/15/26 Cpn 0.74 44935FAD6	258,329.73		6,789.88	0.00	258,329.73
02/15/24	02/15/24	Pay Princpl	73,988.665	HART 2023-A A2A CAR MAT 12/15/25 Cpn 5.19 448979AB0	73,988.67		206.63	0.00	73,988.67
02/15/24	02/15/24	Pay Princpl	180,556.687	HART 2023-B A2A CAR MAT 05/15/26 Cpn 5.77 44933XAB3	180,556.69		2.48	0.00	180,556.69
02/15/24	02/15/24	Pay Princpl	653,934.393	HART 2023-C A1 CAR MAT 11/15/24 Cpn 5.63 44918CAA0	653,934.39		(0.00)	0.00	653,934.39
02/15/24	02/15/24	Pay Princpl	2,682,234.923	JOHN DEERE 2020-B A4 EQP MAT 06/15/27 Cpn 0.72 47787NAD1	2,682,234.92		11,135.11	0.00	2,682,234.92
02/15/24	02/15/24	Pay Princpl	464,333.334	JOHN DEERE 2021-A A3 EQP MAT 09/15/25 Cpn 0.36 47788UAC6	464,333.33		7,952.31	0.00	464,333.33
02/15/24	02/15/24	Pay Princpl	345,851.978	KCOT 2023-2A A1 EQP 144A MAT 07/15/24 Cpn 5.62 500945AA8	345,851.98		0.00	0.00	345,851.98
02/15/24	02/15/24	Pay Princpl	1,381,968.289	NALT 2022-A A3 LEASE MAT 05/15/25 Cpn 3.81 65480LAD7	1,381,968.29		5,771.88	0.00	1,381,968.29

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02/15/24	02/15/24	Pay Princpl	758,674.130	NAROT 2020-B A4 CAR MAT 02/16/27 Cpn 0.71 65479CAE8	758,674.13		4,318.35	0.00	758,674.13
02/15/24	02/15/24	Pay Princpl	311,180.653	TAOT 2022-C A2A CAR MAT 08/15/25 Cpn 3.83 89231CAB3	311,180.65		0.00	6.34	311,180.65
02/15/24	02/15/24	Pay Princpl	219,116.742	WOART 2022-B A2A CAR MAT 10/15/25 Cpn 2.77 98163QAB5	219,116.74		0.00	3.86	219,116.74
02/15/24	02/15/24	Pay Princpl	368,460.115	WOART 2023-A A2A CAR MAT 07/15/26 Cpn 5.18 98164JAB0	368,460.12		0.00	1.57	368,460.12
02/15/24	02/15/24	Pay Princpl	940,126.955	WOART 2023-C A1 CAR MAT 08/15/24 Cpn 5.61 98164FAA0	940,126.95		(0.00)	0.00	940,126.95
02/16/24	02/16/24	Pay Princpl	226,658.082	GMCAR 2021-4 A3 CAR MAT 09/16/26 Cpn 0.68 362554AC1	226,658.08		7,368.26	0.00	226,658.08
02/16/24	02/16/24	Pay Princpl	64,757.994	GMCAR 2023-2 A2A CAR MAT 05/18/26 Cpn 5.10 362583AB2	64,757.99		244.29	0.00	64,757.99
02/16/24	02/16/24	Pay Princpl	20,398.768	GMCAR 2023-2 A2A CAR MAT 05/18/26 Cpn 5.10 362583AB2	20,398.77		75.84	0.00	20,398.77
02/16/24	02/16/24	Pay Princpl	188,010.572	GMCAR 2023-3 A2A CAR MAT 09/16/26 Cpn 5.74 36267KAB3	188,010.57		2.41	0.00	188,010.57
02/20/24	02/20/24	Pay Princpl	518,876.984	DLLMT 2023-1A A1 EQP 144A MAT 05/20/24 Cpn 5.53 232989AA1	518,876.98		(0.00)	0.00	518,876.98
02/20/24	02/20/24	Pay Princpl	274,148.196	ENTERPRISE 2021-1 A2 FLEET 144 MAT 12/21/26 Cpn 0.44 29374EAB2	274,148.20		2,607.64	0.00	274,148.20
02/20/24	02/20/24	Pay Princpl	32,304.554	ENTERPRISE 2021-1 A2 FLEET 144 MAT 12/21/26 Cpn 0.44 29374EAB2	32,304.55		307.27	0.00	32,304.55
02/20/24	02/20/24	Pay Princpl	513,759.452	EFF 2023-2 A1 FLEET 144A MAT 06/20/24 Cpn 5.79 29375NAA3	513,759.45		(0.00)	0.00	513,759.45

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02/20/24	02/20/24	Pay Princpl	540,588.449	GMALT 2022-3 A3 LEASE MAT 09/22/25 Cpn 4.01 380130AD6	540,588.45		4,270.25	0.00	540,588.45
02/20/24	02/20/24	Pay Princpl	221,865.614	GMALT 2023-1 A2A LEASE MAT 06/20/25 Cpn 5.27 362541AB0	221,865.61		0.00	7.72	221,865.61
02/20/24	02/20/24	Pay Princpl	4,016,372.603	HONDA 2020-3 A4 CAR MAT 04/19/27 Cpn 0.46 43813KAD4	4,016,372.60		10,047.24	0.00	4,016,372.60
02/20/24	02/20/24	Pay Princpl	1,468,808.501	HPEFS 2023-2A A1 EQP 144A MAT 10/18/24 Cpn 5.76 44328UAA4	1,468,808.50		(0.00)	0.00	1,468,808.50
02/20/24	02/20/24	Pay Princpl	1,369,920.394	TESLA 2023-B A1 LEASE 144A MAT 09/20/24 Cpn 5.68 88167QAA4	1,369,920.39		(0.00)	0.00	1,369,920.39
02/20/24	02/20/24	Pay Princpl	625,290.038	TLOT 2022-A A3 LEASE 144A MAT 02/20/25 Cpn 1.96 89238LAC4	625,290.04		4,959.63	0.00	625,290.04
02/20/24	02/20/24	Pay Princpl	50,023.203	TLOT 2022-A A3 LEASE 144A MAT 02/20/25 Cpn 1.96 89238LAC4	50,023.20		400.20	0.00	50,023.20
02/20/24	02/20/24	Pay Princpl	103,762.668	VALET 2023-1 A2A CAR MAT 12/21/26 Cpn 5.50 92867WAB4	103,762.67		3.44	0.00	103,762.67
02/22/24	02/22/24	Pay Princpl	427,982.862	DEFT 2023-2 A1 EQP 144A MAT 06/24/24 Cpn 5.64 24703GAA2	427,982.86		(0.00)	0.00	427,982.86
02/25/24	02/25/24	Pay Princpl	680,972.987	BMWLT 2022-1 A3 LEASE MAT 03/25/25 Cpn 1.10 05601XAC3	680,972.99		2,979.50	0.00	680,972.99
02/25/24	02/25/24	Pay Princpl	349,829.658	BMWOT 2023-A A2A CAR MAT 04/27/26 Cpn 5.72 05592XAB6	349,829.66		2.91	0.00	349,829.66

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Fixed Income - cont.									
02/25/24	02/25/24	Pay Princpl	114.969	FHMS KF38 A MAT 09/25/24 Cpn 5.78 3137FBUC8	114.97		0.00	0.02	114.97
			31,452,191.743		31,452,191.75		104,602.89	24.31	31,452,191.75
02/01/24	02/01/24	Mature Long	7,500,000.000	U.S. TREASURY BILL MAT 02/01/24 Cpn 912797GE1	7,300,463.54	199,536.46	(0.00)	0.00	7,500,000.00
02/01/24	02/01/24	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/01/24 Cpn 912797GE1	48,669,756.94	1,330,243.06	0.00	0.00	50,000,000.00
02/01/24	02/01/24	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/01/24 Cpn 912797GE1	48,669,756.94	1,330,243.06	0.00	0.00	50,000,000.00
02/01/24	02/01/24	Mature Long	12,500,000.000	U.S. TREASURY BILL MAT 02/01/24 Cpn 912797GE1	12,335,234.38	164,765.62	0.00	0.00	12,500,000.00
02/01/24	02/01/24	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/01/24 Cpn 912797GE1	49,340,937.50	659,062.50	0.00	0.00	50,000,000.00
02/02/24	02/02/24	Mature Long	20,000,000.000	FHLB DISCOUNT NOTE MAT 02/02/24 Cpn 313384SP5	19,997,083.33	2,916.67	0.00	0.00	20,000,000.00
02/02/24	02/02/24	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 02/02/24 Cpn 313384SP5	49,992,708.33	7,291.67	0.00	0.00	50,000,000.00
02/02/24	02/02/24	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 02/02/24 Cpn 313384SP5	49,992,708.33	7,291.67	0.00	0.00	50,000,000.00
02/02/24	02/02/24	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 02/02/24 Cpn 313384SP5	49,992,708.33	7,291.67	0.00	0.00	50,000,000.00
02/02/24	02/02/24	Mature Long	10,000,000.000	NOVARTIS FINANCE CP 144A MAT 02/02/24 Cpn 6698M4B27	9,983,805.56	16,194.44	0.00	0.00	10,000,000.00

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Tr Date	*St Date*	*Transaction Type*	*Units*	*Description*	*Proceeds / (Cost)*	*Accrued Interest (Purch) or Sold*	*G/L < 1 Yr Amort Cost*	*G/L > 1 Yr Amort Cost*	*Total Amount*
02/05/24	02/05/24	Mature Long	35,000,000.000	BRIGHTHOUSE FINANCIAL CP 144A MAT 02/05/24 Cpn 10924HB52	34,834,177.78	165,822.22	0.00	0.00	35,000,000.00
02/05/24	02/05/24	Mature Long	15,750,000.000	BMW US CAPITAL CP 144A MAT 02/05/24 Cpn 0556C2B51	15,687,157.50	62,842.50	0.00	0.00	15,750,000.00
02/05/24	02/05/24	Mature Long	35,000,000.000	METLIFE SHORT TERM FUND CP 1 MAT 02/05/24 Cpn 59157TB51	34,840,263.89	159,736.11	0.00	0.00	35,000,000.00
02/05/24	02/05/24	Mature Long	4,450,000.000	NOVARTIS FINANCE CP 144A MAT 02/05/24 Cpn 6698M4B50	4,428,956.44	21,043.56	0.00	0.00	4,450,000.00
02/05/24	02/05/24	Mature Long	22,000,000.000	NOVARTIS FINANCE CP 144A MAT 02/05/24 Cpn 6698M4B50	21,922,120.00	77,880.00	0.00	0.00	22,000,000.00
02/06/24	02/06/24	Mature Long	40,000,000.000	AUTOMATIC DATA CP 144A MAT 02/06/24 Cpn 0530A2B66	39,994,111.11	5,888.89	0.00	0.00	40,000,000.00
02/06/24	02/06/24	Mature Long	25,000,000.000	U.S. TREASURY BILL MAT 02/06/24 Cpn 912797JC2	24,565,596.88	434,403.12	0.00	0.00	25,000,000.00
02/06/24	02/06/24	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/06/24 Cpn 912797JC2	49,131,193.75	868,806.25	0.00	0.00	50,000,000.00
02/06/24	02/06/24	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/06/24 Cpn 912797JC2	49,589,683.33	410,316.67	0.00	0.00	50,000,000.00
02/06/24	02/06/24	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/06/24 Cpn 912797JC2	49,589,683.33	410,316.67	0.00	0.00	50,000,000.00
02/06/24	02/06/24	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/06/24 Cpn 912797JC2	49,589,683.33	410,316.67	0.00	0.00	50,000,000.00
02/06/24	02/06/24	Mature Long	15,000,000.000	FHLB DISCOUNT NOTE MAT 02/06/24 Cpn 313384ST7	14,997,812.50	2,187.50	0.00	0.00	15,000,000.00
02/07/24	02/07/24	Mature Long	40,000,000.000	AUTOMATIC DATA CP 144A MAT 02/07/24 Cpn 0530A2B74	39,994,122.22	5,877.78	0.00	0.00	40,000,000.00

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/07/24	02/07/24	Mature Long	30,000,000.000	CREDIT AGRICOLE CP MAT 02/07/24 Cpn 22533TB70	29,995,608.33	4,391.67	0.00	0.00	30,000,000.00
02/07/24	02/07/24	Mature Long	10,000,000.000	SUMITOMO MITSUI CP 144A MAT 02/07/24 Cpn 86563GB76	9,960,025.00	39,975.00	0.00	0.00	10,000,000.00
02/07/24	02/07/24	Mature Long	25,000,000.000	SUMITOMO MITSUI CP 144A MAT 02/07/24 Cpn 86563GB76	24,903,583.33	96,416.67	0.00	0.00	25,000,000.00
02/08/24	02/08/24	Mature Long	10,000,000.000	AIR PRODUCTS & CHEMICALS CP 1 MAT 02/08/24 Cpn 00915SB84	9,911,991.67	88,008.33	0.00	0.00	10,000,000.00
02/08/24	02/08/24	Mature Long	35,000,000.000	CATERPILLAR FIN CP MAT 02/08/24 Cpn 14912DB81	34,917,555.56	82,444.44	0.00	0.00	35,000,000.00
02/08/24	02/08/24	Mature Long	20,000,000.000	KENVUE CP 144A MAT 02/08/24 Cpn 49177FB82	19,911,666.67	88,333.33	0.00	0.00	20,000,000.00
02/08/24	02/08/24	Mature Long	35,000,000.000	MARS INC 144A MAT 02/08/24 Cpn 57167EB80	34,849,159.72	150,840.28	0.00	0.00	35,000,000.00
02/08/24	02/08/24	Mature Long	35,000,000.000	NATL SEC CLEARING CP 144A MAT 02/08/24 Cpn 63763PB81	34,818,972.22	181,027.78	0.00	0.00	35,000,000.00
02/08/24	02/08/24	Mature Long	22,735,000.000	SIEMENS CAPITAL CP 144A MAT 02/08/24 Cpn 82619TB89	22,634,587.08	100,412.92	0.00	0.00	22,735,000.00
02/09/24	02/09/24	Mature Long	27,500,000.000	CATERPILLAR CP 144A MAT 02/09/24 Cpn 14912PB92	27,495,951.39	4,048.61	0.00	0.00	27,500,000.00
02/09/24	02/09/24	Mature Long	35,000,000.000	FHLB DISCOUNT NOTE MAT 02/09/24 Cpn 313384SW0	34,994,915.28	5,084.72	0.00	0.00	35,000,000.00
02/09/24	02/09/24	Mature Long	12,600,000.000	KENVUE CP 144A MAT 02/09/24 Cpn 49177FB90	12,542,386.50	57,613.50	0.00	0.00	12,600,000.00
02/09/24	02/09/24	Mature Long	40,000,000.000	NESTLE CAPITAL CP 144A MAT 02/09/24 Cpn 64105GB94	39,994,133.33	5,866.67	0.00	0.00	40,000,000.00

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/12/24	02/12/24	Mature Long	15,000,000.000	FHLB DISCOUNT NOTE MAT 02/12/24 Cpn 313384SZ3	14,993,475.00	6,525.00	0.00	0.00	15,000,000.00
02/12/24	02/12/24	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 02/12/24 Cpn 313384SZ3	49,978,250.00	21,750.00	0.00	0.00	50,000,000.00
02/12/24	02/12/24	Mature Long	15,000,000.000	MITSUBISHI UFJ TRUST & BANK CP MAT 02/12/24 Cpn 60682WBC1	14,929,066.67	70,933.33	0.00	0.00	15,000,000.00
02/13/24	02/13/24	Mature Long	10,000,000.000	BAYERISCHE LANDESBANK CP MAT 02/13/24 Cpn 07274LBD8	9,813,333.33	186,666.67	0.00	0.00	10,000,000.00
02/13/24	02/13/24	Mature Long	30,000,000.000	NESTLE CAPITAL CP 144A MAT 02/13/24 Cpn 64105GBD5	29,995,600.00	4,400.00	0.00	0.00	30,000,000.00
02/14/24	02/14/24	Mature Long	40,000,000.000	FHLB DISCOUNT NOTE MAT 02/14/24 Cpn 313384TB5	39,994,194.44	5,805.56	0.00	0.00	40,000,000.00
02/15/24	02/15/24	Mature Long	15,000,000.000	U.S. TREASURY BILL MAT 02/15/24 Cpn 912797GN1	14,907,600.00	92,400.00	0.00	0.00	15,000,000.00
02/15/24	02/15/24	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/15/24 Cpn 912797GN1	49,692,000.00	308,000.00	0.00	0.00	50,000,000.00
02/15/24	02/15/24	Mature Long	25,000,000.000	CREDIT AGRICOLE CP MAT 02/15/24 Cpn 22533TBF2	24,974,284.72	25,715.28	0.00	0.00	25,000,000.00
02/15/24	02/15/24	Mature Long	15,000,000.000	EMERSON ELECTRIC CP 144A MAT 02/15/24 Cpn 29101ABF0	14,906,550.00	93,450.00	0.00	0.00	15,000,000.00
02/15/24	02/15/24	Mature Long	35,000,000.000	ELI LILLY & CO CP 144A MAT 02/15/24 Cpn 53245PBF4	34,876,100.00	123,900.00	0.00	0.00	35,000,000.00
02/16/24	02/16/24	Mature Long	30,000,000.000	FHLB DISCOUNT NOTE MAT 02/16/24 Cpn 313384TD1	29,995,700.00	4,300.00	0.00	0.00	30,000,000.00
02/16/24	02/16/24	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 02/16/24 Cpn 313384TD1	49,992,833.33	7,166.67	0.00	0.00	50,000,000.00

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/16/24	02/16/24	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 02/16/24 Cpn 313384TD1	49,992,833.33	7,166.67	0.00	0.00	50,000,000.00
02/20/24	02/20/24	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/20/24 Cpn 912797JE8	49,963,850.00	36,150.00	0.00	0.00	50,000,000.00
02/20/24	02/20/24	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/20/24 Cpn 912797JE8	49,963,850.00	36,150.00	0.00	0.00	50,000,000.00
02/20/24	02/20/24	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/20/24 Cpn 912797JE8	49,963,850.00	36,150.00	0.00	0.00	50,000,000.00
02/20/24	02/20/24	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/20/24 Cpn 912797JE8	49,971,166.67	28,833.33	0.00	0.00	50,000,000.00
02/20/24	02/20/24	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/20/24 Cpn 912797JE8	49,971,166.67	28,833.33	0.00	0.00	50,000,000.00
02/21/24	02/21/24	Mature Long	9,000,000.000	AUTOMATIC DATA CP 144A MAT 02/21/24 Cpn 0530A2BM1	8,998,675.00	1,325.00	0.00	0.00	9,000,000.00
02/21/24	02/21/24	Mature Long	45,000,000.000	CREDIT AGRICOLE CP MAT 02/21/24 Cpn 22533TBM7	44,993,412.50	6,587.50	0.00	0.00	45,000,000.00
02/21/24	02/21/24	Mature Long	36,500,000.000	COLGATE-PALMOLIVE CP 144A MAT 02/21/24 Cpn 19416EBM8	36,494,656.81	5,343.19	0.00	0.00	36,500,000.00
02/21/24	02/21/24	Mature Long	40,000,000.000	NORDEA BANK CP 144A MAT 02/21/24 Cpn 65558JBM8	39,994,122.22	5,877.78	0.00	0.00	40,000,000.00
02/21/24	02/21/24	Mature Long	10,000,000.000	TOTALENERGIES CAPITAL CP 144 MAT 02/21/24 Cpn 89152EBM9	9,998,525.00	1,475.00	0.00	0.00	10,000,000.00
02/22/24	02/22/24	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/22/24 Cpn 912796Z28	49,685,263.89	314,736.11	0.00	0.00	50,000,000.00
02/22/24	02/22/24	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/22/24 Cpn 912796Z28	49,685,263.89	314,736.11	0.00	0.00	50,000,000.00

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Tr Date	St Date	Transaction Type	Units	Description		Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/22/24	02/22/24	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/22/24 Cpn	912796Z28	49,685,263.89	314,736.11	0.00	0.00	50,000,000.00
02/22/24	02/22/24	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/22/24 Cpn	912796Z28	49,949,337.50	50,662.50	0.00	0.00	50,000,000.00
02/22/24	02/22/24	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/22/24 Cpn	912796Z28	49,949,337.50	50,662.50	0.00	0.00	50,000,000.00
02/22/24	02/22/24	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/22/24 Cpn	912796Z28	49,949,337.50	50,662.50	0.00	0.00	50,000,000.00
02/22/24	02/22/24	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/22/24 Cpn	912796Z28	49,956,572.50	43,427.50	0.00	0.00	50,000,000.00
02/22/24	02/22/24	Mature Long	20,000,000.000	U.S. TREASURY BILL MAT 02/22/24 Cpn	912796Z28	19,994,183.78	5,816.22	0.00	0.00	20,000,000.00
02/22/24	02/22/24	Mature Long	29,000,000.000	CREDIT AGRICOLE CP MAT 02/22/24 Cpn	22533TBN5	28,995,754.72	4,245.28	0.00	0.00	29,000,000.00
02/22/24	02/22/24	Mature Long	45,000,000.000	NORDEA BANK CP 144A MAT 02/22/24 Cpn	65558JBN6	44,993,387.50	6,612.50	0.00	0.00	45,000,000.00
02/23/24	02/23/24	Mature Long	42,000,000.000	CREDIT AGRICOLE CP MAT 02/23/24 Cpn	22533TBP0	41,993,851.67	6,148.33	0.00	0.00	42,000,000.00
02/23/24	02/23/24	Mature Long	35,000,000.000	CATERPILLAR CP 144A MAT 02/23/24 Cpn	14912PBP6	34,984,541.67	15,458.33	0.00	0.00	35,000,000.00
02/23/24	02/23/24	Mature Long	34,000,000.000	FHLB DISCOUNT NOTE MAT 02/23/24 Cpn	313384TL3	33,995,117.22	4,882.78	0.00	0.00	34,000,000.00
02/23/24	02/23/24	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 02/23/24 Cpn	313384TL3	49,992,819.44	7,180.56	0.00	0.00	50,000,000.00
02/23/24	02/23/24	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 02/23/24 Cpn	313384TL3	49,992,819.44	7,180.56	0.00	0.00	50,000,000.00

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/23/24	02/23/24	Mature Long	27,000,000.000	FHLB DISCOUNT NOTE MAT 02/23/24 Cpn 313384TL3	26,996,122.50	3,877.50	0.00	0.00	27,000,000.00
02/23/24	02/23/24	Mature Long	20,000,000.000	MITSUBISHI UFJ TRUST & BANK 14 MAT 02/23/24 Cpn 60682WBP2	19,908,377.78	91,622.22	0.00	0.00	20,000,000.00
02/23/24	02/23/24	Mature Long	42,000,000.000	NORDEA BANK CP 144A MAT 02/23/24 Cpn 65558JBP1	41,993,828.33	6,171.67	0.00	0.00	42,000,000.00
02/26/24	02/26/24	Mature Long	40,000,000.000	COMPASS GROUP CP 144A MAT 02/26/24 Cpn 20453PBS2	39,982,333.33	17,666.67	0.00	0.00	40,000,000.00
02/26/24	02/26/24	Mature Long	6,400,000.000	HYDRO-QUEBEC CP 144A MAT 02/26/24 Cpn 44881LBS3	6,394,346.67	5,653.33	0.00	0.00	6,400,000.00
02/26/24	02/26/24	Mature Long	35,000,000.000	WAL-MART STORES CP 144A MAT 02/26/24 Cpn 93114EBS5	34,974,381.94	25,618.06	0.00	0.00	35,000,000.00
02/26/24	02/26/24	Mature Long	5,000,000.000	WAL-MART STORES CP 144A MAT 02/26/24 Cpn 93114EBS5	4,996,340.28	3,659.72	0.00	0.00	5,000,000.00
02/27/24	02/27/24	Mature Long	40,000,000.000	AUTOMATIC DATA CP 144A MAT 02/27/24 Cpn 0530A2BT6	39,994,100.00	5,900.00	0.00	0.00	40,000,000.00
02/27/24	02/27/24	Mature Long	5,000,000.000	EMERSON ELECTRIC CP 144A MAT 02/27/24 Cpn 29101ABT0	4,997,061.11	2,938.89	0.00	0.00	5,000,000.00
02/27/24	02/27/24	Mature Long	10,000,000.000	TOTALENERGIES CAPITAL CP 144 MAT 02/27/24 Cpn 89152EBT4	9,998,525.00	1,475.00	0.00	0.00	10,000,000.00
02/27/24	02/27/24	Mature Long	30,000,000.000	UNITEDHEALTH GROUP CP 144A MAT 02/27/24 Cpn 91058TBT2	29,968,966.67	31,033.33	0.00	0.00	30,000,000.00
02/28/24	02/28/24	Mature Long	25,000,000.000	FHLB DISCOUNT NOTE MAT 02/28/24 Cpn 313384TR0	24,996,409.72	3,590.28	0.00	0.00	25,000,000.00
02/28/24	02/28/24	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 02/28/24 Cpn 313384TR0	49,992,819.44	7,180.56	0.00	0.00	50,000,000.00

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/28/24	02/28/24	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 02/28/24 Cpn 313384TR0	49,992,819.44	7,180.56	0.00	0.00	50,000,000.00
02/28/24	02/28/24	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 02/28/24 Cpn 313384TR0	49,992,819.44	7,180.56	0.00	0.00	50,000,000.00
02/28/24	02/28/24	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 02/28/24 Cpn 313384TR0	49,992,819.44	7,180.56	0.00	0.00	50,000,000.00
02/28/24	02/28/24	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 02/28/24 Cpn 313384TR0	49,992,819.44	7,180.56	0.00	0.00	50,000,000.00
02/28/24	02/28/24	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 02/28/24 Cpn 313384TR0	49,992,819.44	7,180.56	0.00	0.00	50,000,000.00
02/28/24	02/28/24	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 02/28/24 Cpn 313384TR0	49,992,819.44	7,180.56	0.00	0.00	50,000,000.00
02/28/24	02/28/24	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 02/28/24 Cpn 313384TR0	49,992,819.44	7,180.56	0.00	0.00	50,000,000.00
02/29/24	02/29/24	Mature Long	20,000,000.000	CREDIT AGRICOLE CP MAT 02/29/24 Cpn 22533TBV7	19,997,072.22	2,927.78	0.00	0.00	20,000,000.00
02/29/24	02/29/24	Mature Long	35,000,000.000	CANADIAN IMPERIAL BANK CP 144 MAT 02/29/24 Cpn 13608ABV7	34,963,862.50	36,137.50	0.00	0.00	35,000,000.00
02/29/24	02/29/24	Mature Long	32,000,000.000	TVA DISCOUNT NOTE MAT 02/29/24 Cpn 880592TS9	31,990,613.33	9,386.67	0.00	0.00	32,000,000.00
02/29/24	02/29/24	Mature Long	50,000,000.000	TVA DISCOUNT NOTE MAT 02/29/24 Cpn 880592TS9	49,985,333.33	14,666.67	0.00	0.00	50,000,000.00

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
Fixed Income - cont.									
02/29/24	02/29/24	Mature Long	5,000,000.000	UNITEDHEALTH GROUP CP 144A MAT 02/29/24 Cpn 91058TBV7	4,994,827.78	5,172.22	0.00	0.00	5,000,000.00
			3,422,935,000.000		3,412,603,267.13	10,331,732.88	(0.00)	0.00	3,422,935,000.00
02/01/24	02/01/24	Withdrawal	(160,000,000.000)	WD MAT Cpn USD	(160,000,000.00)		(160,000,000.00)	0.00	(160,000,000.00)
02/02/24	02/02/24	Withdrawal	(50,000,000.000)	WD MAT Cpn USD	(50,000,000.00)		(50,000,000.00)	0.00	(50,000,000.00)
02/05/24	02/05/24	Withdrawal	(60,000,000.000)	WD MAT Cpn USD	(60,000,000.00)		(60,000,000.00)	0.00	(60,000,000.00)
02/08/24	02/08/24	Withdrawal	(50,000,000.000)	WD MAT Cpn USD	(50,000,000.00)		(50,000,000.00)	0.00	(50,000,000.00)
02/12/24	02/12/24	Withdrawal	(50,000,000.000)	WD MAT Cpn USD	(50,000,000.00)		(50,000,000.00)	0.00	(50,000,000.00)
02/14/24	02/14/24	Withdrawal	(40,000,000.000)	WD MAT Cpn USD	(40,000,000.00)		(40,000,000.00)	0.00	(40,000,000.00)
02/20/24	02/20/24	Withdrawal	(35,000,000.000)	WD MAT Cpn USD	(35,000,000.00)		(35,000,000.00)	0.00	(35,000,000.00)
02/22/24	02/22/24	Withdrawal	(160,000,000.000)	WD MAT Cpn USD	(160,000,000.00)		(160,000,000.00)	0.00	(160,000,000.00)
02/23/24	02/23/24	Withdrawal	(250,000,000.000)	WD MAT Cpn USD	(250,000,000.00)		(250,000,000.00)	0.00	(250,000,000.00)

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Tr Date	St Date	Transaction Type	Units	Description			Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
Cash - cont.											
02/29/24	02/29/24	Withdrawal	(50,000,000.000)	WD MAT	Cpn	USD	(50,000,000.00)		(50,000,000.00)	0.00	(50,000,000.00)
			(905,000,000.000)				(905,000,000.00)		(905,000,000.00)	0.00	(905,000,000.00)

Account Name: L.A. CARE HEALTH PLAN-LOW DURATION PORT

02/01/2024 through 02/29/2024

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/06/24	02/14/24	Buy	700,000.000	BMWLT 2024-1 A3 LEASE MAT 03/25/27 Cpn 4.98 05611UAD5	(699,982.64)		0.00	0.00	(699,982.64)
02/27/24	02/28/24	Buy	2,320,000.000	U.S. TREASURY NOTE MAT 01/31/29 Cpn 4.00 91282CJW2	(2,286,559.38)	(7,138.46)	0.00	0.00	(2,293,697.84)
			3,020,000.000		(2,986,542.02)	(7,138.46)	0.00	0.00	(2,993,680.48)
02/01/24	02/01/24	Coupon		CA STWD CMTY DEV AUTH REV-CA MAT 02/01/25 Cpn 0.73 13080SZL1		2,745.00	0.00	0.00	2,745.00
02/01/24	02/01/24	Coupon		CA CONTRA COSTA CCD GO/ULT T MAT 08/01/24 Cpn 1.77 212204JE2		1,507.90	0.00	0.00	1,507.90
02/01/24	02/01/24	Coupon		CA COVINA-VALLEY USD GO/ULT T MAT 08/01/24 Cpn 2.03 223093VM4		2,533.75	0.00	0.00	2,533.75
02/01/24	02/01/24	Coupon		CA FRESNO USD GO/ULT TXB MAT 08/01/25 Cpn 0.87 3582326T8		2,607.00	0.00	0.00	2,607.00
02/01/24	02/01/24	Coupon		CA GARDEN GROVE USD GO/ULT T MAT 08/01/24 Cpn 1.97 365298Y51		3,882.85	0.00	0.00	3,882.85
02/01/24	02/01/24	Coupon		CA OAKLAND-ALAMEDA COLISEUM MAT 02/01/25 Cpn 3.64 672211BM0		16,848.88	0.00	0.00	16,848.88
02/01/24	02/01/24	Coupon		CA OAKLAND USD GO/ULT TXB MAT 08/01/25 Cpn 1.38 672325M95		2,900.10	0.00	0.00	2,900.10
02/12/24	02/12/24	Coupon		FHLB C 05/12/21 Q MAT 02/12/26 Cpn 0.60 3130AKXQ4		2,820.00	0.00	0.00	2,820.00
02/15/24	02/15/24	Coupon		BAAT 2023-2A A3 CAR 144A MAT 06/15/28 Cpn 5.74 06054YAC1		3,348.33	0.00	0.00	3,348.33
02/15/24	02/15/24	Coupon		BACCT 2023-A2 A2 CARD MAT 11/15/28 Cpn 4.98 05522RDH8		2,075.00	0.00	0.00	2,075.00

Account Name: L.A. CARE HEALTH PLAN-LOW DURATION PORT

02/01/2024 through 02/29/2024

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/15/24	02/15/24	Coupon		CARMX 2021-2 A3 AUTO MAT 02/17/26 Cpn 0.52 14314QAC8		148.25	0.00	0.00	148.25
02/15/24	02/15/24	Coupon		CARMX 2021-3 A3 CAR MAT 06/15/26 Cpn 0.55 14317DAC4		236.38	0.00	0.00	236.38
02/15/24	02/15/24	Coupon		CARMX 2023-3 A3 CAR MAT 05/15/28 Cpn 5.28 14319BAC6		3,520.00	0.00	0.00	3,520.00
02/15/24	02/15/24	Coupon		CARMX 2023-4 A3 CAR MAT 07/17/28 Cpn 6.00 14318XAC9		1,500.00	0.00	0.00	1,500.00
02/15/24	02/15/24	Coupon		CARMX 2023-4 A3 CAR MAT 07/17/28 Cpn 6.00 14318XAC9		2,500.00	0.00	0.00	2,500.00
02/15/24	02/15/24	Coupon		CARMX 2024-A3 CAR MAT 10/16/28 Cpn 4.92 14318WAD9		1,722.00	0.00	0.00	1,722.00
02/15/24	02/15/24	Coupon		COPAR 2023-2 A3 CAR MAT 06/15/28 Cpn 5.82 14044EAD0		3,395.00	0.00	0.00	3,395.00
02/15/24	02/15/24	Coupon		FORDF 2023-1 A1 FLOOR 144A MAT 05/15/28 Cpn 4.92 34528QHV9		2,870.00	0.00	0.00	2,870.00
02/15/24	02/15/24	Coupon		FORDF 2023-1 A1 FLOOR 144A MAT 05/15/28 Cpn 4.92 34528QHV9		820.00	0.00	0.00	820.00
02/15/24	02/15/24	Coupon		FORDO 2023-B A3 CAR MAT 05/15/28 Cpn 5.23 344930AD4		2,615.00	0.00	0.00	2,615.00
02/15/24	02/15/24	Coupon		FORDO 2023-C A3 CAR MAT 09/15/28 Cpn 5.53 344940AD3		2,304.17	0.00	0.00	2,304.17
02/15/24	02/15/24	Coupon		GFORT 2023-1 A1 FLOOR 144A MAT 06/15/28 Cpn 5.34 361886CR3		4,005.00	0.00	0.00	4,005.00
02/15/24	02/15/24	Coupon		HART 2023-C A3 CAR MAT 10/16/28 Cpn 5.54 44918CAD4		1,385.00	0.00	0.00	1,385.00

Account Name: L.A. CARE HEALTH PLAN-LOW DURATION PORT

02/01/2024 through 02/29/2024

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/15/24	02/15/24	Coupon		JDOT 2023-B A3 EQP MAT 03/15/28 Cpn 5.18 477920AC6		3,237.50	0.00	0.00	3,237.50
02/15/24	02/15/24	Coupon		KUBOTA 2021-2A A3 EQP 144A MAT 11/17/25 Cpn 0.56 50117XAE2		263.00	0.00	0.00	263.00
02/15/24	02/15/24	Coupon		KCOT 2023-2A A3 EQP 144A MAT 01/18/28 Cpn 5.28 500945AC4		2,200.00	0.00	0.00	2,200.00
02/15/24	02/15/24	Coupon		TAOT 2023-D A3 CAR MAT 08/15/28 Cpn 5.54 89239FAD4		1,846.67	0.00	0.00	1,846.67
02/15/24	02/15/24	Coupon		WOART 2022-B A3 CAR MAT 03/15/28 Cpn 3.44 98163QAE9		1,433.33	0.00	0.00	1,433.33
02/16/24	02/16/24	Coupon		GMCAR 2021-2 A3 CAR MAT 04/16/26 Cpn 0.51 380149AC8		34.58	0.00	0.00	34.58
02/16/24	02/16/24	Coupon		GMCAR 2024-1 A3 CAR MAT 12/18/28 Cpn 4.85 36268GAD7		1,562.78	0.00	0.00	1,562.78
02/18/24	02/18/24	Coupon		HAROT 2023-3 A3 CAR MAT 02/18/28 Cpn 5.41 43815QAC1		1,127.08	0.00	0.00	1,127.08
02/20/24	02/20/24	Coupon		GMALT 2023-3 A3 LEASE MAT 11/20/26 Cpn 5.38 379929AD4		1,345.00	0.00	0.00	1,345.00
02/20/24	02/20/24	Coupon		TLOT 2023A A3 LEASE 144A MAT 04/20/26 Cpn 4.93 89239MAC1		2,054.17	0.00	0.00	2,054.17
02/25/24	02/25/24	Coupon		NAVMT 2023-1 A FLOOR 144A MAT 08/25/28 Cpn 6.18 63938PBU2		1,030.00	0.00	0.00	1,030.00
02/29/24	02/29/24	Coupon		FHLMC C 02/28/23 Q MAT 02/28/25 Cpn 4.00 3134GXS88		11,400.00	0.00	0.00	11,400.00
02/29/24	02/29/24	Coupon		FHLMC C 11/28/22 Q MAT 08/28/25 Cpn 4.05 3134GXR63		11,542.50	0.00	0.00	11,542.50

Account Name: L.A. CARE HEALTH PLAN-LOW DURATION PORT

02/01/2024 through 02/29/2024

Tr Date	St Date	Transaction Type	Units	Description			Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/29/24	02/29/24	Coupon		FHLMC C 11/28/2022 Q MAT 08/28/25	Cpn 4.20	3134GXS47		11,970.00	0.00	0.00	11,970.00
02/29/24	02/29/24	Coupon		U.S. TREASURY NOTE MAT 08/31/26	Cpn 0.75	91282CCW9		7,050.00	0.00	0.00	7,050.00
02/29/24	02/29/24	Coupon		U.S. TREASURY NOTE MAT 08/31/27	Cpn 3.13	91282CFH9		13,984.38	0.00	0.00	13,984.38
02/29/24	02/29/24	Coupon		U.S. TREASURY NOTE MAT 08/31/27	Cpn 3.13	91282CFH9		6,718.75	0.00	0.00	6,718.75
02/29/24	02/29/24	Coupon		U.S. TREASURY NOTE MAT 02/29/28	Cpn 4.00	91282CGP0		13,400.00	0.00	0.00	13,400.00
02/29/24	02/29/24	Coupon		U.S. TREASURY NOTE MAT 02/29/28	Cpn 4.00	91282CGP0		23,600.00	0.00	0.00	23,600.00
02/29/24	02/29/24	Coupon		U.S. TREASURY NOTE MAT 02/29/28	Cpn 4.00	91282CGP0		10,900.00	0.00	0.00	10,900.00
02/29/24	02/29/24	Coupon		U.S. TREASURY NOTE MAT 08/31/28	Cpn 4.38	91282CHX2		44,406.25	0.00	0.00	44,406.25
								239,395.60	0.00	0.00	239,395.60
02/01/24	02/01/24	Income	(0.010)	ADJ NET INT MAT	Cpn	USD		(0.01)	0.00	0.00	(0.01)
02/01/24	02/01/24	Income	10,510.280	STIF INT MAT	Cpn	USD		10,510.28	0.00	0.00	10,510.28
			10,510.270					10,510.27	0.00	0.00	10,510.27

Account Name: L.A. CARE HEALTH PLAN-LOW DURATION PORT

02/01/2024 through 02/29/2024

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/27/24	02/28/24	Sell Long	470,000.000	U.S. TREASURY NOTE MAT 05/31/26 Cpn 0.75 91282CCF6	431,390.23	866.80	0.00	(37,136.46)	432,257.03
02/27/24	02/28/24	Sell Long	1,410,000.000	U.S. TREASURY NOTE MAT 01/31/26 Cpn 0.38 91282CBH3	1,298,466.80	406.73	0.00	(101,923.25)	1,298,873.53
			1,880,000.000		1,729,857.03	1,273.53	0.00	(139,059.71)	1,731,130.56
02/15/24	02/15/24	Pay Princpl	38,187.290	CARMX 2021-2 A3 AUTO MAT 02/17/26 Cpn 0.52 14314QAC8	38,187.29		0.00	2.02	38,187.29
02/15/24	02/15/24	Pay Princpl	38,480.292	CARMX 2021-3 A3 CAR MAT 06/15/26 Cpn 0.55 14317DAC4	38,480.29		0.00	2.17	38,480.29
02/15/24	02/15/24	Pay Princpl	50,903.582	KUBOTA 2021-2A A3 EQP 144A MAT 11/17/25 Cpn 0.56 50117XAE2	50,903.58		0.00	0.66	50,903.58
02/16/24	02/16/24	Pay Princpl	8,450.383	GMCAR 2021-2 A3 CAR MAT 04/16/26 Cpn 0.51 380149AC8	8,450.38		0.00	0.18	8,450.38
			136,021.547		136,021.54		0.00	5.02	136,021.54

LA CARE

Cash Activity by Transaction Type GAAP Basis

Accounting Period From 02/01/2024 To 02/29/2024

Cash Date	Trade/Ex-Date	Settle/Pay Date	Custodian	Cusip	Description	Quantity	Income Amount	Principal Amount	Contributions/ Withdrawals	Total Amount
BUY										
02/09/24	02/07/24	02/09/24	TNT77	24422EXH7	JOHN DEERE CAPITAL CORP	2,500,000.00	(9,687.50)	(2,493,325.00)	0.00	(2,503,012.50)
02/09/24	02/07/24	02/09/24	TNT77	59217GFR5	MET LIFE GLOB FUNDING I	2,500,000.00	(10,440.97)	(2,493,950.00)	0.00	(2,504,390.97)
02/14/24	02/14/24	02/14/24	TNT77	665278404	NORTHERN INST GOVT MONEY MKT	3,259,909.47	0.00	(3,259,909.47)	0.00	(3,259,909.47)
TOTAL BUY						8,259,909.47	(20,128.47)	(8,247,184.47)	0.00	(8,267,312.94)
DIVIDEND										
02/28/24	02/28/24	02/28/24	TNT77	665278404	NORTHERN INST GOVT MONEY MKT	2,145,546.59	5,904.82	0.00	0.00	5,904.82
TOTAL DIVIDEND						2,145,546.59	5,904.82	0.00	0.00	5,904.82
INTEREST										
02/01/24	02/01/24	02/01/24	TNT77	31677QBR9	FIFTH THIRD BANK	5,000,000.00	56,250.00	0.00	0.00	56,250.00
02/01/24	02/01/24	02/01/24	TNT77	54438CYK2	LOS ANGELES CA CMNTY CLG DIST	1,100,000.00	4,251.50	0.00	0.00	4,251.50
02/01/24	02/01/24	02/01/24	TNT77	969268DG3	WILLIAM S HART CA UNION HIGH S	2,350,000.00	8,894.75	0.00	0.00	8,894.75
02/05/24	02/05/24	02/05/24	TNT77	458140BY5	INTEL CORP	5,000,000.00	93,750.00	0.00	0.00	93,750.00
02/12/24	02/12/24	02/12/24	TNT77	14913R3A3	CATERPILLAR FINL SERVICE	2,500,000.00	45,000.00	0.00	0.00	45,000.00
02/13/24	02/13/24	02/13/24	TNT77	89236TGT6	TOYOTA MOTOR CREDIT CORP	3,000,000.00	27,000.00	0.00	0.00	27,000.00
02/15/24	02/15/24	02/15/24	TNT77	384802AE4	WW GRAINGER INC	1,000,000.00	9,250.00	0.00	0.00	9,250.00
02/15/24	02/15/24	02/15/24	TNT77	576000ZE6	MASSACHUSETTS ST SCH BLDG AUTH	5,000,000.00	22,125.00	0.00	0.00	22,125.00
02/15/24	02/15/24	02/15/24	TNT77	756109BG8	REALTY INCOME CORP	5,000,000.00	98,750.00	0.00	0.00	98,750.00
02/15/24	02/15/24	02/15/24	TNT77	882508BV5	TEXAS INSTRUMENTS INC	5,000,000.00	115,000.00	0.00	0.00	115,000.00
02/15/24	02/15/24	02/15/24	TNT77	91324PEP3	UNITEDHEALTH GROUP INC	5,000,000.00	131,250.00	0.00	0.00	131,250.00
02/23/24	02/23/24	02/23/24	TNT77	037833BY5	APPLE INC	1,500,000.00	24,375.00	0.00	0.00	24,375.00
02/23/24	02/23/24	02/23/24	TNT77	69353REK0	PNC BANK NA	2,000,000.00	29,500.00	0.00	0.00	29,500.00
TOTAL INTEREST						43,450,000.00	665,396.25	0.00	0.00	665,396.25
SELL										
02/09/24	02/07/24	02/09/24	TNT77	254687FN1	WALT DISNEY COMPANY/THE	3,000,000.00	37,687.50	2,951,100.00	0.00	2,988,787.50
02/14/24	02/14/24	02/14/24	TNT77	665278404	NORTHERN INST GOVT MONEY MKT	2,145,546.59	0.00	2,145,546.59	0.00	2,145,546.59
02/29/24	02/27/24	02/29/24	TNT77	035240AL4	ANHEUSER-BUSCH INBEV WOR	2,500,000.00	37,777.78	2,423,900.00	0.00	2,461,677.78
TOTAL SELL						7,645,546.59	75,465.28	7,520,546.59	0.00	7,596,011.87

LA CARE

Cash Activity by Transaction Type GAAP Basis

Accounting Period From 02/01/2024 To 02/29/2024

Cash Date	Trade/Ex-Date	Settle/Pay Date	Custodian	Cusip	Description	Quantity	Income Amount	Principal Amount	Contributions/ Withdrawals	Total Amount
GRAND TOTAL						61,501,002.65	726,637.88	(726,637.88)	0.00	0.00
Avg Date 14										

BOARD OF GOVERNORS
Executive Committee
Meeting Minutes – March 27, 2024

1055 West 7th Street, 1st Floor, Los Angeles, CA 90017

Members

Alvaro Ballesteros, MBA, *Chairperson*
Ilan Shapiro MD, MBA, FAAP, FACHE, *Vice Chairperson*
Stephanie Booth, MD, *Treasurer*
John G. Raffoul, *Secretary*

Management/Staff

John Baackes, *Chief Executive Officer**
Sameer Amin, MD, *Chief Medical Officer*
Terry Brown, *Chief of Human Resources*
Augustavia J. Haydel, Esq., *General Counsel*
Todd Gower, *Interim Chief Compliance Officer*
Linda Greenfeld, *Chief Products Officer*
Alex Li, MD, *Chief Health Equity Officer*
Tom MacDougall, *Chief Technology & Information Officer*
Noah Paley, *Chief of Staff*
Acacia Reed, *Chief Operating Officer*
Afzal Shah, *Chief Financial Officer*

**Absent ** Via Teleconference*

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Alvaro Ballesteros, *Chairperson,* called to order the regular meetings of the L.A. Care Executive Committee and the L.A. Care Joint Powers Authority Executive Committee regular meetings at 2:03 p.m. The meetings were held simultaneously. He welcomed everyone to the meetings. He provided information on how to submit comments in-person or electronically.	
APPROVE MEETING AGENDA	The Agenda for today's meeting was approved.	**Approved unanimously. 3 AYES (Ballesteros, Booth and Shapiro)**
PUBLIC COMMENT	There were no public comments.	
APPROVE MEETING MINUTES	Board Member Booth proposed an amendment on page 3. There was no objection to including the correction in the minutes. The minutes of the February 28, 2024 meeting were approved as amended.	**Approved unanimously. 3 AYES**
CHAIRPERSON'S REPORT	There was no report from the Chairperson.	

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CHIEF EXECUTIVE OFFICER REPORT	*(Board Member Raffoul joined the meeting)* John Baackes, *Chief Executive Officer,* reported that the Change Healthcare cyber-attack was reported to the Board meeting at the March 7 meeting. Change Healthcare serves as L.A. Care's clearinghouse for electronic claims and the cyber-attack shut down its operations on February 21. L.A. Care immediately notified its providers that relied on electronic claim submission that they could submit claims on paper. L.A. Care is aware that was a great challenge for many providers. Change Healthcare is owned by United healthcare, which also owns Optum, a health services vendor. Arrangements were made to use Optum as the alternate clearinghouse, and it was brought online, after a vetting and testing, on March 12. L.A. Care arranged to use Office Ally as an alternative clearinghouse for some providers. Office Ally had formerly provided clearinghouse services for L.A. Care. L.A. Care is receiving claims thorugh these alternate services. L.A. Care is working with Change Healthcare to continue services when testing is completed. L.A. Care will explore options with multiple clearinghouses and evaluate operations for the future. Claims are being received at or above historical levels and processing is current with claims received. The disruption has caused problems for some of the smaller providers such as community-based organizations, skilled nursing facilities and community based adult services (CBAS) providers. L.A. Care is assisting affected providers with cash advances against future claims, with agreements executed with 81 organizations. L.A. Care has advanced $28,893,000 to providers. It is hoped that the options functioning now will help the organizations resume submitting electronic claims. L.A. Care is prepared to continue to support its providers. Mr. Baackes is in regular contact with regulators at California Department of Managed Care Services (DMHC) and Department of Health Care Services (DHCS) about the incident, L.A. Care's support for providers and processes to recover full claims submission functions. Smaller providers have let him know that they appreciate L.A. Care's transparency and responsiveness. Board Member Booth thanked Mr. Baackes for this work. Mr. Baackes noted that he will provide more information at the April 4 Board meeting about claims clearinghouses, the Medi-Cal redetermination cycle, and other items. He reported that L.A. Care has earned the Health Equity Accreditation from the National Committee for Quality Assurance.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
• Government Affairs Update	Cherie Compartore, *Senior Director, Government Affairs*, reported: • Last week an agreement was reached to take early actions on the California state budget. The Managed Care Organization (MCO) tax has moved forward and was signed by the Governor. It is expected to generate $1.5 billion that would help mitigate the current budget crisis. DHCS can now seek approval from the Centers for Medicare and Medicaid Services (CMS) for higher federal matching funds. • An initiative for the MCO tax is also proposed for the November ballot. Although not formally announced yet, it appears there are sufficient signatures and it will qualify for the November ballot. • The Legislature recent adjourned for spring recess and Legislators will head home to their districts. Legislature will reconvene on April. 1. L.A. Care Government Affairs staff continue to meet with legislative committee consultants and staffers, finalizing policy positions for proposed bills. Staff is preparing for the many hearings to convene when the Legislature returns. The deadline to hear bills with fiscal implications is April 26. • The California Governor announced the appointment of Tyler Sadwith as State Medicaid Director at DHCS. Sadwith formerly served as the Director for Behavioral Health, and he has worked at CMS. • Voters by a narrow margin approved California's Proposition 1. This is a two-part ballot initiative, and includes a bond to build treatment facilities and permanent supporting housing for people with mental health and addiction challenges, as well as for veterans. Chairperson Ballesteros asked how the funding for Prop 1 is distributed. Ms. Compartore responded that managed care health plans will not have a role in the funding distributions. Mr. Baackes noted that some of the funding results from redirecting existing state funding sent to Counties.	
COMMITTEE ISSUES		
Catalina Island Health Grant to support safety net access to health care for L.A. Care members living on Catalina Island **(EXE 100)**	Mr. Baackes met with the Chief Executive Officer of Catalina Island Medical Center, which operates under the name Catalina Island Health. It is the only health care facility on Catalina Island, and it operates a 12-bed facility with 9 acute care beds and 3 skilled nursing beds, an emergency room, and the only outpatient clinic on the island, staffed by two physicians. Catalina Island Health is in dire financial condition. It is estimated to run out of cash by June and would be forced to close.	

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	The Catalina Island Health CEO requested that L.A. Care consider increasing reimbursement for Medi-Cal and provide a $5 million grant. L.A. Care has 733 health plan members on Catalina Island, out of a population of 4,200 residents. An increase in the Medi-Cal payments would not be enough to sustain Catalina Island Health. L.A. Care is nevertheless in negotiations to increase the Medi-Cal funding to support Catalina Island Health. A $2 million dollar grant could keep it operating through at least the end of the year. A subsequent meeting included representatives from Los Angeles County Supervisor Hahn's office, Representative Lowenthal, Senator Gonzalez and Senator Allen, Catalina Island Health leaders and the County Fire Department. The group reviewed potential consequences if the hospital closed. The bottom line is that there would be no medical services on the island other than a chiropractor, and it would become the responsibility of the County Fire Department in emergencies to ferry people off the island by helicopter to medical sites on the mainland. Mr. Baackes is seeking approval to issue a $2 million grant to Catalina Island Health to support safety net access to healthcare for L.A. Care members and others living on Catalina Island. L.A. Care will continue to work with County offices, particularly Supervisor Hahn's office, to find a long-term solution. Mr. Baackes contacted the California Hospital Association to ensure that they are aware of the situation and the actions proposed. He made it clear that L.A. Care is happy to support this effort but is not in a position to sustain the hospital long-term. It is important that L.A. Care consider this support for the safety net. Some may recall that on New Year's Eve 2022, a rural hospital in Kings County closed, leaving residents more than 50 miles away from the nearest hospital. At the time, no organization came forward to offer a safety net or a lifeline. In this case, Catalina Island Health has asked for support and it would be appropriate for L.A. Care to provide the grant and work collaboratively with others to find a long-term solution. Catalina Island Health is the only facility on the island and Medi-Cal is only about 25% of the patient mix. About a million visitors a year go to the island, and they make up most of the traffic that goes to the emergency room, and those patients likely use commercial insurance. Afzal Shah, *Chief Financial Officer* spoke with Catalina Island Health about their financial structure. Mr. Shah noted that around 25% of the revenue	

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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	is through Medi-Cal, and the rest is commercial insurance. Catalina Island Health would like to sustainably enhance the contracting arrangements for all lines of business. Mr. Baackes noted that if Catalina Island Health closed and the Fire Department must ferry people off the island for emergency health care, it would result in unbudgeted expense for the County. Board Member Booth commented that L.A. Care should support Catalina Island Health. By providing funding, it benefits other insurance companies, particularly Health Net, because it is going to keep the hospital going for those health insurers. L.A. Care is the only one providing financial support, but it is the right thing to do. Board Member Raffoul noted that it is good community service. L.A. Care does a lot of work in supporting community needs, and this is one of the most worthy causes, to maintain healthcare on the island. **Motion EXE 100.0424** **To approve delegated authority to Chief Executive Officer, John Baackes, to issue up to a $2 million award to Catalina Island Health to support safety net access to health care for L.A. Care members living on Catalina Island.**	**Approved unanimously.** **4 AYES (Ballesteros, Booth, Raffoul and Shapiro)**
Approve Consent Agenda	Approve the list of items that will be considered on a Consent Agenda for April 4, 2024 Board of Governors Meeting. • March 7, 2024 meeting minutes • Contract with Microsoft (via SHI International) to provide product support services for Information Technology staff supporting critical virtual production infrastructure • Faneuil, Inc. Contract Extension and Funding for Customer Service Center	**Approved unanimously.** **4 AYES**
PUBLIC COMMENTS	There were no public comments.	
ADJOURN TO CLOSED SESSION	The Joint Powers Authority Executive Committee meeting adjourned at 2:29 pm. Augustavia J. Haydel, Esq., *General Counsel* announced the items for discussion in closed session. She announced there is no report anticipated from the closed session. The meeting adjourned to closed session at 2:30 pm. REPORT INVOLVING TRADE SECRET Pursuant to Welfare and Institutions Code Section 14087.38(n) Discussion Concerning New Service, Program, Business Plan	

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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Estimated date of public disclosure: *March 2026* CONTRACT RATES Pursuant to Welfare and Institutions Code Section 14087.38(m) • Plan Partner Rates • Provider Rates • DHCS Rates THREAT TO PUBLIC SERVICES OR FACILITIES Government Code Section 54957 Consultation with: Tom MacDougall, *Chief Information & Technology Officer* CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION Significant exposure to litigation pursuant to Section 54956.9(d)(2) of Ralph M. Brown Act: Three Potential Cases CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act L.A. Care Health Plan's Notice of Contract Dispute under Contract No. 04-36069 Department of Health Care Services (Case No. Unavailable) CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act • Department of Managed Health Care Enforcement Matter Numbers: 18-799, 20-063, 21-428, 21-509, 21-680 • Department of Health Care Services, Office of Administrative Hearings and Appeals, In the matter of: L.A. Care Health Care Plan Appeal No. MCP22-0322-559-MF PUBLIC EMPLOYEE PERFORMANCE EVALUATION, PUBLIC EMPLOYMENT and CONFERENCE WITH LABOR NEGOTIATOR Sections 54957 and 54957.6 of the Ralph M. Brown Act Title: Chief Executive Officer Agency Designated Representative: Alvaro Ballesteros, MBA Unrepresented Employee: John Baackes	
RECONVENE IN OPEN SESSION	The meeting reconvened in open session at 4:30 pm. No reportable actions were taken during the closed session.	

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
ADJOURNMENT	The meeting adjourned at 4:31 pm	

Respectfully submitted by:
Linda Merkens, *Senior Manager, Board Services*
Malou Balones, *Board Specialist III, Board Services*
Victor Rodriguez, *Board Specialist II, Board Services*

APPROVED BY:

_____
Alvaro Ballesteros, MBA, *Board Chairperson*
Date: _____

APPROVED

COMPLIANCE & QUALITY COMMITTEE

BOARD OF GOVERNORS
Compliance & Quality Committee Meeting
Meeting Minutes – March 21, 2024

L.A. Care Health Plan CR 1017-1018, 1055 W. Seventh Street, Los Angeles, CA 90017

Members
Stephanie Booth, *MD, Chairperson*
Al Ballesteros, *MBA*
G. Michael Roybal, *MD*
Fatima Vazquez

** Absent ** Via Teleconference*

Senior Management
John Baackes, *Chief Executive Officer*
Sameer Amin, *MD, Chief Medical Officer*
Augustavia J. Haydel, *General Counsel*
Terry Brown, *Chief of Human Resources*
Todd Gower, *Chief Compliance Officer*
Linda Greenfield, *Chief Product Officer*
Alex Li, *Chief Health Equity Officer*
Edward Sheen, MD, *Senior Quality, Population Health & Informatics Executive, Quality Improvement*
Michael Devine, *Director, Special Investigations Unit*
Michael Sobetzko, *Senior Director, Risk Management and Operations Support*

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Chairperson Stephanie Booth, *MD*, called the L.A. Care Compliance & Quality Committee and the L.A. Care Health Plan Joint Powers Authority Compliance & Quality Committee meetings to order at 2:02 p.m. She announced that members of the public may address the Committee on each matter listed on the agenda before the Committee's consideration of the item by submitting their comments via text, voicemail, or email.	
APPROVAL OF MEETING AGENDA	**The meeting Agenda was approved as submitted.**	**Approved unanimously 4 AYES (Ballesteros, Booth, Roybal, and Vazquez)**
PUBLIC COMMENT	*There was no public comment.*	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
APPROVAL OF MEETING MINUTES	**The Februrary 15, 2024 meeting minutes were approved as submitted.**	**Approved unanimously.**
CHAIRPERSON REPORT • **Education Topics**	In her Chairperson's report, Chairperson Booth emphasized the importance of clear communication, especially regarding numerical data. She suggestsed using percentages and providing context, such as denominators for measurements, to aid in understanding complex information. She also encouraged avoiding excessive use of acronyms and jargon to ensure clarity in reports and documents. She highlighted the need to document discussions and decisions for clarity and future reference. She appreciated the efforts of those who take time to explain concepts and definitions to her, ensuring accurate understanding and documentation of information. Chairperson Booth also addressed the importance of celebrating successes, such as resolving issues without harm, and recommends including dates and historical context in reports to track progress accurately. She emphasized The significance of knowing whose goals or measurements are being discussed to understand their relevance and importance. She suggestsed a structured approach to reviewing documents, noting new information, and comparing it with previous data for informed decision-making. She acknowledged the complexity of the material and suggested keeping notes to aid in real-time discussions and decision-making processes.	
COMPLIANCE & QUALITY COMMITTEE CHARTER PROCESS	Todd Gower, *Chief Compliance Officer*, discussed the Compliance & Quality Committee Charter Process. Mr. Gower stated that the goal is to have a draft document ready for review by the CEO cabinet and Board Members over the next couple of weeks. They are trying to make sure that they are remaining in the current charter format and highlighted in yellow the changes that have been suggested. Chairperson Booth noted that the charter was not included in the packet. Mr. Gower stated that the document is not ready to be made public. Chairperson Booth agreed.	
CHIEF COMPLIANCE OFFICER REPORT	Mr. Todd Gower, *Chief Compliance Officer*, and the Compliance Department staff presented the Chief Compliance Officer Report *(a copy of the full written report can be obtained from Board Services).* Overview • Compliance Officer ICC Report Out • Special Investigations Unit (SIU)	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

- Issues Inventory
- Internal Audit (IA)
- Memorandum of Understanding (MOU)
- Appeal & Grievance (A&G)
- Payment Integrity (PI)

Michael Devine, *Director, Special Investigations Unit,* gave the following update.
Fiscal Year 2023/2024 Year-to-date recoveries & savings dashboard

	Jan – Feb 2024	FY Year-to-date
Recoveries	$2.0M	$2.8M
Savings	$1.4M	$2.7M
Totals	$3.4M	$5.5M

Law Enforcement

Active Criminal Investigations	**47**
Undercover Operations	0
Arrests	2
Pending Prosecution	11
Convictions	3

Special Investigations Unit (SIU) Update

- Meeting with DHCS
- Hospice Fraud Initiative
- Health Care Providers Lab Conviction
- Billing Flaw
- Rafael Malikian (former Physician)
- Dr. D.S.

Upcoming Quarterly Investigative Roundtables

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

March 14, 2024

- Speaker: Karen Weintraub
- EVP, Health Care Fraud Shield

June 13, 2024

- Speaker: Jeanette Calinsky
- Deputy Attorney General, CA DOJ

SIU Open Cases – Aging as of March 1, 2024

Count of Age	Monitoring	Open	Grand Total
0-30	5	13	18
31-60	3	26	29
61-180	11	111	122
Older 180+	328	211	539
Not Promoted	0	132	132
GRAND TOTAL	**347**	**493**	**840**

Time Frame	Cases Opened	Late Notification of Regulatory Reporting
2023 - Q1	80	1
2023 - Q2	95	1
2023 - Q3	82	1
2023 - Q4	95	0
TOTAL	**352**	**3**

Top 5 Allegation Types of Fraud, Waste and Abuse (Allegation Type vs Participant Q4 2022 – Q1 2024)

- Questionable Billing Patterns

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Services Not Rendered / Documented • Identity Theft • Upcoding • Not Medically Necessary Top 5 Referral Source vs Participant from Q4 2022 – Q1 2024 • Internal Employee • Plan Partner • PostShield • PPG • Other Michael Sobetzko, *Senior Director, Risk Management and Operations Support,* reviewed the Issues Inventory update *(a copy of the full report can be obrtainded from Board Services).* The report provided an overview of past issues that have been remediated, administratively closed, or documented for mediation efforts. He mentioned that most of these past issues were included in the packet for further reading. He focused on discussing two new open issues. He addressed the alternative format selection for members with visual or other impairments that affect the ability to read. These members have the right to request alternative formats such as large print or audio-only representations. There is a requirement to capture and report these selections to ensure the organization understands member preferences. Mr. Sobetzko mentioned that there may be inconsistencies in collecting and submitting this information, and this will be further investigated. The second issue discussed was the noncompliance with timely termination of providers. The Credentialing Committee had administratively terminated three enhanced care management providers, but recent checks showed these providers were still active in the system. He noted the need to understand the termination process better, examine the source of the issue, and prevent other providers from remaining active post-termination. Chairperson Booth asked about the remediated cases. Mr. Sobetzko responded that Compliance never deletes remediated issues from its database; instead they are moved to the monitoring category. They continually review issues that may have been remediated, which occasionally leads to a duplicate record. Mr. Gower thanked Mr. Sobetzko for his efforts in collating and analyzing data related to issues inventory, and mentioned similar efforts being made regarding corrective action plans and mitigation activities. He indicated that the organization is working with IT professionals to implement this consolidated system, which is expected to be completed later in the year. The	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	purpose of this system is to ensure that nothing falls through the cracks by providing alerts and notifications about ongoing activities. This proactive approach aims to keep leadership and relevant individuals informed about mitigation activities, audits, and follow-up actions, thereby enhancing overall compliance and risk management within the organization. Maggie Marchese, *Senior Director, Audit Services*, gave an Audit Services Update. Open 2023 Audits: • Data Management and Governance Phase I: Final Audit Report • Date Management and Governance Phase II: Final Audit Report • Provider Quality: PQI (follow-up assessment) • Staffing/Talent Acquisition Assessment: Management responses pending. Open 2024 Audits: • Product Sales and Member Services • Provider Network: Access to Care • Plan Partners Audit: Moved from Q3 to Q1 (replaced Provider Dispute Resolution Audit) • Appropriate Access Controls/ IT System Security: Moved from Q2 to Q1 CAPs Inventory Management/Monitoring: • IA developing a SharePoint designed to incorporate a formal workflow process to track all internal audit-related CAPs. Audit Services – Upcoming Q2 Audit Projects Audits: • Call Center • Provider Operations Follow-Up Assessments: • Claims: Out-of-Area Emergency Services Claims • DSNP Implementation and Oversight Risk Mitigation Plan Implementation Effectiveness Reviews: • HRA Reassessment Efforts Lucy Nakamura, *Director, Provider Network Management,* gave Provider Network Management update. Department of Health Care Services APL23-029 • The 2024 Medi-Cal Managed Care Contract requires all managed care plans (MCPs) to enter into Memorandums of Understanding (MOUs) with counties and third-party entities to	

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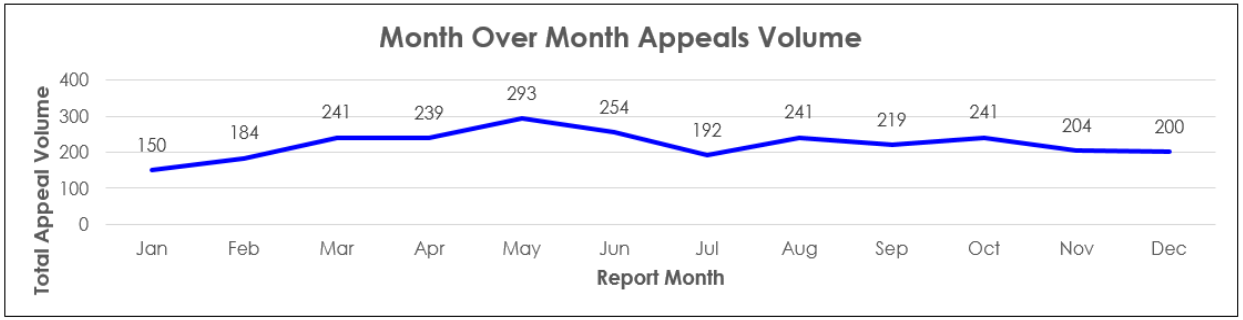
AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

contractually ensure the provision and coordination of whole-system, person-centered for Members.

- On October 11, 2023, DHCS also issued All Plan Letter (APL) 23-029 to explain in details the intent and scope of MCPs responsibilities under the MOUs, including timing of MOUs execution and submission to DHCS and MOUs oversight and monitoring.
- Shortages in staff resources delay and impact the timely initiation and completion of MOUs.
- Until adequate staffing resources are allocated, fulfilling these obligations within the stipulated timeframes will remain challenging.
- Non-compliance with DHCS mandates exposes the L.A. Care and its partners to legal and regulatory consequences, including fines, penalties or other enforcement measures, and places a risk on overall compliance.
- *Note: Estimated total number of MOUs to complete: 100-120 for 2024-2025.*

Demetra Crandall, *Director, Appeals & Grievances,* gave an Appeals & Grievances update.
Appeal Volume 2023

Monthly Appeals Report: Detailed Appeals Data
Reporting Period: 2023
Note: Cells highlighted green indicate highest volume Appeals categories/subcategories for the report month.

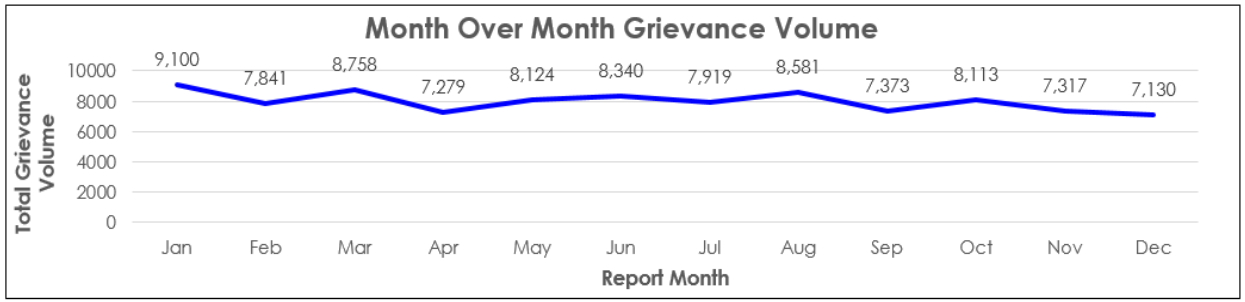


Month Over Month Appeals Volume Detail												
Appeals Category	Report Month											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Access	139	176	232	235	283	230	186	222	210	229	196	164
Billing and Financial Issues	8	8	8	4	8	21	5	16	8	7	7	33
Quality of Care	3	0	1	0	2	3	1	3	1	5	1	3
Total	**150**	**184**	**241**	**239**	**293**	**254**	**192**	**241**	**219**	**241**	**204**	**200**

Grievance Volume 2023

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

Monthly Grievances Report: Detailed Grievances Data
Reporting Period: 2023
Note: Cells highlighted green indicate top 3 highest volume grievance categories/subcategories for the report month.



Month Over Month Grievance Volume Detail

Grievance Category	Report Month											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Access	2,868	2,588	2,752	2,273	2,467	2,686	2,565	2,693	2,324	2,592	2,297	2,285
Attitude and Service	2,326	2,136	2,481	2,061	2,334	2,301	2,413	2,399	2,154	2,340	2,260	2,165
Billing and Financial Issues	3,509	2,788	3,130	2,598	2,895	2,879	2,495	2,933	2,391	2,716	2,417	2,369
Quality of Care	379	320	389	335	418	463	431	540	494	447	335	306
Quality of Practitioner Office Site	18	9	6	12	10	11	15	16	10	18	8	5
Total	**9,100**	**7,841**	**8,758**	**7,279**	**8,124**	**8,340**	**7,919**	**8,581**	**7,373**	**8,113**	**7,317**	**7,130**

Erik Chase, *Senior Director, Claims Integrity,* gave a Payment Integrity Update.
He mentioned the provider disputes disposition and their goal of resolving these disputes within 45 working days. Mr. Chase noted that they are averaging about a 96% completion rate within this timeframe, which is in compliance with their standards. He also mentioned the volume of provider disputes they handle monthly, which is between 32,000 to 36,000. Mr. Chase discussed the claims denial rate, which currently stands at about 21%. He explained that this primarily includes denials that offer an opportunity for providers to make changes or decisions to remediate the issues. He also mentioned the process of claims forwarding and denials related to max paid by primary insurers, which are stripped out as they require no action from providers. Mr. Chase talked about their first pass claims adjudication rate, which aims for a 95% completion rate within 30 calendar days and a 99% rate within 45 working days. He stated that they have been averaging 95% and 99.7% respectively, demonstrating efficient claims processing. Mr. Chase also spoke about their annual goal for payment integrity, which is set at $170 million. He noted that they are currently $16.5 million favorable to this goal due to incremental savings and recoveries achieved by the team. He explained that their efforts focus on recovering overpaid amounts, as recovering these funds after payment typically yields lower returns. Mr. Chase also spoke about upcoming discussions during the Board of Governors meeting where he plans to provide more detailed insights into

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	specific issues and improvements related to payment integrity, coordination of benefits agreements, and challenges faced with certain healthcare changes affecting their metrics.	
CHIEF MEDICAL OFFICER REPORT	Sameer Amin, *MD, MPH, Chief Medical Officer*, reported: A cyber attack on data held by Change Healthcare occurred on February 21. Change Healthcare operates the largest clearinghouse for insurance billing and payments in the country, and has been unable to process claims electronically since the attack. This is a seriosu service disruption they experienced due to this cyber attack. L.A. Care is working with Change Healthcare's corporate parent, Optum, to test and implement an interim electronic claims submission solution using the Optum Intelligent Electronic Data Interchange. This solution serves as an alternative pathway for claims submission while Change Healthcare works on restoring services. Despite initial challenges faced by providers L.A. Care has started receiving claims directly through Optum. The current volume of claims is higher than usual due to the volume of delayed submissions over the past few weeks. Ongoing efforts are underway to explore additional solutions and additional vendors for claims submission. L.A. Care has communicated with the provider community through multiple town halls, to inform them about options to submit paper claims. There has been a significant increase in paper claims volume as providers and facilities seek payment for their services amidst the challenges faced with electronic claims processing. L.A. Care is working to expedite payments to providers, especially service providers such as skilled nursing facilities (SNFs), who are facing financial difficulties. Dr. Amin mentioned that theyL.A. Care has successfully forwarded $30 million in payments to providers over the past few weeks, providing them with much-needed financial support until electronic claim submissions can be processed and paid. Having a highly delegated network and a system that pays a significant portion through capitation has been beneficial in ensuring that many providers continue to receive regular payments. This helps maintain stability within the network despite the disruption caused by the cyber attack on Change Healthcare. Member Roybal asked if there are groups that have been more affected by this or is it pretty uniform. Dr. Amin responded that the severity of the impact depends on the financial situation of the entities more than a direct reliance on Change Healthcare services. Entities that struggle with day-to-day finances and have difficulty paying bills without immediate funding are experiencing the most significant challenges, such as smaller healthcare providers and SNFs. Dr. Amin also noted that certain entities adapt better to the alternate claims pipeline through Optum, particularly those with more sophisticated claims processing systems or easier access to the new pipeline. L.A. Care is actively working to ensure access to the pathway for all providers. L.A. Care has opened up the option for paper claims submissions for those who cannot use the electronic pathway effectively, showing sensitivity to the diverse needs of the provider network.	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CHIEF HEALTH EQUITY OFFICER REPORT	Alex Li, *MD, Chief Health Equity Officer*, reported *(a copy of the written report can be obtained from Board Services):* National Commission on Quality Assurance (NCQA) Health Equity Accreditation On March 11, 2024, L.A. Care was notified by NCQA that L.A. Care achieved the NCQA Health Equity Accreditation status. L.A. Care received a score of 98%, or 86.5 out of 88 possible points. L.A. Care is extremely proud of its work in health equity and achieving this status. There were 170+ health plans out of 1,100+ health plans nationally that have received the NCQA Health Equity Accreditation status. Equity Practice Transformation Program Update The California Department of Health Care Services (DHCS) Equity and Practice Transformation (EPT) program announced that 46 practices selected to L.A. Care as their managed care plan sponsor; 211 out of 700+ practices across California were selected to participate in the program. On March 7, 2024, L.A. Care hosted a welcome session and below is a quick overview of the practice type and their impact on Medi-Cal patients.	

Type of Practice	Total Number of Practices	Total in Direct Network	Medi-Cal Members (LA Care and HealthNet) Impacted
Private	24	8	100,938
FQHCs	22	5	488,981
Totals	**46**	**13**	**589,919**

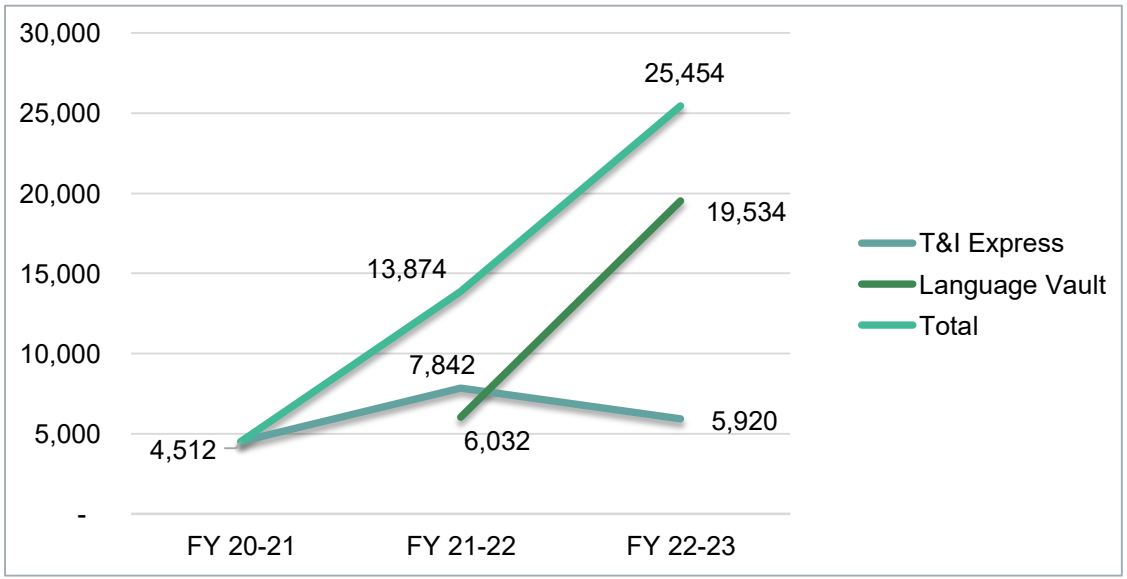
DHCS 2024 Quality Withhold and Incentive Program (QWIP)
On March 11, 2024, DHCS shared with the managed care plans their preliminary proposal for their new Quality Withhold and Incentive Program. The QWIP is intended to be a program where a small percentage of the managed care plan's revenue is withheld and then earned back based on the 8 managed care accountability set (MCAS) and consumer and provider survey responses. The new modification of the program is to have a health equity framework and seeks to require health plans to address sub-populations that perform poorly in the MCAS measures.

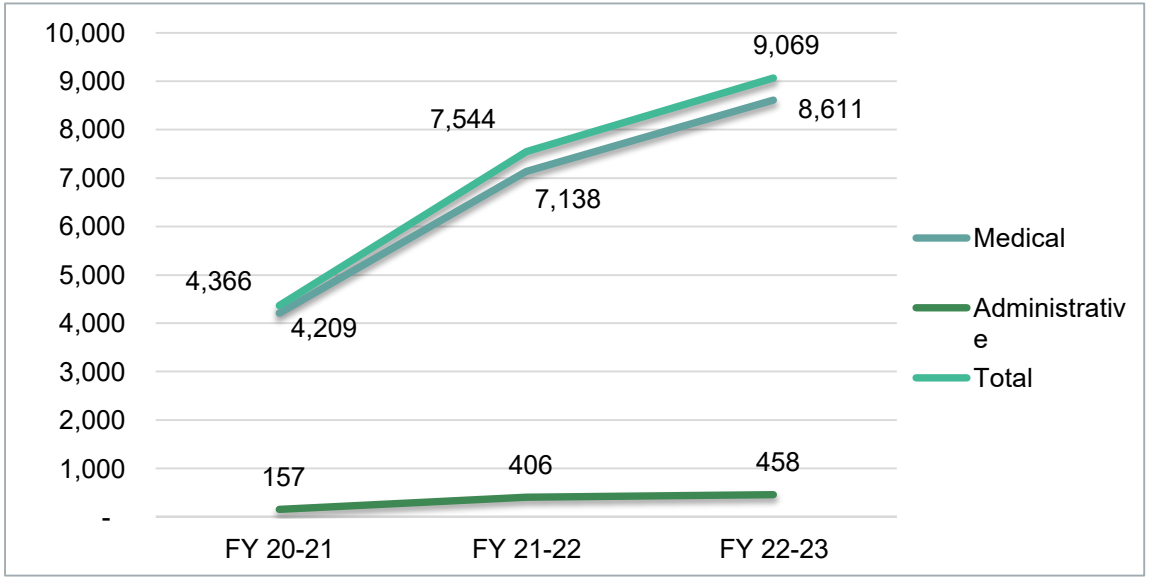
AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

QUALITY OVERSIGHT COMMITTEE (QOC) UPDATE	Edward Sheen, *MD, Senior Quality, Population Health & Informatics Executive, Quality Improvement*, gave a Quality Oversight Committee (QOC) Update *(a copy of the report can be obtained from Board Services).*
	
	Health Education Evaluation FY 2022-2023
	Mission
	To improve member health through the provision of wellness and disease prevention programs, services and resources.
	Goals
	• Provide or coordinate educational programs and services that assist members to:
	  • Modify personal health behaviors
	  • Learn and follow self-care regimens and treatment therapies
	  • Learn to effectively use primary and preventive health care services
	• Support internal L.A. Care business units such as Care Management, and the Community Resource Centers
	• Implement of health education programs to improve HEDIS, CAHPS and CMS Five-Star Quality Ratings
	• Oversee delegated health education functions of Plan Partners
	
	Highlights/Goal Accomplishments
	Doula Benefit
	• Successfully implemented the Medi-Cal Doula benefit in collaboration with the Medi-Cal Product.
	• To date 100 MCLA members have received doula services.
	New Wellness Platform
	• Contracted with a new vendor for the *My* Health In Motion™ wellness platform through an RFP.
	• New feature-full wellness platform launched on January 1, 2024.
	Medically Tailored Meals Program
	• *Meals As Medicine* saw an increase in authorization requests of 122% and a 154% increase in enrollment from the previous fiscal year, greatly surpassing the goal of 25% increase.
	Disease Self-Mmanagement & Prevention Programs
	• The FY 22-23 goal was to increase by 15% the referrals and enrollments into the diabetes, prediabetes, asthma, pediatric healthy weight and adult weight management.
	• While an increase in overall referrals was noted, only a 7% increase in referrals for education on the targeted chronic conditions took place thus falling short of the 15% goal.	

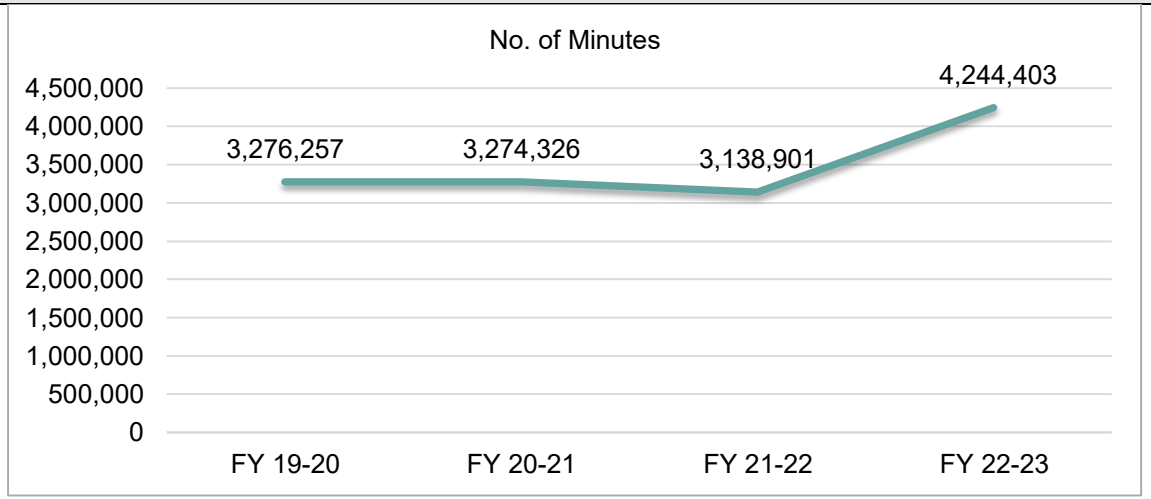
AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Additional Key Accomplishments • Nurse Advice Line redirected 3,276 symptom check calls to appropriate lower level of care; 8% of those were for members that intended to go to the Emergency Department. • An increase of 72% in orders and distribution of health education materials for a total of 55,814 pieces. • Resource Guide on perinatal resources to address maternal health disparities among Black individuals mailed to 1386 members. L.A. Cares About™ programs send monthly mailings with information about resources for newly identified members with diabetes, diabetes and CKD, asthma, COPD and high risk pregnancies. The goal is to drive traffic to the MyHIM™ wellness portal and connect members to education resources such as NAL, health education workshops, coaching and materials.	

L.A.Cares About™		Probable Causes
Letters mailed	73,793	Members do not ▪ open letter ▪ understand letter content ▪ seek resources promoted on letter
*My*HIM™ target conditions workshops completed	40	
*My*HIM™ surveys competed (How did you hear about wellness portal?)	174	
*My*HIM™ survey answer (Heard about wellness portal through a letter)	8	
NAL calls for education on targeted conditions (Unable to directly link receiving letter to NAL utilization)	179	
Self-referrals to Health Education for targeted conditions (Unable to directly link receiving letter to self referrals)	295	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	FY22-23 C&L Program Evaluation C&L Services Unit ensures access to culturally and linguistically appropriate services through provision of language services and provider and member education. This annual evaluation report is for all product lines, which includes: ending of language services utilization uantitative and qualitative analysis aluation of the overall effectiveness of the C&L Program mmunity representatives' feedback on the C&L Program Translation & Alternative. Format 25,454 documents translated in 32 languages • Standard service Translation & Interpretation (T&I): 23%, Rapid service (Language Vault (LV) –Notice of Action letters (NOA)/Notice of Action Resolution (NAR): 77% • 84% increase when compared to FY21-22 • Top three languages: Spanish (70%), Armenian (7%), Chinese (5%) • 89% of standard service (T&I), 98% rapid service (LV) delivered on-time. • 820 alternative formats produced: Large print (75%), Audio (22%), Braille (3%)  	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Face to Face Interpretation 9,069 face-to-face interpreting requests in 31 languages • Medical: 95%, Administrative: 5% • PCPs: 30%, Specialists: 70% • 69% of medical appointments at DHS Rancho (44%) and APHCV (25%) - Top three languages for medical appts: Spanish (52%), Thai (8%), ASL (8%) - 96% of medical requests fulfilled successfully - 97% of members satisfied with services  Telephonic Interpreting 235,875 calls with over 4.2 million minutes in 86 languages • Call Center including Faneuil (72%), CM (5%), EvenMORE (4%) • 27% increase in call volume, 35% increase in call duration Top three languages: Spanish (79%), Mandarin (5%), Armenian (3%) 89% of calls connected in less than 30 seconds 96% of members satisfied with services	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN



Goals: Met Five out of seven goals were met

FY 22-23 Goals		Benchmark	Results	
Member are satisfied ("Very Happy" or "Somewhat Happy") with interpreting and translation services	Face-to-face interpreting	90.0%	96.8%	Met
	Telephonic interpreting	90.0%	95.5%	Met
	Translation	90.0%	99.7%	Met
Deliver translation requests before or on the requested due date.	Standard service (T&I Express)	90.0%	89.3%	*Not met*
	Rapid service (Language Vault)	90.0%	98.4%	Met

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS				ACTION TAKEN
	Telephonic interpreting calls connect in 30 seconds or less.	**90.0%**	**88.8%**	***Not met***	
	Fulfill face-to-face interpreting requests for member medical appointments.	**90.0%**	**96.0%**	**Met**	

Goals: Not Met – Root Cause & Action Taken
Longer connection time to a telephonic interpreter

- *Root cause*: Two major natural disasters; earthquake in Mexico and hurricane in Puerto Rico depleted availability of interpreters especially Spanish, resulting in longer connection time in FY22-23 Q1.
- *Action taken*: Vendor adjusted interpreter hours and allowed overtime to remedy the situation while recruitment and onboarding process continued. The connection time returned to above KPI 96.6% in Q3, 95.2% in Q4.

On-time translation delivery (Standard service, T&I Express)

- *Root cause*: Staff turnover and inconsistency in the way delivery data was captured.
- *Action taken*: On boarded and trained two new Translation Specialists. TThe on-time delivery improved to 88.2% in Q3 and 89.4% in Q4.

Follow-up/Next Steps
FY22-23 C&L Program was able to meet the applicable regulatory requirements and the current needs of L.A. Care members. The program will continue for the following year with no substantive changes.
The C&L Services Unit will continuously pursue initiatives to improve C&L services in the upcoming fiscal year.

- Enhancement of alternative format fulfillment process
- Improvement of Khmer translation quality (Glossary)
- Streamlining face-to-face interpreting workflow
- Enhance provider education opportunities on language services
- Support Health Equity with DEI training implementation
- IT projects (R/E data remediation, Alternate Format data/workflow, NOA translation QNXT)

APPROVED

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
MANAGED CARE ACCOUNTABILITY SETS (MCAS) MEASURE SET MY2023 AND MY2024 (MEDI-CAL)	Bettsy Santana, *MPH, Senior Manager, Quality Improvement Initiatives, Quality Improvement,* gave a report about Managed Care Accountability Sets (MCAS) Measure Set MY2023 and MY2024 (Medi-Cal) *(a copy of the report can be obtained from Board Services).* • The Managed Care Accountability Set (MCAS) is a set of Medi-Cal performance measures that L.A. Care is required to report • For MY 2022, L.A. Care received an intent to sanction in the amount of $890K - L.A. Care has filed an appeal • The MCAS list for MY 2023 has a total of 42 measures with 18 held to the National 50th% as set by the National Committee for Quality Assurance (NCQA), known as the Minimum Performance Level (MPL) - 3 new measures were held to MPL in Measurement Year (MY) 2023 • Currently, we are still collecting data and calculating MY 2023 final rates 2023 Key Findings For MY2023, L.A. Care is at risk of falling below MPL on 9 measures "Topical Fluoride Varnish"* and "Well Care Visits for Children (ages 3-21)" are very close to meeting MPL. We are working hard to ensure we receive all data needed. "Cervical Cancer Screening" rates and "Well Care Visits for Children under 30 Months" have improved but still not at MPL "Follow-up after ED visit for Mental Health Condition (FUM)" and "Follow up after ED visit for Substance Use (FUA)"* have data gap issues that we are working on Measures at risk Rates for MY 2023 as of February 14, 2024	

Measure Description	Measure Type	Rate	50th/ MPL
Cervical Cancer Screening (CCS)	H	50.12%	57.11
Childhood Immunization Status (CIS)	H	25.06%	30.90
Follow-Up After Emergency Department Visit for Substance Use (FUA)	A	26.60%	36.34
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	A	29.79%	54.87

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

Lead Screening in Children (LSC)	H	60.34%	62.79
Prevention - Topical Fluoride For Children	A	16.54%	19.30
Well-Child Visits in the First 30 Months of Life (W30)	A	44.73%	58.38
Well-Child Visits in the First 30 Months of Life (W30)	A	63.46%	66.76
Child and Adolescent Well-Care Visits (WCV)	A	45.30%	48.07

Rates have improved which may lessen the monetary impact for MY 2023.

Highlights
Multiple childhood measures are trending up

- Topical Fluoride Varnish
- Lead Screenings (LSC)
- Well Care Visits for Children 15-30 months (W30 B)
- Child and Adolescent Well-Care Visits (WCV)
- Developmental Screening - Already met MPL
- Immunizations for Adolescent is currently at 75th percentile

We have high performance on two adult measures

- Breast Cancer Screenings is currently at 75th percentile
- Chlamydia Screening is at 90th percentile

MCAS MY 2024/RY 2025

- No substantive changes
- Still 18 Measures held to MPL
  - The diabetes measure transitions from Hemoglobin A1c Control for Patients With Diabetes – HbA1c Poor Control (HBD) to Glycemic Status Assessment for Patients With Diabetes (GSD)
- 23 Measures are reportable
  - Only one measures was dropped from the list from prior year
    - Ambulatory Care – Emergency Department (ED) Visits

APPROVED

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• MY 2025 proposed Changes - 7 additional measures will be held to MPL	
APPROVE QUALITY IMPROVEMENT DOCUMENTS (COM A.0324) • **2023 QUALITY IMPROVEMENT EVALUATION (ALL LINES OF BUSINESS)**	Bettsy Santana, *MPH, Senior Manager, Quality Improvement Initiatives, Quality Improvement,* presented the 2023 Quality Improvement Evaluation (All Lines of Business) and the 2024 Quality Improvement Program to the committee for approval *(a copy of the presentation can be obtainded from Board Services).* Annual QI Evaluation (Fiscal year 22-23) • The Quality Improvement Program Evaluation provides an overview of quality improvement activities and significant accomplishments during the past year, including but not limited to: o Quality and Safety of Clinical Care o Quality of Service o Member Experience o Access to Care • The evaluation documents activities to achieve work plan goals and establishes the groundwork for future quality improvement activities. o Staff throughout L.A. Care contribute to the activities o QI committees oversee the various activities	
• **2024 QUALITY IMPROVEMENT PROGRAM**	The Quality Improvement and Health Equity Program describes the program structure and the formal decision-making arrangement where L.A. Care's goals and objectives are put into an operational framework. Revisions for 2024 General Revisions • Changed from QI program to QI and Health Equity program • Strategic Priorities (2022-2024), Goals, and Objectives were updated • The Staff section only includes directors and above i.e. removed managers from the staffing section New Goals • Implement a Health Equity Mitigation Plan 2023-2025 Scope of the Program • Continued to add language throughout to address providing *equitable* care and services • Removed reference to Kaiser as they now directly contract with the State • Changed Safety Net Initiatives program to Community Supports	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	<u>Motion COM A.0324</u> **Approve the following documents:** • **2023 Quality Improvement Annual Evaluation – All lines of business** • **2024 Quality Improvement & Health Equity Program Description and Work Plan – All Lines of Business**	**Approved unanimously 4 AYES (Ballesteros, Booth, Roybal, and Vazquez)**
PROVIDER QUALITY ISSUES (PQI) FY22-23 REVIEW (ALL LINES OF BUSINESS)	Rhonda Reyes, *Quality Improvement Program Manager III*, and Christine Chueh, *RN MS HCM, CPHQ Director, Provider Quality, Quality Improvement,* gave a report about Provider Quality Issues (PQI) FY22-23 Review (All Lines of Business) *(a copy of the report can be obtainded from Board Services).* Ms. Reyes gave an annual update on the Provider Quality Review Team, which evaluates potential quality of care issues among providers. She mentioned that this year, they processed 7,334 cases, with 29.5% being unsubstantiated referrals and the remaining 5,169 forwarded for clinical review. The increase in processed cases is due to backlog closure and increased staffing. She discussed severity leveling, with 65% of cases having no quality of clinical care issues, 29% having service issues, and 7% having quality of care issues. The stricter approach by nurses led to identifying more quality of care issues this year (7% compared to 3% last year). Ms. Reyes also talked about provider monitoring based on point thresholds and membership sizes. They hold quarterly engagement meetings with high-volume Participating Physician Groups and address issues with timely closure, achieving a 99% closure rate since March 2023 after resolving a backlog issue. They take action against providers for quality of care issues about 90% of the time, with exceptions such as retired providers or those not obligated to respond to corrective action plans.	
PUBLIC COMMENT ON CLOSED SESSION ITEMS	*There was no public ccomment.*	
ADJOURN TO CLOSED SESSION	Augustavia J. Haydel, Esq., *General Counsel*, announced the following items to be discussed in closed session. The JPA Compliance and Quality Committee meeting adjourned and the Compliance and Quality Committee adjourned to closed session at 3:35 P.M. PEER REVIEW Welfare & Institutions Code Section 14087.38(o) CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION Significant exposure to litigation pursuant to Section 54956.9(d)(2) of Ralph M. Brown Act:	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Four potential cases THREAT TO PUBLIC SERVICES OR FACILITIES Government Code Section 54957 Consultation with: Todd Gower, Chief Compliance Officer, Serge Herrera, Privacy Director, and Gene Magerr , Chief Information Security Officer CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act • Department of Managed Health Care Enforcement Matter Numbers: 18-799, 20-063, 21-428, 21-509, 21-680 • Department of Health Care Services, Office of Administrative Hearings and Appeals, In the matter of: L.A. Care Health Care Plan Appeal No. MCP22-0322-559-MF	
RECONVENE IN OPEN SESSION	The Committee reconvened in open session at 4:22 p.m. There was no report from closed session.	
ADJOURNMENT	The meeting adjourned at 4:22 p.m.	

Respectfully submitted by:

Victor Rodriguez, *Board Specialist II, Board Services*
Malou Balones*, Board Specialist III, Board Services*
Linda Merkens*, Senior Manager, Board Services*

APPROVED BY:

_____
Stephanie Booth, MD, *Chairperson*
Date Signed: _____

APPROVED