L.A. CARE BOARD OF GOVERNORS RETREAT / BUSINESS MEETING

September 5, 2024 • 9:00 AM

Lobby Conference Room

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

L.A. Care offices have moved to 1200 W. 7th Street, Los Angeles, CA 90017. Public meetings will continue to be held in the Board Room at 1055 W. 7th Street until early 2025.

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 August 2024	
Medi-Cal	**2,331,026**
L.A. Care Covered	**190,347**
D-SNP	**19,892**
PASC-SEIU	**49,373**
Total membership	**2,590,638**
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**

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L.A. Care HEALTH PLAN®

AGENDA
BOARD OF GOVERNORS RETREAT/MEETING
L.A. Care Health Plan
Thursday, September 5, 2024, 9:00 A.M.
1055 W. 7th Street, Lobby Conference Room 100, Los Angeles, CA 90017

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=m9c454423ce1329a3789e1585fb879aac

To listen to the meeting via teleconference please dial: +1-213-306-3065
English Meeting Access Number 2497 727 9353 Password: lacare
Spanish Meeting Access Number: 2481 597 1792 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.

Light Breakfast (8:30 AM)

Welcome (9:00 AM) — Alvaro Ballesteros, MBA, *Chair*

- Approve today's agenda — *Chair*
- Public Comment (Please read instructions above.) — *Chair*
- Introduction of Speakers — John Baackes, *Chief Executive Officer*
  - Andy Slavitt, *Commissioner, National Academy of Medicine's Commission on Investment Imperatives for a Healthy Nation*
  - John Russell, *Partner, DGA Group Government Relations*

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Fireside Chat & Discussion (9:10 AM) (90 mins) — John Baackes, *Moderator*

- Federal Impacts on L.A. Care — Andy Slavitt
- Presidential Election Possibilities — John Russell
- Questions and discussion from the Board of Governors

CEO Presentation (10:40 AM) (30 mins) — John Baackes

- 2015-2024 Retrospective
- 2024-2027 Plan

Break – 10 minutes

Business Meeting (starts at 11:20 AM)

1. 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".)

- June 6, 2024 Meeting Minutes p.20
- Housing and Homelessness Incentive Program (HHIP) Investment Agreements with the Los Angeles County Department of Health Services Housing for Health & Harm Reduction Division and JWCH Institute to provide access to critical healthcare and social services for the Skid Row community from July 1, 2024 to June 30, 2027. **(BOG 100)** p.56
- Ratify L.A. Care Chief Executive Officer's, John Baackes, execution of Amendment A04 to L.A. Care's Exclusively Aligned Enrollment (EAE) D-SNP Contract Number 22-20236 with the Department of Health Care Services (DHCS) **(EXE 100)** p.58
- 2025 Board and Committee Meeting Schedule **(EXE 101)** p.163
- Pacifica Hospital of the Valley Grant **(EXE 102)** p.165
- L.A. Care's organizational support for California Proposition 35 **(EXE 103)** p.167
- Quarterly Investment Report **(FIN 100)** p.168
- Infosys Contract to provide Information Technology (IT) testing services **(FIN 101)** p.212
- Children's Health Consultant Advisory Committee (CHCAC) Membership **(CHC 100)** p.213
- Children's Health Consultant Advisory Committee (CHCAC) Revised Charter **(CHC 101)** p.214

2. Chairperson's Report — *Chair*

3. Chief Executive Officer Report p.219 — John Baackes

- Vision 2024 Progress Report p.228
- Monthly Grants & Sponsorship Reports p.255
- Government Affairs Update p.262 — Cherie Compartore, *Senior Director, Government Affairs*
  - 2024-25 State Budget Update p.354

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- One-Year Health Equity Impact Report: Health Equity Disparities Mitigation Plan 2023-25 p.357 — Alex Li, MD, *Chief Health Equity Office*

LUNCH BREAK

4. Chief Medical Officer Report p.377 — Sameer Amin, MD, *Chief Medical Officer*
   - MacArthur Park Care Collaborative p.391 — Michael Brodsky, MD, *Senior Medical Director, Community Health*; Charles Robinson, *Senior Director, Community Health*
5. Performance Monitoring August 2024 p.400 — Sameer Amin, MD; Acacia Reed, *Chief Operating Officer*

Public Advisory Committee Reports

6. Temporary Transitional Executive Community Advisory Committee — Fatima Vazquez / Layla Gonzalez, *Consumer member and Advocate member*
7. Technical Advisory Committee — Alex Li, MD, *Committee Chair*
8. Children's Health Consultant Advisory Committee — Alex Li, MD, *Committee Chair*

Board Committee Reports

9. Executive Committee — *Chair*
10. Finance & Budget Committee — Stephanie Booth, MD, *Committee Chair*
    - Chief Financial Officer Report p.487 — Afzal Shah, *Chief Financial Officer*; Jeffrey Ingram, *Deputy Chief Financial Officer*
      - Financial Report as of July 2024 **(FIN 102)** p.515
      - FY 2024-25 Operating Budget **(FIN 103)** p.525
      - Monthly Investment Transactions Reports – March, April, May, June and July 2024 p.560
      - Quarterly Internal Policy Reports p.566
11. Compliance & Quality Committee — Stephanie Booth, MD, *Committee Chair*
12. Provider Relations Advisory Committee — George Greene, Esq., *Committee Chair*
13. Audit Committee — Hector De La Torre, *Committee Chair*
14. Public Comment *(Please read instructions above.)* — *Chair*

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

15. 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: *September 2026*

16. CONTRACT RATES
Pursuant to Welfare and Institutions Code Section 14087.38(m)
- Plan Partner Rates
- Provider Rates
- DHCS Rates

17. CONFERENCE WITH REAL PROPERTY NEGOTIATORS
Section 54956.8 of the Ralph M. Brown Act
Property: 1055 W. 7th St., Los Angeles
Agency Negotiator: John Baackes
Negotiating Parties: Jamison Services, Inc.
Under Negotiation: Price and Terms of Payment

18. 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*

19. 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

20. CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION
Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act
Jones v. L.A. Care Health Plan, L.A. Superior Court Case No. 23STCV04081

21. 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)

22. 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

23. PUBLIC EMPLOYEE PERFORMANCE EVALUATION, PUBLIC EMPLOYMENT and CONFERENCE WITH LABOR NEGOTIATOR

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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 *Chair*

ADJOURNMENT *Chair*

The next meeting is scheduled on October 3, 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 Reception Area, Lobby, at 1055 W. 7th Street, Los Angeles, CA 90017, 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.

L.A. Care HEALTH PLAN
1200 W. 7th Street, Los Angeles, CA 90017
Tel. (213) 428.5500

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)* Lobby Conference Room 100 1055 W. 7th Street Los Angeles, CA 90017 ***All Day Retreat* ****Placeholder meeting*	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)* Lobby Conference Room 100 1055 W. 7th Street Los Angeles, CA 90017 **3rd Wednesday due to Thanksgiving holiday*	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)* Lobby Conference Room 100 1055 W. 7th Street Los Angeles, CA 90017	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)* Lobby Conference Room 100 1055 W. 7th Street Los Angeles, CA 90017 **3rd Wednesday due to Thanksgiving holiday*	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)* Lobby Conference Room 100 1055 W. 7th Street Los Angeles, CA 90017	November 20	George Greene, Esq., *Chairperson* **Staff Contact:** Linda Merkens *Senior Manager, Board Services, x4050*
AUDIT COMMITTEE	Lobby Conference Room 100 1055 W. 7th Street Los Angeles, CA 90017 **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	Lobby Conference Room 100 1055 W. 7th Street Los Angeles, CA 90017 **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	Lobby Conference Room 100 1055 W. 7th Street Los Angeles, CA 90017 **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** Lobby Conference Room 100 1055 W. 7th Street Los Angeles, CA 90017		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	Lobby Conference Room 100 1055 W. 7th Street Los Angeles, CA 90017 ***All Day Retreat.* ***Placeholder meeting*	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)* Lobby Conference Room 100 1055 W. 7th Street Los Angeles, CA 90017	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)* Lobby Conference Room 100 1055 W. 7th Street Los Angeles, CA 90017	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)* Lobby Conference Room 100 1055 W. 7th Street Los Angeles, CA 90017	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	11 AM *(for approximately 2-1/2 hours)* L.A. Care Community Resource Center 2072 E. Palmdale Blvd. Palmdale, CA 93550 (213) 438-5580	Tuesday September 17, 2024 Welcome Meeting Friday October 18, 2024 Friday December 13, 2024	**Staff Contact:** Frank Meza (323) 541-7900 Ramon Garcia (213) 359-0086 *Community Outreach & Education*
REGION 2	10 AM *(for approximately 2-1/2 hours)* L.A. Care Community Resource Center 7868 Van Nuys Blvd. Panorama City CA 91402 (213) 438-5497	Wednesday September 18, 2024 Welcome Meeting Monday November 18, 2024	**Staff Contact:** Martin Vicente (213) 503-6199 Tyonna Baker (213) 760-2050 *Community Outreach & Education*
REGION 3	3 PM *(for approximately 2-1/2 hours)* Community Resource Center in El Monte 3570 Santa Anita Ave. El Monte, CA 91731 (213) 428-1495	Thursday, September 19, 2024 Welcome Meeting Wednesday November 20, 2024	**Staff Contact:** Frank Meza (323) 541-7900 Ramon Garcia (213) 359-0086 *Community Outreach & Education*
REGION 4	10:00 AM *(for approximately 2-1/2 hours)* Community Resource Center in Metro L.A. 11173 W. Pico Blvd. Los Angeles, CA 90064 (310) 231-3854	Friday September 20, 2024 Welcome Meeting Tuesday November 19, 2024	**Staff Contact:** Christopher Maghar (213) 549-2146 Cindy Pozos (213) 545-4649 *Community Outreach & Education*
REGION 5	2:00 PM *(for approximately 2-1/2 hours)* Community Resource Center in West L.A. 1233 S. Western Ave. Los Angeles, CA 90006 (213) 428-1457	Thursday, September 26, 2024 Welcome Meeting Thursday October 17, 2024 Thursday December 19, 2024	**Staff Contact:** Christopher Maghar (213) 549-2146 Cindy Pozos (213) 545-4649 *Community Outreach & Education*

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

REGION 6	10:00 AM *(for approximately 2-1/2 hours)* Community Resource Center in South Los Angeles 5710 Crenshaw Blvd. Los Angeles, CA 90043 Community Resource Center in Lynwood 3200 E. Imperial Highway Lynwood, CA 90262	Wednesday September 25, 2024 Welcome Meeting (Lynwood) Wednesday October 16, 2024 (Lynwood) Wednesday December 18, 2024 (South LA)	**Staff Contact:** Martin Vicente (213) 503-6199 Tyonna Baker (213) 760-2050 *Community Outreach & Education*
REGION 7	10:00 AM *(for approximately 2-1/2 hours)* Community Resource Center in East L.A. 4801 Whittier Blvd. Los Angeles, CA 90022 (213) 438-5570 Community Resource Center in Norwalk 11721 Rosecrans Ave. Norwalk, CA 90650 (562) 651-6060	Tuesday September 24, 2024 Welcome Meeting (East LA) Friday November 15, 2024 (Norwalk)	**Staff Contact:** Kristina Chung (213) 905-8502 Hilda Herrera (213) 605-4197 *Community Outreach & Education*
REGION 8	10:00 AM *(for approximately 2-1/2 hours)* Community Resource Center in Wilmington 911 N. Avalon Blvd. Wilmington, CA 90744 (213) 428-1490 Community Resource Center in Long Beach 5599 Atlantic Ave. Long Beach, CA 90805 (562) 256-9810	Monday September 23, 2024 Welcome Meeting (Long Beach) Monday October 21, 2024 (Wilmington) Monday December 16, 2024 (Long Beach)	**Staff Contact:** Kristina Chung (213) 905-8502 Hilda Herrera (213) 605-4197 *Community Outreach & Education*

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L.A. Care HEALTH PLAN

Schedule of Meetings
September 2024

Monday	Tuesday	Wednesday	Thursday	Friday
2	**3**	**4**	**5** ***Board of Governors Retreat/Meeting*** ***9 am*** *(for approx. 6 hours)*	**6**
9	**10**	**11** ***TTECAC Meeting*** *10 AM* *(for approx. 3 hours)*	**12**	**13**
16	**17** ***Region 1 Welcome Meeting*** *11 AM* *(for approx. 2-1/2 hours)*	**18** ***Region 2 Welcome Meeting*** *10 AM* *(for approx. 2-1/2 hours)*	**19** ***Compliance & Quality Committee Meeting*** ***2 PM*** *(for approx. 2 hours)* ***Region 3 Welcome Meeting*** *3 PM* *(for approx. 2-1/2 hours)*	**20** ***Region 4 Welcome Meeting*** *10 AM* *(for approx. 2-1/2 hours)*
23 ***Region 8 Welcome Meeting*** *10 AM* *(for approx. 2-1/2 hours)*	**24** ***Region 7 Welcome Meeting*** *10 AM* *(for approx. 2-1/2 hours)*	**25** ***Region 6 Welcome Meeting*** *10 AM* *(for approx. 2-1/2 hours)* ***Finance & Budget Committee Meeting*** *1 PM* *(for approx. 1 hour)* ***Executive Committee Meeting*** *2 PM* *(for approx. 2 hours)*	**26** ***Region 5 Welcome Meeting*** *2 PM* *(for approx. 2-1/2 hours)*	**27**
30				

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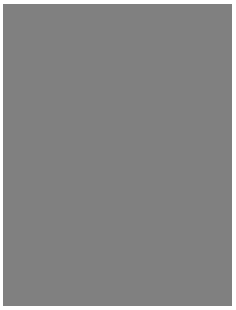
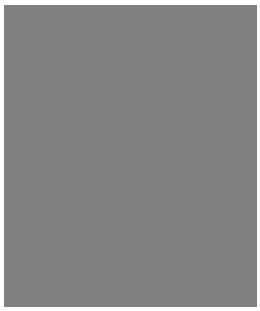
Prepared by mhbalones/printed on 08/29/24

L.A. Care Board of Governors Retreat Guest Speakers



ANDY SLAVITT was President Biden's White House Senior Advisor for the Covid response. He is currently a commissioner on the National Academy of Medicine's Commission on Investment Imperatives for a Healthy Nation. He was previously a working member of President Biden's President's Council of Advisors on Science and Technology (PCAST) working group on public health. He has led many of the nation's most important health care initiatives, serving as President Obama's head of Medicare and Medicaid and overseeing the turnaround, implementation and defense of the Affordable Care Act. Slavitt is the "outsider's insider", serving in leading private and non-profit roles in addition to his government services. He is founder and Board Chair Emeritus of United States of Care, a national non-profit health advocacy organization as well as a founding partner of Town Hall Ventures, a healthcare firm that invests in underrepresented communities. He co-chaired a national initiative on the future of health care at the Bipartisan Policy Center. He chronicles what goes on inside the government and across the nation at town halls, in USA Today, on his award-winning podcast In the Bubble, and formerly on Twitter. He is the author of Preventable, a best-selling account of the US's Coronavirus response released in 2021. A graduate of the University of Pennsylvania and Harvard Business School, he and his wife have two grown sons.



JOHN RUSSELL is a Partner at DGA Group Government Relations. Focusing on federal advocacy and strategic communications, he worked for nearly a decade on Capitol Hill, serving on the leadership staffs of a speaker, a House majority whip and the chairman of the House Campaign Committee. Throughout his career, he has worked both extensively and effectively in the legislative, communications and campaign arenas.

Described by the National Journal's Richard Cohen as experienced and discreet, Mr. Russell has built and maintained strong relationships with members of Congress, as well as committee and personal office staffs. His strong and nuanced working knowledge of the policy, political and personal aspects of Washington, DC, allows him to design winning strategies to accomplish dynamic policy and market objectives. He was named a Top Lobbyist for 2018, 2019 and 2020 by *The Hill* newspaper.

Mr. Russell joined DGA Group from its partner, Dentons, the largest law firm in the world. Earlier in his career, he spent nearly two years working on the floor of the US House of Representatives, interacting with members from both sides of the aisle as he managed the day-to-day legislative operations as a floor assistant and then deputy to the chief of staff for House Speaker J. Dennis Hastert. Before his position with Hastert, he was recognized as the youngest chief of staff on Capitol Hill when he served Congressman J. Randy Forbes, after working as a senior campaign aide during a June 2001 special election.

Prior to that campaign, Mr. Russell was the aide-de-camp to National Republican Congressional Committee Chairman Tom Davis, after running the congressman's successful leadership election in the fall of 2000. Mr. Russell began his Capitol Hill career in the office of Majority Whip Tom DeLay as a staff assistant and rose to become the outreach coordinator responsible for maintaining relationships and building coalitions between key members of the business community and the Republican leadership.

Mr. Russell worked day-to-day in the highest levels on Capitol Hill. This perspective brought lasting relationships and a wealth of real-world experience in designing, implementing and maintaining dynamic, battle-tested legislative and strategic communications plans. He has built high-stakes communications programs for those who face the most stringent levels of media scrutiny. He is well-versed in traditional media and is at the leading edge of ever-growing online news operations. He works on a daily basis with leading newsrooms to bring balance to media coverage of high-profile issues and clients.

CONSENT AGENDA

Board of Governors
Regular Meeting Minutes #328
June 6, 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*
Acacia Reed, *Chief Operating Officer*
Afzal Shah, *Chief Financial Officer*

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
WELCOME	Alvaro Ballesteros, *Board Chairperson,* called to order at 1:04 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. Chairperson Ballesteros invited Board Member Vaccaro to address the Board. Board Member Vaccaro informed Board Members she was not able to attend the meeting in person due to an unexpected health issue, and requested approval to participate remotely. She stated that there are no individuals in the room with her. Board Chairperson Ballesteros welcomed everyone and outlined the information for public comment included on the meeting Agenda.	
APPROVAL OF MEETING AGENDA	**The meeting Agendas were approved as submitted.**	**Unanimously approved by roll call. 10 AYES (Ballesteros, Booth, Contreras, Ghaly, Gonzalez, Raffoul, Roybal, Solis, Vaccaro and Vazquez)**

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Public Comment	*Maria Rabaja asked about Medicare Plus, because she is getting confused on how to use it. Every time they said that she can only use it in Walmart, but when she uses it at Walmart to get some nutritious food, sometimes they do not allow it or they do not pay for it. When she gets a medicine or for healthcare stuff like shampoo, they have something in the catalog on the L.A. Care but at Walmart it does not pay it. She's just really confused on how you use it. And they said he can use it for gas and electric but when she goes to places to pay, they don't allow the card and it doesn't work.* Mr. Baackes requested Acacia Reed, *Chief Operating Officer*, to meet with Mrs. Rabaja to address her concern. *Sylvia Sosio wanted to speak about item 13, a motion regarding buttons in the new building. She expressed her experience as a handicap person. She used to be a very strong woman and now suffers a lot walking with a walker. Los Angeles and many similar cities have become very difficult. It is very difficult to access a bus or some places where you do not have the opportunity of pressing a button. It is very difficult to move and push and hold very heavy doors. Sometimes you find somebody very nice that will open and hold the door for you, but most of the time, no. Please whenever you design a new building, keep in mind handicap people. We have very particular experiences due to our limitations. Thank you.* Mr. Baackes thanked Ms. Sosio for her comment and added that all of this will be taken into consideration for L.A. Care's move to 1200 7th Street building. He added that L.A. Care would probably not be meeting in 1200 7th Street building until the end of the year at the earliest. *Submitted June 5 at 9:18 PM from Jonathan Cooper* *Good afternoon members of the Board of Governors. On behalf of Jonathan Cooper, this is his comment to the Board. My name is Jonathan Cooper. I am an L.A. Care member. I would like to wish the Board, Mr. John Baackes and staff Happy Father's Day on June 16. I would also like to thank all fathers in their role as fathers and role models and to the community for their assistance on this Father's Day. May God bless each and every one of you. From Jonathan Cooper, L.A. Care member.*	
ADJOURN TO CLOSED SESSION	The Joint Powers Authority Board of Directors meeting temporarily adjourned at 1:12 pm. Ms. Haydel announced the following items to be discussed in closed session. The L.A. Care Board of Governors adjourned to closed session at 1:14 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: *June 2026*	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	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* and Gene Magerr, *Chief Information Security Officer* 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 CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act Jones v. L.A. Care Health Plan, L.A. Superior Court Case No. 23STCV04081 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: 23-725, 21-855 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	

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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 2:46 pm. There was no report from closed session. Chairperson Ballesteros welcomed members of the public to the meeting. He provided information about submitting public comment.	
PUBLIC COMMENTS	*Andria McFerson thanked the Chairperson for allowing her to address the Board, and thanked them for listening. She has a neighbor friend. Her friend had a business and was doing great before to COVID-19. Her friend is now is pre homeless, and she has never been through that before. The homeless population is not just people who have made bad decisions about their wellbeing. It is people who have had businesses. If we do have an outreach and engagement department, can L.A. Care get back with her if it deals with homelessness and people who are going through a lot of mental disparities, different resources they may have. Can L.A. Care please talk to her about it so that she can give Sylvia that information? She's a great person. She shouldn't be homeless. She worked all her life.* *Deaka McClain thanked the Board for the opportunity to speak. She expressed she has been waiting for a long time for this day. Ms. McClain is an ECAC At Large member representing seniors and people with disabilities, and Vice Chair of the Temporary Transitional ECAC. Ms. McClain spoke about the doors in this building and in the new building. Ms. McClain read some regulations of the Americans with Disabilities Act (ADA) which require that state and local governments give people with disabilities an equal opportunity to benefit from all of their programs and services and activities, such as public education, employment, transportation, recreation, healthcare, and social services, courts, voting, and town hall meetings, etc. She added this includes this meeting that the public attends. She expressed she understood that the request was tabled and staff is doing research. She thanked staff and asked to not rush the research. She added that the push doors are expensive. She expressed this is not her first time to talk about the ADA and the door. This is about meeting a need. There are people that come to these meetings regularly, disabled or not, who struggled with opening the door. They should not have to rely on a person to open the door for them or should have to wait for somebody to come down the hallway and hope that they open the door. That could cause a mental effect on someone. She wants to express the seriousness of this. Ms. McClain noted that when we are talking about expense, she would hate for something to happen while somebody is here because they got hurt trying to push open a door. She thanked the Board for the time to talk about this. She expressed her appreciation. Ms. McClain stated that staff should look at having an ADA consultant with the research. It is important.*	

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	Received on June 5 at 9:28 pm, from Elizabeth Cooper *She commented on BOG motion 104. She has concern about the ECAC, and hopes that the RCACs still have input. She apologized but stated she just received the board book Wednesday, June 5. She was deeply concerned about whether there will be RCAC participation. She feels the RCAC Chairs should have more communication with members before they approve a motion. They should communicate with the members they represent. She hoped that the Executive Committee will take the consumer involvement more into consideration and make sure the changes they make will allow input from the public and not just the ECAC. She thanked the Board but it has been challenging because she was just reading the board book today.*	
APPROVE CONSENT AGENDA ITEMS	**PUBLIC COMMENT** *Andria McFerson is a member of RCAC 5 and wanted to discuss Item 13 because it says take from table the TTECAC motions. She wanted some sort of clarification and was not quite sure what TTECAC consisted of. If it had anything to do with the budget of the TTECAC, including the previous fiscal years from all the way from 2022 until now. She wanted to know if it has anything to do with that because L.A. Care was to negotiate Medi-Cal contract and plan and all of the things above. She asked to please not quote her on anything having to do with her comment. She is not basically stating that L.A. Care are talking about that. That's an overall question on that particular topic. She is not quite sure.* *Received June 5 at 9:28 pm from Elizabeth Cooper* *She wished everyone a Happy Father's Day for June 16, 2024, and would also like to speak on item 13 of the consent agenda EXE 100. She supports EXE 101 from the consent agenda item. She approves housing, which is very important as one who advocates and one who is a member of the RCACs for a number of years. She supports EXE 101. Motion TCAC 100, she also supports that. She expressed she was reading the board book late. She approves public advisory report 100. She cannot say that she recognized that motion but supports it.* Board Member Booth thanked the staff that prepared the table of the significant changes to the contract included in Motion BOG 102. It was so much better being able to look at what the overall change was and to refer to the area what changed, and what was new. • May 2, 2024 meeting minutes	

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	• Delegate authority to L.A. Care Chief Executive Officer, John Baackes, to negotiate and execute Amendment A02 to the 2024 Medi-Cal Contract 23-30232 between L.A. Care Health Plan and the California Department of Health Care Services **Motion BOG 102.0624*** **To delegate authority to L.A. Care Chief Executive Officer, John Baackes, to negotiate and execute Amendment A02 to the 2024 Medi-Cal Contract 23-30232 between L.A. Care Health Plan and the California Department of Health Care Services.** • Quarterly Investment Report **Motion FIN 100.0624*** **To accept the Quarterly Investment Report for the quarter ending March 31, 2024, as submitted.** • Take from the table Motions **TTECA 100 and TTECA 101 to** continue consideration of these motions to the July 25, 2024 Board Meeting.	**Unanimously approved by roll call. 11 AYES (Ballesteros, Booth, Contreras, Ghaly, Gonzalez, Greene, Raffoul, Roybal, Solis, Vaccaro and Vazquez)**
CHAIRPERSON'S REPORT	Chairperson Ballesteros acknowledged the month of June includes several national types of awareness. A few of them are National Portuguese Heritage Month, National Caribbean American Heritage Month, National PTSD Awareness Month, National Give a Bunch of Balloons Heritage Month, National DJ Month, Men's Health Month, National Papaya Month and National Adopt a Cat Month. There are several holidays in June that are very important. One is Juneteenth, celebrated on June 19, a very important federal holiday. It is celebrated annually to commemorate the ending of slavery in the United States. The holiday's name is a combination of using June and 19th, Juneteenth. On June 19, 1865 Major General Gordon Granger ordered the final enforcement of the emancipation proclamation in Texas after the end of the American Civil War. That is largely considered the end of slavery in the United States and a very important holiday for the African American communities in the United States. Chairperson Ballesteros noted that June is LGBT Awareness Month and Pride Month. He noted that there are a lot of health and access disparities that continue with the LGBTQ populations. In a Kaiser Family Foundation report published on June 30, 2023, among the findings around access and perceptions of healthcare, there are important points that need to be recognized. LGBT people report higher rates of the discrimination during health care visits compared to non-LGBTQ people. LGBTQ people are more likely to have lower incomes and be on public benefits programs. Many LGBTQ people report discrimination with their particular providers. There are high rates of depression and anxiety especially among older	

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	LGBTQ people. A lot of healthcare disparities, especially with access to mental health and housing were reported among younger LGBTQ people. Chairperson Ballesteros expressed his respect for Supervisors Solis, the members of the Board of Supervisors and the elected officials who take the time to participate in some of the larger Pride events. He had the opportunity to see that the Supervisors, along with Board Member Contreras, and a lot of members of the various Los Angeles County Departments, participated in the Pride events. This is important for the community and to younger people, showing them that they matter and they are being seen. He believes these are the first steps to dealing with some of the larger issues the community faces. Chairperson Ballesteros thanked all and encouraged all to learn more about the communities in Los Angeles County that are part of the L.A. Care family.	
CHIEF EXECUTIVE OFFICER REPORT • Department of Managed Health Care Enforcement Matter	**PUBLIC COMMENT** *Andria McFerson is a RCAC 5 member. She asked if there are actual stakeholder members of L.A. Care in the executive committee, in order to help make decisions and provisions to the new motion being presented.* John Baackes, *Chief Executive Officer*, responded that the selection committee being proposed for consumer members will have three members selected by the Executive Community Advisory Committee (ECAC). Mr. Baackes and Alex Li, MD, *Chief Equity Officer*, attended the graduation at UCLA Geffen School of Medicine and the Charles Drew University of Medicine and Science. Nine L.A. Care scholars attend CDU under the UCLA accreditation, and they can participate in that commencement. Mr. Baackes shared a photo with eight of the nine scholars. He met the ninth scholar who had left with his family. It was a wonderful occasion. Seven of the nine scholars will complete residency in Los Angeles, two will go out of state and promised that they will come back to Los Angeles at the end of their residencies. L.A. Care will announce the next eight scholars in July 2024 and Board members will be invited to that occasion. L.A. Care opened the new Panorama City Community Resource Center (CRC) on May 17, 2024. Board Member Vazquez and many RCAC Chairs also attended the opening. It was a bigger event than the previous ones because there was a huge parking lot. There was a tent and two local school bands, and it was a very inclusive ceremony. This replaced the CRC that had been in Pacoima. One band was from Pacoima and the other from Panorama City, and it was a very local-flavored event. Two more CRCs will open before the end of the year which will complete L.A. Care's expansion to 14 CRCs.	

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	Mr. Baackes stated that L.A. Care was accredited by the National Committee on Quality Assurance (NCQA) since before his tenure. L.A. Care originally was NCQA accredited as a Medi-Cal plan. Over the years, L.A. Care has earned accreditations for each of its product lines; L.A. Care has separate NCQA accreditation for Medicare and for Covered California. The NCQA accreditations are renewed every three years and are subject to audit. Recently, L.A. Care's accreditation had been under review and had a corrective action plan. Mr. Baackes was pleased to announce that L.A. Care passed that accreditation review with flying colors and is now fully accredited in all three product lines. L.A. Care also recently announced receiving Health Equity accreditation from NCQA earlier this spring. Mr. Baackes provided an update on the redetermination process. L.A. Care has completed all twelve months *(a copy of his presentation can be obtained by contacting Board Services)*. As of May 2024, L.A. Care had 2,331,000 Medi-Cal members. L.A. Care has added 51,352 new members who were released from hold. These were people who had not completed their redetermination process which were put on hold for 90 days, and 2,800 of them came off. They completed the process and eligibility was reestablished back to the effective date of their being put on hold. L.A. Care lost 8,704 who were disenrolled because they no longer qualified. Most of these are people whose income exceeded the ceiling of 138 % of the federal poverty law level or may have moved out of Los Angeles County. L.A. Care had 52,800 people placed on hold for 90 days who did not complete the redetermination process. During the 90 day period, if they complete the process, they will be reinstated back to that date. This brings L.A. Care's current Medi-Cal enrollment to 2,324,000. About 49% of the members were redetermined through the ex parte process. The California Department of Health Care Services (DHCS) had obtained waivers from Centers for Medicare and Medicaid Services (CMS) and was able to use information from other databases and could conclude without the participation of the member that they were qualified. Those people received a letter in the mail saying they have been redetermined as eligible for another year and had to do nothing. Members also renewed by completing a 20-page packet, and 19% of L.A. Care's members renewed with that process. There were 600,000 or 26% who were terminated because their eligibility was put on hold and never completed the process. L.A. Care had 126,000 members who were terminated because they were determined ineligible, likely because their income had exceeded the 138% limit. After the twelve month period, L.A. Care still has 135,000 members on hold. During this month, L.A. Care lost 350,000 placed on hold; 120,000 were released from hold and regained coverage. L.A. Care will probably not report on this again for 90 days, because the 135,000 on hold will have up to 90 days to complete the process. Mr. Baackes summarized the monthly progression, beginning with 2,735,000 total Medi-Cal enrollment and currently at 2,324,000, with a net loss of 410,000. In January 2024 L.A. Care lost 287,000 members who had enrolled with Kaiser, because of the new contract directly	

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	between DHCS and Kaiser. To measure the real effect of the redetermination process on L.A. Care enrollment, the Kaiser enrollees should be removed from the equation, leaving a net loss of 122,980 (5%). L.A. Care has analyzed the members who were dis-enrolled, and he invited Phinney Ahn, *Executive Director, Medi-Cal*, to provide that information. Ms. Ahn noted that during the last board meeting this topic was discussed in light of the high volume of members enrolling. Staff reviewed the new enrollments to see how many had a prior affiliation with L.A. Care. It was determined that almost 50% had some type of a prior enrollment with L.A. Care. When staff dug a little bit deeper, of those 50% about 40% had been enrolled with L.A. Care within the last few months. It was concluded that many of the members have been dis-enrolled from Medi-Cal due to redeterminations or whatever reasons. They may have discovered their loss of coverage a month or two or three after being discontinued and had to re-enroll because they were outside of that 90 day reinstatement period, and chose L.A. Care as their health plan again. About 350,000 members were terminated after being on hold and a good portion of them came back to L.A. Care. Mr. Baackes acknowledged and thanked Board Member Contreras for the good working relationship L.A. Care had with Los Angeles Department of Public and Social Services during this process. There was a lot of data exchanged so that L.A. Care files were updated with the most current information for both agencies. Board Member Supervisor Solis asked about the number of undocumented adults in the expansion. Mr. Baackes noted of the additional undocumented members eligible for Medi-Cal, L.A. Care picked up 164,000. Most of those came in the first three months of 2024, and enrollments continue to trickle in. That is close to the estimate of 170,000 members. This was a big part of why L.A. Care's loss in members was only 5 %, because L.A. Care got that influx of the undocumented adults between the ages of 26 and 49. Supervisor Solis added that this number could potentially keep growing because this is a relatively new program that is not well known. Mr. Baackes agreed. He noted that L.A. Care was recently called upon to assist with the Catalina Island Hospital. During this project, L.A. Care learned that there are many undocumented residents on the island who work in the hospitality industry, and those people are likely eligible for Medi Cal. At a community event 30 families enrolled in one day. L.A. Care is pleased that California can take credit for making access to health care available to almost everyone. Mr. Baackes commented on the 2024-25 California State budget and its impact on Medi-Cal. Last year, the managed care organization (MCO) tax was reinstated on health plans like L.A.	

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	Care and commercial plans. The tax that is raised draws down an equal dollar amount from the federal government. The tax had been in effect for nine years until it expired in 2021. In 2022, California felt no need to renew it because there was such a large budget surplus. During the first nine years, the federal matching funds were placed in the general fund. In 2022, L.A. Care was involved with a coalition of health care payers, hospitals, doctors, clinics, unions, and all the health plans, in a push to get the tax reinstated and direct the proceeds from the federal drawdown to Medi-Cal to increase provider reimbursement. The tax was reinstated in last year's state budget. It was estimated that over a three year period, the MCO tax would yield $19 billion in additional federal funding with $8 billion going to the general fund and the balance to be used to increase Medi Cal reimbursement to providers. When California's Governor announced the revised budget in May, he indicated that all the proceeds from the MCO tax would be swept into the general fund because of the state's budget deficit. That would leave none of the funds to increase reimbursement to Medi-Cal providers. As it stands today, in the budget bills California legislators have reinstated funding for Medi-Cal that health plans like L.A. Care could receive, but postponed it for one year to 2026. It is a gesture because it does not mean Medi-Cal health plans like L.A. Care would receive funds this year. A similar vote would be required to get it in the budget in 2026. Those who have served in the legislature know that budget decisions can't be made prospectively, it must be done in the current year. The coalition that had proposed the tax originally also pursued a ballot initiative. There is great concern about budgeting by ballot initiatives, but with a ballot initiative on the tax, the federal match would go to Medi Cal, it would then be more difficult for future governors and legislators to redirect the money in some other way. The ballot initiative has qualified and was certified by the Secretary of State. There is no proposition number yet, but there will be a ballot initiative this fall that will ask voters to approve that the MCO tax proceeds would go to Medi Cal reimbursement for providers. It presents a problem for health plans to not have the additional funding for next year for the providers. It is hoped that the proposition is successful, and would produce the kind of increases hoped for to fund Medi-Cal providers. Mr. Baackes reported that L.A. Care settled two enforcement actions with the Department of Managed Healthcare (DMHC). One dating back to November 2023 regarding L.A. Care's handling of a payment for ambulance transportation from Mexico to San Diego. There was an improper denial of the claims for those emergency services. The settlement offer with the State is $10,000. L.A. Care signed a letter of agreement to that effect in March. The second matter involves for a violation of a claim for emergency services and a covered benefit. L.A. Care failed to pay the claim within 45 days and failed to resolve the member's grievances. L.A. Care have settled that for a $40,000 fine that was signed also in March. Board Member Contreras clarified that the continuous coverage unwinding officially ended as of May 31, 2024. DPSS is back to business as usual and awaiting further direction from	

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	regulators about future changes. The waivers relate to the federal poverty level and the stable income waiver. The increased numbers are for automatic renewal and remain in place only until December 31, 2024, and will go away after that. There is active advocacy for those to remain in place. In terms of state budget implications, nothing changed with the Medi-Cal expansion of eligibility, but for the In-Home Support Services (IHSS) customers, if you are undocumented, you are no longer eligible for IHSS as of July 1, 2024. This includes those that were recently enrolled in January 1, 2024 with the latest expansion. Those that were enrolled in prior years in the first phases of the expansion are still in the budget proposal. This is being tracked very closely and there is active advocacy for that to change. Mr. Baackes thanked Board Member Contreras. He added that he did not realize that the waivers had time limits. Board Member Contreras clarified that those were put in place specifically because of the challenges with a number of people falling off Medi-Cal. Mr. Baackes noted that the IHSS issue is important to L.A. Care's Elevating the Safety Net program, through which L.A. Care trains IHSS workers. L.A. Care has trained about 900-1000 a year. This will have the most impact for those folks. Supervisor Solis asked if L.A. Care is in any kind of a position to help or lobby. Mr. Baackes noted that L.A. Care and its trade association, the Local Health Plans of California, is addressing this. L.A. Care included the training in the Elevating the Safety Net program to invest in educating those IHSS caregivers, because 90% of them are family members selected by the beneficiary, and most of them have no training. L.A. Care has found that when their client is an L.A. Care member the training helps these workers be more effective as part of L.A. Care's care team - it adds real value. L.A. Care has been following the data that shows when the beneficiary has an IHSS worker that has gone through training, the use of emergency room services drops and readmissions to hospitals also drop. It is a very good investment by L.A. Care. L.A. Care is not included in the capitation from the state to pay the IHHS workers, that program is outside the funding from the county and the state. L.A. Care is training the IHSS workers because there is value for the members.	
• Monthly Grants and Sponsorships Reports	Mr. Baackes referred Board Members to the written reports included in the meeting materials.	
• Government Affairs Update o 2024-25 State Budget Update	Cherie Compartore, *Senior Director, Government Affairs,* referred to the information in the meeting materials related to the Governor's May Revise, and she provided an update on the Legislative actions taken on the Governor's May Revise.	

	Children's Hospital Directed Payments The Legislature rejected the Governor's proposal to fund the Children's Hospital Directed Payment program. Medi-Cal Equity and Practice Transformation (EPT) Payments to Providers The Legislature agreed with the Governor to eliminate future funding for the program when current funding expires in one year. Medi-Cal: Adult Acupuncture Benefit The Legislature rejected the Governor's proposal to eliminate the adult acupuncture Medi-Cal benefit. California Food Assistance Program (CFAP) Expansion CFAP is the state-funded Cal Fresh counterpart included in the 2022 budget that allowed undocumented income-eligible individuals aged 55 and over to receive food assistance. The Legislature agreed with the Governor for the 2027-28 budget year to an expansion of CFAP to undocumented seniors. In-Home Supportive Services (IHSS) Benefit for the Undocumented The Legislature rejected the Governor's budget proposal to eliminate the In-Home Supportive Services (IHSS) benefit for undocumented Medi-Cal enrollees. In-Home Supportive Services (IHSS) Backup Provider System (BUPS) The Legislature modified the Governor's budget proposal to provide temporary IHSS services from backup providers to those who receive IHSS when their regular IHSS providers are unavailable. The Legislature rejected the Governor's budget proposal to eliminate the backup provider system but to instead reduce the program funding to reflect lower utilization. Covered California – Health Care Affordability Reserve Fund (Reserve Fund) Beginning in 2025-26, transfers $109 million from individual mandate penalty payments from the Health Care Affordability Reserve Fund to the General Fund. The revenue from the penalty was originally intended to offset General Fund expenditures for enrollee costs for the Covered California state subsidy program. The Reserve Fund is intended to mitigate adverse federal actions or inactions, including the non-renewal of Inflation Reduction Act premium subsidy enhancements. Per the Administration, the Reserve Fund will still contain adequate funding for subsidy enhancements in 2024-25. Local Public Health Funding The Legislature modified the Governor's budget proposal that would have eliminated Post-Pandemic Public Health Infrastructure Funding. The Legislature instead delayed the new health investments to be delayed one year until January 2026. Increase Directed Payments to Public Hospitals	

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	The Legislature approved the Governor's budget proposal to increase directed payments to public hospitals via the Enhanced Payment Program and Quality Incentive Pool programs. The amount of the increased payment is not yet clear. The proposal allows the Administration to collect administrative fees. Over the next several weeks, budget negotiations will continue between Legislative Leadership and the Governor, and the main budget bill is expected to be sent to the Governor by June 15 in compliance with state law. The new fiscal year starts on July 1. The main budget bill will be followed by budget "trailer" bills which contain the details for implementation of the provisions in the main bill, including a trailer bill dedicated to health related items. There is no deadline for passing the trailer bills. Mr. Baackes noted in regard to the Children's Hospital issue, there was a ballot initiative proposed to restore funding that had been cut. If the funding is reinstated in the budget, the ballot initiative will be withdrawn. Board Member Booth asked about other provisions in the May Revise as the report referred just to items to which the legislature objected. Ms. Compartore responded that once the final June 15 Budget Bill is signed, Government Affairs will provide an updated memo. Board Member Booth commented that the May Revise provided funding for two hospital items and took hundreds of millions from other items. Mr. Baackes responded that his understanding is that the funding was restored because the children's hospitals agreed to withdraw their ballot initiative. Board Member Contreras noted that the backup program that was referenced for IHSS is the state program. There is a local county program that was established by the Board of Supervisors in 2008, and that program remains. Board Member Gonzalez asked about the status of Assembly Bill AB 1783 related to funding healthcare for illegal immigrants. Ms. Compartore responded that AB 1783 is still active, pending referral and it will likely not move forward. There has been a lot of opposition to it and based on some of the Republicans and Democrats comments in Committee, it's probably going to fail.	
CHIEF MEDICAL OFFICER	**PUBLIC COMMENT** *Andria McFerson, RCAC 5, as a co-Chair, she was very interested in the topic of L.A. Care's support for members experiencing homelessness. Years ago as a*	

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• L.A. Care's Support for Members Experiencing Homelessness	*RCAC 6 Chair, she filed a motion to support L.A. Care reaching out to the homeless, mentally, physically and overall medically, having psychological evaluations in order to place them in the proper programs to become housed. Some examples she spoke about were necessities. They were domestic violence victims relocating. That is a necessity and there are different psychological evaluations sometimes for people to express themselves and let everyone know the reasons why they are homeless. There are people who may have learning disabilities and they need special work training programs in order to make sure they have some sort of budget in order to stay housed, once they are housed. They are developmentally delayed and seniors having housing with caseworkers or overall assistance once they become housed in order to stay housed, and adhere to their support for members experiencing homelessness. It needed to include some sort of psychological evaluation and those medical professionals could adhere to their mental necessities in order to stay housed. That is what she wants to concentrate on. If the L.A. Care support members experiencing homelessness, if Dr. Amin does have information on psychological evaluations, she thinks that is very important. If he cannot basically explain that today about how those provisions are being used with any sort of L.A. Care programs, then can he come to the advisory committees and explain it in layman's terms so that we can understand how L.A. Care engages in some sort of evaluations having to do with that because she thinks that is very important. She was homeless and it is because she was having seizures having to do with epilepsy. She kept losing jobs, could not finish school because she kept having seizures on campus. She wasn't homeless because of her own fault. A psychological evaluation would have been great for her too, on different programs and resources that she had throughout at Los Angeles County that adhered to her medical mental necessities. That is the reason why, and a lot of different people that she knows, like her friend with cancer. Her friend was actually housed and had some sort of assistance, so that was great because she advocated for that. She also has a friend who was developmentally delayed. He has assistance now and it was a successful program. How's L.A. Care implementing that?* Sameer Amin, MD, *Chief Medical Officer*, noted he will work on arranging talks at the RCAC meetings about Enhanced Care Management (ECM) and other community supports programs. Dr. Amin talked about L.A. Care's Community Health Department and the work they are doing around the unhoused. L.A. Care formed the Community Health Department about a year and a half ago. That department handles social services, community supports, behavioral health, and the work for the unhoused. L.A. Care wanted to have a home for a lot of its transformative	

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	programs. Programs that members could actually see and use to fundamentally change their lives. The department as it was established has been run by Michael Brodsky, MD, *Senior Medical Director, Community Health*, and Charles Robinson, *Senior Director, Community Health.* They have made fundamental decisions regarding the community supports programs and L.A. Care's investments. Dr. Amin outlined L.A. Care's strategy to address the housing crisis in Los Angeles County (*a copy of his presentation can be obtained by contacting Board Services).* L.A. Care's programs combine to provide a uniquely comprehensive suite of services to address critical member needs: • Finding Housing and Staying Housed • Short Term Housing Solutions • Increasing Availability of Permanent Housing • Access to Healthcare and Social Services Dr. Amin highlighted the investment that L.A. Care health plan has made and will make in the next few years for the unhoused. L.A. Care is becoming one of the county's largest contributors to fixing the housing crisis and is on track to spend $1.2 billion from 2022 through 2029 to support unhoused members. It is a significant investment. L.A. Care has provided housing services for nearly 20,000 members since 2022. Housing services help members find, access and maintain permanent housing. L.A. Care's data showed there are about 70,000 unhoused throughout Los Angeles County; about 45,000-50,000 are L.A. Care members. L.A. Care has served 19,306 members through March 31, 2024. Of those engaged with our Housing program, 24% have transitioned from a temporary to permanent housing, and 80% have received housing through L.A. Care navigation services within six months of initial engagement. The additional funding from 2024 to 2029 will help L.A. Care reach the rest of the members in need of health services. Board Member Booth asked about the length of time those in permanent housing are followed to know if the housing is really permanent. Dr. Amin responded that there are some housing modalities that are distinctly short term, a motel or a temporary tiny home. Permanent housing is a lease in an apartment that is permanent. Often the reasons why a member may be unhoused are not fully solved in the time it takes to get into permanent housing. L.A. Care has ongoing services to stabilize their tenancy. Often those are very intense case management services focused on mental health and drug abuse programs to keep them in their home. In response to Chairperson Ballesteros, Dr. Amin confirmed that L.A. Care has assisted 19,000 members with various supports, through housing navigation, housing deposits or tenancy support services.	

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	Supervisor Solis asked how funding goes through to the community. Dr. Amin responded that L.A. Care invests directly into services, not only for interim housing but also expanding access to permanent housing units. These are categorized as Assistance with Daily Living (ADL) support, direct coordination with Inside Safe, and enhancing permanent housing availability through unit acquisition and master leasing. He provided details on achievements in this area: • 95 individual grants to interim housing facilities planned through 2027 to support ADL upgrades • Augmented services available in interim housing sites and shelters across all SPAs by the end of 2024 • Weekly coordination with Inside Safe & Pathway Home to ensure member access to services • Over 600 units made available through the end of 2023, with a total of 1,700 permanent housing units planned through 2027 Dr. Amin noted that it is planned through 2027 to particularly support facilities with ADL upgrades so that those who have disabilities can get into interim housing facilities. Dr. Amin responded that augmented ADL services include support with bathing and showering, toileting, shopping for food and clothing, and allow for somebody to become truly stable in their home. Mr. Baackes commented that Board Member Contreras had earlier asked a related question, and he noted that these services are part of the package of hosted services covered by CalAIM. Dr. Amin stated it is a combination of a number of different funds. CalAIM is made up of three areas: Enhanced Care Management (ECM), Community Supports Programs which are a host of about 14 different programs, and Population Health Management. There are two or three different community supports programs that specifically speak to the unhoused in CalAIM. So some of the funding comes through CalAIM as part of Community Supports. Housing and Homelessness Incentive Program (HHIP) is a separate housing incentive program that started two years ago that L.A. Care has spent for a lot of the things particularly around master leasing. There are other services that have also gone into the unhoused through ECM. It is layered funding that is braided together to make a significant impact with the unhoused. Mr. Baackes commented that L.A. Care staff is very familiar with the funding sources but needs to be clear in providing information to the Board where the CalAIM funds are used. Dr. Amin stated that it is a combination of CalAIM and HHIP. There was a decision made in forming the Community Health Department that all 14 community supports programs be fully	

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	funded, particularly programs that are associated with the unhoused. It was also a much targeted investment with L.A. Care's HHIP fund that created significant impact. The Community Health Department also organized how L.A. Care provides medical services to the unhoused. The Field Medicine Program was created to provide medical services for the unhoused and includes street medicine for the unhoused. The Community Health Department makes sure that there are street medicine services available through providers contracted with L.A. Care in every SPA. Every SPA has a regional anchor provider that L.A. Care can contact to make sure that a patient determined by field medicine providers as needing long term support can access care at a regional anchor service site. Or a patient needing longitudinal primary care can do that at a regional anchor service. They can switch a primary care provider (PCP) assignment if needed, to that regional anchor. L.A. Care uses a map with regional anchors and street medicine only providers laid out, and it also has floating providers. L.A. Care has covered the entire county with medical services that can be provided to the unhoused. As part of that field medicine program, there are different areas of high density where we see that there's a lot of unhoused members where particular services can be made available. The investment is $30 million for capacity building incentives and $30 million in performance incentives, a lot of which is going to the providers connecting the members to social services, helping them get a true medical home and getting members into longitudinal primary care. L.A. Care is supporting ten new street teams for five years and organizing care across the entire county in a population based way. In the high density areas like skid row, a significant investment of $30 million will be made into a Skid Row care collaborative that L.A. Care helped organize between L.A. Christian, JWCH, and Los Angeles County Department of Health Services (DHS) to provide specific services in Skid Row. The new Crocker Street Campus is part of it, with a new brick and mortar facility, provide safe services, community ambassadors and harm reduction services. And some funding will go to enhanced healthcare services along with transportation. All of that is going to go into this $30 million investment as part of the field medicine program specifically in Skid Row. We think it will make a significant difference there. He reviewed the new services, specialty medical services, including observation beds and extended hours for urgent care. There will also be pharmacy services available. L.A. Care will share funding with LA Christian and JWCH for services on the DHS Crocker Street campus. A major goal was that all the healthcare providers that are in Skid Row will be working together to coordinate care for members. Dr. Amin recognized the outstanding work of dedicated L.A. Care leaders: Delia Mojarro, *Director, Social Services*, Matilda Gonzalez Flores, *Director, Community Health*, Karl Calhoun, *Director, Housing Initiatives*, and Kevin Burns, MD, *Medical Director, CalAIM*. He also recognized the outstanding work of the 25 members of the cross-functional L.A. Care housing team that is	

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	doing important work to reach out to every unhoused L.A. Care member to connect them with needed services. Supervisor Solis thanked Dr. Amin for the presentation and she acknowledged the hard work by staff. She's excited about what's happening in particular at the Crocker Street site in Skid Row. She began representing all of Skid Row through redistricting almost two years ago. It is quite a challenge. She's glad to see funding is going into street medicine and in the new hub. She's been down there many times and is working with DHS. She acknowledged Board Member Ghaly and her team as well as the Los Angeles County Department of Mental Health. It is exciting to think about transforming that whole area in a variety of ways. She thanked Dr. Amin and complimented him on that. She noted that in looking at population areas and density, there is another part of Los Angeles that right now is going through some major challenges. That is the McArthur Park and Westlake areas. There is high number of homeless, high substance abuse and mental health needs at MacArthur Park. If there is a way to kind of direct some of the team to start looking there, because there really is a major substance abuse problem. Every day in the news we hear something going on there. She's concerned about the lack of infrastructure and services there. She has spoken to some members on this Board about the problems and they've been helpful, there is need for more of a strategic effort because it could be the next hot spot. She would love to work with Dr. Amin and the staff on that, along with LA City Council Member Eunisses Hernandez, whose district overlaps in that area. Dr. Amin appreciates Supervisor Solis' comments and he noted that L.A. Care is in alignment, and plans to get the field medicine program up and running at McArthur Park, with a regional anchor provider, a floating provider and street medicine service in the very short term that is going to help. L.A. Care is also reviewing the potential for services similar to what is being done with Skid Row, and there are exciting plans on the docket. Dr. Amin added it's always important to us that we don't talk about things only in the abstract. For field medicine programs, L.A. Care sent letters of intent on April 29 and applications were received on May 24. A map was finished yesterday, is being vetted internally and it will go back to the providers probably in the next week, so that they can review the areas they will cover and then it will become a reality. In terms of Crocker Street, L.A. Care is internally reviewing the investment agreement through legal and other services to make sure that the investment agreement is sound. It should be approved by June 21 and will probably be sent to JWCH, LA Christian and DHS by July 1. Board Member Booth pointed out that it makes her happy that in reading the report, she noticed L.A. Care is making sure that for members who have their own physician, the physician will get a report about the street medicine care provided. This is very important. She hoped that	

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	Dr. Amin can follow up to ensure that reports go out. Dr. Amin thanked Board Member Booth, and added that it is important to L.A. Care to not disintermediate an unhoused member from the traditional services that they have been receiving. From a clinical leadership standpoint, anytime care is delivered in an acute or an urgent fashion and away from providing longitudinal primary care, the patient suffers. It is critically important to report to a primary care provider on services provided in the street. In developing the performance incentives for street medicine providers, L.A. Care doubled and tripled down on coordinating with the primary care doctor. A substantial share of the performance incentive that that they can earn is providing information back to a primary care provider (PCP). Dr. Booth noted that one concern would be that the primary care doctor might be just happy enough to have patients see street medicine doctors all the time, because the PCP would still get the managed care fee. L.A. Care plans to contract the street medicine providers so a floating provider will be able to switch primary care assignment to themselves if the member is seeing that provider so frequently that that provider becomes their primary care provider. If the street medicine provider who's seeing that member in the street is interacting with the member who expressed the member does not feel comfortable with their primary care doctor, that the member needs a provider who is very specialized in this type of medicine. The street medicine provider can refer the member to the regional anchor provider and switch the member's PCP assignment to the regional anchor provider. The anchor provider has committed to us that they will see that member as the PCP. Chairperson Ballesteros commented that he's been working in Skid Row for almost 21 years, working with DHS, LA Christian, L.A. Care and Health Net to put this together. It took a long time. He thinks that Dr. Amin's staff put the time and the effort into understanding the needs and to get community input. This is the single biggest investment that he has seen in 21 years in Skid Row. The single biggest investment by non-County entities in 21 years, although obviously LA County has invested really big. This investment in the health care infrastructure, in extended hours, to have the ability in Skid Row to get care until 9:00 p.m. That's going to be very important for individuals that otherwise would go to the emergency rooms or go without care. The specialty network that will bring cardiology, dermatology, physical therapy, gastroenterology care and other specialists right into Skid Row, where these individuals are so important. We know that when a referral is written for a consult or to go to a specialist, these patients don't make it there unfortunately because of their situation. L.A. Care's investment is going to bring those services right to where the clients are. And that is the first time that he has seen that happen in 21 years. He really appreciates that and believes that is going to make a tremendous difference for these patients.	

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	Board Member Vazquez thanked Dr. Amin for his update and expressed that this is a very important topic because it impacts all of L.A. Care members. (*Board Member Vazquez spoke in Spanish and this is a summary of her remarks translated into English.*) All the members that are here know and realize the process that has been going on, with all the collaboration. The people that use public transportation know the needs that are out there. She has been in areas where there were a lot of homeless people before, and recently she has been through the same areas and has seen that those people are not there any longer, so that means that they are probably transitioning. There are areas without homeless people or people with mental health needs. Many members have been concerned about this because they have been attacked. But these are people that need some help and we will keep working on this. We know that this process takes time, and we would like to reach the most people out there that are homeless and need housing. She is the representative for these members and is aware and will be keeping an eye on the process.	
Performance Monitoring May 2024	Dr. Amin presented a Performance Monitoring May 2024 report. *(A copy of the report may be requested by contacting Board Services.)* L.A. Care wants to be a transparent organization and has encouraged other health plans to do the same. Dr. Amin introduced the management team members who will review the report. Tara Nelson, *Senior Director, Utilization Management*, presented results for utilization management (UM). For expedited or urgent pre-service request decisions made within 72 hours from the receipt of the request, this is when a provider is requesting something urgently and L.A. Care needs to make sure that that decision is made timely. For the past six months, L.A. Care has been consistently above 99 %. These are requests that can come from a PCP specialist hospital. For standard or routine requests, those decisions are made timely within five business days. Results are consistently 99 % to 100 % the past six months, ensuring that the request is assigned, has adequate coverage, and there are no delays in getting the service for the member. For expedited urgent requests, decisions are made within 72 hours. This is concurrent service when the member is in the hospital or admitted to a hospital and the facility is asking for authorization for that admission. L.A. Care is in the upper 90 %. L.A. Care has increased the team over the past years to make sure that these are processed promptly and getting those decisions out to the providers. For post service request decisions, the timeframe is 30 calendar days. The member was admitted to the hospital and already went home, L.A. Care finds out after the member has been discharged, and that the hospital would like to have an authorization for the admission or anything outpatient based which could be home health or any providers that saw this member and would like authorization after the fact. There is a 30-day time frame to complete and results are in the upper ninetieth percent. In November there was a small dip. An assessment was	

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	done, and L.A. Care revised the assignments. The results were in the 99th percentile the next month and UM has maintained that consistency since. Dr. Amin noted that the results show the percentage of the time that L.A. Care is doing its job and getting care out to members. There has been a sea change in compliance here and we are achieving 99.6, 99.7 and 100 %. Two or three years ago the numbers were not this high. This is a big change. He complimented the team for doing it, and noted that L.A. Care has made a significant investment over the last year and a half in utilization management services. The UM team is staffed up by 40 % in terms of full-time employees (FTEs). There is also great leadership in place, Tara Nelson is one, to bring L.A. Care into a position where these numbers are consistently close to one hundred percent. Priti Golechha, *Senior Medical Director, Care Delivery Innovation*, presented utilization metrics for population health management in terms of utilization, with independent provider associations (IPAs) and the provider network. For the directly contracted provider network (MCLA line of business) inpatient admissions per member per month performance for how many members were admitted as inpatients and a separate graph for non-OB inpatient admissions to focus on performance for non-obstetrical (OB) patients going to hospitals. Performance has improved year over year. L.A. Care has worked on case management, enhanced case management, different initiatives, housing initiatives, but it might not be cause and effect data. There was an improvement in inpatient admissions compared to last year for the same month, taking into account the seasonal variation. The non OB patient admission statistics drill down further into performance of the providers (PPGs and IPAs). It shows that depending on the size of PPG the network average is going to be affected; the larger PPGs are going to have a larger sway on the network average. There might be an opportunity to focus on initiatives to help those providers to bring down their hospital admissions. The data from November 2022 to October 2023 for hospital admission and discharge, with readmission within 30 days show improvement. This could be due to work done in improving case management and transitions of care management. Staff is continuing to review potential for improvement. Results for the provider network are within the normal range of the network average. For the PPGs the 30 day readmission is really high and there may be opportunities to create initiatives and strategies to prevent the re-hospitalization for those members. L.A. Care is also reviewing Emergency Department (ED) utilization for members, and this metric is similar to last year. L.A. Care is continuing to review the data and explore potential initiatives to lower ED use, to encourage members to visit their PCPs instead of the ED. L.A. Care also reviewed the potentially avoidable ED use metric. This identifies the diagnosis for members using the ED where the member should be going to their PCP, but they ended up in ED. The results do not show improvement year over year, and L.A. Care is investigating	

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	further to improve PCP utilization and prevent members from going to ED and use either telehealth services or the PCP. L.A. Care plans to have conversation about avoidable ED utilization and the primary care utilization to encourage members to use the primary care offices and avoid that ED utilization. L.A. Care created a one page document with all the metrics to review with each provider. Among those metrics is data related to member access to services and member experience data through different surveys we do with members. L.A. Care shares the numbers with providers, against a benchmark. There are quality metrics as well. The metrics show the population health management for the provider, and where there are opportunities to improve access, care, and member experience. Board Member Booth asked about the potentially avoidable admissions to the emergency department, and she wonders if the providers that have the really (bad) high scores are the ones that are out of compliance with the telephone messages that they need to record and let patients know what to do if they need service after hours. Ms. Golechha responded that an analysis was not done in that area, and it may be an opportunity for further review. L.A. Care is reviewing provider visits for a member after hospital discharge to determine any correlation, because for members who do not receive transition of care services, it may be likely the member will visit the ED or be readmitted to the hospital. Dr. Amin responded to Board Member Booth, that her idea is part of a concept that the quality improvement department, which directs member surveys about specialty access, primary care access and afterhours access, is connected to the over- and under- utilization process. This is one of the reasons for presenting providers with broad data about their members that could indicate areas for improvement. Dr. Amin noted that there are distinct improvements in the length of stay at the hospital and hospital readmissions. Much of that improvement is coming from the services that are being delivered through enhanced care management, complex case management, and in the work explaining potential issues in the joint operating meetings with the delegated provider groups. All of that has helped contribute to the improvement in care that we are seeing. The data can be used to show delegated provider groups and specific providers where they can improve. L.A. Care is actively holding bidirectional conversations with delegated entities and providers. Dr. Amin reviewed the services that L.A. Care is delivering through CalAIM. L.A. Care will provide all of the 14 community supports programs by July, which is a grand achievement for L.A. Care. Ongoing programs include housing navigation and tenancy support services, housing deposits, recuperative care, medically tailored meals, environmental accessibility, adaptations, sobering center, personal care and homemaker and respite services. In 2023, about	

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	18,692 members received these services. L.A. Care has 75 contracted providers for ECM, serving about 35,000 patients that have come in and out of the ECM program. He anticipates the ECM membership will increase dramatically in the coming year. Acacia Reed, *Chief Operating Officer*, introduced Suma Simcoe, *Deputy Chief Operating Officer*, who provided a report on Claims Performance (*a copy of her report can be obtained by contacting Board Services*). Ms. Simcoe joined L.A. Care in October 2023 and has made tremendous efforts to improve performance and bring stability back to the organization. Ms. Simcoe reported that events that greatly affected claims processing since last year. In mid-August 2023, L.A. Care began coordination of benefit agreement implementation by coordinating the primary payer and the secondary payer claims. The volume of claims received was much higher than expected. The Change Healthcare cyberattack on February 21, 2024 effectively stopped claims receipts because most claims were received through that channel. The skilled nursing facilities rates were updated four times, and each update retroactively affects claims. The retroactive Call The Car contract changes caused a high volume of claims to be reprocessed. The SB 510 legislation required reviewing and retroactively adjusting claims. L.A. Care receives an average of 1.3 million claims in a month. The claims volume was really low in February due to the Change Healthcare issue. In April claims volume was 1.5 million, with professional claims at the highest volume followed by Uniform Billing form used by the facilities for billing outpatient/home health/hospice etc. (UBO4), SNF and hospital inpatient claims. The percentage of claims submitted electronically is very high. Ms. Simcoe reviewed details about claims processing and mitigation work on improper processing. Ms. Simcoe reported that in December 2023, Provider Dispute Resolution (PDR) volume was high and the contract change with Call the Car is one cause. The turnaround time for PDRs is now down to 39 days, and the goal is to reduce it to 20-25 days. Dr. Amin noted that the purpose of the presentation was to help the Board members feel comfortable with the expertise and the degree of effort that Ms. Reed, Ms. Simcoe and the operations team have made to ensure claims are paid appropriately and quickly, and the amount of effort that's going into utilization management. Dr. Amin mentioned that a performance report will be included in future board meeting packets and major changes will be reviewed with Board members. L.A. Care leadership will continue to discuss the report in detail during the Provider Relations Advisory Committee meetings, and there may also be discussions during Compliance & Quality Committee meetings. Board Member Gonzalez asked if Call The Car (CTC) trip data will be included in the report. She noted that is really useful information for members, as many of them complain about difficulties getting picked up and other difficulties with CTC. Dr. Amin responded that the	

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	CTC metrics are included. He suggested that Noah Paley, *Chief of Staff*, is ready and available to address that right now. Noah Paley, *Chief of Staff*, noted that for discharges and transfers for routine pickup, compliance with the Service Level Agreement is 98%. The required performance level for discharges and transfers is one hundred percent. In the fourth quarter of 2023, there were issues with the performance level of CTC. L.A. Care collaborated extensively over the last several months with CTC and required various improvements. A corrective action plan is in place, and CTC has already implemented enhancements that has resulted in the improvement in CTC performance on on-time discharges and transfers and improvement in routine pickups. Some enhancements for discharges and transfers involve a dedicated team that providers can contact, working directly with CTC to arrange rides for discharges and transfers. In addition, CTC is developing a portal for hospital and facilities like dialysis centers and SNFs, a request for a ride can be made directly through that portal. CTC is working on finalizing a manual that will be shared with facilities. CTC will pilot this program with certain facilities. Another enhancement is that L.A. Care will work with CTC in processing member grievances about rides. CTC has established a grievance portal directly between CTC and L.A. Care that will be available next month. There are a variety of improvements with its driver pool. It's increasing its driver pool, and requiring attestations from drivers to follow prescribed protocols that are necessary to address such issues as modifying pickup times and a variety of things that impact a member's ability to effectively use CTC. L.A. Care has a dedicated team that is continuously monitoring performance and working on implementing the enhancements. Dr. Amin noted that it takes time to see some of the improvement. We believe these actions will improve the member experience. L.A. Care is monitoring performance. Dr. Amin noted that L.A. Care re-contracted with CTC last year to ensure significant commitments on performance to L.A. Care and its members. L.A. Care is tracking performance. When performance metrics are out of line, L.A. Care immediately began working with CTC to make specific changes that we believe would improve the member experience. Ms. Gonzalez invited Mr. Paley to attend an ECAC meeting. Mr. Paley agreed to present information about CTC to ECAC. Mr. Paley noted that the current contract with CTC is for one year. L.A. Care could submit a notice of termination based on performance levels. He stressed the high level of collaboration with CTC leadership and operational team. There is a detailed corrective action plan with specific steps in place that L.A. Care is monitoring, and it has resulted in performance improvement again. The transfer trips are below the service level, but have increased by more than 10 % after L.A. Care provided a notice of deficiency and implemented a corrective action plan. Board Member Vazquez appreciates the updates and asked about a way the member could tell	

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	us if CTC is fulfilling or satisfying member needs. (*Board Member Vazquez spoke in Spanish and this is a summary of her remarks translated into English.*) Board Member Vazquez asked when a member has a medical appointment or other kind of appointment, is there a number that the member could call to provide feedback? Mr. Paley responded that feedback can be provided directly to CTC through their call center and can be provided to L.A. Care through the customer solutions center, and will then be communicated to CTC through the collaboration was mentioned earlier. Board Member Vazquez indicated she wants members invited to provide a comment or a review of the ride experience, similar to other ride services. Mr. Paley will make a recommendation to include this on the mobile app so that we can have contemporaneous feedback suggested by Board Member Vazquez. Board Member Booth expressed her appreciation of the presentation format, she noted that the information is there, she can read it, and she can understand. Mr. Baackes added that he hopes board members who have any business with competing health plans asks them to disclose this information as well. The L.A. Care information is now in the public domain. He cannot think of another health plan that provides this level of detail. Chairperson Ballesteros thanked Ms. Reed for the presentation with great visuals and lots of data and it's really helpful. Ms. Reed responded it is a team effort.	
MOTIONS FOR CONSIDERATION		
• Approval of delegation of authority to destroy certain records associated with L.A. Care's move to 1200 W. 7th Street, Building	*The items on the Agenda brought to the Board from the Executive Community Advisory Committee (ECAC) were discussed at the next item, ECAC report.* Ms. Haydel presented a motion requesting approval of delegation of authority to destroy certain records associated with L.A. Care's move to 1200 W. 7th Street, Building. In light of the upcoming move to 1200 W. 7th Street, staff seeks delegation of authority to the General Counsel to prepare and implement guidance regarding retention and destruction of Local Initiative Health Authority for Los Angeles County and L.A. Care Health Plan Joint Powers Authority records. Such delegation of authority is requested to include authorization to destroy certain records, without making a copy thereof, after the same is no longer required, unless prohibited by law. Specifically, records will be authorized to be destroyed in accordance with such guidance given by the General Counsel and with written consent of General Counsel, without further action by the Board, upon the written request of any Chief Officer (or their respective designees) attesting that the records are not the subject of any claim, litigation, investigation or audit, and that their destruction is not otherwise prohibited. For the sake of clarity, this	

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	delegation does not authorize the destruction of any records that are prohibited by law, including records affecting the title to real property or liens thereon, court records where litigation is pending, records required to be kept by statute or contract (for the time-period required therein), records subject to a legal hold for the period of such hold and the minutes, resolutions and other governance documents. Board Member Booth commented that she is uncomfortable when printed documents are destroyed because it is a loss of institutional knowledge of what has happened, what people have tried and what people have failed with and what does work. She asked, besides the legal implications, are there any limitations regarding what items are being recommended for destruction or being kept or copied. Ms. Haydel responded this is really actually to destroy paper documents, electronic records will be maintained, which are electronic copies of the documents that are required to be retained. There are interim documents, interim notes, and reports that a public entity would not routinely maintain as records and are not covered by the retention required. Board Member Booth noted that could mean a loss of some institutional knowledge, of the history of what has been tried, what has worked, how and why it worked or did not work. If there is not a legal requirement to retain a document, it's going to be destroyed. She thinks some documents would be potentially important in the future. Ms. Haydel clarified that the motion is to delegate authority to staff to develop guidelines for records retention. Staff will identify what records need to be maintained in general for their programs, and that would have to go through legal review so that it meets the requirements of the law. But in general this is to help staff transition from 1055 building to 1200 building. Board Member Booth asked if there is a more specific way that ensures that important documents that may be used for reference at a future date will not get destroyed, i.e., information about processes? Chairperson Ballesteros asked if staff could receive guidance to take Board Member Booth's comments into consideration, and look carefully for historical references among documents that are not mandated to be retained. Board Member Booth responded that she is hoping they will do that, but nothing really that Ms. Haydel said readily reassured her of that. Chairperson Ballesteros suggested that Board Member Booth's comments be taken as additional guidance. Board Member Booth noted that documents should be destroyed only when someone is willing to take accountability for that destruction, and a record is kept of the names of the documents and who authorized a document to be destroyed. Board Member Booth recommended that attention is paid to the type of documents that could be useful in the future in terms of processes and how things happened, what has been tried, what's done well, and what has not failed, etc. Ms. Haydel responded that Board Member Booth recommendation will be added in the guideline.	

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	Board Member Gonzalez noted that to be clear, this will be guidance. These would be guidelines on what is and what's not to be shredded, so there's more room at the new building. These documents would be scanned and stored electronically. **<u>Motion BOG 103.0624</u>** **To delegate authority to the General Counsel (including her respective designees) to prepare and implement guidance regarding retention and destruction of records that authorizes the destruction of certain Local Initiative Health Authority for Los Angeles County and L.A. Care Health Plan Joint Powers Authority records, without making a copy thereof, after the same is no longer required, unless prohibited by law. Records shall be authorized as appropriate for destruction in accordance with General Counsel's guidance, upon the written request of any Chief Officer (or their respective designees), with the written consent of the General Counsel, without further action of the Board. Notwithstanding, this delegation does not authorize the destruction of any records affecting the title to real property or liens thereon, court records where litigation is pending, records required to be kept by statute or contract (for the time-period required therein), records subject to a legal hold for the period of such hold and the minutes, resolutions and other governance documents.**	**Unanimously approved by roll call. 9 AYES (Ballesteros, Booth, Contreras, Gonzalez, Greene, Raffoul, Roybal, Solis, and Vazquez)**
ADVISORY COMMITTEE REPORT		
Transitional Temporary Executive Community Advisory Committee (TTECAC)	**PUBLIC COMMENT** *Demetria Saffore asked about term limits for RCAC members. It was her understanding back in 2009 that term limits for the committees did not apply to the RCAC members but only to ECAC and Board members. She wanted to know if the term limits proposed today is a staff recommendation or was that a recommendation from California.* Mr. Baackes responded that the committee report from Board Members Gonzalez and Vazquez will make clear that the ECAC is endorsing a staff recommendation. *Andria McFerson is a member of RCAC 5. Please understand that she is a little taken back by this whole situation, so please forgive her if she sounds emotional. She had brain surgery, so she's doing the best that she can at this point. She disagrees with the motion due to certain changes made to the RCACs. Chair De La Torre, unfortunately, this proposal does not state solely the stakeholder rights given by the California state legislator or the DHCS requirements in its totality. The proposal in its totality does not state all of these rights. They are provisions made by the staff members. That is why she disagrees with the proposal, things like there*	

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	should be term limits, like what her fellow RCAC members said. These term limits are not a part of that overall requirement of the state or DHCS. And who made that change? And why is that even being a part of this motion? Please take that out of the motion, she's asking. Also who will write the applications that they have to fill out? Specifically will that be staff? This is too broad of a motion or a statement because the CAC members are members of the medical managed health care plan, who have a right to be a stakeholder. Who will make specific the new structure overall, and what would it consist of? Because all year the staff proposed the reconstruction of the consumer advisory committee and it did consist of a lot of plans and it didn't contain just new requirements. But staff had written that there be a round table, 13 members with no Robert's Rule of Order, and I am so glad that they took that out but all RCACs did not hear this change. And so all RCACs were not able to vote on that same proposal. It changed from month to month. So the TTECAC who voted on this and approved it, they approved it not according to their own RCACs. Their own specific decision on that and I could not quite understand that. As far as the ECAC, who consists of the ECAC? Does it have an actual L.A. Care member that receives a L.A. Care health plan? And if those provisions are going to be made by the ECAC members, can we add someone who is a member of L.A. Care. Unfortunately, just like now, the transportation has taken away most of the members who wanted to comment on these things. So, different things like that are what we have to deal with on a regular basis, having to do with staff provisions. So can we make it in unison with ADA rights? All kinds of different things like that so that we can equally have the opportunity to participate in a support group and speak together. She doesn't agree with the motion. Board Member Vazquez reported that the TTECAC met on May 14, 2024. (*Board Member Vazquez spoke in Spanish and this is a summary of her remarks translated into English.*) She thanked all the members that attended the TTECAC in person and to those present today. 1. Roger Rabaja (R1) 2. Ana Rodriguez (R2) 3. Lidia Parra (R3) 4. Silvia Poz (R4) 5. Joyce Sales (R6) 6. Maritza Lebron (R7) 7. Ana Romo (R8) 8. Deaka McClain (R9) 9. Elizabeth Cooper (R2) 10. Maria Sanchez (R5)	

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	11. Damares O Hernandez de Cordero (R10) 12. Estela Lara (R4) She thanked the members that attended the ECAC meeting both virtually and in person. The comments and questions were greatly appreciated. • Mr. Baackes gave a CEO update. • Linda Carberry presented L.A. Care's Member Experience Survey Results. She described the measures that were met and those that needed improvement. Of the measures that needed improvement the following are ongoing issues: not having a primary care doctor, getting an appointment for urgent care, and customer service was not courteous/respectful. • TTECAC members have expressed an interest as to why the motions brought forth from TTECAC were tabled and if they can be revisited by the board. TTECAC approved the proposed changes to the restructuring of the Community Advisory Committees. • I would like to comment that the board needs to revisit the proposed motions and put them to a vote. Whether they pass or not, at least so that TTECAC can move forward with the Board's decision. I would also like to remind the Board of the recent Federal decision to have health facilities provide accessibility to people with disabilities. Board Member Gonzalez thanked the Board for considering the TTECAC motions which were previously tabled. Board Member Gonzalez looks forward to revisiting those motions at the next board meeting. Board Member Gonzalez reported that the Community Partners Roundtable met on May 22. Mariah Walton presented information on the sponsorships that L.A. Care provides: the paperwork required, presentation, timeframe, dollar limits, and the focus on the social determinants of health. Allen Delaney and Associates gave a presentation on their organization, the Good Seed, and ways they assist the community. Hector Solorzano from the Pomona Valley Pride Center gave a presentation on the services and events his organization provides for the LGBTQ population. Karol Curiel-Kozycz from Plus Me Project gave a presentation on how they assist students with writing stories about themselves, their origins, their goals, families, achievements, and adversities they overcame. Gilmar Flores from Breathe Southern California promoted their free Lung Health Screening Event on May 28. The next Community Partners Roundtable is scheduled to meet on July 24. Board Member Gonzalez commented on the earlier report on IHSS and the programs for backup caregivers. There are two backup programs in Los Angeles County. One is through the State, to help recipients coming out of the hospital to avoid hospitalization. Just like L.A. Care gives money for the education of IHSS healthcare providers, this program helps people avoid getting into the hospital. The County program for IHSS is to provide coverage for caregivers in cases of emergency. It does not cover vacations, it's not respite care. It is to cover people that have had an accident, were injured or sick. This program can then help temporarily. It uses the	

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	same hours that IHSS has. It is basically there to help people needing care to avoid hospitalization, and is underutilized by the program. Cutting these two programs would be detrimental to the health of people that are using IHSS, and the dollar amounts that they are cutting is almost negligible in comparison to the entire dollar amount for the IHSS program.	
• Delegate authority to the Executive Committee of the Board of Governors to approve the revisions to the Operating Rules of the Consumer Advisory Committees (CAC) and Executive Community Advisory Committee (ECAC)	Mr. Baackes reported on the changes in structure for the community advisory committees (*a copy of his presentation can be obtained by contacting Board Services).* In L.A. Care's new Medi-Cal contract there are provisions related to community advisory committees. He pointed out that most managed care plans did not previously operate community advisory committees, so it is new for those health plans. L.A. Care is the outlier, having always had a comprehensive community advisory program. There is no provision in the contract that requires L.A. Care to consult with existing advisory committees about the proposed changes. L.A. Care staff voluntarily made the effort to discuss the advisory committee requirements with the current committee members. Staff was not trying to force the changes on advisory committees. Presentations were made throughout 2023 and there was feedback from advisory committee members. The Board and staff have heard public comments at the Board meetings. At the beginning of this year, Mr. Baackes asked staff to schedule another round of meetings with each of the 11 RCACs. He and Dr. Amin each attended four RCAC meetings. Staff came back to the RCACs with a refreshed proposal that was not the same as what was distributed in 2023. The new Medi-Cal contract took effect January 1, 2024 with new provisions for community advisory committees. One new provision is that L.A. Care is required to have a selection committee. The selection committee membership has to be defined and the member composition of the community advisory committees (CAC) must reflect the diversity of the health plan members. Plans must report annually on the composition of those committees and their proceedings. L.A. Care is proposing: 1. Establishment of member term limits. Term limits will be two four-year terms to assure opportunity to match any changes in population diversity and ensure diversity. Staff is recommending two four-year terms to mirror the terms of the Board of Governors. 2. There is no reference in the State contract on the number of CACs. L.A. Care has had 11 RCAC regions for over 20 years. Staff proposes to reduce it to 8 regions, using the geographic boundaries of the Los Angeles County service planning areas (SPAs). This allows L.A. Care to provide the community advisory committees with valuable data on the health status and disparities of those communities, aligned with the County SPAs. 3. Target membership is 25 members for each CAC. This is refreshed from a previous proposal. The current RCAC membership varies by CAC. There are currently a total of	

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	140 members in the 11 RCAC regions. With the new regions, there will be a total of 200 - an increase of 60 members. 4. All 140 current RCAC members will be assigned to a CAC in the new format based on their address. They do not have to go through the application or selection process. 5. The RCACs currently have six meetings a year and the proposal is to keep it at six meetings a year. Community advisory committee meetings will be held at L.A. Care's Community Resource Centers (CRCs). The agendas will adhere to the use of the Brown Act and Robert's Rules of Order. The agendas for the meetings will include time for discussion of topics that the community advisory committee members want to bring up. If they would like to have a specific topic, with expert advice, that will be done as well. 6. Transportation to and from the RCAC/ECAC meetings will be provided. Child supervision will be available at the community resource centers. He noted that a comment was made that the presentation changed over the course of the eleven meetings. During the visits with the CACs suggestions were made for changes and he directed those changes. He takes responsibility for that. 7. The stipends will essentially be doubled. 8. There is now a requirement for a selection committee to screen and approve community advisory committee members. There was none before. Community advisory membership must reflect diversity of the plan members. The membership to now has been random according to the volunteers who wish to participate. The selection committee will use diversity data and other objective criteria for selection. The requirement is the plan must report annually on membership diversity and on the proceedings of the meetings. That was not a requirement previously. The proposal was made available to all RCAC members and the chairs of each of the existing community advisory committees were asked to approve, disapprove or modify this particular presentation in advance. They approved it. He also acknowledged to the CAC members that if something isn't working after we get this done, we can come back and change it. To those members here today, he would like to say that we didn't have to do it this way. L.A. Care could have just implemented the provisions in the contract and gone on with it. But staff went to the members. You were heard, and he thinks this is a responsible answer. L.A. Care is currently out of compliance, and he hopes that the motion that was adopted by ECAC, which is currently publicly posted for public comment, will be ultimately supported by the Executive Committee. Board Member Vazquez thanked Mr. Baackes for his presentation and update (*Board Member Vazquez spoke in Spanish and this is a summary of her remarks translated to English*). CAC members have been hearing this information for a long time. RCAC members were able to listen to all the presentations ever since the very start. Members now have the summary of the meetings that were held with Mr. Baackes and Dr. Amin. The proposal reflects what the members were	

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	saying at those meetings. She thanked Mr. Baackes and Dr. Amin for the opportunities for members to express their views and concerns, and have all of that taken into account. Board Members can now take the next step. Board Member Contreras asked about the requirements for diversity in the groups. Mr. Baackes responded that the State is not that clear on that, so L.A. Care staff is interpreting it to be diversity in race, ethnicity and health status. People who are disabled, people who are from different races and ethnicity should be reflected in each group. L.A. Care asked for clarification, and expect the regulators will send an all plan letter, but could not get to it until probably July. Board Member Contreras noted that when the SPA councils were in place, there was also an American Indian Council that was separate, and recognizing diversity geographically might mean that the numbers may not be as large. In terms of healthcare, she's thinking about the LGBTQ plus community and being able to meet those needs, and again, it will not necessarily be reflected geographically. Mr. Baackes agreed it is very complicated. The State contract language is very vague, and L.A. Care asked for clarification and will follow the guidance from regulators. Board Member Roybal noted that the motion before the Board is to delegate authority to the Executive Committee to make the changes, including to formally go from eleven to eight RCAC regions. The Board is delegating to the Executive Committee today and going from eleven to eight, which he thinks makes a lot of sense. As Mr. Baackes was saying, this will help in viewing health data at the SPA level using data on health outcomes developed by LA County. It will help L.A. Care plan, make decisions and support things in general, regarding health care, and how our members are responding to activities in their communities. Board Member Roybal thinks it's a really good idea. Supervisor Solis thanked staff and the CAC members participating in the meetings. She is pleased that members approve the restructure. The Board has heard so much on this topic in the last year and a half. She's glad that there's been clarification and that the state is actually requiring us to become compliant and to use Robert's Rules of Order and to use all the appropriate tools that are made available for public meetings. It may be a learning challenge perhaps for some. But for others she thinks it is going help bring conformity and standardization where it is needed, and increases participation because the number of people that will be engaged is going up quite significantly. Chairperson Ballesteros echoed the Supervisor's comments on the increased participation and added that the stipend will also increase. Members have expenses that they we need to consider, so he appreciates that.	

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	Motion BOG 104.0624 **To delegate authority to the Executive Committee of the Board of Governors to approve the revisions to the Operating Rules of the Consumer Advisory Committees (CACs) and Executive Community Advisory Committee (ECAC), the transition from 11 RCAC areas of representation to 8 and an enhanced CAC member volunteer stipend structure as approved by the Temporary Transitional Executive Community Advisory Committee (TTECAC) at its meeting of May 14, 2024.**	**Unanimously approved by roll call. 9 AYES**
BOARD COMMITTEE REPORTS		
Executive Committee	**PUBLIC COMMENT** *Andria McFerson asked about the Executive Committee membership, because it is written that it is only three members and there are no L.A. Care Health Plan members who have L.A. Care Health Plan.* Chairperson Ballesteros clarified that it is the Executive Committee of the Board. *Ms. McFerson asked if they have some sort of stakeholder who is a member of L.A. Care.* Mr. Baackes responded that the L.A. Care Board of Governors has two member representatives who are members of the health plan or a member advocate, Board Members Gonzalez and Vazquez. There is no requirement that a member of the Executive Committee or other Board Committees, except ECAC, be a health plan member. One cannot be on the Executive Committee unless a member of the Board of Governors. There are only two members, a health plan member and a member representative, on the 13-member Board. *Ms. McFerson asked if she could talk with Ms. Haydel for clarification.* Chairperson Ballesteros asked Ms. Haydel to contact Ms. McFerson. Chairperson Ballesteros reported that the Executive Committee met on May 22, 2024 (*approved minutes can be obtained by contacting Board Services and will be available on the L.A. Care website).* • The Committee reviewed and approved a motion for approve revisions to Human Resources Policies: HR-112 (Leave of Absence), HR-125 (Sick Leave for Per Diem, Part-Time, and Non-Regular Employees), HR-301 (Background Checks), HR-312 (Recruitment) which does not require full Board approval. • The Committee received a report on the proposal for meeting state requirements for Community Advisory Committees (CAC) and approved a motion to begin 30-day posting of revised CAC Operating Rules.	
Finance & Budget Committee	**PUBLIC COMMENT** *Andria McFerson commented that she's not quite sure whether this pertains to it. Her name is Andria McFerson and she's part of RCAC 5. Chief Financial Officer*	

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	report, the financial report, monthly investment transaction report, quarterly reports required by internal policies. She's not quite sure whether it has anything to do with the RCAC budget and, how that money was spent throughout the fiscal years and if that money was spent and if it would be rolled over that budget, is a part of community involvement and engagement. There have been a lot of different things having to do with COVID 19 and different things having to do with a lot of mortality rates increasing. So with that, if there were more peer on peer communication and events and just different things like that since it's lifted, that would be great. But they had no opportunity to make any decisions having to do with that due to a temporary TECAC and a lack of RCAC meetings and the opportunity to file motions in order to spend the budget since those provisions were made, those restrictions were made. So with that, do they still have those same amounts and where will they be rolled over for the next fiscal year so that they can now do more outreach towards many different people throughout the community and that would consist of seniors, that would consist of people who may have suffered from COVID and no longer have COVID but they have a lot of physical issues having to do with that and don't know that they have different coverage from L.A. Care. And it would be great to have that opportunity to have information to the undocumented so that they can know that now they do have coverage. And then also, different information to people who are not just low income. People who now are mid-income and that would make it so that L.A. Care can give that information to them as well because a lot of people cannot afford insurance, but they do work fully. So that means that L.A. Care does have those options for them as well, but they have absolutely no idea so that if they can spend that budget money, the prior budget money and the budget money that we have here, that would be great for outreach to the community. So with that, please give them an opportunity to know what type of budget that they have, whether it be rolled over, and give them the opportunity to vote on different things having to do with their own communities. Mr. Baackes noted that this was previously addressed. The funds were rolled over and will be available as the new community advisory committees meet to disperse as they see fit. Committee Chairperson Booth reported that the Finance & Budget Committee met on May 22. The Committee reviewed and approved a motion for a contract amendment with Imagenet LLC, to provide L.A. Care with scanning solution services to convert paper claims into electronic format. This motion does not require full board approval. Committee also reviewed and approved the Quarterly Investment Report that was earlier approved today on the consent agenda.	

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	Approval of the financial reports was postponed to the next Board Meeting. Due to time constraints the Financial Performance Report, the Monthly Investments Transactions Reports and the Quarterly Internal Policy Reports were deferred to the next Board of Governors meeting on July 25, 2024.	
Compliance & Quality Committee	*Due to time constraints the Compliance & Quality Committee report was deferred to the next Board of Governors meeting on July 25, 2024.*	
Provider Relations Advisory Committee	On behalf of Committee Chair, George Greene, Esq., Dr. Amin provided the PRAC Report. The Committee met May 15 *(contact Board Services to obtain a copy of approved meeting minutes).* • The Committee received a report on Participating Physician Group (PPG) Scorecard and Internal Performance Metrics. • He presented a dashboard for CalAim Community Supports Services similar to the report made earlier in this meeting.	
ADJOURN TO CLOSED SESSION	The Joint Powers Authority Board of Directors meeting adjourned at 5:45 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 5:46 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: *June 2026* CONTRACT RATES Pursuant to Welfare and Institutions Code Section 14087.38(m) • Plan Partner Rates • Provider Rates • DHCS Rates *There were no discussions on the following agenda items.* 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 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: 23-725, 21-855 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 L.A. Care Board of Governors and the L.A. Care Health Plan Joint Powers Authority Board of Directors reconvened in open session at 5:51 pm. There was no report from closed session.	
ADJOURNMENT	The meeting was adjourned at 5:52 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 _____

Board of Governors
MOTION SUMMARY

Date: September 5, 2024 **Motion No. BOG 100.0924**

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

Requesting Department: Community Health

Issue: Execute a contract with the Department of Health Services (DHS) Housing for Health & Harm Reduction Division and a contract JWCH Institute to support the L.A. Care designed Skid Row Care Collaborative.

☒ **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 two (2) investments for a combined total of $20,723,100.10 with the following two (2) entities:

- DHS Housing for Health & Harm Reduction Division in the amount of $7,012,900
- JWCH Institute in the amount of $13,710,200

These investments will support the L.A. Care designed Skid Row Care Collaborative in the implementation of projects that will increase the availability of comprehensive medical services and contribute to improved health outcomes for homeless members. Projects will include a specialty medical services Hub, extended hours and urgent care, referrals to rapid re-housing and interim housing, capital improvements, Skid Row transportation system, as well as other projects to coordinate care for members receiving care at the Hub. Additionally, this investment will also support DHS' implementation of the Community Ambassador Program, a Safe Services Hub, a Harm Reduction Health Hub at Crocker Campus as a partner of the Skid Row Care Collaborative.

L.A. Care is partnering with JWCH Institute and the DHS Housing for Health & Harm Reduction Division based on their extended experience providing and coordinating housing and homeless services for the County of Los Angeles, and their 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 enhance access to critical healthcare and social services, promote care coordination, and reduce uncoordinated care for residents in high density regions, improve access to Community Supports, Enhanced Care Management services, and other necessary resources for individuals with complex health, mental health and substance use conditions who are unhoused and housed residents in the community. The services that DHS and JWCH Institute will implement through this HHIP investment will bring new social services and other critical support to homeless members in Skid Row.

Budget Impact: The funding has not been approved in the previous HHIP motion, however we have allocated funds to this investment from the final HHIP earnings.

Motion: **To authorize staff to execute two (2) Housing and Homelessness Incentive Program (HHIP) investment agreements for a combined amount of up to $20,723,100 with the Los Angeles County Department of Health Services Housing for Health & Harm Reduction Division and JWCH Institute to provide access to critical healthcare and social services for the Skid Row community from July 1, 2024 to June 30, 2027.**

Board of Governors
MOTION SUMMARY

Date: September 5, 2024 **Motion No. EXE 100.0924**

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

Requesting Department: Legal Services Department

Issue: Request to ratify execution of Amendment A04 to L.A. Care's Exclusively Aligned Enrollment (EAE) D-SNP contract (contract number 22-20236) with the Department of Health Care Services (DHCS).

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

Background: L.A. Care received Amendment A04 to the EAE D-SNP contract on June 13, 2024. DHCS required that the Plan submit the executed Amendment on or before June 20, 2024 and did not approve an extension to submit. Amendment A04 extends the contract term to December 31, 2025. This amendment allows for the continuation of the services identified in the original agreement.

Member Impact: The Plan's D-SNP Members are positively impacted by extending the Plan's contract applicable to the D-SNP line of business.

Budget Impact: Finance has reviewed for impact on relevant budgets.

Motion: **To ratify L.A. Care Chief Executive Officer's, John Baackes, execution of Amendment A04 to L.A. Care's Exclusively Aligned Enrollment (EAE) D-SNP Contract Number 22-20236 with the Department of Health Care Services (DHCS).**

Exhibit A
SCOPE OF WORK

Exclusively Aligned Enrollment D-SNP

1. Service Overview

A. This Contract is being executed with this Contractor that is a Dual Eligible Special Needs Plan (D-SNP), Local Initiative Health Authority for LA County, that will be referred to in this Contract as D-SNP Contractor. The Medicare Advantage organization offering the D-SNP, D-SNP Contractor's parent organization, or another entity that is owned and controlled by the D-SNP Contractor's parent organization L.A. Care Health Plan must also hold a Medi-Cal Managed Care Health Plan (MCP) Contract with California Department of Health Care Services (DHCS), or must be a subcontracted delegate health plan as defined in Welfare and Institutions Code (W&I) section 14184.208(h)(6), also referred to as an Exclusively Aligned Enrollment (EAE) D-SNP. D-SNP Contractor must have a Medicare Advantage Contract (H-Contract) that only includes D-SNPs within California in accordance with 42 CFR section 422.107(e). The H-Contract must include both EAE and Non-EAE plan benefit packages.

B. This D-SNP Contract is a Care Coordination and benefit coordination agreement. D-SNP Contractor is responsible for coordinating the delivery of all benefits covered by both Medicare and Medi-Cal, including those benefits not covered by the Medicare Advantage health plan under whose authority the D-SNP Contractor operates, and the Medi-Cal benefits identified in the Exhibit H attachment to this Contract and referenced below in Provision 3 of this Exhibit A. Coordination responsibility includes coordination of those Medi-Cal Services that are delivered via Medi-Cal Fee-For-Service (FFS), managed care, or other Medi-Cal delivery systems. These Medi-Cal benefits and services are defined in the contents of this D-SNP Contract.

C. This D-SNP Contract is for Applicable Integrated Plans as defined in 42 CFR section 422.561. D-SNP Contractor must limit enrollment to full-benefit Dual Eligible Members enrolled in an affiliated MCP, per 42 CFR section 422.561, that holds a capitated contract with DHCS or is a subcontracted delegate health plan as defined in W&I 14184.208(h)(6). Through the capitated MCP Contract, Medi-Cal benefits include primary care and acute care, including Medicare cost-sharing as defined in 28 Social Security Act (SSA) section 1905(p)(3)(B), (C), and (D), without regard to the

limitation of that definition to qualified Medicare beneficiaries. Members enrolled in Applicable Integrated Plans have Skilled Nursing Facility (SNF) services (with coverage for a minimum of 180 days), Home Health Services (as defined at 42 CFR section 440.70), and Durable Medical Equipment (DME) including equipment and appliances, as well as medical supplies (as defined at 42 CFR section 440.70(b)(3)) covered by the capitated MCP Contract.

2. Project Representatives

A. The project representatives during the term of this D-SNP Contract will be:

Department of Health Care Services	D-SNP Contractor
Managed Care Operations Division Attn: Procurement & Contract Development Branch Chief	Local Initiative Health Authority for LA County Attn: Todd Gower, Chief Compliance Officer
Telephone: (916) 449-5000 FAX: (916) 449-5090	Telephone: 213-523-1854 925-595-1021 Email: TGower@lacare.org

B. Direct all inquiries to:

Department of Health Care Services	D-SNP Contractor
Managed Care Operations Division Attn: Michelle Retke, Division Chief	Local Initiative Health Authority for LA County Attn: Todd Gower, Chief Compliance Officer
MS 4408 P.O. Box 997413 Sacramento, CA 95899-7413	1200 West 7th Street Los Angeles, CA 90017
Telephone: (916) 449-5000 FAX: (916) 449-5090	Telephone: 213-523-1854 925-595-1021 Email: TGower@lacare.org

C. Either party may make changes to the information above by giving written notice to the other party. Said changes shall not require an

Exhibit A
SCOPE OF WORK

amendment to this D-SNP Contract.

3. See the following attachments for a detailed description of the services to be performed:

   A. Exhibit A: Scope of Work

   B. Exhibit H

Exhibit A, Attachment 1
COORDINATION OF CARE

1. Care Coordination

This D-SNP Contract is a Care Coordination and benefit coordination agreement between D-SNP Contractor and DHCS. D-SNP Contractor is responsible for coordinating the delivery of all benefits and services covered by both Medicare and Medi-Cal, including when Medi-Cal Services are delivered via Medi-Cal FFS, managed care, or other Medi-Cal delivery systems. Without limitation, when Medically Necessary for the Member, D-SNP Contractor must coordinate care with providers and other entities for the Medi-Cal Services outlined in Exhibit H. D-SNP Contractor must educate Members through Member handbook and other contacts that D-SNP Contractor, and not the Member, is responsible for coordination of the Member's Medi-Cal and Medicare Services.

A. For coordination of behavioral health services, including specialty mental health and substance use disorder services, D-SNP Contractor must establish a cooperative working relationship with the Member's MCP and/or the county behavioral agency for care coordination, information sharing, and oversight. County behavioral health plan contact information can be found at the following link: https://www.dhcs.ca.gov/services/MH/MHSUD/Pages/CountyProgAdmins.aspx.

B. For coordination of In-Home Supportive Services (IHSS), D-SNP Contractor must establish a cooperative working relationship with the County IHSS Office for care coordination, information sharing, and oversight. County IHSS Office contact information can be found at: https://www.cdss.ca.gov/inforesources/county-ihss-offices.

C. For coordination of Medi-Cal dental benefits, D-SNP Contractor must contact the DHCS Dental Administrative Service Organization (ASO) for provider information and the coordination of dental benefits for Members enrolled in Medi-Cal dental fee-for-service or contact the Medi-Cal Dental Managed Care Plan for Members enrolled in Medi-Cal Dental Managed Care. ASO contact information can be found at the following link: https://smilecalifornia.org/contact-us/ and below are Medi-Cal Dental Managed Care contact information:

Liberty Dental Plan
Sacramento: (888) 703-6999 or (877) 855-8039 (TTY/TTD)

Exhibit A, Attachment 1
COORDINATION OF CARE

Los Angeles: (888) 703-6999 or (877) 855-8039 (TTY/TTD)

Health Net Dental Plan
Sacramento: (800) 977-7307 | TTY (800) 977-7307 (TTY 711)
Los Angeles: (800) 977-7307 | TTY (800) 977-7307 (TTY 711)

Access Dental Plan
Sacramento: (877) 821-3234 | TTY: (800) 735-2929
Los Angeles: (888) 414-4110 | TTY: (800) 735-2929

Please note: the Dental Managed Care Plans are subject to change. DHCS reserves the right to provide updated contact information for Dental Managed Care plans.

D. For coordination of Medi-Cal pharmacy benefits, D-SNP Contractor must contact Medi-Cal Rx, and contact information can be found at: https://medi-calrx.dhcs.ca.gov/home/contact.

E. If D-SNP Contractor offers Supplemental Benefits as referenced in Exhibit E, Attachment A, Definitions, of this Contract, also including Special Supplemental Benefits for the Chronically Ill (SSBCI) or Expanded Primarily Health-Related Benefits (EPHRB), those services must be coordinated as needed to ensure D-SNP Contractor tracks Member use of Supplemental Benefits and exhausts Supplemental Benefits prior to or concurrent with authorization of or referral for Medi-Cal benefits, including but not limited to Dental, Vision, Transportation, Community Supports, and Behavioral Health.

F. D-SNP Contractor must implement a Special Needs Plan Model of Care (MOC). In addition to meeting requirements detailed at 42 CFR section 422.101(f) and earning approval from the National Committee for Quality Assurance (NCQA), the Contractor must include State-specific requirements outlined in the 2025 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx. D-SNP Contractor must additionally comply with State-specific Care Coordination requirements, which are fully outlined in the 2025 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on the DHCS website and may be amended from time to time. These State-specific requirements, which are outlined fully in the 2025 CalAIM Dual Eligible Special

Exhibit A, Attachment 1
COORDINATION OF CARE

Needs Plan (D-SNP) Policy Guide, include the following:

1) Incorporating Medi-Cal data into the D-SNP risk stratification process;

2) Incorporating Medi-Cal Services and providers, including palliative care teams as appropriate, into the development and execution of the Member's care plan and care team, including Medi-Cal Services accessed through the aligned MCP as well as Medi-Cal FFS and other Medi-Cal delivery systems (including Home and Community-Based Services programs);

3) Including a question in the Member's Health Risk Assessment (HRA) to identify any engaged Caregiver and submit the HRA tool to DHCS;

4) Assessing of Caregiver support needs, if a Member identifies a Caregiver, as part of the D-SNP assessment process;

5) Providing on at least an annual basis as feasible, and with the Member's consent, face-to-face encounters for the delivery of health care or care management or Care Coordination services;

6) Incorporating trained Dementia Care Specialists in care teams and encouraging primary care providers to leverage Dementia Care Aware resources for any primary care appointment to detect cognitive impairment;

7) Utilizing Long-Term Services and Supports (LTSS) liaisons in supporting care transitions;

8) Including four (4) or more populations of focus from the Medi-Cal Enhanced Care Management (ECM) program and demonstrating how the D-SNP Contractor's model of care includes and reflects the delivery of ECM core services;

9) Providing and coordinating inpatient and outpatient/community-based palliative care referrals and services for Members who meet Medi-Cal criteria for palliative care; and

10) Discussing advance care planning in the annual wellness visit or other provider visits.

G. D-SNP Contractor is not responsible to provide or pay for any Medi-Cal benefits, or Medicare cost sharing obligations which are covered in full through Medi-Cal FFS or MCP Contract. Medi-Cal MCPs are responsible to pay Medicare cost sharing obligations for contracted benefits for MCP members. In addition, the MCP Contract requires the MCP to enter into a Coordination of Benefits Agreement with the Medicare program through the Centers for Medicare & Medicaid Services (CMS), and to participate in Medicare's automated claims crossover process for full-benefit Dual Eligible Members, in accordance with 42 CFR section 438.3(t). D-SNP Contractor shall maintain a current knowledge and familiarity of Medi-Cal benefits through ongoing reviews of California laws, rules, policies, and further guidance as posted on the DHCS website or otherwise provided by DHCS. D-SNP Contractor shall coordinate with the aligned MCP to support Medi-Cal eligibility retention efforts to the extent permitted by law, and guidance from CMS and DHCS. D-SNP Contractor shall timely coordinate Medi-Cal Services requiring referral and coordination of care as outlined in Exhibit H for its Members under this Contract.

This Provision details D-SNP Contractor's specific Medicare-Medi-Cal care coordination requirements. Medi-Cal Services are described in Title XIX of the Social Security Act, 42 CFR parts 440 and 441; the California Medicaid State Plan; Exhibit H; the DHCS and Medi-Cal websites and other relevant materials.

2. Information Sharing

A. D-SNP Contractor is responsible for complying with State policy implementing federal information sharing requirements for D-SNPs per 42 CFR section 422.107(d)(1), for the purpose of coordinating Medicare and Medi-Cal covered services between settings of care for all Members. This State policy is in addition to federal requirements for hospitals regarding electronic notifications listed in 42 CFR section 482.24(d). The goal of the information sharing policy is for D-SNP Contractor, either directly or through contracted providers or other entities, to timely notify the Member's MCP, or hospital and SNF admissions. Timely notification supports the coordination of and referrals to Medicare and Medi-Cal Services, including Home and Community Based Services.

1) To the extent permissible under applicable federal and State law and regulations, and not inconsistent with the Member's expressed privacy preferences, D-SNP Contractor will require their contracted hospitals and SNFs to use a secure email data exchange through a Health Information Organization, or an electronic process approved by DHCS, to inform D-SNP Contractor in a timely manner of any hospital or SNF admissions for all Members.

2) D-SNP Contractor will require contracted hospitals to make this notification either immediately prior to, or at the time of, the Member's discharge or transfer from the hospital's inpatient services, if applicable.

3) To the extent permissible under applicable federal and State law and regulations, and not inconsistent with the Member's expressed privacy preferences, D-SNP Contractor will require their contracted SNFs to use a secure email, a data exchange through a Health Information Organization, or an electronic process approved by DHCS, to inform D-SNP Contractor of any SNF admission, discharge, or transfer for all Members. For SNF admissions, D-SNP Contractor will require contracted SNFs to make this notification within 48 hours after any SNF admission. For SNF discharges or transfers, D-SNP Contractor will require contracted SNFs to make this notification in advance, if at all possible, or at the time of, the Member's discharge or transfer from the SNF.

4) In the event that the D-SNP Contractor authorizes another entity or entities to perform these notifications, D-SNP Contractor must retain responsibility for complying with this requirement. The D-SNP Contractor ultimately retains the responsibility for the notification requirements that are delegated to its contracted hospitals and SNFs.

B. D-SNPs will coordinate care management for their Members and facilitate Member access to needed LTSS, including in community-based settings to support care transitions.

3. Integrated Materials

A. D-SNP Contractor is responsible for providing integrated Member materials to Members. The State requirements described in this

Exhibit A, Attachment 1
COORDINATION OF CARE

Paragraph are in addition to all existing Medicare marketing and communications requirements outlined in 42 CFR Part 422 Subpart V, 42 CFR Part 423 Subpart V, and 42 CFR section 438.10(d)(2), and as described in the Medicare Communications and Marketing Guidelines (MCMG). Required integrated Member materials will include:

1) Annual Notice of Change (ANOC);

2) Member Handbook;

3) Summary of Benefits;

4) Member Identification (ID) Card;

5) Provider/Pharmacy directory; and

6) List of Covered Drugs (Formulary).

B. D-SNP Contractor must have a single Member services/customer service phone number for Members to contact D-SNP Contractor regarding their Medicare or Medi-Cal benefits. D-SNP Contractor must use the single Member services phone number in all integrated Member materials.

C. D-SNP Contractor will be required to make all integrated Member materials available in the threshold languages for their aligned MCP Service Area. Threshold languages include both:

1) Medicare's five percent (5%) threshold for language translation as outlined in 42 CFR Part 422 Subpart V and 42 CFR Part 423 Subpart V); and

2) DHCS prevalent language requirements, i.e. the DHCS threshold and concentration standard languages, as specified in APL 21-004 or subsequent iterations guidance to Contractors on specific translation requirements for their Service Areas.

D. D-SNP Contractor must have a process for ensuring that Members can make a standing request to receive materials in alternative formats and in any non-English languages, at the time of request and on an ongoing basis thereafter, in accordance with 42 CFR section 422.2267 and section 423.2267, APL 21-004 or subsequent

iterations, APL 22-002 or subsequent iterations, and the 2025 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide as applicable. The process must include how D-SNP Contractor will keep a record of the Member's information and utilize it as an ongoing standing request so the Member does not need to make a separate request for each item of material, and how a Member can change a standing request for preferred language and/or format.

E. D-SNP Contractor must identify in its provider directory those providers that accept both Medicare and Medi-Cal, i.e. providers that are currently registered providers under Medi-Cal and are also within D-SNP Contractor's network. D-SNP Contractor must comply with existing federal and State guidelines regulating print and online provider directories. Print and online directories for D-SNP Contractor must reflect all contracted and in-network providers for D-SNP Members. The provider directories must show the providers that are in the D-SNP Medicare and/or Medi-Cal networks in a clear manner for Members.

F. D-SNP Contractor must submit all communication and marketing materials in the Health Plan Management System (HPMS) that are required to be submitted as described here and in the MCMG under D-SNP Contractor's Medicare contract ID number. The multi-plan submission process is not applicable to D-SNP only contracts. In addition, when a third party, such as a pharmacy benefit manager (PBM), creates and distributes Member-specific materials on behalf of multiple organizations, it is not acceptable to use the material ID for another organization for materials the third-party providers to D-SNP enrollees. The material must be submitted in HPMS using a separate material ID number for the D-SNP contract and that material ID number must be included in the material. Additional guidance including the submission and review process for integrated Member materials is fully outlined in the 2025 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on DHCS' website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

G. D-SNP Contractor must have a single Application Programming Interface (API) for Members to access both Medicare and Medi-Cal information.

4. State-Specific Supplemental Benefits

Exhibit A, Attachment 1
COORDINATION OF CARE

Using Medicare rebate dollars, D-SNP Contractor must provide, at a minimum, the following supplemental benefits to Members:

A. $0 copay for one (1) routine eye exam every year; and

B. Every two (2) years, $100 for eyeglasses (frames and lenses) or up to $100 for contact lenses.

5. Quality and Data Reporting

A. D-SNP Contractor is responsible for reporting quality measures to DHCS. These quality measures are fully outlined in the 2025 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on DHCS' website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

B. This reporting will include:

1) Selected Healthcare Effectiveness Data and Information Set (HEDIS) measures, calculated at the plan benefit package (PBP) level for the PBPs included in this Contract;

2) State-specific Care Coordination and LTSS process measures;

3) State-specific dementia measures;

4) State-specific ECM-like care management measures;

5) State-specific palliative care measures; and

6) Integrated Appeals and Grievances data.

DHCS will add additional measures as needed, and details will be provided in the 2025 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on DHCS' website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

6. Consumer Participation in Governance Boards

A. D-SNP Contractor must comply with federal requirements outlined in 42 CFR section 422.107(f) in addition to State-specific requirements outlined below. D-SNP Contractor must ensure

consumer participation in governance boards that will provide regular feedback to the D-SNP Contractor on issues of duals-related topics, including plan management and Member care. D-SNP Contractor must consider region-specific meetings based on geographic county proximity rather than one State-wide setting, and ensure that the committee completes the following:

1) Meets at least quarterly throughout the Contract Year;

2) Has at least four (4) Member seats for individuals who have knowledge and perspective of EAE D-SNP topics to facilitate a variety of Member perspectives and unique lived experiences, including those using services such as Home and Community Based Services and Long-Term Care;

3) Includes a ratio of Members on the governance board focused on duals-related topics relative to the ratio of dual eligible Members enrolled with D-SNP Contractor;

4) Includes a reasonably representative sample of the population enrolled in D-SNP including Members, Member's family members, consumer advocates, and caregivers that reflect the demographic diversity of the D-SNP population, including individuals with disabilities; and

5) Solicits input on ways to improve access to Covered Services, coordination of services (including all Medicare and Medi-Cal services), and health equity for underserved populations, among other topics.

B. D-SNP Contractor is responsible for reporting their committee charter and membership to DHCS annually by March 1, 2025, through its DHCS Contract Manager via email. D-SNP Contractor is also responsible for reporting meeting minutes and agendas to DHCS quarterly through its DHCS Contract Manager via email no later than 30 days after the end of each quarter. DHCS reserves the right to review and approve Enrollee membership. D-SNP Contractor can engage and recruit Members serving on existing committees.

7. State Guidance

A. In addition to the terms and conditions of this Contract, D-SNP Contractor must comply with State-specific departmental

guidance in the 2025 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on DHCS' website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

B. To the extent that State guidance conflicts with Medicare requirements or regulations, D-SNP Contractor must comply with Medicare requirements and regulations. For purposes of this Provision State guidance only conflicts with Medicare requirements or regulations to the extent that the guidance requires conduct that would violate Medicare requirements or regulations.

8. Coverage Area and Eligible Beneficiaries

A. This Contract covers the Medicare H-contract and Plan Benefit Package (PBP) listed within the following table.

Plan PBPs	H-Contract	Service Area of PBP	Eligible Populations within PBP
001	H1224	Los Angeles County	QMB+, SLMB+, and other Full-Benefit Medi-Cal

B. Members covered under this Contract must include all full-benefit Dual-Eligible Beneficiaries 21 years of age or older, such as Qualified Medicare Beneficiaries Plus (QMB+), Specified Low-Income Medicare Beneficiaries Plus (SLMB+), and other full-benefit Dual-Eligible Beneficiaries who are enrolled with D-SNP Contractor and with the aligned Medi-Cal MCP. Covered Members include those who meet the following:

1) Are enrolled with D-SNP Contractor;

2) Who reside in the following county or counties to maximize the continuum of services available through both Medicare and Medi-Cal: Los Angeles County

3) Are already enrolled in the MCP affiliated with D-SNP Contractor.

C. D-SNP Contractor agrees to conduct enrollment of eligible

persons in accordance with the policies and procedures set forth in this Contract and maintain EAE for the duration of the D-SNP Contract term.

9. Certification and Enrollment Reporting

A. D-SNP Contractor must submit to DHCS a certification, signed by the Chief Operations Officer or similar executive officer, that attests to the number of Members enrolled in D-SNP Contractor's D-SNP as of the effective date of this Contract.

B. By the fifth working day of each month during the term of this Contract, D-SNP Contractor must submit a report to DHCS, signed by the Chief Operations Officer or similar executive officer, summarizing the previous month's Enrollment numbers.

10. Member Billing Prohibitions

A. D-SNP Contractor and its contracted providers are prohibited from imposing cost-sharing requirements on Members that would exceed the amounts permitted under the California Medicaid State Plan, Section 1852(a)(7) of the Social Security Act, and 42 CFR section 422.504(g)(1)(iii). D-SNP Contractor must not bill any Member (including full-benefit Dual Eligible Beneficiaries such as QMB+, SLMB+, and other full-benefit Dual Eligible Beneficiaries) for Medicare cost sharing amounts, including deductibles, coinsurance, and copayments, in accordance with Section 1902(n)(3)(B) of the Social Security Act, which prohibits a Medicare provider from billing a full-benefit Dual Eligible Beneficiary for Medicare cost sharing amounts, including deductibles, coinsurance, and copayments.

B. Any Dual Eligible Beneficiary (including full-benefit Dual Eligible Beneficiaries such as QMB+, SLMB+, and other full-benefit Dual Eligible Beneficiaries) has no legal obligation to make further payment to a provider or to D-SNP Contractor for Medicare Part A or Part B cost sharing amounts. D-SNP Contractor's provider agreements must specify that a contracted Medicare provider agrees to accept D-SNP Contractor's Medicare reimbursement as payments in full for services rendered to Dual Eligible Enrollees, or to bill Medi-Cal or the Member's Medi-Cal MCP as applicable for

any additional Medicare payments that may be reimbursed by Medi-Cal. D-SNP Contractor's provider agreements must require a contracted Medicare provider to comply with Welfare and Institutions Code section 14019.4.

11. Provider Network Requirements

A. D-SNP Contractor can obtain Medi-Cal participating providers by reviewing the California Health and Human Services Open Data Portal. Medi-Cal FFS Provider data can be found at: https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers. Medi -Cal Managed Care Provider Network data can be found at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-provider-listing. Alternatively, D-SNP Contractor can obtain the file from the affiliated MCP.

B. D-SNP Contractor must comply with all applicable network guidance and network requirements outlined in the 2025 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on the DHCS website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

C. D-SNP Contractor that offers Dental Supplemental Benefits must report to DHCS on the level of overlap for their Medicare dental network and the Medi-Cal Dental network, as outlined in the 2025 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide.

12. Medicare Continuity of Care

A. D-SNP Contractor must comply with State-specific requirements for Medicare primary and specialty care provider continuity of care. D-SNP Contractor must also comply with State-specific requirements for Durable Medical Equipment continuity of care as outlined in 42 CFR section 422.100(I)(2)(iii) and APL 23-022 or subsequent iterations to the extent that this requirement applies to the D-SNP Contractor. Further guidance is outlined in the 2025 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on the DHCS website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx. D-SNP Contractor must provide Members with the following:

1) A 12-month continuity of care period from the date of the Member's Enrollment in the D-SNP, for primary and specialty providers with whom the Member has a pre-existing relationship and who are willing to work with the D-SNP Contractor; and

2) Access to Medically Necessary Medicare-covered Durable Medical Equipment and medical supplies.

13. Medi-Cal and Medicare Eligibility Verification and MCP Enrollment Verification

A. It is the responsibility of D-SNP Contractor to verify the Medi-Cal eligibility of a Member. To facilitate this verification, D-SNP Contractor will have real-time access to the Medi-Cal eligibility verification system.

B. To obtain Medicare Advantage and Medi-Cal eligibility, D-SNP Contractor must validate eligibility through its existing on-line and/or batch Medicare and Medi-Cal eligibility user interfaces.

1) Medicare and/or Medi-Cal eligibility systems will indicate whether a beneficiary is currently enrolled or is pending enrollment in a MCP at the time of the inquiry.

2) If the beneficiary meets the criteria for enrollment listed in Provision 8, Coverage Area and Eligible Beneficiaries, the eligible beneficiary may be enrolled with D-SNP Contractor.

C. D-SNP Contractor must ensure appropriate training of plan personnel and contracted providers regarding the use of the Medi-Cal Automated Eligibility Verification System (AEVS) interface and the appropriate interpretation of its eligibility results.

D. D-SNP Contractor's providers may use the Medicare Administrative Contractor (MAC) online provider portal to check their patient's Medicare eligibility. Additional information on checking Medicare eligibility can be found on the following link: https://www.cms.gov/MAC-info.

14. Medicare Deeming Period

Exhibit A, Attachment 1
COORDINATION OF CARE

For those Members who have lost Medi-Cal eligibility, D-SNP Contractor is required to maintain enrollment for such Members for at least a three-month deeming period following notification that the Member lost Medi-Cal eligibility. This requirement does not preclude D-SNP Contractor from offering a longer deeming period. D-SNP Contractor should inform its DHCS Contract Manager of the deeming period that it will provide.

15. Contract Term

This D-SNP Contract is effective from January 1, 2025, through December 31, 2025.

16. Termination

DHCS retains the right to terminate this D-SNP Contract at any time for cause or no cause.

17. Compensation

The State of California and DHCS must not provide any remuneration or other form of compensation for the performance of any duties or obligations provided under this D-SNP Contract.

18. CMS Documentation

A. D-SNP Contractor must submit to DHCS, after execution of this Contract but no later than September 30, 2024, a complete and accurate copy of the Medicare Advantage bid for the contract containing the PBPs covered by this Contract, as approved by CMS.

B. If not included in the approved bid, the D-SNP Contractor must also provide to DHCS the following information, in a format as specified by DHCS, after execution of this Contract but no later than September 30, 2024 to the DHCS contract manager:

1) The current approved model of care, if not already submitted to DHCS.

2) A list of approved Supplemental Benefits included in the initial annual Medicare Advantage bid submission to CMS.

3) A list of approved Supplemental Benefits, inclusive of all benefits listed in the final Plan Benefit Package.

C. D-SNP Contractor must submit to DHCS copies of CMS reporting, compliance, and audit findings.

19. Medicare Encounter Data Requirements

D-SNP Contractor must submit to DHCS electronic records of all encounters, including encounters resulting in zero Medicare claims, monthly, in a mutually agreed upon format. Each encounter record must be specific to the Member and provider, listing all the data elements required for each service. This data will provide DHCS with information on services paid for by Medicare. Additional details regarding this requirement are fully outlined in the 2025 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on the DHCS website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

20. Integrated Appeals and Grievances

A. D-SNP Contractor must adhere to the State-specific requirements described in this Contract, in addition to all existing Medicare requirements. In addition, D-SNP Contractor must implement a unified approach to appeals and grievances per 42 CFR sections 422.629-422.634, 438.210, 438.400, and 438.402. 42 CFR section 422.629(c) allows the State, at its discretion, to implement standards for timeframes or notice requirements that are more protective for the Member than required by 42 CFR section 422.630 through 422.634.

B. D-SNP Contractor must provide information about its Integrated Appeals and Grievance system to all providers and subcontractors at the time they enter into a contract, including, at a minimum, information on Integrated Appeals, Integrated Grievances, State Hearings, and Independent Medical Review (IMR) procedures and timeframes, as applicable.

C. D-SNP Contractor must maintain records of the Integrated Appeals, Integrated Grievances, and Integrated Organization Determinations. The record of each Integrated Appeals, Integrated Grievances, and Integrated Organization Determinations must be accurately maintained in a manner accessible to the State and available upon request to CMS. Additionally, D-SNP Contractor must establish, implement, maintain, and oversee an Integrated Grievance and Integrated Appeal system to ensure the receipt,

review, and resolution of Integrated Grievances and Appeals. D-SNP Contractor must ensure that the following requirements are met through its Integrated Grievance and Integrated Appeal system.

D. Integrated Appeals and Grievances procedures apply to all benefits offered under D-SNP Contractor including optional supplemental benefits. For benefits that are carved out, such as Medi-Cal Dental, D-SNP Contractor must also follow the regulations at 42 CFR section 422.562(a)(5) and 422.629(e) that require D-SNP Contractor to provide Members reasonable assistance completing forms and taking other procedural steps to assist Members with appeals and grievances. This includes offering to assist Members with obtaining Medi-Cal covered services and navigating Medi-Cal appeals and grievances in connection with the Member's own Medi-Cal coverage, regardless of whether such coverage is in Medi-Cal fee-for-service or a separate Medi-Cal Dental Managed Care Plan. If the Member accepts the assistance, the D-SNP Contractor should assist the Member as needed, such as identifying and reaching out to a Medi-Cal fee-for-service point of contact, providing assistance in filing an appeal or grievance, helping to obtain documentation to support a request for Medi-Cal appeal or grievance, or completing paperwork that may be needed in filing an appeal or grievance.

E. For Integrated Grievances, D-SNP Contractor must have the following:

1) Procedure to allow a Member, Member's authorized representative, or their provider to file a standard or expedited Integrated Grievance orally or in writing with D-SNP Contractor at any time.

2) Procedure to ensure D-SNP Contractor sends a written acknowledgement of an Integrated Grievance that is dated and postmarked within five (5) calendar days of receipt in accordance with Health and Safety Code (H&S) section 1368(a)(4)(A) and 28 California Code of Regulations (CCR) section 1300.68(d)(1) and 42 CFR section 422.629(g).

3) Procedure to resolve standard Integrated Grievances as expeditiously as the Member's health condition requires, but no later than 30 calendar days from receipt of the Integrated Grievances in accordance with 42 CFR section 422.630.

4) Procedure to resolve expedited Integrated Grievances within 24 hours in accordance with 42 CFR section 422.630.

5) Procedure to provide a written resolution to the Member for an Integrated Grievance within the resolution timeframe for a standard and expedited Integrated Grievance when:

   a) The Member submits an Integrated Grievance in writing;

   b) The Member requests a written response;

   c) The Integrated Grievance is related to quality of care, coverage dispute, or disputed health care service involving medical necessity or experimental or investigational treatment; or

   d) The Integrated Grievance is not resolved by the next business day, regardless of the type of Integrated Grievance or how it is filed.

6) Procedure to log and report all Integrated Grievances.

F. For Integrated Organization Determinations, D-SNP Contractor must have the following:

1) Procedure for D-SNP Contractor to consider both Medicare and Medi-Cal coverage criteria when making an Integrated Organization Determination.

2) Procedure to provide timely notice of standard Integrated Organization Determinations as expeditiously as the Member's health condition requires, and no later than 14 calendar days from when it receives the request in accordance with 42 CFR section 422.631(d)(2)(i)(B).

3) Procedure to provide notice to Members of their appeal rights and State Hearing rights for all fully or partially denied Integrated Organization Determinations.

4) Procedure to include the most current State Hearing form with the Integrated Organization Determination notice when the following requirements are met:

a) The denied Integrated Organization Determination is not for a Medicare-only service or benefit; and

b) The Integrated Organization Determination is relating to a denial, in whole or in part, of a Medi-Cal Service or benefit, including cases where there is an overlap of Medicare and Medi-Cal.

5) For Knox-Keene licensed plans, a procedure to ensure compliance with H&S section 1367.01, including making Integrated Organization Determinations in a timely fashion appropriate for the nature of the Member's condition, not to exceed five (5) business days from D-SNP Contractor's receipt of information reasonably necessary to make the Integrated Organization Determination, and no later than 14 calendar days from the receipt of request in accordance with H&S section 1367.01(h)(1) and 42 CFR section 422.631(d)(2)(i)(B).

6) For Knox-Keene licensed plans, a procedure to inform Members of their rights to an IMR in accordance with the Knox-Keene Act, including but not limited to H&S sections 1368.03, 1370.4, and 1374.30, 28 CCR sections 1300.70.4 and 1300.74.30, and including verbatim language required by H&S section 1368.02(b), as well as the most recent IMR form, application instructions, the Department of Managed Health Care's (DMHC's) toll-free telephone number, and an envelope addressed to DMHC when the following requirements are met:

a) The denied Integrated Organization Determination is for experimental or investigational therapy, or is a denial of urgent care or emergency service;

b) The denied Integrated Organization Determination is not for a Medicare-only service or benefit; and

c) The Integrated Organization Determination is relating to a denial, in whole or in part, of a Medi-Cal Service or benefit, including cases where there is an overlap of Medicare and Medi-Cal.

7) Procedure to provide timely notice of expedited Integrated

Organization Determinations as expeditiously as the Member's health condition requires, and no later than 72 hours from when D-SNP Contractor receives the request in accordance with 42 CFR section 422.631(d)(2)(iv).

8) Procedure to ensure deadlines for integrated organization determinations are not extended in accordance with H&S section 1367.01.

9) Procedure to ensure that prior to terminating, suspending, or reducing a previously approved item or service, D-SNP Contractor must provide Members with an integrated coverage decision letter at least ten (10) calendar days in advance of the effective date of the adverse organization determination in accordance with 42 CFR section 422.631(d)(2)(i)(A).

10) For Knox-Keene licensed plans, a procedure to ensure that D-SNP Contractor must not rescind or modify an integrated organization authorization after the Provider renders the health care service in good faith in accordance with H&S section 1371.8.

G. For Integrated Appeals, D-SNP Contractor must have the following:

1) Procedure to provide written acknowledgement of receipt of all Integrated Appeals within five (5) calendar days in accordance with 42 CFR section 422.629(g) and H&S section 1368(a)(4)(A).

2) Procedure to resolve standard Integrated Appeals as expeditiously as the Member's health condition requires but to not exceeding 30 calendar days from the date of receipt of the request in accordance with 42 CFR section 422.633(f)(1).

3) Procedure to inform Members of their rights to a State Hearing and include the most current State Hearing form when the following requirements are met:

a) The denied Integrated Appeal decision is not for a Medicare-only service or benefit; and

b) The Integrated Appeal relates to a denial, in whole or

in part, of a Medi-Cal Service or benefit, including cases where there is an overlap of Medicare and Medi-Cal.

4) For Knox-Keene licensed plans, a procedure to ensure that the Medi-Cal External Appeals processes are in accordance with DMHC's IMR System set forth in Article 5.55 of the Knox-Keene Act and the regulations promulgated thereunder.

5) For Knox-Keene licensed plans, a procedure to inform Members of their right to request an IMR in accordance with the Knox-Keene Act, including but not limited to H&S sections1368.03 and 1374.30, and 28 CCR section 1300.74.30, and including the verbatim language required by H&S section 1368.02, as well as the most recent IMR form, application instructions, DMHC's toll-free telephone number, and an envelope addressed to DMHC when the following requirements are met:

   a) The denied Integrated Appeal decision is not for a Medicare-only service or benefit; and

   b) The Integrated Appeal is relating to a denial, in whole or in part, of a Medi-Cal Service or benefit, including cases where there is an overlap of Medicare and Medi-Cal.

6) Procedure to resolve expedited Integrated Appeals within 72 hours of receipt of the Appeal in accordance with 42 CFR section 422.633(f)(2).

7) Procedure to ensure deadlines for Integrated Appeals of Medicare and Medi-Cal Services are not extended in accordance with APL 21-011 or any subsequent iterations of this APL.

8) Procedure to ensure D-SNP Contractor is obtaining all relevant information needed to make an Integrated Appeal decision within the required timeframes.

9) Procedure to ensure D-SNP Contractor continues the Member's benefits per 42 CFR section 422.632 while the Integrated Appeal is pending if all of the following are met:

a) The Member files a request to continue benefits within ten calendar days of notice of adverse integrated organization determination;

b) The integrated appeal involves the termination, suspension, or reduction of previously authorized services;

c) The services were ordered by an authorized provider; and

d) The period covered by the original authorization has not expired.

H. For a Reversal of Integrated Appeal Decisions, D-SNP Contractor must have the following:

1) Procedure to authorize or provide the service under dispute if D-SNP Contractor reverses its decision to deny, limit, or delay services that were not provided while the Appeal was pending within the following timeframes:

a) As expeditiously as the Member's health condition requires and no later than 72 hours from the date it reverses its determination; or

b) With the exception of a Medicare Part B drug, 30 calendar days after the date D-SNP Contractor receives the request for the Integrated Appeal; or

c) For a Medicare Part B drug, seven (7) calendar days after the date D-SNP Contractor receives the request for the Integrated Appeal.

2) Procedure to authorize or provide the disrupted service(s) if a State Hearing officer reverses D-SNP Contractor's Integrated Appeal decision to deny, limit, or delay services that were not provided while the Appeal was pending, as expeditiously as the Member's health condition requires but no later than 72 hours of the date it receives notice reversing the determination in accordance with 42 CFR section 422.634(d)(2).

3) Procedure to effectuate decisions made by a Part C independent review entity, an administrate law judge or attorney adjudicator at the Office of Medicare Hearings and Appeals, or the Medicare Appeals Council to reverse D-SNP Contractor's decision under the same timelines applicable to other Medicare Advantage plans as specified in 42 CFR sections 422.618,422.619, and 422.634(d)(3).

4) For Knox-Keene licensed plans, the procedure to promptly implement the decision of an IMR that a disputed health care service is medically necessary in accordance with H&S section 1374.3.

21. Additional Guidance

A. For Marketing materials, D-SNP Contractor must include information about Medi-Cal Dental benefits. Additional details regarding this requirement are fully outlined in the 2025 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on the DHCS website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

B. D-SNP Contractor must include information about Medi-Cal Dental benefits in any materials that provide Member information about D-SNP Dental Supplemental Benefits. Additional details regarding this requirement are fully outlined in the 2025 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on the DHCS website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

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Exhibit C
GENERAL TERMS AND CONDITIONS

1. APPROVAL: This Agreement is of no force or effect until signed by both parties and approved by the Department of General Services, if required. D-SNP Contractor may not commence performance until such approval has been obtained.

2. AMENDMENT: No amendment or variation of the terms of this Agreement shall be valid unless made in writing, signed by the parties and approved as required. No oral understanding or Agreement not incorporated in the Agreement is binding on any of the parties.

3. ASSIGNMENT: This Agreement is not assignable by D-SNP Contractor, either in whole or in part, without the consent of the State in the form of a formal written amendment.

4. AUDIT: D-SNP Contractor agrees that the awarding department, the Department of General Services, the Bureau of State Audits, or their designated representative shall have the right to review and to copy any records and supporting documentation pertaining to the performance of this Agreement. D-SNP Contractor agrees to maintain such records for possible audit for a minimum of three (3) years after final payment, unless a longer period of records retention is stipulated. D-SNP Contractor agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. (Government Code Section 8546.7, Public Contract Code Section 10115 et seq., and California Code of Regulations, Title 2, Section 1896).

5. INDEMNIFICATION: D-SNP Contractor agrees to indemnify, defend and save harmless the State, its officers, agents and employees from any and all claims and losses accruing or resulting to any and all contractors, suppliers, laborers, and any other person, firm or corporation furnishing or supplying work services, materials, or supplies in connection with the performance of this Agreement, and from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by D-SNP Contractor in the performance of this Agreement.

6. DISPUTES: D-SNP Contractor shall continue with the responsibilities under this Agreement during any dispute.

7. TERMINATION FOR CAUSE: The State may terminate this Agreement and be relieved of any payments should D-SNP Contractor fail to perform the requirements of this Agreement at the time and in the manner herein provided. In the event of such termination the State may proceed with the work in any

Exhibit C
GENERAL TERMS AND CONDITIONS

manner deemed proper by the State. All costs to the State shall be deducted from any sum due D-SNP Contractor under this Agreement and the balance, if any, shall be paid to D-SNP Contractor upon demand.

8. INDEPENDENT CONTRACTOR*:* D-SNP Contractor, and the agents and employees of D-SNP Contractor, in the performance of this Agreement, shall act in an independent capacity and not as officers or employees or agents of the State.

9. RECYCLING CERTIFICATION: D-SNP Contractor shall certify in writing under penalty of perjury, the minimum, if not exact, percentage of post- consumer material as defined in the Public Contract Code Section 12200, in products, materials, goods, or supplies offered or sold to the State regardless of whether the product meets the requirements of Public Contract Code Section 12209. With respect to printer or duplication cartridges that comply with the requirements of Section 12156(e), the certification required by this subdivision shall specify that the cartridges so comply (Public Contract Code Section12205).

10. NON-DISCRIMINATION CLAUSE: During the performance of this Agreement, D-SNP Contractor shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (cancer), age (over 40*),* marital status, and denial of family care leave. D-SNP Contractor shall insure that the evaluation and treatment of their employees and applicants for employment are free from such discrimination and harassment. D-SNP Contractor shall comply with the provision*s* of the Fair Employment and Housing Act (Government Code Section 12990 (a-f) et seq.) and the applicable regulations promulgated thereunder (California Code of Regulations, Title 2, Section 8101 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code Section 12990 (a-f), set forth in Chapter 5 of Division 4 of Title 2 of the California Code of Regulations, are incorporated into this Agreement by reference and made a part hereof as if set forth in full. D-SNP Contractor shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other Agreement.

11. CERTIFICATION CLAUSES: The CONTRACTOR CERTIFICATION CLAUSES contained in the document CCC 307 are hereby incorporated by reference and made a part of this Agreement by this reference as if attached hereto.

12. TIMELINESS: Time is of the essence in this Agreement.

13. COMPENSATION:

Exhibit C
GENERAL TERMS AND CONDITIONS

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

14. GOVERNING LAW: This D-SNP Contract is governed by and shall be interpreted in accordance with the laws of the State of California.

15. ANTITRUST CLAIMS:

    [Intentionally Left Blank – Not applicable to this D-SNP Contract]

16. CHILD SUPPORT COMPLIANCE ACT:

    [Intentionally Left Blank – Not applicable to this D-SNP Contract]

17. UNENFORCEABLE PROVISION: In the event that any provision of this Agreement is unenforceable or held to be unenforceable, then the parties agree that all other provisions of this Agreement have force and effect and shall not be affected thereby.

18. PRIORITY HIRING CONSIDERATIONS: If this D-SNP Contract includes services in excess of $200,000, D-SNP Contractor shall give priority consideration in filling vacancies in positions funded by the D-SNP Contract to qualified recipients of aid under Welfare and Institutions Code Section 11200 in accordance with Public Contract Code Section 10353.

Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

1. Federal Equal Opportunity Requirements

A. D-SNP Contractor will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. D-SNP Contractor will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. D-SNP Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC 4212). Such notices shall state D-SNP Contractor's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

B. D-SNP Contractor will, in all solicitations or advancements for employees placed by or on behalf of D-SNP Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

C. D-SNP Contractor will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of D-SNP Contractor's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

D. D-SNP Contractor will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act

of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

E. D-SNP Contractor will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

F. In the event of D-SNP Contractor's noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this D-SNP Contract may be cancelled, terminated, or suspended in whole or in part and D-SNP Contractor may be declared ineligible for further federal and State contracts in accordance with procedures authorized in Federal Executive Order No. 11246 as amended and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

G. D-SNP Contractor will include the Provisions of Paragraphs A through G in every purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or

(38 USC 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each vendor. D-SNP Contractor will take such action with respect to any purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions including sanctions for noncompliance provided, however, that in the event D-SNP Contractor becomes involved in, or is threatened with litigation by a vendor as a result of such direction by DHCS, D-SNP Contractor may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

2. Travel and Per Diem Reimbursement

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

3. Procurement Rules

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

4. Equipment Ownership / Inventory / Disposition

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

5. Subcontract Requirements

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

6. Income Restrictions

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

7. Audit and Record Retention

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

8. Site Inspection

The State, through any authorized representatives, has the right at all reasonable times to inspect or otherwise evaluate the work performed or being performed hereunder and the premises in which it is being performed. If any inspection or evaluation is made of the premises of D-SNP Contractor, D-SNP Contractor shall provide all reasonable facilities and assistance for the safety and convenience of the authorized representatives in the performance of their duties. All inspections and evaluations shall be

performed in such a manner as will not unduly delay the work.

9. Federal Contract Funds

It is mutually understood between the parties that this D-SNP Contract may have been written before ascertaining the availability of congressional appropriation of funds, for the mutual benefit of both parties, in order to avoid program and fiscal delays which would occur if the D-SNP Contract were executed after that determination was made.

10. Intellectual Property Rights

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

11. Air or Water Pollution Requirements

Any federally funded agreement in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5:

A. Government contractors agree to comply with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act [42 USC 1857(h)], Section 508 of the clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR part 15).

B. Institutions of higher education, hospitals, nonprofit organizations and commercial businesses agree to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

12. Prior Approval of Training Seminars, Workshops or Conferences

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

13. Confidentiality of Information

A. D-SNP Contractor and its employees, agents shall protect from unauthorized disclosure names and other identifying information concerning persons either receiving services pursuant to this D-SNP Contract or persons whose names or identifying information become available or are disclosed to D-SNP Contractor, its employees or agents as a result of services performed under this D-SNP Contract, except for statistical information not identifying any such person.

B. D-SNP Contractor and its employees or agents shall not use such identifying information for any purpose other than carrying out D-SNP Contractor's obligations under this D-SNP Contract.

C. D-SNP Contractor and its employees, or agents shall promptly transmit to the DHCS program contract manager all requests for disclosure of such identifying information not emanating from the client or person.

D. D-SNP Contractor shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the client, any such identifying information to anyone other than DHCS without prior written authorization from the DHCS program contract manager.

E. For purposes of this Provision, identity shall include, but not be limited to name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

F. As deemed applicable by DHCS, this Provision may be supplemented by additional terms and conditions covering personal health information (PHI) or personal, sensitive, and/or confidential information (PSCI). Said terms and conditions will be outlined in one or more exhibits that will either be attached to this D-SNP Contract or incorporated into this D-SNP Contract by reference.

14. Documents, Publications and Written Reports

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

15. Dispute Resolution Process

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

16. Financial and Compliance Audit Requirements

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

17. Human Subjects Use Requirements

By signing this D-SNP Contract, D-SNP Contractor agrees that if any performance under this D-SNP Contract includes any tests or examination of materials derived from the human body for the purpose of providing information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such

examinations are performed shall meet the requirements of 42 USC 263a (CLIA) and the regulations thereto.

18. Novation Requirements

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

19. Debarment and Suspension Certification

A. By signing this D-SNP Contract, D-SNP Contractor agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

B. By signing this D-SNP Contract, D-SNP Contractor certifies to the best of its knowledge and belief, that it and its principals:

1) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency;

2) Have not within a three-year period preceding this D-SNP Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, State or local) transaction or contract under a public transaction; violation of federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

3) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, State or local) with commission of any of the offenses enumerated in Subprovision B.(2) herein;

4) Have not within a three-year period preceding this D-SNP Contract had one or more public transactions (federal, State or local) terminated for cause or default;

5) Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

6) Will include a clause entitled, “Debarment and Suspension Certification’’ that essentially sets forth the provisions herein, in all

lower tier covered transactions and in all solicitations for lower tier covered transactions.

C. If D-SNP Contractor is unable to certify to any of the statements in this certification, the Contractor shall submit an explanation to the DHCS program funding this D-SNP Contract.

D. The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

E. If D-SNP Contractor knowingly violates this certification, in addition to other remedies available to the Federal Government, the DHCS may terminate this D-SNP Contract for cause or default.

20. Smoke-Free Workplace Certification

A. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where Women, Infants, and Children (WIC) coupons are redeemed.

B. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party.

C. By signing this D-SNP Contract, D-SNP Contractor certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994.

21. Covenant Against Contingent Fees

Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

D-SNP Contractor warrants that no person or selling agency has been employed or retained to solicit/secure this D-SNP Contract upon an agreement of understanding for a commission, percentage, brokerage, or contingent fee, except *bona fide* employees or *bona fide* established commercial or selling agencies retained by D-SNP Contractor for the purpose of securing business. For breach or violation of this warranty, DHCS shall have the right to annul this D-SNP Contract without liability or in its discretion to deduct from the D-SNP Contract price or consideration, or otherwise recover, the full amount of such commission, percentage, and brokerage or contingent fee.

22. Payment Withholds

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

23. Performance Evaluation

DHCS may, at its discretion, evaluate the performance of D-SNP Contractor at the conclusion of this D-SNP Contract. If performance is evaluated, the evaluation shall not be a public record and shall remain on file with DHCS. Negative performance evaluations may be considered by DHCS prior to making future contract awards.

24. Officials Not to Benefit

No members of or delegate of Congress or the State Legislature shall be admitted to any share or part of this D-SNP Contract, or to any benefit that may arise therefrom. This Provision shall not be construed to extend to this D-SNP Contract if made with a corporation for its general benefits.

25. Four-Digit Date Compliance

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

26. Prohibited Use of State Funds for Software

D-SNP Contractor certifies that it has appropriate systems and controls in place to ensure that State funds will not be used in the performance of this Contract for the acquisition, operation or maintenance of computer software in violation of copyright laws.

27. Use of Small, Minority Owned and Women's Businesses

Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

28. Alien Ineligibility Certification

By signing this D-SNP Contract, D-SNP Contractor certifies that he/she is not an alien that is ineligible for State and local benefits, as defined in Subtitle B of the Personal Responsibility and Work Opportunity Act. (8 USC 1601, et. seq.)

29. Union Organizing

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

30. Contract Uniformity (Fringe Benefit Allowability)

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

31. Lobbying Restrictions and Disclosure Certification

(Applicable to federally funded contracts in excess of $100,000 per 31 USC Section 1352)

A. Certification and Disclosure Requirements

1) Each person (or recipient) who requests or receives a contract, grant, or sub-grant, which is subject to 31 USC Section 1352, and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment 1, consisting of one page, entitled “Certification Regarding Lobbying”) that the recipient has not made, and will not make, any payment prohibited by Paragraph B of this provision.

2) Each recipient shall file a disclosure (in the form set forth in Attachment 2, entitled “Standard Form-LLL ‘disclosure of Lobbying Activities’”) if such recipient has made or has agreed to make any payment using non appropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph b of this provision if paid for with appropriated funds.

3) Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph a(2) herein. An event that materially affects the accuracy of the information reported includes:

Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

a) A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

b) A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

c) A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

4) Each person (or recipient) who requests or receives from a person referred to in Paragraph a(1) of this provision a contract, grant or sub-grant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

5) All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph a(1) of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

B. Prohibition

Section 1352 of Title 31, USC, provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

Exhibit E, Attachment 1
DEFINITIONS

As used in this D-SNP Contract, unless otherwise expressly provided or the context otherwise requires, the following definitions of terms will govern the construction of this D-SNP Contract:

1. **Aligned Enrollment** means, per 42 CFR section 422.2, the Enrollment in a D-SNP of a full-benefit Dual Eligible Beneficiary whose Medi-Cal benefits are covered under a Medi-Cal managed care organization contract under section 1903(m) of the Social Security Act between California and D-SNP Contractor's MA organization, which is the parent organization, or another entity that is owned and controlled by D-SNP Contractor's parent organization.

2. **Applicable Integrated Plan** means, per 42 CFR section 422.561, the Medi-Cal managed care organization through which D-SNP Contractor, its parent organization, or another entity that is owned and controlled by its parent organization, covers Medi-Cal services for Dual Eligible Beneficiaries enrolled with D-SNP Contractor and such Medi-Cal managed care organization.

3. **Care Coordination or Coordination of Care** means a process used by a person or team to assist Members in accessing Medicare and Medi-Cal Services, as well as social, educational, and other support services, regardless of the funding source for the services. It is characterized by advocacy, communication, and resource management to promote quality, cost effectiveness, and positive outcomes.

4. **Care Coordinator** means a clinician or other trained individual who is employed or contracted by the Member's primary care provider or D-SNP Contractor, serves on one (1) or more Interdisciplinary Care Teams (ICT), and coordinates and facilitates meetings and other activities of those ICTs, as well as participates in the Health Risk Assessment of each Member on whose ICT they serve.

5. **Caregiver** means, per CY 2024 Physician Fee Schedule (Final Rule), an adult family member or other individual who has significant relationship with, and who provides a broad range of assistance to a Member with a chronic or other health condition, disability, or functional limitation, and a family member, friend or neighbor who provides unpaid assistance to a Member with a chronic illness or disabling condition.

6. **Centers for Medicare & Medicaid Services (CMS)** means the federal agency responsible for management of the Medicare and Medicaid programs.

Exhibit E, Attachment 1
DEFINITIONS

7. **Confidential Information** means specific facts or documents identified as “confidential" by any law, regulations or contractual language.

8. **Covered Service(s)** means Care Coordination or Coordination of Care. This is the only service covered under this Contract.

9. **California Department of Health Care Services (DHCS)** means the single State Department responsible for administration of the federal Medicaid (referred to as Medi-Cal in California) Program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.

10. **D-SNP Contract** means this written agreement between DHCS and the D-SNP Contractor.

11. **Dementia Care Specialists** means D-SNP care coordinators/managers trained in understanding Alzheimer's disease and related dementias, symptoms, and progression; understanding and managing behaviors and communication problems; understanding caregiver stress and its management; and connecting enrollees and caregivers to community resources.

12. **Department of Health and Human Services (DHHS)** means the federal agency responsible for management of the Medicare and Medicaid programs.

13. **Director** means the Director of the California Department of Health Care Services.

14. **Dual-Eligible Beneficiary (or Enrollee)** means an individual who is enrolled for benefits under Part A of Title 42 of the United States Code (commencing with Section 1395c) and Part B of Title 42 of the United States Code (commencing with Section 1395j) and is also eligible for medical assistance under the Medi-Cal State Plan. This Contract is only for full-benefit Dual-Eligible Beneficiaries (QMB+, SLMB+, and other full-benefit Dual-Eligible Beneficiaries).

15. **Enrollment** means the process by which a beneficiary eligible for enrollment, as contained in Exhibit A, Attachment 1, Provision 8, and becomes a Member of the D-SNP Contractor’s D-SNP.

16. **Exclusively Aligned Enrollment** means that State Policy has limited a D-SNP’s membership to individuals with Aligned

Exhibit E, Attachment 1
DEFINITIONS

Enrollment.

17. **Facility** means any premise that is:

A. Owned, leased, used or operated directly or indirectly by or for D-SNP Contractor or its affiliates for purposes related to this Contract, or

B. Maintained by a provider to provide services on behalf of D-SNP Contractor.

18. **Grievance** means any complaint or dispute, other than one that constitutes an organization determination, expressing dissatisfaction with any aspect of D-SNP Contractor's or provider's operations, activities, or behavior, regardless of whether remedial action is requested.

19. **Integrated Appeal** means any of the procedures that deal with, or result from, adverse integrated organization determinations by D-SNP Contractor on the health care services the Member believes they are entitled to receive, including a delay in providing, arranging for, or approving the health care services such that a delay would adversely affect the health of the Member, or on any amounts the Member must pay for a service. An Integrated Appeal is made by a Member in an Applicable Integrated Plan and is subject to the Integrated Reconsiderations procedures in 42 CFR sections 422.629, 422.633, and 422.634.

20. **Integrated Grievance** means a dispute or complaint that would be defined and covered, for Grievances filed by a Member in a non-applicable integrated plan, under 42 CFR section 422.564 or 42 CFR sections 438.400 through 438.416. Integrated Grievances do not include Appeals procedures and QIO complaints, as described in 42 CFR section 422.564(b) and (c). An Integrated Grievance made a Member in an Applicable Integrated Plan is subject to the Integrated Grievance procedures in 42 CFR sections 422.629 and 422.630.

21. **Integrated Organization Determination** means an organization determination that would otherwise be defined and covered, for a non-Applicable Integrated Plan, as an organization determination under 42 CFR section 422.566, an adverse benefit determination under 42 CFR section 438.400(b), or an action under 42 CFR 431.201. An Integrated Organization Determination is made by a Member in an Applicable Integrated Plan and is subject to the Integrated Organization

Determination procedures in 42 CFR sections 422.629, 422.631, and 422.634.

22. **Medi-Cal Managed Care Health Plan (MCP)** means a managed care health plan that contracts with DHCS for provision or arrangement of Medi-Cal benefits and services. For the purposes of this Contract, this includes Subcontracted Delegate Health Plans. A Subcontracted Delegate Health Plan is a health care service plan that is a subcontractor of a MCP that DHCS determines to have assumed the entire financial risk for all Medi-Cal Services provided to a Dual Eligible Beneficiary that are covered under the applicable comprehensive risk contract of the MCP.

23. **Medi-Cal Fee-For-Service (FFS)** means the Med-Cal delivery system in which providers submit claims to and receive payments from DHCS for services covered under Medi-Cal and rendered to Medi-Cal recipients.

24. **Medi-Cal Services** means all services covered by the Medi-Cal program as identified in Exhibit H, which is attached to this Contract.

25. **Medically Necessary or Medical Necessity** means reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I section 14059.5(a) and Title 22 CCR section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.

26. **Member** means any Dual-Eligible Beneficiary who is enrolled in with D-SNP Contractor.

27. **Service Area** means the county or counties that D-SNP Contractor is approved to operate in under the terms of this D-SNP Contract. A Service Area may have designated zip codes (under the U.S. Postal Service) within a county that are approved by DHCS to operate under the terms of this D-SNP Contract.

28. **State** means the State of California.

29. **Supplemental Benefits** means all of the following under Medicare Advantage definitions: Initial and Expansion Primarily Health Related Supplemental Benefits, Special Supplemental Benefits for the Chronically Ill, and Value Based-Insurance Design Model benefits.

Exhibit E, Attachment 1
DEFINITIONS

30. **Subcontracted Delegate Health Plan** means a health care service plan that is a subcontractor of a Medi-Cal MCP that DHCS determines to have assumed the entire financial risk for all Medi-Cal Services provided to a Member that is covered under the applicable comprehensive risk contract of the MCP.

31. **Working day(s)** mean State calendar (State Appointment Calendar, Standard 101) working day(s).

Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

1. Governing Law

In addition to Exhibit C, Provision 14, Governing Law, D-SNP Contractor also agrees to the following:

A. If it is necessary to interpret this D-SNP Contract, all applicable laws may be used as aids in interpreting the D-SNP Contract. However, the parties agree that any such applicable laws shall not be interpreted to create contractual obligations upon DHCS or D-SNP Contractor, unless such applicable laws are expressly incorporated into this D-SNP Contract in some section other than this provision, Governing Law. The parties agree that any remedies for DHCS' or D-SNP Contractor's non-compliance with laws not expressly incorporated into this D-SNP Contract, or any covenants implied to be part of this D-SNP Contract, shall not include money damages, but may include equitable remedies such as injunctive relief or specific performance. This D-SNP Contract is the product of mutual negotiation, and if any ambiguities should arise in the interpretation of this D-SNP Contract, both parties shall be deemed authors of this D-SNP Contract.

Any provision of this D-SNP Contract which is in conflict with current or future applicable federal or State laws or regulations is hereby amended to conform to the provisions of those laws and regulations. Such amendment of the D-SNP Contract will be effective on the effective date of the statutes or regulations necessitating it and binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

B. Such amendment will constitute grounds for termination of this D-SNP Contract in accordance with the procedures and provisions of Provision 18, Paragraph C, Termination – D-SNP Contractor below. The parties shall be bound by the terms of the amendment until the effective date of the termination.

C. All existing policy guidance issued by DHCS, including the D-SNP Policy Guide, can be viewed at https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx and shall be complied with by D-SNP Contractor. All policy guidance issued by DHCS subsequent to the effective date of this D-SNP Contract must provide clarification of D-SNP Contractor's obligations pursuant to this D-SNP Contract, and may include instructions to D-

SNP Contractor regarding implementation of mandated obligations pursuant to changes in State or federal statutes or regulations, or pursuant to judicial interpretation. In the event DHCS determines that there is an inconsistency between this D-SNP Contract and DHCS policy guidance, the D-SNP Contract shall prevail.

2. Entire Agreement

This written D-SNP Contract and any amendments constitute the entire agreement between the parties. No oral representations are binding on either party unless such representations are reduced to writing and made an amendment to the D-SNP Contract.

3. Amendment Process

In addition to Exhibit C, Provision 2, Amendment, D-SNP Contractor also agrees to the following:

Should either party, during the life of this D-SNP Contract, desire a change in this D-SNP Contract, that change shall be proposed in writing to the other party. The other party must acknowledge receipt of the proposal within ten (10) calendar days of receipt of the proposal. The party proposing any such change has the right to withdraw the proposal any time prior to acceptance or rejection by the other party. Any proposal must set forth an explanation of the reason and basis for the proposed change and the text of the desired amendment to this D-SNP Contract which would provide for the change. If the proposal is accepted, this D-SNP Contract will be amended to provide for the change mutually agreed to by the parties on the condition that the amendment is approved by DHHS, and the State Department of Finance, if necessary.

4. Change Requirements

A. General Provisions

The parties recognize that during the life of this D-SNP Contract, the Medi-Cal Managed Care program will be a dynamic program requiring numerous changes to its operations and that the scope and complexity of changes will vary widely over the life of the D-SNP Contract. The parties agree that the development of a system which has the capability to implement such changes in an orderly and timely manner is of considerable importance.

B. D-SNP Contractor's Obligation to Implement

The D-SNP Contractor must make changes mandated by DHCS. In the case of mandated changes in regulations, statutes, federal or State guidelines, or judicial interpretation, DHCS may direct the D-SNP Contractor to immediately begin implementation of any change by issuing a change order. If DHCS issues a change order, the D-SNP Contractor must implement the required changes while discussions are taking place. DHCS may, at any time, within the general scope of the D-SNP Contract, by written notice, issue change orders to the D-SNP Contract.

5. Delegation of Authority

DHCS intends to implement this D-SNP Contract through a single administrator, called the "Contracting Officer." The Director of DHCS will appoint the Contracting Officer. The Contracting Officer, on behalf of DHCS, will make all determinations and take all actions as are appropriate under this D-SNP Contract, subject to the limitations of applicable Federal and State laws and regulations. The Contracting Officer may delegate his/her authority to act to an authorized representative through written notice to the D-SNP Contractor.

D-SNP Contractor will designate a single administrator; hereafter called the "Contractor's Representative." The Contractor's Representative, on behalf of the D-SNP Contractor, will make all determinations and take all actions as are appropriate to implement this D-SNP Contract, subject to the limitations of the D-SNP Contract, Federal and State laws and regulations. The Contractor's Representative may delegate their authority to act to an authorized representative through written notice to the Contracting Officer. The Contractor's Representative will be empowered to legally bind the D-SNP Contractor to all agreements reached with DHCS. D-SNP Contractor shall designate Contractor’s Representative in writing and shall notify the Contracting Officer in accordance with Exhibit E, Attachment 2, Provision 13, Notices.

6. Authority of the State

Sole authority to establish, define, or determine the reasonableness, the necessity and level and scope of covered services under the Medi-Cal program administered in this D-SNP Contract or coverage for such services, or the eligibility of the beneficiaries or providers to participate in the Medi-Cal Program resides with DHCS. Sole authority to establish or interpret policy and its application related to the above areas will reside with DHCS.

The D-SNP Contractor may not make any limitations, exclusions, or changes in covered services; any changes in definition or interpretation of covered services; or any changes in the administration of the D-SNP Contract related to the scope of covered services, allowable coverage for those covered services, or eligibility of beneficiaries or providers to participate in the program, without the express, written direction or approval of the Contracting Officer.

7. Fulfillment of Obligations

No covenant, condition, duty, obligation, or undertaking continued or made a part of this D-SNP Contract will be waived except by written agreement of the parties hereto, and forbearance or indulgence in any other form or manner by either party in any regard whatsoever will not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed or discharged by the party to which the same may apply; and, until performance or satisfaction of all covenants, conditions, duties, obligations, and undertakings is complete, the other party will have the right to invoke any remedy available under this D-SNP Contract, or under law, notwithstanding such forbearance or indulgence.

8. Prohibition Against Assignments or Delegation of D-SNP Contractor's Duties and Obligations Under this D-SNP Contract

The D-SNP Contractor must not negotiate or enter into any agreement to assign or delegate the duties and obligations under this D-SNP Contract. If D-SNP Contractor fails to comply with this Provision, DHCS may terminate the D-SNP Contract for cause in compliance with Exhibit E, Attachment 2, Provision 17.

9. Prohibition Against Novations

D-SNP Contractor must not enter any novation agreements without prior discussion with DHCS.

10. Obtaining DHCS Approval

D-SNP Contractor must obtain written approval from DHCS prior to commencement of operation under this D-SNP Contract:

A. Within five (5) working days of receipt, DHCS must acknowledge in writing the receipt of any material sent to DHCS pursuant to this Provision.

B. Within 60 calendar days of receipt, DHCS must make all reasonable efforts to approve in writing the use of such material provided to DHCS pursuant to this Provision to provide D-SNP Contractor with a written explanation why its use is not approved or provide a written estimated date of completion of DHCS' review process. If DHCS does not complete its review of submitted material within 60 calendar days of receipt, or within the estimated date of completion of DHCS review, D-SNP Contractor may elect to implement or use the material at D-SNP Contractor's sole risk and subject to possible subsequent disapproval by DHCS. This Provision must not be construed to imply DHCS approval of any material that has not received written DHCS approval.

11. Program

DHCS reserves the right to review and approve any changes to D-SNP Contractor's protocols, policies, and procedures as specified in this D-SNP Contract.

12. Certifications

D-SNP Contractor must comply with certification requirements set forth in 42 CFR 438.604 and 42 CFR 438.606.

In addition to Exhibit C, Provision 11, Certification Clauses, D-SNP Contractor also agrees to the following:

With respect to any report, invoice, record, papers, documents, books of account, or other Contract required data submitted, pursuant to the requirements of this D-SNP Contract, the Contractor's Representative or their designee will certify, under penalty of perjury, that the report, invoice, record, papers, documents, books of account or other Contract required data is current, accurate, complete and in full compliance with legal and contractual requirements to the best of that individual's knowledge and belief, unless the requirement for such certification is expressly waived by DHCS in writing.

13. Notices

All notices to be given under this D-SNP Contract will be in writing and will be deemed given when sent via certified mail or electronic mail (email). DHCS and D-SNP Contractor will designate email addresses for notices sent via email. Notices sent via certified mail must be addressed to the

following DHCS and D-SNP Contractor contacts:

California Department of Health Care Services	Local Initiative Health Authority for LA County
Managed Care Operations Division Attn: Michelle Retke, Division Chief MS 4408 P.O. Box 997413 Sacramento, CA 95899-7413	Attn:John Baackes, CEO 1200 West 7th Street Los Angeles, CA, 90017

14. Term

The D-SNP Contract is effective January 1, 2025, and continues in full force and effect through December 31, 2025.

15. Service Area

The Service Area covered under this D-SNP Contract is stated in Exhibit A, Provision 8, Coverage Area and Eligible Beneficiaries. All D-SNP Contract provisions apply separately to each county within the Service Area.

16. D-SNP Contract Extension

DHCS has the exclusive option to extend the term of this D-SNP Contract for any reason, in any county within the Service Area, with at least nine (9) months' written notice to D-SNP Contractor before the end of the D-SNP Contract term.

17. Termination for Cause and Other Terminations

In addition to Exhibit C, Provision 7, Termination for Cause, D-SNP Contractor also agrees to the following:

A. DHCS-Initiated Terminations

1) DHCS will terminate this D-SNP Contract in the event that the Director determines that the health and welfare of Members is jeopardized by the continuation of the D-SNP Contract. Termination pursuant to the requirements in this Provision's Paragraph A.1) will be effective immediately upon the provision of written notice provided by DHCS to D-SNP Contractor.

2) Termination for Cause

a) DHCS may terminate this D-SNP Contract should D-SNP Contractor fail to perform the requirements of this Contract. In the event of such termination, DHCS may proceed with providing the services required under this D-SNP Contract in any manner deemed proper by DHCS.

b) DHCS may terminate this D-SNP Contract in the event that D-SNP Contractor enters negotiations to change ownership or actually changes ownership, enters negotiations to assign or delegate its duties and obligations under this D-SNP Contract to another party or actually assigns or delegates its duties or obligations under the D-SNP Contract.

c) Should DHCS terminate this D-SNP Contract for cause under this Provision's Paragraph A.2) of this D-SNP Contract, DHCS will provide D-SNP Contractor with at least 60 calendar days' notice prior to the effective date of termination, unless potential beneficiary harm requires a shorter notice period. D-SNP Contractor agrees that this notice provision is reasonable.

d) DHCS must terminate this D-SNP Contract under this Provision and pursuant to the provisions of Welfare and Institutions Code, Section 14197.7, and California Code of Regulations, Title 22, Section 53873.

B. D-SNP Contractor-Initiated Terminations

D-SNP Contractor may only terminate this D-SNP Contract when a change in contractual obligations is created by a State or federal change in the Medi-Cal program, or a lawsuit, that substantially alters the conditions under which the D-SNP Contractor entered into this D-SNP Contract, such that the D-SNP Contractor can demonstrate this to the satisfaction of DHCS.

C. Termination of Obligations

All obligations to provide services under this D-SNP Contract will

automatically terminate on the date the operations period ends.

18. Disputes

D-SNP Contractor must comply with and exhaust the requirements of this Provision when it initiates a contract dispute with DHCS. In addition to Exhibit C, Provision 6, Disputes, D-SNP Contractor also agrees to the following:

A. Disputes Resolution by Negotiation

D-SNP Contractor agrees to make best efforts to resolve all contractual issues by negotiation and mutual agreement at the DHCS Contracting Officer level before appealing to the DHCS Office of Administrative Hearings and Appeals (OAHA). D-SNP Contractor must exhaust OAHA's appeal process before filing a writ in Sacramento County Superior Court. During the negotiations to resolve Contractor's issues, DHCS and Contractor may agree, in writing, to an extension of time for continuing negotiations to resolve Contractor's dispute before the decision of the DHCS Contracting Officer is issued.

B. Notice of Dispute

1) Within 30 calendar days from the date that the alleged dispute arises or otherwise becomes known to D-SNP Contractor, D-SNP Contractor must serve a written Notice of Dispute to the DHCS' Contracting Officer. D-SNP Contractor's failure to serve its Notice of Dispute within 30 calendar days from the date the alleged dispute arises or otherwise becomes known to D-SNP Contractor constitutes a waiver of all issues raised in D-SNP Contractor's Notice of Dispute.

2) The D-SNP Contractor's Notice of Dispute must include, based on the most accurate and substantiating information then available to the D-SNP Contractor, the following:

a) That it is a dispute subject to the procedures set forth in this Provision.

b) The date, nature, and circumstances of the conduct which is subject of the dispute.

c) The names, phone numbers, functions, and conduct of each D-SNP Contractor, DHCS/State official or employee involved in or knowledgeable about the alleged issue that is the subject of the dispute.

d) The identification of any substantiating documents and the substances of any oral communications that are relevant to the alleged conduct. Copies of all identified documents will be attached.

e) Copies of all substantiating documentation and any other evidence.

f) The factual and legal bases supporting Contractor's Notice of Dispute.

g) The cost impact to D-SNP Contractor directly attributable to the alleged conduct, if any.

h) D-SNP Contractor's desired remedy.

3) The required documentation set forth above, in this Provision's Paragraph B.2), will serve as the basis for any subsequent appeal.

4) After D-SNP Contractor submits its Notice of Dispute with all accurate available substantiating documentation, D-SNP Contractor must comply with the requirements of Title 22, CCR, Section 53851(d) and must diligently continue performance of this D-SNP Contract, including compliance with contract requirements that are the subject of, or related to, D-SNP Contractor's Notice of Dispute.

5) If D-SNP Contractor requests and DHCS agrees, D-SNP Contractor's Notice of Dispute may be decided by an Alternate Dispute Officer (ADO). DHCS will designate an ADO who was not directly involved in the alleged conduct that prompted D-SNP Contractor's Notice of Dispute.

6) Any appeal of the DHCS Contracting Officer or ADO's decision to OAHA or a writ seeking review of OAHA's decision in Sacramento County Superior Court shall be limited to the issues and arguments set forth and properly documented in D-

SNP Contractor's Notice of Dispute, that were not waived or resolved.

C. The DHCS Contracting Officer's or ADO's Decision

Any disputes concerning performance of this D-SNP Contract will be decided by the DHCS Contracting Officer or the ADO in a written decision stating the factual basis for the decision. Within 30 calendar days of receipt of a Notice of Dispute, the Contracting Officer or the ADO shall either:

1) Find in favor of D-SNP Contractor, in which case the DHCS Contracting Officer or ADO may correct the earlier conduct which caused D-SNP Contractor to file a dispute; or

2) Deny D-SNP Contractor's dispute and, where necessary, direct the manner of future performance; or

3) Request additional substantiating documentation in the event the information in D-SNP Contractor's notification is inadequate to permit a decision to be made under Paragraphs B.2) or C.1) above. If the DHCS Contracting Officer or ADO determines that additional substantiating information is required, they will provide D-SNP Contractor with a written request identifying the issue(s) requiring additional substantiating documentation. D-SNP Contractor must provide that additional substantiating documentation no later than 30 calendar days from receipt of the request. Upon receipt of this additional requested substantiating information, the DHCS Contracting Officer or ADO shall have 30 calendar days to issue a decision. Failure to supply additional substantiating information requested by the DHCS Contracting Officer or ADO, or otherwise notify the DHCS Contracting Officer or ADO that no additional documents exist, within the time period specified above shall constitutes D-SNP Contractor's waiver of issues raised in D-SNP Contractor's Notice of Dispute.

A copy of the decision shall be served on D-SNP Contractor.

D. Appeal of Contracting Officer's or Alternate Dispute Officer's Decision

1) D-SNP Contractor will have 30 calendar days following the receipt of the DHCS Contracting Officer or ADO's decision to

appeal the decision to the Director, through the OAHA. All of D-SNP Contractor's appeals are governed by Health and Safety Code, section 100171, except Government Code section 11511 will not apply.

2) All of D-SNP Contractor's appeals must be in writing and be filed with the OAHA and a copy sent to the Chief Counsel of DHCS and the DHCS Contract Manager. D-SNP Contactor's appeal shall be deemed filed on the date it is received by the OAHA. D-SNP Contractor's appeal will be known as Statement of Disputed Issues and must specifically set forth the unresolved issue(s) that remain in dispute and issues that have not been waived because of D-SNP Contractor's failure to provide all substantiating documentation to DHCS, as specified in Paragraph C of this Provision, and include D-SNP Contractor's contentions as to those issues. Additionally, D- SNP Contractor's appeal will be limited to those issues raised in its Notice of Dispute filed pursuant to Paragraph B, Notification of Dispute that have not been resolved or waived.

3) D-SNP Contractor has the burden of proof of demonstrating that its position is correct and must show by a preponderance of evidence that:

   a) DHCS acted improperly such that it breached this Contract; and

   b) D-SNP Contractor sustained a cost impact directly related to DHCS' breach.

4) OAHA's jurisdiction is limited to issues and arguments raised in the Notice of Dispute that were not waived by the untimely filing of the Notice of Dispute or Statement of Disputed Issues, by D-SNP's Contractor's failure to provide all requested substantiating documentation requested by the DHCS Contracting Officer or ADO, or by D-SNP's Contractor failure to notify the DHCS Contracting Officer or ADO that no additional documents exist within the required timeframe as required in Paragraph C(3), or otherwise resolved by D-SNP Contractor and DHCS.

E. No Obligation to Pay Interest

If D-SNP Contractor prevails on its Notice of Dispute pursuant to a DHCS Contracting Officer's or ADO's decision, an OAHA decision, or an order or decision issued by the Sacramento County Superior Court or any California court of appeal, DHCS will not be required to pay interest on any amounts found to be due or owing to D-SNP Contractor arising out of the Notice of Dispute or any subsequent litigation.

F. D-SNP Contractor Duty to Perform

D-SNP Contractor must comply with all requirements of 22 CCR section 53851(d) and continue to perform all obligations under this D-SNP Contract, including continuing D-SNP Contract requirements that are the subject of, or related to, D-SNP Contractor's Notice of Dispute until there is a final decision from the DHCS Contracting Officer, the ADO or a decision on an appeal in Sacramento County Superior Court or any California Court of Appeal or the California Supreme Court.

G. Waiver of Claims

D-SNP Contractor waives all claims or issues if it fails to timely submit a Notice of Dispute with all substantiating documents within the timeframes set forth in Paragraph B of this Provision. D-SNP Contractor also waives all claims or issues set forth in its Notice of Dispute if it fails to timely submit all additional substantiating documentation within 30 calendar days at the DHCS Contracting Officer or ADO's request, or if it fails to notify the DHCS Contracting Officer or ADO, within 30 calendar days of DHCS Contracting Officer's or ADO's request, that no additional documents exist. D-SNP Contractor also waives all claims or issues set forth in its Notice of Dispute if it fails to timely appeal the DHCS Contracting Officer or ADO's decision in the manner and within the time specified in this Provision 18. D-SNP Contractor's waiver includes all damages whether direct or consequential in nature.

19. Audit

In addition to Exhibit C, Provision 4, Audit, D-SNP Contractor agrees to the following:

The D-SNP Contractor must maintain such books and records necessary to disclose how the D-SNP Contractor discharged its obligations under

this D- SNP Contract. These books and records will disclose the quantity of Covered Services provided under this D-SNP Contract, the quality of those services, the manner for those services, the persons eligible to receive Covered Services, and the manner in which the Contractor administered its daily business.

A. Books and Records

These books and records include, but are not limited to, all physical records originated or prepared pursuant to the performance under this D- SNP Contract including working papers; reports submitted to DHCS; all medical records, medical charts and prescription files; and other documentation pertaining to Covered Services rendered to Members.

B. Records Retention

Notwithstanding any other records retention time period set forth in this D-SNP Contract, these books and records must be maintained for a minimum of five years from the end of the current Fiscal Year in which the date of service occurred; in which the record or data was created or applied; and for which the financial record was created or the D-SNP Contract is terminated, or, in the event the D-SNP Contractor has been duly notified that DHCS, Department of Health and Human Services (DHHS), Department of Justice (DOJ) or the Comptroller General of the United States, or their duly authorized representatives, have commenced an audit or investigation of the D-SNP Contract, until such time as the matter under audit or investigation has been resolved, whichever is later.

20. Inspection Rights

In addition to Exhibit D(F), Provision 8, Site Inspection, D-SNP Contractor also agrees to the following:

A. Through the end of the records retention period specified in Provision 19, Audit, Paragraph B, Records Retention above, D-SNP Contractor must allow the DHCS, DHHS, the Comptroller General of the United States, DOJ Bureau of Medi-Cal Fraud, Department of Managed Health Care (DMHC), and other authorized State agencies, or their duly authorized representatives, including DHCS' external quality review organization contractor, to audit, inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this

D-SNP Contract, and to inspect, evaluate, and audit any and all premises, books, records, equipment, contracts, computers, or other electronic systems and facilities maintained by D-SNP Contractor pertaining to these services at any time during normal business hours. Books and records include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract, including working papers, reports, and books of account, medical records, prescription files, laboratory results, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members. Upon request, through the end of the records retention period specified in Provision 19, Audit, Paragraph B, Records Retention above, D-SNP Contractor shall furnish any record, or copy of it, to DHCS or any other entity listed in this section, at D-SNP Contractor's sole expense.

B. Access Requirements and State's Right to Monitor

Authorized State and federal agencies have the right to monitor all aspects of the D-SNP Contractor's operation for compliance with the provisions of this D-SNP Contract and applicable federal and State laws and regulations. Such monitoring activities include, but are not limited to, inspection and auditing of D-SNP Contractor and provider management systems and procedures, and books and records as the Director deems appropriate, at any time during the D-SNP Contractor's normal business hours. The monitoring activities may be announced or unannounced.

21. Confidentiality of Information

In addition to Exhibit D(F), Provision 13, Confidentiality of Information, D-SNP Contractor also agrees to the following duties and responsibilities with respect to confidentiality of information and data:

A. Notwithstanding any other provision of this D-SNP Contract, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42, CFR, Section 431.300 et seq., Welfare and Institutions Code, Section 14100.2, and regulations adopted thereunder. For the purpose of this D-SNP Contract, all information, records, data, and data elements collected and maintained for the operation of the D-SNP Contract and pertaining to Members shall be protected by the D-SNP Contractor from unauthorized disclosure.

D-SNP Contractor may release medical records in accordance with applicable law pertaining to the release of this type of information. D-SNP Contractor is not required to report requests for medical records made in accordance with applicable law. Exhibit G is hereby incorporated into this Contract by reference.

B. With respect to any identifiable information concerning a Member under this D-SNP Contract that is obtained by the D-SNP Contractor, the D-SNP Contractor:

1) Will not use any such information for any purpose other than carrying out the express terms of this D-SNP Contract;

2) Will promptly transmit to DHCS all requests for disclosure of such information, except requests for medical records in accordance with applicable law;

3) Will not disclose, except as otherwise specifically permitted by this D-SNP Contract, any such information to any party other than DHCS without DHCS' prior written authorization specifying that the information is releasable under 42 CFR, Section 431.300 et seq., Welfare and Institutions Code, Section 14100.2, and regulations adopted thereunder; and

4) Will, at the termination of this D-SNP Contract, return all such information to DHCS or maintain such information according to written procedures sent to the D-SNP Contractor by DHCS for this purpose.

22. Third-Party Tort and Workers' Compensation Liability

D-SNP Contractor must identify and notify DHCS' Third Party Liability and Recovery Division of all instances or cases in which D-SNP Contractor believes an action by the Medi-Cal Member involving casualty insurance or tort or Workers' Compensation liability of a third party could result in recovery by the Member of funds to which DHCS has lien rights under Welfare and Institutions Code Article 3.5 (commencing with Section 14124.70), Part 3, Division 9, D-SNP Contractor shall make no claim for recovery of the value of case management rendered to a Member in such cases or instances and such case or instance shall be referred to DHCS' Third Party Liability and Recovery Division within ten (10) calendar days of discovery. To assist DHCS in exercising its responsibility for such recoveries, D-SNP Contractor shall meet the following requirements:

A. If DHCS requests service information and/or copies of reports for Covered Services to an individual Member, D-SNP Contractor must deliver the requested information within 30 calendar days of the request.

B. Information to be delivered must contain the following data items:

1) Member name.

2) Full 14-digit Medi-Cal number.

3) Social Security Number.

4) Date of birth.

5) Diagnosis code and description of illness/injury (if known).

6) Procedure code and/or description of services rendered (if known).

C. D-SNP Contractor must identify to DHCS' Third Party Liability and Recovery Division the name, address and telephone number of the person responsible for receiving and complying with requests for mandatory and/or optional at-risk service information.

D. If D-SNP Contractor receives any requests from attorneys, insurers, or beneficiaries for copies of referrals, D-SNP Contractor must refer the request to the Third Party Liability and Recovery Division with the information contained in Paragraph B above, and provide the name, address and telephone number of the requesting party.

E. Use the TPLManagedCare@dhcs.ca.gov inbox for all communications regarding D-SNP Contractor's service and utilization information, and paid invoices and claims submissions, to submit questions or comments related to the preparation and submission of these reports, and for issues related to accessing the secure file transfer protocol folders.

23. Records Related To Recovery for Litigation

A. Upon request by DHCS, D-SNP Contractor must timely gather, preserve and provide to DHCS, in the form and manner specified by DHCS, any information specified by DHCS, subject to any lawful

privileges, in D-SNP Contractor's possession, relating to threatened or pending litigation by or against DHCS.

B. If D-SNP Contractor asserts that any requested documents are covered by a privilege, D-SNP Contractor must:

1) Identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and

2) State the privilege being claimed that supports withholding production of the document.

C. Such a request must include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against DHCS. D-SNP Contractor acknowledges that time may be of the essence in responding to such request. D-SNP Contractor must use all reasonable efforts to immediately notify DHCS of any subpoenas, document production requests, or requests for records, received by D-SNP Contractor related to this D-SNP Contract.

24. Equal Opportunity Employer

D-SNP Contractor must comply with all applicable federal and State employment discrimination laws. D-SNP Contractor will, in all solicitations or advertisements for employees placed by or on behalf of the D-SNP Contractor, state that it is an equal opportunity employer, and will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, a notice to be provided by DHCS, advising the labor union or workers' representative of the D-SNP Contractor's commitment as an equal opportunity employer and will post copies of the notice in conspicuous places available to employees and applicants for employment.

25. Discrimination Prohibitions

A. Member Discrimination Prohibition

D-SNP Contractor must not unlawfully discriminate against Members or beneficiaries eligible for enrollment into Contractor’s D-SNP on the basis of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information marital status, gender, gender identity, marital status, gender, gender

identity, sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56, in accordance with the statutes identified in Exhibit E, Attachment 2, Provision 26 below, rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulations. For the purpose of this D-SNP Contract, discrimination includes, but is not limited to, the following:

1) Denying any Member case any Covered Services;

2) Providing to a Member any Covered Service which is different, or is provided in a different manner or at a different time from that provided to other Members under this Contract except where medically indicated;

3) Subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service;

4) Restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, treating a Member or a beneficiary eligible for enrollment into the Contractor's D-SNP differently from others in determining whether he or she satisfies any admission, Enrollment, quota, eligibility, membership, or other requirement or condition which individuals must meet in order to be provided any Covered Service;

5) Assigning times or places for the provision of services on the basis of the sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56.

6) Failing to make Auxiliary Aids available, or to make reasonable accommodations in policies, practices, or procedures, when necessary to avoid discrimination on the basis of disability;

7) Failing to ensure meaningful access to programs and activities for Limited English Proficient (LEP) Members and potential enrollees.

8) D-SNP Contractor must take affirmative action to ensure that Members are provided Covered Services without regard to sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56, except as needed to provide equal access to Limited English Proficient (LEP) Members or Members with disabilities, or as medically indicated.

9) For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genes will include, but are not limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

B. Discrimination Related to Health Status

D-SNP Contractor must not discriminate among eligible individuals on the basis of their health status requirements or requirements for health care services during Enrollment, re-enrollment or disenrollment. D-SNP Contractor will not terminate the Enrollment of an eligible individual based on an adverse change in the Member's health.

26. Federal and State Nondiscrimination Requirements

D-SNP Contractor must comply with all applicable federal requirements in Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities, as amended); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973, as amended; Titles I and II of the Americans with Disabilities Act of 1990, as amended; Section 1557 of the Patient Protection and Affordable Care Act of 2010; and federal implementing regulations issued under the above-listed statutes. D-SNP Contractor shall also comply with California nondiscrimination requirements, including, without limitation, the Unruh Civil Rights Act, Sections 7405 and 11135 of the Government Code, Section 14029.91 of the Welfare and Institutions Code, and state implementing regulations.

27. Discrimination Grievances

Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

D-SNP Contractor must process a grievance for discrimination as required by APL 21-004 or subsequent iterations, and in accordance with federal and State nondiscrimination law as stated in 45 CFR section 84.7; 34 CFR section 106.8; 28 CFR section 35.107; and W&I Code section 14029.91(e)(4).

A. D-SNP Contractor must designate a discrimination grievance coordinator responsible for ensuring compliance with federal and State nondiscrimination requirements, and investigating discrimination grievances related to any action that would be prohibited by, or out of compliance with, federal or State nondiscrimination law.

B. D-SNP Contractor must adopt procedures to ensure the prompt and equitable resolution of discrimination grievances by D-SNP Contractor. D-SNP Contractor will not require a Member or potential enrollee to file a discrimination grievance with D-SNP Contractor before filing with the DHCS Office of Civil Rights or the U.S. Health and Human Services Office for Civil Rights.

C. Within ten calendar days of mailing a discrimination grievance resolution letter, D-SNP Contractor must submit the following information regarding the discrimination grievance in a secure format to the DHCS Office of Civil Rights:

    1) The original discrimination grievance;

    2) The provider’s or other accused party’s response to the discrimination grievance;

    3) Contact information for the personnel primarily responsible for investigating and responding to the discrimination grievance on behalf of D-SNP Contractor;

    4) Contact information for the person filing the discrimination grievance, and for the provider or other accused party that is the subject of the discrimination grievance;

    5) All correspondence with the person filing the discrimination grievance regarding the discrimination grievance, including, but not limited to, the

discrimination grievance acknowledgment letter and resolution letter; and

6) The results of D-SNP Contractor's investigation, copies of any corrective action taken, and any other information that is relevant to the allegation(s) of discrimination.

28. Nondiscrimination Notice and Language Taglines

A. D-SNP Contractor must post (1) a DHCS-approved nondiscrimination notice, and (2) language taglines in a conspicuously visible font size in English, the threshold languages, and at least the top 15 non-English languages in the State, and any other languages, as determined by DHCS, explaining the availability of free language assistance services, including written translation and oral interpretation, and information on how to request Auxiliary Aids and services, including materials in alternative formats. The nondiscrimination notice and taglines shall include D-SNP Contractor's toll-free and TTY/TDD telephone number for obtaining these services, and shall be posted in the Member Services Guide/Evidence of Coverage, and in all Member information, informational notices, and materials critical to obtaining services targeted to Members, potential Members, applicants, and members of the public, in accordance with APL 21-004 and APL 22-002 or subsequent iterations, 42 CFR section 438.10(d)(2)-(3), and W&I Code section 14029.91(f) and 14029.92(c).

B. D-SNP Contractor's nondiscrimination notice must include all information required by W&I Code section 14029.91(e) and APL 21-004 or subsequent iterations, any additional information required by DHCS, and must provide information on how to file a discrimination grievance with:

1) Both D-SNP Contractor and the DHCS Office of Civil Rights, if there is a concern of discrimination in the Medi-Cal program based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation or identification with any other persons or groups defined in Penal Code 422.56. (W&I Code section 14029.91(e); H&S Code section 11135; and

2) The United States Department of Health and Human Services Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, sex, age, or disability. (W&I Code section 14029.91(e)).

29. Small Business Participation and Disabled Veteran Business Enterprises (DVBE) Reporting Requirements

A. D-SNP Contractor must comply with applicable requirements of California law relating to Disabled Veteran Business Enterprises (DVBE) commencing at Public Contract Code section 10230.

B. If for this D-SNP Contract, D-SNP Contractor made a commitment to achieve small business participation, then D-SNP Contractor must annually and within 60 calendar days of receiving final payment under this D-SNP Contract report to DHCS the actual percentage of small business participation that was achieved per Government Code section 14841.

C. If for this D-SNP Contract, D-SNP Contractor made a commitment to achieve DVBE participation, then D-SNP Contractor must annually and within 60 calendar days of receiving final payment under this D-SNP Contract certify in a report to DHCS the following:

1) The total amount Contractor received under the Contract;

2) The name and address of the DVBE(s) that participated in the performance of the Contract;

3) The amount each DVBE received from Contractor;

4) That all payments under the Contract have been made to the DVBE; and

5) The actual percentage of DVBE participation that was achieved, per Mil. & Vets. Code section 999.5(d), and Government Code section 14841.

30. Word Usage

Unless the context of this D-SNP Contract clearly requires otherwise, (a) the plural and singular numbers is deemed to include the other; (b) the masculine, feminine, and neuter genders shall each be deemed to include the others; (c) "shall," "will," "must," or "agrees" are mandatory, and "may"

is permissive; (d) "or" is not exclusive; and (e) "includes" and "including" are not limiting.

31. Federal False Claims Act Compliance

Effective January 1, 2007, D-SNP Contractor must comply with 42 USC Section 1396a (a)(68), Employee Education About False Claims Recovery, as a condition of receiving payments under this D-SNP Contract. Upon request by DHCS, D-SNP Contractor must demonstrate compliance with this provision, which may include providing DHCS with copies of D-SNP Contactor's applicable written policies and procedures and any relevant employee handbook excerpts.

Exhibit G
BUSINESS ASSOCIATE ADDENDUM

1. This Agreement has been determined to constitute a business associate relationship under the Health Insurance Portability and Accountability Act (HIPAA) and its implementing privacy and security regulations at 45 Code of Federal Regulations, Parts 160 and 164 (collectively, and as used in this Agreement)

2. The term “Agreement” as used in this document refers to and includes both this Business Associate Addendum and the contract to which this Business Associate Agreement is attached as an exhibit, if any.

3. For purposes of this Agreement, the term “Business Associate” shall have the same meaning as set forth in 45 CFR section 160.103.

4. The Department of Health Care Services (DHCS) intends that Business Associate may create, receive, maintain, transmit or aggregate certain information pursuant to the terms of this Agreement, some of which information may constitute Protected Health Information (PHI) and/or confidential information protected by Federal and/or state laws.

4.1 As used in this Agreement and unless otherwise stated, the term “PHI” refers to and includes both “PHI” as defined at 45 CFR section 160.103 and Personal Information (PI) as defined in the Information Practices Act at California Civil Code section 1798.3(a). PHI includes information in any form, including paper, oral, and electronic.

4.2 As used in this Agreement, the term “confidential information” refers to information not otherwise defined as PHI in Section 4.1 of this Agreement, but to which state and/or federal privacy and/or security protections apply.

5. D-SNP Contractor (however named elsewhere in this Agreement) is the Business Associate of DHCS acting on DHCS's behalf and provides services or arranges, performs or assists in the performance of functions or activities on behalf of DHCS, and may create, receive, maintain, transmit, aggregate, use or disclose PHI (collectively, “use or disclose PHI”) in order to fulfill Business Associate’s obligations under this Agreement. DHCS and Business Associate are each a party to this Agreement and are collectively referred to as the "parties.”

6. The terms used in this Agreement, but not otherwise defined, shall have the same meanings as those terms in HIPAA. Any reference to statutory or regulatory language shall be to such language as in effect or as amended.

Exhibit G
BUSINESS ASSOCIATE ADDENDUM

7. **Permitted Uses and Disclosures of PHI by Business Associate**. Except as otherwise indicated in this Agreement, Business Associate may use or disclose PHI only to perform functions, activities or services specified in this Agreement on behalf of DHCS, provided that such use or disclosure would not violate HIPAA if done by DHCS.

   7.1 Specific Use and Disclosure Provisions. Except as otherwise indicated in this Agreement, Business Associate may use and disclose PHI if necessary for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. Business Associate may disclose PHI for this purpose if the disclosure is required by law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware that the confidentiality of the information has been breached.

8. **Compliance with Other Applicable Law**

   8.1 To the extent that other state and/or federal laws provide additional, stricter and/or more protective (collectively, more protective) privacy and/or security protections to PHI or other confidential information covered under this Agreement beyond those provided through HIPAA, Business Associate agrees:

      8.1.1 To comply with the more protective of the privacy and security standards set forth in applicable state or federal laws to the extent such standards provide a greater degree of protection and security than HIPAA or are otherwise more favorable to the individuals whose information is concerned; and

      8.1.2 To treat any violation of such additional and/or more protective standards as a breach or security incident, as appropriate, pursuant to Section 18. of this Agreement.

   8.2 Examples of laws that provide additional and/or stricter privacy protections to certain types of PHI and/or confidential information, as defined in Section 4. of this Agreement, include, but are not limited to the Information Practices Act, California Civil Code sections 1798-1798.78, Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, Welfare and Institutions Code section 5328, and California Health and Safety Code section 11845.5.

8.3 If Business Associate is a Qualified Service Organization (QSO) as defined in 42 CFR section 2.11, Business Associate agrees to be bound by and comply with subdivisions (2)(i) and (2)(ii) under the definition of QSO in 42 CFR section 2.11.

9. Additional Responsibilities of Business Associate

9.1 Nondisclosure. Business Associate shall not use or disclose PHI or other confidential information other than as permitted or required by this Agreement or as required by law.

9.2 Safeguards and Security.

9.2.1 Business Associate shall use safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and other confidential data and comply, where applicable, with subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of the information other than as provided for by this Agreement. Such safeguards shall be, at a minimum, at Federal Information Processing Standards (FIPS) Publication 199 protection levels.

9.2.2 Business Associate shall, at a minimum, utilize an industry-recognized security framework when selecting and implementing its security controls, and shall maintain continuous compliance with its selected framework as it may be updated from time to time. Examples of industry-recognized security frameworks include but are not limited to

9.2.2.1 NIST SP 800-53 – National Institute of Standards and Technology Special Publication 800-53

9.2.2.2 FedRAMP – Federal Risk and Authorization Management Program

9.2.2.3 PCI – PCI Security Standards Council

9.2.2.4 ISO/ESC 27002 – International Organization for Standardization / International Electrotechnical Commission standard 27002

9.2.2.5 IRS PUB 1075 – Internal Revenue Service Publication 1075

Exhibit G
BUSINESS ASSOCIATE ADDENDUM

9.2.2.6 HITRUST CSF – HITRUST Common Security Framework

9.2.3 Business Associate shall maintain, at a minimum, industry standards for transmission and storage of PHI and other confidential information.

9.2.4 Business Associate shall apply security patches and upgrades, and keep virus software up-to-date, on all systems on which PHI and other confidential information may be used.

9.2.5 Business Associate shall ensure that all members of its workforce with access to PHI and/or other confidential information sign a confidentiality statement prior to access to such data. The statement must be renewed annually.

9.2.6 Business Associate shall identify the security official who is responsible for the development and implementation of the policies and procedures required by 45 CFR Part 164, Subpart C.

9.3 Business Associate's Agent. Business Associate shall ensure that any agents, subcontractors, subawardees, vendors or others (collectively, "agents") that use or disclose PHI and/or confidential information on behalf of Business Associate agree to the same restrictions and conditions that apply to Business Associate with respect to such PHI and/or confidential information.

10. **Mitigation of Harmful Effects**. Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI and other confidential information in violation of the requirements of this Agreement.

11. **Access to PHI.** Business Associate shall make PHI available in accordance with 45 CFR section 164.524.

12. **Amendment of PHI.** Business Associate shall make PHI available for amendment and incorporate any amendments to protected health information in accordance with 45 CFR section 164.526.

13. **Accounting for Disclosures.** Business Associate shall make available the information required to provide an accounting of disclosures in accordance with 45 CFR section 164.528.

Exhibit G
BUSINESS ASSOCIATE ADDENDUM

14. **Compliance with DHCS Obligations.** To the extent Business Associate is to carry out an obligation of DHCS under 45 CFR Part 164, Subpart E, comply with the requirements of the subpart that apply to DHCS in the performance of such obligation.

15. **Access to Practices, Books and Records.** Business Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI on behalf of DHCS available to DHCS upon reasonable request, and to the federal Secretary of Health and Human Services for purposes of determining DHCS' compliance with 45 CFR Part 164, Subpart E.

16. **Return or Destroy PHI on Termination; Survival.** At termination of this Agreement, if feasible, Business Associate shall return or destroy all PHI and other confidential information received from, or created or received by Business Associate on behalf of, DHCS that Business Associate still maintains in any form and retain no copies of such information. If return or destruction is not feasible, Business Associate shall notify DHCS of the conditions that make the return or destruction infeasible, and DHCS and Business Associate shall determine the terms and conditions under which Business Associate may retain the PHI. If such return or destruction is not feasible, Business Associate shall extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

17. **Special Provision for SSA Data.** If Business Associate receives data from or on behalf of DHCS that was verified by or provided by the Social Security Administration (SSA data) and is subject to an agreement between DHCS and SSA, Business Associate shall provide, upon request by DHCS, a list of all employees and agents and employees who have access to such data, including employees and agents of its agents, to DHCS.

18. **Breaches and Security Incidents.** Business Associate shall implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and take the following steps:

18.1 Notice to DHCS.

18.1.1 Business Associate shall notify DHCS **immediately** upon the discovery of a suspected breach or security incident that involves SSA data. This notification will be provided by email upon discovery of the breach. If Business Associate is unable to provide notification by email, then Business Associate shall provide notice by telephone to DHCS.

Exhibit G
BUSINESS ASSOCIATE ADDENDUM

18.1.2 Business Associate shall notify DHCS **within 24 hours by email** (or by telephone if Business Associate is unable to email DHCS) of the discovery of:

18.1.2.1 Unsecured PHI if the PHI is reasonably believed to have been accessed or acquired by an unauthorized person;

18.1.2.2 Any suspected security incident which risks unauthorized access to PHI and/or other confidential information;

18.1.2.3 Any intrusion or unauthorized access, use or disclosure of PHI in violation of this Agreement; or

18.1.2.4 Potential loss of confidential data affecting this Agreement.

18.1.3 Notice shall be provided to the DHCS Program Contract Manager (as applicable), the DHCS Privacy Office, and the DHCS Information Security Office (collectively, "DHCS Contacts") using the DHCS Contact Information at Section 18.6. below.

Notice shall be made using the current DHCS "Privacy Incident Reporting Form" ("PIR Form"; the initial notice of a security incident or breach that is submitted is referred to as an "Initial PIR Form") and shall include all information known at the time the incident is reported. The form is available online at https://www.dhcs.ca.gov/formsandpubs/laws/priv/Documents/Privacy-Incident-Report-PIR.pdf.

Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of PHI, Business Associate shall take:

18.1.3.1 Prompt action to mitigate any risks or damages involved with the security incident or breach; and

18.1.3.2 Any action pertaining to such unauthorized disclosure required by applicable Federal and State law.

18.2 Investigation. Business Associate shall immediately investigate such security incident or confidential breach.

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18.3 Complete Report. To provide a complete report of the investigation to the DHCS contacts within ten (10) working days of the discovery of the security incident or breach. This "Final PIR" must include any applicable additional information not included in the Initial Form. The Final PIR Form shall include an assessment of all known factors relevant to a determination of whether a breach occurred under HIPAA and other applicable federal and state laws. The report shall also include a full, detailed corrective action plan, including its implementation date and information on mitigation measures taken to halt and/or contain the improper use or disclosure. If DHCS requests information in addition to that requested through the PIR form, Business Associate shall make reasonable efforts to provide DHCS with such information. A "Supplemental PIR" may be used to submit revised or additional information after the Final PIR is submitted. DHCS will review and approve or disapprove Business Associate's determination of whether a breach occurred, whether the security incident or breach is reportable to the appropriate entities, if individual notifications are required, and Business Associate's corrective action plan.

18.3.1 If Business Associate does not complete a Final PIR within the ten (10) working day timeframe, Business Associate shall request approval from DHCS within the ten (10) working day timeframe of a new submission timeframe for the Final PIR.

18.4 Notification of Individuals. If the cause of a breach is attributable to Business Associate or its agents, Business Associate shall notify individuals accordingly and shall pay all costs of such notifications, as well as all costs associated with the breach. The notifications shall comply with applicable federal and state law. DHCS shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made.

18.5 Responsibility for Reporting of Breaches to Entities Other than DHCS. If the cause of a breach of PHI is attributable to Business Associate or its subcontractors, Business Associate is responsible for all required reporting of the breach as required by applicable federal and state law.

18.6 DHCS Contact Information. To direct communications to the above referenced DHCS staff, D-SNP Contractor shall initiate contact as indicated here. DHCS reserves the right to make changes to the contact information below by giving written notice to Business Associate. These changes shall not require an amendment to this Agreement.

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BUSINESS ASSOCIATE ADDENDUM

DHCS Program Contract Manager	DHCS Privacy Office	DHCS Information Security Office
See the Scope of Work Exhibit for Program Contract Manager information. If this Business Associate Agreement is not attached as an exhibit to a contract, contact the DHCS signatory to this Agreement.	Privacy Office c/o: Office of HIPAA Compliance Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov Telephone: (916) 445-4646	Information Security Office DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov

19. **Responsibility of DHCS.** DHCS agrees to not request the Business Associate to use or disclose PHI in any manner that would not be permissible under HIPAA and/or other applicable federal and/or state law.

20. **Audits, Inspection and Enforcement**

20.1 From time to time, DHCS may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement. Business Associate shall promptly remedy any violation of this Agreement and shall certify the same to the DHCS Privacy Officer in writing. Whether or how DHCS exercises this provision shall not in any respect relieve Business Associate of its responsibility to comply with this Agreement.

20.2 If Business Associate is the subject of an audit, compliance review, investigation or any proceeding that is related to the performance of its obligations pursuant to this Agreement, or is the subject of any judicial or administrative proceeding alleging a violation of HIPAA, Business Associate shall promptly notify DHCS unless it is legally prohibited from doing so.

21. **Termination**

21.1 **Termination for Cause**. Upon DHCS' knowledge of a violation of this Agreement by Business Associate, DHCS may in its discretion:

21.1.1 Provide an opportunity for Business Associate to cure the violation and terminate this Agreement if Business Associate does not do so within the time specified by DHCS; or

21.1.2 Terminate this Agreement if Business Associate has violated a material term of this Agreement.

21.2 Judicial or Administrative Proceedings. DHCS may terminate this Agreement if Business Associate is found to have violated HIPAA, or stipulates or consents to any such conclusion, in any judicial or administrative proceeding.

22. Miscellaneous Provisions

22.1 Disclaimer. DHCS makes no warranty or representation that compliance by Business Associate with this Agreement will satisfy Business Associate's business needs or compliance obligations. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI and other confidential information.

22.2. Amendment.

22.2.1 Any provision of this Agreement which is in conflict with current or future applicable Federal or State laws is hereby amended to conform to the provisions of those laws. Such amendment of this Agreement shall be effective on the effective date of the laws necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

22.2.2 Failure by Business Associate to take necessary actions required by amendments to this Agreement under Section 22.2.1 shall constitute a material violation of this Agreement.

22.3 Assistance in Litigation or Administrative Proceedings. Business Associate shall make itself and its employees and agents available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers and/or employees based upon claimed violation of HIPAA, which involve inactions or actions by the Business Associate.

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22.4 **No Third-Party Beneficiaries**. Nothing in this Agreement is intended to or shall confer, upon any third person any rights or remedies whatsoever.

22.5 **Interpretation**. The terms and conditions in this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA and other applicable laws.

22.6 **No Waiver of Obligations**. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

January 1, 2022 – December 31, 2026[i]
Updated May 22, 2024

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Acupuncture Services	Other Practitioners' Services and Acupuncture Services	Acupuncture services are limited to treatment performed to prevent, modify, or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition.	**X**	
Audiological Services	Audiology Services	Audiological services are covered when provided by persons who meet the appropriate requirements	**X**	
Behavioral Health Treatment (BHT)	Preventive Services - EPSDT	The provision of medically necessary BHT services to eligible Medi-Cal members under 21 years of age as required by the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate and state plan.	**X**[ii]	
Blood and Blood Derivatives	Blood and Blood Derivatives	A facility that collects, stores, and distributes human blood and blood derivatives. Covers certification of blood ordered by a physician or facility where transfusion is given.	**X**	

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MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
California Children Services (CCS)	EPSDT	California Children Services (CCS) are services authorized by the CCS program for the diagnosis and treatment of the CCS eligible conditions of a specific Member.	X[iii]	
Certified Family Nurse Practitioner	Certified Family Nurse Practitioners' Services	A certified family nurse practitioner who provides services within the scope of their practice.	X	
Certified Pediatric Nurse Practitioner Services	Certified Pediatric Nurse Practitioner Services	Covers the care of mothers and newborns through the maternity cycle of pregnancy, labor, birth, and the immediate postpartum period, not to exceed six weeks; can also include primary care services.	X	
Childhood Lead Poisoning Case Management (Provided by the Local County Health Departments)	EPSDT	A case of childhood lead poisoning (for purposes of initiating case management) as a child from birth up to 21 years of age with one venous blood lead level (BLL) equal to or greater than 15 µg/dL, or two BLLs equal to or greater than 10 µg/dL that must be at least 30 and no more than 600 calendar days apart, the first specimen is not required to be venous, but the second must be venous.		X

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Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Chiropractic Services	Chiropractors' Services	Services provided by chiropractors, acting within the scope of their practice as authorized by California law, are covered, except that such services are limited to treatment of the spine by means of manual manipulation.	X[iv]	
Chronic Hemodialysis	Chronic Hemodialysis	Procedure used to treat kidney failure - covered only as an outpatient service. Blood is removed from the body through a vein and circulated through a machine that filters the waste products and excess fluids from the blood. The “cleaned” blood is then returned to the body. Chronic means this procedure is performed on a regular basis. Prior authorization required when provided by renal dialysis centers or community hemodialysis units.	X	
Community Based Adult Services (CBAS)		CBAS Bundled services: An outpatient, facility-based service program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, meals, and transportation to eligible Medi-Cal beneficiaries. CBAS Unbundled Services: Component parts of CBAS center services delivered outside of centers, under certain conditions.	X	

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Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Community Health Workers	Preventive Services	Preventive services by unlicensed community health workers, promotores, and community health representatives to prevent disease, disability, and other health conditions or their progression.	X[v]	
Comprehensive Perinatal Services	Extended Services for Pregnant Women-Pregnancy Related and Postpartum Services	Obstetrical, psychosocial, nutrition, and health education services, and related case coordination provided during pregnancy and up to 12 months following the last day of pregnancy.	X	
Dental Services (Covered under Medi-Cal)		Professional services performed or provided by dentists including diagnosis and treatment of malposed human teeth, of disease or defects of the alveolar process, gums, jaws, and associated structures; the use of drugs administered in-office, anesthetics, and physical evaluation; consultations; home, office, and institutional calls.	X[vi]	
Dyadic Services		Integrated physical and behavioral health screening and services for child, caregiver, and family.	X[5]	

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Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Doula Services		Personal support by unlicensed providers to pregnant beneficiaries and their families throughout pregnancy, labor, and in the post-partum period.	X[5]	
Durable Medical Equipment	DME	Assistive medical devices and supplies. Covered with a prescription; prior authorization is required.	X	
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	EPSDT	Medicaid program's benefit for children and adolescents, providing a comprehensive array of prevention, diagnostic, and treatment services for low-income infants, children, and adolescents under age 21, as specified in Section 1905(r) of the Social Security Act.	X	
Erectile and/or Sexual Dysfunction Drugs		Drugs for which the only FDA-approved indication is the treatment of sexual dysfunction or erectile dysfunction are not a benefit of the program. Drugs that are FDA-approved for the treatment of sexual dysfunction or erectile dysfunction in addition to one or more other indications, are a benefit only if the drug has is used for a FDA-approved indication outside of the treatment of sexual dysfunction or erectile dysfunction.		X

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Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Expanded Alpha-Fetoprotein Testing (Administered by Genetic Disease Branch of CDPH)		A simple blood test recommended for all pregnant women to detect if they are carrying a fetus with certain genetic abnormalities such as open neural tube defects, Down Syndrome, chromosomal abnormalities, and defects in the abdominal wall of the fetus.		X
Eyeglasses, Contact Lenses, Low Vision Aids, Prosthetic Eyes and Other Eye Appliances	Eyeglasses, Contact Lenses, Low Vision Aids, Prosthetic Eyes, and Other Eye Appliances	Eye appliances are covered on the valid prescription of a physician or optometrist.	X[vii]	
Federally Qualified Health Centers (FQHC) (Medi-Cal covered services only)	FQHC	Services described in 42 U.S.C. Section 1396d(a)(2)(C) furnished by an entity defined in 42 U.S.C. Section 1396d(l)(2)(B)).	X	
Hearing Aids	Hearing Aids	Hearing aids are covered only when supplied by a hearing aid dispenser on prescription of an otolaryngologist, or the attending physician where there is no otolaryngologist available in the community, plus an audiological evaluation including a hearing aid evaluation which must be	X	

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Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
		performed by or under the supervision of the above physician or by a licensed audiologist.		
1915(c) Home and Community- Based Waiver Services (Does not include EPSDT Services)		Provided and reimbursed as Medi-Cal covered benefits only: (1) For the duration of the applicable federally approved waiver, (2) To the extent the services are set forth in the applicable waiver approved by the HHS; and (3) To the extent the Department can claim and be reimbursed federal funds for these services.		X
Home Health Agency Services	Home Health Services- Home Health Agency	Covered as specified below when prescribed by a physician, physician assistant, nurse practitioner, or clinical nurse specialist and provided at the home of the beneficiary in accordance with a written treatment plan which the physician reviews every 60 days.	X	
Home Health Aide Services	Home Health Services- Home Health Aide	Covers skilled nursing or other professional services in the residence including part-time and intermittent skilled nursing services, home health aide services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker.	X	

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Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Home Health Pharmacy Services-Total Parenteral and Enteral Nutrition under Medi-Cal Rx.	Home Health	Nutritional products medically necessary because of chronic illness or trauma for patients who cannot be sustained through oral feeding and when used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions that preclude the full use of regular food that are billed by a pharmacy on a pharmacy claim, including formula, pumps, tubing, and general sub-categories, as described in the Medi-Cal Rx All Plan Letter (APL 20-020: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-020.pdf).		**X**
Home Health Other Pharmacy Services-Total Parenteral and Enteral Nutrition	Home Health	Nutritional products medically necessary because of chronic illness or trauma for patients who cannot be sustained through oral feeding and when used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions that preclude the full use of regular food that are billed on medical and institutional claims as described in the Medi-Cal Rx All Plan Letter (APL 20-020: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL2	**X**	

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Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
		0-020.pdf).		
Hospice Care	Hospice Care	Covers services limited to individuals who have been certified as terminally ill in accordance with Title 42, CFR Part 418, Subpart B, and who directly or through their representative volunteer to receive such benefits in lieu of other care as specified.	X	
Hospital Outpatient Department Services and Organized Outpatient Clinic Services	Clinic Services and Hospital Outpatient Department Services and Organized Outpatient Clinic Services	A scheduled administrative arrangement enabling outpatients to receive the attention of a healthcare provider. Provides the opportunity for consultation, investigation, and minor treatment.	X	
Human Immunodeficiency Virus and AIDS drugs		Human Immunodeficiency Virus and AIDS drugs that are listed in the Medi-Cal Provider Manual		X

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MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Hysterectomy	Inpatient Hospital Services	Except for previously sterile women, a nonemergency hysterectomy may be covered only if: (1) The person who secures the authorization to perform the hysterectomy has informed the individual and the individual's representatives, if any, orally and in writing, that the hysterectomy will render the individual permanently sterile, (2) The individual and the individual's representative, if any, has signed a written acknowledgment of the receipt of the information in and (3) The individual has been informed of the rights to consultation by a second physician. An emergency hysterectomy may be covered only if the physician certifies on the claim form or an attachment that the hysterectomy was performed because of a life-threatening emergency in which the physician determined that prior acknowledgement was not possible and includes a description of the nature of the emergency.	X	
Indian Health Services (Medi- Cal covered services only)		Indian means any person who is eligible under federal law and regulations (25 U.S.C. Sections 1603c, 1679b, and 1680c) and covers health services provided directly by the United States Department of Health and Human Services,	X	

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MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
		Indian Health Service, or by a tribal or an urban Indian health program funded by the Indian Health Service to provide health services to eligible individuals either directly or by contract.		
Inpatient Hospital Services	Inpatient Hospital Services	Covers delivery services and hospitalization for newborns; emergency services without prior authorization; and any hospitalization deemed medically necessary with prior authorization.	X	
Laboratory, Radiological and Radioisotope Services	Laboratory, X-Ray and Laboratory, Radiological and Radioisotope Services	Covers exams, tests, and therapeutic services ordered by a licensed practitioner.	X[viii]	
Licensed Midwife Services	Other Practitioners' Services and Licensed Midwife Services	When provided by a licensed midwife, the following are covered Medi-Cal services: (1) Attendance at cases of normal childbirth and (2) The provision of prenatal, intrapartum, and postpartum care, including family planning care, for the mother, and immediate care for the newborn.	X	

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MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Local Educational Agency (LEA) Services	Local Education Agency Medi-Cal Billing Option Program Services	LEA health and mental health evaluation and health and mental health education services, which include any or all of the following: (A) Nutritional assessment and nutrition education, consisting of assessments and non-classroom nutrition education delivered to the LEA eligible beneficiary based on the outcome of the nutritional health assessment (diet, feeding, laboratory values, and growth), (B) Vision assessment, consisting of examination of visual acuity at the far point conducted by means of the Snellen Test, (C) Hearing assessment, consisting of testing for auditory impairment using at-risk criteria and appropriate screening techniques as defined in Title 17, California Code of Regulations, Sections 2951(c), (D) Developmental assessment, consisting of examination of the developmental level by review of developmental achievement in comparison with expected norms for age and background, (E) Assessment of psychosocial status, consisting of appraisal of cognitive, emotional, social, and behavioral functioning and self-concept through tests, interviews, and behavioral evaluations and (F) Health education and anticipatory guidance		**X**

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MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
		appropriate to age and health status, consisting of non- classroom health education and anticipatory guidance based on age and developmentally appropriate health education.		
Long Term Care (LTC) Facility Services		Medically necessary care in a LTC facility or setting, including the following: • Skilled Nursing Facility (SNF), including a distinct part or unit of a hospital; • Intermediate Care Facility (ICF); • Intermediate Care Facility for Developmentally Disabled (ICF/DD); • Intermediate Care Facility for Developmentally Disabled with Habilitative (ICF/DDH); • Intermediate Care Facility for Developmentally Disabled with Nursing (ICF/DDN); • Subacute facility; • Pediatric Subacute Facility.	*Prior to 1/1/2023:* **X**[ix,x,xi] *After 1/1/2023 for SNF (in all counties):* **X** *After 1/1/2024 for ICF/DD, ICF/DDH, ICF/DDN, Subacute, and Pediatric Subacute*: **X**	**X**[15]
Medi-Cal Substance Abuse Services	Substance Abuse Treatment Services	Medically necessary substance abuse treatment to eligible beneficiaries includes: counseling services and behavioral therapy related to the drugs and biologicals covered under the		**X**

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Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
		SUPPORT Act.		
Medical Supplies	Medical Supplies	Supplies are medically necessary when prescribed by a licensed practitioner. Does not include medical supplies carved-out to Medi-Cal Rx that are billed by a pharmacy on a pharmacy claim including medical supplies described in the Medi-Cal Rx All Plan Letter (ALP 20-020: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-020.pdf).	**X**	
Medical & Non-Medical (NMT) Transportation Services	Transportation - Medical & Non-Medical Transportation (NMT) Services	Covers ambulance, litter van and wheelchair van medical transportation services when the beneficiary's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care. NMT is transportation by private or public vehicle for beneficiaries who do not have another way to get to their appointment.	**X**	

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Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Nurse Anesthetist Services	Other Practitioners' Services and Nurse Anesthetist Services	Covers anesthesiology services performed by a nurse anesthetist within the scope of his or her licensure.	X	
Nurse Midwife Services	Nurse-Midwife Services	An advanced practice registered nurse who has specialized education and training in both Nursing and Midwifery, is trained in obstetrics, and provides care for mothers and newborns through the maternity cycle of pregnancy, labor, birth, and the immediate postpartum period, not to exceed six weeks.	X	
Optometry Services	Optometrists' Services	Covers eye examinations and prescriptions for corrective lenses.	X	
Organ and Bone Marrow Transplant Surgeries	Transplant	Medically necessary donor and recipient organ and bone marrow transplant surgeries for adult and pediatric transplant recipients and donors, including related services such as organ procurement and living donor care.	X	

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Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Outpatient Mental Health	Outpatient Mental Health	Services provided by licensed health care professionals acting within the scope of their license for adults and children diagnosed with a mental condition as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) resulting in mild to moderate distress or impairment of mental, emotional, or behavioral functioning. Services include: • Preventive mental health services for potential mental health disorders not yet diagnosed • Behavioral health screenings and interventions • Mental health evaluation and treatment, including individual, group and family psychotherapy • Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition. • Outpatient services for purposes of monitoring drug therapy • Psychiatric consultation • Outpatient laboratory, drugs, supplies and supplements	X[xii]	

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MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
		• Mental health services for beneficiaries 21 years and over with mild to moderate distress or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders • Mental health services for beneficiaries under age 21 regardless of level of distress or impairment or the presence of a diagnosis, unless the recipient meets the criteria for Specialty Mental Health Services		
Organized Outpatient Clinic Services	Clinic Services and Organized Outpatient Clinic Services	In-home medical care waiver services and nursing facility waiver services are covered when prescribed by a physician and provided at the beneficiary's place of residence in accordance with a written treatment plan indicating the need for in- home medical care waiver services or nursing facility waiver services and in accordance with a written agreement between the Department and the provider of service.	**X**	

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MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Outpatient Heroin Detoxification Services	Outpatient Heroin Detoxification Services	Can cover various medications and treatments, allowing for day-to-day functionality for a person choosing to not admit as an inpatient. Routine elective heroin detoxification services are covered, subject to prior authorization, only as an outpatient service. Outpatient services are limited to a maximum period of 21 days. Inpatient hospital services shall be limited to patients with serious medical complications of addiction or to patients with associated medical problems which require inpatient treatment.		X
Part D Drugs		Drug benefits for full-benefit dual eligible beneficiaries who are eligible for drug benefits under Part D of Title XVIII of the Social Security Act.		X
Personal Care Services	Personal Care Services	Services for categorically needy beneficiaries with a chronic, disabling condition that causes functional impairment that is expected to last at least 12 consecutive months or that is expected to result in death within 12 months and who is unable to remain safely at home without the services. Benefit known as In Home Supportive Services (IHSS).	X[14]	X[14]

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Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Pharmaceutical Services and Prescribed Drugs under Medi-Cal Rx	Pharmaceutical Services and Prescribed Drugs	Pharmacy benefits carved-out to Medi-Cal Rx, which are pharmacy benefits that are billed by a pharmacy on a pharmacy claim, including covered outpatient drugs and physician administered drugs, as described in the Medi-Cal Rx All Plan Letter (APL 20-020: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-020.pdf).		**X**
Other Pharmaceutical Services and Prescribed Drugs	Pharmaceutical Services and Prescribed Drugs	Covers Pharmacy benefits that are billed on medical and institutional claims, including physician administered drugs, other outpatient drugs, legend, non-legend and specialty drugs that are not carved-out to Medi-Cal Rx as discussed above, and further described in Medi-Cal Rx All Plan Letter (APL 20-020: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-020.pdf).	**X**	
Pharmacist Services	Pharmacist Services	Pharmacists in a community pharmacy setting furnishing specified categories of drugs (furnishing of naloxone, self-administered hormonal contraceptives, nicotine replacement therapy, HIV pre-exposure and post-exposure prophylaxis, and initiating and administrating	**X**	

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Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
		immunizations).		
Physician Services	Physician Services	Covers primary care, outpatient services, and services rendered during a stay in a hospital or nursing facility for medically necessary services. Can cover limited mental health services when rendered by a physician, and limited allergy treatments.	X	
Podiatry Services	Other Practitioners' Services and Podiatrists' Services	Medically necessary Office visits are covered. All other outpatient services are subject to the same prior authorization procedures that govern physicians, and are limited to medical and surgical services necessary to treat disorders of the feet, ankles, or tendons that insert into the foot, secondary to or complicating chronic medical diseases, or which significantly impair the ability to walk. Services rendered on an emergency basis are exempt from prior authorization.	X	
Preventive Services	Preventive Services	All preventive services articulated in the state plan.	X	

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MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Prosthetic and Orthotic Appliances	Prosthetic and Orthotic Appliances	All prosthetic and orthotic appliances necessary for the restoration of function or replacement of body parts as prescribed by a licensed physician, podiatrist or dentist, within the scope of their license, are covered when provided by a prosthetist, orthotist or the licensed practitioner, respectively	X	
Physical Therapy and Occupational Therapy	Physical Therapy and Occupational Therapy	Physical therapy and occupational therapy are covered when provided by persons who meet the appropriate requirements	X	
Private Duty Nursing	EPSDT	Private duty nursing is the planning of care and care of clients by nurses, whether a registered nurse or licensed practical nurse for individuals under 21 years of age.	X[2]	
Rehabilitation Center Outpatient Services	Rehabilitative Services	A facility providing therapy and training for rehabilitation on an outpatient basis. The center may offer occupational therapy, physical therapy, vocational training, and special training.	X	
Rehabilitation Center Services	Rehabilitative Services	A facility which provides an integrated multidisciplinary program of restorative services designed to upgrade or maintain the physical functioning of patients.	X	
Respiratory Care	Physician	A provider trained and licensed for respiratory	X	

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Services	Services	care to provide therapy, management, rehabilitation, diagnostic evaluation, and care of patients with deficiencies and abnormalities affecting the pulmonary system and aspects of cardiopulmonary and other systems.		
Rural Health Clinic Services	Rural Health Clinic Services	Services described in 42 U.S.C. Section 1396d(a)(2)(B) furnished by a rural health clinic as defined in 42 U.S.C. Section 1396d(l)(1).	**X**	
Scope of Sign Language Interpreter Services	Sign Language Interpreter Services	Sign language interpreter services may be utilized for medically necessary health care services	**X**	
Services provided in a State or Federal Hospital		California state hospitals provide inpatient treatment services for Californians with serious mental illnesses. Federal hospitals provide services for certain populations, such as the military, for which the federal government is responsible.		**X**
Specialty Mental Health Services		Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services.		**X**[xiii]

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Specialized Rehabilitative Services in Skilled Nursing Facilities and Intermediate Care Facilities	Special Rehabilitative Services	Specialized rehabilitative services are covered. Such service must include the medically necessary continuation of treatment services initiated in the hospital or short-term intensive therapy expected to produce recovery of function leading to either (1) a sustained higher level of self- care and discharge to home or (2) a lower level of care. Specialized rehabilitation service shall be covered.	X[9]	
Speech Pathology	Speech Pathology	Services are covered when provided by persons who meet the appropriate requirements.	X	
State Supported Services		State funded abortion services that are provided through a secondary contract.	X	
Swing Bed Services	Inpatient Hospital Services	Swing bed services is additional inpatient care services for those who qualify and need additional care before returning home.	X	
Targeted Case Management Services (provided by Local Governmental Agencies)	Targeted Case Management	Persons who are eligible to receive targeted case management services must consist of the following Medi-Cal beneficiary groups: (1) high risk children under the age of 21, (2) medically fragile individuals; (3) children with an Individualized Education Plan or Individualized Family Service Plan; (4) individuals at risk of institutionalization; (5) individuals in jeopardy of		X

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
		negative health or psycho-social outcomes; and (6) individuals with a communicable disease. Targeted case management services must include at least one of the following service components: A documented assessment identifying the beneficiary's needs, development of a comprehensive, written, individual service plan, implementation of the service plan includes linkage and consultation with and referral to providers of service, assistance with accessing the services identified in the service plan, crisis assistance planning to coordinate and arrange immediate service or treatment needed in those situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate or reduce a crisis situation for a specific beneficiary, periodic review of the beneficiary's progress toward achieving the service outcomes identified in the service plan to determine whether current services should be continued, modified or discontinued.		

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Transitional Inpatient Care Services	Nursing Facility and Transitional Inpatient Care Services	Focuses on transition of care from outpatient to inpatient. Inpatient care coordinators, along with providers from varying settings along the care continuum, should provide a safe and quality transition.	X	
Tuberculosis (TB) Related Services (Provided by the Local County Health Departments)	TB Related Services	Covers TB care and treatment in compliance with the guidelines recommended by American Thoracic Society and the Centers for Disease Control and Prevention.		X

[i] Coverage and reimbursement of COVID-19 vaccines and administration are carved out of Medi-Cal managed care for all eligible populations and are exclusively covered and reimbursed through the State's fee-for-service delivery system by all applicable providers.
[ii] Benefit coverage is limited to only beneficiaries under 21 years of age for services rendered pursuant to EPSDT requirements.
[iii] California Children Services (CCS) covered in COHS counties with the exception of Ventura County (Gold Coast Health Plan). CCS not covered in Non-COHS counties and Ventura County.
[iv] Chiropractic coverage is limited to only beneficiaries in "Exempt Groups": 1) beneficiaries under 21 years of age for services rendered pursuant to EPSDT program; 2) beneficiaries residing in a SNF (Nursing Facilities Level A and Level B, including subacute care facilities; 3) beneficiaries who are pregnant; 4) CCS beneficiaries; 5) beneficiaries enrolled in the PACE; 6) beneficiaries who receive services at an FQHC or RHC; and 7) beneficiaries in hospital outpatient settings. Chiropractic services are not available at Indian Health Clinics except for those in the exempt groups.
[v] Coverage of benefit subject to federal approval in the Medi-Cal State Plan.
[vi] Dental services are carved in to managed care for Health Plan of San Mateo.
[vii] The fabrication of eyeglasses lenses are carved out statewide to FFS Medi-Cal contracted optical laboratories, with the exception of specialty

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

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lenses (including lenses that exceed contract lab ranges), which remain the responsibility of the managed care plan.
[viii] Coverage and reimbursement of COVID-19 testing in school settings, to be carved out of managed care, covered and reimbursed through the state's Fee For Service delivery system.
[ix] Only covered for the month of admission and the following month in Non-COHS. Services covered in COHS.
[x] Services covered under managed care only in MLTSS Eligible Beneficiary Authorized Counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. IHSS benefits are not part of this covered service.
[xi] ICF-DD residents are exempt from managed care plan enrollment in Coordinated Care Initiative Counties.
[xii] Services provided by primary care physicians; psychiatrists; psychologists; licensed clinical social workers; or other specialty mental health provider. Solano County for Partnership Health plan (COHS) covers specialty mental health, and Kaiser GMC covers inpatient, outpatient, and specialty mental health services.
[xiii] Kaiser members in Solano and Sacramento counties carved into managed care until 7/1/2023.
[14] Personal care services benefit carved-in to SCAN Connections and SCAN Connections at Home, and members of those plans are not eligible for In Home Supportive Services (IHSS). For all other plans, the IHSS personal care services benefit is carved-out of Medi-Cal managed care and is administered and authorized by county agencies.
[15] Intermediate Care Facility for Developmentally Disabled (ICF/DD) – Continuous Nursing Care (ICF/DD-CN) Homes are not subject to the LTC Carve-In Policy

STATE OF CALIFORNIA - DEPARTMENT OF GENERAL SERVICES

STANDARD AGREEMENT - AMENDMENT

STD 213A (Rev. 4/2020)

SCO ID:

AGREEMENT NUMBER	AMENDMENT NUMBER	Purchasing Authority Number
22-20236	A04	

☒ CHECK HERE IF ADDITIONAL PAGES ARE ATTACHED 102 PAGES

1. This Agreement is entered into between the Contracting Agency and the Contractor named below:

CONTRACTING AGENCY NAME
Department of Health Care Services

CONTRACTOR NAME
Local Initiative Health Authority for LA County

2. The term of this Agreement is:

START DATE
January 1, 2023

THROUGH END DATE
December 31, 2025

3. The maximum amount of this Agreement after this Amendment is:
Budget Act Line Items 4260-601-0912 and 4260-601-0555

4. The parties mutually agree to this amendment as follows. All actions noted below are by this reference made a part of the Agreement and incorporated herein:

I. Amendment effective date: December 31, 2024 or until approved by DGS (if DGS approval is needed).

II. Purpose of amendment: It extends the contract term to December 31, 2025. DHCS is obtaining a continuation of the services identified in the original agreement.

III. Paragraph 2 (term) on the face of the original STD 213 is amended to read: January 1, 2023 through December 31, 2025. All references to the former contract term of January 1, 2023 through December 31, 2024 in any exhibit incorporated into this agreement are hereinafter deemed to read January 1, 2023 through December 31, 2025.

All other terms and conditions shall remain the same.

IN WITNESS WHEREOF, THIS AGREEMENT HAS BEEN EXECUTED BY THE PARTIES HERETO.

CONTRACTOR

CONTRACTOR NAME (if other than an individual, state whether a corporation, partnership, etc.)
Local Initiative Health Authority for LA County

CONTRACTOR BUSINESS ADDRESS	CITY	STATE	ZIP
1055 West 7th Street	Los Angeles	CA	90017

PRINTED NAME OF PERSON SIGNING	TITLE
John Baackes	Chief Executive Officer

CONTRACTOR AUTHORIZED SIGNATURE	DATE SIGNED

STATE OF CALIFORNIA - DEPARTMENT OF GENERAL SERVICES

STANDARD AGREEMENT - AMENDMENT

STD 213A (Rev. 4/2020)

SCO ID:

☐ CHECK HERE IF ADDITIONAL PAGES ARE ATTACHED _____ PAGES

AGREEMENT NUMBER	AMENDMENT NUMBER	Purchasing Authority Number
22-20236	A04	

STATE OF CALIFORNIA

CONTRACTING AGENCY NAME			
Department of Health Care Services			
CONTRACTING AGENCY ADDRESS	CITY	STATE	ZIP
1501 Capitol Avenue, MS 4415, P.O. Box 997413	Sacramento	CA	95899
PRINTED NAME OF PERSON SIGNING	TITLE		
Michelle Retke	Chief, Managed Care Operations Division		
CONTRACTING AGENCY AUTHORIZED SIGNATURE	DATE SIGNED		
CALIFORNIA DEPARTMENT OF GENERAL SERVICES APPROVAL	EXEMPTION (If Applicable)		
	Welfare & Institutions Code section 14087.55(c)		

Board of Governors
MOTION SUMMARY

Date: September 5, 2024 **Motion No. EXE 101.0924**

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

Issue: Approval of 2025 schedule of meetings for the Board of Governors and Committees.

Background: The meetings are scheduled according to these guidelines established by the Board:

- Eight Board meetings in 2025, with two tentatively scheduled meetings in March and October; with meeting cancellations determined by agenda content.
- Finance & Budget and Executive Committee meetings on the fourth Wednesday. Ten Finance & Budget and ten Executive Committee meetings are scheduled; with meeting cancellations determined by agenda content.
- Ten Compliance & Quality Committee meetings on the 3rd Thursday; with meeting cancellations determined by agenda content.
- Four Provider Relations Advisory Committee meetings on the 3rd Wednesday; with meeting cancellations determined by agenda content.
- Audit, Governance and Services Agreement Committees meet as needed.
- Ten Executive Community Advisory Committee meets on 2nd Wednesday.
- Five Children's Health Consultant Advisory Committee meets on 2nd Tuesday every two months; with meeting cancellations determined by agenda content.
- Four Technical Advisory Committee meets on 2nd Thursday quarterly; with meeting cancellations determined by agenda content.

The schedule is consistent with L.A. Care's enabling statute (California Welfare & Institutions Code Section 14087) which requires six board meetings per year, and the proposed meeting frequency is in line with other public health plans in California.

Member Impact: Public input is welcome at all Board and Committee meetings.

Budget Impact: None.

Motion: To approve the attached 2025 Board of Governors & Committees meeting schedule.

2025 Regular Board and Committee Meeting schedule

BoG: Board of Governors, meets 1st Thursdays of the month at 1:00 pm, and meets all day in September for strategic discussion

C&Q: Compliance and Quality Committee, meets 3rd Thursdays of the month at 2:00 p.m.

Exec: Executive Committee meets 4th Wednesdays of the month at 2:00 p.m.

F&B: Finance & Budget Committee meets 4th Wednesday of the month at 1:00 p.m.

PRAC: Provider Relations Advisory Committee meets Quarterly 3rd Wednesday of meeting month at 9:30 a.m.

CHCAC: Children's Health Consultant Advisory Committee meets 3rd Tuesdays every 2 months at 8:30 a.m.

ECAC: Executive Community Advisory Committee meets 2nd Wednesdays of the month at 10:00 a.m.

TAC: Technical Advisory Committee meets 2nd Thursday of meeting month at 2:00 PM

JPA and **LACH**: Joint Powers Authority and L.A. Care Community Health Plan meet concurrently with a BoG meeting

Meetings are usually held at 1200 W. 7th Street, 90017, Except where *offsite* meetings are indicated below or if a different address is posted on the meeting agenda.

January 2025 *No Board meeting* 1/9 - TAC 1/21 – CHCAC 1/16 – C&Q 1/22 –F&B, Exec	February 2025 2/6 – BoG 2/12 – ECAC 2/19 – PRAC 2/20 – C&Q 2/26 –F&B, Exec	March 2025 ***3/6 BoG (tentative)*** 3/12 – ECAC 3/18 – CHCAC 3/20 - C&Q 3/26 – F&B, Exec TBD – GOV
April 2025 4/3 – BoG 4/9 – ECAC 4/10 - TAC 4/17 – C&Q 4/23 – F&B, Exec	May 2025 5/1– BoG 5/14 – ECAC 5/15 – C&Q 5/20 – CHCAC 5/21 - PRAC 5/28 – F&B, Exec	June 2025 6/5 – BoG (*offsite)** 6/11 – ECAC 6/19 – C&Q 6/25 – F&B, Exec
July 2025 *No Committee Meetings* 7/9 - ECAC 7/24 – BOG	August 2025 *No Board meeting* *No ECAC meeting* 8/14 – TAC 8/21 – C&Q 8/19 – CHCAC 8/20 - PRAC 8/27 – F&B, Exec TBD – Audit	September 2025 9/4 – BoG (*all day retreat)* 9/10 - ECAC 9/18 – C&Q 9/24 - F&B, Exec TBD –GOV
October 2025 ***10/2 BoG (tentative)*** 10/9 - TAC 10/8 – ECAC 10/16 – C&Q 10/21 - CHCAC 10/22 - F&B, Exec	November 2025 11/6 – BoG 11/12 – ECAC 11/19 – PRAC 11/19 - F&B, Exec** ***Due to Thanksgiving holiday* 11/20 – C&Q	December 2025 12/4 – BoG 12/10 – ECAC TBD – Audit *No other meetings*

**Offsite locations are tentative*

Board of Governors
MOTION SUMMARY

Date: September 5, 2024 **Motion No. EXE 102.0924**

Committee: Executive **Chairperson:** Alvaro Ballesteros

Issue: To approve delegated authority to the Chief Executive Officer, John Baackes, to issue up to $1 million to Pacifica Hospital of the Valley to support safety net access to health care for L.A. Care members.

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

Background: L.A. Care's mission is to serve low income and vulnerable populations and to support the safety net providers that serve them. Pacifica Hospital of the Valley is a 231-bed acute care hospital servicing underserved communities primarily in the San Fernando Valley. The majority of their patients, 84%, live in poverty. The requested funding is part of a larger proposal to serve as a bridge while executing their redesign plan. L.A. Care funding would help avoid an interruption of services.

Since the COVID pandemic and while working toward seismic compliance, Pacifica has experienced financial hardship. The recent delay of QAF program reimbursement and the Change Healthcare cyberattack worsened the financial situation. Pacifica is working on a redesign plan to improve its financial position. The redesign will include both financial and operational processes to improve its revenue position.

Pacifica has a strong focus on behavioral health, including mental health and substance abuse. The redesign includes:

- Beds for dually diagnosed patients, with or without COVID-19, an area of shortage statewide.
- An intake program for released incarcerated patients to assess and treat mental health issues for former prisoners being transitioned into the community.
- Additional capacity of 12 emergency unit chairs in the Empath unit, providing enhanced patient care for behavioral health patients in the emergency room.
- A pilot project with Care Solace to provide extensive resources to mental health clients post-acute care discharge.

Pacifica is in the process of securing financing for this capital project, which also includes a seismic retrofit, and L.A. Care's grant will serve as a bridge until funding is secured. Without this funding, Pacifica will have to reduce staffing, bed capacity, and other clinical services, and may ultimately lead to permanent closure.

Member Impact: Supporting Pacifica 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.

Budget Impact: The Chief Financial Officer will work with the Chief Executive Officer to identify the appropriate source of funding for this grant.

Motion: **To approve delegated authority to Chief Executive Officer, John Baackes, to issue up to a $1 million award to Pacifica Hospital of the Valley to support safety net access to health care for L.A. Care members with behavioral health needs.**

Board of Governors
MOTION SUMMARY

Date: September 5, 2024 **Motion No. EXE 103.0924**

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

Issue: Request to express L.A. Care's support for California Proposition 35 (MCO Tax)

Background: This motion seeks approval to express L.A. Care's support for California Proposition 35 (MCO Tax). Proposition 35 makes permanent the existing tax on managed health care insurance plans (currently set to expire in 2026), which, if approved by the federal government, provides revenues to pay for health care services for low-income families with children, seniors, disabled persons, and other Medi-Cal recipients.

Proposition 35 requires revenues to be used only for specified Medi-Cal services, including primary care and specialty care, emergency care, family planning, mental health, and prescription drugs. Further, it prohibits revenues from being used to replace Medi-Cal funding and caps administrative expenses and requires independent audits of programs receiving funding.

Proposition 35 will increase funding for Medi-Cal and other health programs between roughly $2 billion and $5 billion annually, including federal funds.

Member Impact: The impact on L.A. Care's membership is expected to be positive, as it increases funding for safety-net providers.

Budget Impact: This motion does not have any budgetary impact for L.A. Care.

Motion: To approve L.A. Care's organizational support for California Proposition 35.

Board of Governors
MOTION SUMMARY

Date: September 5, 2024 **Motion No. FIN 100.0924**

Committee: Finance & Budget **Chairperson:** Stephanie Booth, M.D.

Issue: Accept the Investment Report for the quarter ended June 30, 2024.

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

Background: Per L.A. Care's Investment Policy, the Finance & Budget Committee is responsible for reviewing L.A. Care's investment portfolio to confirm compliance with the Policy, including its diversification and maturity guidelines.

Member Impact: N/A

Budget Impact: L.A. Care budgets a reasonable return on investment holdings.

Motion: **To accept the Quarterly Investment Report for the quarter ending June 30, 2024, as submitted.**

DATE: August 28, 2024

TO: Finance & Budget Committee

FROM: Afzal Shah, *Chief Financial Officer*

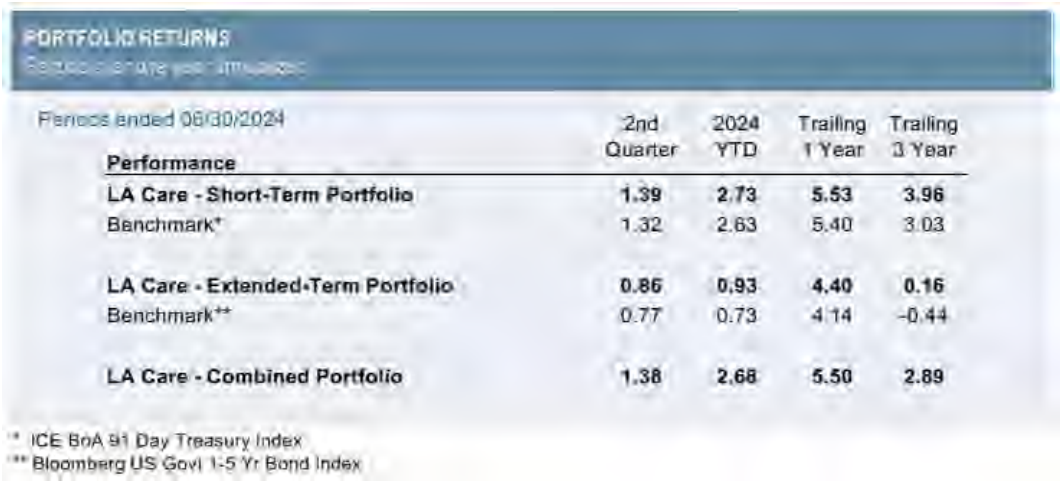
SUBJECT: Quarterly Investment Report – June 2024

As of June 30 2024, L.A. Care's combined investments value was approximately $3.76 billion. Interest income, amortization, realized gains and losses was approximately $53.5 million for the quarter. Unrealized gain due to market price fluctuations was approximately $1.8 million for the quarter. The rate of return for the quarter was 1.37%. Based upon an independent compliance review performed as of June 30, 2024, LA Care is in compliance with its investment policy guidelines pursuant to the California Government Code and the California Insurance Code.

At quarter end $3.3 billion (or approx. 87% of total investments) and $0.3 billion (or approx. 9% of total investments) were under the management of Payden & Rygel and New England Asset Management, respectively. Both are external professional investment management firms. A list of the securities held under management of these two firms are attached. Below are the same securities grouped by investment type:

	Payden	NEAM	Combined
Cash and Money Market Mutual Fund	2%	0%	2%
U.S. Treasury Securities	64%	0%	58%
U.S. Agency & Municipal Securities	7%	3%	7%
Commercial paper	14%	0%	13%
Corporate bonds	0%	97%	9%
Asset Backed and Mortgage Backed Securities	9%	0%	8%
Negotiable CDs	2%	0%	1%
Other	2%	0%	2%
	100%	100%	100%
Average credit quality:	AA+	A1	
Average duration:	0.25 years	2.64 years	
Average yield to maturity:	5.24%	5.13%	

The funds managed by Payden & Rygel are managed as two separate portfolios based on investment style – 1) the short-term portfolio and 2) the extended term portfolio. The short-term portfolio had approximately $3,180 million invested as of June 30, 2024, and returned 1.39% for the quarter. The comparative benchmark returned 1.32% for the quarter. The extended term portfolio had approximately $94 million invested June 30, 2024, and returned 0.86% for the quarter. The comparative benchmark had a return of 0.77%.



PORTFOLIO RETURNS

Periods ended 06/30/2024

Performance	2nd Quarter	2024 YTD	Trailing 1 Year	Trailing 3 Year
LA Care - Short-Term Portfolio	**1.39**	**2.73**	**5.53**	**3.96**
Benchmark*	1.32	2.63	5.40	3.03
LA Care - Extended-Term Portfolio	**0.86**	**0.93**	**4.40**	**0.16**
Benchmark**	0.77	0.73	4.14	-0.44
LA Care - Combined Portfolio	**1.38**	**2.68**	**5.50**	**2.89**

* ICE BoA 91 Day Treasury Index
** Bloomberg US Govt 1-5 Yr Bond Index

The $344 million portfolio managed by New England Asset Management, Inc (NEAM), focused on corporate fixed income bonds returned 0.96% for the quarter. The comparative benchmark returned 0.91% for the quarter.

L.A. Care also invests with 2 government pooled investment funds, the Local Agency Investment Fund (LAIF) and the Los Angeles County Pooled Investment Fund (LACPIF). L.A. Care's investment balances as of June 30, 2024 were $6 million in LAIF and $11 million in LACPIF.

The Local Agency Investment Fund (LAIF) yielded approximately 1.10% for the quarter. The fund's total portfolio market value as of May 31, 2024, was $162 billion, with a weighted average maturity of 217 days. LAIF is administered and overseen by the State Treasurer's office. The fund's investment holdings as of May 31, 2024 were as follows:

U.S. Treasury Securities	57%
Agencies	23%
CD's and bank notes	9%
Commercial paper	7%
Time deposits	3%
Other	1%
	100%

The Los Angeles County Pooled Investment Fund (LACPIF) yielded approximately 1.00% for the quarter. The fund's total market value as of May 31, 2024, was approximately $58 billion, with a weighted average maturity of 654 days. LACPIF is administered and overseen by the Los Angeles County Treasurer. The fund's most recent published investment holdings (as of May 31, 2024) were as follows:

U.S. Govt. and Agency Securities	67%
Commercial paper	29%
CD's	4%
	100%

Lastly, L.A. Care's investment balance in the BlackRook Liquidity T-Fund, a Money Market fund that invests in US Treasury obligations, was $125 million at quarter end, and returned 1.05% for the quarter.

LA Care Securities Holdings

as of June 30, 2024

Porfolio	CUSIP/Identifier	Security	Type	Par	Maturity date
Payden	USD	NORTHERN INST GOVT MONEY MKT	Cash/Money Market Funds	71,875,041	NA
NEAM	USD	NORTHERN INST GOVT MONEY MKT	Cash/Money Market Funds	827,644	NA
Payden	912797JS7	U.S. TREASURY BILL	U.S. Treasury Security	200,000,000	7/18/2024
Payden	912797KQ9	U.S. TREASURY BILL	U.S. Treasury Security	240,000,000	7/23/2024
Payden	912797JU2	U.S. TREASURY BILL	U.S. Treasury Security	130,000,000	8/1/2024
Payden	912797KW6	U.S. TREASURY BILL	U.S. Treasury Security	144,000,000	8/6/2024
Payden	912797KB2	U.S. TREASURY BILL	U.S. Treasury Security	150,000,000	8/15/2024
Payden	912797KK2	U.S. TREASURY BILL	U.S. Treasury Security	160,000,000	9/12/2024
Payden	912797KL0	U.S. TREASURY BILL	U.S. Treasury Security	100,000,000	9/19/2024
Payden	912797LJ4	U.S. TREASURY BILL	U.S. Treasury Security	150,000,000	9/24/2024
Payden	912797KM8	U.S. TREASURY BILL	U.S. Treasury Security	97,000,000	9/26/2024
Payden	912797LS4	U.S. TREASURY BILL	U.S. Treasury Security	200,000,000	10/8/2024
Payden	912797KT3	U.S. TREASURY BILL	U.S. Treasury Security	300,000,000	10/10/2024
Payden	912797LU9	U.S. TREASURY BILL	U.S. Treasury Security	30,000,000	10/22/2024
Payden	912797LE5	U.S. TREASURY BILL	U.S. Treasury Security	95,000,000	11/21/2024
Payden	91282CJD4	U.S. TREASURY FRN	U.S. Treasury Security	50,000,000	10/31/2025
Payden	91282CKM2	U.S. TREASURY FRN	U.S. Treasury Security	10,000,000	4/30/2026
Payden	91282CBT7	U.S. TREASURY NOTE	U.S. Treasury Security	1,445,000	3/31/2026
Payden	91282CBW0	U.S. TREASURY NOTE	U.S. Treasury Security	1,595,000	4/30/2026
Payden	91282CCP4	U.S. TREASURY NOTE	U.S. Treasury Security	2,350,000	7/31/2026
Payden	91282CCW9	U.S. TREASURY NOTE	U.S. Treasury Security	1,880,000	8/31/2026
Payden	91282CCZ2	U.S. TREASURY NOTE	U.S. Treasury Security	1,405,000	9/30/2026
Payden	91282CDQ1	U.S. TREASURY NOTE	U.S. Treasury Security	930,000	12/31/2026
Payden	91282CKR1	U.S. TREASURY NOTE	U.S. Treasury Security	230,000	5/15/2027
Payden	91282CKV2	U.S. TREASURY NOTE	U.S. Treasury Security	2,590,000	6/15/2027
Payden	91282CEW7	U.S. TREASURY NOTE	U.S. Treasury Security	2,470,000	6/30/2027
Payden	91282CFB2	U.S. TREASURY NOTE	U.S. Treasury Security	1,975,000	7/31/2027
Payden	91282CFH9	U.S. TREASURY NOTE	U.S. Treasury Security	1,325,000	8/31/2027
Payden	91282CFZ9	U.S. TREASURY NOTE	U.S. Treasury Security	1,530,000	11/30/2027
Payden	91282CGH8	U.S. TREASURY NOTE	U.S. Treasury Security	1,950,000	1/31/2028
Payden	91282CGP0	U.S. TREASURY NOTE	U.S. Treasury Security	2,395,000	2/29/2028
Payden	91282CGT2	U.S. TREASURY NOTE	U.S. Treasury Security	11,105,000	3/31/2028
Payden	91282CHA2	U.S. TREASURY NOTE	U.S. Treasury Security	2,580,000	4/30/2028
Payden	91282CHE4	U.S. TREASURY NOTE	U.S. Treasury Security	680,000	5/31/2028
Payden	91282CHK0	U.S. TREASURY NOTE	U.S. Treasury Security	2,505,000	6/30/2028
Payden	91282CHQ7	U.S. TREASURY NOTE	U.S. Treasury Security	3,755,000	7/31/2028
Payden	91282CHX2	U.S. TREASURY NOTE	U.S. Treasury Security	230,000	8/31/2028
Payden	91282CJA0	U.S. TREASURY NOTE	U.S. Treasury Security	1,810,000	9/30/2028
Payden	91282CJN2	U.S. TREASURY NOTE	U.S. Treasury Security	3,925,000	11/30/2028

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Payden	91282CJW2	U.S. TREASURY NOTE	U.S. Treasury Security	4,420,000	1/31/2029
Payden	91282CKD2	U.S. TREASURY NOTE	U.S. Treasury Security	2,100,000	2/28/2029
Payden	91282CKG5	U.S. TREASURY NOTE	U.S. Treasury Security	465,000	3/31/2029
Payden	91282CKP5	U.S. TREASURY NOTE	U.S. Treasury Security	3,490,000	4/30/2029
Payden	91282CKT7	U.S. TREASURY NOTE	U.S. Treasury Security	1,180,000	5/31/2029
Payden	313588YW9	FNMA DISCOUNT NOTE	U.S. Agency Security	45,000,000	7/2/2024
Payden	313384YX1	FHLB DISCOUNT NOTE	U.S. Agency Security	94,000,000	7/3/2024
Payden	313385AZ9	FHLB DISCOUNT NOTE	U.S. Agency Security	10,300,000	1/24/2025
Payden	3134GYFM9	FHLMC C 8/1/23 Q	U.S. Agency Security	5,000,000	8/1/2024
Payden	3130AWYQ7	FHLB C 8/28/24 Q	U.S. Agency Security	4,500,000	8/28/2025
Payden	3134H1AZ6	FHLMC C 8/28/24 Q	U.S. Agency Security	5,000,000	8/28/2025
Payden	3130AYP59	FHLB C 2/26/2024 M	U.S. Agency Security	10,000,000	1/26/2026
Payden	3130B0UY3	FHLB C 10/17/2024 M	U.S. Agency Security	15,000,000	4/17/2026
Payden	3134GXS88	FHLMC C 02/28/23 Q	U.S. Agency Security	570,000	2/28/2025
Payden	3137EAEU9	FHLMC	U.S. Agency Security	570,000	7/21/2025
Payden	3134GXR63	FHLMC C 11/28/22 Q	U.S. Agency Security	570,000	8/28/2025
Payden	3134GXS47	FHLMC C 11/28/2022 Q	U.S. Agency Security	570,000	8/28/2025
Payden	3134GX3A0	FHLMC C 12/30/2022 Q	U.S. Agency Security	610,000	9/30/2025
Payden	3135G06G3	FNMA	U.S. Agency Security	410,000	11/7/2025
Payden	3130AKXQ4	FHLB C 05/12/21 Q	U.S. Agency Security	940,000	2/12/2026
Payden	4581X0DT2	INTER-AMERICAN DEV BANK FRN SOFRINDX	Non U.S. Government Bond	15,000,000	2/10/2026
Payden	4581X0DY1	INTER-AMERICAN DEV BANK FRN SOFRINDX	Non U.S. Government Bond	15,000,000	9/16/2026
Payden	459058KK8	INTL BK RECON & DEVELOP FRN SOFRINDX	Non U.S. Government Bond	5,720,000	9/23/2026
Payden	459058LD3	INTL BANK RECON & DEVELOP SOFRINDX FRN	Non U.S. Government Bond	5,000,000	2/23/2027
Payden	45828RAA3	INTER-AMERICAN DEV BANK FRN SOFRINDX	Non U.S. Government Bond	7,800,000	10/5/2028
Payden	4581X0EC8	INTER-AMERICAN DEV BANK FRN SOFRINDX	Non U.S. Government Bond	19,371,000	2/15/2029
Payden	13606KYN0	CANADIAN IMPERIAL BANK YCD FRN SOFRRATE	Negotiable CD	8,700,000	7/29/2024
Payden	06367DFG5	BANK OF MONTREAL CHICAGO YCD	Negotiable CD	10,000,000	8/29/2024
Payden	86959TEL6	SVENSKA HANDELSBANKEN NY YCD FRN SOFR	Negotiable CD	14,300,000	2/21/2025
Payden	83050P5X3	SKANDINAVISKA BK YCD FRN SOFRRATE	Negotiable CD	15,000,000	3/7/2025
Payden	13068BLB1	CA STATE GO/ULT CP TXB	Municipal Securities	12,625,000	7/2/2024
Payden	54466DBE4	CA LOS ANGELES WASTEWATER CP TXB	Municipal Securities	10,750,000	7/10/2024
Payden	54270XDS3	NY LONG ISLAND POWER AUTH CP TXB	Municipal Securities	7,500,000	9/10/2024
Payden	20772KJW0	CT STATE OF CONNECTICUT GO/ULT TXB	Municipal Securities	210,000	7/1/2024
Payden	284035AC6	CA CITY OF EL SEGUNDO POBS TXB	Municipal Securities	500,000	7/1/2024
Payden	664845EA8	CA NORTHERN CA PUB POWER TXB	Municipal Securities	410,000	7/1/2024
Payden	842475P66	CA SOUTHERN CA PUBLIC POWER TXB	Municipal Securities	900,000	7/1/2024
Payden	212204JE2	CA CONTRA COSTA CCD GO/ULT TXB	Municipal Securities	170,000	8/1/2024
Payden	223093VM4	CA COVINA-VALLEY USD GO/ULT TXB	Municipal Securities	250,000	8/1/2024

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Payden	365298Y51	CA GARDEN GROVE USD GO/ULT TXB	Municipal Securities	395,000	8/1/2024
Payden	378460YD5	CA GLENDALE USD GO/ULT TXB	Municipal Securities	250,000	9/1/2024
Payden	798736AW4	CA SAN LUIS WESTLANDS WTR DIST TXB	Municipal Securities	410,000	9/1/2024
Payden	861398CH6	CA STOCKTON PFA WTR REV-GREEN-TXB	Municipal Securities	300,000	10/1/2024
Payden	544587Y44	CA LOS ANGELES MUNI IMPT CORP LEASE TXB	Municipal Securities	500,000	11/1/2024
Payden	13080SZL1	CA STWD CMTY DEV AUTH REV-CAISO-TXB	Municipal Securities	750,000	2/1/2025
Payden	672211BM0	CA OAKLAND-ALAMEDA COLISEUM AUTH-TXBL	Municipal Securities	925,000	2/1/2025
Payden	64990FD43	NY STATE DORM AUTH PERS INC TAX TXB	Municipal Securities	680,000	3/15/2025
Payden	91412HFM0	CA UNIVERSITY OF CALIFORNIA TXB	Municipal Securities	750,000	5/15/2025
Payden	088006JZ5	CA BEVERLY HILLS PFA LEASE REV TXB	Municipal Securities	670,000	6/1/2025
Payden	13034AN55	CA INFRA & ECON BANK-SCRIPPS TXB	Municipal Securities	500,000	7/1/2025
Payden	3582326T8	CA FRESNO USD GO/ULT TXB	Municipal Securities	600,000	8/1/2025
Payden	672325M95	CA OAKLAND USD GO/ULT TXB	Municipal Securities	420,000	8/1/2025
Payden	5445872T4	CA LOS ANGELES MUNI IMPT CORP LEASE TXB	Municipal Securities	360,000	11/1/2025
Payden	20772KQJ1	CT STATE GO/ULT TXB	Municipal Securities	640,000	6/15/2026
Payden	576004HD0	MA ST SPL OBLG REV-SOCIAL TXB	Municipal Securities	440,000	7/15/2027
NEAM	54438CYK2	LOS ANGELES CA CMNTY CLG DIST	Municipal Securities	1,100,000	8/1/2025
NEAM	969268DG3	WILLIAM S HART CA UNION HIGH S	Municipal Securities	2,350,000	8/1/2025
NEAM	576000ZE6	MASSACHUSETTS ST SCH BLDG AUTH	Municipal Securities	5,000,000	8/15/2025
NEAM	13063D3A4	CALIFORNIA ST	Municipal Securities	1,000,000	10/1/2026
Payden	3137FBUC8	FHMS KF38 A	Mortgage-Backed Security	21,542	9/25/2024
Payden	3137FVNA6	FHMS KI06 A 1MOFRN CMBS	Mortgage-Backed Security	101,572	3/25/2025
Payden	3136ANLN5	FNA 2015-M6 FA	Mortgage-Backed Security	2,184,073	1/25/2026
Payden	3137H3KA9	FHMS KI07 A SOFRFRN	Mortgage-Backed Security	6,950,000	9/25/2026
Payden	3137H4RC6	FHMS KI08 A 1MOFRN CMBS	Mortgage-Backed Security	2,286,612	10/25/2026
Payden	3137FCK52	FHMS KS09 A	Mortgage-Backed Security	12,791,662	10/25/2027
NEAM	458140BP4	INTEL CORP	Corporate Security	2,500,000	3/25/2025
NEAM	341081FZ5	FLORIDA POWER & LIGHT CO	Corporate Security	2,500,000	4/1/2025
NEAM	369550BK3	GENERAL DYNAMICS CORP	Corporate Security	5,000,000	4/1/2025
NEAM	438516CB0	HONEYWELL INTERNATIONAL	Corporate Security	5,000,000	6/1/2025
NEAM	29157TAC0	EMORY UNIVERSITY	Corporate Security	1,000,000	9/1/2025
NEAM	29157TAC0	EMORY UNIVERSITY	Corporate Security	3,305,000	9/1/2025
NEAM	68233JBZ6	ONCOR ELECTRIC DELIVERY	Corporate Security	3,000,000	10/1/2025
NEAM	64952WDW0	NEW YORK LIFE GLOBAL FDG	Corporate Security	5,000,000	1/15/2026
NEAM	64952WDW0	NEW YORK LIFE GLOBAL FDG	Corporate Security	5,000,000	1/15/2026
NEAM	927804FU3	VIRGINIA ELEC & POWER CO	Corporate Security	5,000,000	1/15/2026
NEAM	06406RAQ0	BANK OF NY MELLON CORP	Corporate Security	5,000,000	1/28/2026
NEAM	74005PBQ6	LINDE INC/CT	Corporate Security	2,250,000	1/30/2026
NEAM	037833BY5	APPLE INC	Corporate Security	1,500,000	2/23/2026

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NEAM	20030NBS9	COMCAST CORP	Corporate Security	3,500,000	3/1/2026
NEAM	14913R2K2	CATERPILLAR FINL SERVICE	Corporate Security	5,000,000	3/2/2026
NEAM	74456QCF1	PUBLIC SERVICE ELECTRIC	Corporate Security	4,000,000	3/15/2026
NEAM	74456QCF1	PUBLIC SERVICE ELECTRIC	Corporate Security	5,000,000	3/15/2026
NEAM	90320WAF0	UPMC	Corporate Security	1,000,000	4/15/2026
NEAM	95000U2N2	WELLS FARGO & COMPANY	Corporate Security	2,000,000	4/30/2026
NEAM	95000U2N2	WELLS FARGO & COMPANY	Corporate Security	5,000,000	4/30/2026
NEAM	95000U2N2	WELLS FARGO & COMPANY	Corporate Security	3,000,000	4/30/2026
NEAM	459200JZ5	IBM CORP	Corporate Security	1,250,000	5/15/2026
NEAM	57629WDE7	MASSMUTUAL GLOBAL FUNDIN	Corporate Security	5,000,000	7/16/2026
NEAM	61761J3R8	MORGAN STANLEY	Corporate Security	3,000,000	7/27/2026
NEAM	931142ER0	WALMART INC	Corporate Security	5,000,000	9/17/2026
NEAM	46625HRV4	JPMORGAN CHASE & CO	Corporate Security	3,500,000	10/1/2026
NEAM	743756AB4	PROV ST JOSEPH HLTH OBL	Corporate Security	1,500,000	10/1/2026
NEAM	26884ABF9	ERP OPERATING LP	Corporate Security	1,252,000	11/1/2026
NEAM	025816CM9	AMERICAN EXPRESS CO	Corporate Security	5,000,000	11/4/2026
NEAM	641062AV6	NESTLE HOLDINGS INC	Corporate Security	5,000,000	1/14/2027
NEAM	756109AS3	REALTY INCOME CORP	Corporate Security	3,750,000	1/15/2027
NEAM	31677QBR9	FIFTH THIRD BANK	Corporate Security	5,000,000	2/1/2027
NEAM	771196BV3	ROCHE HOLDINGS INC	Corporate Security	5,000,000	3/10/2027
NEAM	771196BV3	ROCHE HOLDINGS INC	Corporate Security	2,500,000	3/10/2027
NEAM	29736RAJ9	ESTEE LAUDER CO INC	Corporate Security	1,500,000	3/15/2027
NEAM	20030NDK4	COMCAST CORP	Corporate Security	2,500,000	4/1/2027
NEAM	10373QAZ3	BP CAP MARKETS AMERICA	Corporate Security	5,000,000	4/14/2027
NEAM	437076CN0	HOME DEPOT INC	Corporate Security	2,750,000	4/15/2027
NEAM	437076CN0	HOME DEPOT INC	Corporate Security	2,000,000	4/15/2027
NEAM	907818EP9	UNION PACIFIC CORP	Corporate Security	1,000,000	4/15/2027
NEAM	46647PCB0	JPMORGAN CHASE & CO	Corporate Security	2,500,000	4/22/2027
NEAM	91159HHR4	US BANCORP	Corporate Security	7,000,000	4/27/2027
NEAM	904764AY3	UNILEVER CAPITAL CORP	Corporate Security	7,500,000	5/5/2027
NEAM	67021CAM9	NSTAR ELECTRIC CO	Corporate Security	1,000,000	5/15/2027
NEAM	67021CAM9	NSTAR ELECTRIC CO	Corporate Security	2,500,000	5/15/2027
NEAM	74456QBS4	PUBLIC SERVICE ELECTRIC	Corporate Security	1,500,000	5/15/2027
NEAM	927804GH1	VIRGINIA ELEC & POWER CO	Corporate Security	3,100,000	5/15/2027
NEAM	59217GFB0	MET LIFE GLOB FUNDING I	Corporate Security	3,500,000	6/30/2027
NEAM	61747YEC5	MORGAN STANLEY	Corporate Security	2,000,000	7/20/2027
NEAM	06051GJS9	BANK OF AMERICA CORP	Corporate Security	5,000,000	7/22/2027
NEAM	458140BY5	INTEL CORP	Corporate Security	5,000,000	8/5/2027
NEAM	14913R3A3	CATERPILLAR FINL SERVICE	Corporate Security	2,500,000	8/12/2027

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NEAM	756109BG8	REALTY INCOME CORP	Corporate Security	5,000,000	8/15/2027
NEAM	010392FY9	ALABAMA POWER CO	Corporate Security	5,000,000	9/1/2027
NEAM	010392FY9	ALABAMA POWER CO	Corporate Security	2,000,000	9/1/2027
NEAM	89236TKJ3	TOYOTA MOTOR CREDIT CORP	Corporate Security	3,000,000	9/20/2027
NEAM	539830BV0	LOCKHEED MARTIN CORP	Corporate Security	5,000,000	11/15/2027
NEAM	278865BP4	ECOLAB INC	Corporate Security	5,000,000	1/15/2028
NEAM	756109BH6	REALTY INCOME CORP	Corporate Security	2,500,000	1/15/2028
NEAM	69353RFJ2	PNC BANK NA	Corporate Security	3,000,000	1/22/2028
NEAM	882508BV5	TEXAS INSTRUMENTS INC	Corporate Security	5,000,000	2/15/2028
NEAM	91324PEP3	UNITEDHEALTH GROUP INC	Corporate Security	5,000,000	2/15/2028
NEAM	210518DS2	CONSUMERS ENERGY CO	Corporate Security	3,000,000	3/1/2028
NEAM	210518DS2	CONSUMERS ENERGY CO	Corporate Security	1,650,000	3/1/2028
NEAM	04636NAF0	ASTRAZENECA FINANCE LLC	Corporate Security	5,000,000	3/3/2028
NEAM	49177JAF9	KENVUE INC	Corporate Security	1,000,000	3/22/2028
NEAM	49177JAF9	KENVUE INC	Corporate Security	1,000,000	3/22/2028
NEAM	58769JAG2	MERCEDES-BENZ FIN NA	Corporate Security	2,000,000	3/30/2028
NEAM	02361DAS9	AMEREN ILLINOIS CO	Corporate Security	2,500,000	5/15/2028
NEAM	29736RAS9	ESTEE LAUDER CO INC	Corporate Security	3,000,000	5/15/2028
NEAM	29736RAS9	ESTEE LAUDER CO INC	Corporate Security	2,500,000	5/15/2028
NEAM	68233JCQ5	ONCOR ELECTRIC DELIVERY	Corporate Security	1,000,000	5/15/2028
NEAM	74153WCS6	PRICOA GLOBAL FUNDING 1	Corporate Security	5,000,000	5/30/2028
NEAM	440452AH3	HORMEL FOODS CORP	Corporate Security	1,000,000	6/3/2028
NEAM	440452AH3	HORMEL FOODS CORP	Corporate Security	1,600,000	6/3/2028
NEAM	38141GWL4	GOLDMAN SACHS GROUP INC	Corporate Security	10,000,000	6/5/2028
NEAM	02665WEM9	AMERICAN HONDA FINANCE	Corporate Security	1,000,000	7/7/2028
NEAM	02665WEM9	AMERICAN HONDA FINANCE	Corporate Security	3,000,000	7/7/2028
NEAM	24422EXB0	JOHN DEERE CAPITAL CORP	Corporate Security	5,000,000	7/14/2028
NEAM	46647PDG8	JPMORGAN CHASE & CO	Corporate Security	5,000,000	7/25/2028
NEAM	883556CK6	THERMO FISHER SCIENTIFIC	Corporate Security	5,000,000	10/15/2028
NEAM	29379VBT9	ENTERPRISE PRODUCTS OPER	Corporate Security	5,000,000	10/16/2028
NEAM	771196CF7	ROCHE HOLDINGS INC	Corporate Security	2,000,000	11/13/2028
NEAM	00287YBF5	ABBVIE INC	Corporate Security	7,000,000	11/14/2028
NEAM	59217GFR5	MET LIFE GLOB FUNDING I	Corporate Security	5,000,000	1/8/2029
NEAM	59217GFR5	MET LIFE GLOB FUNDING I	Corporate Security	2,500,000	1/8/2029
NEAM	58769JAR8	MERCEDES-BENZ FIN NA	Corporate Security	5,000,000	1/11/2029
NEAM	24422EXH7	JOHN DEERE CAPITAL CORP	Corporate Security	2,500,000	1/16/2029
NEAM	91159HJK7	US BANCORP	Corporate Security	5,000,000	2/1/2029
NEAM	210518DV5	CONSUMERS ENERGY CO	Corporate Security	2,000,000	2/15/2029
NEAM	110122EF1	BRISTOL-MYERS SQUIBB CO	Corporate Security	5,000,000	2/22/2029

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NEAM	875127BM3	TAMPA ELECTRIC CO	Corporate Security	5,000,000	3/1/2029
NEAM	64105MAA9	NESTLE CAPITAL CORP	Corporate Security	1,500,000	3/12/2029
NEAM	10373QBX7	BP CAP MARKETS AMERICA	Corporate Security	4,500,000	4/10/2029
NEAM	89236TMF9	TOYOTA MOTOR CREDIT CORP	Corporate Security	3,500,000	5/16/2029
NEAM	210518DW3	CONSUMERS ENERGY CO	Corporate Security	2,750,000	5/30/2029
NEAM	24422EXT1	JOHN DEERE CAPITAL CORP	Corporate Security	4,000,000	6/11/2029
NEAM	437076DC3	HOME DEPOT INC	Corporate Security	1,750,000	6/25/2029
Payden	71708EG17	PFIZER CP 144A	Commercial Paper	20,000,000	7/1/2024
Payden	63763PG52	NATL SEC CLEARING CP 144A	Commercial Paper	25,000,000	7/5/2024
Payden	29101AG81	EMERSON ELECTRIC CP 144A	Commercial Paper	25,000,000	7/8/2024
Payden	59515MG82	MICROSOFT CP 144A	Commercial Paper	27,037,000	7/8/2024
Payden	60682WG85	MITSUBISHI UFJ TRUST & BANK 144A CP	Commercial Paper	20,000,000	7/8/2024
Payden	42786TGA0	HERYSHEY CO CP 144A	Commercial Paper	20,000,000	7/10/2024
Payden	58768JGA0	MERCEDES-BENZ CP 144A	Commercial Paper	40,000,000	7/10/2024
Payden	49177FGC8	KENVUE CP 144A	Commercial Paper	25,000,000	7/12/2024
Payden	43851TGF7	HONEYWELL INTL CP 144A	Commercial Paper	44,000,000	7/15/2024
Payden	63763PGF0	NATL SEC CLEARING CP 144A	Commercial Paper	5,521,000	7/15/2024
Payden	63763PGH6	NATL SEC CLEARING CP 144A	Commercial Paper	20,000,000	7/17/2024
Payden	57167EGJ1	MARS INC CP 144A	Commercial Paper	40,000,000	7/18/2024
Payden	6698M4GK2	NOVARTIS FINANCE CP 144A	Commercial Paper	20,000,000	7/19/2024
Payden	69372AGN6	PACCAR FINANCIAL CP	Commercial Paper	20,000,000	7/22/2024
Payden	43707LGP8	HOME DEPOT CP 144A	Commercial Paper	12,150,000	7/23/2024
Payden	82619TGX9	SIEMENS CAPITAL CP 144A	Commercial Paper	18,055,000	7/31/2024
Payden	43707LH51	HOME DEPOT CP 144A	Commercial Paper	7,500,000	8/5/2024
Payden	71708EH57	PFIZER CP 144A	Commercial Paper	10,000,000	8/5/2024
Payden	58768JHG6	MERCEDES-BENZ CP 144A	Commercial Paper	6,500,000	8/16/2024
Payden	55078TJD0	LVMH MOET HENNESSY LOUIS CP 144A	Commercial Paper	25,000,000	9/13/2024
Payden	09659BJR2	BNP PARIBAS NY CP	Commercial Paper	30,000,000	9/25/2024
Payden	04033GAA5	ARIFL 2023-B A1 FLEET 144A	Asset-Backed Security	409,614	10/15/2024
Payden	44328UAA4	HPEFS 2023-2A A1 EQP 144A	Asset-Backed Security	727,251	10/18/2024
Payden	12511QAA7	CCG 2023-2 A1 EQP 144A	Asset-Backed Security	991,262	11/14/2024
Payden	34535EAA0	FORDO 2024-A A1 CAR	Asset-Backed Security	2,604,688	4/15/2025
Payden	65480LAD7	NALT 2022-A A3 LEASE	Asset-Backed Security	291,499	5/15/2025
Payden	23346MAA4	DLLAD 2024-1A A1 EQP 144A	Asset-Backed Security	3,759,690	5/20/2025
Payden	29375RAA4	EFF 2024-2 A1 FLEET 144A	Asset-Backed Security	4,157,302	5/20/2025
Payden	362541AB0	GMALT 2023-1 A2A LEASE	Asset-Backed Security	142,271	6/20/2025
Payden	89231CAB3	TAOT 2022-C A2A CAR	Asset-Backed Security	213,516	8/15/2025
Payden	47788UAC6	JOHN DEERE 2021-A A3 EQP	Asset-Backed Security	1,147,512	9/15/2025
Payden	380130AD6	GMALT 2022-3 A3 LEASE	Asset-Backed Security	1,529,975	9/22/2025

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Payden	448979AB0	HART 2023-A A2A CAR	Asset-Backed Security	356,812	12/15/2025
Payden	23346HAB3	DLLST 2024-1A A2 EQP 144A	Asset-Backed Security	800,000	1/20/2026
Payden	78414SAC8	SBALT 2024-A A2 LEASE 144A	Asset-Backed Security	4,281,762	1/20/2026
Payden	14315FAE7	CARMX 2020-3 A4 CAR	Asset-Backed Security	781,080	3/16/2026
Payden	233874AB2	DTRT 2024-1 A2 EQP	Asset-Backed Security	3,700,000	4/15/2026
Payden	437927AB2	HAROT 2023-2 A2 CAR	Asset-Backed Security	3,915,583	4/15/2026
Payden	05592XAB6	BMWOT 2023-A A2A CAR	Asset-Backed Security	2,997,404	4/27/2026
Payden	06428AAB4	BAAT 2023-1A A2 CAR 144A	Asset-Backed Security	2,795,642	5/15/2026
Payden	44933XAB3	HART 2023-B A2A CAR	Asset-Backed Security	2,226,702	5/15/2026
Payden	44935FAD6	HART 2021-C A3 CAR	Asset-Backed Security	1,814,450	5/15/2026
Payden	362583AB2	GMCAR 2023-2 A2A CAR	Asset-Backed Security	558,566	5/18/2026
Payden	14317DAC4	CARMX 2021-3 A3 CAR	Asset-Backed Security	2,609,556	6/15/2026
Payden	448988AB1	HALST 2024-A A2A LEASE 144A	Asset-Backed Security	1,999,238	6/15/2026
Payden	36269FAB2	GMALT 2024-1 A2A LEASE	Asset-Backed Security	2,500,000	6/22/2026
Payden	88166VAB2	TESLA 2024-A A2A LEASE 144A	Asset-Backed Security	500,000	6/22/2026
Payden	98164JAB0	WOART 2023-A A2A CAR	Asset-Backed Security	1,768,432	7/15/2026
Payden	362548AD1	GMALT 2023-2 A3 LEASE	Asset-Backed Security	10,000,000	7/20/2026
Payden	05611UAB9	BMWLT 2024-1 A2A LEASE	Asset-Backed Security	3,000,000	7/27/2026
Payden	39154TCH9	GALC 2024-1 A2 EQP 144A	Asset-Backed Security	2,500,000	8/17/2026
Payden	39154TBW7	GALC 2022-1 A3 EQP 144A	Asset-Backed Security	5,000,000	9/15/2026
Payden	362554AC1	GMCAR 2021-4 A3 CAR	Asset-Backed Security	2,236,335	9/16/2026
Payden	36267KAB3	GMCAR 2023-3 A2A CAR	Asset-Backed Security	1,761,764	9/16/2026
Payden	36269WAB5	GMALT 2024-2 A2A LEASE	Asset-Backed Security	3,800,000	9/21/2026
Payden	34529NAD2	FORDL 2023-B A3 LEASE	Asset-Backed Security	10,509,000	10/15/2026
Payden	44934FAC9	HALST 2024-B A2B LEASE 144A	Asset-Backed Security	7,650,000	10/15/2026
Payden	98163CAF7	WORLD OMNI 2020-C A4 CAR	Asset-Backed Security	4,900,645	10/15/2026
Payden	501689AB9	LADAR 2024-1A A2 CAR 144A	Asset-Backed Security	2,925,538	11/16/2026
Payden	89239FAB8	TAOT 2023-D A2A CAR	Asset-Backed Security	3,547,950	11/16/2026
Payden	78437VAC4	SBALT 2024-B A2 LEASE 144A	Asset-Backed Security	5,100,000	11/20/2026
Payden	881943AC8	TEVT 2023-1 A2B CAR 144A	Asset-Backed Security	5,100,000	12/21/2026
Payden	92866EAB5	VWALT 2024-A A2A LEASE	Asset-Backed Security	2,800,000	12/21/2026
Payden	92867WAB4	VALET 2023-1 A2A CAR	Asset-Backed Security	990,445	12/21/2026
Payden	14687TAD9	CRVNA 2021-P2 A4 CAR	Asset-Backed Security	2,810,000	1/10/2027
Payden	14687KAC0	CRVNA 2021-P4 A3 CAR	Asset-Backed Security	6,790,064	1/11/2027
Payden	44918CAB8	HART 2023-C A2A CAR	Asset-Backed Security	1,824,330	1/15/2027
Payden	36268GAC9	GMCAR 2024-1 A2B CAR	Asset-Backed Security	1,300,000	2/16/2027
Payden	58770JAC8	MBALT 2024-A A2B LEASE	Asset-Backed Security	3,000,000	2/16/2027
Payden	96042UAB7	WLAKE 2023-P1 A2 CAR 144A	Asset-Backed Security	4,422,940	2/16/2027
Payden	14318WAB3	CARMX 2024-A2A CAR	Asset-Backed Security	2,200,000	3/15/2027

LA Care Securities Holdings

as of June 30, 2024

Porfolio	CUSIP/Identifier	Security	Type	Par	Maturity date
Payden	505920AB4	LADAR 2024-2A A2 CAR 144A	Asset-Backed Security	7,300,000	3/15/2027
Payden	379931AB4	GMCAR 2024-2 A2A CAR	Asset-Backed Security	8,500,000	3/16/2027
Payden	14318MAD1	CARMX 2022-3 A3 CAR	Asset-Backed Security	12,345,505	4/15/2027
Payden	448973AB3	HART 20024-A A2A CAR	Asset-Backed Security	3,700,000	4/15/2027
Payden	16144BAB4	CHAOT 2024-1A A2 CAR 144A	Asset-Backed Security	2,600,000	4/26/2027
Payden	14319EAC0	CARMX 2024-2 A2A CAR	Asset-Backed Security	4,200,000	5/17/2027
Payden	78435VAB8	SFAST 2024-1A A2 CAR 144A	Asset-Backed Security	2,701,268	6/21/2027
Payden	14688NAB5	CRVNA 2024-P1 A2 CAR 144A	Asset-Backed Security	3,900,000	8/10/2027
Payden	23346MAB2	DLLAD 2024-1A A2 EQP 144A	Asset-Backed Security	5,900,000	8/20/2027
Payden	55318CAB0	MMAF 2024-A A2 EQP 144A	Asset-Backed Security	2,400,000	9/13/2027
Payden	14318DAC3	CARMX 2023-1 A3 CAR	Asset-Backed Security	6,600,000	10/15/2027
Payden	98163TAD5	WOART 2022-C A3 CAR	Asset-Backed Security	9,500,000	10/15/2027
Payden	17305EGX7	CCCIT 2023-A2 A2 CARD	Asset-Backed Security	5,000,000	12/8/2027
Payden	92348KCM3	VZMT 2024-1 A1B PHONE	Asset-Backed Security	1,900,000	12/20/2028
Payden	29375CAB5	EFF 2023-1 A2 FLEET 144A	Asset-Backed Security	9,047,066	1/22/2029
Payden	92348KAZ6	VZMT 2022-6 A PHONE	Asset-Backed Security	10,000,000	1/22/2029
Payden	361886DB7	GFORT 2024-1A A2 FLOORPLAN 144A	Asset-Backed Security	1,400,000	3/15/2029
Payden	34528QJB1	FORDF 2024-1 A2 FLOORPLAN 144A	Asset-Backed Security	10,000,000	4/15/2029
Payden	50117XAE2	KUBOTA 2021-2A A3 EQP 144A	Asset-Backed Security	313,344	11/17/2025
Payden	14314QAC8	CARMX 2021-2 A3 AUTO	Asset-Backed Security	160,619	2/17/2026
Payden	380149AC8	GMCAR 2021-2 A3 CAR	Asset-Backed Security	40,521	4/16/2026
Payden	14317DAC4	CARMX 2021-3 A3 CAR	Asset-Backed Security	330,544	6/15/2026
Payden	379929AD4	GMALT 2023-3 A3 LEASE	Asset-Backed Security	300,000	11/20/2026
Payden	05611UAD5	BMWLT 2024-1 A3 LEASE	Asset-Backed Security	700,000	3/25/2027
Payden	17305EGW9	CCCIT 2023-A1 A1 CARD	Asset-Backed Security	450,000	12/8/2027
Payden	500945AC4	KCOT 2023-2A A3 EQP 144A	Asset-Backed Security	500,000	1/18/2028
Payden	58770JAD6	MBALT 2024-A A3 LEASE	Asset-Backed Security	700,000	1/18/2028
Payden	43815QAC1	HAROT 2023-3 A3 CAR	Asset-Backed Security	250,000	2/18/2028
Payden	477920AC6	JDOT 2023-B A3 EQP	Asset-Backed Security	750,000	3/15/2028
Payden	98163QAE9	WOART 2022-B A3 CAR	Asset-Backed Security	500,000	3/15/2028
Payden	14319BAC6	CARMX 2023-3 A3 CAR	Asset-Backed Security	800,000	5/15/2028
Payden	344930AD4	FORDO 2023-B A3 CAR	Asset-Backed Security	600,000	5/15/2028
Payden	34528QHV9	FORDF 2023-1 A1 FLOOR 144A	Asset-Backed Security	900,000	5/15/2028
Payden	06054YAC1	BAAT 2023-2A A3 CAR 144A	Asset-Backed Security	700,000	6/15/2028
Payden	14044EAD0	COPAR 2023-2 A3 CAR	Asset-Backed Security	700,000	6/15/2028
Payden	361886CR3	GFORT 2023-1 A1 FLOOR 144A	Asset-Backed Security	900,000	6/15/2028
Payden	14318XAC9	CARMX 2023-4 A3 CAR	Asset-Backed Security	800,000	7/17/2028
Payden	89239FAD4	TAOT 2023-D A3 CAR	Asset-Backed Security	400,000	8/15/2028
Payden	63938PBU2	NAVMT 2023-1 A FLOOR 144A	Asset-Backed Security	200,000	8/25/2028

LA Care Securities Holdings

as of June 30, 2024

Porfolio	CUSIP/Identifier	Security	Type	Par	Maturity date
Payden	344940AD3	FORDO 2023-C A3 CAR	Asset-Backed Security	500,000	9/15/2028
Payden	14318WAD9	CARMX 2024-A3 CAR	Asset-Backed Security	600,000	10/16/2028
Payden	44918CAD4	HART 2023-C A3 CAR	Asset-Backed Security	300,000	10/16/2028
Payden	05522RDH8	BACCT 2023-A2 A2 CARD	Asset-Backed Security	500,000	11/15/2028
Payden	09709AAC6	BAAT 2024-1A A3 CAR 144A	Asset-Backed Security	1,000,000	11/15/2028
Payden	47800RAD5	JDOT 2024-A A3 EQP	Asset-Backed Security	700,000	11/15/2028
Payden	36268GAD7	GMCAR 2024-1 A3 CAR	Asset-Backed Security	400,000	12/18/2028
Payden	65479VAB2	NMOTR 2024-B A FLOORPLAN 144A	Asset-Backed Security	600,000	2/15/2029
Payden	47786WAD2	JDOT 2024-B A3 EQP	Asset-Backed Security	700,000	3/15/2029
Payden	34528QJA3	FORDF 2024-1 A1 FLOORPLAN 144A	Asset-Backed Security	900,000	4/15/2029
Payden	63938PBW8	NAVMT 2024-1 A FLOOR 144A	Asset-Backed Security	400,000	4/25/2029

Local Agency Investment Fund
P.O. Box 942809
Sacramento, CA 94209-0001
(916) 653-3001

July 01, 2024

LAIF Home
PMIA Average Monthly Yields

LOCAL INITIATIVE HEALTH AUTHORITY
FOR LOS ANGELES COUNTY
DIRECTOR, ACCOUNTING SERVICES
1055 WEST 7TH STREET, 10TH FLOOR
LOS ANGELES, CA 90017

Tran Type Definitions

June 2024 Statement

Account Summary

Total Deposit:	0.00	Beginning Balance:	5,568,004.05
Total Withdrawal:	0.00	Ending Balance:	5,568,004.05

COUNTY OF LOS ANGELES
TREASURER AND TAX COLLECTOR

Kenneth Hahn Hall of Administration
500 West Temple Street, Room 462
Los Angeles, California 90012
Telephone: (213) 584-1571 Fax: (213) 626-1701
ttc.lacounty.gov and propertytax.lacounty.gov

ELIZABETH BUENROSTRO GINSBERG
TREASURER AND TAX COLLECTOR

Board of Supervisors

HILDA L. SOLIS
First District

HOLLY J. MITCHELL
Second District

LINDSEY P. HORVATH
Third District

JANICE HAHN
Fourth District

KATHRYN BARGER
Fifth District

July 9, 2024

L.A. Care Health Plan
1055 West 7th Street, 10th Floor
Los Angeles, California 90017

MONTHLY eCAPS REPORT

Attached please find for your review and reference, the Balance Sheet Detail Activity by Fund report from eCAPS for the month ended June 30, 2024.

Should you have any questions, you may contact Marivic Liwag, Assistant Operations Chief, of my staff at (213) 584-1252 or mliwag@ttc.lacounty.gov.

Very truly yours,

ELIZABETH BUENROSTRO GINSBERG
Treasurer and Tax Collector

Jennifer Koai
Operations Chief

JK:ML:mn

Attachments

Balance Sheet Detail Activity By Fund

June 1, 2024 - June 30, 2024

Fiscal Year: 2024 **Fiscal Period:** 12
Fund Class: TT15 TTC-ICG LAPIF

Balance Sheet Category	Balance Sheet Class	Balance Sheet Account	Record Date	Document	Description	Beginning Balance	Debits	Credits	Ending Balance
Asset									
1A Pooled Cash & Investments									
	100 Cash								
		1000 Cash							
						10,270,956.98	0.00	0.00	10,270,956.98
			06/01/2024	JVA AC IA052400029 86	INTEREST ALLOCATION FOR THE MONTH ENDING May 31, 2024	0.00	242,205.08	0.00	10,513,162.06
		Total for 1000 Cash				**$10,270,956.98**	**$242,205.08**	**$0.00**	**$10,513,162.06**
	Total for 100 Cash					**$10,270,956.98**	**$242,205.08**	**$0.00**	**$10,513,162.06**
Total for 1A Pooled Cash & Investments						**$10,270,956.98**	**$242,205.08**	**$0.00**	**$10,513,162.06**
Total for Asset						**$10,270,956.98**	**$242,205.08**	**$0.00**	**$10,513,162.06**
Total for Los Angeles Care Health Plan						**$10,270,956.98**	**$242,205.08**	**$0.00**	**$10,513,162.06**
Total for TT15 TTC-ICG Los Angeles County Pool Investment Fund						**$10,270,956.98**	**$242,205.08**	**$0.00**	**$10,513,162.06**

LOCAL INITIATIVE HEALTH AUTHORITY
FOR LOS ANGELES COUNTY
1055 W 7TH ST FL 10
LOS ANGELES CA 90017-2750

DATE	INVESTMENT/ REDEMPTION	INVESTMENT BALANCE	FUND RATE	ACCOUNT FEE	NET DIV RATE	DIVIDEND ACCRUED	TICKER SYMBOL
6/30/24		125,000,000.00	5.1920%	1.0000%	4.1920%	14,356.25	TSTXX

MTD TOTAL DIVIDENDS ACCRUED	369,708.30	AVG. DAILY DIVIDEND RATE	4.1793
MTD TOTAL DIVIDENDS PAID	392,403.32	AVG. DAILY INVESTMENT BAL.	107,611,133.04
YTD TOTAL DIVIDENDS PAID	1,593,937.21	TARGET BALANCE	.00

ACCRUED DIVIDENDS OF 369,708.30 WILL BE CREDITED TO DDA ACCOUNT ON 07/01/24.

TICKER SYMBOL TSTXX IS BLACKROCK LIQUIDITY FUNDS - T-FUND - INSTITUTIONAL SHARE CLASS

L.A. Care Health Plan
Quarterly Investment Compliance Report
April 1, 2024 through June 30, 2024

OVERVIEW

The California Government Code requires the L.A. Care Treasurer to submit a quarterly report detailing its investment activity for the period. This investment report covers the three-month period from April 1, 2024 through June 30, 2024.

PORTFOLIO SUMMARY

As of June 30, 2024, the market values of the portfolios managed by Payden & Rygel and New England Asset Management are as follows:

Portfolios	Payden & Rygel
Cash Portfolio #2365	*$3,179,633,733.97*
Low Duration Portfolio #2367	*$94,177,744.42*
Total Combined Portfolio	**$3,273,811,478.39**

Portfolios	NEAM
Government and Corporate Debt	**$343,721,961.80**

COMPLIANCE WITH ANNUAL INVESTMENT POLICY

Based on an independent compliance review of the Payden & Rygel and NEAM portfolios performed by Wilshire (using 3rd party data), L.A. Care is in compliance with the investment guidelines pursuant to the California Government Code and California Insurance Code. The Payden & Rygel and NEAM investment reports for L.A. Care are available upon request.

L.A. Care has invested funds in California's Local Agency Investment Fund (LAIF) and the Los Angeles County Treasurer's Pooled Investment Fund (LACPIF). In a LAIF statement dated July 1, 2024, the June 30, 2024 balance is reported as $5,568,004.05 with accrued interest of $61,482. In the LACPIF statement dated July 9, 2024, the June 30, 2024 balance is reported as $10,513,162.06. The LACPIF account balance does not reflect accrued interest.

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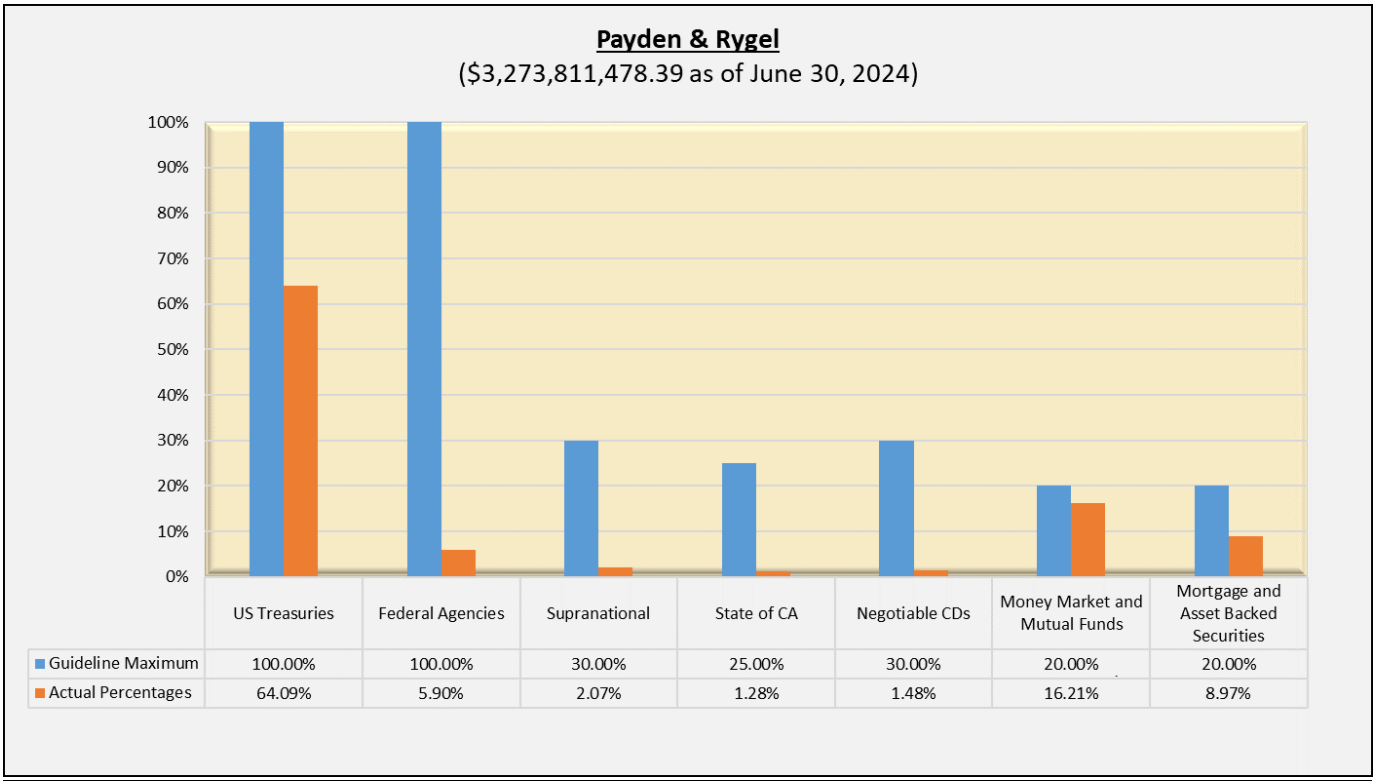
Payden & Rygel Compliance Verification

California Government Code Compliance Verification Detail as of June 30, 2024



	Maximum Permitted Maturity		Actual Maximum Maturity		Compliance
	#2365	#2367	#2365	#2367	
	Enhanced Cash	Low Duration	Enhanced Cash	Low Duration	
US Treasuries	5 Years	5 Years	1.84 Years	4.92 Years	YES
Federal Agencies	5 Years	5 Years	1.80 Years	1.63 Years	YES
Supranational	5 Years	5 Years	4.64 Years	NA	YES
State of CA	5 Years	5 Years	0.20 Years	3.05 Years	YES
Negotiable CDs	270 Days	270 Days	250 days	-	YES
Money Market and Mutual Funds	NA	NA	1 Day	1 Day	YES
Mortgage and Asset Backed Securities	5 Years	5 Years	4.80 Years	4.82 Years	YES

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Payden & Rygel Compliance Verification

Combined #2365 and #2367 Portfolios as of June 30, 2024

	Govt. Code Section 53601	Insur. Code Sections 1170-1182 1191-1202
US Treasuries	*YES (1)(2)(3)*	*YES (4)(5)*
Federal Agencies	*YES (1)(2)(3)*	*YES (4)(5)*
Supranational	*YES (1)(2)(3)*	*YES (4)(5)*
State of CA	*YES (1)(2)(3)*	*YES (4)(5)*
Negotiable CDs	*YES (1)(2)(3)*	*YES (4)(5)*
Money Market and Mutual Funds	*YES (1)(2)(3)*	*YES (4)(5)*
Mortgage and Asset Backed Securities	*YES (1)(2)(3)*	*YES (4)(5)*

(1) Approved security
(2) Meets minimum rating (A3/A-)
(3) Meets diversification maximums (max market value of issue: 5%)
(4) NAIC High Grade Obligations
(5) Authorized by Insurance Code Sections 1174 and 1194.5
(6) Authorized by Insurance Code Section 1196.1

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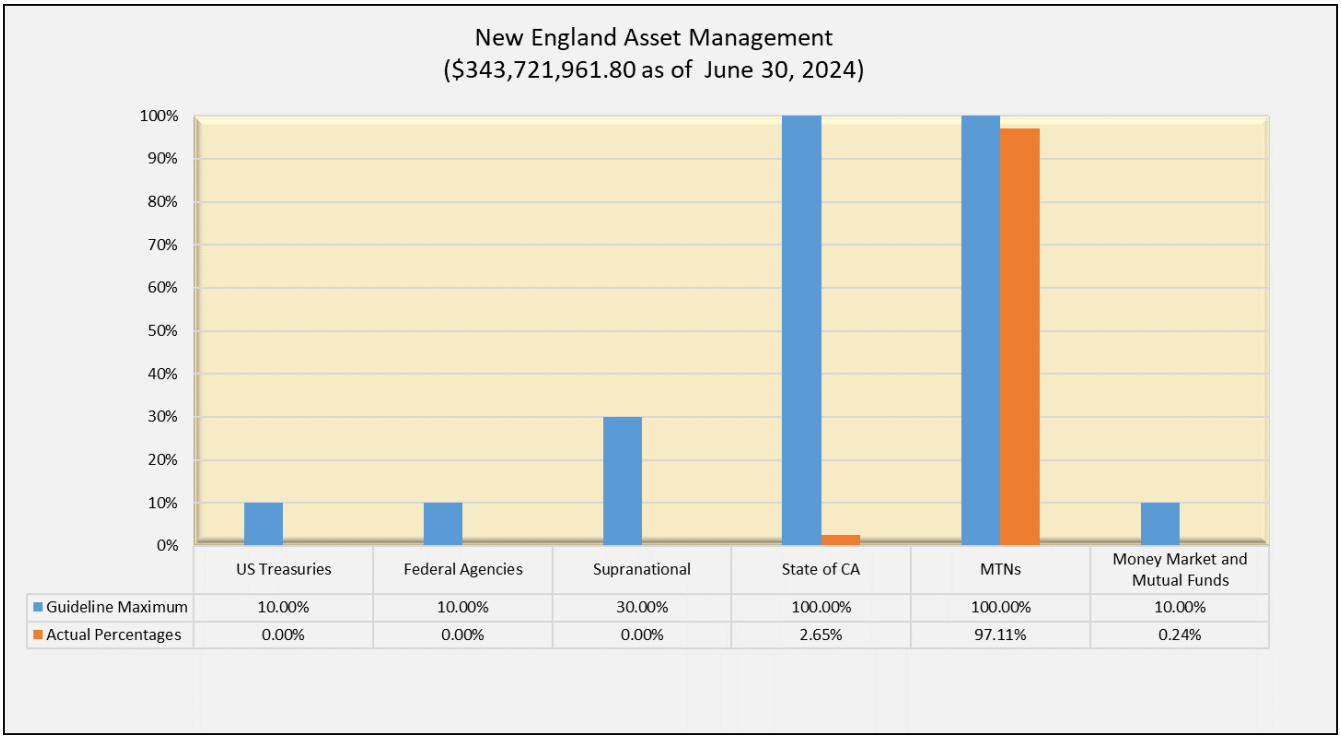
New England Asset Management Compliance Verification

California Government Code Compliance Verification Detail as of June 30, 2024



	Maximum Permitted	Actual Maximum Maturity	Compliance
	NEAM	NEAM	
US Treasuries	5 Years	-	**YES**
Federal Agencies	5 Years	-	**YES**
Supranational	5 Years	-	**YES**
State of CA	5 Years	2.26 Years	**YES**
MTNs	5 Years	4.99 Years	**YES**
Money Market and Mutual Funds	NA	1 Day	**YES**

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New England Asset Management Compliance Verification

As of June 30, 2024

	Govt. Code Section 53601	Insur. Code Sections 1170-1182 1191-1202
US Treasuries	*YES (1)(2)(3)*	*YES (4)(5)*
Federal Agencies	*YES (1)(2)(3)*	*YES (4)(5)*
Supranational	*YES (1)(2)(3)*	*YES (4)(5)*
State of CA	*YES (1)(2)(3)*	*YES (4)(5)*
MTNs	*YES (1)(2)(3)*	*YES (4)(5)*
Money Market and Mutual Funds	*YES (1)(2)(3)*	*YES (4)(5)*

(1) Approved security
(2) Meets minimum rating (A3/A-)
(3) Meets diversification maximums (max market value of issue: 5%)
(4) NAIC High Grade Obligations
(5) Authorized by Insurance Code Sections 1174 and 1194.5
(6) Authorized by Insurance Code Section 1196.1

Based on an independent review of Payden & Rygel's and New England Asset Management's month-end portfolios performed by Wilshire, L.A. Care's portfolios are compliant with its Annual Investment Guidelines, the California Government Code, and the Insurance Code sections noted above. In addition, based on the review of the latest LAIF and LACPIF reports and their respective investment guidelines, the LAIF and LACPIF investments comply with the Annual Investment Policy, the California Government Code, and the California Insurance Code.

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MARKET COMMENTARY

Economic Highlights

- **GDP**: Real GDP growth slowed during the quarter, equaling 1.4%. Consumer spending was modest, contributing 1.0% to growth, while private and government spending were both up, contributing around 1%. Imports jumped during the quarter and net exports/imports detracted from growth. The Atlanta Federal Reserve's GDPNow forecast for the second quarter of 2024 currently stands at 2.2%.
  Source: Bureau of Economic Analysis.

- **Interest Rates**: The Treasury curve was up during the second quarter. The 10-year Treasury closed at 4.40%, up 20 basis points. The 10-year real yield (i.e., net of inflation) rose 23 basis points to 2.11%. The Federal Open Market Committee (FOMC) left their overnight rate unchanged, targeting a range of 5.25% to 5.50%. The committee's current median outlook is for a rate of 5.125% by the end of 2024.
  Source: U.S. Treasury

- **Inflation**: Consumer price changes have slowed recently as the Consumer Price Index rose 0.7% for the three months ending May. For the one-year period, the CPI was up 3.3%. The 10-year breakeven inflation rate was down slightly at 2.29% in June versus 2.32% in March.
  Source: Dept. of Labor (BLS), U.S. Treasury

- **Employment**: Jobs growth has pushed higher, with an average of 249,000 jobs/month added during the three months ending in May. The unemployment rate actually ticked higher at 4.0%, up from 3.9% in February. Wage growth has picked up recently, equaling 0.4% in May.
  Source: Dept. of Labor (BLS)

U.S. Fixed Income Markets

The U.S. Treasury yield curve was up across most of the maturity spectrum during the quarter, and to a greater degree in the long end of the curve. The 10-year Treasury yield ended the quarter at 4.40%, up 20 basis points from March. Credit spreads were up during the quarter with high yield bond spreads up 10 basis points after falling below 3% in March. The Federal Open Market Committee (FOMC) met twice during the quarter, as scheduled, and left the overnight rate unchanged, targeting a range of 5.25% to 5.50%. The Fed's "dot plot" is messaging that the current expectation is for a modest decrease in rates in 2024, by -0.25% after the June meeting. Both GDP and inflation numbers have been favorable in the United States, as Fed Chair Jerome Powell said about rates, "Fortunately, we have a strong economy and we have the ability to approach this question carefully."

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QUARTERLY PORTFOLIO REVIEW

Payden&Rygel

LA CARE HEALTH PLAN

[2ND QUARTER 2024]

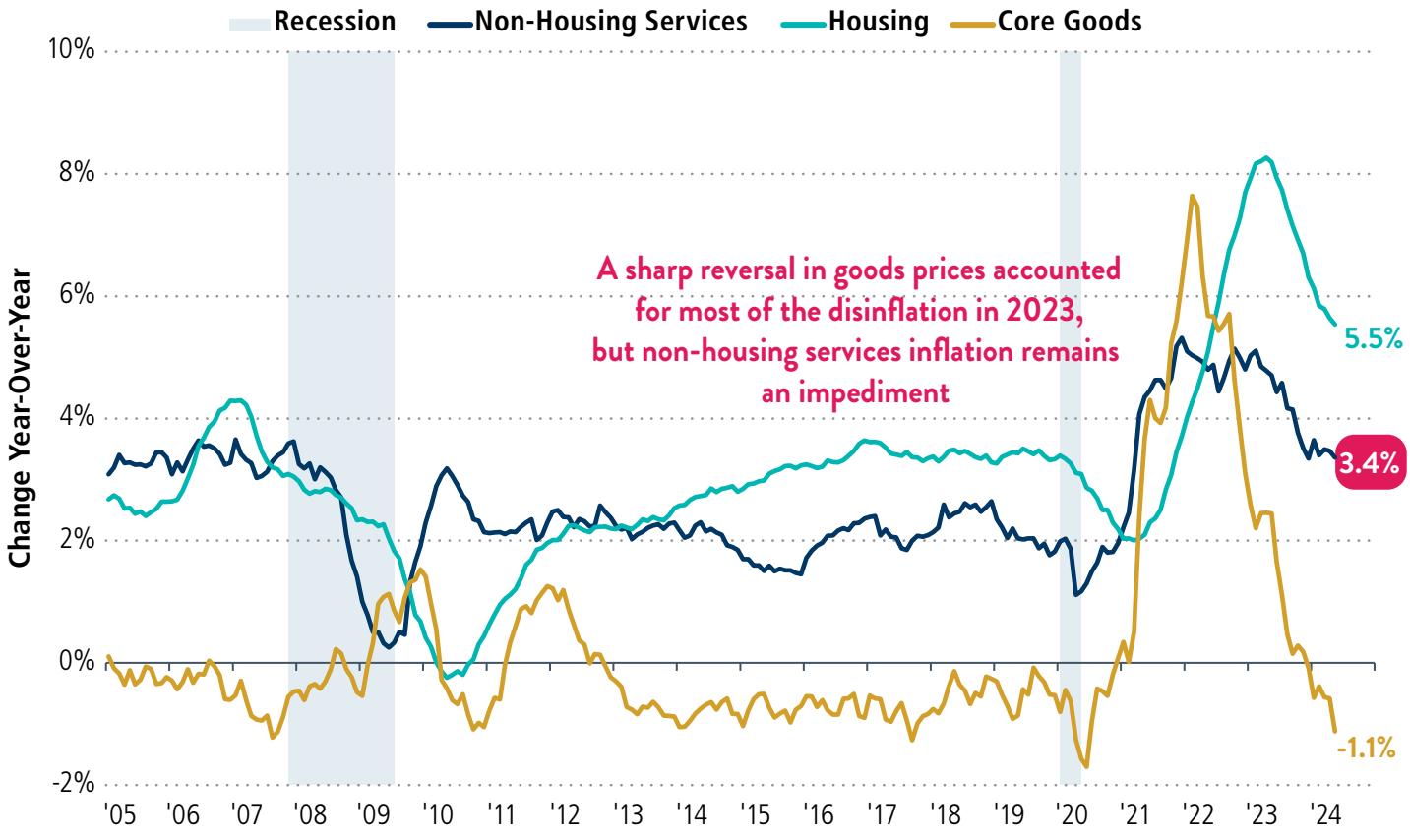
PAYDEN.COM
LOS ANGELES | BOSTON | LONDON | MILAN

MARKET MEMO | FROM THE DESK OF JOAN PAYDEN

Investors continue to assess the many crosscurrents in the global economy and capital markets.

- Although the **unemployment rate increased** to 4% in May, stellar payroll jobs growth at a three-month average pace of 249,000 per month indicates that the **U.S. labor market remains tight**.
- Meanwhile, **inflation made modest progress** in the second quarter. The core Personal Consumption Expenditures (PCE) Price Index increased at an average monthly rate of 0.23% from March to May. The year-over-year inflation reading slowed from 2.8% to 2.6% in May, but **unfavorable base effects could keep inflation readings near 3%.**
- The Fed communicated that the confidence to cut rates would necessitate **several months of target-consistent inflation readings.**
- Globally, the ECB and the BoC initiated their first rate cut in June as inflation returns to targets. Amid disparate inflation environments, **global policymakers have more room to diverge from the Fed.**

SERVICES PRICES REMAIN THE KEY BARRIER TO FURTHER PROGRESS ON INFLATION



Source: Bureau of Economic Analysis

Portfolio Review and Market Update – 2nd Quarter 2024

PORTFOLIO CHARACTERISTICS (As of 06/30/2024)

Market Value	3,273,811,478
Avg Credit Quality	AA+
Avg Duration	0.25
Avg Yield to Maturity	5.24%

SECTOR ALLOCATION

Sector	Market Value	% of Port
Cash	71,875,041	2.20%
Money Market	507,623,382	15.51%
Treasury	2,098,650,654	64.10%
Agency	193,264,522	5.90%
Government Related	68,335,740	2.09%
Credit	-	0.00%
ABS/MBS	292,178,654	8.92%
Municipal	41,883,485	1.28%
Total	3,273,811,478	100.0%

MATURITY DISTRIBUTION

Sector	Market Value	% of Port
<90 day	2,322,487,820	70.9%
90 days - 1 Year	797,923,851	24.4%
1 - 2 Years	82,671,934	2.5%
2 - 5 years	70,727,873	2.2%
Total	3,273,811,478	100%

PORTFOLIO RETURNS
Periods over one year annualized

Periods ended 06/30/2024

Performance	2nd Quarter	2024 YTD	Trailing 1 Year	Trailing 3 Year
LA Care - Short-Term Portfolio	**1.39**	**2.73**	**5.53**	**3.96**
Benchmark*	1.32	2.63	5.40	3.03
LA Care - Extended-Term Portfolio	**0.86**	**0.93**	**4.40**	**0.16**
Benchmark**	0.77	0.73	4.14	-0.44
LA Care - Combined Portfolio	**1.38**	**2.68**	**5.50**	**2.89**

* ICE BoA 91 Day Treasury Index
** Bloomberg US Govt 1-5 Yr Bond Index

L.A. CARE HEALTH PLAN SHORT TERM PORTFOLIO

Portfolio Review and Market Update – 2nd Quarter 2024

PORTFOLIO CHARACTERISTICS (As of 06/30/2024)

Market Value	3,179,633,734
Avg Credit Quality	AA+
Avg Duration	0.18
Avg Yield to Maturity	5.25%

SECTOR ALLOCATION

Sector	Market Value	% of Port
Cash	71,530,785	2.25%
Money Market	507,623,382	15.96%
Treasury	2,037,443,261	64.08%
Agency	189,126,646	5.95%
Government Related	68,335,740	2.15%
Corporate Credit	-	0.00%
ABS/MBS	274,544,657	8.63%
Municipal	31,029,264	0.98%
Total	3,179,633,734	100.0%

MATURITY DISTRIBUTION

Sector	Market Value	% of Port
<90 day	2,318,431,460	72.9%
90 days - 1 Year	792,237,919	24.9%
1 - 2 Years	63,975,191	2.0%
2 - 5 years	4,989,164	0.2%
Total	3,179,633,734	100.0%

PORTFOLIO RETURNS

Periods over one year annualized

Periods ended 06/30/2024

Performance	2nd Quarter	2024 YTD	Trailing 1 Year	Trailing 3 Year
L.A. Care - Short-Term Portfolio	**1.39**	**2.73**	**5.53**	**3.96**
Benchmark*	1.32	2.63	5.40	3.03

* ICE BofA 91 Day Treasury Index

Portfolio Review and Market Update – 2nd Quarter 2024

PORTFOLIO CHARACTERISTICS (As of 06/30/2024)

Market Value	94,177,744
Avg Credit Quality	AA+
Avg Duration	2.63
Avg Yield to Maturity	4.75%

SECTOR ALLOCATION

Sector	Market Value	% of Port
Cash	344,256	0.37%
Money Market	-	0.00%
Treasury	61,207,393	64.99%
Agency	4,137,877	4.39%
Government Related	-	0.00%
Credit	-	0.00%
ABS/MBS	17,633,997	18.72%
Municipal	10,854,221	11.53%
Total	94,177,744	100.0%

MATURITY DISTRIBUTION

Sector	Market Value	% of Port
<90 day	4,056,360	4.3%
90 days - 1 Year	5,685,932	6.0%
1 - 2 Years	18,696,743	19.9%
2 - 5 years	65,738,709	69.8%
Total	94,177,744	100%

PORTFOLIO RETURNS

Periods over one year annualized

Periods ended 06/30/2024

Performance	2nd Quarter	2024 YTD	Trailing 1 Year	Trailing 3 Year
LA Care - Extended-Term Portfolio	**0.86**	**0.93**	**4.40**	**0.16**
Benchmark**	0.77	0.73	4.14	-0.44

** Bloomberg US Govt 1-5 Yr Bond Index

[Q2] **SECTOR OUTLOOKS:**

THOUGHTS FROM OUR STRATEGISTS

Though markets welcomed recent cooling inflation data, **we remain cautious as to whether that progress can be sustained.** Our GDP growth expectations remains strong, driven by the resilient labor market and a U.S. consumer that, while not perfect, remains fundamentally sound. Market pricing indicates two rate cuts by year-end versus our one.

Equities:

THINKING OUTSIDE THE MAGNIFICENT SEVEN

- Fundamentals remain positive, but above-average valuations suggest return expectations in 2H24 may be more muted.
- Lesser-known avenues to express the artificial intelligence theme in portfolios exist in select utilities, automation companies, data centers, and semiconductors.
- In a concentrated market, active management emphasizing cash flow generation and balance sheet strength is crucial.

High Yield and Loans:

POSITIVE FUNDAMENTAL BACKDROP UNDERPINNING RETURN POTENTIAL

- Robust growth prospects and earnings have allowed high yield companies to refinance and extend maturities, improving credit fundamentals.
- Energy remains attractive, as high oil prices have allowed companies to generate significant free cash flow.
- High coupons bolstered 1H24 performance for bank loans; we remain selective in lower quality issues.

Investment Grade Corporates :

ATTRACTIVE INCOME GENERATION

- All-in yields near 5.5%, though below their recent peak, still deliver attractive income.
- We like areas poised to benefit from the constructive macroeconomic outlook and trading at compelling valuations, such as BBB technology, autos, REITs, and insurance.
- Risk-adjusted return prospects remain compelling given healthy coupons and potential price upside from possible rate cuts.

Emerging Markets:

FOCUS ON STRUCTURAL GROWTH

- Economic activity has been resilient in EM countries, with stable growth, lower inflation, and solid external accounts.
- We are most interested in countries benefiting from longer term secular growth trends, particularly in Latin America.
- Within EM corporates, we have the highest conviction in companies generating consistent cash flows, operating in fiscally and economically resilient countries, and boasting robust competitive advantages.

Securitized Sectors:

RESILIENT CONSUMER SUPPORTING SECURITIZED CREDIT

- Consumer ABS near-term collateral performance is expected to be within manageable ranges, with structures designed to delever bonds and mitigate against credit deterioration.
- Digital infrastructure sectors within commercial ABS provide ample investment opportunities at attractive spreads.
- Commercial CMBS requires a keen eye on deal selection.

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LOS ANGELES | BOSTON | LONDON | MILAN

PAYDEN.COM

OUR STRATEGIES

Multi-Sector

Short Maturity Bonds

U.S. Core Bond

Absolute Return Fixed Income

Strategic Income

Global Fixed Income

Liability Driven Investing

Sector-Specific

Emerging Markets Debt

Government/Sovereign

High Yield Bonds & Loans

Inflation-Linked/TIPS

Investment Grade Corporate Bonds

Municipal Bonds (U.S.)

Securitized Bonds

Income-Focused Equities

Equity Income

Payden&Rygel

LOS ANGELES
333 South Grand Avenue
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213 625-1900

BOSTON
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LONDON
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L.A. Care Health Plan

NEAM's L.A. Care Board Report

Data as of June 30, 2024

Please refer to last page of this presentation for important disclosures.

Table of Contents

Portfolio Summary

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L.A. Care Health Plan - Comparative Overview

	12/31/2023	3/31/2024	6/30/2024	Change since 3/31/2024
Portfolio Overview (000's Omitted)				
Book Value	344,090	346,473	348,354	1,881
Market Value	336,739	337,585	340,293	2,708
Total Unrealized Gain/Loss	(7,351)	(8,888)	(8,061)	827
Net Gains	2,793	1,256	875	(381)
Net Losses	(10,144)	(10,144)	(8,936)	1,207
Realized Gain / Loss	(1,887)	(533)	(594)	
Annualized Book Income	11,064	11,758	12,635	877
After Tax Book Income	8,741	9,289	9,982	693
Asset Types				
Cash / Cash Equivalents	0.2%	0.6%	0.2%	(0.3%)
Taxable Fixed Income	99.8%	99.4%	99.8%	0.3%
Portfolio Yields				
Book Yield (Before Tax)	3.22%	3.39%	3.63%	0.23%
Book Yield (After Tax)	2.54%	2.68%	2.87%	0.18%
Market Yield	4.69%	5.04%	5.13%	0.09%
Fixed Income Analytics				
Average OAD	2.64	2.62	2.64	0.02
Average Life	2.98	2.99	3.03	0.04
Average OAC	8.54	8.47	8.68	0.21
Average Quality	A+	A+	A+	
144A %	12.32%	15.60%	15.23%	(0.37%)
Average Purchase Yield	5.04%	4.88%	5.05%	0.17%
Average Spread Over Tsy	82	80	61	(20)
5 Year US Govt On The Run	3.83%	4.21%	4.33%	0.12%

	12/31/22	09/30/23	12/31/23	12/31/24	Change since 12/31/2023
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
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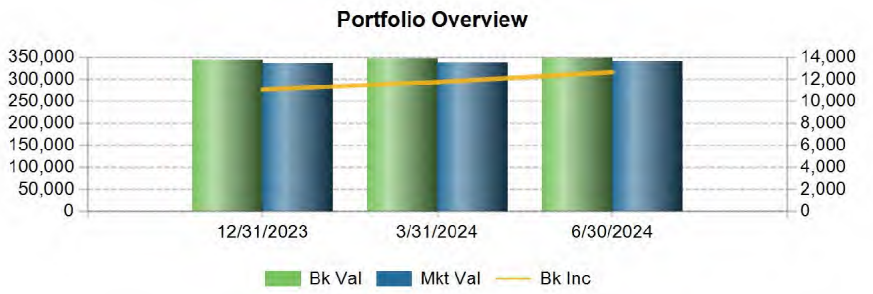

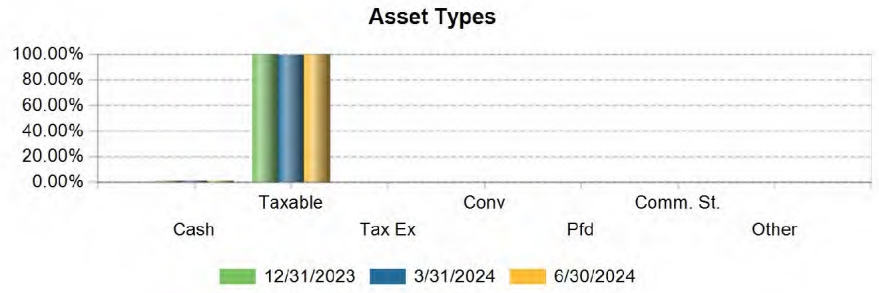

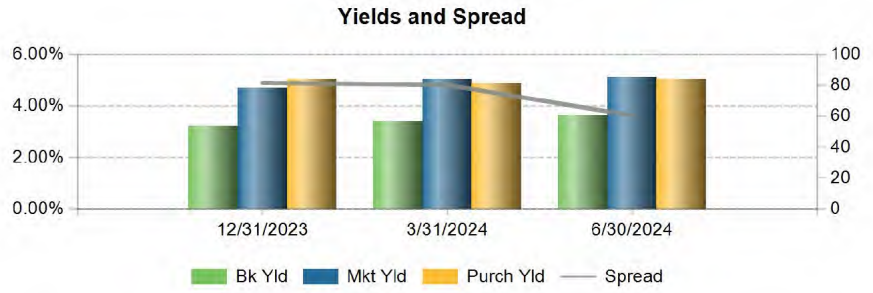

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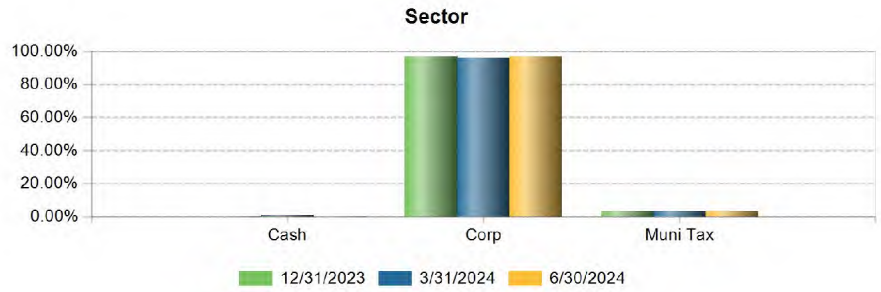
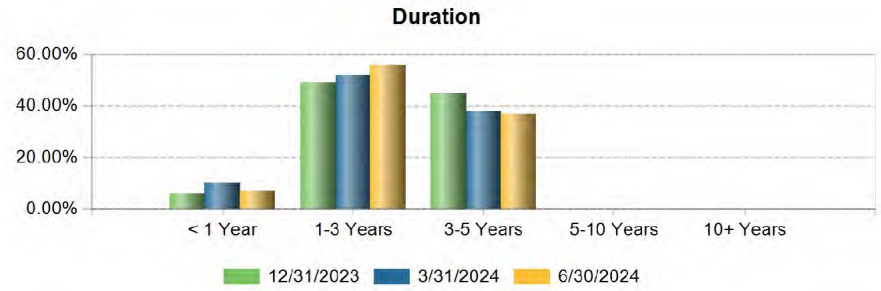
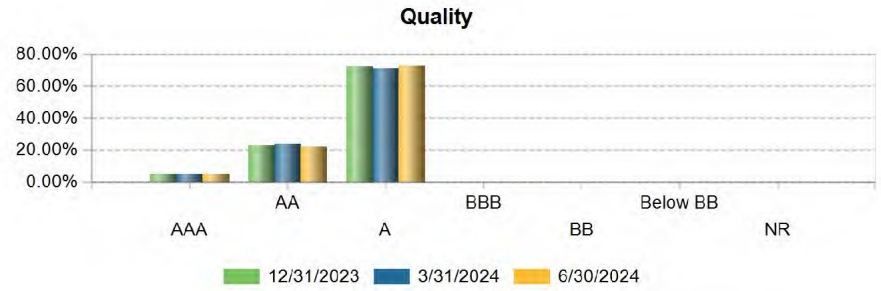
L.A. Care Health Plan - Fixed Income Summary

	12/31/2023	3/31/2024	6/30/2024	Change since 3/31/2024
Sector				
Cash & Cash Equivalents	< 1%	1%	< 1%	(1%)
Corporates	97%	96%	97%	1%
Municipals - Taxable	3%	3%	3%	-
Fixed Income	100%	100%	100%	
Duration				
< 1 Year	6%	10%	7%	(3%)
1-3 Years	49%	52%	56%	4%
3-5 Years	45%	38%	37%	(1%)
Average Duration	2.64	2.62	2.64	0.02
Quality				
AAA	5%	5%	5%	-
AA	23%	24%	22%	(2%)
A	72%	71%	73%	2%
Average Quality	A+	A+	A+	

Average Portfolio Rating at 6/30/24					
	Moody	S&P	Fitch	Lowest	Highest
Average Rating	A1	A	A+	A	A+







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Activity Report

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L.A. Care Health Plan - Transaction Summary

(000's Omitted)

Purchases	Market Value	%	Spread (Bp)	Book Yld	High	Duration
Corporates	24,752	100.0	61	5.05	A+	4.25
Total Purchases	24,752	100.0	61	5.05	A+	4.25

Sales	Market Value	%	Realized G/L	Trade / Book Yld	High	Duration
Corporates	21,356	100.0	(594)	5.58 / 1.52	A+	0.73
Total Sales	21,356	100.0	(594)	5.58 / 1.52	A+	0.73

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Performance Report

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L.A. Care Health Plan - Performance Report Not Tax Adjusted

	Jun 2024 Market*	Jun 2024	May 2024	Apr 2024	Q2	YTD	12 Month	Annualized 3 Year	Annualized 5 Year	Annualized Inception	Inc Date
LA Care HealthPlan	343,722	0.58	0.97	(0.59)	0.96	1.19	5.34	0.46	1.74	2.11	Jan 2018
Barclay Bloomberg U.S. Credit: 1-5 Yr A- or better (Highest)		0.61	0.99	(0.68)	0.91	1.36	5.40	0.14	1.42	1.93	Jan 2018
Difference		(0.03)	(0.02)	0.09	0.05	(0.17)	(0.06)	0.32	0.32	0.18	

* Market values (in 000's) include accrued income

Please see the accompanying Disclosure Page for important information regarding this Performance Exhibit.

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L.A. Care Health Plan - Performance Report Not Tax Adjusted

Disclosures

Management start date is 10/1/17 and performance start date is 1/1/18 to allow for seasoning.

The performance results reflect LA Care Health Plan's portfolio managed by NEAM. A Daily Valuation Methodology that adjusts for cash flows is utilized to calculate portfolio performance. Portfolio returns are calculated daily and geometrically linked to create monthly gross of fee rates of return. Performance results are reported gross of management fees and of custody fees and other charges by the custodian for your account and net of commissions, mark-ups or mark-downs, spreads, discounts or commission equivalents. The performance results for your account are shown in comparison to an index that has been chosen by you. The securities comprising this index are not identical to those in your account. The index is comprised of securities that are not actively managed and does not reflect the deduction of any management or other fees or expenses. Past performance is not indicative of future performance.

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Appendix

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Risk Reports

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L.A. Care Health Plan - Profile Report

Distribution by Class

	Quantity	Book	Market	Unrealized Gain/ Loss	Book Yield	OAY	OAD	OAC	Avg Life	% of Portfolio
Cash & Cash Equivalents	827,644	827,644	827,644	-	5.13	5.13	0.08	0.05	0.08	0.24
Corporates	288,907,000	284,236,125	278,561,300	(5,674,825)	3.78	5.14	2.66	8.51	3.07	81.86
144A	54,000,000	53,802,024	51,829,066	(1,972,958)	3.24	5.11	2.86	10.88	3.15	15.23
Municipals - Taxable	9,450,000	9,488,512	9,074,847	(413,664)	1.13	5.18	1.19	2.12	1.24	2.67
Total Portfolio	**353,184,644**	**348,354,305**	**340,292,857**	**(8,061,448)**	**3.63**	**5.14**	**2.64**	**8.68**	**3.03**	**100.00**

Rating Analysis - Highest

	% of Portfolio
AAA	4.88
AA	22.24
A	72.88
BBB	-
Below BBB	-
NR	-
Total Fixed Income	**100.00**
Equity	-
Total	**100.00**

Average Rating: A+

Scenario Analysis - % of Market

	-300	-200	-100	-50	+50	+100	+200	+300
Cash & Cash Equivale	0.24	0.16	0.08	0.04	(0.04)	(0.08)	(0.16)	(0.24)
Corporates	8.33	5.48	2.70	1.34	(1.32)	(2.61)	(5.14)	(7.58)
144A	9.10	5.95	2.92	1.45	(1.42)	(2.81)	(5.52)	(8.12)
Municipals - Taxable	3.66	2.42	1.20	0.60	(0.59)	(1.18)	(2.34)	(3.47)
Total Portfolio	**8.30**	**5.45**	**2.69**	**1.33**	**(1.31)**	**(2.60)**	**(5.11)**	**(7.54)**

Key Rate Duration

	Market Value	1 Year	2 Year	3 Year	5 Year	7 Year	10 Year	15 Year	20 Year	30 Year
Cash & Cash Equival	827,644	0.08	-	-	-	-	-	-	-	-
Corporates	278,561,300	0.19	0.44	1.28	0.75	< 0.00	-	-	-	-
144A	51,829,066	0.15	0.56	1.11	1.04	< 0.01	-	-	-	-
Municipals - Taxable	9,074,847	0.86	0.28	0.06	-	-	-	-	-	-
Total Portfolio	**340,292,857**	**0.20**	**0.45**	**1.22**	**0.78**	**< 0.00**	**-**	**-**	**-**	**-**

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NEAM's portfolio management tools utilize deterministic scenario analysis to provide an estimated range of total returns based on certain assumptions. These assumptions include the assignment of probabilities to each possible interest rate and spread outcome. We assume a 12 month investment horizon and incorporate historical return distributions for each asset class contained in the analysis. These projected returns do not take into consideration the effect of taxes, fees, trading costs, changing risk profiles, operating cash flows or future investment decisions. Projected returns do not represent actual accounts or actual trades and may not reflect the effect of material economic and market factors.

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Board of Governors
MOTION SUMMARY

Date: September 5, 2024 **Motion No. FIN 101.0924**

Committee: Finance & Budget **Chairperson:** Stephanie Booth, MD

Issue: Execute a contract with Infosys to provide Testing Services for all of Information Technology (IT).

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

Background: We are consolidating our Quality Assurance testing, (QA Test), with Infosys as a three-year contract, totaling $23,715,760 and yielding a savings of $5,200,000. The new 3-year total contract with Infosys (FY25 to FY27) would cost $18,515,760 for Solutions Delivery and EDM combined.

Member Impact: The new contract will allow us to achieve consistency in testing services and improve the quality of IT changes through improved regression testing and testing automation. We will be able to minimize production disruptions tied to IT changes, and in turn will help improve the member experience.

Budget Impact: As we are consolidating the vendors and staying within the current spend for Testing services, there is no impact to budget.

Motion: **To authorize staff to execute a contract in the amount of $18,515,760 with Infosys to provide Information Technology (IT) testing services for the period of October 1, 2024 to September 30, 2027.**

L.A. Care
HEALTH PLAN

Board of Governors
MOTION SUMMARY

Date: September 5, 2024

Motion No. CHC 100.0924

Committee:

Chairperson: Tara Ficek, MPH

Issue: Approval of Children's Health Consultant Advisory Committee (CHCAC) member

Background:

Member Impact: None

Budget Impact: None

Motion: **To appoint Lina Shah, MD, Medical Director, Medical Management, Utilization Management, as member of the Children's Health Consultant Advisory Committee (CHCAC), for the Medical Director for Quality Management of L.A. Care Health Plan seat.**

L.A. Care
HEALTH PLAN

Board of Governors
MOTION SUMMARY

Date: September 5, 2024

Motion No. CHC 101.0924

Committee:

Chairperson: Tara Ficek, MPH

Issue: Approval of Revisions to the Children's Health Consultants Advisory Committee (CHCAC) Charter

Background:

Member Impact: None

Budget Impact: None

Motion: **To approve the Revisions to the Children's Health Consultants Advisory Committee (CHCAC) Charter, as presented.**

and of the

L.A. Care Health Plan Joint Powers Authority Board of Directors

Children's Health Consultant Advisory Committee CHARTER

I. General Information

The Children's Health Consultant Advisory Committee (CHCAC) is a public advisory committee focusing on the health and health-related issues impacting the maternal, child and adolescent population served by L.A. Care Health Plan and the L.A. Care Health Plan Joint Powers Authority (all references herein to L.A. Care Health Plan shall also include by reference the L.A. Care Health Plan Joint Powers Authority as applicable). Its membership includes, but is not limited to, highly qualified individuals with expertise in areas such as children and family services, maternal and child health care, obstetrics, pediatrics, mental health, dental care, school based care, health advocacy, community-based services, LAC/DHS maternal and children's health programs and other experts and stakeholders in children's health care. Each member of the committee shall be appointed by the nominating entity for the seat the member is representing, or by the Chairperson of the Board of Governors for L.A. Care Health Plan.

The scope and nature of the issues considered by CHCAC relate most closely, though not exclusively, to activities and functions under the purview of the Chief Health Equity ~~Medical~~ Officer (CHE~~M~~O). As such, the CHE~~M~~O serves as the primary conduit for information exchange between CHCAC, L.A. Care Health Plan management, including all organizational areas, and the L.A. Care Board of Governors.

II. 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 the maternal, child and adolescent populations serviced by L.A. Care Health Plan and provide advisory feedback and recommendations on those items as requested.

B. To develop and present recommendations to the CHE~~M~~O and L.A. Care Board of Governors about issues relating to the maternal, child and adolescent populations serviced by L.A. Care Health Plan.

Committee Responsibilities

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

A. Creation of an annual workplan or ~~on~~~~and~~ periodic status reports to the L.A. Care Board of Governors on the implementation of the workplan or recommended technical advice.

B. Review of policies related to the service models used by L.A. Care Health Plan in order to recommend related public policy as collectively recommended by the various professional fields represented by its members.

C. Provision of expert advice to the L.A. Care's Board of Governors and ~~CHEMO, L.A. Care~~ staff ~~and L.A. Care's Board of Governors~~ concerning L.A. Care Health Plan's proposals/activities impacting the health plan's maternal, child and adolescent populations and providers.

D. Regular communication with one's respective nominating entity to identify the nominating entity's issues and represent these issues to the committee and to share the committee's actions.

IV. Committee Operations & Organizational Interface

Key aspects of committee operations and organizational interface include:

A. The committee shall meet at least every other month.

.

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

C. 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.

D. The appointed member shall be limited to serving two consecutive four years terms or a maximum of 8 years cumulatively. Appointment or reappointment is contingent upon approval of L.A. Care Board of Governors.

E. L.A. Care Health Plan Board Services staffs the committee, in consultation and collaboration with the CHEM~~6/12/2024 2:09:58 PM~~O.

F. The ~~Children's Health Care Provider Representative to the L.A. Care Board of Governors~~Chairperson of CHCAC ~~–~~is the committee's designated L.A. Care Board of Governors representative. ~~The committee, in collaboration with the Children's Planning Council, is responsible for selecting this Board member.~~

G. The committee shall periodically 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 are~~

~~presented to the L.A. Care Board of Governors by the Children's Health Care Provider Representative.~~

Signed: _____

Secretary, Board of Governors

Date: _____

CHIEF EXECUTIVE OFFICER REPORT

August 26, 2024

TO: Board of Governors

FROM: John Baackes, *Chief Executive Officer*

SUBJECT: CEO Report – August 2024

This summer, L.A. Care has been active in the community to support students and families across Los Angeles County. Our L.A. Care and Blue Shield of California Promise Community Resource Centers hosted 16 back-to-school events and gave away 18,000 backpacks to help student better prepare for the new school year. As a health plan that understands the link between social needs and overall health and well-being, we are thrilled to provide backpacks and essential school supplies to countless families who continue to feel the pinch from the ever-growing cost of living. When students are better prepared for school, they are more confident and more likely to succeed in school, and that is a big win for everyone.

We are also proud to announce our seventh group of Elevating the Safety Net medical school scholarship awardees. Eight students from underrepresented communities each received a full-ride medical school scholarship worth nearly $428,000, allowing them to graduate without medical school debt. This new group of scholarship recipients brings the total number of L.A. Care scholars to fifty-six. What is especially important is that all of these scholars have expressed a desire to work in underserved communities, like those that L.A. Care serves. We heard from many students that these scholarships are transformational for them and their families. We should all be proud of the many ways we touch our members and the entire community through our work, and it will never be done until there is an end to inequality in our society.

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

	Since Last CEO Report	As of 08/26/24
Provider Recruitment Program Physicians hired under PRP[1]	3	192
Provider Loan Repayment Program Active grants for medical school loan repayment[1]	—	192
Medical School Scholarships Grants for medical school scholarships[2]	8	56
Elevating Community Health Home care worker graduates from CCA's IHSS training program	—	7,006

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 June through August.

L.A. Care's Collaboration on Addressing Youth Mental Health Crisis
L.A. Care, along with its plan partners, other local health plans, and L.A. County Department of Mental Health are working to support the Los Angeles County Office of Education combat the mental health crisis among youth by offering mental telehealth services to over one million k-12 public school students free of charge through Hazel Health. L.A. Care supports the mental health needs of members and students by leveraging telehealth to improve access to prompt evaluation and treatment. We believe this initiative will provide an accessible, expandable, and sustainable model to bring mental health treatment to students across L.A. County. In collaboration with another local health plan, L.A. Care has helped allocate up to $24 million to cover the services for all Local Education Agencies over two years. As part of the California Governor's Student Behavioral Health Incentive Program, funds are provided by the Department of Health Care Services.

L.A. Care Health Plan Commits $4.7 Million in New Round of Grants to Transform Medi-Cal
L.A. Care is proud to announce that it committed $4.7 million in Incentive Payment Program (IPP) funding to 33 providers and community-based organizations offering Enhanced Care Management and Community Supports as part of CalAIM. Since 2022, L.A. Care has now committed a total of $20 million in IPP grants. The incentive payments will ensure that these providers and CBOs have the support needed to help CalAIM succeed in offering more equitable and coordinated care for our members and others in Los Angeles County.

L.A. Care Expands Support for Members Experiencing Homelessness
We are meeting members where they are, by sending our social service teams to temporary housing locations to enroll L.A. Care members in housing navigation and enhanced care management services. We want to do everything we can to get our members experiencing homelessness into permanent housing, and this new project will help speed up the process. Many of these members will need a variety of social service supports, and meeting them at temporary housing sites is a great way to identify all their needs. Since launch, L.A. Care social worker teams have visited 16 interim housing sites. We plan to continue expanding the program by adding more temporary housing sites and strengthening program infrastructure to support that expansion.

L.A. Care Addresses Prior Authorization Burden
After conducting an extensive review of historical utilization approvals, L.A. Care has updated its list of codes requiring Prior Authorization, significantly reducing the number of services that require authorization. Twenty-four percent of existing codes were removed, which will help avoid delays in member care, speed up discharge requests, and decrease the administrative burden for providers.

Los Angeles Business Journal Awards L.A. Care CEO Excellence in Health Care Award
I am humbled to announce that the Los Angeles Business Journal has awarded me the Excellence in Health Care Award for my leadership at L.A. Care since March of 2015 and community impact. The Excellence in Health Care Award recognizes the accomplishments of individuals and organizations that make great strides to provide better quality health care in Los Angeles. I am grateful for the opportunity to lead L.A. Care and honored to receive this recognition.

Attachments
CALÓ News - L.A. County Addresses Youth Mental Health Crisis with School-Based Collaboration
Modern Healthcare - L.A. Care Cuts 24% of Prior Authorization Requirements
Becker's Payer Issues – How a California Payer is Tackling the Housing Crisis
L.A. Care Medicare Plus Enrollee Advisory Committee Meeting Summary

L.A. County addresses youth mental health crisis with school-based collaboration

Amairani Hernandez Jun 21, 2024 Updated Jul 2, 2024 0

Research shows the number of youth mental health hospitalizations and suicides has increased in the last decade.

According to the National Alliance of Mental Illness, (NAMI) 1 in 6 U.S. youth aged six through17 experience a mental health disorder each year, while 50% of all lifetime mental illness begins by age 14, and 75% by age 24.

With the support of LA Care Health Plan, Health Net, their plan partners, and L.A. County Department of Mental Health, the Los Angeles County Office of Education (LACOE) is offering mental telehealth services to over one million K-12 public school students free of charge through Hazel Health to combat the mental health crisis among youth.

“There are a couple of reasons why schools want to do this. Schools have found that kids tend to perform better if mental health and substance abuse issues are addressed,” said psychiatrist Michael Brodsky. “So there are a lot of good reasons on the school district side. On the medical side, on the health plan side, we like to see kids get treatment for their conditions. We don't want them to suffer in silence.” To help make mental healthcare more accessible for students, all Local Education Agencies (LEA) in the county can participate in the Hazel Health virtual mental health program.

Hazel Health provides school-based telehealth to nearly three million students in over a hundred school districts across fourteen states, consistently meeting and exceeding the needs of students wherever they are, either at school or home. The program also works with parents and school staff to make the best care decisions for students. Hazel Health’s mission is to transform children’s access to health care, intervening earlier to help fuel better learning and health outcomes to create thriving communities.

Currently, the Los Angeles Unified School District and Compton Unified School District have already made the decision to leverage this service. L.A. Care Health Plan and Health Net are allocating up to $24 million to cover the services for all LEAs over two years. As part of Governor Gavin Newsom's Student Behavioral Health Incentive Program (SBHIP), funds are provided by the Department of Health Care Services.

“We are excited about this endeavor and honored to have such trusted partners join us in our efforts to ensure students receive every support possible on their education journey. Providing access to quality, responsive mental health services is not only important for their academic success, it is also our moral imperative,” said Compton Unified School District Superintendent Dr. Darin Brawley.

Compton Unified School District (CSUD) is located in the south-central region of Los Angeles County. CUSD encompasses the city of Compton and portions of the cities of Carson and Los Angeles. The district currently serves over 18,000 students at 36 sites. CUSD is a district that is rising, with a high school graduation rate nearing 90%, dramatic facility improvements, increasing college acceptance rates and a focus on STEAM throughout all schools.

According to the 2022 California Health Care Almanac, one in 14 children has an emotional disturbance that limits functioning in family, school or community activities. And according to the California Master Plan for Kids’ Public Health, over 284,000 youth cope with major depression with 66 percent of youth with depression not receiving treatment. Alarmingly, suicide rates for kids ages 10 though18 increased 20 percent between 2019 and 2020.

Dr. Brodsky said that the most serious signs to look out for are when kids try to hurt themselves. “The state of California tracks every year the rates of kids either trying to hurt themselves or going to emergency rooms. And you could see the graphs went up and up and up,” he said. “The rising numbers started even before COVID and even before the murders of George Floyd and Brianna Taylor, but they didn't get better. They kept going up. So there were a lot of reasons to be worried and fortunately, the state paid attention to this.”

In addition, depression in kids should be monitored if they are feeling down frequently for a week or more, according to Dr. Broadsky. “That’s no longer feeling down but rather an early sign of depression,” he said.

He also said that during the pandemic era and as of now there has been an increase of mental health awareness, racial inequities, health disparities and systemic racism. “There's really been a lot of attention in California in trying to check in with the kids,” Dr. Broadsky said.

“Even before COVID-19, the incidence of adolescent depression, suicidal ideation and emergency room visits was on the rise, and mental health resources have not kept pace with rising levels of student distress, depression and traumatic experiences,” said John Baackes, L.A. Care CEO. “L.A. Care saw an opportunity to support the mental health needs of members and students by leveraging telehealth to improve access to prompt evaluation and treatment. We believe this initiative will provide an accessible, expandable, and sustainable model to bring mental health treatment to students across L.A. County.”

A phased deployment approach is being used for all LA County LEA's that opt-in to the program. District leaders are learning about the implementation process and next steps through information sessions hosted by LACOE and the Hazel Health virtual telehealth program. Also with Hazel, they are presenting a new model for what collaborating between public, private, and community stakeholders can look like.

"Providing access to early intervention services, systematically, at this scale has the potential to change the trajectory for students struggling with mental health across L.A. County," said Josh Golomb, Chief Executive Officer at Hazel Health. "This model provides more equitable access to care at an unprecedented rate for students from families who may otherwise not benefit from it and can truly change lives."

Now that Hazel Health is being integrated into schools, students and parents have easier access to mental health resources. "We helped put this program together in schools so that teachers or parents could ask for help and we could try to get help for kids while they're in school because a lot of times kids are spending most of their time in school," Dr. Broadsky said. "Parents and kids take different approaches to asking for help. Some will go to their regular doctor and ask for help. Others will go to the emergency room when it's too late and that's where some of the worrying data comes from."

According to data from the American Psychiatric Association, each year, 243,000 Latinos in the U.S. attempt to take their own lives and 17% of high school-age Latinos experience suicidal thoughts. Additionally, between 2011 and 2021, suicide death rates have increased substantially among the Latino community, with a 39% increase per 100,000 people, according to an analysis from the CDC WONDER underlying cause of death data.

The importance of timely intervention and prevention cannot be overstated. The virtual mental health platform Hazel allows California-licensed therapists from across the country to support students in a convenient manner. "Fortunately, we developed this plan, and we specifically chose to work with a company that has this video version of counseling that selects therapists who work in communities of color and Latino communities," Dr. Broadsky said.

The partners are committed to connecting students to therapists who reflect on and understand diverse populations. More than 60 percent of Hazel Health therapists identify as people of color, and more than 30 percent are bilingual. This commitment to culturally competent care is unique among service providers and reflects the LEAs' commitment to equity and inclusion.

Whether it's in school or at home with parents, teachers, and students, Dr. Broadsky believes that mental health awareness is crucial to saving lives and ending suffering in silence. If you or someone you know is experiencing mental health problems, you can call the 988 hotline. Help is also available in Spanish.

Modern Healthcare

August 07, 2024 03:16PM 2 HOURS AGO

L.A. Care cuts 24% of prior authorization requirements

Hayley DeSilva

Getty

L.A. Care Health Plan has cut 24% of its prior authorization requirements in what the insurance company characterized as an effort to lighten administrative burdens for providers, reduce discharge times and avoid care delays.

Some specialty care visits, laboratory tests, medical equipment and catheter supplies will no longer require prior authorization, the insurer said in a news release Wednesday. The company has axed roughly 14,000 billing codes from its list of those requiring prior authorization, CEO John Baackes said in an interview.

L.A. Care offers four lines of health coverage plans to more than 2.5 million members, including Medicaid beneficiaries and those dually eligible for Medicare and Medicaid. The company has eliminated the requirements for all of its coverage lines.

Certain services, including inpatient care, clinical trials and transplant surgery, will still require prior authorization for L.A. Care members.

The company will continue weighing whether more cuts are necessary and whether some requirements should be reinstated, Beackes said.

Several insurance companies have recently made moves to dial back services that require prior authorization. Blue Cross Blue Shield of Michigan announced in September 2023 it would cut prior authorization requirements by 20% for Medicare and commercial enrollees. The month prior, Cigna said it would lift the requirements for more than 600 procedures in its commercial plans, representing 25% of requirements for commercial enrollees.

Beackes said he plans to retire from his position in early January. L.A. Care is in the process of appointing his successor.

BECKER'S
PAYER ISSUES

How a California payer is tackling the housing crisis

L.A. Care is working to connect members in temporary care

The program refers social service teams to L.A. Care temporary housing locations in Los Angeles to enroll members in housing navigation and care outreach, according to an Aug. 13 news release from L.A. Care.

L.A. Care, the largest publicly funded health plan in the nation, is the first health plan to do this kind of outreach, according to its news release.

Since beginning the program in March, L.A. Care has referred around 100 members into housing and care navigation, and is on track to refer 200 people by the end of the year, Charlie Robinson, senior director of health, told Becker's.

"We're still working on different operations, data sharing, and things like that to make sure that we can engage 100% of the people in interim housing," Mr. Robinson said. "We're not there yet, and that's our goal. We want to make sure anyone that is in interim housing is engaged, has services and is on track to move into permanent supportive housing."

In 2024, more than 70,000 people are experiencing homelessness in L.A. County. L.A. Care has between 50,000 and 55,000 members experiencing homelessness on any given day, Mr. Robinson said.

"We're trying to construct a program that meets the moment in terms of providing services to these individuals," Mr. Robinson said.

California is leaning on its Medicaid plans to address housing and other social drivers of health in the state. In 2022, the state began implementing CalAIM, a multiyear initiative aimed at addressing social determinants of health.

In a 2023 survey, almost half of those tasked with implementing the program said it had overall improved access to services.

The CalAIM program has empowered L.A. Care to develop services within a managed care infrastructure, Mr. Robinson said. Housing navigators bill L.A. Care for claims like a primary care provider or specialist, which can give organizations a lot more certainty around revenue, Mr. Robinson said.

It also brings housing and social service providers into the broader managed care network, he said.

"What that will continue to allow us to do is experience with further care coordination, and value-based care models in a way that allows us to think of social services in a very comparable way to how we think about more standard healthcare services we've been delivering for years," he said.

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 third quarter of our fiscal year, from April 1 through June 30.**

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

Operational Excellence

Achieve operational excellence by improving health plan functionality.

Goals	Q3: April – June 2024 Highlights
Build out information technology systems that support improved health plan functionality.	• L.A. Care completed the reprioritization of the roadmap for the VOICE program. Working on the agent console (what L.A. Care staff use) and refining requirements for the member and provider portals. • Callidus, the SAP cloud-based commission software solution for managing incentives and compensation programs for brokers, completed the Requirements Gathering and Design phases.
Support and sustain a diverse and skilled workforce and plan for future needs.	• Succession planning for senior leadership roles is underway. • Cohort three of the Management Certificate Program is up and running and cohort two of the program will graduate in July 2024. Five participants have been promoted to supervisor roles.
Ensure long-term financial sustainability.	• FY23-24 Q2 administrative expenses were higher by $2.1M vs 4+8 forecast. We continue to update our forecast as strategic investments and other administrative needs change.
Mature L.A. Care's family of product lines, taking an "all products" approach whenever possible.	• L.A. Care Covered membership exceeded 183,000 members. • Medicare Plus (D-SNP) Special Election Period (SEP) net membership growth continues on a monthly basis, with current net July 2024 membership now over 19,700 members and projected to surpass 20,000 by end of SEP. • L.A. Care implemented system enhancements that enable members in all lines of business to be assigned to clinics rather than individual Primary Care Providers (PCPs) affiliated with those clinics. • L.A. Care finalized the development of an integrated and filterable performance scorecard to measure service delivery at the practice level. These scorecards include quality, utilization, and member experience measures and benchmarks, and will be shared with PPGs and directly contracted PCPs to facilitate performance improvements.

High Quality Network

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

Goals	Q3: April – June 2024 Highlights
Mature and grow our Direct Network.	• L.A. Care is establishing centralized data tables to ensure consistent, current provider and service delivery data across departments. • L.A. Care is expanding the utilization of field medicine providers to deliver primary care services, including preventative care, to unhoused members.
Improve our quality across products and providers.	• A new metric to measure the volume of accepted versus rejected service claims is in development for Direct Network primary care providers. The report will include claims denial reasons, which will be used to follow-up with directly contracted primary care practices to remediate claims submissions. The measure will be introduced in the Measurement Year 2025 Direct Network P4P Program. • L.A. Care exceeded the DHCS Minimum Performance Level threshold for 11 of the 18 measures on the Medi-Cal Accountability Set for Measurement Year 2023.
Invest in providers and practices serving our members and the L.A. County safety net.	• A Transform L.A. participating practice sustained the final phase of transformation for one year and will be the first to graduate from the program. • L.A. Care confirmed the eight new Elevating the Safety Net scholarship recipients from Charles R. Drew University of Medicine and Science and UCLA David Geffen School of Medicine who will be awarded in July at L.A. Care's annual White Coat Ceremony and Celebration. • L.A. Care will award a total of 3.32M for safety net infrastructure grants. The Robert E. Tranquada MD Safety Net Initiative XV projects will assess up to 20,168 patients for social/emotional intervention and disease management programs, and the Oral Health Initiative XV projects will reduce barriers for 6,138 patients in need of dental services.

Member Centric Care

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

Goals	Q3: April – June 2024 Highlights
Operate all components of California Advancing and Innovating Medi-Cal (CalAIM) as they are launched.	• L.A. Care completed preparations for the launch of the remaining two of the 14 CalAIM Community Supports (CS) services that will go live on July 1st: Day Habilitation and Short Term Post Hospitalization Housing.
Establish and implement a strategy for a high-touch care management approach.	• Care Managers increased engagement with California Children's Services (CCS) members this quarter compared to the previous quarter due to initiation of targeted outreach to offer Care Management to CCS members.
Ensure that the services we provide to members promote equity and are free of implicit and explicit bias.	• Community Benefit's 2023 pilot initiative to help residents from under-resourced communities obtain living wage jobs resulted in 164 women and youth ages 16-30 years old being placed and trained in high demand/high growth fields with earnings at or approaching L.A. County's living wage standard. • L.A. Care has partnered with a local clinic in a year-long project to improve the rate of well-child visits. • L.A. Care awarded 5 organizations the Health Equity Award. These organizations advocated for tenant's rights, increased vaccinations in vulnerable communities during the COVID-19 pandemic, addressed student and family health care needs at a school-based health center, and worked to improve infant and maternal mortality rates.

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	Q3: April – June 2024 Highlights
Drive improvements to the Affordable Care Act by serving as a model of a successful public option.	• L.A. Care continued to connect plans interested in participating in Covered California with helpful resources.
Optimize members' use of Community Resource Centers and expand our member and community offerings.	• New CRCs in West L.A. and Panorama City opened, bringing the total of open centers to 12. • Completed a hypertension control pilot program for members at two CRCs. The new collaboration was between the American Heart Association and the L.A. Care Health Promoters Program.
Drive change to advance health and social services for our members and the community.	• L.A. Care hosted a Gun Violence Safety event at the Lynwood Community Resource Center. The event featured a Gun Violence Awareness Survivor's Panel, free gun locks, and educational resources on gun safety. • L.A. Care launched a Health Information Exchange (HIE) Participation Measure within the Physician Pay for Performance (P4P) program to encourage HIE Participation Milestones, including involvement in California's Health and Human Services Data Exchange Framework. • The Housing Initiatives team is working to bring new needed services to L.A. Care members, including the L.A. County Field Medicine program and the Skid Row Care Collaborative.

APPENDIX

Detailed Vision 2024 Progress Report
Fiscal Year Quarter 3
April – June 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 development and grooming phase. Engagement of an outside consulting firm has remained steady in order to support timely delivery of scheduled deployments. Initial system build demonstrations for the agent console has started and is targeted to deploy at the end of Q4. Requirements grooming for both the member and provider portals are also underway and are anticipated to deploy in Q1 of 2025. Additional planning to enhance the interactive voice response (IVR) has continued in order to support customer experience improvement strategies. Exploratory planning has been initiated 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).	Callidus, the SAP cloud-based commission software solution for managing incentives and compensation programs for brokers, completed the Requirements Gathering and Design phases in Q3. The project is currently in the Build and Test phases and projected to complete these phases in Q4. The Ariba Procurement system implementation Request for Proposal (RFP) process was completed in Q3. The announcement of the implementation partner along with a project kick-off date is anticipated for Q4.
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 finalize and obtain signoff for all functional and nonfunctional 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. • Finalizing the documentation of all provider subnetworks.

Build out information technology systems that support improved health plan functionality.	
Tactics	**Update**
	• Finalizing protocols for data migration. • Migrating data for testing purposes. • Analyzing and identifying all upstream and downstream dependencies. • Identifying all system integration dependencies, including VOICE/provider portal, member assignment application, claims platform, and Utilization Management/Care Management platform, among other systems. • 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.	L.A. Care's Information Technology Department continues to modernize our technology and data architecture through the execution of our strategic priorities. The VOICE Customer Relationship Management Program continues to stay on target for the delivery of a modernized Customer Relationship Management ecosystem. The program is on track to deliver a new agent console, new provider portal, and member portal by the end of 2024. By the end of June, we will have completed all major deliverables of the Clinical Data Repository Program and as a result we have evolved our ability to ingest clinical data into to our Health Services ecosystem. We have further modernized our data architecture by making key design decisions around the technology solutions that will enable us to migrate our data to the cloud over the next two years. We are in the final stages of a FY Q4 delivery of a new Utilization Management (UM) system and a new solution for Potential Quality of Care Issues (PQI) System. Work also continues on the new Appeals and Grievance (A&G) System and the current delivery target is October 31, 2024. The PQI, UM, and A&G implementations will round out the balance of the delivery of the Care Catalyst Program. And finally, our Provider Target State Program remains on target and it will vastly improve our provider data quality by creating a single source of truth for all provider data.
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.	In preparation for the succession planning of the Senior Director of Financial Compliance role, we have been working with the Chief Financial Officer (CFO) to create a Success Profile. Intake calls for succession planning are scheduled with our Chief Information Officer and Chief of Staff.
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: 37.3% Hispanic or Latino; 22.1% Asian; 15% Black or African American; 10.7% White; 4.7% Native Hawaiian or Other Pacific Islander; 0.25% American Indian/Alaskan Native; 3% two or more races; 7.1% non-applicable. Additionally, our employees are 69.3% Female and 30.7% Male.
Improve managed care and Management Services Organization (MSO) acumen among staff.	L.A. Care continues to partner with Local Health Plans of California (LHPC) to help educate our employees on Managed Care services. In Q3, employees attended the following educational sessions: • Medi-Cal Managed Care Eligibility and Enrollment 101 (attended by 73 employees) • Medi-Cal Managed Care Compliance 101 (attended by 100 employees)
Promote retention of staff in an evolving work environment.	Cohort three of the Management Certificate Program is up and running, and cohort two of the program will graduate in July 2024. We have had three participants promoted into supervisor roles from cohort two, and one participant promoted into a supervisor role from cohort three. In addition, one graduate from cohort one was promoted to a supervisor role during this reporting period. We rolled out Team Index data from the Employee Engagement Survey to teams in the organization that scored in the T3 category (a lower score), actively walked a number of them during the process of creating action plans in support of their concerns. Additional support was provided to all teams as needed.

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.	*Providing FY23-24 Q2 results as Q3 financials won't be available until next month* FY23-24 Q2 administrative expenses were higher by $2.1M vs 4+8 Forecast. The initial expense targets for FY23-24 were updated as part of the 4+8 forecast in February and incorporated additional spend related to strategic investments across the enterprise. In addition to expanding headcount, there has been targeted increases in purchased services related 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): Membership continues to grow (exceeds 183k effective members) through the Special Enrollment Period (SEP) mainly due to continued effectuation of new members through the SB 260 process; • Planning is underway for the Plan Year 2025 Renewal Period and 2025 Open Enrollment Period (OEP), including multi-cultural outreach for Deferred Action for Childhood Arrivals (DACA) recipients who will be eligible for ACA coverage beginning November 2024. • Auto-assignment from SB 260 continues, but is projected to slow significantly post Medi-Cal Redetermination (July 2024 forward). Medicare Plus (D-SNP): SEP net membership growth continues on a monthly basis, with current net July 2024 membership now over 19,700 members and projected to surpass 20,000 by end of SEP;

Mature L.A. Care's family of product lines, taking an "all products" approach whenever possible.	
Tactics	**Update**

	• Plan Year-to-Date Enrollments are currently over 5,700; +6.7% year over year increase.
	• We continue to look at ways to increase resources in outreach, as there is a high volume of Medi-Cal Duals (approximately 140k+) that are eligible for Medicare Plus.
	
	Medi-Cal (MCLA): The Continuous Coverage Unwinding period has ended, and regular monthly Medi-Cal eligibility determination has resumed.
	• While membership is currently projected to decline, there are strategies that Sales is working on with the Medi-Cal Product Team to turn around the trends mainly being driven by the State projected budget decline. These strategies include:
	  ○ Working more closely with our current contracted Community Based Organizations that are Medi-Cal certified enrollers;
	  ○ Planning for DACA outreach.
	
	Marketing
	
	L.A. Care Covered (LACC): Focus remained on engaging our target audience through strategic outreach efforts. We continued to focus on an SB260 direct mail campaign for those losing Medi-Cal eligibility. We also continued a lean digital marketing campaign for the Special Enrollment Period (SEP), tailoring messaging and creative to effectively address audience needs while staying aligned with our overarching product objectives. Our focus remains to encourage eligible individuals to take action and enroll in LACC. Our Shop and Compare tool is still in place for potential members to compare plan pricing.
	
	Medicare Plus (D-SNP): Our Marketing, Sales, and Product teams have collaboratively developed a robust strategy and framework for FY25. With our messaging hierarchy and creative work already in development, we are well ahead of last year's progress. Our approach for D-SNP members focuses on targeted, personalized, and accessible campaigns that cater to their unique needs. By employing a multi-channel strategy that emphasizes education and engagement, we aim to build strong connections, leading to better health outcomes and higher member satisfaction.

Mature L.A. Care's family of product lines, taking an "all products" approach whenever possible.	
Tactics	**Update**
	Medi-Cal (MCLA): We are actively promoting the older adult expansion with a targeted awareness campaign. This includes increasing our visibility in key public spaces and executing high-performance digital marketing strategies. The Plan Partner campaign has been given an incremental run. We will continue to run our current digital assets through September to maintain momentum. We have also been displaying a redetermination message on digital towers (outdoor billboards) to keep this critical information front and center. Overall, the new planning process has fostered extensive dialogue among key stakeholders, ensuring that all perspectives are considered. This has facilitated a collaborative environment, enhancing the quality and comprehensiveness of our plan development. We are well ahead in our planning for FY25 compared to previous years. This proactive approach puts us in a strong position to execute our go-to-market strategy effectively and meet our objectives.
Engage in a provider network strategy that meets distinct business and competitive needs of all products and ensures that members receive high-value care.	To enhance care quality, accessibility, and member satisfaction, L.A. Care implemented system enhancements that enable members in all lines of business to be assigned to clinics rather than individual Primary Care Providers (PCPs) affiliated with those clinics. L.A. Care continued to host monthly Provider Engagement Events at Community Resource Centers and quarterly Physician Advisory Collaborative events for providers in both L.A. Care's direct and delegated Participating Physician Group networks. In response to feedback from these events, L.A. Care updated the Direct Network Reference Guide to incorporate additional information and remove details already outlined in the Universal Provider Manual. L.A. Care finalized the development of an integrated and filterable performance scorecard to measure service delivery at the practice level. These scorecards, which include quality, utilization, and member experience measures and benchmarks, will be shared with PPGs and directly contracted PCPs to facilitate performance improvements. In addition to ongoing Joint Operation Meetings (JOMs) with PPGs, L.A. Care is scheduling a series of quarterly regional JOMs with PCPs to review scorecards aggregated at the regional level and discuss L.A. Care's available programs, services, and incentives to support PCPs in managing the care of their assigned members.

Mature L.A. Care's family of product lines, taking an "all products" approach whenever possible.	
Tactics	**Update**
	Following regional JOMs, L.A. Care staff will meet with individual, directly contracted primary care practices to identify the causes of performance deficiencies and assist in developing action plans to enhance performance.

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 streamline operations and increase efficiency, L.A. Care is establishing centralized data tables to ensure consistent and current provider and service delivery data across departments. These tables will (i) support standardized data validation and normalization protocols and (ii) populate the integrated and filterable performance scorecards referenced above.

Mature and grow our Direct Network.	
Tactics	**Update**
	To improve initial health appointment (IHA) compliance, L.A. Care is (i) broadening the communication channels used to outreach to members to encourage IHAs and (ii) implementing system alerts to notify customer center representatives when a member who has not completed an IHA calls in. In addition, L.A. Care staff will meet with individual, directly contracted primary care practices to identify the causes of low primary care utilization and IHA compliance.
Strategically address gaps in the Direct Network to meet all member needs countywide.	L.A. Care continued to collaborate with regulators and provide documentation in support of a filing to request approval for increasing membership in the Direct Network. Additionally, L.A. Care is expanding the utilization of field medicine providers to deliver primary care services, including preventative care, to unhoused members. L.A. Care continues to maintain sufficient network adequacy and to address any adequacy gaps as they occur.
Increase access to virtual care by implementing L.A. Care's Virtual Specialty Care Program (V-SCP).	Since the start of the pilot V-SCP program for our high volume Direct Network primary care providers (PCPs) began in July 2023: • We have received a total of 112 eConsults submitted and five telehealth visits; • The eConsult specialists have responded back to the primary care provider in 24 hours or less and around 68% of the eConsults needed an in-person visit.

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.	• The Incentives Team conducted a provider webinar geared towards solo providers and clinics about the Measurement Year (MY) 2024, Physician Pay-for-Performance (P4P) and Direct Network P4P incentive programs in May. • Q4 2023 Capitated Claims Reports and the first Prospective Practice-level Provider Opportunity Reports were distributed via the Provider Portal. 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.

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

	• The Measurement Year (MY) 2024 Direct Network Pay-for-Performance Program Description was distributed in May. Major changes for 2024 mirror changes made for the Medi-Cal Value Initiative for IPA Performance (VIIP) Program, including:
	  ○ 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.
	• A new metric to measure the volume of accepted versus rejected service claims is currently in development for Direct Network primary care providers. The measure was approved at the May DNA Workgroup Meeting and is modeled on a new Encounter measure for the VIIP+P4P programs, called Percentage of Encounter Rejections. The report will include claims denial reasons, which will be used to follow-up with directly contracted primary care practices to remediate claims submissions. The measure will also be introduced in the MY 2025 Direct Network P4P Program.
	• Direct Network Pay-for-Performance (P4P) Performance Improvement Scenario Reports are being distributed to primary care providers in the Direct Network via the Provider Portal in late June. This report provides estimates of potential incentive awards based on higher performance scenarios for MY 2022.

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.	For Measurement Year (MY) 2023 on the 18 Medi-Cal Accountability Set (MCAS) measures held to the Minimum Performance Level (MPL); • 11 measures exceeded the DHCS MPL threshold • 15 measures improved compared to MY2022 • 3 measures had significant improvements year-end compared to MY2022 L.A. Care deployed various text message campaigns in Q3; these campaigns provided health education and encouraged members to schedule their annual preventive check-ups, mammography exams, colorectal cancer screenings, and well-baby visits. Over 350,000 members have received text messages so far in 2024. Mailers were sent to members

Improve our quality across products and providers.	
Tactics	**Update**
	providing health education, and reminders that they are due for breast cancer screenings, cervical cancer screenings, and colorectal cancer screenings. Automated call campaigns went out providing information on alternative options for care outside of the emergency room and reminding parents/guardians to schedule well-baby visits.
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.
Improve clinical performance for children's care.	Two phone-based reminder campaigns launched in late April. The first campaign highlighted the importance of preventive services, such as developmental screenings and immunizations during well-child visits. Text messages were sent out for parents/guardians to schedule well-child visits for their infants and toddlers. In the second campaign, automated phone calls were made to parents/guardians, reminding them to schedule well care visits for their children ages 0-21 years of age. In June, Community Health Workers continued outreaching to parents/guardians of infants and toddlers who needed one more visit to complete their well-child visit series.

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.:** Coaches continue to work with practices to report on a well-child visit-related HEDIS measure. Transform L.A. is supporting practice use of Provider Opportunity Reports (POR) and Cozeva as alternative data sources for their monthly measure reports. The team is continuing work with eMed, an electronic health record (EHR) software, to add the Well Child Visit 30 measure within the practices' HEDIS reporting dashboard.

Invest in providers and practices serving our members and the L.A. County safety net.	
Tactics	**Update**
	Help Me Grow LA: Practices continued to work on incorporating developmental screening tools into their electronic medical records (EMRs) and to improve their referral processes. The second and final installment of the program's mini grant funds were distributed to practices in June. The funds are to support online screening tool subscriptions and to embed the tools into the practices' EMRs to streamline current workflows and reduce administrative burdens. Practice coaches are continuing to work to strengthen connections between practices and Regional Centers. **EQuIP-LA:** We continue to collaborate with the Quality Performance Management team who prepares the rolling 12-month HEDIS measures reports (Controlling Blood Pressure, A1c Poor Control, and Colorectal Cancer Screening) to ensure we meet the programs' deliverables. Two out of the four practices are currently participating in the Race, Ethnicity, and Language (REaL) Data Accelerator training course, offered through the California Quality Collaborative (CQC)/Purchaser Business Group on Health (PBGH) program office. The 12-week, online program equips practices to improve REaL data collection in order to strengthen equity-focused primary care. **Equity & Practice Transformation:** All 46 primary care practices completed and submitted their first deliverable in April, the Population Health Management Capabilities Assessment Tool (phmCAT). This tool provides an assessment of each practice's care delivery areas. Practices will receive directed payments for this deliverable by October 2024.
Provide practice coaching to support patient-centered care.	**Transform L.A.:** As of April 2024, the program practices have achieved improvements of 38% for Glycemic Assessment in Patients with Diabetes (>9%) against the Minimum Performance Level (MPL) of 38%, and 60% in Controlling High Blood Pressure against the MPL of 61%. One practice has sustained the final phase of transformation, Phase Five, for one year, and they are the first to graduate from the program. Two additional practice have achieved the final stage of transformation and are on track to graduate next year after sustaining their achievements for one year. **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

Invest in providers and practices serving our members and the L.A. County safety net.	
Tactics	**Update**
	achieved increases of 52% and 20% respectively over their baselines. The coaches are working with practices to develop sustainability plans for this final program year including using reports that quality improvement (QI) activities (or Plan-Do-Study-Act (PDSA), etc.) can be built around; dedicating staff time to QI projects; and creating QI teams. **EQuIP-LA:** Quality improvement work continues, with practices working on their PDSA cycles (conducting small tests of change) to improve three HEDIS measures: A1c >9% (Poor Control), Controlling Blood Pressure, and Colorectal Cancer Screening. Practices have been focusing on patient outreach, identifying patients due or overdue for screenings or blood tests. Practices are also participating in education events hosted by Purchaser Business Group on Health (PBGH). **Equity & Practice Transformation:** L.A. Care received the Initial Provider Incentive Payment (IPIP) funds in June 2024. The funds will support five additional practice coaches for all 46 practices to complete the program requirements. Practice coaches are expected to start by mid-July. The California Governor has proposed to reduce funding by 80% to the program for the 2024-2025 state budget. Pending the finalization of the new budget, both DHCS and the Population Health Learning Center are restructuring the program based upon the expected approval of the funding cuts. We will receive an official update by July 2024.

Invest in providers and practices serving our members and the L.A. County safety net.	
Tactics	**Update**
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 168 active providers totaling slightly more than $22.4 million in investment. There are currently 21 vacancies. **Provider Loan Repayment Program:** Of the 192 physicians awarded, we have 97 active awards, including 79 new awardees and 18 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 June 2024, CDU and UCLA confirmed the 8 new 2025 scholars who will be introduced in July 2024 during L.A. Care's annual White Coat Ceremony and Celebration. **In-Home Supportive Services Training Program Center for Caregiver Advancement (CCA):** Three hundred twenty-nine students graduated from the Trimester 21st cohort. CCA's Trimester 22 cohort is currently underway. Overall, 7,006 students have completed the L.A. Care training course as of June 2024.
Utilize the Community Health Investment Fund (CHIF) to leverage opportunities for providers to increase quality and access to care.	Community Benefits received 27 Robert E. Tranquada MD Safety Net Initiative (Tranquada) XV applications and 25 Oral Health Initiative (OHI) XV applications, amounting to more than $7M to prevent, reduce and manage disease through multi-disciplinary approaches that address patients' social determinants of health or barriers to care. Following review, the department is making recommendations for 14 Tranquada and 10 Oral Health XV awards, totaling 3.32M for safety net infrastructure grants. The Tranquada projects propose to outreach, engage, and assess up to 20,168 patients for social/emotional intervention and disease management programs. The Oral health projects will reduce barriers for 6,138 patients in need of dental services. Overall, the proposed 2023-2024 Healthcare Infrastructure and Innovation grants will mitigate disparities that are associated with social determinants of health (SDOH) in disease management, and expand access to care for up to 26,306 patients.

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 (ECM):** L.A. Care continues to expand our provider network to support our efforts with increasing ECM enrollment. To ensure quality outcomes and regulatory compliance, we revamped our provider monitoring and auditing process. The new process will take effect in FY Q4. L.A. Care ECM Team will continue to identify and improve our processes to increase our ECM enrollment. **Community Supports:** L.A. Care will launch the remaining two of the 14 CalAIM Community Supports (CS) services on July 1, 2024 (Day Habilitation and Short Term Post Hospitalization Housing). During Q3, activities were ongoing in preparation for the new CS launch. The CS provider network continues to expand to support increased CS member engagement. Furthermore, activities are ongoing to support cohesive and efficient CS program operations across the various CS service areas related to data and reporting, provider network management, member engagement, and compliance.
Ensure CalAIM Population Health Management (PHM) requirements are met.	• The Population Health Department hosted a Community Partnership Kick-Off meeting in late June. In this meeting, all the Health Plan and Local Health Jurisdictions worked together to develop a strategy to meet the CalAIM SMART goal of improving maternal and infant mortality health. • The Initial Health Appointment (IHA) updates: ○ IHA Data Enhancements: Monthly IHA compliance reports are 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 ○ Additionally these reports will be shared in the Quality Improvement (QI) Joint Operations Meetings (JOMs) and utilized by the monitoring team to prioritize monitoring. ○ Pay-for-Performance started incentive payments for completed IHAs in May 2024.
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

Operate all components of California Advancing and Innovating Medi-Cal (CalAIM) as they are launched.	
Tactics	**Update**
	Pediatric Sub-Acute Care benefits. The Carve-In for these benefits were implemented successfully. YTD (Jan-May), we have authorized services for 334 ICF-DD members and 23 Pediatric Sub-Acute Care members. Internal stakeholders continue to meet weekly to discuss challenges and resolutions to ensure that ICF-DD members' needs are met. Managed Long Term Services and Supports (MLTSS) continues to facilitate the monthly MCP alignment meeting to discuss best practices and to align with some processes. Provider Network Management (PNM) continues to work with ICF-DD Providers closely to resolve contracting/credentialing challenges and ensures network readiness. MLTSS along with other internal stakeholders participated in some DHCS webinars to share best practices in a panel discussion and in an interview forum. To provide continuous support to the ICF-DD providers, liaisons continue to be available for questions, and the quarterly webinar with ICF-DD providers is scheduled for July to go over processes.

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 engagement with California Children's Services (CCS) members this quarter compared to the previous quarter due to initiation of targeted outreach to offer Care Management to CCS members. Compared to Q2, Care Managers had an increase in members who graduated from Care Management with care plan goals successfully met. Care Management also increased the overall number of members supported under Transitional Care Services (TCS) in Q3 compared to Q2 2024. Care Management Community Health Workers (CHWs) achieved an increase in face-to-face engagement with members this quarter. Face-to-face encounters particularly increased in areas such as East L.A., Lynwood, and Pacoima/Panorama City. In support of TCS, the CHWs continue to provide transition support to members discharging from inpatient facilities. Finally, CHWs received training to better serve D-SNP members and conduct various assessments such as the Patient Health Questionnaire 9 – Screening for Depression (PHQ-9) and the Benjamin Rose Institute Caregiver Strain Instrument.

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.	Effective January 1, 2024, the program eligibility has expanded to include D-SNP members. Palliative care referrals YTD (from Oct 2023-May 2024) is 481. There is an increase in referrals from Jan-May of 2023 compared to Jan-May of 2024. 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.	In September 2023, Community Benefits launched a pilot initiative to help residents from under-resourced communities obtain living wage jobs in high demand/high growth fields to create and sustain economically secure households. During this quarter, grantee reports indicate that 164 women and youth ages 16-30 years old have been trained and placed in technical and service industry positions with earnings at or approaching L.A. County's living wage standard ($22/hour). An additional sixty clients are enrolled in a cyber-security or computer engineering academy, which will prepare graduates for full-time positions earning at least $25/hour. GAAINS II grant partners have been implementing culturally congruent strategies to enhance prenatal experiences and reduce the toxic stress of systemic racism, resulting in 115 out of 116 (99%) Black birthers who had live births as of the six month report. Ten GAAINS III grant partners were approved to implement additional Black birth equity projects to begin in Q3. L.A. Care continues to host the L.A. County Health Equity Officers meeting. During the April meeting, discussion topics included social determinants of health screenings, sexual

Ensure that the services we provide to members promote equity and are free of implicit and explicit bias.	
Tactics	**Update**
	orientation and gender identity data updates, and updates on Senate Bill 923, Transgender, gender diverse and/or intersex (TGI) Inclusion Act. Member Equity Council continues to track the 16 goals/metrics that align with the four Health Equity Zones (HE Z) in our Health Equity and Disparities Mitigation Plan (2023-2025). The four Health Equity Zones are: • HE Z 1 - Address Key Health Disparities • HE Z 2 - Lead Change • HE Z 3 - Move Towards Equitable Care • HE Z 4 - Embrace Diversity, Equity, and Inclusion The Consumer Health Equity Council was held in June and focused on L.A. Care's health education portal, My Health In Motion (HE Z 4). Additionally, L.A. Care has worked with Health Information Exchange, LANES, to import and extract member gender identity demographic information collected by the providers (HE Z 3).

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 has partnered with a local clinic in a year-long project to improve the rate of well-child visits. The teams are identifying a population experiencing disparities to focus their efforts on.
	• Various mailers, including asthma management packets, diabetes management refrigerator magnets and blood pressure management refrigerator magnets, are being sent to populations experiencing disparities in these clinical areas.
	• Text messaging campaign activity as of May 2024:
	  ○ Twenty-seven active LACC members and 228 active MCLA members enrolled in the postpartum campaigns;
	  ○ Sixteen LACC members and 20 MCLA members enrolled in the prenatal campaigns. Of these 36 members, all 20 MCLA members identify as Black/African American.

Ensure that the services we provide to members promote equity and are free of implicit and explicit bias.	
Tactics	**Update**
	• We continue to expand our doula provider network. The L.A. County Department of Public Health AAIMM Doula Program contract finalized in May. Full contracts are being finalized with Birth Workers of Color Collective and So Amazing Doula. L.A. Care is currently fully contracted with one doula organization, The Doula Network, and working under a Letter of Agreement (LOA) with two additional independent doulas. L.A. Care has recommended 149 members for doula services since the Doula Benefit program inception on January 1, 2023. Of the 149 members, 33 identify as Black/African American. • Pregnancy educational mailings were distributed to 2,082 prenatal members in April and May. These educational mailings included 193 Health Pregnancy Black/African American Resources Guides that were sent to eligible members. Within the same timeframe, 1,148 Healthy Mom (Postpartum) Outreach Calls were conducted. • L.A. Care social media channels shared posts on Black Maternal Health Week in April, Maternal Mental Health Month in May, and Home Visiting Day.
Implement initiatives to promote diversity among providers, vendors, and purchased services.	We have completed embedding vendor diversity into the Procurement/Request for Proposal (RFP) processes. A method has been established for sourcing diverse vendors. We have updated the RFP training materials to include Diversity language and have provided training to internal stakeholders on the inclusion of diverse vendors for their business opportunities. In addition, a mechanism is now in place to track and report on L.A. Care's diversity spends. L.A. Care awarded 5 organizations the Health Equity Award. These organizations advocated for tenant's rights, increased vaccinations in vulnerable communities during the COVID-19 pandemic, addressed student and family health care needs at a school-based health center, and worked to improve infant and maternal mortality rates. The Provider Equity Council has designed an initiative to introduce photographs of primary care physicians (PCP) in the provider directory. Pictures of PCPs can add significant value for members. Studies indicate that visual cues, such as gender and ethnicity, can resonate with members, fostering a sense of connection and trust. This initiative aims to increase the number of members that self-select their primary care physicians, rather than being auto-assigned. Members who choose their own physicians are more likely to engage actively in their healthcare, such as utilizing preventive services, which can ultimately lead to better health outcomes and higher satisfaction.

Ensure that the services we provide to members promote equity and are free of implicit and explicit bias.	
Tactics	**Update**
	The efforts to include primary care provider (PCP) photos in our online provider directory continue to be underway. The business case has been re-worked and we are now gathering the system requirements. Phase 1 will be a pilot by selecting one participating physician group (PPG) across LACC, MCLA, and D-SNP lines of business. The workgroup aims to have the provider directory enhancement by mid-year 2025. Upon launch and monitoring, the council will draft a roadmap of future phases.
Offer providers Diversity, Equity, and Inclusion resources to promote bias-free care.	As of now, L.A. Care is on track to implement the DHCS all plan letter (APL), 23-025, Diversity Equity and Inclusion (DEI) Training Plan for community health care providers, health plans, and other managed care organization staff. L.A. Care is collaborating and leading the L.A. County-wide effort along with our Plan Partners and other local health plans. L.A. Care is also co-chairing the state-wide local plan DEI collaborative.

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.	Continued to connect plans interested in participating in Covered California with helpful resources.

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.	New CRCs in West L.A. and Panorama City opened, bringing the total of open centers to 12. Construction continues on final two sites in South L.A. and Lincoln Heights.
Partner with community-based organizations to offer a range of services onsite.	Completed a successful hypertension control pilot program for members at two CRCs. The new collaboration was between the American Heart Association and the L.A. Care Health Promoters Program.

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 hosted a Gun Violence Safety event in June, during Gun Violence Prevention month, at the Lynwood Community Resource Center. The event included a Gun Violence Awareness Survivor's Panel that featured community voices and was moderated by L.A. Care's Quality Medical Director. Approximately 60 community members attended the event and received free gun locks and educational resources on gun safety. In June, the Wilmington Community Resource Center (CRC) hosted its first Camp CRC event. Women Against Gun Violence and Moms Demand Action were in attendance and held activities for children. Gun locks were also distributed by the L.A. County Office of Violence Prevention.
Support regional Health Information Exchanges (HIE).	L.A. Care launched round one of the Health Information Exchange (HIE) Adoption incentive for hospitals and Skilled Nursing Facilities (SNFs) in March, aimed at further enhancing HIE adoption and supporting their participation in California's Health and Human Services (CalHHS) Data Exchange Framework (DxF); this was followed by Round two in May. We have allocated $2.2M towards this effort and to-date, we have funded 30 SNFs and eight hospitals. In April, L.A. Care launched an HIE Participation Measure within the Physician Pay for Performance (P4P) program to encourage achieving HIE Participation Milestones, including involvement in CalHHS DxF.

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 team has taken significant steps forward with several innovative new projects that will bring new needed services to L.A. Care members. We've completed the application process and selected our network provider for the new L.A. County Field Medicine program. We've completed the mapping of the entire county using ArcGIS technology and assigned field medicine providers to coverage regions based on homeless density in those regions. We've also completed planning and will be finalizing contract agreements with our three participating providers for the Skid Row Care Collaborative, an innovative new concept that will integrate services and resources of three providers in the Skid Row area. On the Community Supports side, we've completed preparations for the launch of our new Day Habilitation program, which will go live on July 1, 2024 with our initial cohort of providers.

July 2024
Grants & Sponsorships Report
September 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	**3C Community Clinic**	To mitigate disparities through integrated clinical interventions and social support through service referral to ensure 200 Korean American patients are screened for depression or anxiety and at least 100 patients improve PHQ-9 and GAD-7.	7/11/2024	Robert E. Tranquada, MD Safety Net Initiative XV Grant	$ 150,000	$ -	$ 150,000
2	**Achievable Health**	Support the expansion of access to care for seniors and people with disabilities and other differently abled individuals in Los Angeles County through the utilization of adaptive equipment.	7/17/2024	Acessible Equipment Fund Grant	$ 14,419	$ -	$ 14,419
3	**AltaMed Health Services Corporation**	East LA Meets Napa: This sponsorship supports the work AltaMed does to increase access to quality healthcare to Los Angeles residents.	7/18/2024	Sponsorship	$ -	$ 10,000	$ 10,000
4	**APLA Health & Wellness**	Will engage at least 1,800 at-risk MSM to increase the amount of MSM using PrEP for at least 600 patients, and sustain the usage of PrEP for at least 450 at risk MSM.	7/11/2024	Robert E. Tranquada, MD Safety Net Initiative XV Grant	$ 150,000	$ -	$ -
5	**Arroyo Vista Family Health Foundation**	2024 National Health Center Week - Children's Back to School: This sponsorship supports National Health Center Week.	7/15/2024	Sponsorship	$ -	$ 3,000	$ 3,000
6	**Asian Pacific Health Care Venture, Inc.**	Will screen at least 8,000 patients, navigate community resources for at least 800 patients, and reduce HbA1c and blood pressure levels for Hispanic patients with diabetes and/or hypertension.	7/11/2024	Robert E. Tranquada, MD Safety Net Initiative XV Grant	$ 150,000	$ -	$ 150,000
7	**Be Social Productions**	Summer Health Fair: This sponsorship supports a health and wellness resource fair serving the Hispanic community in Lynwood.	7/22/2024	Sponsorship	$ -	$ 4,000	$ 4,000
8	**Breastfeeding Task Force of Greater Los Angeles**	BreastfeedLA "Know Your Rights" Day: This sponsorship supports a two-day event that will bring community members and professionals together to explore crucial topics affecting families in the childbearing years. Attendees will explore birthing people's rights, paid family leave, lactation rights and more.	7/15/2024	Sponsorship	$ -	$ 6,500	$ 6,500
9	**Cabrillo Marine Aquarium**	Grand Grunion Gala 2024: This sponsorship is a fundraising gala for the Cabrillo Marine Aquarium, which is a pivot event brought to us by the CRC Wilmington site to support early childhood education.	7/30/2024	Sponsorship	$ -	$ 2,750	$ 2,750
10	**Care Harbor**	Women's Health free clinic: This sponsorship supports Care Harbor's efforts to bring health care services such as dental, medical, vision, mental health referrals, screenings, and social service resources to women.	7/15/2024	Sponsorship	$ -	$ 10,000	$ 10,000
11	**Comprehensive Community Health Centers (CCHC)**	CCHC National Health Center Week - Multicultural Health Fair and Children's Appreciation Day: This event supports National Health Center Week focused on the health of children and families in Los Angeles Unified School District.	7/15/2024	Sponsorship	$ -	$ 5,000	$ 5,000
12	**Eisner Pediatric and Family Medical Center**	National Health Center Week: This sponsorship supports their National Health Center Week activities.	7/16/2024	Sponsorship	$ -	$ 2,500	$ 2,500
13	**Eriksson Ad Venture**	El Dia Del Salvadoreno: This is a community festival event celebrating the culture and heritage of Salvadoran's in Los Angeles	7/22/2024	Sponsorship	$ -	$ 3,500	$ 3,500

14	**Every Day Action**	Monthly Fundraiser Events: This sponsorship raises funds and awareness surrounding food insecurity for those experiencing homelessness	7/5/2024	Sponsorship	$ -	$ 5,000	$ 5,000
15	**FundaMental Change**	FundamMental Change Golf Tournament and Wellness Retreat: This sponsorship is a golf fundraiser brought to us by John Baackes, to support the FundaMental nonprofit organization in their programmatic efforts toward mental health wellness, advocacy and mental health caregivers.	7/22/2024	Sponsorship	$ -	$ 10,000	$ 10,000
16	**Garfield Health Center**	To enhance access to oral healthcare, will engage at least 1,200 Latino patients to facilitate oral healthcare access through care coordination services.	7/11/2024	Oral Health Initiative XV Grant	$ 125,000	$ -	$ 125,000
17	**Garfield Health Center**	To identify at-risk patients and engage in tailored tiered levels of care management and closed-loop referrals for at least 981 patients, and improve HEDIS measures by 5% such as Hemoglobin A1c Control for Patients with Diabetes.	7/11/2024	Robert E. Tranquada, MD Safety Net Initiative XV Grant	$ 150,000	$ -	$ 150,000
	Garfield Health Center	Cumulative Total Line	-	Sponsorship/Grants			**$ 275,000**
18	**Gracelight Community Health**	To increase service capacity and access to care at their Echo Park and Westlake North sites. Will serve at least 800 patients, reduce untreated dental caries for seniors and adults, and increase screenings and dental sealants for children and teenagers.	7/11/2024	Oral Health Initiative XV Grant	$ 95,000	$ -	$ 95,000
19	**Harbor Community Clinic dba Harbor Community Health Centers**	To mitigate disparities through tailored clinical interventions for diabetic patients. Will enhance comprehensive diabetic management services through addressing social determinants of health by serving at least 1,170 diabetic patients.	7/11/2024	Robert E. Tranquada, MD Safety Net Initiative XV Grant	$ 150,000	$ -	$ 150,000
20	**Helpline Youth Counsel**	This project will support Helpline Youth Counseling, Inc. (HYC) Dream Resource Centers, which are safe environments at five high-need secondary schools. Services to be implemented include social and civic engagement programming.	7/11/2024	Ad Hoc Grant	$ 100,000	$ -	$ 100,000
21	**Herald Christian Health Center**	To decrease oral health barriers by outreaching and providing patient education and other coordination services to at least 800 patients, assist at least 500 limited English-speaking patients in completing a Social Determinants of Health screening.	7/11/2024	Oral Health Initiative XV Grant	$ 125,000	$ -	$ 125,000
22	**Herald Christian Health Center**	To mitigate disparities through tailored clinical interventions for newly enrolled Medi-Cal members and existing patients by enhancing enrollment assistance and navigation services for at least 1,000 patients.	7/11/2024	Robert E. Tranquada, MD Safety Net Initiative XV Grant	$ 150,000	$ -	$ 150,000
	Herald Christian Health Center	Cumulative Total Line	-	Sponsorship/Grants			**$ 275,000**
23	**It's Bigger Than Us**	5th Annual Back 2 School Festival: This sponsorship supports the provision of access to health, wellness, and educational resources in South LA.	7/19/2024	Sponsorship	$ -	$ 5,000	$ 5,000
24	**JWCH Institute Inc.**	To enhance access to oral healthcare for patients, will identify and refer at least 1,000 diabetic patients without a dental visit to the dental clinic, provide dental care for at least 578 pateints with diabetes, and decrease periodontal inflammation for at least 50% during their next dental visit.	7/11/2024	Oral Health Initiative XV Grant	$ 100,000	$ -	$ 100,000

25	**JWCH Institute, Inc.**	To mitigate disparities through tailored clinical interventions for pediatric patients to improve well-child utilization and immunization rates. Will provide targeted outreach, education, and navigation services to at least 1,102 pediatric patients and families.	7/11/2024	Robert E. Tranquada, MD Safety Net Initiative XV Grant	$ 150,000	$ -	$ 150,000
	JWCH Institute, Inc.	**Cumulative Total Line**	-	**Sponsorship/Grants**			**$ 250,000**
26	**Kheir Clinic**	Support the expansion of access to care for seniors and people with disabilities and other differently abled individuals in Los Angeles County through the utilization of adaptive equipment.	7/17/2024	Acessible Equipment Fund Grant	$ 12,188	$ -	$ 12,188
27	**LA County Medical Association**	153rd Installation of President and Officers: This event supports the medical professional community in addressing various issues including food insecurity, childhood obesity, school nutrition, mental health, gun violence prevention, and medical debt to name a few.	7/18/2024	Sponsorship	$ -	$ 5,000	$ 5,000
28	**Los Angeles Christian Health Center**	To mitigate disparities through tailored clinical interventions by enhancing quality improvement infrastructure to empower providers to deliver data-driven, optimal care. Will provide targeted outreach to at least 2,000 patients with diabetes and hypertension in need of screenings and chronic disease and wellness exams.	7/11/2024	Robert E. Tranquada, MD Safety Net Initiative XV Grant	$ 150,000	$ -	$ 150,000
29	**Northeast Valley Health Corporation**	2024 National Health Center Week: This sponsorship supports National Health Center Week.	7/5/2024	Sponsorship	$ -	$ 2,500	$ 2,500
30	**Northeast Valley Health Corporation**	Community Resource Day: This event is a community health fair focused on providing health resources and services to individuals and families in the San Fernando and Santa Clarita Valleys.	7/23/2024	Sponsorship	$ -	$ 5,000	$ 5,000
31	**Northeast Valley Health Corportation**	To increase dental care utilization amongst hypertensive persons experiencing homeless (PEH) in Van Nuys. Will engage at least 100 PEH medical patients to participate in at least three education classes related to oral health and blood pressure.	7/11/2024	Oral Health Initiative XV Grant	$ 125,000	$ -	$ 125,000
32	**Northeast Valley Health Corportation**	To mitigate disparities through tailored clinical interventions for adult patients by providing targeted outreach to at least 1,000 patients, completing social determinant of health screening for at least 700 patients.	7/11/2024	Robert E. Tranquada, MD Safety Net Initiative XV Grant	$ 150,000	$ -	$ 150,000
	Northeast Valley Health Corportation	**Sponsorship and Grant combination line.**	-	**Sponsorship/Grants**			**$ 282,500**
33	**Pediatric and Family Medical Center dba Eisner Health**	To reduce oral health barriers to care among Los Angeles Unified School District students and residents. Will provide at least 1,000 patients with mobile dental services, and increase African American and Hispanic/Latinx patients age 5-19 that have a recall exam and fluoride treatment by 10%.	7/11/2024	Oral Health Initiative XV Grant	$ 125,000	$ -	$ 125,000
34	**South Central Family Health Center**	SCFHC 2nd Annual Family Health Day: This sponsorship supports National Health Center Week.	7/5/2024	Sponsorship	$ -	$ 3,000	$ 3,000
35	**Southside Coalition of Community Health Centers**	CCP focuses on providing care coordination for community health center patients living in South Los Angeles who are admitted to Dignity Health-California Hospital Medical Center (CHMC) or receive care in CHMC's emergency department.	7/11/2024	Ad Hoc Grant	$ 150,000	$ -	$ 150,000
36	**Special Needs Network, Inc.**	Back to School Health + Resource Fair: This annual back-to-school event supports the special needs community and features vaccination clinics and health screenings, and offers healthy meals and nutrition, free school supplies and backpacks, and focuses on special needs resources to ensure inclusive support for all families, particularly those impacted by educational and health disparities.	7/22/2024	Sponsorship	$ -	$ 5,000	$ 5,000

37	**Student Health SVCS Support Fund**	Salute to Student Health: This sponsorship helps to bridge the gap between health and education to improve student wellness. John Baackes will be honored during the fundraising event.	7/15/2024	Sponsorship	$ -	$ 10,000	$ 10,000
38	**T.H.E. Clinic dba T.H.E. Health and Wellness Centers**	To reduce oral health barriers to care, will purchase dental equipment and complete minor physical renovation to expand service capacity and provide dental care to at least 500 Black and Latinx patients. Will refer at least 125 patients to Enhanced Care Management/Registered Dietician, provide dental screenings to at least 100 Black and Latinx patients with diabetes, at least 50 Latinx and Black patients will receive tropical fluoride treatment, and will decrease no-show rate and average wait time for dental appointments.	7/11/2024	Oral Health Initiative XV Grant	$ 125,000	$ -	$ 125,000
39	**The Los Angeles Free Clinic dba Saban Community Clinic**	to mitigate disparities through tailored clinical interventions for patients at risk or already diagnosed with diabetes by completing a comprehensive health risk assessment and referring to social or internal services for at least 235 patients, providing close-loop referral for diabetes management program for 140 patients, and improving HbA1c levels by .7 points for at least 60 patients.	7/11/2024	Robert E. Tranquada, MD Safety Net Initiative XV Grant	$ 150,000	$ -	$ 150,000
40	**UCLA Health Sound Body Sound Mind**	Project will deliver comprehensive physical education programs and resources to five middle schools with high need student populations located in SPA 6.These programs and resources include new school fitness centers, exercise accessories, teacher professional development, and an exercise and nutrition curriculum.	7/11/2024	Ad Hoc Grant	$ 266,000	$ -	$ 266,000
41	**University Muslim Medical Association dba UMMA Clinic**	to mitigate disparities through tailored clinical interventions by serving at least 300 patients with type II diabetes or A1c levels over 9, completing social determinant of health assessment and providing behavioral health and case management services for at least 200 patients, reduce mental health distress for at least 60 patients with diabetes, and improve HbA1c levels for at least 50 patients.	7/11/2024	Robert E. Tranquada, MD Safety Net Initiative XV Grant	$ 150,000	$ -	$ 150,000
42	**University of Southern California**	6th Annual California Street Medicine Symposium: This sponsorship supports the work L.A. Care, HealthNet, and USC are doing to bring street medicine solutions to those who need the access to care.	7/18/2024	Sponsorship	$ -	$ 5,500	$ 5,500
43	**Venice Family Clinic**	Venice Family Clinic National Health Center Week: This sponsorship supports National Health Center Week.	7/5/2024	Sponsorship	$ -	$ 5,000	$ 5,000
44	**Venice Family Clinic**	to mitigate disparities through tailored clinical interventions by screening at least 1,600 patients for food insecurity status and connecting at least 450 food insecure patients to sustainable food insecurity resources - including providing ready-made meals, creating and distributing a Food Rx guide with local food resources, and refering to nutrition classes. Will improve at least 225 patients food insecurity status and decrease A1c levels for at least 10% of patients with uncontrolled diabetes.	7/11/2024	Robert E. Tranquada, MD Safety Net Initiative XV Grant	$ 150,000	$ -	$ 150,000
	Venice Family Clinic	**Sponsorship and Grant combination line.**	**-**	**Sponsorship/Grants**			**$ 155,000**
45	**Via Care Community Health Center**	To enhance access to oral healthcare for pediatric patients, will provide outreach and screening at LA Dental Society events in partnership with KIPP schools, serve at least 960 patients ages 0-17, provide follow up treatment to at least 588 6-9 year olds with oral health screenings and warm hand-offs to dental, and reduce childhood caries for at least 480 children presenting with two or more dental caries.	7/11/2024	Oral Health Initiative XV Grant	$ 125,000	$ -	$ 125,000

46	**Via Care Community Health Center**	to mitigate disparities through tailored clinical interventions for high risk and obese prenatal women by integrating nutrition into OB/GYN services. Will provide nutrition counseling and external closed-loop food resource referrals for at least 680 women, at least 238 women will reduce their BMI, and 10% will self-report an increase in fruit and vegetable consumption.	7/11/2024	Robert E. Tranquada, MD Safety Net Initiative XV Grant	$ 150,000	$ -	$ 150,000
	Via Care Community Health Center	**Sponsorship and Grant combination line.**	**-**	**Sponsorship/Grants**			**$ 275,000**
47	**Watts Healthcare Corporation**	To enhance access to oral healthcare, and will engage and serve 800 new patients, reduce oral emergency visits, and refer dental patients for further medical screenings and evaluations for diabetes, hypertension, and oral cancer.	7/11/2024	Oral Health Initiative XV Grant	$ 125,000	$ -	$ 125,000
48	**White Memorial Community Health Center**	To enhance access to oral health care for prenatal patients, will hire a Population Health Coordinator to serve at least 200 prenatal patients.	7/11/2024	Oral Health Initiative XV Grant	$ 125,000	$ -	$ 125,000
49	**White Memorial Community Health Center**	To mitigate disparities through tailored clinical interventions for at-risk pediatric and adult patients by providing enhanced care coordination services including closed-loop referrals for at least 100 patients, and reduce emergency department utilization and hospital admissions by 50%.	7/11/2024	Robert E. Tranquada, MD Safety Net Initiative XV Grant	$ 125,000	$ -	$ 125,000
	White Memorial Community Health Center	**Sponsorship and Grant combination line.**	**-**	**Sponsorship/Grants**			**$ 250,000.00**
				Total of grants and sponsorships approved in July 2024	**$ 3,812,607**	**$ 108,250**	**$ 3,920,857**

L.A. Care Medicare Plus Enrollee Advisory Committee Meeting Summary

Meeting Date: August 20, 2024, Time: 2:00pm-3:30pm
Attendees: Six L.A. Care Medicare Plus members; in-person meeting at L.A. Care Headquarters. Address: 1055 W. 7th Street, Los Angeles, CA 90017

Meeting Summary

I. L.A. Care Updates

a. Staff informed the attendees about the following:

i. **L.A. Care Awards Eight New Medical School Scholarships to Students from Underrepresented Communities:** L.A. Care Health Plan is proud to announce its seventh cohort of Elevating the Safety Net medical school scholarship awardees that took place during a special "white coat" ceremony. Eight students from underrepresented communities received a full-ride medical school scholarship worth nearly $428,000, allowing them to graduate without medical school debt. Elevating the Safety Net is a $205 million initiative, which launched in 2018 to address a growing physician shortage across the country – a shortage projected to be 86,000 by 2036.

ii. **New Summer Food Program:** SUN Bucks, also known as Summer EBT (S-EBT), is a new program to help families buy food for their school-aged children during the summer. Families will get $120 ($40 per month) between June through September for each eligible child to buy groceries during the summer.

iii. **L.A. Care Health Plan Has Committed $509 Million to Support the Health of Los Angeles County Residents:** L.A. Care published a print and digital Community Impact Report highlighting this commitment. L.A. Care recognizes that non-medical factors can significantly impact health outcomes. To ensure healthy communities, it is critical to address basic needs like food, housing, education, transportation and employment – often referred to as social needs, or social determinants of health.

iv. **Medi-Cal Renewals/Redetermination:** Staff reminded committee members that Medi-Cal renewals have begun. The local Med-Cal office will send them a letter or a renewal form to complete. They will need to complete the renewal by the due date printed on the form. If not, they can lose their Medi-Cal coverage. Staff provided website information, benefitscal.com and contact information for DPSS at 1-866-613-3777.

v. **Updates on Community Resource Center (CRC) programming:** The Community Resource Center in South L.A. will open in mid-October. It's located at 5710 Crenshaw Blvd Los Angeles, CA 90043. It will be open Monday through Friday from 9:00am to 5:00pm.

The Community Resource Centers will have their free flu and COVID-19 vaccine events from September 13 to November 8, 2024. Individuals who get a vaccine will receive a free $20 grocery gift card, while supplies last. Additionally, adults aged 18 and older can get free blood sugar and blood pressure readings.

II. Member Experience Initiatives: Advancing Health Equity

a. Staff provided members an overview and received input on the L.A. Care Medicare Plus member experience initiative: Advancing Health Equity – what is it and why it is important, Improved Communication and Resources, Elevating the D-SNP Member Orientation with an Animated Video, Year-To-Date Accomplishments, and more

III. Annual Check-Up Member Survey (Texting)

a. Staff provided information and received input about the results of the Annual Check-Up Member Survey. The survey aims to identify and address critical gaps in healthcare access while gauging the barriers that might impede members from seeking essential healthcare services.

IV. Close-Out

a. Members got instructions on how to contact L.A. Care Member Relations staff for help with member issues.
b. The next L.A. Care Medicare Plus Enrollee Advisory Committee meeting will be Tuesday, November 12, 2024, from 2:00 pm - 3:30 pm, via conference call.

Legislative Matrix

Last Updated: August 30, 2024

Bills by Issue

2024 Legislation (96)

Bill Number	Status	Position
AB 106	**Enacted**	**Monitor**

Title
Budget Acts of 2022 and 2023.

Description
AB106, 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	Status	Position
AB 157	**Passed Senate**	**None**

Title
Budget Act of 2024.

Description
AB157, as amended, span.DottedLeaders::after {content:".....";}Committee on Budget Gabriel . span.DottedLeaders::after {content:".....";}Budget Act of 2023. Budget Act of 2024. The Budget Act of 2024 made appropriations for the support of state government for the 2024–25 fiscal year. This bill would amend the Budget Act of 2024 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. span.DottedLeaders::after {content:".....";}This bill would express the intent of the Legislature to enact statutory changes, relating to the Budget Act of 2023.

Primary Sponsors
Jesse Gabriel

Bill Number	Status	Position
AB 158	**Passed Senate**	**None**

Title
Budget Acts of 2022 and 2023.

Description
AB158, as amended, span.DottedLeaders::after {content:".....";}Committee on Budget Gabriel . span.DottedLeaders::after {content:".....";}Budget Act of 2023. 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 and repealing items of appropriation and making other changes. This bill would declare that it is to take effect immediately as a Budget Bill.span.DottedLeaders::after {content:".....";}This bill would express the intent of the Legislature to enact statutory changes, relating to the Budget Act of 2023.

Primary Sponsors
Jesse Gabriel

Bill Number	Status	Position
AB 177	**Passed Senate**	**Monitor**

Title
Health.

Description
AB 177, as amended, Committee on Budget. Health. (1) 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. Existing law requires the department, by January 1, 2025, to adopt emergency regulations to implement the recommendations in a specified report of the California State Auditor. Existing law requires the department to maintain the general moratorium on new hospice agency licenses until the department adopts the regulations. Existing law requires the moratorium to end the date the emergency regulations are adopted.This bill would extend the deadline by which the department is required to adopt those regulations to January 1, 2026, and would require the moratorium to end January 1, 2027, or one year after the date the emergency regulations are adopted.(2) Existing law requires a disability insurance policy issued, amended, renewed, or delivered on or after January 1, 2024, to provide coverage for medically necessary treatment of mental health and substance use disorders and cover services identified in a fee-for-service reimbursement schedule published by the State Department of Health Care Services when those services are delivered at schoolsites, regardless of the network status of the local educational agency, institution of higher education, or health care provider. Existing law requires the Insurance Commissioner to issue guidance to disability insurers regarding compliance with these provisions. Existing law, as part of the Children and Youth Behavioral Health Initiative, requires the State Department of Health Care Services to develop and maintain a school-linked statewide provider network of schoolsite behavior health counselors and requires a health care service plan, insurer, or Medi-Cal managed care plan that covers necessary schoolsite services, as specified, to comply with all administrative requirements to cover and reimburse the services set forth by the network administrator.This bill would require the commissioner to additionally issue guidance to disability insurers regarding compliance with provisions regarding administrative requirements to cover and reimburse services under the school-linked statewide behavioral health provider network.(3) 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 Medica... (click bill link to see more).

Primary Sponsors
House Budget Committee

Bill Number	Status	Position
AB 869	**Passed Senate**	**Monitor**

Title
Hospitals: seismic safety compliance.

Description
AB 869, as amended, Wood. Hospitals: seismic safety compliance. (1) 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.The bill would require all rural, district, and distressed acute care hospitals to provide the department with a seismic safety compliance plan by no later than July 1, 2026, that describes how the hospital intends to meet the seismic safety requirements described above.(2)Existing law establishes the Distressed Hospital Loan Program 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.This bill would qualify a general acute care hospital that received a distressed hospital loan for an extension of the seismic safety standards described above until January 1, 2032. If the department determines that the cost of design and construction for compliance with these seismic safety standards will result in a financial hardship for a distressed hospital that may result in hospital closure, and state funds, federal grants, or private funds are not available to assist with the cost of compliance, the bill would authorize the distressed hospital to delay compliance until January 1, 2035. The bill would require the department to confirm a distressed hospital’s lack of ability to comply and that the cost of compliance may result in hospital closure, or would substantially impact the accessibility to health care in communities surrounding the distressed hospital. The bill would authorize the department to implement these provisions through emergency regulations.This bill would authorize a Distressed Hospital Loan Program recipient, a small hospital, a rural hospital, a critical access hospital, or a health care district hospital, as defined, and except as specified, to seek approval from the Department of Health Care Access and Information for a delay to the January 1, 2030, compliance deadline described above by up to 3 years. The bill would require hospitals seeking a delay to submit a seismic compliance plan, as specified, and, if necessary, a Nonstructural Performance Category-5 evaluation report.... (click bill link to see more).

Primary Sponsors
Jim Wood, Eduardo Garcia

Bill Number	Status	Position
AB 892	**Passed Senate**	**Monitor**

Title
Kern County Hospital Authority.

Description
AB 892, as amended, 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. Existing law requires the authority to maintain financial and accounting records.Existing law, the California Public Records Act, requires state and local agencies to make their records available for public inspection, unless an exemption from disclosure applies. Existing law requires the authority to comply with the act, except as specified.This bill would subject the Kern Medical Center Foundation to the California Public Records Act in the same manner as the authority.The bill would require the authority and the Kern Medical Center Foundation to maintain accounting records and to report accounting transactions in accordance with generally accepted accounting principles, as specified. The bill would require the authority, at least once every 12 months, to engage the services of a qualified accountant of accepted reputation to conduct a financial audit of the accounts and records of both the authority and the Kern Medical Center Foundation, as specified, to prepare a report of the audit, and to make copies of the reports available to the public on the authority’s internet website.By creating new duties for 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.This bill would make legislative findings and declarations as to the necessity of a special statute for the County of Kern and Kern Medical Center Foundation.

Primary Sponsors
Jasmeet Bains

Bill Number	Status	Position
AB 1282	**Passed 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. Existing law authorizes the State Department of Public Health to, among other things, enforce its regulations and protect and preserve the public health.This bill would require the department, in consultation with the commission, to report to specified policy committees of the Legislature, on or before December 31, 2026, 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 the mental health of children and youth is positively, negatively, or neutrally impacted by use of social media and (2) recommendations to strengthen children and youth resiliency strategies and California’s use of mental health services related to social media use. The bill would require the department to explore, among other things, the child and youth populations that use social media, including disproportionate rates and impacts among specific groups, and the negative behavioral health risks, as specified, associated with social media use and misuse among children and youth. The bill would require the department to additionally consult with certain communities in preparing the report, and prior to publication. The bill would repeal these provisions on January 1, 2030.

Primary Sponsors
Josh Lowenthal

Bill Number	Status	Position
AB 1316	**Passed Senate**	**Monitor**

Title
Emergency services: psychiatric emergency medical conditions.

Description
AB 1316, 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 assessment, evaluation, and crisis intervention, or placement for evaluation and treatment, under prescribed circumstances. The bill would make conforming and clarifying 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 poststabilization care services required under specified federal law, emergency room professional services, and facility charges for emergency room visits. The bill would require coverage for emergency services necessary to relieve or eliminate a psychiatric emergency m... (click bill link to see more).

Primary Sponsors
Jacqui Irwin, Chris Ward

Bill Number	Status	Position
AB 1470	**Passed Senate**	**Monitor**

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

Description
AB 1470, 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	Status	Position
AB 1842	**Passed Senate**	**Monitor**

Title
Health care coverage: Medication-assisted treatment.

Description
AB 1842, as amended, 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 require a group or individual health care service plan or health insurer offering an outpatient prescription drug benefit to provide coverage without prior authorization, step therapy, or utilization review for at least one medication approved by the United States Food and Drug Administration in each of 4 designated categories, including medication for the reversal of opioid overdose, including a naloxone product or another opioid antagonist. 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	Status	Position
AB 1876	**In Senate**	**Monitor**

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

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	Status	Position
AB 1895	**Passed Senate**	**Monitor**

Title
Public health: maternity ward closures.

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 operates a perinatal unit and expects challenges in the next 6 months that may result in a reduction or loss of perinatal services, to report specified information to the Department of Health Care Access and Information, including, but not limited to, the number of medical staff and employees working in the perinatal unit and the hospital’s prior performance on financial metrics. The bill would require the Department of Health Care Access and Information to forward the provided information to the State Department of Health Care Services and the State Department of Public Health. The bill would require this information be kept confidential to the extent permitted by law. The bill would require, within 3 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 and the State Department of Health Care Services, to conduct a community impact assessment to identify the 3 closest hospitals operating a perinatal unit, their distance from the challenged facility, and whether those hospitals have any restrictions on their reproductive health services. The bill would require the Department of Health Care Access and Information to provide the community impact assessment to specified entities and would require these entities to keep the community impact assessment confidential. If the hospital plans to close its perinatal unit, the bill would require the hospital to provide public notice of the proposed 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 closure. The bill would require the public to be pe... (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	Status	Position
AB 1936	**Passed Senate**	**Monitor**

Title
Maternal mental health screenings.

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, at least one additional screening during the first 6 weeks of the postpartum period, and additional postpartum screenings, 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, Susan Rubio

Bill Number	Status	Position
AB 1975	**Passed Senate**	**Monitor**

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

Description
AB 1975, as amended, 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 a covered benefit under the Medi-Cal program, through both the fee-for-service and managed care delivery systems, no sooner than July 1, 2026, upon appropriation and 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 the department to define the qualifying medical conditions for covered interventions and delineate the services included in the definition of a medically supportive food and nutrition intervention. 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, upon appropriation, to establish a medically supportive food and nutrition benefit stakeholder group, with a specified composition, to advise the department on certain related items, such as the scope of the benefit, among others.

Primary Sponsors
Mia Bonta

Organizational Notes

Last edited by Cherie Compartore at May 14, 2024, 3:52 PM
Support: Local Health Plans of California , California Association of Health Plans

Bill Number	Status	Position
AB 1977	**Passed Senate**	**Monitor**

Title
Health care coverage: behavioral diagnoses.

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. The bill would require a treatment plan to be made available to the plan or insurer upon request. 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	Status	Position
AB 2013	**Passed Senate**	**Monitor**

Title
Generative artificial intelligence: training data transparency.

Description
AB 2013, Irwin. Generative 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, and before each time thereafter that a generative artificial intelligence system or service, as defined, or a substantial modification to a generative artificial intelligence system or service, released on or after January 1, 2022, is made available to Californians for use, regardless of whether the terms of that use include compensation, a developer of the system or service to post on the developer’s internet website documentation, as specified, regarding the data used to train the generative artificial intelligence system or service. The bill would require that this documentation include, among other requirements, a high-level summary of the datasets used in the development of the system or service, as specified.

Primary Sponsors
Jacqui Irwin

Bill Number	Status	Position
AB 2063	**Passed Senate**	**Monitor**

Title
Health care coverage.

Description
AB 2063, 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 (VEBA) 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 instead authorize the director to authorize one pilot program in southern California, under which providers approved by the department may undertake risk-bearing arrangements with a VEBA, as specified above, if certain criteria are met. The bill would extend that repeal date to January 1, 2030. The bill would extend the period of time authorized for the pilot program 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

Organizational Notes

Last edited by Cherie Compartore at May 14, 2024, 3:53 PM
Oppose: California Association of Health Plans

Bill Number	Status	Position
AB 2072	**Passed Senate**	**Monitor**

Title
Group health care coverage: biomedical industry.

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, 2026, to provide the health policy committees of the Legislature the most recent annual filings of compliance. The bill would require the Department of Managed Health Care to conduct an analysis of the impacts on the small employer health insurance market in California of health care service plans currently issuing large group contracts to small employers through MEWAs, as specified. The bill would require the Department of Insurance to conduct an analysis of the impacts on the small employer health insurance market in California of health insurers currently issuing large group policies to small employers through MEWAs, as specified. The bill would authorize the departments to coordinate with each other. The bill would require the departmen... (click bill link to see more).

Primary Sponsors
Akilah Weber

Bill Number	Status	Position
AB 2105	**Passed Senate**	**Monitor**

Title
Coverage for PANDAS and PANS.

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 Cherie Compartore at May 14, 2024, 3:54 PM
Oppose: California Association of Health Plans

Bill Number	Status	Position
AB 2115	**In Senate**	**Monitor**

Title
Controlled substances: clinics.

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 practitioner authorized to prescribe a narcotic drug at a nonprofit or free clinic, as specified, to dispense the narcotic drug from clinic supply 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 reporting, labeling, and recordkeeping requirements. The bill would require clinics with a supply of narcotic drugs being dispensed pursuant to these provisions to establish policies or procedures for dispensing the narcotics, as specified. 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 classifies certain controlled substances into designated schedules. Existing law prohibits a controlled substance classified in Schedule II from being dispensed without a prescription, except when dispensed directly to the user in an amount not to exceed a 72-hour supply for the patient when the patient is not expected to require any additional amount of the controlled substance beyond the 72 hours.This bill would additionally authorize a practitioner to directly dispense no more than a 3-day supply of a Schedule II controlled substance to be dispensed to the ultimate user at one time for the purpose of initiating maintenance treatment or detoxification treatment, as specified.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.This bill would require th... (click bill link to see more).

Primary Sponsors
Matt Haney

Bill Number	Status	Position
AB 2129	**Passed Senate**	**Monitor**

Title
Immediate postpartum contraception.

Description
AB 2129, 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 licensed birth 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	Status	Position
AB 2132	**Passed Senate**	**Monitor**

Title
Health care services: tuberculosis.

Description
AB 2132, as amended, Low. Health care services: tuberculosis. 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 generally 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 a patient who is 18 years of age or older receiving health care services in a facility, clinic, center, office, or other setting, where primary care services are provided, to be offered tuberculosis screening, if tuberculosis risk factors are identified, to the extent these services are covered under the patient’s health care coverage, except as specified. 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. The bill would prohibit a health care provider that 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.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 requires the department to adopt an option made available under federal Medicaid law to pay allowable tuberculosis-related services for persons infected with tuberculosis, as specified.This bill would require a Medi-Cal managed care plan to ensure access to care for latent tuberculosis infection and active tuberculosis disease and coordination with local health department tuberculosis control programs for plan enrollees with active tuberculosis disease, as specified.

Primary Sponsors
Evan Low

Bill Number	Status	Position
AB 2198	**Passed Senate**	**Monitor**

Title
Health information.

Description
AB 2198, as amended, 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 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 requires health care service plans and health insurers, commencing January 1, 2024, to establish and maintain specified application programming interfaces (API), including patient access API, for the benefit of enrollees, insureds, and contracted providers. Existing law authorizes the departments to require health care service plans or health insurers, as applicable, to establish and maintain provider access API and prior authorization support API if and when final federal rules are published .This bill would, except for Medi-Cal dental managed care contracts, exclude a specialized plan or insurer that issues, sells, renews, or offers a contract or policy covering dental or vision services from the above-described API requirements, and would instead require a specialized plan or insurer that issues, sells, renews, or offers a contract or policy covering dental or vision services and meets specified enrollment requirements to comply with the above-described API requirements beginning January 1, 2027, or when the final federal rules for impacted payers are implemented, whichever is later.This bill would instead require the departments, commencing January 1, 2027, or when final federal rules are implemented, whichever occurs later, to require health care service plans and health insurers to establish and maintain patient access API, provider access API, payer-to-payer API, and prior authorization API. The bill, until January 1, 2027, would authorize the departments to issue guidance relating to these provisions not subject to the Administrative Procedure Act, as specified. Because a 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
Heath Flora

Bill Number	Status	Position
AB 2237	**Passed Senate**	**Monitor**

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

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 placed 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.

Primary Sponsors
Cecilia Aguiar-Curry

Bill Number	Status	Position
AB 2250	**In Senate**	**Monitor**

Title
Social determinants of health: screening and outreach.

Description
AB 2250, as amended, 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 standardized codes when documenting patient responses to questions asked in these screenings, and would require providers to use existing tools or protocols to conduct the 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 until regulations are adopted, and would require the departments to coordinate in the development of guidance and regulations. 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 bill would provide that these provisions will be implemented only upon an appropriation by the Legislature.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	Status	Position
AB 2258	**Passed Senate**	**Monitor**

Title
Health care coverage: cost sharing.

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 these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program. The bill would authorize the Insurance Commissioner to impose a civil penalty of not more than $5,000 against an insurer for each violation of these provisions, or not more than $10,000 per violation if the violation was willful.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	Status	Position
AB 2271	**Passed Senate**	**Monitor**

Title
St. Rose Hospital.

Description
AB 2271, as amended, Ortega. St. Rose Hospital. 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 (HCAI) to administer this loan program. Existing law authorizes the Board of Supervisors of the County of Alameda to establish the Alameda Health System Hospital Authority for the management, administration, and control of the medical center in that county. Existing law authorizes the hospital authority to acquire and possess real or personal property and to dispose of real or personal property other than that owned by the county, as may be necessary for the performance of its functions.This bill would require HCAI, subject to review and approval by the Department of Finance, as specified, to approve the forgiveness of any loans under the Distressed Hospital Loan Program for the St. Rose Hospital in the City of Hayward if the hospital is acquired by the Alameda Health System Hospital Authority. The bill would require HCAI 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.This bill would declare that it is to take effect immediately as an urgency statute.

Primary Sponsors
Liz Ortega

Bill Number	Status	Position
AB 2293	**Passed Senate**	**Monitor**

Title
Joint powers agreements: health care services.

Description
AB 2293, as amended, Mathis. Joint powers agreements: health care services. (1) 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, 2032, 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, until January 1, 2034, 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, as specified. 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 or to engage in specified other acts, including employing physicians and surgeons or charging for professional services rendered by physicians and surgeons. The bill would require an authority formed to be governed by a board of directors, composed as determined by the participating public agency or agencies. The bill would prohibit the representation of private, nonprofit mutual benefit corporations on the board of directors from exceeding 50%. The bill would define terms for its purposes. (2) Existing law sets forth requirements for the solicitation and evaluation of bids and the awarding of contracts by public entities, including requirements applicable if the public entity is required by statute or regulation to obtain an enforceable commitment that a bidder, contractor, or other entity will use a skilled and trained workforce, as defined, to complete a contract or project. Except as specified, existing law requires that, for workers employed on public works, as defined, not less than the general prevailing rate of per diem wages, determined as provided by the Director of Industrial Relations, for work of a similar character in the locality in which the public work is performed be paid to those workers, as provided. This bill, except as specified, would require a joint powers authority formed pursuant to the bill, when undertaking a project applicable to the construction or refurbishment of health facilities, to obtain an enforceable commitm... (click bill link to see more).

Primary Sponsors
Devon Mathis

Bill Number	Status	Position
AB 2297	**Passed Senate**	**Monitor**

Title
Hospital and Emergency Physician Fair Pricing Policies.

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 or the patient’s family, as defined, 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 the availability of a patient’s health savings account held by the patient or the patient’s family, as specified. The bill would revise the definition of patient’s family, 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, among other things, recent pay stubs or income tax returns. The bill would prohibit a hospital or an emergency physician from imposing time limits for applying for charity care or discounted payments, and would prohibit a hospital or emergency physician from denying eligibility based on the timing of a patient’s application. The bill would authorize a hospital or emergency physician to waive or... (click bill link to see more).

Primary Sponsors
Laura Friedman

Bill Number	Status	Position
AB 2302	**Passed Senate**	**Monitor**

Title
Open meetings: local agencies: teleconferences.

Description
AB 2302, 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 furthers the constitu… (click bill link to see more).

Primary Sponsors
Dawn Addis

Bill Number	Status	Position
AB 2319	**Passed Senate**	**Monitor**

Title
California Dignity in Pregnancy and Childbirth Act.

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 specified health care providers at hospitals that provide perinatal care, alternative birth centers, or primary care clinics, as specified. 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, by February 1 of each year, commencing in 2026, provide the Attorney General with proof of compliance with these provisions, as specified. The bill would authorize the Attorney General to pursue civil penalties for violations of these provisions, as s... (click bill link to see more).

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

Bill Number	Status	Position
AB 2327	**Passed Senate**	**Monitor**

Title
Optometry: mobile optometric offices.

Description
AB 2327, Wendy Carrillo. Optometry: mobile optometric offices. 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 regulates the ownership and operation of mobile optometric offices, as defined, including, among other things, requiring the owner and operator of a mobile optometric office to file a quarterly report containing specified information. 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 authorize the owner and operator of a mobile optometric office to instead file the above-described quarterly reports as a single, annual report during the first renewal period of 2 years, as specified. The bill would also extend the deadline for the board to adopt the above-described regulations to 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	Status	Position
AB 2339	**Passed Senate**	**Monitor**

Title
Medi-Cal: telehealth.

Description
AB 2339, as amended, 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.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	Status	Position
AB 2340	**Passed Senate**	**Monitor**

Title
Medi-Cal: EPSDT services: informational materials.

Description
AB 2340, 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, 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 a maximum number of calendar days after that beneficiary’s enrollment in a managed care plan or initial Medi-Cal eligibility determination and annually thereafter, as specified by the department.

Primary Sponsors
Mia Bonta

Bill Number	Status	Position
AB 2428	**Passed Senate**	**Monitor**

Title
Medi-Cal: Community-Based Adult Services.

Description
AB 2428, 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.

Primary Sponsors
Lisa Calderon, Bill Dodd

Bill Number	Status	Position
AB 2434	**Passed Senate**	**Monitor**

Title
Health care coverage: multiple employer welfare arrangements.

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 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, 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 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 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 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 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 department. This bill would require the department, on or before June 30, 2028, to provide the health policy committees of the Legislature with the most recent filings. The bill would require the department to conduct an analysis of the impacts of MEWAs on the small employer health insurance market, as specified, authorize the department to coordinate with the Department of Insurance for the analysis, require health care service plans, health insurers, and MEWAs to comply with requests for information, and require the department to post a report summarizing its analysis on its internet website on or before July 1, 2026. The bill, on or after June 1, 2025, would prohibit a plan 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 th... (click bill link to see more).

Primary Sponsors
Tim Grayson

Bill Number	Status	Position
AB 2435	**Passed Senate**	**Monitor**

Title
California Health Benefit Exchange.

Description
AB 2435, 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	Status	Position
AB 2442	**Passed Senate**	**Monitor**

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

Description
AB 2442, 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	Status	Position
AB 2446	**Passed Senate**	**Monitor**

Title
Medi-Cal: diapers.

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. Under existing law, incontinence medical supplies are covered by the Medi-Cal program.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 diseases of the skin. 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 limit the diapers provided pursuant to these provisions to an appropriate supply based on the diagnosed condition and the age of the beneficiary. The bill would require the department to seek any necessary federal approval to implement this section. The bill would make these provisions contingent upon an appropriation by the Legislature. This bill would establish diapers as a covered Medi-Cal benefit for a child greater than 3 years of age who has been diagnosed with a condition, as specified, that contributes to incontinence, and for an individual under 21 years of age if necessary to correct or ameliorate a condition pursuant to certain federal standards. The bill would limit the provided diapers to an appropriate supply based on the diagnosed condition and the age of the Medi-Cal beneficiary.The bill would require the department to seek any necessary federal approvals to implement these provisions. The bill would condition implementation of these provisions on receipt of any necessary federal approvals, the availability of federal financial participation, and an appropriation by the Legislature.

Primary Sponsors
Liz Ortega

Bill Number	Status	Position
AB 2467	**Passed Senate**	**Monitor**

Title
Health care coverage for menopause.

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 as specified, to include coverage for evaluation and treatment options for perimenopause and menopause. The bill would require a health care service plan or health insurer to annually provide clinical care recommendations, as specified, for hormone therapy to all contracted primary care providers who treat individuals with 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 Aug 21, 2024, 2:59 PM
Oppose: California Association of Health Plans (Removed)

Bill Number	Status	Position
AB 2556	**Enacted**	**Monitor**

Title
Behavioral health and wellness screenings: notice.

Description
AB 2556, 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, except as specified, or health insurer to provide to enrollees and insureds a written or electronic notice regarding the benefits of a behavioral health and wellness screening, as defined, for children and adolescents 8 to 18 years of age. The bill would require a health care service plan or insurer to provide the notice annually. 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	Status	Position
AB 2630	**Passed Senate**	**Monitor**

Title
Pupil health: oral health assessment.

Description
AB 2630, Bonta. Pupil health: oral health assessment. Existing law requires a pupil, while enrolled in kindergarten in a public school, or while enrolled in first grade in a public school if the pupil was not previously enrolled in kindergarten in a public school, to present proof of having received an oral health assessment by a licensed dentist, or other licensed or registered dental health professional operating within the professional’s scope of practice, that was performed no earlier than 12 months before the date of the initial enrollment of the pupil, as provided.This bill would define “kindergarten” for these purposes as including both transitional kindergarten and kindergarten, and would require the above-described proof only once during a 2-year kindergarten program. To the extent the bill would impose additional duties on public schools, 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
Mia Bonta

Bill Number	Status	Position
AB 2636	**Passed Senate**	**Monitor**

Title
Mello-Granlund Older Californians Act.

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 repeal obsolete provisions, such as the Senior Center Bond Act of 1984.Existing law establishes the Senior Housing Information and Support Center within the department 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.This bill would repeal the provisions establishing the Senior Housing Information and Support Center.

Primary Sponsors
Jasmeet Bains

Bill Number	Status	Position
AB 2703	**In Senate**	**Monitor**

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

Description
AB 2703, as amended, 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 that FQHC services and RHC services be reimbursed on a per-visit basis and defines a visit as a face-to-face encounter, or other modality of interaction, as specified, between a patient and specified practitioners.This bill would add to that list of practitioners a licensed professional clinical counselor.Existing law authorizes an FQHC or RHC to apply for an adjustment to its per-visit rate based on a change in the scope of services provided by the FQHC or RHC and includes in the definition of a change in the scope of services any changes in any of the federally defined FQHC services or RHC services, among other things. Existing law requires an FQHC or RHC that does not provide certain services, including marriage and family therapist services, and later elects to add those services and bill them as a separate visit to process the addition of the services as a change in scope of service, as specified.This bill would remove the requirement for an FQHC or RHC that does not provide marriage and family therapist services, but later elects to add those services and bill them as a separate visit, to file for a change in scope of service.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 or associate professional clinical counselor 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 or associate professional clinical counselor under those conditions. The bill would make conforming changes with regard to supervision by a licensed behavioral health practitioner, as required by the associate’s applicable clinical licensing board.

Primary Sponsors
Cecilia Aguiar-Curry

Organizational Notes

Last edited by Cherie Compartore at Jul 29, 2024, 9:07 PM
Support: Local Health Plans of California

Bill Number	Status	Position
AB 2715	**Passed Senate**	**Monitor**

Title
Ralph M. Brown Act: closed sessions.

Description
AB 2715, 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 with specified individuals on, among other things, matters posing a threat to the security of essential public services, as specified.This bill would additionally authorize a legislative body to hold a closed session with other law enforcement or security personnel and to hold a closed session on a threat to critical infrastructure controls or critical infrastructure information, as defined, relating to cybersecurity.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	Status	Position
AB 2749	**Passed Senate**	**Monitor**

Title
California Health Benefit Exchange: financial assistance.

Description
AB 2749, 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 necessary to determ... (click bill link to see more).

Primary Sponsors
Jim Wood

Bill Number
AB 2756

Status
Enacted

Position
Monitor

Title
Pelvic Floor and Core Conditioning Pilot Program.

Description
AB 2756, 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 San Diego County 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.This bill would make legislative findings and declarations as to the necessity of a special statute for San Diego County.

Primary Sponsors
Tasha Boerner

Bill Number
AB 2767

Status
Enacted

Position
Monitor

Title
Financial Solvency Standards Board: membership.

Description
AB 2767, 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 and individuals with training and experience in large group health insurance purchasing.

Primary Sponsors
Miguel Santiago

Bill Number	Status	Position
AB 2843	**Passed Senate**	**Monitor**

Title
Health care coverage: rape and sexual assault.

Description
AB 2843, as amended, 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 July 1, 2025, to provide coverage without cost sharing for emergency room medical care and followup health care treatment for an enrollee or insured who is treated following a rape or sexual assault for the first 9 months after the enrollee initiates treatment, as specified. 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	Status	Position
AB 2859	**Passed Senate**	**Monitor**

Title
Emergency medical technicians: peer support.

Description
AB 2859, 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 civil or 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 EMS provider.

Primary Sponsors
Jim Patterson

Bill Number	Status	Position
AB 2860	**Passed Senate**	**Monitor**

Title
Licensed Physicians and Dentists from Mexico programs.

Description
AB 2860, 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. The bill would require the Dental Board of California to, notwithstanding existing requirements to provide specified federal taxpayer information, issue a 3-year nonrenewable permit to an applicant who has not provided an individual taxpayer identification number or social security number if the applicant meets specified conditions.Commencing January 1, 2025, the bill would authorize the Medical Board of Califor... (click bill link to see more).

Primary Sponsors
Eduardo Garcia

Organizational Notes

Last edited by Cherie Compartore at May 29, 2024, 7:01 PM
Support: Local Health Plans of California, California Primary Care Association (Co-Sponsor), Clinica De Salud Del Valle De Salinas (Co-Sponsor)

Bill Number	Status	Position
AB 2885	**In Senate**	**Monitor**

Title
Artificial intelligence.

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.Exi... (click bill link to see more).

Primary Sponsors
Rebecca Bauer-Kahan, Tom Umberg

Bill Number	Status	Position
AB 2930	**In Senate**	**Monitor**

Title
Automated decision systems.

Description
AB 2930, as amended, Bauer-Kahan. Automated decision systems. 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, as prescribed, a deployer, as defined, and a developer of an automated decision system, as defined, to perform an impact assessment on any automated decision system before the system is first deployed and annually thereafter that includes, among other things, a statement of the purpose of the automated decision system and its intended benefits, uses, and deployment contexts. The bill would require a deployer or a developer to provide any impact assessment that it performed to the Civil Rights Department and would exempt an impact assessment provided to the department from the California Public Records Act, as prescribed.This bill would require a deployer to, prior to an automated decision system making a consequential decision, as defined, or being a substantial factor, as defined, in making a consequential decision, notify any natural person that is subject to the consequential decision that an automated decision system is being used and to provide that person with specified information. The bill would require a deployer that has deployed an automated decision system to make, or be a substantial factor in making, a consequential decision concerning a natural person, to provide to the natural person, among other things, an opportunity to correct any incorrect personal data. The bill would, if a consequential decision is made solely based on the output of an automated decision system, require a deployer to, if technically feasible, accommodate a natural person’s request to not be subject to the automated decision system and to instead be subject to an alternative selection process or accommodation, as prescribed.This bill would prohibit a deployer from using an automated decision system if an impact assessment identifies a reasonable risk of algorithmic discrimination, which the bill would define to mean the condition in which an automated decision system contributes to unlawful discriminat... (click bill link to see more).

Primary Sponsors
Rebecca Bauer-Kahan

Organizational Notes

Last edited by Joanne Campbell at Aug 19, 2024, 7:15 PM
Oppose - California Association of Health Plans

Bill Number	Status	Position
AB 2998	**Passed Senate**	**Monitor**

Title
Opioid overdose reversal medications: pupil administration.

Description
AB 2998, 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, in good faith and not for compensation, naloxone hydrochloride or another opioid antagonist 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 12 years of age or older, 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, a naloxone hydrochloride nasal spray or any other opioid overdose reversal medication that is federally approved for over-the-counter, nonprescription use, as provided. The bill would prohibit a pupil 12 years of age or older of those local educational agencies who administers those opioid antagonists on a schoolsite or while participating in school activities 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 those opioid antagonists, 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 those opioid antagonists.

Primary Sponsors
Tina McKinnor

Bill Number	Status	Position
AB 3030	**In Senate**	**Monitor**

Title
Health care services: artificial intelligence.

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. Existing law, the Medical Practice Act, establishes the Medical Board of California for the licensing, regulation, and discipline of physicians and surgeons. Existing law, the Osteopathic Act, enacted by an initiative measure, establishes the Osteopathic Medical Board of California for the licensing and regulation of osteopathic physicians and surgeons. This bill would require a health facility, clinic, physician’s office, or office of a group practice that uses generative artificial intelligence to generate written or verbal patient communications pertaining to patient clinical information, as defined, to ensure that those communications include both (1) a disclaimer that indicates to the patient that a communication was generated by generative artificial intelligence, as specified, and (2) clear instructions describing how a patient may contact a human health care provider, as specified. The bill would exempt from this requirement a communication read and reviewed by a human licensed or certified health care provider. Under the bill, a violation of these provisions by a physician would be subject to the jurisdiction of the Medical Board of California or Osteopathic Medical Board of California, as appropriate.

Primary Sponsors
Lisa Calderon

Bill Number	Status	Position
AB 3059	**Passed Senate**	**Monitor**

Title
Human milk.

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.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 donor human milk that was obtained from a tissue bank licensed by the State Department of Public Health. The bill would exempt from licensing requirements a hospital storing or distributing human milk obtained from a licensed tissue bank. The bill would require hospitals that collect, process, store, or distribute human milk in any other circumstance to obtain a tissue bank license. To the extent that the bill would expand the class of hospitals subject to tissue bank licensing requirements, thereby expanding a crime, the bill would impose a state-mandated local program.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. Existing law generally requires a health care service plan or health insurance policy to provide an enrollee or insured with basic health care services, as specified.This bill would include, in the above-described basic health care services, medically necessary pasteurized donor human milk obtained from a tissue bank licensed by the State Department of Public Health.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	Status	Position
AB 3063	**Passed Senate**	**Monitor**

Title
Pharmacies: compounding.

Description
AB 3063, as amended, 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, for purposes of those provisions, specify that the addition of a flavoring agent to a conventionally manufactured product is not considered compounding if certain conditions are met, including that the flavoring agent does not alter a medication’s concentration beyond the level of variance accepted by the United States Pharmacopeia. The bill would require the addition of the flavoring agent to be documented in the prescription record, as specified. 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	Status	Position
AB 3129	**In Senate**	**Monitor**

Title
Health care system consolidation.

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 before a transaction between the private equity group or hedge fund and a health care facility, provider, or provider group, as those terms are defined, and any of those entities that directly or indirectly control, are controlled by, are under common control of, or are otherwise affiliated with a payor, 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 transaction. 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 before a transaction between a private equity group or hedge fund and a nonphysician provider or a provider, with specified gross 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 health care facility’s, provider group’s, or provider’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 transaction will ensure continued health care access in the relevant markets. The bill would require the Attorney General to grant or deny the waiver within 45 days, as prescribed.The bill would authorize the Attorney General to consent to, give conditional consent to, or not consent to a transaction between a private equity group or hedge fund and a health care facility, provider group, or provider if the transaction 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 commun... (click bill link to see more).

Primary Sponsors
Jim Wood, Melissa Hurtado

Bill Number	Status	Position
AB 3156	**In Senate**	**Monitor**

Title
Medi-Cal managed care plans: enrollees with other health care coverage.

Description
AB 3156, as amended, Joe Patterson. Medi-Cal managed care plans: enrollees with other health care coverage. 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, under 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 federal law, in accordance with third-party liability rules, Medicaid is generally the payer of last resort if a beneficiary has another source of health care coverage in addition to Medicaid coverage.Under this bill, in the case of a Medi-Cal managed care plan enrollee who also has other health care coverage and for whom the Medi-Cal program is a payer of last resort, the department would be required to ensure that a provider that is not contracted with the plan and that is billing the plan for Medi-Cal allowable costs not paid by the other health care coverage does not face administrative requirements significantly in excess of the administrative requirements for billing those same costs to the Medi-Cal fee-for-service delivery system. Under the bill, in the case of an enrollee who meets those coverage criteria, except as specified, a Medi-Cal fee-for-service provider would not be required to contract as an in-network provider with the Medi-Cal managed care plan in order to bill the plan for Medi-Cal allowable costs for covered health care services.The bill would require a Medi-Cal managed care plan to provide assistance to Medi-Cal providers and beneficiaries, upon request, on options for maintaining health care relationships between beneficiaries and existing providers that are contracted with, or have agreements with, a beneficiary’s primary form of health care coverage, if the beneficiary transitions from receiving services under the Medi-Cal fee-for-service delivery system to being an enrollee of the managed care plan. The bill would also prohibit a Medi-Cal fee-for-service provider from being required to contract with a Medi-Cal managed care plan in order to provide services to an enrollee who fits the above-described criteria and to bill the Medi-Cal managed care plan.The bill would authorize a Medi-Cal managed care plan to require a letter of agreement, or a similar agreement, under either of the following circumstances: (1) if a covered service requires prior authorization, or if a service is not covered by the other health care coverage but is a covered service under the plan, as specified, or (2) if an enrollee requires a covered service and meets the requirements for continuity of care or the completion of covered services through a Medi-Cal m... (click bill link to see more).

Primary Sponsors
Joe Patterson, Stephanie Nguyen

Bill Number	Status	Position
AB 3161	**Passed Senate**	**Monitor**

Title
Health facilities: patient safety and antidiscrimination.

Description
AB 3161, as amended, Bonta. Health facilities: patient safety and antidiscrimination. (1)Existing law provides for the licensure and regulation of health facilities by the State Department of Public Health. Existing law requires health facilities, as defined, to report an adverse event, as described, to the department within prescribed timeframes. A violation of these provisions is a crime.This bill would also require health facilities to provide certain demographic information to the department when reporting the adverse event. By creating a new crime, this bill would impose a state-mandated local program.(2)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 complainants to be provided with information on how to file a complaint with the Civil Rights Department.(3)ExistingExisting law provides for the licensure and regulation of health facilities by the State Department of Public Health. 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 allows anyone involved to make a report of a patient safety event to the health facility, and a process for a team of facility staff to conduct analyses related to root causes of patient safety events. A violation of these provisions is a crime.This bill would require the reporting system to include anonymous reporting options. The bill would also require analysis of patient safety events by specified sociodemographic factors to identify disparities in these events and would state the intent of the Legislature that a health facility use prescribed strat... (click bill link to see more).

Primary Sponsors
Mia Bonta

Bill Number	Status	Position
AB 3215	**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

Bill Number	Status	Position
AB 3221	**Passed Senate**	**Monitor**

Title
Department of Managed Health Care: review of records.

Description
AB 3221, 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. The bill would declare that these provisions are declaratory of and clarify existing law with regard to the director’s enforcement authority.Existing law enumerates acts or omis... (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	Status	Position
AB 3245	**Passed Senate**	**Monitor**

Title
Coverage for colorectal cancer screening.

Description
AB 3245, as amended, 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, or equivalent, in accordance with the most current recommendations established by another accredited or certified guideline agency approved by the California Health and Human Services 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	Status	Position
AB 3275	**Passed Senate**	**Monitor**

Title
Health care coverage: claim reimbursement.

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. Commencing January 1, 2026, this bill instead would require a health care service plan, including a Medi-Cal managed care plan, or health insurer to reimburse a complete claim or a portion thereof within 30 calendar days after receipt of the claim, or, if a claim or portion thereof does not meet the criteria for a complete claim or portion thereof, to notify the claimant as soon as practicable, but no later than 30 calendar days that the claim or portion thereof is contested or denied. The bill would authorize the departments to issue guidance and regulations related to these provisions. The bill would exempt the guidance and amendments from the Administrative Procedure Act until December 31, 2027. Existing law requires health care service plans to establish a grievance process, as specified. This bill would require a complaint made by an enrollee to a health care service plan about a delay or denial of a payment of a claim to be treated as a grievance subject to that grievance process. Existing law creates the Managed Care Administrative Fines and Penalties Fund. This bill would require that an administrative fee assessed upon a health care service plan for a violation of the above-descr... (click bill link to see more).

Primary Sponsors
Esmeralda Soria, Robert Rivas

Organizational Notes

Last edited by Cherie Compartore at May 14, 2024, 4:03 PM
Oppose: Local Health Plans of California, California Association of Health Plans

Bill Number	Status	Position
SB 136	**Enacted**	**Monitor**

Title
Medi-Cal: managed care organization provider tax.

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	Status	Position
SB 242	**Passed Assembly**	**Monitor**

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

Description
SB 242, Skinner. California Hope, Opportunity, Perseverance, and Empowerment (HOPE) for Children Trust Account Program. Existing law, the California Hope, Opportunity, Perseverance, and Empowerment (HOPE) for Children Trust Account Act, establishes a 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 the 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 are considered to be owned by the state until an eligible youth withdraws or transfers money from their HOPE trust account. This bill would, among other things, require the Treasurer to verify the cause of death of the parent, Indian custodian, or legal guardian and to verify the minor’s family household income prior to the death of the parent, Indian custodian, or legal guardian once the Treasurer receives government-issued documents or a statement signed by a person who is eligible to do so under penalty of perjury that establishes the identity of the child and that the person whose death certificate was provided was the child’s parent, Indian custodian, or legal guardian. By expanding the crime of perjury, this bill would impose a state-mandated local program. The bill would also state the intent of the Legislature that all eligible children will be automatically enrolled for a HOPE trust account to the extent possible, and would require the Treasurer to, in order to achieve this goal, collaborate with the State Department of Social Services and any other relevant governmental agencies to gather data to maximize participation in the HOPE Trust Account Program for eligible children and youth, as specified. Under the bill, individual records or source data associated with the establishment of a HOPE trust account would not be subject to disclosure under the California Public Records Act.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 account from being consider... (click bill link to see more).

Primary Sponsors
Nancy Skinner

Bill Number	Status	Position
SB 339	**Enacted**	**Monitor**

Title
HIV preexposure prophylaxis and postexposure prophylaxis.

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	Status	Position
SB 427	**Passed Assembly**	**Monitor**

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

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	Status	Position
SB 516	**Passed Assembly**	**Monitor**

Title
Health care coverage: prior authorization.

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. This bill would require the Department of Managed Health Care and the Department of Insurance, by July 1, 2025, to issue instructions to health care service plans and health insurers to report specified information relating to prior authorization, as defined, including designated health care services (services), items, and supplies subject to prior authorization and the percentage rate at which health care service plans, health insurers, or their delegated entities, approve or modify those services, items, and supplies. The bill would require health care service plans and health insurers to report that information to the relevant department by December 31, 2025, or as otherwise specified. The bill would require the relevant department to evaluate the reports received from the health care service plans and health insurers, and identify the services, items, and supplies most frequently approved by the plans or insurers or their delegated entities, as specified. The bill would require each department, after evaluating the reports received from health care service plans and health insurers, to identify, and by December 31, 2026, to publish a list of, the most frequently approved or modified services, items, and supplies, based on a prescribed threshold percentage rate. The bill would authorize the department to consider certain factors when determin... (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	Status	Position
SB 607	**Passed Assembly**	**Monitor**

Title
Controlled substances.

Description
SB 607, 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	Status	Position
SB 729	**Passed Assembly**	**Monitor**

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

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 July 1, 2025, 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	Status	Position
SB 819	**In Assembly**	**Monitor**

Title
Medi-Cal: certification.

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	Status	Position
SB 895	**Passed Assembly**	**Monitor**

Title
Community colleges: Baccalaureate Degree in Nursing Pilot Program.

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 office of 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 10 community college districts statewide and would require the chancellor’s office to identify and select eligible community college districts based on specified criteria. The bill would require the chancellor’s office to develop a process designed to assist community college districts with nursing programs that are applying for national accreditation for the purpose of qualifying for the pilot program, as provided. The bill would require each participating community college district to give priority registration for enrollment in the pilot program to students with an associate degree in nursing from that community college district. 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, as specified, to be submitted to the Legislature on or before July 1, 2032. The bill would repeal these provisions as of January 1, 2034.

Primary Sponsors
Richard Roth, Anna Caballero, Eloise Reyes

Bill Number	Status	Position
SB 942	**Passed Assembly**	**Monitor**

Title
California AI Transparency Act.

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 make available an artificial intelligence (AI) detection tool at no cost to the user that meets certain criteria, including that the AI detection tool is publicly accessible. The bill would require a covered provider to offer the user an option to include a manifest disclosure in image, video, or audio content, or content that is any combination thereof, created or altered by the covered provider’s generative artificial intelligence (GenAI) system that, among other things, identifies content as AI-generated content and is clear, conspicuous, appropriate for the medium of the content, and understandable to a reasonable person. The bill would require a covered provider to include a latent disclosure in AI-generated image, video, audio content, or content that is any combination thereof, created by the covered provider’s GenAI system that, among other things, to the extent that it is technically feasible and reasonable conveys certain information, either directly or through a link to a permanent internet website, regarding the provenance of the content. The bill would require a covered provider that knows a third-party licensee modified a licensed GenAI system such that it is no longer capable of including the disclosures described above in content the system creates or alters to revoke the license within 96 hours of discovering the licensee’s action and would require a third-party licensee to cease using a licensed GenAI system after the license for the system has been revoked by the covered provider.This bill would make a covered provider that violates these provisions liable for a civil penalty in the amount of $5,000 per violation to be collected in a civil action filed by the Attorney General, a city attorney, or a county counsel, as prescribed. The bill would, fo... (click bill link to see more).

Primary Sponsors
Josh Becker

Bill Number	Status	Position
SB 957	**Passed Assembly**	**Monitor**

Title
Data collection: sexual orientation, gender identity, and intersex status.

Description
SB 957, as amended, Wiener. Data collection: sexual orientation, gender identity, and intersex status. (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.This bill would replace the term “intersexuality” with the term “variations in sex characteristics/intersex status” and would make conforming changes to related provisions.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.The bill would specify that the provisions above do not require (1) the State Department of Public Health to collect demographic data from an individual under 18 years of age, as specified, or (2) health care providers or other third parties to collect, disclose, or report information that is not voluntarily provided self-identification information pertaining to sexual orientation, gender identity, and variations in sex characteristics/intersex status (SOGISC).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 its 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 Heal... (click bill link to see more).

Primary Sponsors
Scott Wiener

Bill Number	Status	Position
SB 966	**Passed Assembly**	**Monitor**

Title
Pharmacy benefits.

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, to apply for a license from the Department of Insurance to operate as a pharmacy benefit manager no later than January 1, 2027. The bill would establish application qualifications and requirements, and would require initial license and renewal fees to be collected into the newly created Pharmacy Benefit Manager Account in the Insurance Fund, to be available to the department for use, upon appropriation by the Legislature, as specified, for costs related to licensing and regulating pharmacy benefit managers.This bill would require a pharmacy benefit manager to file with the department at specified annual intervals 2 reports, one of which discloses product benefits specific to the purchaser, and the other of which includes information about categories of drugs and the pharmacy benefit manager’s contracts and revenues. The bill would specify that the contents of the reports are not to be disclosed to the public. The bill would require the department, at specified annual intervals, to prepare 2 reports based on the reports submitted by pharmacy benefit managers, and would require the department to post its reports 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. The bill would require a pharmacy benefit manager to disclose to the Department of Insurance all types of fees it receives and how the fees are calculated.The bill would make a violation of the above-specified provisions subject to specified civil penalties. The bill would establish various filing and service requirements when a proceeding is brought for a violation of specified requirements by a pharmacy benefit manager. The bill would create the Pharmacy Benefit Manager Fines and Penalties Account in the General Fund, into which fines and administrative penalties would be deposited.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 polic... (click bill link to see more).

Primary Sponsors
Scott Wiener, Aisha Wahab, Devon Mathis

Organizational Notes

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

Bill Number	Status	Position
SB 1099	**Passed Assembly**	**Monitor**

Title
Newborn screening: genetic diseases: blood samples collected.

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 until the department has provided 5 annual reports, 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 during the previous calendar year. The bill would require the department to additionally set fee guidelines to cover the costs of reporting. The bill would require the annual report to be made available to the public on the department’s internet website, and would require the report to be posted even after the above-described 5th report has been provided to the Legislature.This bill would make other conforming changes.

Primary Sponsors
Janet Nguyen

Bill Number	Status	Position
SB 1112	**Passed Assembly**	**Monitor**

Title
Childcare: alternative payment programs.

Description
SB 1112, as amended, Menjivar. Childcare: alternative payment programs. 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 federal law establishes the Child Care and Development Fund authorized under the Child Care and Development Block Grant Act of 2014 and administered by states to provide assistance to low-income families who need childcare due to specified reasons. Existing federal law requires a portion of those funds to be used to disseminate information on existing resources for developmental screenings and descriptions of how a family may utilize those resources to obtain developmental screenings. Existing law authorizes, upon departmental approval, the use of appropriated funds for alternative payment programs to allow for maximum parental choice. Existing law authorizes the reimbursement to those programs for the cost of child care paid to child care providers and the administrative and support services costs of the alternative program.This bill would state that the costs allowable for administration shall include, but not be limited to, costs associated with disseminating the above-described information.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 authorize Medi-Cal managed c... (click bill link to see more).

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	Status	Position
SB 1119	**Passed Assembly**	**Monitor**

Title
Hospitals: seismic compliance.

Description
SB 1119, as amended, 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 additionally authorize the department to waive the requirements of the act for 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. The bill would specify additional dates for the hospital or medical center to report to the department on its progress, would authorize the department to grant no more time than is necessary for the hospital to fully comply with the standards, and would impose a fine of $5,000 per calendar day if the hospital fails to comply with specified requirements or demonstrate adequate progress, as specified.This bill would declare that it is to take effect immediately as an urgency statute.

Primary Sponsors
Josh Newman

Bill Number	Status	Position
SB 1120	**In Assembly**	**Monitor**

Title
Health care coverage: utilization review.

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 disability insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or disability 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 disability 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 disability insurer, as applicable, for failure to comply with those requirements. This bill would require a health care service plan or disability insurer, including a specialized health care service plan or specialized health insurer, that uses an artificial intelligence, algorithm, or other software tool for the purpose of utilization review or utilization management functions, or that contracts with or otherwise works through an entity that uses that type of tool, to ensure compliance with specified requirements, including that the artificial intelligence, algorithm, or other software tool bases its determination on specified information and is fairly and equitably applied, as specified. 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

Organizational Notes

Last edited by Cherie Compartore at Jul 9, 2024, 5:26 PM
Oppose Unless Amended: California Association of Health Plans

Bill Number	Status	Position
SB 1131	**Passed Assembly**	**Monitor**

Title
Medi-Cal providers: family planning.

Description
SB 1131, Gonzalez. Medi-Cal providers: family planning. 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 establishes, under the Medi-Cal program, the Family Planning, Access, Care, and Treatment (Family PACT) Program, administered by the Office of Family Planning within the department. Under Family PACT, comprehensive clinical family planning services are provided to a person who has a family income at or below 200% of the federal poverty level and who meets other eligibility criteria to receive those services.Existing law makes the Family PACT Program inoperative if the program is determined to no longer be cost effective, as specified. If the program becomes inoperative, existing law requires all persons who have received, or are eligible to receive, comprehensive clinical family planning services pursuant to Family PACT to receive family planning services under other specified provisions of the Medi-Cal program or under the State-Only Family Planning Program, which is also established within the department.Existing law requires enrolled providers in the Family PACT Program or the State-Only Family Planning Program to attend a specific orientation approved by the department and requires providers who conduct certain services to have prior training in those services.This 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, but no more than 10, service addresses under one site certifier. The bill would require any orientation or training that the department requires of a site certifier to comply with specified requirements, including, among others, being offered through a virtual platform and being offered at least once every other month.For purposes of both of the above-described programs, existing law requires the program to disenroll as a program provider any individual who, or any entity that, has a license, certificate, or other approval to provide health care that is revoked or suspended by a federal, California, or other state’s licensing, certification, or other approval authority, that is otherwise lost, or that is surrendered while a disciplinary hearing is pending, as specified.This bill would authorize the department to elect to not disenroll an individual or entity as a program provider if the revocation, suspension, loss,... (click bill link to see more).

Primary Sponsors
Lena Gonzalez

Bill Number	Status	Position
SB 1180	**Passed Assembly**	**Monitor**

Title
Health care coverage: emergency medical services.

Description
SB 1180, as amended, 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 establishes 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 or triage paramedic assessments, respectively.This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after July 1, 2025, to establish a process to reimburse for services provided by a community paramedicine program, a triage to alternate destination program, and a mobile integrated health program, as defined.The bill would require those contracts 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 that they would pay for the same covered services received from a contracting program. The bill would prohibit reimbursement rates adopted pursuant to this provision from exceeding the health care service plan’s or health insurer’s usual and customary charges for services rendered.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 bill would condition this Medi-Cal coverage on an appropriation, receipt of any necessary federal approvals, and the availability of federal financial participation.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	Status	Position
SB 1184	**Passed Assembly**	**Monitor**

Title
Mental health: involuntary treatment: antipsychotic medication.

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, except for the second 30-day period.Existing law establishes a process for hearings to determine a 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. Existing law generally requires the capacity hearings described above to be held within 24 hours of the filing of a petition to determine a person’s capacity to refuse treatment. Existing law authorizes the hearing to be postponed in certain circumstances, but prohibits the hearing from being held beyond 72 hours of the filing of the petition.This bill would authorize, except as specified, a person’s treating physician to request a hearing for a new determination of a person’s capacity to refuse treatment with antipsychotic medication at any time in the 48 hours prior to the end of the duration of the current detention period when it reasonably appears to the treating physician that it is necessary for the person to be detained for a subsequent detention period and their capacity has not been restored.The bill would require, under exigent circumstances, the hearing to determine a person’s capacity to refuse treatment to be held as soon as reasonably practicable and within 24 hours. The bill would require, under exigent circumstances, an order for treatment with antipsychotic medication to remain in effect at the beginning of the 14-day period, or the additional 30-day period after the 14-day intensive treatment period, or the second 30-day period, provided that a petition for a new determination on the questi... (click bill link to see more).

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	Status	Position
SB 1213	**Passed Assembly**	**Monitor**

Title
Health care programs: cancer.

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, commencing no later than July 1, 2026, an individual is eligible to receive treatment services if the individual has a family income at or below 250% of the federal poverty level as determined by the provider performing the screening and diagnosis.

Primary Sponsors
Toni Atkins, Anthony Portantino

Bill Number	Status	Position
SB 1238	**Passed Assembly**	**Monitor**

Title
Health facilities.

Description
SB 1238, as amended, Eggman. Health facilities. (1) Existing law defines “health facility” to include a “psychiatric health facility” that is licensed by the State Department of Health Care Services and provides 24-hour inpatient care for people with mental health disorders. Existing law requires that such care include, but is not limited to, psychiatry, clinical psychology, psychiatric nursing, social work, rehabilitation, drug administration, and food services for persons whose physical health needs can be met in an affiliated hospital or in outpatient settings.This bill would expand the definition of “psychiatric health facility” to also include a facility that provides 24-hour inpatient care for people with severe substance use disorders, or cooccurring mental health and substance use disorders. The bill would expand that 24-hour inpatient care also include substance use disorder services, as medically necessary and appropriate. The bill would specify that psychiatric health facilities to only admit persons with stand-alone severe substance use disorders involuntarily pursuant to specified requirements.The bill would authorize a psychiatric health facility to admit persons diagnosed only with a severe substance use disorder when specified conditions are met. The bill would authorize the department to implement, interpret, or make specific these provisions, in whole or in part, by means of plan or county letters, information notices, plan or provider bulletins, or other similar instructions, until the time when regulations are adopted no later than December 31, 2027.(2) Under existing law, regulations adopted by the department are to include standards appropriate for 2 levels of disorder: (1) involuntary ambulatory psychiatric patients, and (2) voluntary ambulatory psychiatric patients.This bill would instead require regulations to include standards appropriate for 3 levels of disorder: (1) involuntary ambulatory patients receiving treatment for a mental health disorder, (2) voluntary ambulatory patients receiving treatment for a mental health disorder, and (3) involuntary ambulatory patients receiving treatment for a severe substance use disorder.(3) Existing law requires the program aspects of a psychiatric health facility to be reviewed and approved by the department to include, among others, activities programs, interdisciplinary treatment teams, and rehabilitation services. Existing law requires proposed changes in the standards or regulations affecting health facilities that serve persons with mental health disorders to be effected only with review and coordination of the California Health and Human Services Agency.This bill would expand these program aspects to also include substance use disorder services, ... (click bill link to see more).

Primary Sponsors
Susan Eggman

Bill Number	Status	Position
SB 1249	**Passed Assembly**	**Monitor**

Title
Mello-Granlund Older Californians Act.

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 would require the department, by September 30, 2026, to take various actions, including, among others, identifying older adult and family caregiver support programs and services and developing a statewide consumer engagement plan. The bill would require the department to develop regulations that address specified topics relating to area agency on aging designations. The bill would require those deliverables to be informed by data from validated sources, which may include, among others, the United States Census.This bill would also recast and revise various other provisions of the act, including by replacing use of the word “senior” and similar terminology with the term “older adult.” The bill would repeal obsolete provisions, such as the Senior Center Bond Act of 1984.Existing law establishes the Senior Housing Information and Support Center within the department 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 would repeal the provisions establishing the Senior Housing Information and Support Center.

Primary Sponsors
Richard Roth, Jasmeet Bains

Bill Number	Status	Position
SB 1257	**Enacted**	**Monitor**

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

Description
SB 1257, 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	Status	Position
SB 1289	**Passed Assembly**	**Monitor**

Title
Medi-Cal: call centers: standards and data.

Description
SB 1289, as amended, Roth. Medi-Cal: call centers: standards and 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, with stakeholder input, statewide minimum standards for assistance provided by a county’s call center 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 require a county with a call center as described above, commencing on January 1, 2026, and each month thereafter, to collect and submit to the department call-center data metrics, including, among other information, total call volume, average call wait times by language, and average call abandonment rate. By creating new duties for counties relating to call-center 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 call-center data. 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, with the initial report due on May 15, 2026.The bill would require the department to implement these provisions, without taking any regulatory action, by means of an all-county letter or similar instruction. The bill would require the department to adopt regulations thereafter in accordance with certain provisions.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 provi... (click bill link to see more).

Primary Sponsors
Richard Roth

Bill Number	Status	Position
SB 1300	**Passed Assembly**	**Monitor**

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

Description
SB 1300, Cortese. Health facility closure: public notice: inpatient psychiatric and perinatal 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 unit or a perinatal unit 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 require the health facility to provide public notice of the proposed elimination of the supplemental service of either inpatient psychiatric unit or perinatal unit, as specified. The bill would require the health facility to conduct at least one noticed public hearing within 60 days of providing public notice of the proposed elimination of the inpatient psychiatric unit or perinatal unit and would require the health facility to accept public comment. The bill would require the health facility to post the public hearing notice and the agenda along with the public notice. The bill would require the health facility holding the public hearing to meet prescribed requirements, including notifying the board of supervisors of the county in which the health facility is located when a public hearing is scheduled and inviting the board of supervisors to provide testimony on the impacts of the elimination of the services to the county and community health systems.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

Bill Number	Status	Position
SB 1319	**Passed Assembly**	**Monitor**

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

Description
SB 1319, 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	Status	Position
SB 1320	**Enacted**	**Monitor**

Title
Mental health and substance use disorder treatment.

Description
SB 1320, 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	Status	Position
SB 1354	**Passed Assembly**	**Monitor**

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

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, and 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. The bill would find and declare that this requirement is declaratory of existing law and thus not reimbursable under Medi-Cal Long-Term Care Reimbursement Act or any other Medi-Cal ratesetting provisions, as specified. The bill would specify that if reimbursement is found to be required by state or federal law or regulation, as specified, the above requirement shall only become operative upon appropriation by the Legislature. The bill would also provide that this requirement and the above-described prohibition against discrimination on the basis of payment source be implemented only to the extent that these provisions do not conflict with federal law, that any necessary federal approvals are obtained, and that federal financial participation for the Medi-Cal program is available and is not otherwise jeopardized.Existing federal regulations require certain nursing facilities to post their resident census and specified nurse staffing data on a daily basis.This bill would require a skilled nursing facility that participates as a provider under the Medi-Cal program to make publicly available its current daily resident census and nurse staffing data, as defined. The bill would require the facility to make t... (click bill link to see more).

Primary Sponsors
Aisha Wahab

Bill Number	Status	Position
SB 1369	**Passed Assembly**	**Monitor**

Title
Dental providers: fee-based payments.

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 April 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 written 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 authorization to the health care service plan, health insurer, or contracted vendor. The bill would require a health care service plan, health insurer, or contracted vendor that obtains written authorization to opt in or opt out of fee-based payment to apply the decision to include both the dental provider's entire practice and all products or services covered pursuant to a contract with the dental provider, as specified.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	Status	Position
SB 1385	**Enacted**	**None**

Title
Medi-Cal: community health workers: supervising providers.

Description
SB 1385, Roth. Medi-Cal: community health workers: supervising 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 through various delivery systems, including fee-for-service and managed care. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Under existing law, community health worker services are a covered Medi-Cal benefit subject to any necessary federal approvals. Under existing law, a community health worker is 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. Existing law requires a Medi-Cal managed care plan to engage in outreach and education efforts to enrollees, and to notify providers, about the community health worker services benefit, as specified.This bill would require a Medi-Cal managed care plan, no later than July 1, 2025, to adopt policies and procedures to effectuate a billing pathway for supervising providers to claim for the provision of community health worker services to enrollees during an emergency department visit and as an outpatient followup to an emergency department visit. The bill would require that the policies and procedures be consistent with guidance developed by the department for use by supervising providers to claim for community health worker services to Medi-Cal members in the fee-for-service delivery system in the settings described above.The bill would define a “supervising provider” for purposes of these provisions as an enrolled Medi-Cal provider that is authorized to supervise a community health worker pursuant to the federally approved Medicaid state plan amendment and that ensures that a community health worker meets the qualifications as required by the department, as specified.

Primary Sponsors
Richard Roth

Bill Number	Status	Position
SB 1423	**Passed Assembly**	**Monitor**

Title
Medi-Cal: Rural Hospital Technical Advisory Group.

Description
SB 1423, as amended, Dahle. Medi-Cal: Rural Hospital Technical Advisory Group. 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 sets forth various other provisions regarding Medi-Cal reimbursement in consideration of small and rural hospitals.This bill would require the department to convene a Rural Hospital Technical Advisory Group, with a certain composition of stakeholders, at least bimonthly during the 2025 calendar year. The bill would set forth the purposes of the advisory group, including, among other things, analyzing the continued ability of small, rural, or critical access hospitals, as defined, to remain financially viable under existing Medi-Cal reimbursement methodologies, to provide related recommendations, and to identify key contributors to the financial challenges of those hospitals, as specified.The bill would require, by March 31, 2026, the department, in consultation with the advisory group, to report to the Legislature on the findings and recommendations arising out of the convenings, as specified.

Primary Sponsors
Brian Dahle

Bill Number	Status	Position
SB 1511	**Passed Assembly**	**Monitor**

Title
Health omnibus.

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)(3) 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, an... (click bill link to see more).

Primary Sponsors
Senate Health Committee

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July 9, 2024

To: L.A. Care Board of Governors

From: Government Affairs Department

Subject: 2024-25 State Budget Update

The Legislature and Governor reached a budget agreement on Saturday, June 22, 2024.

As indicated previously, there will be additional "mini trailer bills" that will be considered throughout the summer and these bills are not subject to the same timelines as the main and health budget bills.

The early action budget package, which included $17.3 billion in solutions, has already been accounted for in the final 2024-25 budget.

Following are areas of significance to L.A. Care operations and strategic interests that are included in the May Revise:

- Medi-Cal Caseload Estimates
  The 2024-25 budget assumes a Medi-Cal caseload decline of 4.38%, representing 14.5 million Medi-Cal beneficiaries at the end of June 2025.

- Medi-Cal Managed Care Organization (MCO) Tax
  The budget reflects the $3.8 billion in General Fund savings from the Early Action plan that was approved earlier this year. The budget allocates $133 million for 2024-25, $728 million for 2025-26, and $1.2 billion for 2026-27 for new Medi-Cal provider rate increases and investments from the MCO Tax. It also includes about $300 million in provider rate increases effective January 1, 2024. Overall, the agreement invests $1 billion less than the DHCS Term Sheet but covers more provider types and services. However, if the MCO Tax Ballot initiative passes in November, specified provisions relating to the MCO tax legislation will be repealed.

  The annual state funds amount of the rate increases taking effect January 1, 2025, are:
  - Emergency Department Physician Services ($100 million)
  - Abortion Care and Family Planning ($90 million)
  - Ground Emergency Medical Transportation ($50 million)
  - Air Emergency Medical Transportation ($8 million)
  - Community-Based Adult Services ($8 million)
  - Congregate Living Health Facilities ($8 million)
  - Pediatric Day Health Centers ($3 million)
  - Community Health Workers to achieve 100 percent of Medicare rate

  The annual state funds amount of the rate increases and investments taking effect January 1, 2026, are:

- Physician/Non-Physician Professional Health Services ($753 million)
  - Private-Duty Nursing ($62 million)
  - Services and Supports for FQHCs/RHCs ($50 million)
  - Continuous Coverage for Children Aged 0 through 4 ($33 million)
  - Non-Emergency Medical Transportation ($25 million)

- Children's Hospitals Directed Payments
  Effective July 2024, provides $230 million ($115 million state funds/$115 million federal funds) annually to support new directed payments to Children's Hospitals, with half the costs funded by federal funds and half from the Medi-Cal Provider Payment Reserve Fund derived from the MCO tax. This is new funding for the children's hospitals

- Medi-Cal: Equity and Practice Transformation (EPT) Payments to Providers
  Eliminates future funding for the program. Specifically the program was reduced from $700 million to $140 million. Approximately $113 million remains in the program after distribution of $25 million in incentive dollars. DHCS indicates the remaining funds will be allocated between directed payments and the learning center. The EPT Payments Program was intended to be a five-year program that supports qualifying providers in improving quality, health equity, and primary care infrastructure to address identified health care coverage gaps and to move towards value-based payment methodologies. L.A. Care has 46 enrolled practices in the EPT program. We will need more information from DHCS to understand how this funding reduction will impact the EPT program.

- Medi-Cal: Adult Acupuncture Benefit
  Retains the adult acupuncture Medi-Cal benefit.

- California Food Assistance Program (CFAP) Expansion
  Delays the expansion of CFAP expansion to undocumented seniors for 2 years, thus delaying implementation of the benefit to the 2027-28 budget year. CFAP is the state-funded Cal Fresh counterpart passed in the 2022 budget that allowed undocumented income-eligible individuals aged 55 and over to receive food assistance.

- Medi-Cal Continuous Eligibility for Children (0 – 4 years) (Trigger Investment Approved in 2022-23 budget)
  Includes the use MCO Tax dollars to implement 0-5 years of age for continuous Medi-Cal eligibility, effective 01/01/26, unless the MCO Tax ballot initiative passes in November.

- In-Home Supportive Services (IHSS) Benefit for the Undocumented
  Retains the In-Home Supportive Services (IHSS) benefit for all undocumented Medi-Cal enrollees.

- In-Home Supportive Services (IHSS) Backup Provider System (BUPS)
  Retains the IHSS BUPS. This program provides temporary IHSS services from backup providers to those who receive IHSS when their regular IHSS providers are unavailable.

- Behavioral Health Transformation
  Allocates $17 million General Fund dollars to implement the Behavioral Health Transformation program. Will need more information from DHCS on the details of this.

- Children and Youth Behavioral Health Initiative Reduction
  Program that funds school-linked health partnerships and grants, behavioral health services and supports platform, public education campaign, and youth suicide reporting and crisis response pilot. Includes language:
  - Allows Local Education Agencies (LEAs)to bill plans directly (i.e., outside of the TPA) where a direct relationship between the two entities exists
  - Requires the TPA to create and administer a mechanism for the sharing of data with plans necessary to facilitate timely claims processing, payment, and reporting, avoid duplication of claims

- Allows for tracking of grievance remediation, and to facilitate coordination of care and continuity of care for enrollees.
- Does not allow the health plan fee to be assessed prior to the commencement of the contract between DHCS and the TPA
- Requires DHCS to consider the assessed volume of claims and providers or practitioners credentialed and enrolled by the TPA when determining the health plan fee.

➢ Covered California – Health Care Affordability Reserve Fund (Reserve Fund)
Beginning in 2025-26, transfers $109 million from the Health Care Affordability Reserve Fund to the General Fund. The money in the Reserve Fund is from individual mandate penalty payments. The revenue from the penalty was originally intended to offset General Fund expenditures for the Covered California state subsidy program to help offset enrollee costs. In addition, the Reserve Fund is intended to mitigate adverse federal actions or inactions, including the non-renewal of Inflation Reduction Act premium subsidy enhancements. Per the Administration, the Reserve Fund will still contain adequate funding for subsidy enhancements in 2024-25,

➢ Increase Directed Payments to Public Hospitals
Increase directed payments to public hospitals via the Enhanced Payment Program and Quality Incentive Pool programs. In addition, an administrative fee will be assessed on these intergovernmental transfers and retained by the Department. The Administration has not provided additional information on a specific percentage or dollar amount for the increase of directed payments. ($37 million General Fund cost in 2024-25 and $74 million ongoing)

➢ SB 525 Implementation
Delays the implementation of the minimum wage increase of $25 per hour for various healthcare personnel, including those working in hospitals, nursing homes, and other defined healthcare settings. The budget includes provisions that would delay the effective date until one of two conditions are met:
- State cash receipts during the first quarter exceed 3% of the projected amount of the wage increase or;
- DHCS obtains federal approval to implement a 1/1/25 Hospital Quality Assurance Fee Waiver

Government Affairs will continue to provide updated information on the budget process. If you have any questions, please contact Cherie Compartore, Senior Director of Government Affairs.

State Budget Links:
- https://ebudget.ca.gov/FullBudgetSummary.pdf
- https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB159
- https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240AB107
- https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202320240SB136
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-

One-Year Health Equity Impact Report:

Health Equity Disparities Mitigation Plan 2023-25

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

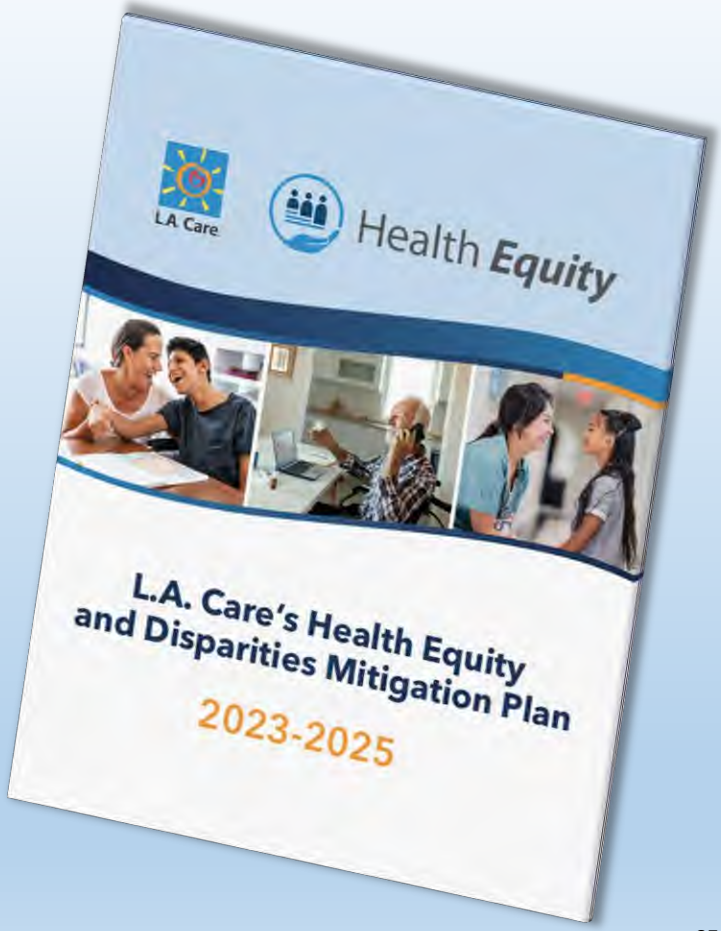
Presented by: Alexander (Alex) Li, MD

Health Equity

Background

In June 2023, L.A. Care published a two-year Health Equity Disparities Mitigation (HEDM) plan that serves as a guide for how L.A. Care would address immediate and longstanding health and social inequities.

This report provides a mid-point progress update centered around the four health equity zones, highlighting select objectives.



Health Equity Zones

1. Address key health disparities: close racial and ethnic gaps in health outcomes
among members.

2. Lead change: provide leadership and be an ally for community partners to promote health equity and social justice.

3. Move towards equitable care: ensure that our members have access to care and services that are free of bias and that our providers are supported in delivering equitable, culturally tailored care.

***4. Embrace Diversity, Equity, and Inclusion*:** Serve as a model in supporting an equitable and inclusive work environment, as reflected in our workforce and business practices.

Zone 1: Address Key Health Disparities Updates

Close racial and ethnic gaps in health outcomes among members

Spotlight on:

Black and African-American Maternal Health

Physical Health and Behavioral Health Wellness for Youth

Health Equity Zone 1: Objective 2

Improve the health of Black and African-American birthing individuals and infants

We have awarded grants to 19 CBOs to expand infrastructure and coordination of social services with health care services. Our next objective is to begin regional planning for Inglewood/West LA, South LA and Antelope Valley.

Advocacy

- AYPH
- BreastfeedLA
- Coalition for Black Birth Justice

Training/Consulting

- Beauty for Ashes Maternal Wellness Inc.
- DIVERSITY UPLIFTS, INC

Breastfeeding/ Maternal Health

- CinnaMoms
- Maternal Mental Health
- St. John's Community Health

Doula/Doula Hub

- Happy Mama Health Baby Community
- Frontline Doulas
- Public Health

Health Equity Zone 1: Objective 4

Invest in Physical and Behavioral Health Wellness Programs for School-Aged Youth

Local Districts, L.A. Care and
UCLA Sound Body and Sound Mind

In 2024, L.A. Care Health Equity and Community Benefits departments partnered to fund new exercise equipment **for South LA middle schools**.

Projected impact estimated 4,760 pupils (average) across five participating Los Angeles middle schools. Lasting 10-year investment in youth **will impact an estimated 47,600 students**.

LYNWOOD
UNIFIED SCHOOL DISTRICT

LAUSD

Zone 2 Move Towards Equitable Care Updates

Provide leadership and be an ally for community partners to promote health equity and social justice.

Spotlight on:

LA County Children's Health Disparities Roundtable And Policy Recommendations

Gun Violence Prevention

Health Equity Zone 2: Objective 1

Coordinate and collaborate with internal and external partners like L.A. County's educational, health, and social service departments to create shared agendas and plans

In November 2023, LA County Children's Health Disparities Roundtable – hosted by L.A. Care & Children's Hospital Los Angeles (CHLA)

Objective: Convene stakeholders including health advocates, CHLA, Los Angeles County, and LAUSD, to find **actionable solutions** and address issues leading to **health disparities in children** and develop a **framework to inform policy**.

Health Equity Zone 2: Objective 1 – cont.

LA County Children's Health Disparities Roundtable Recommendations

Goal 1: Publish three papers in 2024

- Brief titles include
  - ***Child and Youth with Complex Needs and Conditions***,
  - ***Vaccine Catch-up and Misinformation***, and
  - ***Child Welfare***
- To be posted on L.A. Care's Health Equity Website

Goal 2: Create a network and a cadre of stakeholders who can advocate on the same set of recommendations.

- Roster with experts in attendance at the roundtable provided

Health Equity Zone 2: Objective 2

Promote prevention of gun violence education and amplify Office of Violence Prevention firearm safety training to L.A. County clinicians.

2023: Three provider trainings on Gun Violence Prevention. Total providers trained: **267**

2024: **Two** community events on preventing gun violence with gun locks distributed at Community Resource Centers. Total community members reached**: 150**

LOS ANGELES COUNTY OVP OFFICE OF VIOLENCE PREVENTION

County of Los Angeles Public Health

Digital Billboard Campaign – April 2024

Collaboration: L.A. Care, Los Angeles County Medical Association, Los Angeles County DPH-Office of Violence Prevention

Gun Violence Prevention Campaign Overview

Duration: 4/1 - 5/12

Total spots delivered: **~475K**

Total impressions delivered: **~ 28M**

Online lock requests: **971**

Gun locks distributed: **1,807**

Zone 3 Move Towards Equitable Care Updates

Ensure that our members have access to care and services that are free of bias and that our providers are supported in delivering equitable, culturally tailored care

Spotlight on:

Recognize Providers that Promote Health Equity

Health Equity Impact Assessment Tool

Health Equity Zone 3: Objective 3

Recognize providers that promote health equity through the Provider Equity Award at the annual Provider Recognition event

For the 3rd Annual Provider Equity Awards, these leaders received recognition for their commitment to health equity in Los Angeles:

Roland Palencia Safety Net Award
- **Los Angeles Christian Health Centers**
- **Northeast Valley Health Corporation**

Community Health Investment Fund Award
- **Inquilinos Unidos**

School-Based Health Centers Award
- **St. John's Community Health**

Maternal and Child Health Award
- **Los Angeles County African American Infant & Maternal Mortality Prevention Initiative**

Health Equity Zone 3: Objective 5

Create a process and analyze other services with a health equity approach

Created: internal health equity impact assessment, adapted from other sources – **7 questions**

- Systematically and consistently embed equity questions to enterprise projects
- Help provide more equitable care for diverse member population

Guidance: Technical Advisory Committee, including UCLA Health Researcher

Impact: Currently being piloted in workflow for all L.A. Care IT projects to identify those that are relevant.

Zone 4 Embrace diversity, equity, and inclusion Updates

Serve as a model in supporting an equitable and inclusive work environment, as reflected in our workforce and business practices

Spotlight on:

NCQA Health Equity Accreditation

DEIB Training and Affinity Groups

Zone 4: Objective 1

Prepare, develop, and implement a diversity, equity, and inclusion (DEI) training plan that is specific to the needs of L.A. Care and meets DHCS regulatory requirements

There is a **collective impact** of Diversity Equity, Inclusion and Belonging (DEIB) initiatives underway by our **Human Resources**, **internal equity councils**, and employee **affinity groups.**

Amplifying Staff Voices Panel Series: Celebrating Black Voices in Healthcare

The LatinX Collective

Zone 4: Objective 2

Ensure compliance with all regulatory, contractual, and accreditation health equity requirements in a timely manner

- L.A. Care **scored 98%** of our 27.5 points across Medicaid, Medicare and Exchange product lines.
- L.A. Care is **among the 15% of health plans nationwide** to have received NCQA HEA accreditation status. Accredited from March 2024-2027.

2024-25 Health Equity and Disparities Plan: Three Key Focus

- Implement the DHCS DEI Health Equity Training Requirements
- Create and publish a L.A. Care Health Disparities Dashboard
- Work closer with key community partners on addressing disparities for Black, Latino/Hispanic and American Indian/Alaskan Native with chronic disease and improving the health of Black birthing individual and infants.

Thank You L.A. Care Board, Staff and Our Great Partners for the Continued Commitment to Our Members and Providers!

CHIEF MEDICAL OFFICER'S REPORT

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

CMO Report: September 2024

Health Services Update

Medical Management
Quality Management
Community Health
Pharmacy

Sameer Amin, MD
Chief Medical Officer, Health Services

Contents

Strategy Management

*As part of our annual strategic planning efforts, L.A. Care's Health Services (HS) Department is planning a two-day **Strategy Summit** engaging senior leadership and management across all HS functional areas to plan the 2025 Health Services Program Strategy, a first of its kind living strategic guiding document meant to (1) facilitate the bi-directional cascade of information within the department and between the department and its external business unit partners across the enterprise, and (2) designed to promote strategic alignment, integration, and collaboration.*

In addition to mapping out the department's strategic goals and objectives for the upcoming year in alignment with the enterprise strategic vision and goals, we are generating a list of strategic initiatives meant to address the following priority areas:

- **Streamlining Medical Management**: Identifying interdependencies within and between the Medical Management department to ensure seamless integration, authorization and referrals of new, policy-driven programs and services, e.g., CalAIM Enhanced Care Management (ECM), Transitional Care Services (TCS), and Community Supports (CS)

- **Optimizing Population Health Management:** Focusing on improving Care Coordination and Integration, Data Analytics and Technology, and Preventive and Proactive Care including Chronic Condition and Disease Management for enhanced population-based and member-centric outcomes and reduced adverse utilization.

- **Clearing Pathways for Collaboration with External Business Unit Partners:** Enhancing the ways in which the Health Services team engages with and critical enterprise teams like Finance, Operations, Compliance, and IT to maintain operational stability and achieve strategic agility in an rapidly changing regulatory landscape and industry environment.

The next issue of this report will provide an executive summary-level detail of the topics addressed and the decisions made as part of the finalization of the 2025 Health Services Program Strategy. Stay tuned!

Medical Management

Enhanced Care Management (ECM)

Enhanced Care Management (ECM) *under CalAIM is designed to provide personalized, intensive care coordination for Medi-Cal members with complex health and social needs. ECM brings together medical, behavioral, and social services to ensure a comprehensive, person-centered approach. By coordinating care across different providers and agencies, ECM aims to improve health outcomes, reduce hospitalizations, and lower healthcare costs, supporting CalAIM's goal of transforming Medi-Cal into a more holistic and equitable healthcare system.*

Enrollment

L.A. Care continues to work towards the goal of enrolling 30,000 members in ECM. The initial Q2 2024 enrollment data, including Plan Partners, shows 16,725 members enrolled, reflecting a 7% increase from the previous quarter (15,759). This growth in Q2 2024 was driven almost entirely by L.A. Care, thanks to the ECM team's enrollment push, which included new incentive payments and improved referral and lead processes.

Contracting and Network

Providers have responded well to the Payment Model (PUPM) amendment, and the team is closely monitoring any risks for those who may not meet the October 1, 2024 signature deadline. L.A. Care's ECM network now includes 85 contracted providers. To focus on Providing Access and Transforming Health (PATH) initiative provider-recipients and providers with a Justice-Involved specialty, we have slowed the overall growth of our network. While we expect further growth throughout 2024, new providers joining later this year will primarily be those with expertise in Justice-Involved, Birth Equity, or Child Welfare populations.

Audit and Oversight

Our ECM Monitoring and Oversight Program launched in Q3, during which we audited 30 ECM providers and reviewed over 80 member cases.

Key Findings: Since this was our first audit, we uncovered areas for improvement:

- Inconsistent or incomplete documentation by providers.
- Gaps in the development of care plans.
- Issues with timely and accurate Transitions of Care (TCS) interventions

Performance Highlights:

- Highest Performing Area: Enhanced Care Coordination ranked the highest in our audit.
- Lowest Performing Area: TCS interventions ranked the lowest.

Next Steps:

- Gap Closure Plans: We will provide all providers with a Gap Closure Plan to track progress on addressing the identified issues.
- Expanded Audits: In the next quarter, we plan to expand the audit to include more providers

Care Management for Dual Eligible Special Needs Plans (D-SNP)

Case Volumes

Through July 2024, the DSNP Care Management (CM) team experienced an uptick in both new referrals and overall active high-risk and complex cases under management. This increase resulted from the Health Risk Assessment (HRA) process for new DSNP enrollees and existing members needing their annual reassessments, as well as cases identified through predictive modeling as eligible to receive ECM-like services. In July 2024 alone, there were 97 new DSNP CM referrals. In total, over 1,111 DSNP CM cases were active with the LAC Care Management team, representing approximately 5.6% of the entire DSNP membership.

Care Management for MCLA Members

Case Volumes

- During July 2024, the LAC CM team created 416 MCLA CM cases and conducted initial outreach to offer members CM support.
- In total, over 1,500 MCLA CM cases were active, with members either participating or in active outreach.
- For **Transitional Care Services (TCS)**, the LAC team sustained an increase in the number of high-risk TCS cases outreached through July. During that month, over 2,300 members were contacted and offered TCS support. The team is collaborating with the Analytics Team to enhance and expand real-time admission notifications via Health Information Exchanges (HIEs). Currently, all but two contracted hospitals in Los Angeles County (West Hills and Lakewood) are on an HIE platform. Our data algorithms help immediately identify members who fall under the "DHCS High Risk" category for TCS purposes. Low risk TCS members began receiving post discharge notification of their ability to access TCS services. To date, a total of 42 low risk members have contacted the TCS Central Intake Line to request TCS support.

Utilization Management

Timeliness of UM Decisions and Notifications

The UM department has shown exceptional operational compliance from January to June 2024, with nearly all quantitative compliance measures for timeliness of decisions and notifications consistently exceeding 95% across multiple lines of business, including MCLA, LACC, PASC, and D-SNP. This improvement is particularly notable in light of the updated measures for

commercial lines of business, which now account for extensions and have contributed to the enhanced compliance rates. Not a single measure fell below 90%, underscoring the department's commitment to maintaining high standards of timeliness and accuracy in UM processes. The department's success in these areas highlights its strong adherence to regulatory requirements and its effectiveness in delivering timely care decisions to members.

Managed Long Term Services and Supports (MLTSS)

CalAIM & Community Supports (CS)

Efforts to increase referrals and enrollment in all MLTSS CS-administered programs continue. Services are promoted in various provider forums as well as through internal education and training for cross-functional teams across the organization. Referrals to Personal Care and Homemaking Services have seen a significant increase, averaging 137 per month since October 2023, compared to an average of 40 per month in the previous fiscal year. Referrals to Respite Care and Environmental Accessibility Adaptations also continue to rise, with a current authorization rate of 73%, an increase of 3% points since the last report.

Nursing Facility Transition and Diversion to Assisted Living Facility (NFTD) and Community Transition Services (CTS) to home and other private community settings became effective on January 1, 2024. Currently, three providers are contracted, with more to be added during the scheduled Letter of Interest process. Referrals for both programs have steadily increased, originating from hospitals, skilled nursing facilities, and internal teams (Utilization Management and Care Management) via Interdisciplinary Care Teams (ICTs). To date, the average number of referrals is 20, an increase from 17 in the last report, with an authorization rate of 97%, an increase from 82% in the last report. Trends and outcomes will continue to be monitored and reported.

CalAIM & Benefits Standardization

Since January 1, 2024, Intermediate Care Facilities for the Developmentally Disabled (ICF-DD) long-term care became a Medi-Cal Managed Care covered service. Contracting efforts are ongoing with nearly 200 facilities throughout the county, most of which are new to managed care. Phase I of DHCS's Post Implementation Network Readiness Requirements has been completed and approved, and Phase II is currently underway, with a due date for DHCS submission in June 2024. The L.A. Care MLTSS, Provider Network Management (PNM), and Credentialing teams have worked to ensure all DHCS requirements are met. As of April this year, the ICF-DD census was 326, and has increased to 337 by end of July 2024.

Quality Management

Health Education, Cultural, and Linguistic Services (HECLS)

Meals as Medicine Program

The Community Supports Meals as Medicine (MAM) program has been experiencing steady growth. In July, the program hit 500+ service authorization requests, the highest number since the program's inception in January 2022, and as compared to the latest record of ~400 requests in the last reporting term for April 2024. The team is evaluating staffing plans against operating model to prepare for future surges.

Doula Program

To date, 185 L.A. Care Medi-Cal pregnant members have been recommended for doula services. 108 members have been serviced by a Doula. Data pending on 33 members from contracted doula organizations. Remaining 44 members were either not interested or unable to contact.

DHCS Transitional Care Services (TCS) for Birthing Individuals

This TCS program for Birthing Individuals moved under Health Education maternal programs in May. Every pregnant member who has had a hospital discharge is contacted by a Community Health Worker/Case Manager, who connects them to relevant resources and facilitates scheduling of provider follow-up visit.

Fight the Glue and Covid Campaign

The campaign will be launching in September with multipronged activities including a social media campaign, automated calls, texting campaign, *MyHIM* member portal messaging, member newsletter, email blast to PPG network on the importance of educating and vaccinating all patients, and flu and Covid vaccine clinics at local CRCs.

Initiatives

Improved Quality Performance Resulting in Reduced Policy Sanctions

L.A. Care is seeing substantial decrease in Medi-Cal measurement year (MY) 2023 Managed Care Accountability Set (MCAS) sanctions, from $890,000 in MY 2022 to $300,000. For measurement year 2023, 15 out of 18 measures showed significant performance improvements. Lack of reliable state data feeds for the Follow Up After Emergency Department Visit for Substance Abuse (FUA) and Follow Up After Emergency Department Visit for Mental Illness (FUM) HEDIS measures remains a challenge. The 2024 performance trends are positive with many measures showing YTD improvement compared to 2023.

One headwind to keep in mind is impact of Kaiser plan partner exit which will has “across the board” impact on quality measure performance based on Kaiser’s historical performance lifting measures. Overall, the organization is seeing better performance compared to the previous year in prioritized quality domains.

Well-Child Visits in the First 30 Months of Life

L.A. Care continues discussions with Quality Health Partners (QHP) on co-hosting WCV events with Blue Shield Promise at the Community Resource Centers (CRCs). L.A. Care has begun contract discussions with QHP and plans on attending a Blue Shield Promise event on August 23rd to observe.

DHCS Child Health Equity Collaborative

L.A. Care is conducting a site visit to Northeast Valley Health Corporation-Sun Valley on July 30 to observe the member journey for Hispanic and Latino infants receiving well child exams, developmental screening, and vaccinations to complete the requirements for Intervention 2. Additionally, the project team will conduct six interviews: three with providers, office staff, and medical directors and three with caregivers and families of patients to better understand member needs and opportunities for clinic-level improvement. The next submission is due August 15th.

Provider Quality Review (PQR)

Operational Efficiency Monitoring

The PQR team has maintained a timely closure rate of above 99% for FY2023-2024.

Audits & Oversight

PQR has completed Q2 2024 oversight of Appeals and Grievances (A&G) and Customer Solution Center (CSC) to audit and identify any potential missed quality of care or service concerns for PQI investigation. Collectively, 27 cases in Q2 2024 (18 from A&G and 9 from CSC) were identified as opportunities for potential quality review. The PQR team continues to provide collaborative feedback to drive process improvements with both departments and value their collaborative spirit.

Collaboration with A&G

In May 2024, A&G implemented a new quality of care review process with physician review of grievances; however, without RN reviewers. The new workflow transitioned to include RN reviewers in July 2024. PQR conducted multiple clinical training sessions in July - August 2024, to support the newly on-boarded A&G RNs to ensure full implementation. PQR continues to provide additional training support, as needed to ensure potential quality of care concerns are addressed.

Stars/HEDIS Performance

- **Overall HEDIS domain performance is thus far projected to increase from 2.50 Stars rating in MY2023 to 2.79 Stars rating in MY2024.** Pharmacy is also projected to increase in overall domain performance of 3.15 Star ratings in MY2023 to 3.62 Stars rating in MY2024 resulting from an increased effort of LAC internal pharmacy-staffed programs.

- Operation domain performance however is projected to decline from 3.80 to 3.62 Stars rating. The decline in the Operations domain is due to a significant decline in the Reviewing Appeals Decision measure.

- **LACC MY2023** is projected to earn, using June 2024 refresh data, an overall summary indicator rating of 76 achieving a Star Rating of 3, just 4 points short of achieving a 4 Star

- **LACC MY2024 year to date**, using June 2024 data, is performing higher than prior year to date. Clinical Quality is performing at 60.080 year to date which is 8 points higher than same time last year. Overall projected year-end rating for MY2024 is currently projected at 76.100 and at a Star Rating of 3.

Population Health Management (PHM)

PHM Program Description:

The PHM team has completed the draft of the 2024 PHM Program Description, incorporating CalAIM requirements and intervention updates. The review is currently in process, after which the document will be finalized and posted publicly.

Collaborative Efforts and SMART Goals:

The PHM team is leading collaborative efforts with local health departments and L.A. County health plans to reduce maternal and infant mortality disparities for Black and Native American persons by 10-15% annually, aiming to achieve a BOLD goal of 50% reduction by December 2025. This includes:

- Advancing the Doula Hub initiative.
- Collaborating with SCAN on a SMART goal for older populations.
- Engaging a consultant from HMA to facilitate efforts, with the contract in progress.
- Developing regular workgroups focused on resources/funding, planning, and data, with the next deliverable on track for October.

Population Health Informatics

Health Information Ecosystem (HIEc)

Health Information Exchange (HIE) Amendments: The Hospital Services Agreement (HSA) is being updated to require mandatory participation in HIEs for hospitals, ensuring compliance with CMS 9115-F standards for ADT notifications and engagement with the California Health and Human Services (CalHHS) Data Exchange Framework (DXF). Similar updates are being applied to Skilled Nursing Facility contracts to facilitate more efficient information exchange.

Incentive Programs: Participation in HIEs is a critical component of the newly launched Hospital Pay-for-Performance (P4P) and Skilled Nursing Facility (SNF) P4P Programs. These programs offer ongoing incentives for achieving HIE participation milestones. A new HIE Participation Measure has been introduced within the Physician P4P program, enabling Federally Qualified Health Centers (FQHCs), small, and solo providers to earn annual incentives by achieving HIE-related milestones, promoting the adoption and meaningful use of HIEs.

Incentives

We stablished the new L.A. Care Provider Honor Roll to recognize providers who scored in the top 20% of the Physician P4P Program. This will be an annual recognition where providers are sent a window cling to display in their offices. The 2024 letters and window clings were mailed out in July, ongoing communications via print and web to publicize the honor roll will happen.

Community Health

Community Supports (CS) Operations & Reporting

Why it matters: *Community Supports are a part of the Department of Health Care Services' (DHCS) broader effort to provide enhanced care and address social determinants of health through the Medi-Cal program. These support are offered under the California Advancing and Innovating Medi-Cal (CalAIM) initiative, which aims to improve health outcomes for Medi-Cal beneficiaries by offering a broader range of services that go beyond traditional medical care.*

Community Supports (CS) Provider Network

L.A. Care established a provider network for community supports by identifying, contracting with, and coordinating a range of community-based organizations, service providers, and other entities that can deliver the non-medical services covered as part of the CS benefit. A robust provider network for these services is crucial for organization to effectively address social determinants of health, improve member outcomes, and reduce healthcare costs by ensuring comprehensive, coordinated care.

In our last report, we informed you that for the January 2025 contracting cycle, the CS provider Letter of Interest (LOI) was released in May of this year to support the development of the CS provider network. Review of the CS certification applications has since been completed and we are actively notifying selected providers of their inclusion of the network.

Latest in CS Implementation and Member Engagement

The newest community supports launched in July, including **Day Habilitation** and **Short-Term Post-Hospitalization Housing (STPHH)**. Day Habilitation provides structured activities and skill-building programs designed to enhance daily living skills, socialization, and community integration for individuals with disabilities or chronic conditions. The STPHH benefit offers temporary housing and support services for individuals transitioning from a hospital stay, ensuring a safe recovery environment while addressing immediate housing needs and preventing readmissions.

Behavioral Health Services

Spotlight: Behavioral Health Services for L.A. County's Students

The DHCS Student Behavioral Health Incentive Program (SBHIP) aims to enhance access to behavioral health services for students by incentivizing managed care plans to collaborate with schools, providers, and community organizations, thereby addressing mental health and substance use needs among California's youth. This program focuses on early intervention, prevention, and reducing barriers to care within the school setting. L.A. Care's participation is in collaborative partnership with Health Net, Los Angeles County Department of Mental Health, and the Los Angeles County Office of Education (LACOE).

Thus far, we have met all program milestones from initial planning and engagement to service delivery expansion and monitoring and reporting. We have been awarded 75% of DHCS' available funding to date, and we are currently on target to meet our goal of reaching 100% funding by the end of the calendar year.

Hazel Health has partnered with applicable schools and school districts to provide students with access to telehealth services for mental health care, including counseling and therapy sessions, in the school environment or remotely. 53 Local Education Agencies (LEAs) with 675 schools total are currently referring members for BH services though Hazel Health. The majority of referrals come from school staff (84%) and the remaining 16% come from self-referrals from students.

Lastly, in the Children and Youth Behavioral Health Inititive (CYBHI), there was an update to the school behavioral health fee schedule. Carelon Behavioral Health has been selected by DHCS as the Third Party Administrator (TPA) for CYBHI. L.A. Care already has an established working relationship with Carelon, which should help implement the new process for this initiative, including using the same process for payments that is currently established.

Housing Initiatives

Housing CS, Day Habilitation CS, Field Medicine, HHIP

Housing (Housing Navigation CS, Tenancy Sustaining Services CS, Housing Deposits CS):

Member enrollment and network: As of August 12, 12,914 members were enrolled in L.A. Care's housing programs, of which 9,338 were assigned to DHS. This is a 24% increase in enrollment (2,517 additional members) from the beginning of the year.

Field and Street Medicine: Launch and Operations

After the Request for Applications (RFA) was distributed in April, resulting in 20 submissions, final provider selection letters were distributed to 19 qualifying organizations on July 10, 2024. Final coverage areas were including in the selection letter, and the L.A. map and participating providers were also shared. Of these providers, ten organizations were selected to receive capacity-building funds to set up new Field Medicine teams based on coverage in each region. The investment agreement is being finalized and will include specific metrics the organization will report.

Pharmacy Department

Medication Adherence Programs

Comprehensive Adherence Solutions Program (CASP): Since 2023, we have implemented several new interventions and enhancements. These efforts include expanding collaboration to 19 Participating Physician Groups (PPGs), deploying the Navitus RISE Customer Relationship Management (CRM) solution to facilitate timely member identification and engagement, partnering with AdhereHealth for additional adherence outreach, and collaborating with our Advanced Analytics Lab (AAL) to utilize predictive analytics for improved member prioritization and outreach. We have increased member calls, set new monitoring targets, and introduced weekly interactive customer service training for our staff. We are closely monitoring our performance and remain committed to improving adherence rates.

Pharmaco-adherence Mailers: Internally managing mailer distribution for DSNP and LACC/D members and providers is expected to yield cost savings of approximately $154,000, starting in June 2024. As of August 15, a total of 536 DSNP and 625 LACC provider mailers have been sent out, along with 1,925 DSNP and 8,521 LACC member mailers. Pharmacy is also working on deploying a faxing workflow through Retrarus WebExpress, as a low-cost supplemental form of communication with providers.

mPulse Mobile Inc. Text Campaigns: Pharmacy has launched two new text message campaigns on July 7, 2024 to further support the medication adherence measures. These text campaigns focus on reminding members that they are overdue for a medication refill and have an interactive feature that allows members to inform us that they would like 100-day supplies of their medications. The text messages will reduce member fatigue from calls and as of August 12, 932 members have already expressed interest in receiving a 100-day supply of their medications.

Refill Reminder Robocalls: Pharmacy has been collaborating with our Customer Solutions Center (CSC) to relaunch the refill reminder robocalls on July 22, 2024. The robocall logic was updated to identify and call members who are overdue for a medication refill, rather than those with an upcoming refill, to reduce member abrasion. As of August 19, 761 total robocall attempts have been made to DSNP and LACC members. Of these, 277 calls successfully connected with the members.

AdhereHealth Vendor Collaboration: Pharmacy started a new collaboration with AdhereHealth to engage members in medication adherence. This program focuses on non-adherent and unengaged high-risk members. Medication adherence outreach to the first cohort of members started on July 31, 2024.

Medication Therapy Management (MTM) Program

CMS requires health plans to offer MTM services to Medicare members, including an annual comprehensive medication review (CMR). L.A. Care's MTM submission for program year 2025 was approved. 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), has achieved a 66% completion rate of eligible members as of August 12, 2024, a significant improvement from 2023 Q3 at 61%.

Additional Pharmacy Programs

Asthma Medication Ratio (AMR):

The AMR measure assess members 5-64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year. This is important as appropriate medication management for members with asthma could reduce the need for rescue medication – and prevent ER visits, inpatient admissions and missed days of work or school.

The Pharmacy Data Analytics team worked with Quality Performance Management to create an updated National Drug Code (NDC) list that would positively impact AMR performance, contingent on auditor approval. Additionally, prescribers of non-compliant members with a short-

acting beta agonist (SABA) prescription will be faxed a general notice to prescribe inhaled corticosteroid (ICS)-formoterol as the preferred reliever therapy per clinical guidelines.

PA Accel: This is automated prior authorization (PA) program, which operates at the point of sale by utilizing member's medical and pharmacy data. Medications requiring prior authorization may approve seamlessly at the pharmacy if criteria are met. The program went into production on May 14, 2024 for our DSNP line of business and is now also currently rolled out for LACC and PASC. In the month of July, 330 requests were approved through PA Accel, reducing the need for Prior Authorizations by 45%.

Figure 1. Benefits of the PA Accel program as compared to the original PA process.

MacArthur Park Care Collaborative

Overview prepared for the L.A. Care Board of Governors

L.A. Care HEALTH PLAN

For All of L.A.

September 2024

At a Glance: L.A. Care's strategy to address the housing crisis

L.A. Care's various programs combine to provide a uniquely comprehensive suite of services to address critical member needs

Finding Housing & Staying Housed

Short Term Housing Solutions

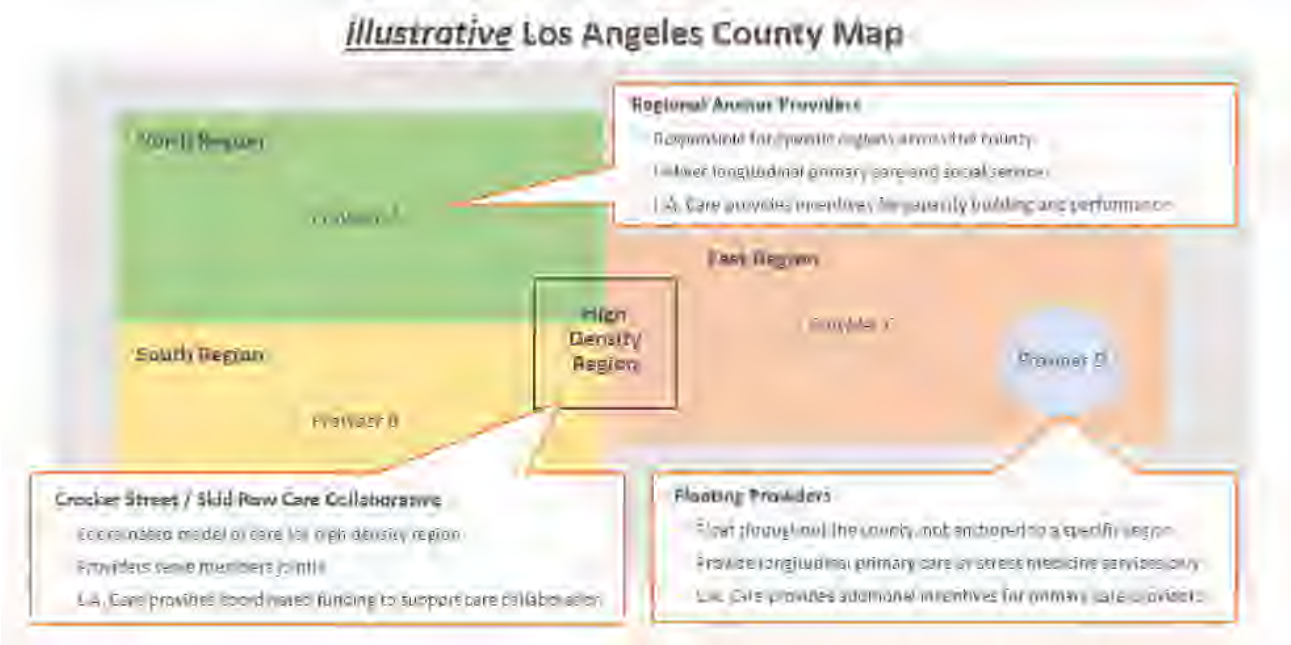
Increasing Availability of Permanent Housing

Access to Healthcare & Social Services

Focus for today

Review: Field Medicine advances care for the unhoused through a novel geographic approach

The Field Medicine Program will support 10 new teams for 5 years & organize care using a population-based approach for the first time in LA County



Field Medicine Program has launched, on track to provide county-wide coverage

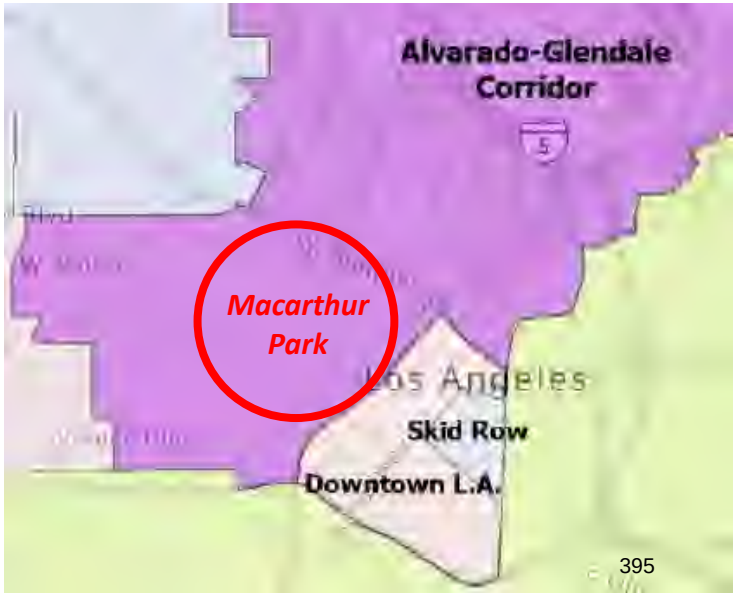
Nineteen providers to deliver services to L.A. Care members across **15 distinct Field Medicine regions** across the county

L.A. Care is developing a second Care Collaborative in MacArthur Park

Like Skid Row, MacArthur Park is a high-density region with a critical need for enhanced services & care coordination

The MacArthur Park Care Collaborative includes:

1. Carving out MacArthur Park from the Alvarado-Glendale Field Medicine region
2. Creating a specialized zone to meet the specific health and social services needs of the neighborhood
3. Care Collaborative to act as the “Regional Anchor” and facilitate care coordination



Proposed components of the MacArthur Park Care Collaborative

Enhanced Field Medicine services

- Additional Field Medicine team dedicated to the park and surrounding neighborhood
- Integrated overdose response teams
- Behavioral health services

Harm Reduction Health Hub

- Respite / observation beds
- Community health workers / community ambassadors
- Connection to housing navigation, ECM and other social services
- Hygiene, nutrition, laundry

Coordination among all key stakeholders

- Dedicated coordinators to support collaboration among providers
- Coordination with City & County interim housing programs

Free transit connections

- Shuttle to connect field-based services with brick-and-mortar harm reduction and clinical services
- Possible connection to Skid Row Care Collaborative specialty care hub

Augmented clinic-based medical services

- Expansion of existing SUD / sobering and primary care brick and mortar services located in proximity to MacArthur Park and surrounding neighborhood

KEY: Clinical Services | Social Services | Coordination & Logistics

MacArthur Park Care Collaborative principal planning partners

Partner		Type
Department of Health Services	Health Services LOS ANGELES COUNTY	County Agency
Department of Public Health	County of Los Angeles Public Health	County Agency
County Supervisorial District 1	Los Angeles County Supervisor HILDA L. SOLIS First District	Elected Office
Los Angeles City Council District 1	EUNISSES HERNANDEZ L.A. City Councilmember | District 1	Elected Office

Potential MacArthur Park Care Collaborative provider partners

Potential Partner	Services that could support MacArthur Park Care Collaborative	Field Medicine Program Participation
Los Angeles County Department of Public Health	Behavioral Health	Key Stakeholder
Los Angeles County Department of Health Services	Harm Reduction & Coordination	Skid Row Care Collaborative & Field Medicine Primary Care Provider – Regional Anchor
Clinica Monsenor Oscar A. Romero	Field Medicine Primary Care, SUD, harm reduction & other clinic-based services	Field Medicine Primary Care Provider - Regional Anchor
Healthcare In Action	Field Medicine Primary Care	Field Medicine Primary Care Provider – Floating
UCLA Homeless Healthcare	Field Medicine/Street Medicine	Field Medicine Primary Care Provider – Floating (Contract Pending)
USC Street Medicine	Field Medicine/Street Medicine	Field Medicine Primary Care Provider – Floating (Contract Pending)

Next Steps

L.A. Care to meet with principal planning partners to:

- Review detailed view of key services
- Align on budget & investment timeframe
- Discuss project governance
- Outline provider selection methodology & process

Provider Relations Sub-Committee Quarterly Meeting

Performance Monitoring
August 2024

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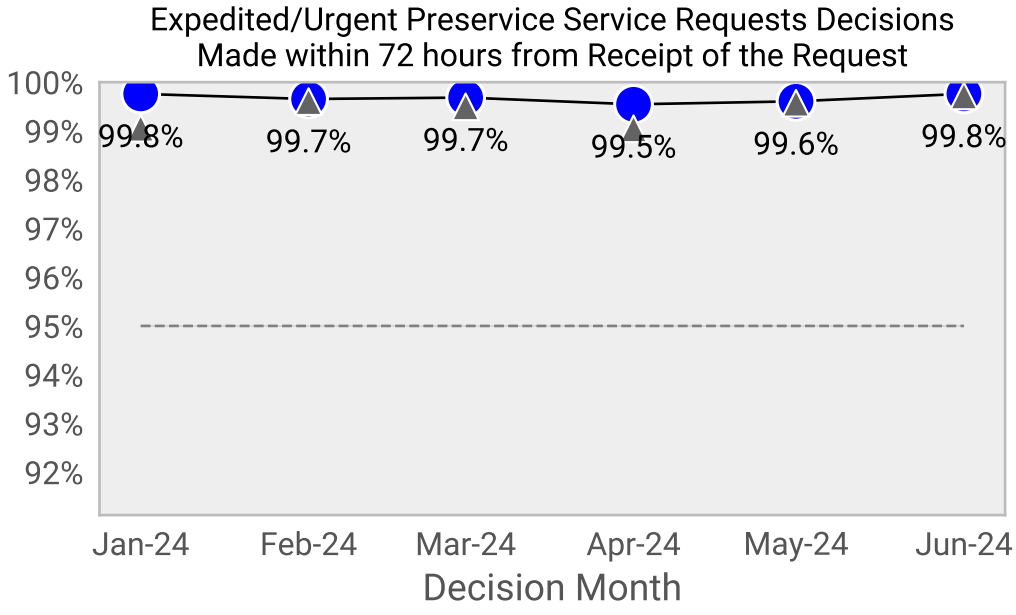
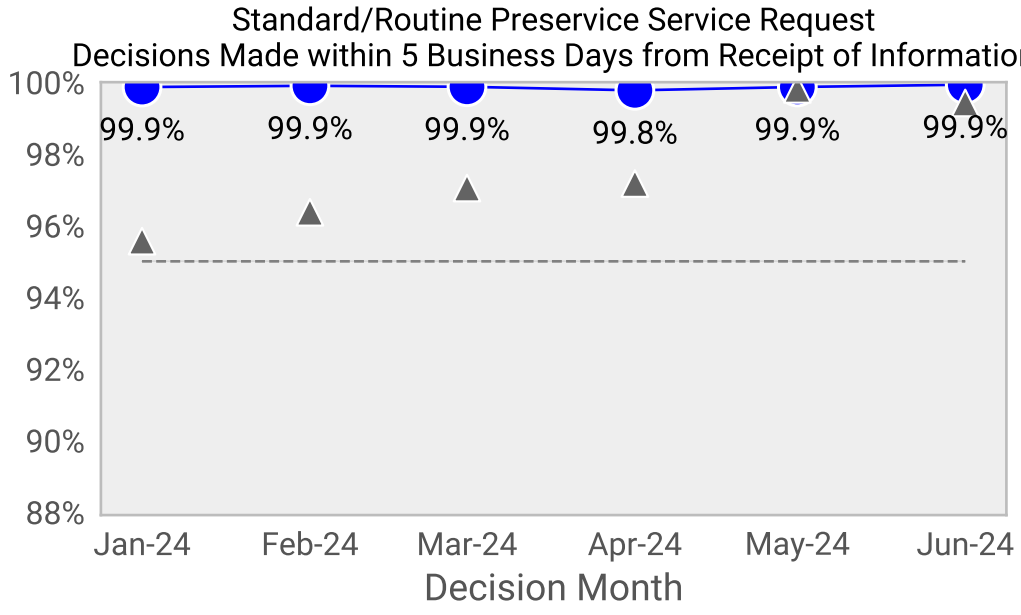
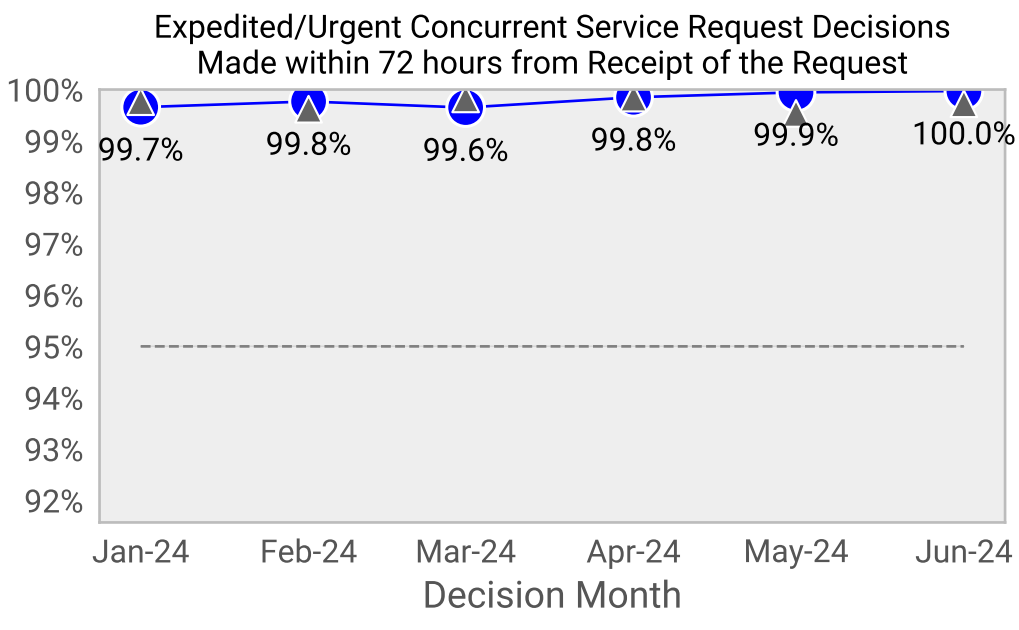
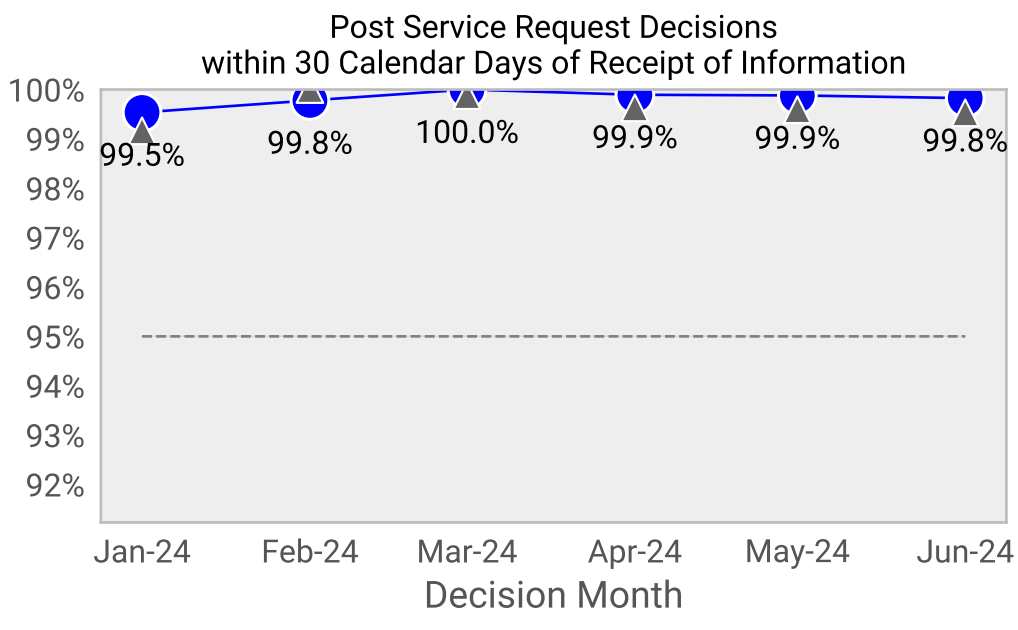
Medical Management

MCLA Authorization Processing Timeliness





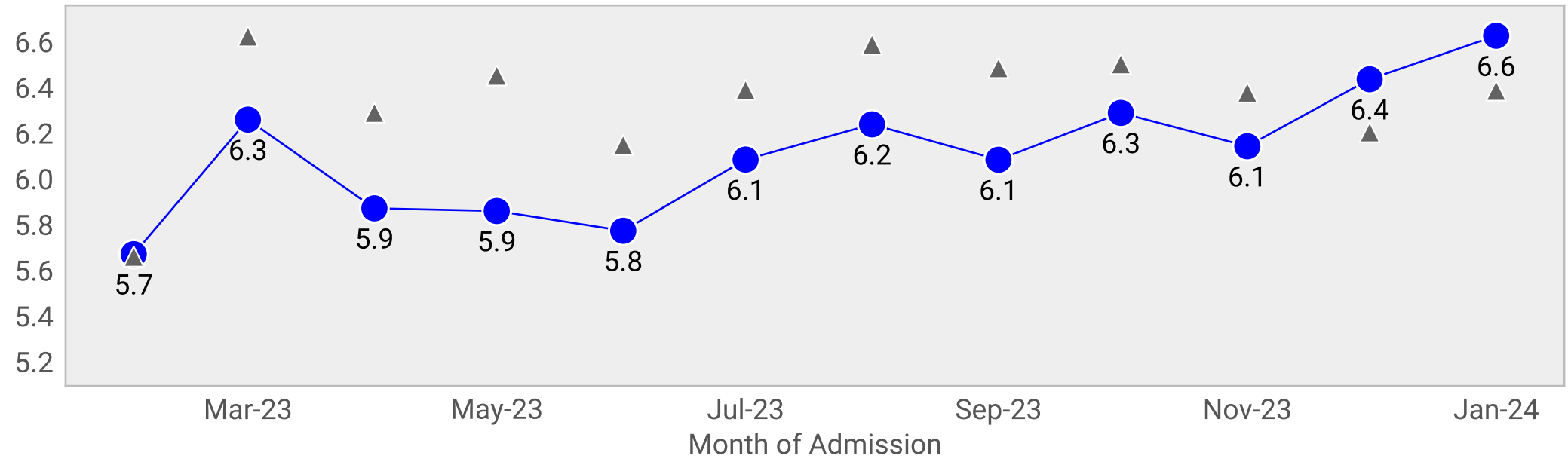




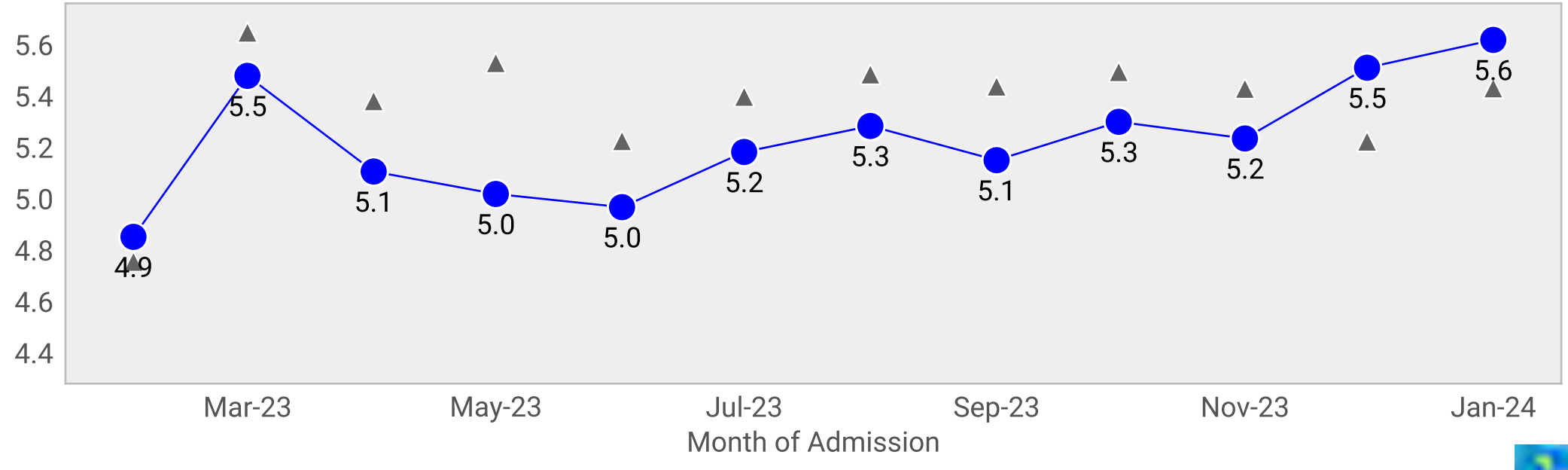
Triangles display the previous year's performance for the same month.

Only includes authorizations processed directly by L.A. Care.

Total MCLA In-Patient Hospital Admissions PTMPM



Non-Obstetrics MCLA In-Patient Hospital Admissions PTMPM

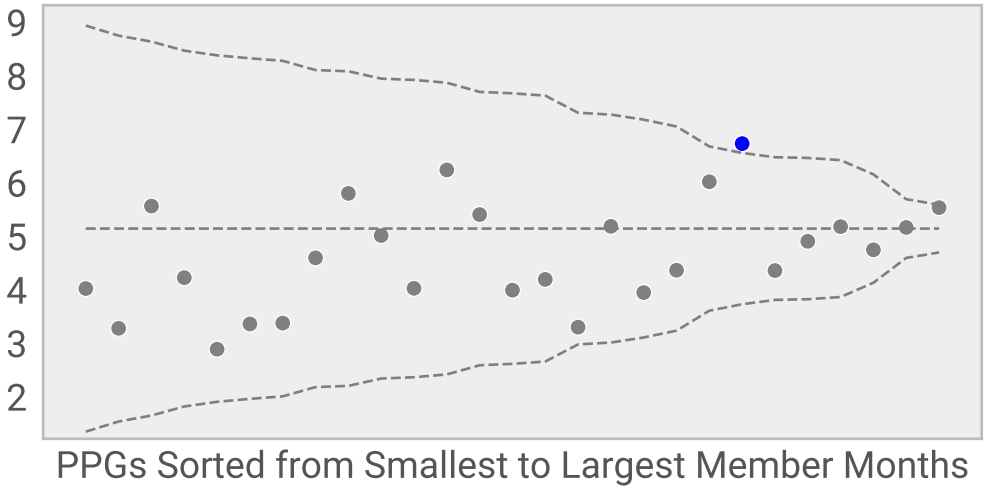


Triangles display the previous year's performance for the same month.

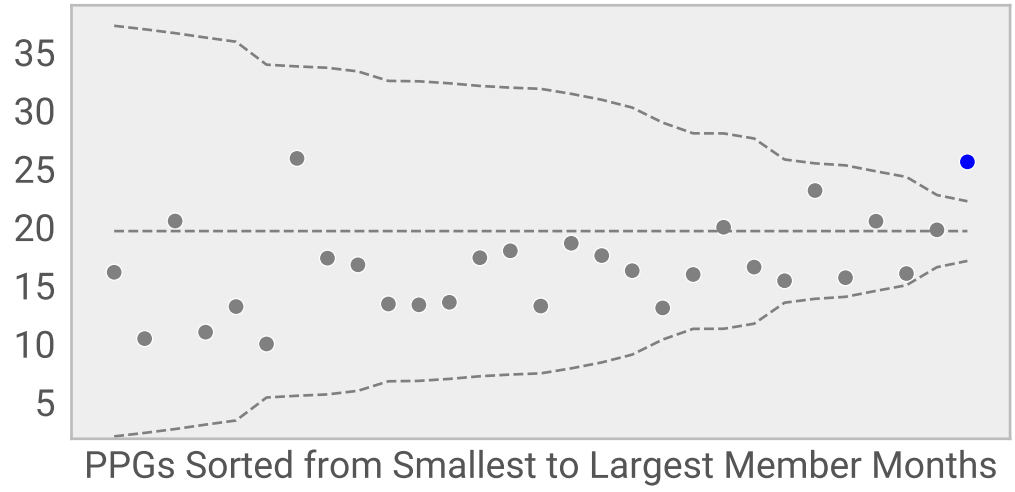
404

MCLA Non-Obstetrics In-Patient Admissions PMTPM by Segment and PPG
U' Charts
Assessment Period: Feb 2023 through Jan 2024

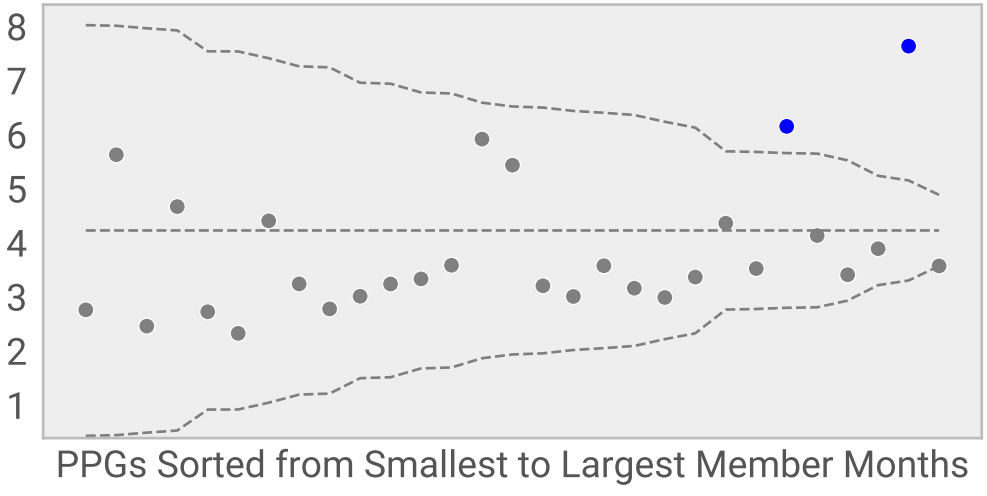
MCE



SPD



TANF - Adult



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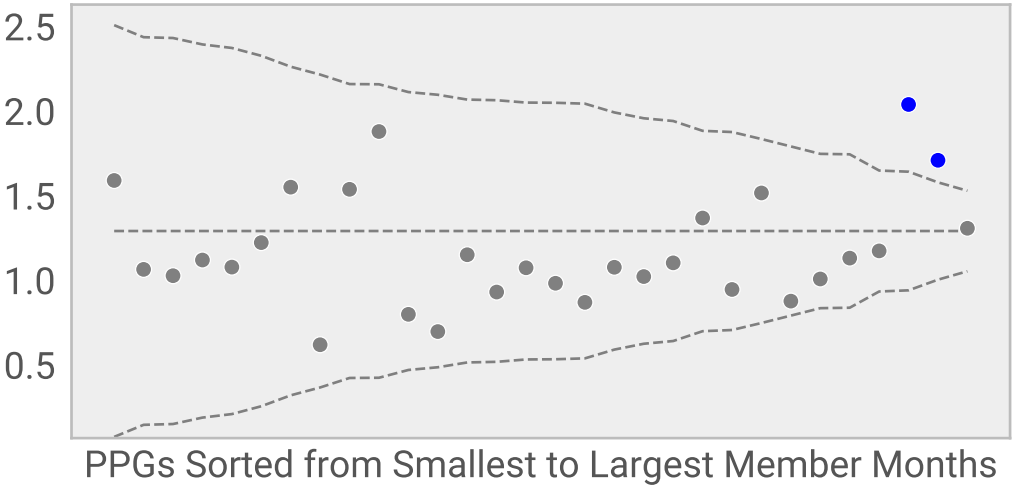

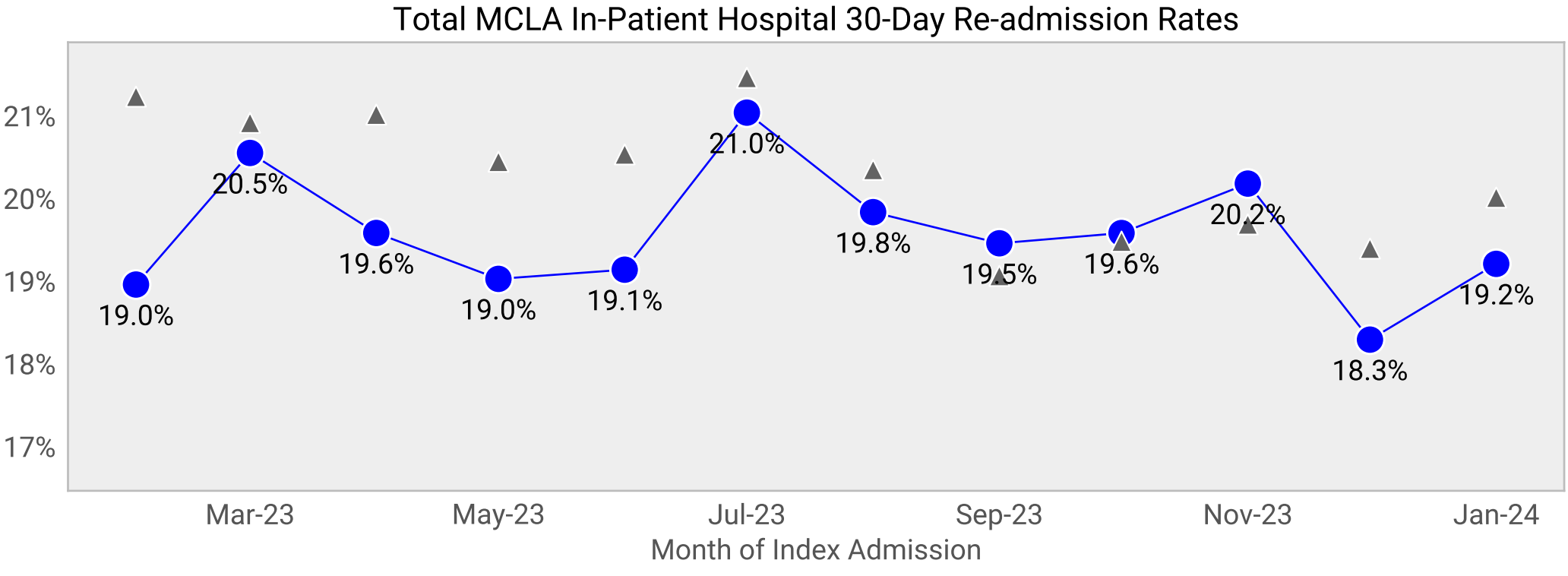

Triangles display the previous year's performance for the same month.

MCLA In-Patient Hospital 30-Day Readmission Rates by Segment and PPG
P Charts
Assessment Period: Feb 2023 through Jan 2024

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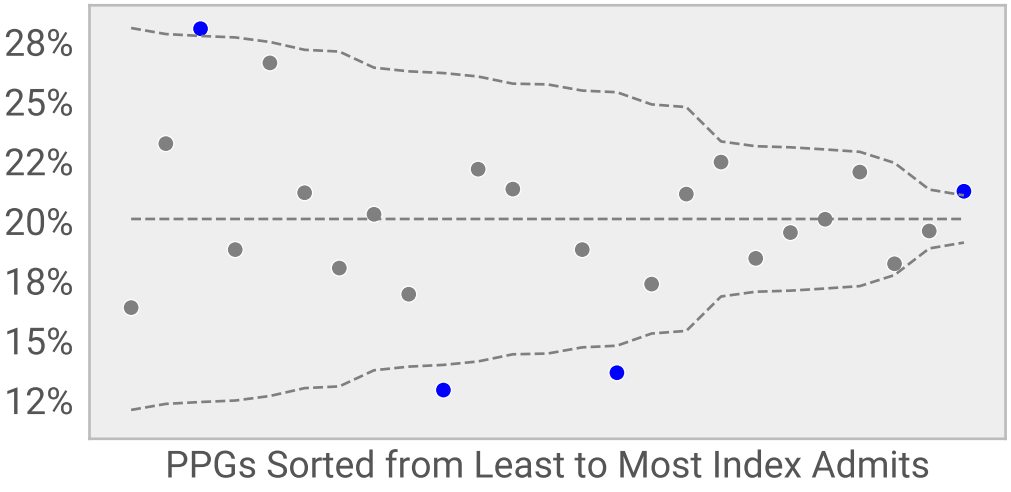

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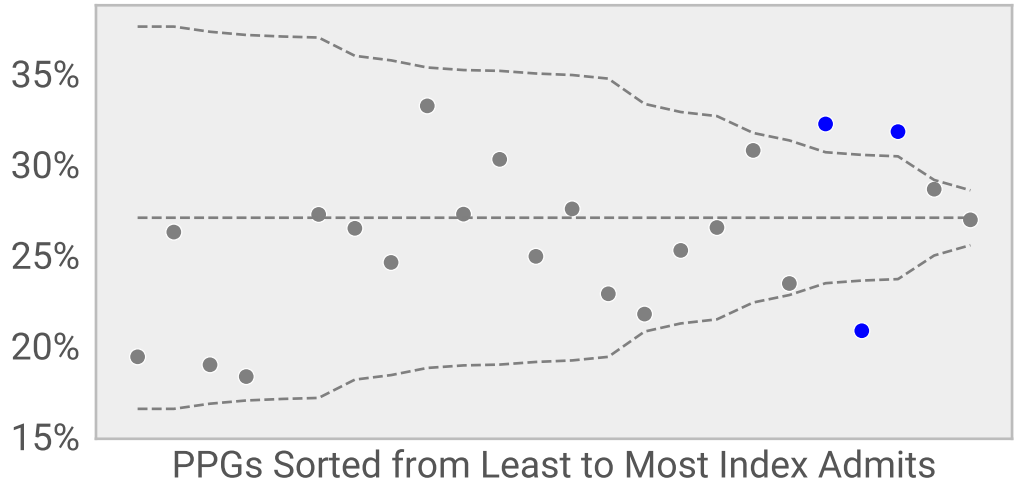
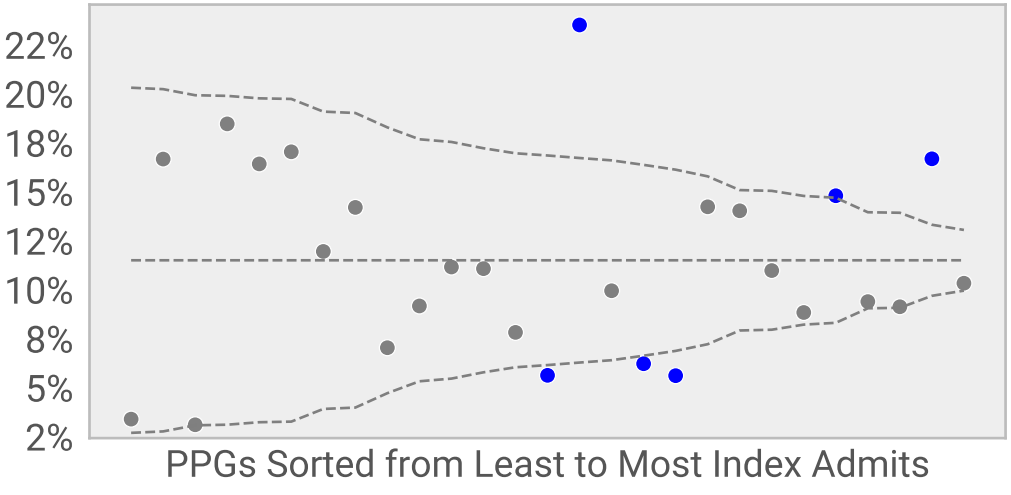
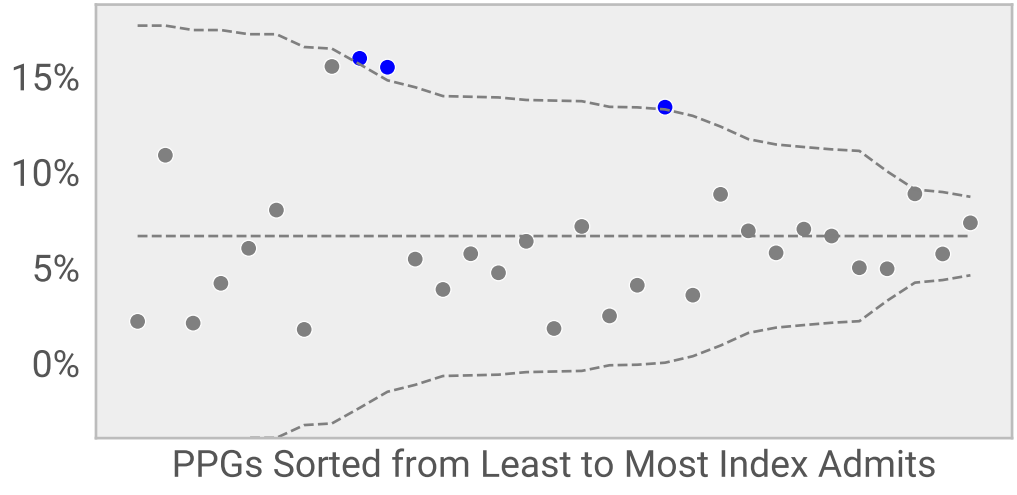
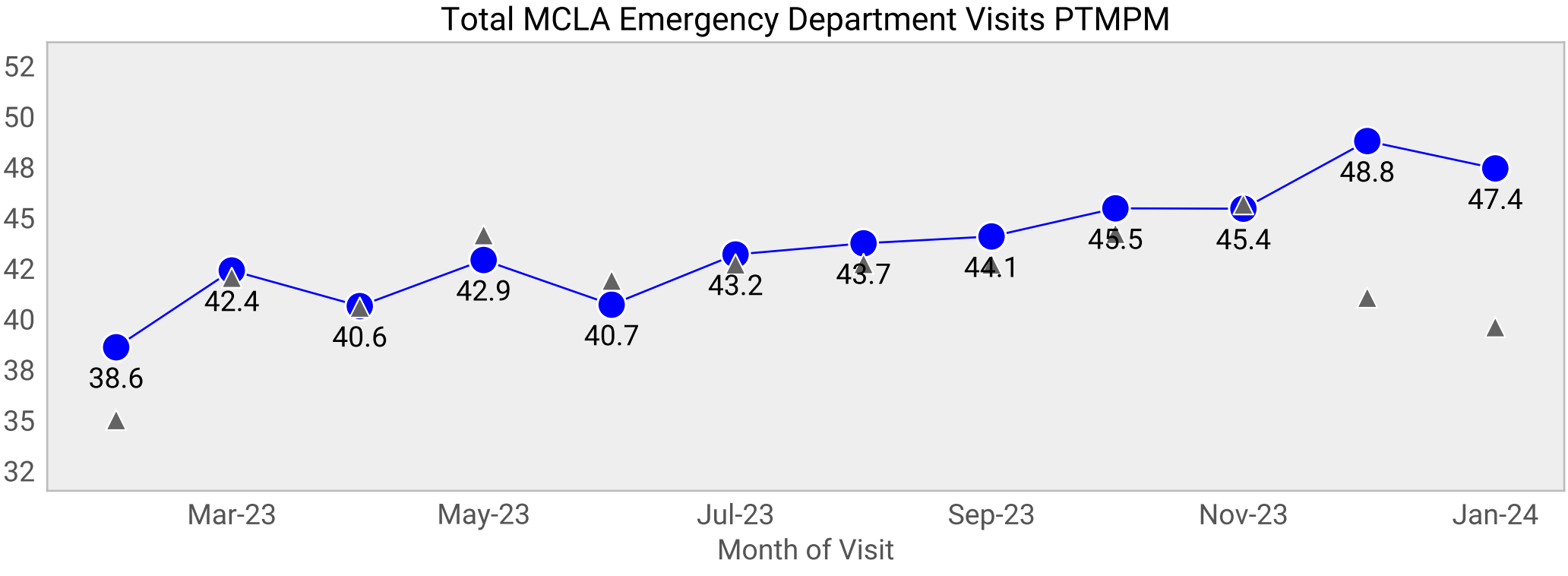


TANF - Adult



TANF - Child

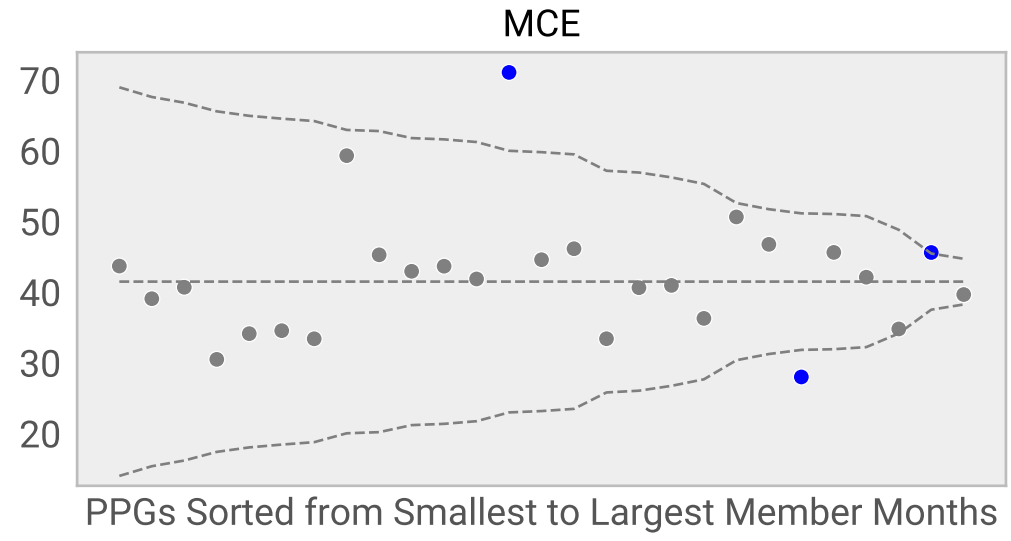


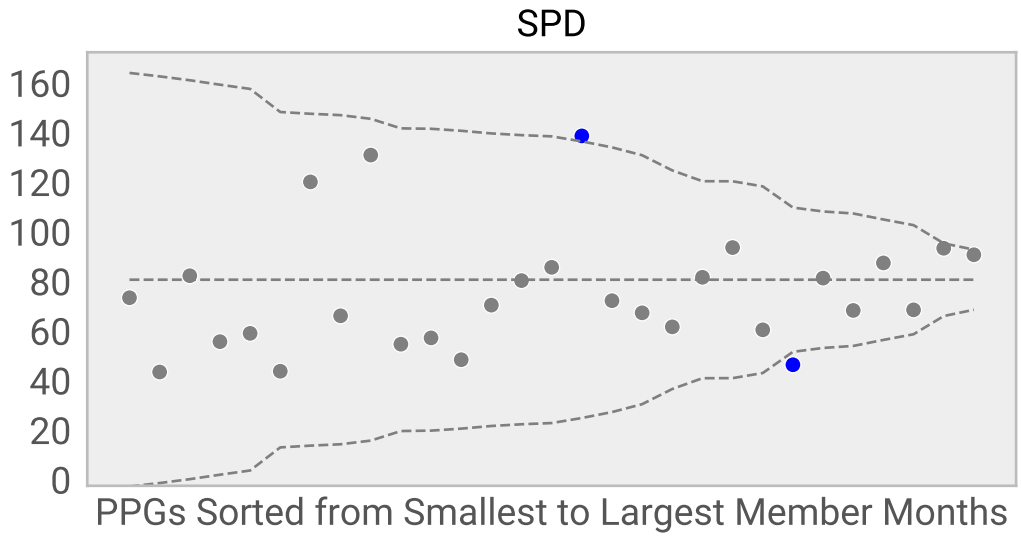


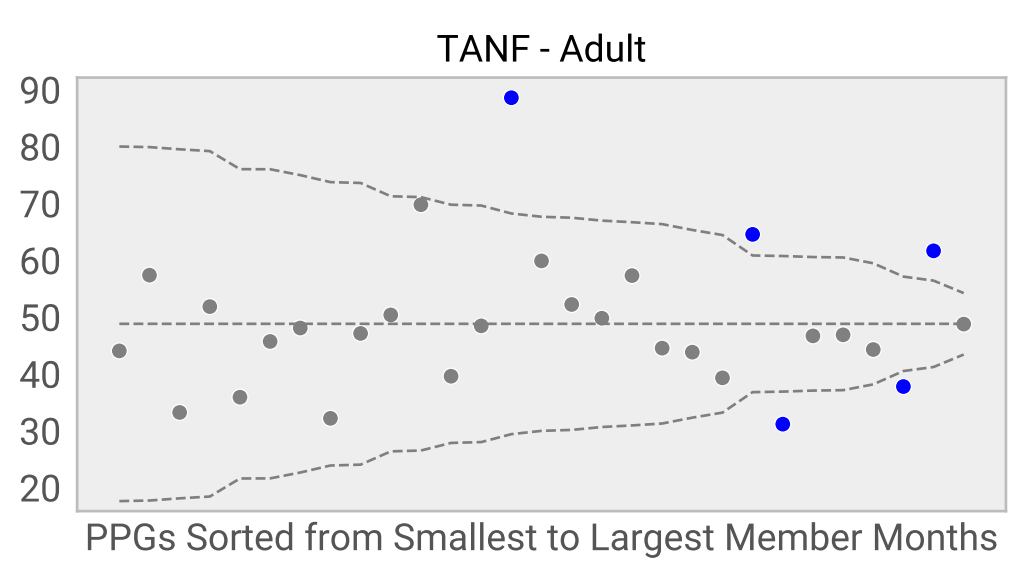
Emergency Department Visits include both Out-Patient visits and visits that result in an In-Patient admission.

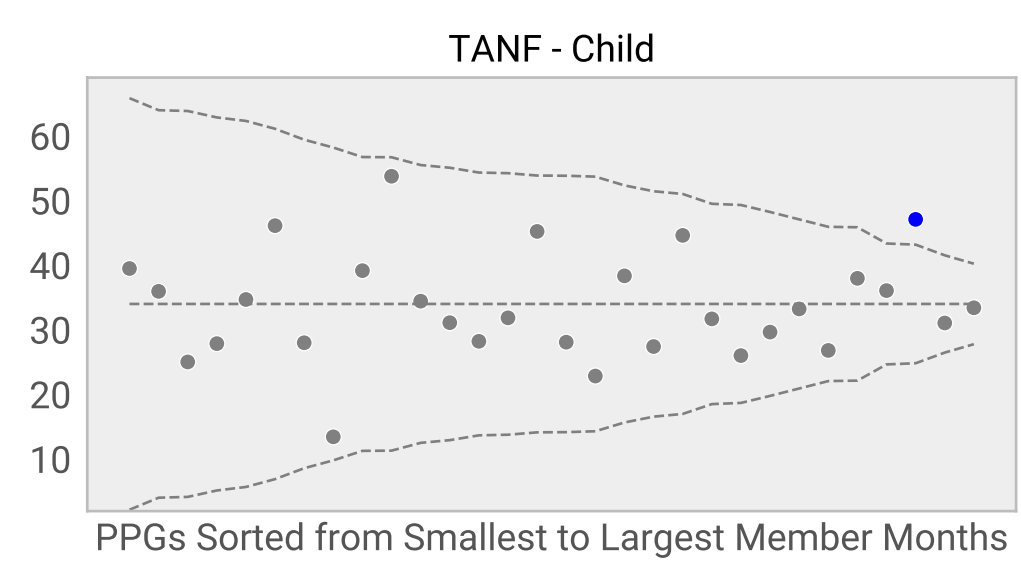
Triangles display the previous year's performance for the same month.

Total MCLA Emergency Department Visits PTMPM by Segment and PPG
U' Charts
Assessment Period: Feb 2023 through Jan 2024

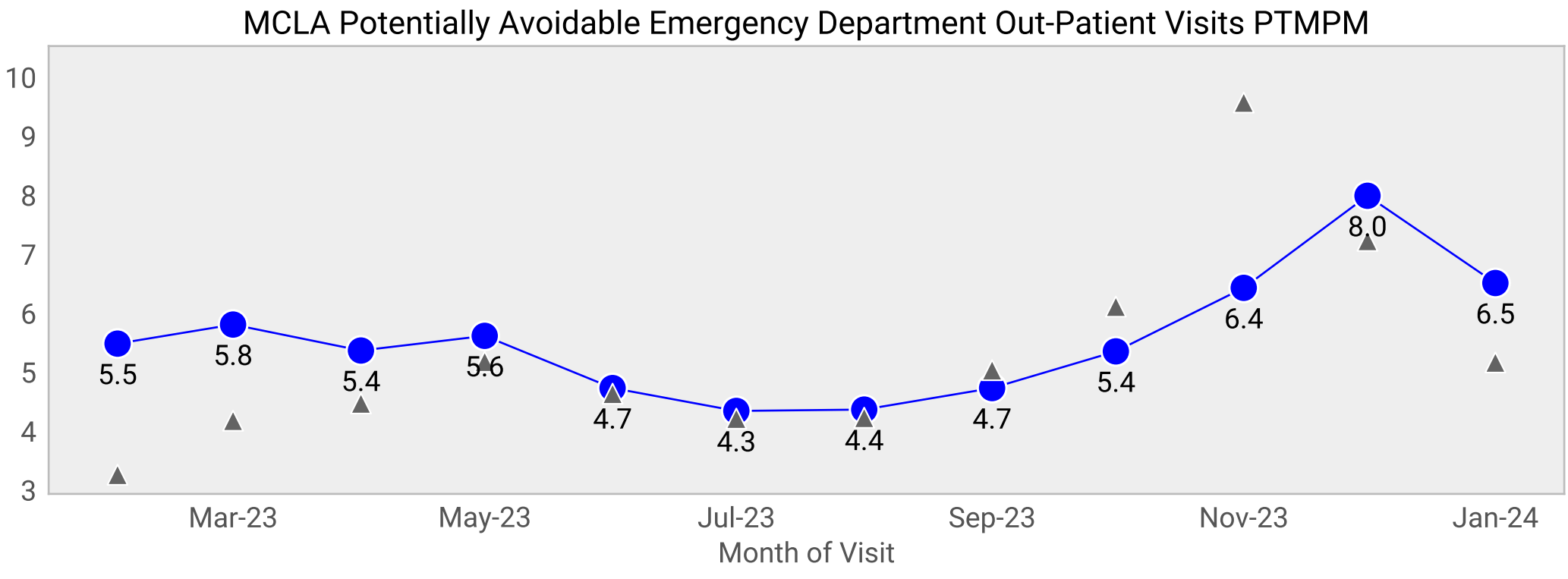








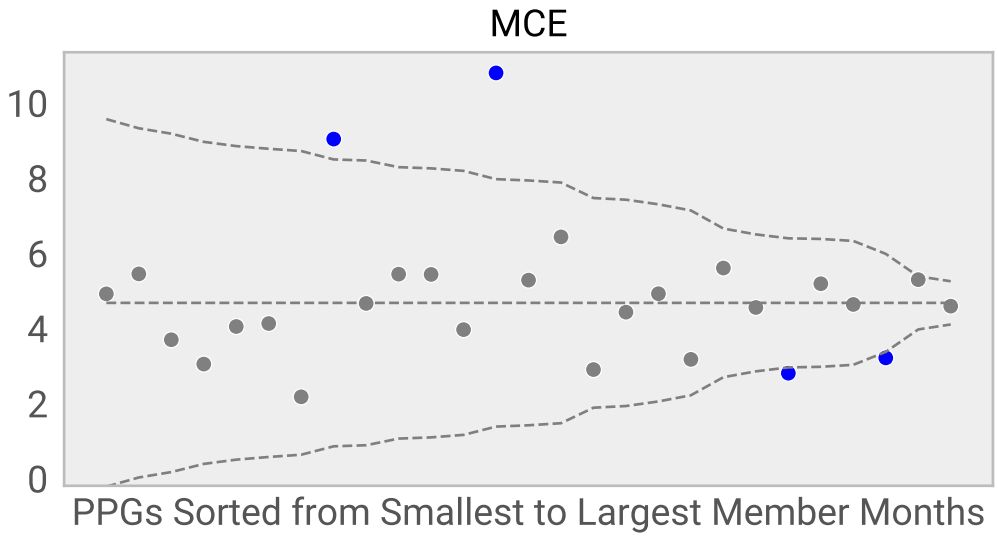
Emergency Department Visits include both Out-Patient visits and visits that result in an In-Patient admission.

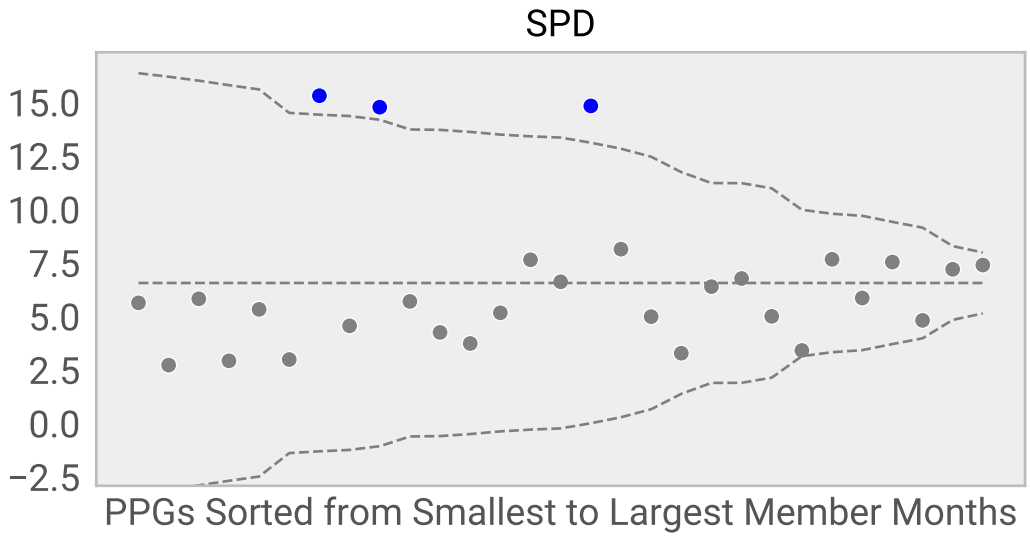


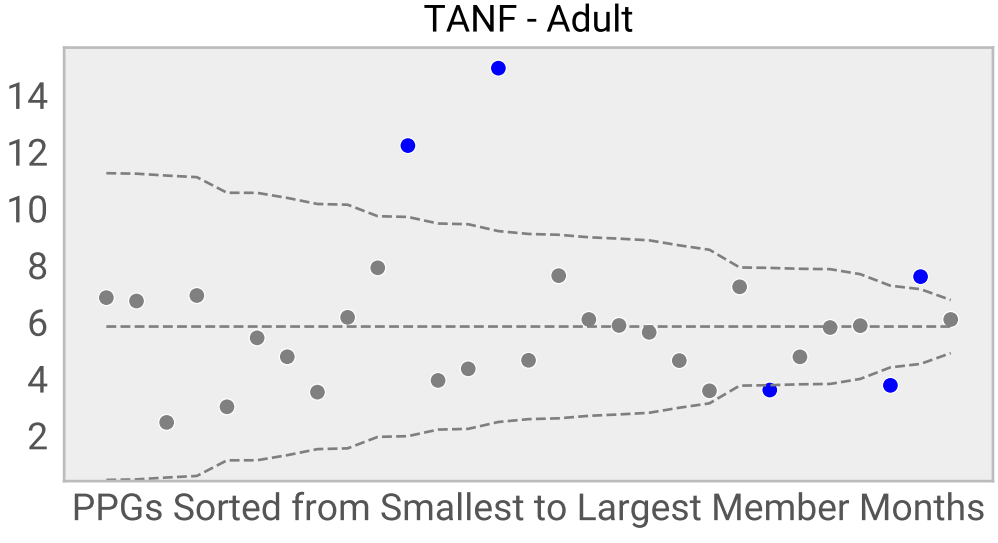
"Potentially Avoidable" identification uses the Agency for Health Research and Quality's Emergency Department Prevention Quality Indicator logic.

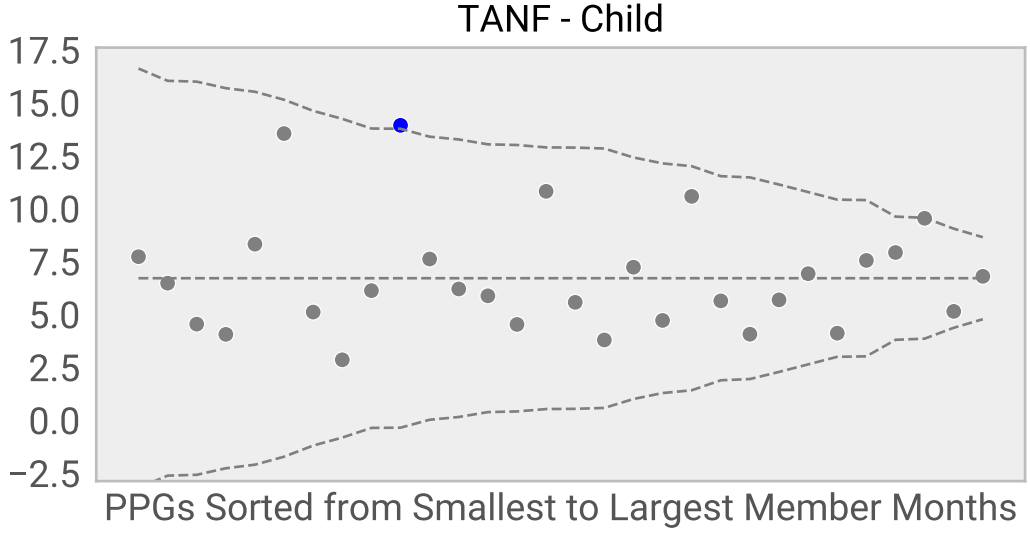
Triangles display the previous year's performance for the same month.

MCLA Potentially Avoidable Emergency Department Visits PTMPM by Segment and PPG
U' Charts
Assessment Period: Feb 2023 through Jan 2024









"Potentially Avoidable" identification uses the Agency for Health Research and Quality's Emergency Department Prevention Quality Indicator logic.

411

L.A. Care Provider "Face Sheet" Measures

Providing a single view of PPG performance across critical Quality, Medical Management, and Member Experience metrics.

Quality

Breast Cancer Screening
Cervical Cancer Screening
Child and Adolescent Well-Care Visits
Childhood Immunization Status
Controlling High Blood Pressure
Developmental Screening in the First Three Years of Life
Follow-Up After ED Visit for Substance Abuse: 30 days
Immunizations for Adolescents: Combo 2
Initial Health Screening
Lead Screening in Children
Prenatal & Postpartum Care: Postpartum Care
Prenatal & Postpartum Care: Timeliness of Prenatal Care
Topical Flouride for Children
Well-Child Visits in the First 30 Months of Life: First 15 Months
Well-Child Visits in the First 30 Months of Life: Age 15 Months-30 Months

Medical Management

% of Members Utilizing Primary Care
Professional Follow-Up Visits after In-Patient Hospital Discharge Rate
Total Emergency Department Visits PTMPM
Potentially Avoidable Emergency Department Visits PTMPM
Total In-Patient Admissions - Observed-to-Expected Ratio
Total non-Obstetric In-Patient Admissions - Observed-to-Expected Ratio

Member Experience

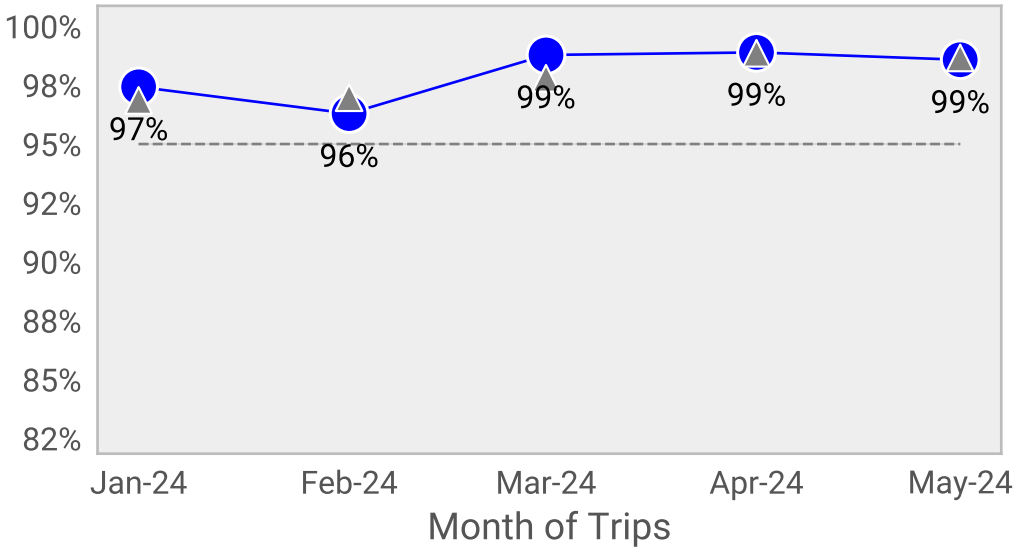
Access Grievance Data
Care Coordination (CG-CAHPS)
Getting Appoinments and Care Quickly (CG-CAHPS) - Adults
Getting Appoinments and Care Quickly (CG-CAHPS) - Children
PAAS - After Hours Access
PAAS - After Hours Call-Back Timeliness
PAAS - PCP Routine Appointment
PAAS - PCP Urgent Appointment
PAAS - Preventive Check-Up, Adult Well-Woman Exam
PAAS - Preventive Check-Up, Well-Child Exam
PAAS - Specialty Initial Prenatal Visit
PAAS - Specialty Routine Appointment
PAAS - Specialty Urgent Appointment

Total Members Receiving CalAIM Community Support Services from January 2024 to June 2024: 19,473

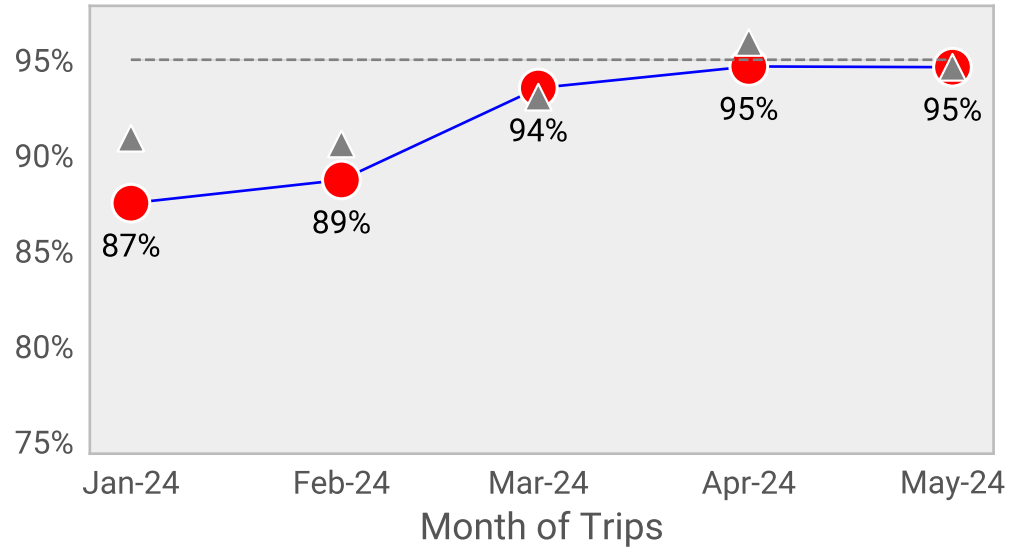
Call the Car

Call the Car On-Time Pick-Up Performance

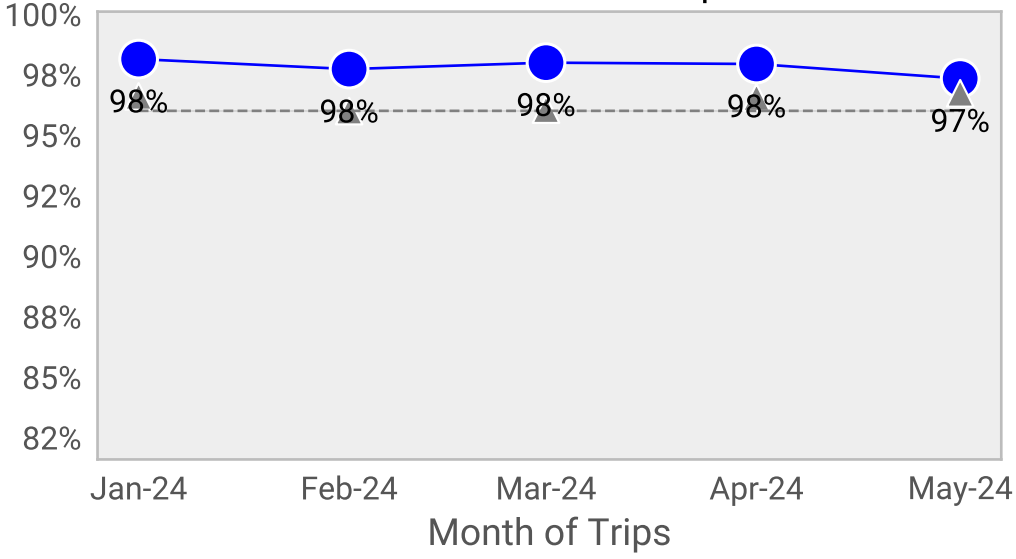
Call the Car Discharge Trips Rate



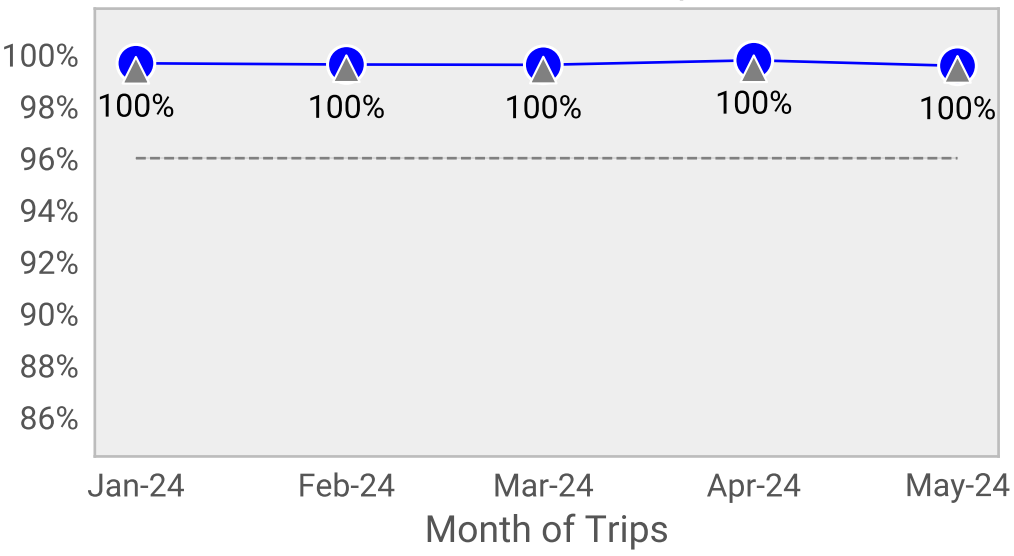
Call the Car Transfer Trips Rate



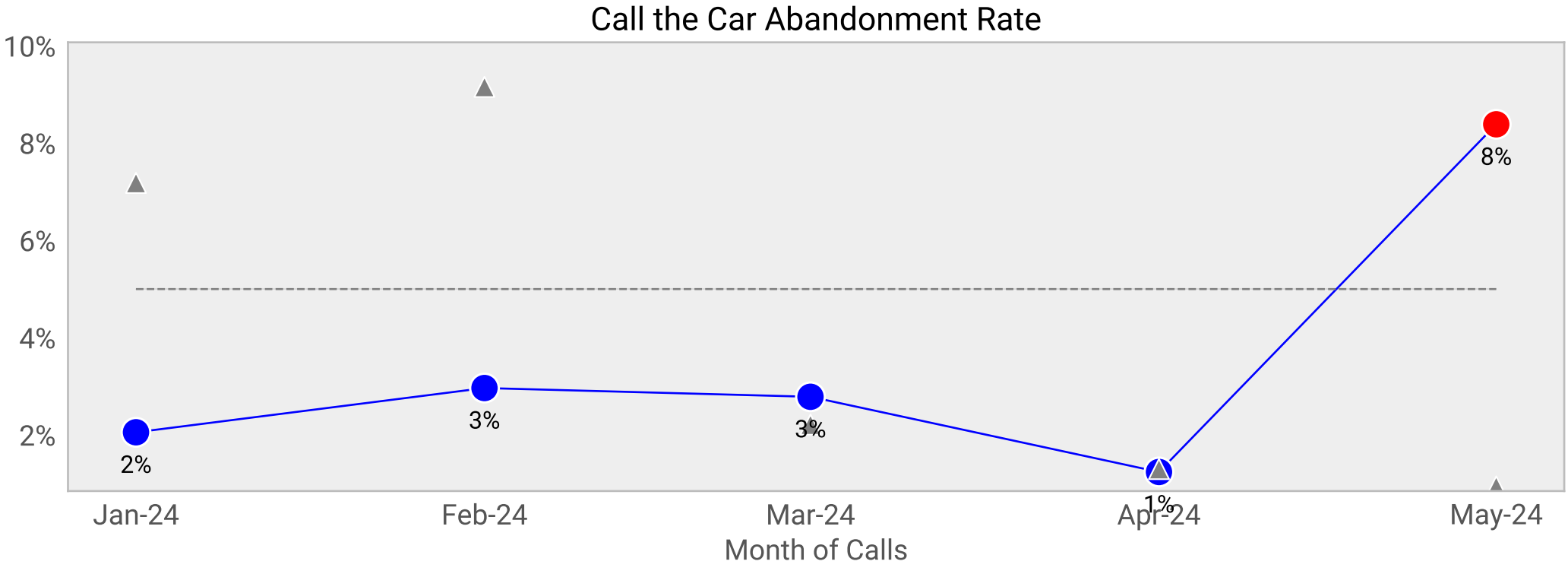
Call the Car Scheduled Trips Rate



Call the Car Will Call Trips Rate



Triangles display the previous year's performance for the same month.

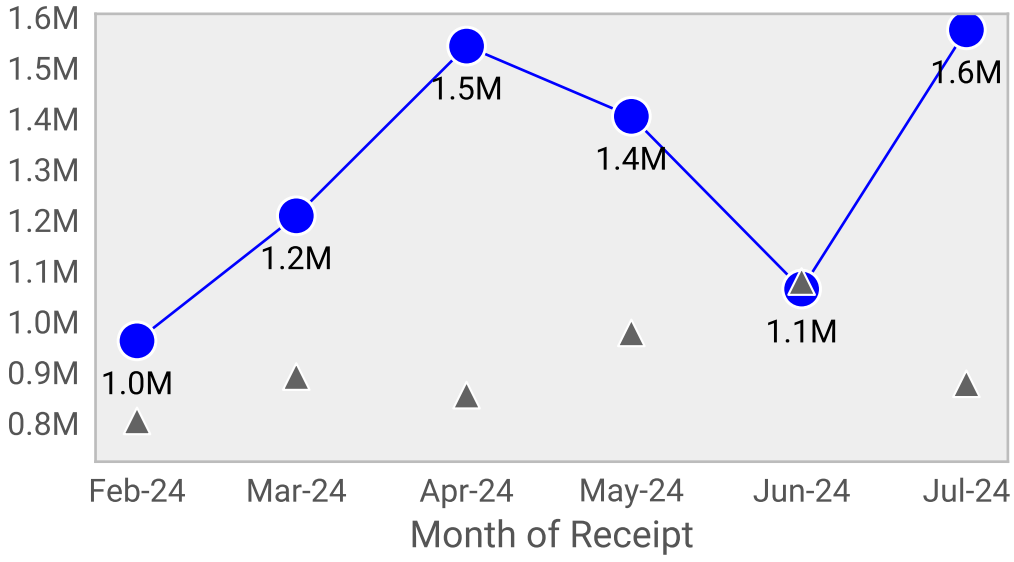


Triangles display the previous year's performance for the same month.

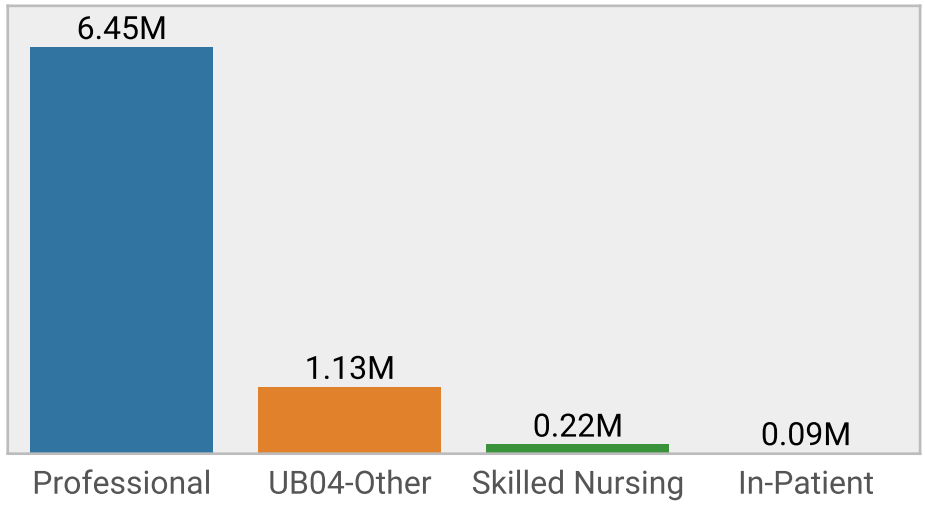
Claims Operations

MCLA Claims Received

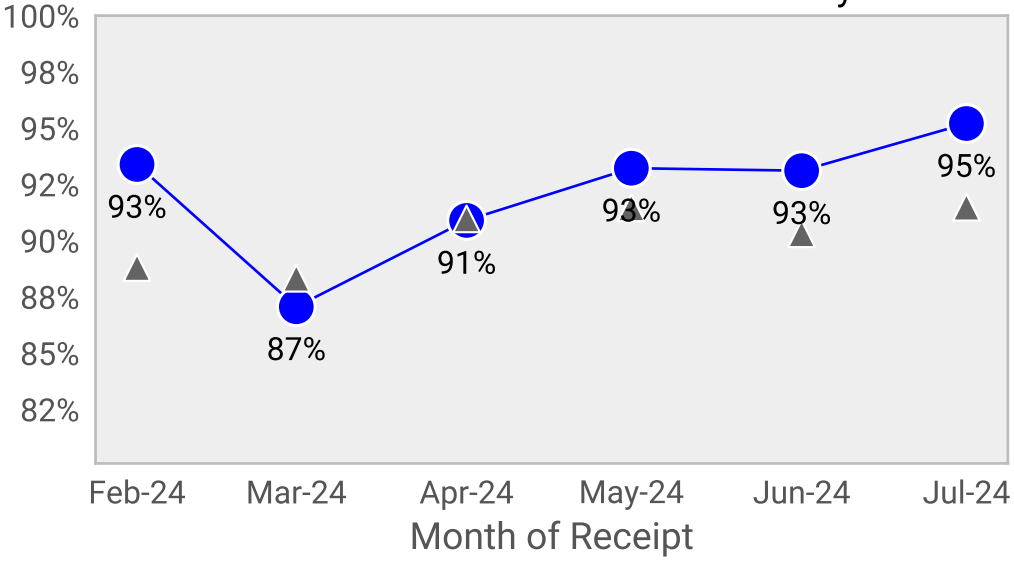
Total Claims Volume Received



Most Recent 6 Months' Volume by Service Type

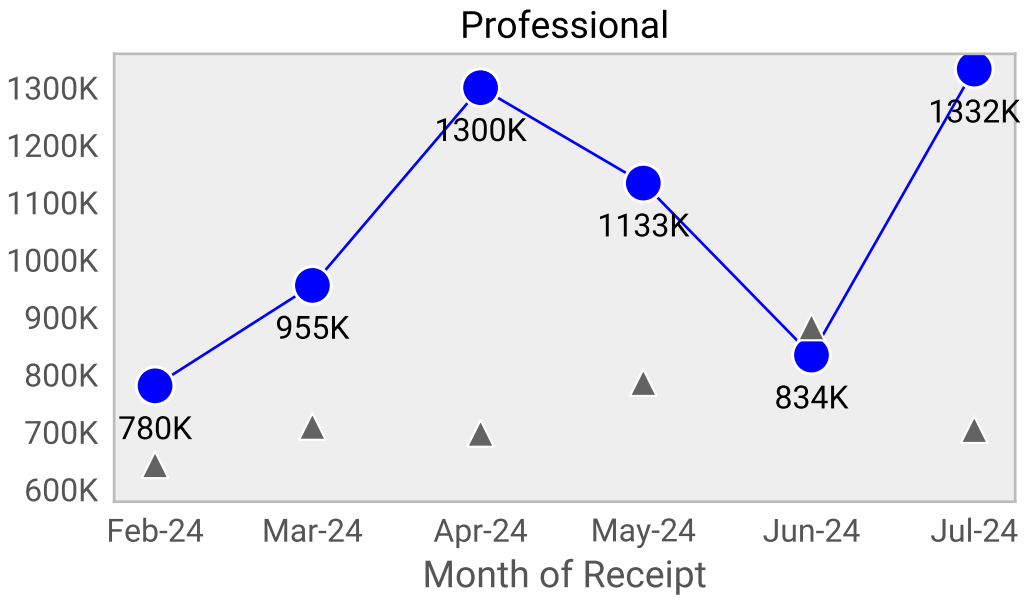


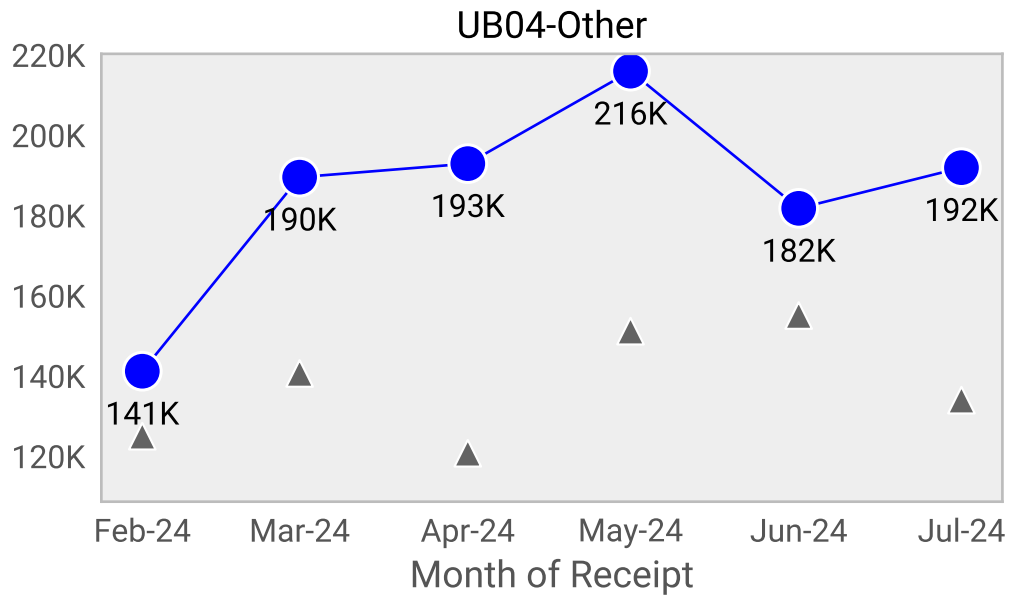
% of Claims Submitted Electronically

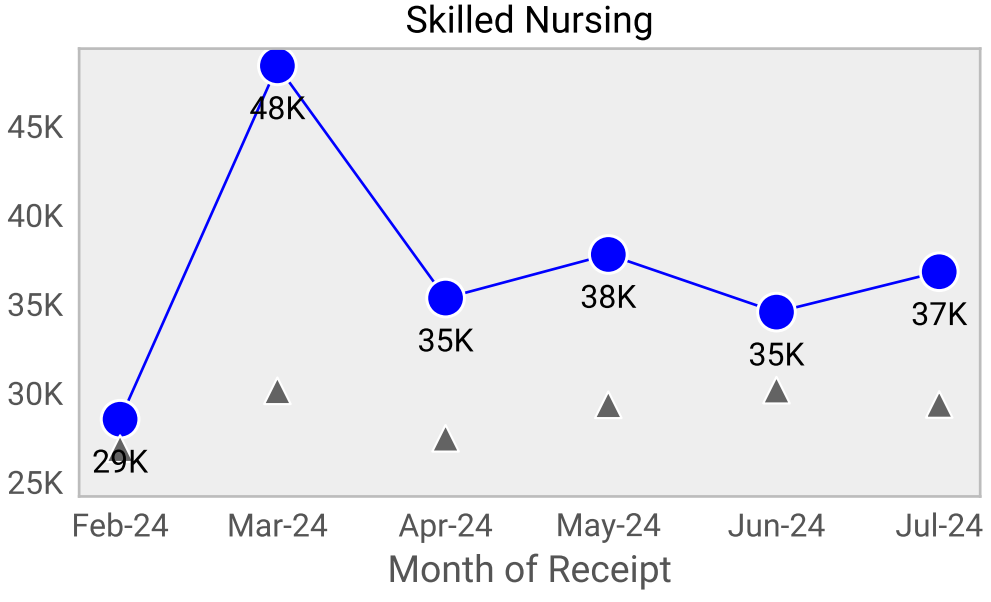


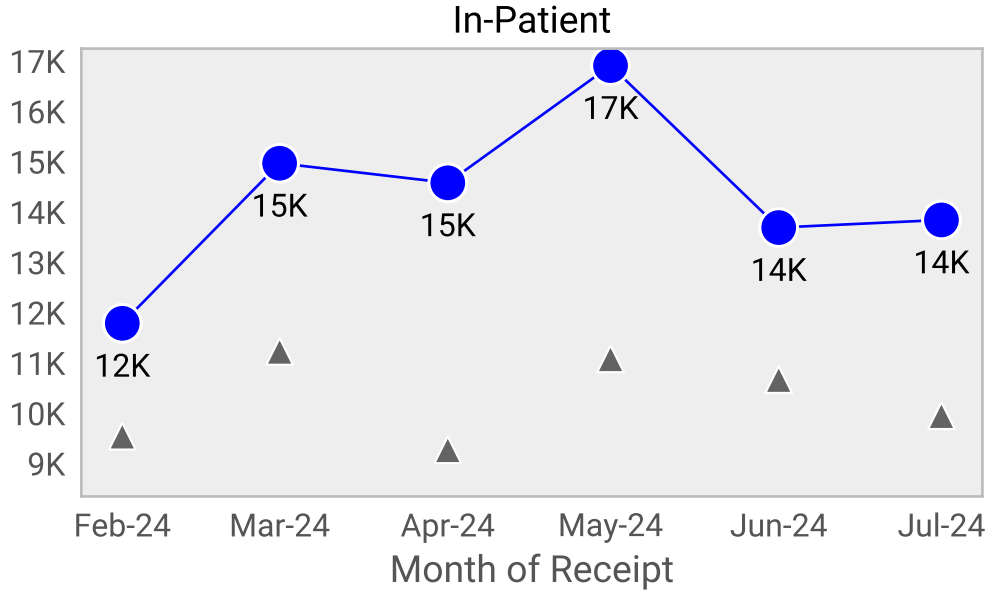
Triangles display the previous year's performance for the same month.

MCLA Claims Volume Received by Service Type





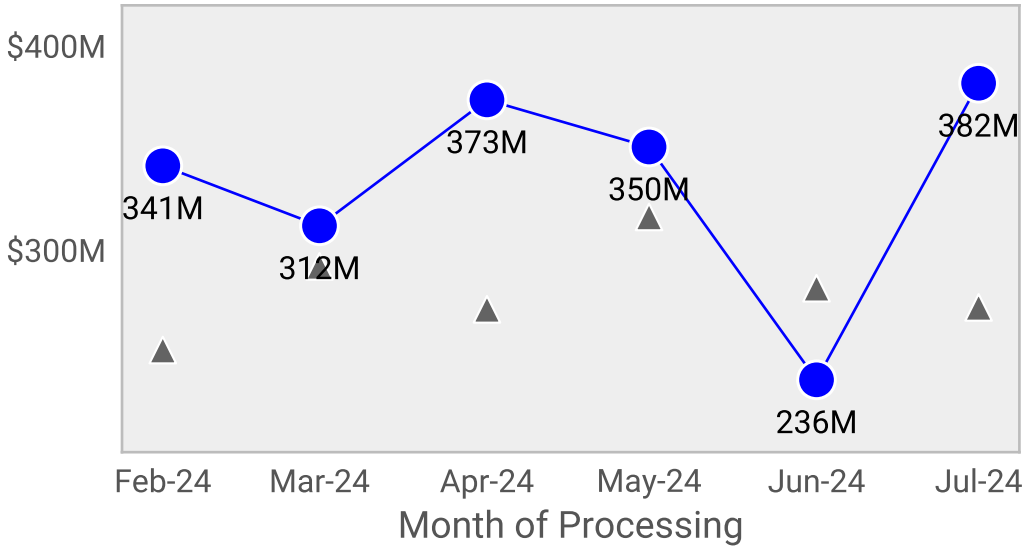




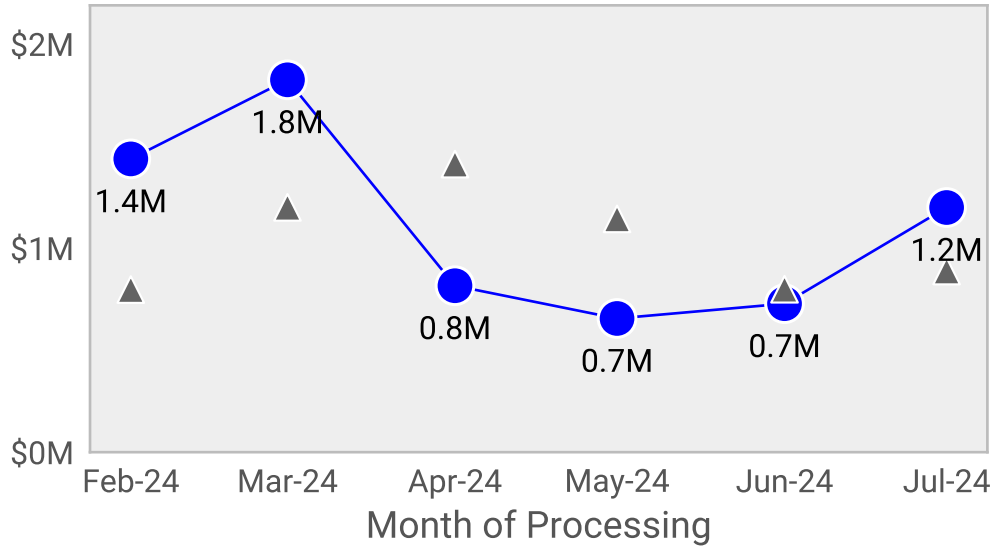
Triangles display the previous year's performance for the same month.

MCLA Payment Processing

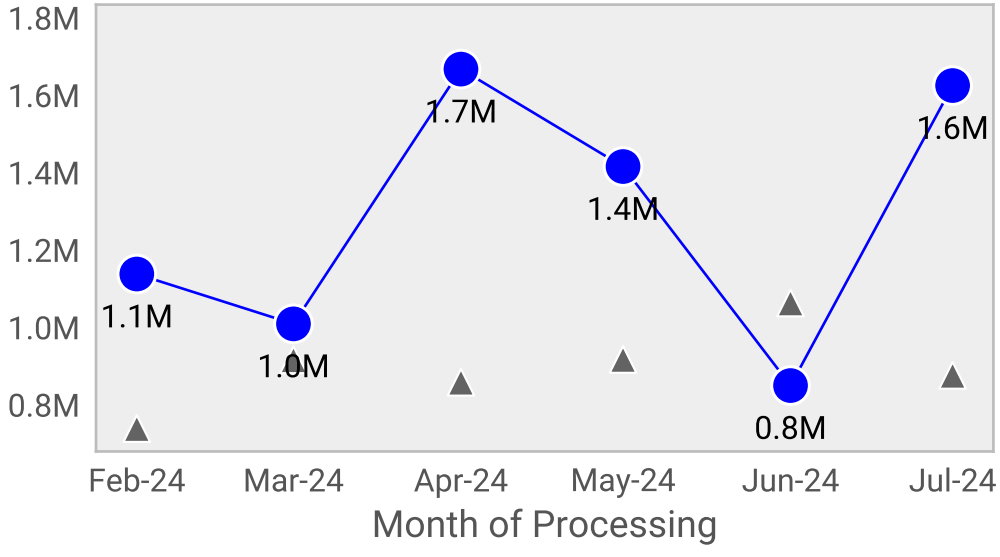
Total Paid (including Interest)



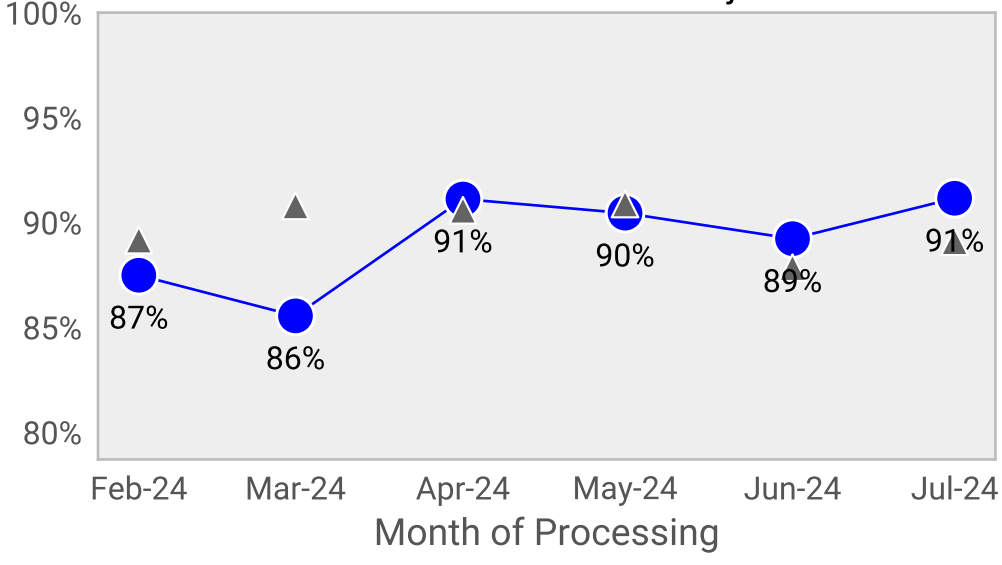
Total Interest Paid



Total First-Pass Adjudicated Claims Volume



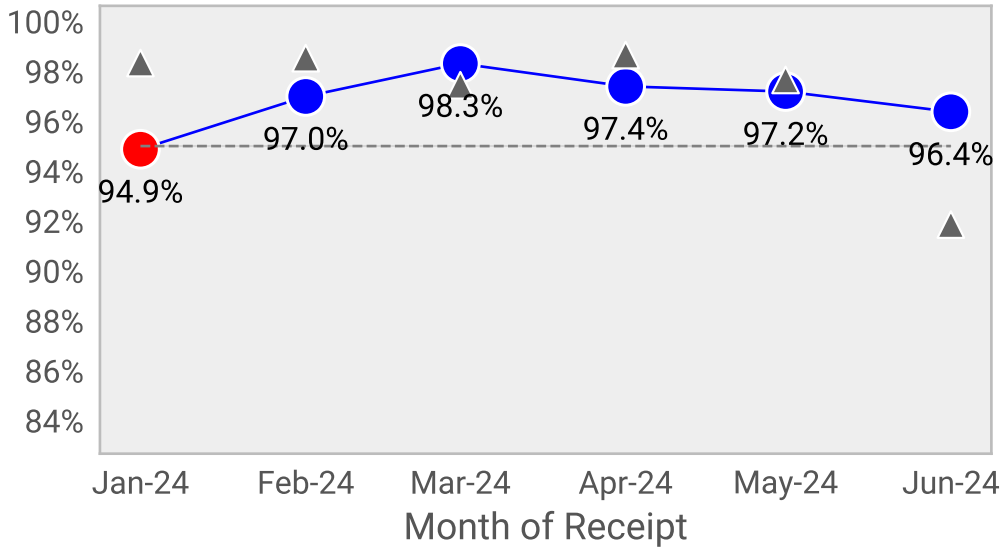
% of First-Pass Claims Auto-Adjudicated



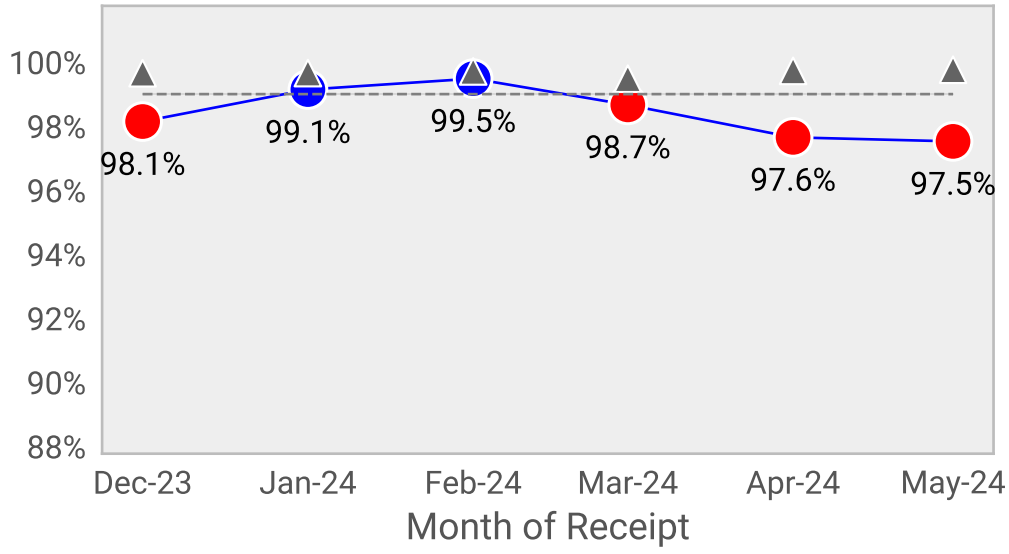
Triangles display the previous year's performance for the same month.

MCLA Claims Processing Timeliness

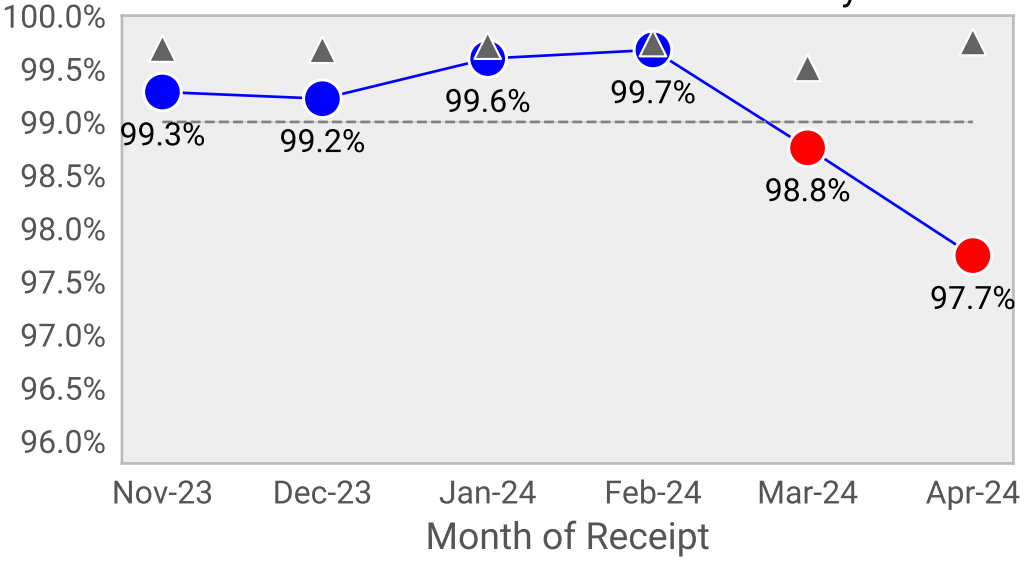
% Processed within 30 Calendar Days



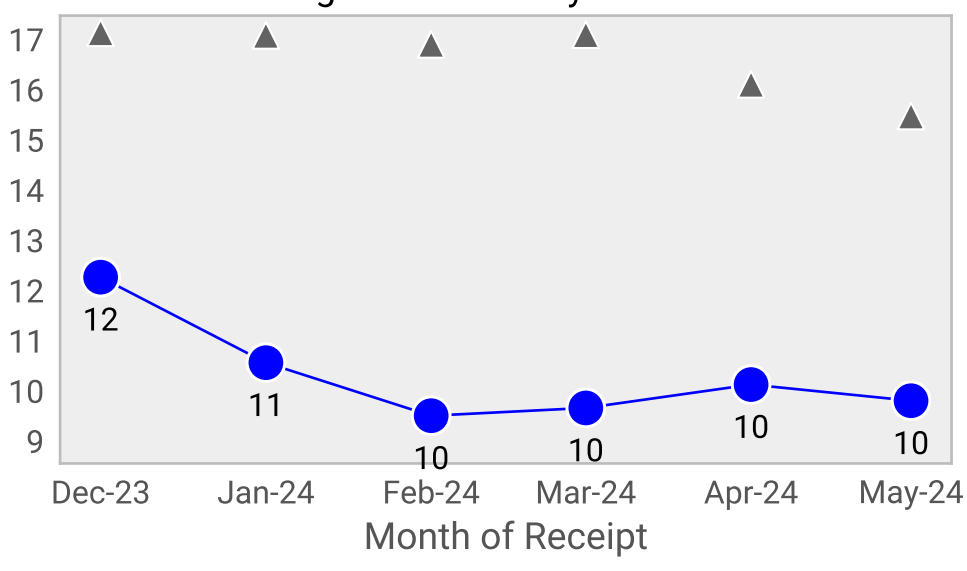
% Processed within 45 Business Days



% Processed within 90 Calendar Days



Average Calendar Days to Process



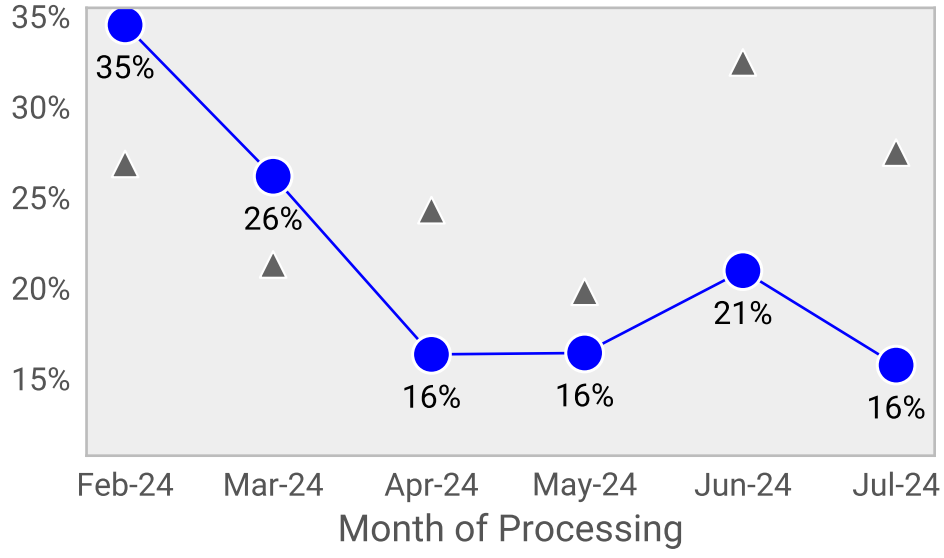
Triangles display the previous year's performance for the same month.

The most recent 6 months displayed is different for each plot, accounting for the time needed to maturely report each measure.

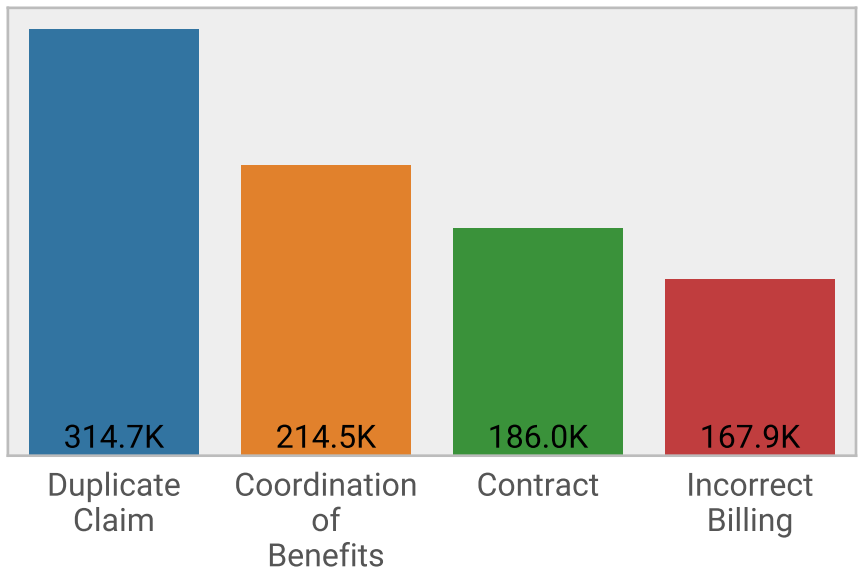
421

MCLA Claim Denials and Adjustments

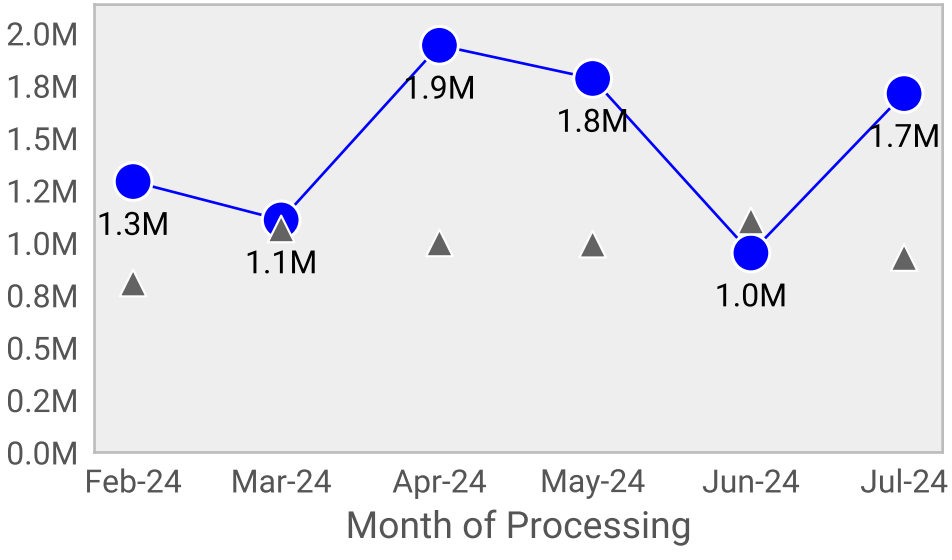
First-Pass Claims Denial Rate



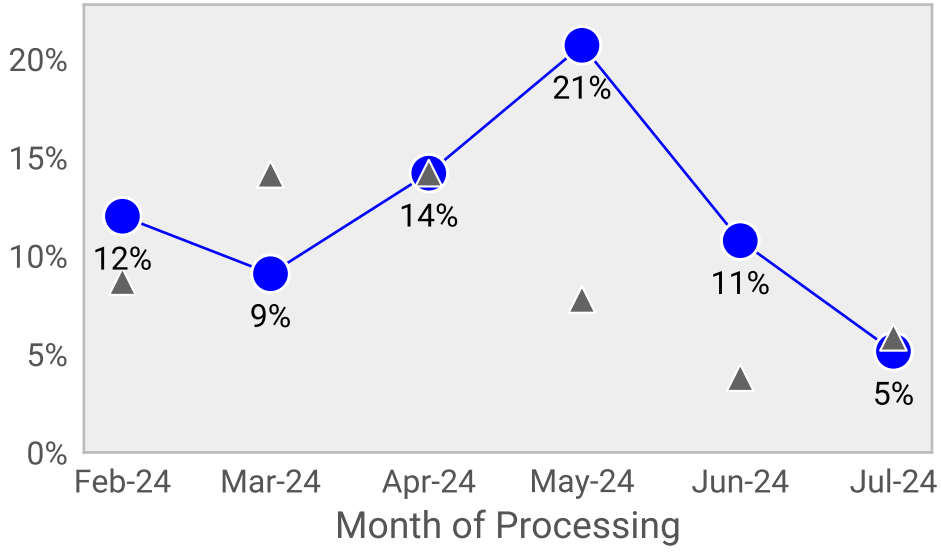
Most Recent 6 Months' Denial Volume by Reason



Total Claims Processed (Originals + Adjustments)



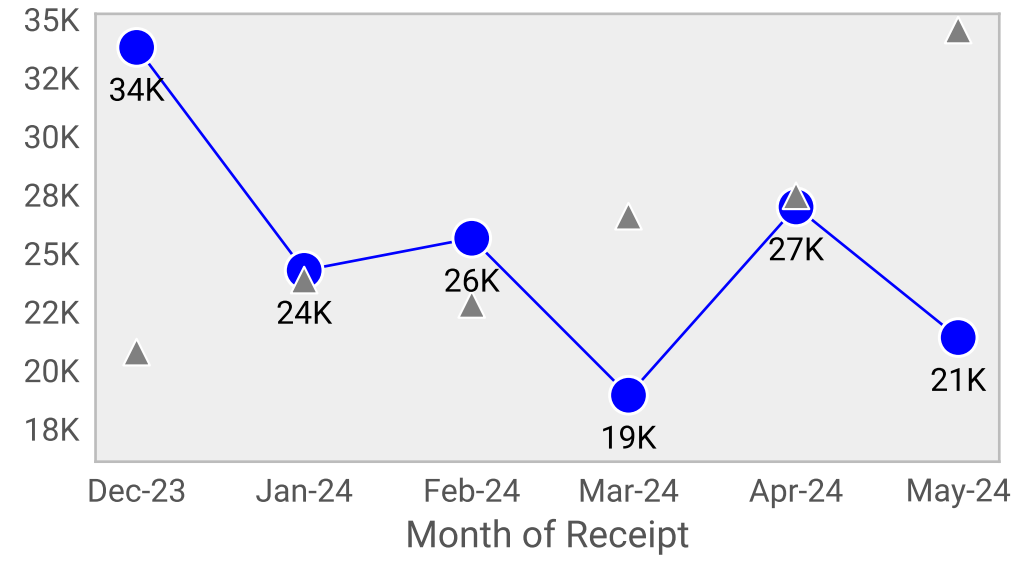
% of Total Claims Processed that are Adjustments



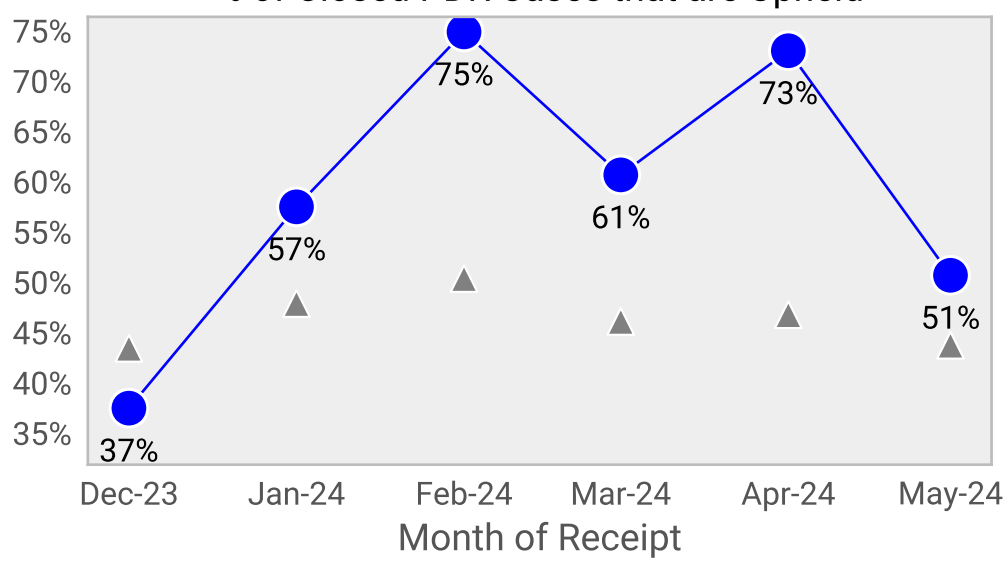
Triangles display the previous year's performance for the same month.

MCLA Provider Dispute Resolution Processing

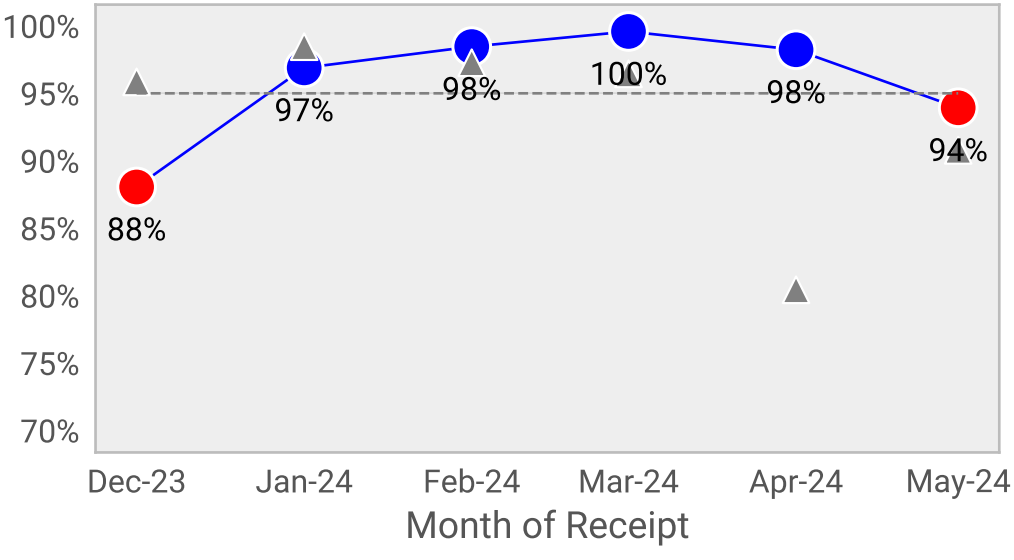
PDR Volumes Received



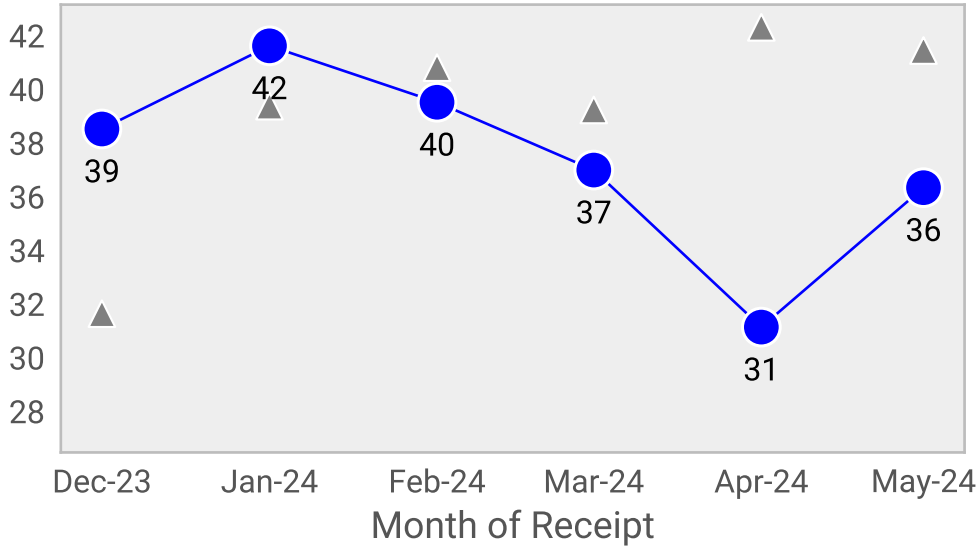
% of Closed PDR Cases that are Upheld



% of PDR Cases Closed within 45 Business Days



Average Business Days to Process PDRs



Triangles display the previous year's performance for the same month.

PUBLIC ADVISORY COMMITTEES

- Temporary Transitional Consumer Advisory Committee

- Children's Health Consultant Advisory Committee

- Technical Advisory Committee

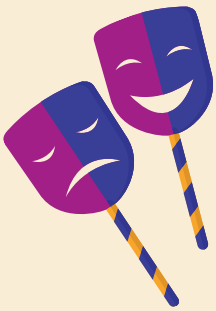
L.A. Care's Regional Community Advisory Committees (RCACs)

Celebration of Community Voices

Empowering Individuals and Communities for Effective Advocacy

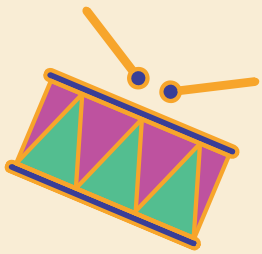
NEW MEMBER ORIENTATION

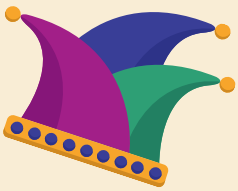
2 Day Event - Must Attend Both Sessions



Day 1 - Thursday, August 15, 2024
8:30 a.m. - 3:00 p.m.

Day 2 - Friday, August 23, 2024
8:30 a.m. - 3:00 p.m.





St. Anne's Conference Center
155 N. Occidental Blvd., Los Angeles, CA 90026

All eligible RCAC members will receive a stipend and transportation for both events

Please confirm your attendance by contacting the Commuity Outreach & Engagement Toll Free Line at 1-888-522-2732

L.A. Care HEALTH PLAN®

Board of Governors

Temporary Transitional Executive Community Advisory Committee (TTECAC)

Meeting Minutes – May 14, 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	Izmir Coello, Interpreter	Layla Gonzalez, Advocate, Board of Governors
Ana Rodriguez, TTECAC Chair and RCAC 2 Chair	Henry Cordero, Interpreter	Fatima Vazquez, Member, Board of Governors
Lidia Parra, RCAC 3 Chair	Sonia Hernandez, Interpreter	John Baackes, Chief Executive Officer, L.A. Care
Silvia Poz, RCAC 4 Chair	Isaac Ibarlucea, Interpreter	Sameer Amin, MD, Chief Medical Officer, L.A. Care
Maria Sanchez, RCAC 5 Chair	Eduardo Kogan, Interpreter	Francisco Oaxaca, Chief of Communication and Community Relations
Joyce Sales, RCAC 6 Chair	Katelynn Mory, Captioner	Tyonna Baker, Community Outreach Field Specialist, CO&E
Martiza Lebron, RCAC 7 Chair	Andrew Yates, Interpreter	Malou Balones, Board Specialist, Board Services ***
Ana Romo, RCAC 8 Chair **		Linda Carberry, Manager, Quality Performance Management ***
Tonya Byrd, RCAC 9 Chair		Kristina Chung, Community Outreach Field Specialist, CO&E
Damares O Hernández de Cordero, RCAC 10 Chair		Auleria Eakins, Manager, CO&E
Maria Angel Refugio, RCAC 11 Chair		Ramon Garcia, Community Outreach Field Specialist, CO&E
Lluvia Salazar, At-Large Member	Estela Lara, Public	Hilda Herrera, Community Outreach Field Specialist, CO&E
Deaka McClain, TTECAC Vice-Chair and At Large Member		Christopher Maghar, Community Outreach Field Specialist, CO&E
		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		Alfredo Mora, Staff Augmentation, Facilities Services
		Victor Rodriquez, Board Specialist, Board Services Martin Vicente, Community Outreach Field Specialist, CO&E

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. Chairperson Rodriguez 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/85168784894 Teleconference Call –In information/Site Call-in number: 1-415-655-0002 Participants Access Code: 2485 211 9339 (English) Call-in number: 1-415-655-0002 Participants Access Code: 2488 678 0242 (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 May 14, 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** (The following Public Comment was submitted via email) *Good morning ECAC and members of the public,* *Hello my name is Andria McFerson, I am a RCAC member who has been a part of this Committee for many years and throughout those years for the record we have never had a public ECAC meeting on a different day other the 2nd Wednesday of the month unless it was agreed upon by either the BOG or the ECAC in itself. You are all very important and today is a very important day that shows all the people we represent how important they are because we represent all people who are low income from all perspectives. Whether they are children, seniors, disabled, undocumented or just low income in the county of Los Angeles today we are all counting on you.* *Estela Lara said good morning to the committee. It has been ages since she has attended a TTECAC meeting. She thought they had forgotten about her. She wanted to say hello to the everyone. There are few people that are new and haven't met her. She is a member of RCAC 4 and used to be a member of RCAC 2. She is currently invested in this new restructure that they are about to have. She is happy to see and want Fatima look. She is looking forward to finding out what committees they will belong to. L.A. Care's 2.1 million members need their support. They are subject matter experts at what they due. She also mentioned this at the Board meeting. They are BOG influencers, She thanked the committee for holding this meeting and looks forward to it.* **The Agenda for today's meeting was approved.**	**Approved Unanimously. 12 AYES (Byrd, Cordero, Lebron, McClain, Parra, Rabaja, Refugio, Rodriguez, Romo, Sales, Salazar, and Sanchez)**

APPROVE MEETING MINUTES	Member Poz stated that the minute should reflect an excused absence. Member Salazar stated that her comments were not included in the meeting minutes. Mr. Meza asked her if she knew what comments are missing. Member Salazar stated that she spoke about the opening of Panorama City Community Resource Center. Mr. Rodriguez stated that he will follow up with her and include her comments in the meeting minutes. **The May 14, 2024 Meeting minutes were approved as submitted.**	**Approved Unanimously. 11 AYES (Byrd, Cordero, Lebron, McClain, Parra, Rabaja, Refugio, Rodriguez, Romo, Sales, and Sanchez)** **1 Abstention Salazar**
NEW BUSINESS		
MEMBER EXPERIENCE SURVEY RESULTS	Linda Carberry, *Manager, Quality Performance Management,* gave a presentation about L.A. Care's Member Experience Survey Results *(a copy of the full presentation can be obtained from CO&E).* Member Sales stated that she is here as the RCAC 6 chair. Her question, looking at page 9 where it says health care providers within the network. Her concern is not having enough providers within the network. Every time she needs to see a specialist, it is completely out of her area. She asked what is being done to get better access to providers at L.A. Care. Ms. Carberry stated that there may be staff in the room that is better equipped to answer that question. Mr. Baackes stated that historically, L.A. Care worked with medical groups known as practice associations to contract doctors. However, since 2016, they have offered direct enrollment for doctors, bypassing third parties. The Department of Managed Health Care capped this direct enrollment, but L.A. Care is petitioning to lift the cap because many doctors want to contract directly. He highlighted that medical groups are reluctant to add more providers due to financial concerns, but direct contracts would allow for better reimbursement for doctors. Additionally, he discussed the problem of "medical deserts" in Los Angeles County, areas where doctors do not set up practices due to insufficient Medi-Cal reimbursement. L.A. Care has implemented a grant program to attract doctors to these underserved areas by offering financial incentives, such as $125,000 grants and medical school debt retirement. Mr. Baackes emphasized the importance of having providers who are ethnically and racially compatible with their patients to build trust and improve health outcomes. To address this, L.A. Care provides scholarships to students of color who commit to working in underserved communities after their education. So far, they have awarded 48 scholarships, focusing on underrepresented groups, including women, African Americans, Latinos, and Asians. Despite meeting state requirements for an adequate number of doctors, the distribution remains problematic, with an oversupply in affluent	

	areas and shortages in underserved regions. Member Sales asked if L.A. Care is looking out of state and Historically Black Colleges and Universities (HBCU). Mr. Baackes stated that Charles Drew University is an HCBU. L.A. Care can recruit out of state, but the grants are awarded by doctors and the entities that receive the funds from L.A. Care. Member Byrd stated that she has never taken this survey and noted that possibly no one in the room has gotten this survey. Ms. Carberry stated that it is a very small sample, but do not know which members receive it. They are kept anonymous. She said it is likely that no one in the room will get it because L.A. Care has such a large membership. She said that it is very costly to send out these surveys. If a member saw a doctor, they may receive a survey. Member Salazar thanked Ms. Carberry for her presentation. She questioned why they would survey her about a doctor that she has only seen once. She would prefer to take a survey based on the doctor she sees regularly. Ms. Carberry responded that without knowing what surveyed they received she is unable to answer that question. She would need to see or know what type of questions she was asked. She will check to see if any of the look back periods could be the reason why she received that survey. Ms. Vazquez has three questions. She asked how many members receive the survey, when can the member expect to see the survey, and how is the survey distributed. Mr. Carberry stated that a member can receive a survey from the period of January to May or June of each year; the survey can be taken online, texted, phone call, and QR code. Most popular are online and QR code.	
STANDING ITEMS		
MEMBER ISSUES	Member Poz regarding Call The Car, she was supposed to be picked up around 9:00 A.M. She was told the driver would be there in seven minutes, she checked on her Uber driver and it had been sent somewhere else. The address was not correct, the driver's system would autocorrect the address and would not list it properly and would send the driver in another direction. She suggested that they should have a sign at hospitals letting people know that they may have transportation offered through their insurance. Member McClain suggested that she call Member Services to file a complaint. It has happened to her several times. Member Sales said she has a question about Call The Car. Is it a shared ride? Member McClain responded that sometimes Call The Car will send a vendor or sometimes a shared ride. It is decided when the appointment is made. Member Sales stated that she is going to have a procedure and wants to know if this is the ideal transportation for her in case she is not able to get there on her own. Member McCain stated that she should call Member Services first so she can fill out a form over the phone to schedule transportation. Member Poz stated that she can also call Call The Car directly.	

	Member Salazar stated that she had to fill out redetermination papers. She said that it can take 30 minutes over the phone. She was advised that she can submit her documents online on the application she downloaded on her phone. She noted that she had a great experience and recommended that everyone that needs to fill out their documents and submit them on the application. Member Lebron stated that part of the training for drivers should be about not having their music so loud in the car. Sometimes members need to make calls to the doctor's office while they are on the way to their appointment. Member Poz provided the number to Call the Car 626-298-8185 this number is also good to check on rides for RCAC and TTECAC meetings. Dr. Eakins stated that that number is for medical services. Member Poz stated that she was advised by Call the Car that the number is the same number. Member Byrd stated that DPSS changed their attitude, she still has to wait a few hours but once she gets help they are very willing to help her. Mr. Baackes pointed out that the contract with Call the Car is renewed every year. He noted that there aren't many vendors out there. There are service performance requirements with them. They have shared this in the past and he will ask them to do so again in the future.	
BOARD MEMBERS REPORT	Ms. Gonzalez and Ms. Vazquez gave the following Board Member report: The Board of Governors met on May 2. 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. Roger Rabaja (R1) 2. Ana Rodriguez (R2) 3. Estela Lara (R2) 4. Silvia Poz (R4) 5. Joyce Sales (R6) 6. Maritza Lebron (R7) 7. Ana Romo (R8) 8. Deaka McClain (R9)	

	9. Elizabeth Cooper (R2) 10. Maria Sanchez (R5) 11. Jo Ann Cannon (R6) 12. Damares O Hernandez de Cordero (R10) • Chairperson Ballesteros acknowledged that May is Asian Pacific Islander and Pacific Islander Heritage Month. He acknowledged those communities and hopes this month we all learn more about the Asian Pacific Islanders and Pacific Islanders members of Los Angeles County. He attended L.A. Care's Provider Recognition Awards last week. From his perspective, it was a wonderful event. He complimented Mr. Baackes and the L.A. Care staff for their work on the recognition for providers. It was held in this building and it was apparent that the community members and the organizations honored felt a lot of pride and were very happy to receive the recognition. • Mr. Baackes gave a Chief Executive Officer report. He gave an update on Medi-Cal Redeterminations and the Change Healthcare Cyber-attack. • Dr. Amin reported on the efforts made over the past year and a half to increase reimbursements for providers and facilities, a key focus in strengthening the safety net in Los Angeles County. Despite financial support, addressing provider and facility burden remains crucial, leading to a concerted effort by the health plan to reduce administrative workload, particularly in prior authorization. He discussed the philosophy and importance of prior authorizations in healthcare, highlighted challenges in the complex process leading to provider frustration, and outlined strategies for streamlining the process within the network. • Motion TTECA 100 and TTECA 101 were tabled for consideration at a future Board meeting. The Board determined that more detailed information is needed on both of the motions. Member McClain asked for the Board Members personal experience when taking motions to the board at the May 2 meeting. She was displeased, because it was tabled and the conversation that the Board had in regards to the motions. She will be attending the June Board meeting to make a comment and correct some comments that were made. Ms. Gonzalez stated that the Board was not opposed to passing the motion regarding push button at publicly accessible doors, but first wanted to make sure that it was feasible in terms of cost and tabled the motion until more research was done before making a decision. The motion to change the Board meeting time will be looked into in more detail. Member McClain stated that the Board did not receive all the information they needed to make a decision.	
NEW BUSINESS		

REFRESH PROPOSAL FOR MEETING STATE REQUIREMENT FOR COMMUNITY ADVISORY COMMITTEES	John Baackes, *Chief Executive Officer*, and Sameer Amin, *MD, Chief Medical Officer*, gave a presentation about the Proposal for Meeting State Requirements for Community Advisory Committee *(a copy of the written report can be obtained from CO&E).* Mr. Baackes began by addressing an update from the Biden administration, announcing that starting November 1st, 2024, DACA recipients will be eligible to enroll in Covered California and receive tax credits and premium assistance. While the estimated number of beneficiaries is around 100,000 nationwide, it is seen as a positive step. Those who apply could have coverage as early as December 1st, 2024. Mr. Baackes then spoke about the proposal to meet state requirements for community advisory boards. He noted that this has been a longstanding issue causing frustration and angst among those involved. A new state contract, effective January 1st, 2024, required compliance by May 1st, which L.A. Care missed. They must now make amends with the state. The key requirements include: • Selection Committee: L.A. Care must establish a selection committee to review and approve community advisory committee members. Unlike many other health plans starting from scratch, L.A. Care has a long history of multiple advisory committees reflecting the size of L.A. County, but has never had a selection committee before. • Diversity Representation: The composition of the community advisory committees must reflect the diversity of the plan's membership. For example, if 90% of the plan's members were Latino, 90% of the advisory committee should be Latino. Although this specific scenario does not reflect L.A. Care's actual makeup, it illustrates the requirement. The composition will be based on the specific sections of L.A. County from which members come. • Annual Reporting: L.A. Care must report annually on the composition of the advisory committees and the outcomes of their proceedings. Mr. Baackes emphasized the importance of adhering to these requirements to ensure that the advisory committees accurately reflect the racial and ethnic diversity of the plan's membership. He paused to ensure clarity on these points before continuing. *Member Sayles asked a question that was not captured on the recording due to her not speaking into the microphone.* Mr. Baackes responded that the RCAC membership has to reflect the diversity of the community. Dr. Amin responded that there needs to be a mix of members that reflect L.A. Care membership. Member Sayles said that using this last RCAC meeting that Dr. Amin attended as an example, the majority was Hispanic for RCAC 6. She asked if that is supposed to be the	

	composition. Mr. Baackes responded no, L.A. Care would first need to decide on the community advisory committees profile of the racial makeup and ethnic makeup and the gender makeup of each of the proposed 8 and then the committee itself should reflect that diversity, whatever it is. Dr. Amin clarified that the focus is on ensuring that the Regional Community Advisory Committees (RCACs) reflect the diversity of their respective regions. He emphasized that the composition of these committees should be a representation of the membership's makeup within each specific region. This explanation aimed to address the question about the importance of regional diversity in the committees' formation. Mr. Baackes explained that over the past year, they held numerous meetings in 2023 to gather feedback from existing Regional Community Advisory Committees (RCAC) and Executive Community Advisory Committees (ECAC). However, due to some confusion and lack of clarity, they decided to revisit these discussions. In the first four months of the year, the RCACs met in their original formats and locations to discuss the proposals again. Mr. Baackes and Dr. Amin attended most of these meetings to listen and gather input. Based on the feedback, they revised the proposal, which was now being presented as a refreshed version incorporating the community's suggestions. Dr. Sameer Amin emphasized that the new proposal reflects the feedback they received from the community during their visits to the RCACs. He clarified that the updated proposal includes changes based on the input from those meetings, and he hopes that members will recognize their own contributions in the revised proposal. Chairperson Rodriguez thanked them for listening to the members. Member McClain asked if these are changes proposed by staff or the state. Mr. Baackes stated that the changes requested by the state are on the first slides. The changes on screen reflect the changes that are requested by the membership. Dr. Amin stated that this is a much more simplified proposal. There needs to be a selection process. Staff recommended to get rid of the roundtables. He said he is going to amend the agendas of the Community Advisory Committees to incorporate more discussion that would have happened in the round tables. Mr. Baackes provided an overview of proposed changes to the membership and structure of regional advisory committees. He mentioned that the current membership includes 140 active members across 11 committees. The proposal suggests reducing the number of committees to 8 but increasing the total number of members to 200, with each committee having 25 members. This would mean an addition of 60 new members. The frequency of meetings will remain the same, with each committee meeting occurring six times a year. However, there will be changes to the stipends. Currently, members receive $70 per meeting, but this amount will be doubled. The annual stipend for the Chair, currently $600, will increase to $1,080. Additionally, for the Executive Community Advisory Committee	

	(ECAC) meetings, which currently occur 11 times annually, the proposal is to reduce this to 10 meetings to align with the Board of Governors' schedule. Members will receive $50 per meeting, totaling $550 annually, while the Chair will receive $100 per meeting, totaling $1,100 annually. Member Sayles asked what will be the next steps. Mr. Baackes responded that he will request the Chair to conduct a vote among the members to approve or disapprove the proposed changes. He encouraged members to discuss any ideas or amendments they might have before the vote, hoping the presentation was clear and well-understood. Dr. Amin spoke about the importance of incorporating members' feedback into the new proposal. He noted three key changes based on the input received: increasing the number of RCAC members to 25 per committee to enhance representation, maintaining the frequency of meetings at six per year, and addressing confusion around community round tables by integrating open discussion spaces within RCAC meetings. He noted that these adjustments aim to simplify and improve the process while ensuring familiarity for members. Mr. Baackes shared the areas of the Service Planning Areas on screen. Mr. Baackes confirmed that all 140 current members will be appointed to the new community advisory committees, despite needing to fill out an application as required by the new contract. Members will start with a fresh 4-year term limit and must go through the selection committee for any subsequent terms. Meetings will be held at resource centers, with standardized agendas that include community input and topics for discussion advertised in advance. Additionally, transportation and childcare will be provided at the resource centers to facilitate member participation. Mr. Baackes proposed that the ECAC decide whether to support the final proposal, with or without modifications, to be forwarded to the L.A. Care Board of Governors for adoption in their June meeting. He emphasized the importance of ensuring that information from RCAC discussions is effectively communicated up the chain to the ECAC and Board of Governors, facilitating action on issues raised by members. Dr. Amin reiterated the focus on enhancing support for RCACs, including improved communication and transportation provisions. He assured members that they will be transitioned to the new advisory committees without displacement, starting fresh terms as required by state regulations. <u>PUBLIC COMMENT</u> (The following Public Comment was submitted via email by Andria McFerson) ***Regarding the, Refresh Proposal for Meeting State Requirements for Community Advisory Committee. I would like to know shortly what are the only state requirements, what was the date they these requirements had to be submitted, how does this effect and how will it effect the ECAC and RCAC***	

	member. Will we be hand chosen RCAC members? Who will choose the committee members, will LA Care have their own requirements has for each committee member and how will this effect the ECAC members? Who are in the seats right now? How long will these Chairs be in the seats they sit in now and can we all vote against this proposal today? Can our ECAC representatives vote against this today? Mr. Baackes noted that all her concerns were covered in the presentation. *Ms. Lara stated that the map in the PowerPoint is too small and should have been bigger.* Mr. Baackes stated that those on the left are the current RCACs, the right side show the new SPAs. The number have nothing to do with the RCACs. Mr. Oaxaca stated that they are listed in the order of which the Community Resource Centers were opened. *Ms. Lara stated that she likes that the membership and stipends slide. It will allow more. She has been advocating for a $100 for years now. She said the stipend has not been increased for 20 years now.* Mr. Baackes stated that he is unsure about that. *Ms. Lara said she advocated for $200 double that amount. She said if L.A. Care has a budget for millions of dollars for the rest of the motions that it approves, 200 bucks is nothing for their feedback. She noted that the Board of Governor's meeting she said they are subject matter experts. She thanked him for listening to the members.* Member Poz asked if transportation will be for everyone or just people with special needs. Mr. Baackes responded that it will be provided to everyone. Member Poz asked how long the term limits will be. Mr. Baackes stated that they will have two four-year term limits. He noted that Board Members also have the same length in term limits. She asked is they will have to submit a new application. Mr. Baackes stated that they do not have to submit a new application. Mr. Oaxaca stated that members already have their applications on file. Member Poz asked when will members know what SPA they belong to and where they will meet. Mr. Baackes responded that once this is adopted by the Board they will figure out their new arrangements. Dr. Amin clarified that everyone that is currently a RCAC member will continue to be a RCAC member. Current RCAC members may be moved to a new region. Member Poz asked about the roundtables. Dr. Amin stated that there will no longer be any roundtables. He noted that all RCAC members will remain RCAC members and they will start new terms.	

	Member Lebron said she liked the concept of the roundtables, but noted that now that it will be combined with the RCACs she thinks it will be better. She said that the meetings should be longer. [inaudible and full discussion was not captured on transcript] Mr. Oaxaca stated that the agendas will be modified to create a space and time to have longer discussions on specific topics. He said he would like for them to reinforce their communication between the RCACs and ECAC. Member Salazar stated that this is a big change. The recommendations were flipped. She noted that now roundtables will not be added and they will not have to reapply. Mr. Baackes stated that they will be appointed to their new RCACs and their four-year terms start once the Board approves this proposal. Member Salazar asked about the stipends. Mr. Oaxaca stated that RCAC members will receive a stipend and TTECAC members receive an additional stipend for attending as a chair. Member Sayles clarified that currently they receive $70 to attend a RCAC and if approve, the amount will go up to $140. Member Salazar stated that At-Large members should not be treated as members, they should be treated as Chairs. Mr. Baackes stated that an At-Large will be stipend the same amount as a RCAC Chair when they attend ECAC. Member Sayles that the stipend and structure should reflect their commitments and time they spend and the things they do as RCAC Chairs are more involved. She noted that the importance of them coming together and making community change and L.A. Care change is not for the stipend. It would not be receiving as if they were working a regular job. They are volunteering their time and a stipend is an honorary thank you for volunteering their time a helping L.A. Care. Mr. Baackes noted that if you're a RCAC Chair they are making $1,080 a year and additional $1,000 if they attend every ECAC. Member Sayles stated that they should keep in mind that they receive transportation and don't have parking issues, and they get reimbursement for using their personal vehicles. Member Refugio stated that she does not think it was necessary to lower the number of RCACs. She noted the change will affect the members of her RCAC. She would like to know if the meeting locations can be rotated. The meetings held in RCAC 11, some members have children that are disabled and would like to know if their stipend can be increased. Mr. Baackes stated that first of all the location of the meeting will be decided by the committee. That won't be decided by staff. They can alternate where to hold these meetings. If the TTECAC chooses to approve these changes the Board can take it up at their June 6 meeting and if it is approved these changed will be implemented as soon as possible so that the RCACs get back to a regular meeting schedule.	

	Member Poz asked how the child reimbursements will work. She has a special needs child that can't be at meetings. She noted that she leaves her special needs child at a babysitter and they would be reimbursed. Mr. Baackes stated that staff will reinstate that. Member Sayles that children will receive child care at the Community Resource Centers. She noted that the stipends and reimbursements should not be the reason why they attend and participate as RCAC members. She said that they are volunteering to help L.A. Care improve the services that it provides its members. It should not be about the compensation. Member Parra noted that they are combining the membership of RCAC 3 and RCAC 11. She asked if they go over the 25-member limit will they all be allowed to be in the RCAC. Mr. Baackes stated they will all be able to join. Member Damares asked how the rest of the RCAC members will be advised of these changes. Mr. Baackes stated that assuming it is adopted today and then adopted by the Board on June 6, a comprehensive communication will go out to all RCAC members. Member Deaka McClain raised several concerns and questions regarding the proposed changes. She questioned how data specific to L.A. Care members would be collected effectively after consolidating from 11 to 8 committees, given that other insurance providers also serve the same regions. Member McClain expressed concern that combining RCACs into 8 larger committees might make it difficult for members to attend meetings due to potential travel challenges, despite the availability of different location. She spoke about the importance of stipends, noting that while members volunteer, the stipends help cover personal responsibilities and should be maintained or increased. Member McClain suggested that the Vice Chair should receive a stipend comparable to the Chair due to the responsibilities involved. She also asked about the future of member At-large positions and whether current office holders would need to reapply or if new elections would be held for these roles under the new guidelines. Mr. Baackes responded that each new advisory committee will elect its own Chair. Current Chairs can be re-elected or new Chairs can be chosen by the committee members. Current at-large members will remain in their roles, as there are no proposed changes to these positions. Mr. Baackes emphasized the importance of understanding the community's overall health status. He noted that L.A. Care members' insights on their specific health experiences compared to the broader community are valuable. Dr. Amin highlighted the importance of having a broader perspective within the SPA framework. By knowing what other community members are experiencing, individuals can compare their own access to care and overall health services. This comparison allows members to identify disparities and provide more informed feedback, highlighting areas where Medi-Cal members may not be receiving adequate care. This broader understanding is essential for bringing valuable input back to the organization to address these issues.	

	Member McClain asked how can the data be accurate if there are other health plans. Mr. Baackes responded that they are also part of the community. Member McClain responded that they should be focused on L.A. Care. Mr. Baackes highlighted the importance of understanding the broader community environment through SPA data, which includes all residents regardless of their health plan. This comprehensive data allows members to compare their own status and identify disparities within the context of the entire community. By evaluating their own situation against broader social determinants of health, members can gain valuable insights and contribute more effectively to addressing community health issues. This broader perspective aims to make members better informed and more capable of evaluating their role and status within their regional committee and the community as a whole. Chairperson Rodriguez asked if the committee would like to take a vote or would they like to continue to discuss. Member Lebron asked how the proposal will be approved, with changes or without changes. Member Salazar expressed concerns about the speed at which the new changes are being introduced. She pointed out that the members have just been presented with this information, which is overwhelming. Member Salazar emphasized the need for more time to absorb the details and suggested that it's too soon to make a decision. Mr. Baackes began by explaining the importance of his and Dr. Amin's attendance at as many meetings as possible, emphasizing his role as the Chief Executive Officer responsible for ensuring compliance with the organization's state contract. He expressed regret for the delay in presenting the changes, acknowledging that it was presented to the members at the last minute. He then outlined the changes made in response to feedback from the members. He addressed the issue of roundtables, noting that they were universally disliked and difficult to understand, leading to their removal from the proposal. He mentioned the dissatisfaction with reducing the number of meetings from six to four, which prompted the decision to revert back to six meetings. Another significant change was the increase in the number of committee members to facilitate greater participation. Baackes explained that this decision aimed to address concerns about representation and diversity within the committees. Dr. Amin emphasized the importance of bringing the discussion to a conclusion, acknowledging that the members have been engaged in this process for a long time. He highlighted the need to transition into something new and for the members to become comfortable with the changes. Dr. Amin noted that the presentation had been streamlined to focus on the essential changes necessary to move forward, in compliance with organizational requirements. He suggested that it was time to proceed and requested a vote to finalize the decision.	

	Member Salazar asked if they are on a timeline. Chairperson Rodriguez stated they went over the deadline. Mr. Baackes stated that they needed to be compliance on May 1. Chairperson Rodriguez asked the committee can make changes after they approve the proposal. Mr. Baackes that change can be made after the Board adopts the proposal. Dr, Amin noted that they are approving the outline. Mr. Baackes stated that he also has authority to make administrative changes such as keeping the childcare reimbursement. Member Romo moved to adopt the proposal as long as they are able to make changes in the future. Mr. Meza stated that they can approve today and make modifications in the future. Mr. Baackes noted that modifications can be made after the Board adopts it. **TTECAC moved to approved the proposal for meeting State requirements for Community Advisory Committees** Mr. Baackes expressed his gratitude and reflected on the challenging yet important process of evolving and growing L.A. Care, the largest Medi-Cal managed care plan in the state. He acknowledged the difficulty due to the many voices involved but appreciated the mutual listening that has taken place. He then announced his decision to leave L.A. Care at the end of the year after nearly 10 years. Although he will be there for another 7.5 months, he plans to continue making significant contributions. Baackes shared that working with L.A. Care has been the most satisfying experience of his career, especially because of the meaningful dialogue with the community. He thanked everyone for their cooperation and support.	**Approved Unanimously. 12 AYES (Byrd, Cordero, Lebron, McClain, Parra, Poz, Rabaja, Refugio, Rodriguez, Sales, Salazar, and Sanchez)**
FUTURE AGENDA ITEM SUGGESTIONS		
	Member Para would like a presentation on Call The Car. Member Lebron stated that she would like to know more about the Health Promoters program. Member Refugio reminded the committee of how to properly dispose of their medication. Member McClain would like an update on the procurement of evacuation chairs.	
PUBLIC COMMENTS		
	Chairperson Rodriguez stated that she would like a Member Advocate or Health Navigator present at TTECAC meetings. Member Refugio stated that RCAC members participate from the heart, but the stipends do help. Member Lebron stated that the food cards can also be an option as a stipend. Those were an option in the past.	
ADJOURNMENT		
ADJOURNMENT	The meeting was adjourned at 1:27 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 6/12/24

Board of Governors

Temporary Transitional Executive Community Advisory Committee (TTECAC)

Meeting Minutes – June 12, 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*	Izmir Coello, *Interpreter*	Layla Gonzalez, *Advocate, Board of Governors*
Ana Rodriguez, *TTECAC Chair and RCAC 2 Chair*	Henry Cordero, *Interpreter*	Fatima Vazquez, *Member, Board of Governors*
Lidia Parra, *RCAC 3 Chair* *	Sonia Hernandez, *Interpreter*	Sameer Amin, MD, *Chief Medical Officer, L.A. Care*
Silvia Poz, *RCAC 4 Chair*	Isaac Ibarlucea, *Interpreter*	Francisco Oaxaca, *Chief of Communication and Community Relations*
Maria Sanchez, *RCAC 5 Chair* *	Eduardo Kogan, *Interpreter*	Tyonna Baker, *Community Outreach Field Specialist, CO&E*
Joyce Sales, *RCAC 6 Chair*	Katelynn Mory, *Captioner*	Malou Balones, *Board Specialist, Board Services* ***
Martiza Lebron, *RCAC 7 Chair*	Andrew Yates, *Interpreter*	Idalia De La Torre, *Field Specialist Supervisor, CO&E*
Ana Romo, *RCAC 8 Chair*		Auleria Eakins, *Manager, CO&E*
Tonya Byrd, *RCAC 9 Chair*		Ramon Garcia, *Community Outreach Field Specialist, CO&E*
Damares O Hernández de Cordero, *RCAC 10 Chair*		Christopher Maghar, *Community Outreach Field Specialist, CO&E*
Maria Angel Refugio, *RCAC 11 Chair*	Estela Lara, *Public*	Frank Meza, *Community Outreach Field Specialist, CO&E*
Lluvia Salazar, *At-Large Member*	Russel Mahler, *Public*	Alfredo Mora, *Staff Augmentation, Facilities Services*
Deaka McClain, *TTECAC Vice-Chair and At Large Member*	Kimberly Martinez, *Public*	Victor Rodriquez, *Board Specialist, Board Services*
	Maria Mayoral, *Public* ***	Prity Thanki, *Local Government Advisor, Government Affairs* ***
	Andrea McFerson, *Public*	Martin Vicente, *Community Outreach Field Specialist, CO&E*
	Maria Rabaja, *Public*	
* *Excused Absent* ** *Absent* *** *Via teleconference*	Demetria Saffore, *Public*	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Ana Rodriguez, *TTECAC Chairperson*, explained the meeting rules guidelines and 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. Chairperson	

	Rodriguez 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. Chairperson Rodriguez called the meeting to order at 10:02 A.M.	
APPROVE MEETING AGENDA	Chairperson Rodriguez stated that there will be a change in the order of agenda items. Ms. De La Torre stated that Ms. Thanki will give her update after the approval of the meeting minutes. **PUBLIC COMMENT** *Andria McFerson started by thanking the Chair for the opportunity to speak, and expressed her honor in representing her community. She noted the importance of the advisory committee in providing information to L.A. Care, which makes significant decisions about their healthcare. Ms. McFerson then stated that the meeting agenda should include discussions from RCAC meetings, with Chairs representing their communities by bringing up member issues. She insisted that the agenda should cover both positive and negative topics affecting everyone they represent. She mentioned that the agenda needs to reflect these discussions and suggested transitioning from a temporary committee to a regular ECAC. Ms. McFerson stressed the responsibility of Chairs to speak up and follow motions to maintain regular meetings. She stated that comments should be made after the introduction and discussion of agenda items, that's how it was done before. This way, members can understand the items fully before commenting. She concluded by thanking the Chair again.* **The Agenda for today's meeting was approved.**	**Approved Unanimously. 11 AYES (Byrd, Cordero, Lebron, McClain, Poz, Rabaja, Refugio, Rodriguez, Romo, Salazar, and Sales)**
APPROVE MEETING MINUTES	Member Salazar stated that her comments on page seven are incorrect. She meant that she reapplied for Medi-Cal, it was a new application, no redetermination. She said that her wait time was over an hour. It took 30 minutes for the agent to help her apply for Medi-Cal. She also mentioned that her documents can be uploaded on the application. Member Lebron stated that one of her comments has "inaudible" in it. She asked that people speak up if they are unable to hear her. **The May 14, 2024 Meeting minutes were approved as submitted.**	**Approved Unanimously. 11 AYES**
STANDING ITEM		
GOVERNMENT AFFAIRS	Prity Thanki, *Local Government Advisor, Government Affairs Department*, gave a Government Affairs Department Update (*a copy of the written report can be obtained from CO&E*).	

DEPARTMENT UPDATE	**PUBLIC COMMENT** *Andria McFerson made a comment concerning the 2022 health trigger investments, specifically pointing out that they do not include share of cost reform. She noted the necessity of adjusting the income threshold for certain individuals, specifically those whose incomes are between 122% and 138% of the federal poverty level. She illustrated her point with the example of her neighbor's mother, a retired nurse. Despite having retirement benefits, this woman struggles to afford her monthly rent due to rising costs. Often, she has to resort to payday loans to cover her rent. Ms. McFerson argued that increasing the income threshold would help individuals like her neighbor's mother afford their prescriptions. Ms. McFerson noted that her neighbor's mother has some coverage from her previous job but still needs a subsidy to manage her expenses.* Ms. Thanki responded that she does not have the answer to that question since it is related to Medi-Cal and whether or not this individual receives benefits and how they receive benefits. She recommend that Ms. McFerson contact DPSS. She noted that this was included in the May Revise and it is not final. Member Poz thanked the chair and vice chair, and expressed gratitude to Ms. Prity for her report. She acknowledged that the budget details are not final and mentioned that revisions are expected by June 15. Member Poz then asked if there were any ways to advocate against certain triggers being implemented. She inquired if there was any advice on how to contact legislators or if there were specific letters that could be sent to prevent these measures from taking effect. Ms. Prity Thanki responded by affirming that advocacy is possible and encouraged Ms. Poz to contact her legislator. She mentioned that many advocacy groups are already addressing the issue. Prity noted that with the June 15 deadline approaching, time was limited, but still advised contacting legislators. She explained that ongoing negotiations between the Governor and the legislators have been happening since May. Member Poz asked of the names of the backup programs. Ms. Thanki stated that she did not have the names on hand and can obtain them for her. Ms. Gonzalez stated that she has the name available. The name of the program is the backup provider system, which is from the state. The program in danger of being eliminated is the backup attendant program, which is from the county. The difference is money, where it comes from and who qualifies. Member Sales said good morning to everyone. She asked Ms. Thanki if these pending revisions and June 15 will be the date that decisions will be made or is it further out? Ms. Thanki responded that what happens next is that the legislature has until June 15. So what they'll do is around May 15, she thinks it was May 12, when the governor released this	

	proposal and then the legislature has been working back and forth negotiating with them. So they are going to give him their revised proposal and that is what they'll send over to him. And then the governor has until June 30 to sign that proposal. Member Sales stated that on June 30 will be a final. Ms. Thanki confirmed. Member Sales noted that based on these, what is it, 122 and 138 income percentages. Ms. Thanki responded that she does not know. She does not have the number in front of her. She will obtain that information and forward to CO&E for distribution.	
OLD BUSINESS		
REVIEW THE REDLINED VERSION OF THE OPERATING RULES FOR THE CONSUMER ADVISORY COMMITTEES OF L.A. CARE HEALTH PLAN	Francisco Oaxaca, *MBA, Chief, Communication and Community Relations*, presented the redlined version of the Operating Rules for the Consumer Advisory Committees of L.A. Care Health Plan (*a copy of the revised operating rules can be obtained from CO&E).* **PUBLIC COMMENT** *Andria McFerson thanked the chair for allowing her to speak. She explained that she attended a Board meeting where a proposal by John Baackes, Chief Executive Officer, was unanimously approved. The Board believed that the TTECAC had also approved this proposal. Ms. McFerson pointed out that there was a mix-up. The March RCACs heard one proposal, while the April RCACs heard a different one. This meant that the TTECAC members did not vote on the same proposal, making the vote seem invalid. Because of this, when the Board representatives voted in favor, it didn't truly count. Ms. McFerson noted the importance of discussing the structure of their meetings. She mentioned that an ECAC meeting was coming up, where they would discuss the RCACs' structure. She urged everyone to contact ECAC members to ensure their voices are heard, noting that there are currently no L.A. Care members on the ECAC.* *Estela Lara greeted the Committee and shared that she misses the meetings and being part of the RCAC as Chair, although she is now a regular committee member. She emphasized the importance of the operating rules and questioned whether they include an annual review. She suggested that revising the rules annually is important, even if sometimes it might seem unnecessary or redundant. She mentioned that she noticed highlights mentioned by Mr. Oaxaca but felt they were reviewed quickly. She stated that she needs to go back and examine the details to understand what changes or additions have been made. She admitted that, at the moment, she doesn't fully understand what is being agreed upon because she is not on the committee and hasn't seen all the changes. She stressed that reviewing the document every year is crucial to ensure clarity and awareness of any updates.*	

Member Mahler noted that Mr. Oaxaca mentioned term limits for the RCACs, but that never affect them because term limits only affects the Board. That should not be admitted into this agenda. They are a RCAC member and they do not have term limits.

Member Poz said she was confused because the last time they approved something, it was only about four important points. Now, there are many more things being shown, which might be causing the confusion. She also asked about the 25 members. She wanted to know what would happen to the members moving in from other RCACs and how new members would be brought in if there are already a few from the RCAC. Mr. Oaxaca explained that there are currently about 140 active members who will be moved to their new RCACs automatically. There is also a waiting list of around 90 people interested in joining RCACs. The selection committee will review their applications to fill about 60 open spots across all RCACs. Some RCACs have anywhere from 8 to over 30 members. The RCACs with over 30 members will stay as they are, and new members will be added to the RCACs that haven't yet reached 25 members. The goal is to have a total of 200 members.

Member Salazar asked if it matters when a member receives an excused or unexcused absence. She asked if they both count the same. Mr. Oaxaca confirmed that they both count as an absence. Member Salazar stated that she does not agree and did not see this on any of the changes they spoke about last time. She said if a member has a medical emergency and absence can't be avoided. There is much in the operating rules that they did not agree on. Mr. Oaxaca responded that the absence policy has never been implemented before. Most members that leave the RCACs resign or leave the county. Member Salazar stated that two absences will not work for RCAC members. Mr. Oaxaca clarified that it's up to three absences. He noted that the RCACs only meet six times a year and three absences is half of the year.

Member McClain commented on the confusion expressed by Member Silvia Poz and Member Lluvia Salazar. She suggested adding a discussion about revising procedures more frequently to future agenda items. Member McClain emphasized the importance of reviewing these procedures annually to ensure they are up-to-date. She then raised a question about term limits in elections, noting that the current rules allow for 8 years of service. Member McClain wondered if someone could return after their term limit ends or if they would need to take a break first. Mr. Oaxaca responded that the term limits are similar to the Board's. Member McClain asked if these Operating Rules were presented last month. Mr. Oaxaca responded that they were presented with the changes from the DHCS contract. Some of those changes were covered by the operating rules and others were not. Today he

	is presenting the changes that were not covered in the Operating Rules. He stated that the Board will vote on these.	
2024-2025 BOARD OF GOVERNORS ELECTIONS	Auleria Eakins, *Ed.D, MPA, Manager, Community Outreach & Engagement Department*, presented the following motion *(a copy of the materials can be obtained from Board Services):* To approve the proposed timeline, application, and rules for the election of nominees to the two consumer Board Seats. **PUBLIC COMMENT** *Andria McFerson, from RCAC 5, thanked the chair and co-chair and raised several concerns. She questioned the wording of a motion that allows ECAC chairs to remain until the BOG election, noting it doesn't specify their roles. She also asked when RCACs would start and why the timeline is so long. Andria suggested that if RCACs begin, there shouldn't be a need for a year-long timeline to replace BOG seats. She also raised objections about a provision requiring TTECAC membership to run for Layla's position on the BOG. Ms. McFerson wanted clarification on whether current incumbents like Layla and Fatima meet the qualifications and represent organizations. She noted the importance of not restricting the Member Advocate position to TTECAC members and urged the chairs to consider amendments before approving the motion.* Ms. Gonzalez responded to Ms. McFerson's concerns by clarifying the requirements outlined in the motion. She pointed out that the position of ECAC consumer advocate requires candidates to be nominated by a consumer member of L.A. Care. Additionally, the consumer advocate must either be a member of L.A. Care Health Plan or be employed by a community-based organization that represents the population served by L.A. Care. Ms. Gonzalez emphasized that the motion does not specify that the person must be a member of L.A. Care or the RCAC, focusing instead on their role in advocating for the community served by L.A. Care. Ms. Poz asked if the current member representatives will stay in their seat until 2025, with the exception of Ms. Gonzalez until they find a replacement. Dr. Eakins responded that they are being asked to consider keeping them on until the next election. Ms. Poz asked if there is no way they can find someone in the RCACs to take their place. Dr. Eakins stated that L.A. Care have a large partner based organizations and have been working very hard to find a replacement. Ms. Idalia De La Torre discussed the timeline for extending Ms. Vazquez and Ms. Gonzalez's roles until next year. She clarified that while the current motion suggests June 2024, they would need to formally decide on the extension by July or September at the latest. This decision would be made by the ECAC, considering that	

	RCACs reconvene in August, providing more clarity on positions and eligibility for elections. Ms. Poz stated that they should conduct a vote again and start fresh. Ms. De La Torre explained that once the RCACs reconvene, they will decide on the Chairs and vice Chairs, who will then represent the committee at the ECAC. She noted that the transition from TTECAC back to ECAC will occur at this point. Ms. De La Torre emphasized the importance of continuity in committee rules during this transition period. She supported the proposal for Layla and Fatima to potentially extend their roles for another year while finalizing logistical details for the committee and RCACs. Member Salazar asked if they are voting to start over again or either they'll do another term. Ms. De La Torre clarified that the committee will vote on the timeline. Member Salazar asked what the timeline is for. Dr. Eakins clarified that the timeline presented serves as a structured plan moving forward, detailing steps and decisions to be made. It outlines approvals and allows for adjustments as needed during the process. The timeline helps manage time effectively, ensuring tasks are completed according to schedule each month. This response addresses the structure and purpose of the timeline in managing proceedings and decision-making within the committee. **<u>MOTION</u>** **To approve the proposed timeline, application, and rules for the election of nominees to the two consumer Board Seats.**	**Approved.** **6 AYES (Cordero, Lebron, Rabaja, Refugio, Rodriguez, and Salazar)** **2 Nay (Poz and Romo)** **3 Abstentions (Sales, Byrd, and McClain)**
STANDING ITEMS		
BOARD MEMBERS REPORT	Ms. Gonzalez and Ms. Vazquez gave the following Board Member report: The Board of Governors met on June 6. 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. Roger Rabaja (R1) 2. Ana Rodriguez (R2) 3. Silvia Poz (R4) 4. Joyce Sales (R6) 5. Maritza Lebron (R7)	

	6. Ana Romo (R8) 7. Deaka McClain (R9) 8. Andria McFerson (R5) • Approval of motion TTECA 100 and motion TTECA 101 will be considered at the July 25 Board meeting. • Mr. Baackes gave a Chief Executive Officer report. As part of his report Mr. Baackes gave an update about and shared a picture of graduated Elevating the Safety Net Scholars and Phinney Ahn gave an update on L.A. Care's Medi-Cal Membership. • Dr. Amin gave a Chief Medical Officer report, he will give an update later today. • Mr. Baackes presented motion Board 104, to Delegate authority to the Executive Committee of the Board of Governors to approve the revisions to the Operating Rules of the Consumer Advisory Committees (CAC) and Executive Community Advisory Committee (ECAC) **PUBLIC COMMENT** *Andria McFerson spoke about the importance of community members attending the ECAC meeting to provide their own feedback on decisions affecting low-income individuals, seniors, and the disabled. She highlighted that current BOG seats are not part of the ECAC or executive committee, stressing that no L.A. Care members will be involved in decisions regarding the new structure of RCACs and ECAC. Andria encouraged everyone to participate in the upcoming ECAC meeting to ensure community voices are heard.* Member McClain asked for clarification on whether the structure changes they voted on were going to the Executive Committee of the Board instead of the full Board. She felt this was not previously communicated and asked if they could attend the executive committee meeting to voice their concerns. Member McClain also explained her previous comments about accessibility issues, emphasizing that the building's doors, though ADA-compliant, lack push buttons that would benefit everyone, including those without disabilities. She intends to raise these points again at the executive committee meeting. Ms. De La Torre responded that the executive committee meeting is a public meeting, and attendees are welcome to make comments during the public comment session. She explained that sometimes decisions are pushed to the executive committee if there are no scheduled meetings in the upcoming months to ensure timely decisions.	
MEMBER ISSUES	**PUBLIC COMMENT** *Demetra Saffore from RCAC 4 reported that her provider can't see her due to a shortage of providers at her clinic, and she hasn't seen her provider in over a*	

	year. She thinks the provider network for L.A. Care is too small and wants to know what L.A. Care is doing to expand it to avoid these issues. Ms. Gonzalez explained that L.A. Care is trying to address the provider shortage by hiring directly, offering scholarships to medical students to encourage them to stay in Los Angeles, and working to maintain the MCO tax for additional funding. She mentioned efforts to improve doctor retention and recruitment, noting that these changes take time. Despite the slow progress, she reassured that members' concerns are being heard and efforts are ongoing. *Ms. McFerson from RCAC 5 spoke about issues faced by L.A. Care low-income members. She mentioned that they often get dropped by their doctors, lack preventive care, and face under diagnosis or misdiagnosis. Many cannot afford post-care treatments or prescriptions, which is problematic. She suggested that L.A. Care doctors should undergo empathy training and meet certain qualifications. Additionally, she highlighted the importance of L.A. Care working with community-based organizations for outreach and mental health support, sharing a specific case of a person in mental distress needing integrated care and resources to avoid homelessness.* Member McClain responded that she and Ms. Vazquez sit on the Equity Steering Committee and will bring this issue up. Member McClain shared a concern from a senior with a disability who had trouble getting on the doctor's exam table from her wheelchair. The doctor's staff wouldn't help due to liability issues, and when the senior switched doctors, she found they didn't have the necessary lift equipment, or the staff wasn't trained to use it. This caused her to miss appointments and endure repeated bus trips. Member McClain suggested putting this issue, along with the need for proper exam tables and training, on the agenda for the next meeting and informed the senior about L.A. Care's transportation services.	
UPDATE FROM CHIEF EXECUTIVE OFFICER	Sameer Amin, *MD, Chief Medical Officer*, gave a Chief Executive Officer Update on behalf of John Baackes, *Chief Executive Officer (a copy of the report can be obtained from CO&E).* **PUBLIC COMMENT** *Andria McFerson expressed appreciation for L.A. Care's progress in addressing homelessness, noting that she had previously been told homelessness was unrelated to healthcare. She recommended including psychological evaluations in programs for the homeless, based on her own experience. She emphasized that staff should be empathetic and understand the specific needs of individuals, such as domestic violence victims or those with developmental delays.*	

	Dr. Amin responded that he agrees with her and the Crocker Street campus will embed those resources in there and so will the street medicine providers who are going out into the street. It's actually the reason why he came on L.A. Care about a year and a half ago, we formulated a new department specifically to deal and coordinate the services to deal with and coordinate the services that she is referring to. Initiatives and community support programs and they are so intricately tied together that they are part of the same department and the clinical leader of that department is actually a psychiatrist. *Estela Lara expressed pride and excitement about L.A. Care's new collaboration, hoping it will become a national model. She expressed her willingness to support the initiative and highlighted its overdue necessity. She shared a personal anecdote about her niece getting food for a homeless person, demonstrating the importance of the program's mission.* Dr. Sameer Amin noted the need for a cultural shift towards creating significant, tangible change in the community through large-scale, transformative processes. He spoke about ongoing initiatives like the field medicine program and efforts in Skid Row, aiming to impact L.A. Care members tangibly. Dr. Amin expressed his commitment to helping all 50,000 L.A. Care members find permanent housing, ensuring the broader community sees the positive outcomes. He also mentioned collaboration with Health Net to support an additional 20,000 individuals, fostering a cohesive healthcare ecosystem. Member Salazar expressed concern about the focus on referrals for homelessness support. She emphasized the need for preventive measures for those at risk of becoming homeless, such as individuals unable to pay rent or feed their children. She questioned how to utilize the support before reaching the point of homelessness, rather than seeking help after becoming homeless. Dr. Amin acknowledged Member Salazar's concerns and noted that while the current $1.2 billion investment is targeted towards those who are unhoused, there are also preventive care initiatives and intensive case management programs in place. He clarified that the funds discussed in the meeting are specifically allocated and restricted for addressing homelessness, but assured that there are other resources and programs within L.A. Care aimed at providing support and services to prevent homelessness as well. Member Salazar noted the need for preventive measures rather than reactive ones. She expressed concern about imminent homelessness due to financial instability and the challenges of affording basic necessities like rent and food for her family. Member Salazar stressed the importance of accessing support before reaching a crisis point, seeking guidance on how to utilize services proactively to prevent homelessness. Dr. Amin acknowledged Member Salazar's concerns and spoke about ongoing efforts to address homelessness. He appreciated her passion and reiterated that while their current funding and programs are focused on those currently unhoused, there are also community support programs and	

	preventive care initiatives in place. He clarified that the $1.2 billion investment discussed is specifically targeted for homelessness-related services, and while it may not directly cover all preventive aspects mentioned, there are existing intensive case management programs and other services available. He expressed openness to further discussions and presentations on their various case management programs. Chairperson Rodriguez thanked Dr. Amin for this report and noted that she was once homeless. She said when homeless people hear about this project it gives them encouragement, but it also reminds her about the obstacles she has overcome. Dr. Amin addressed two main points in his comments. He acknowledged the enormity of the homelessness problem and stressed that despite efforts from experienced partners, the issue persists not due to lack of effort but due to its complexity. He emphasized the importance of starting somewhere, even if progress is incremental, and building upon it over time. He highlighted the need for continuous improvement and adjustment in their programs and investments to effectively tackle the issue. Regarding the process of getting individuals into their system, Dr. Amin discussed ongoing efforts to train providers, community-based organizations, and local services on how to refer people effectively. He mentioned collaborations with county and city services to facilitate easy access to community health services. He noted that their outreach efforts have been deliberate, engaging with various communities such as Montebello and El Monte, as well as areas like Skid Row, to connect with individuals who need assistance. Member Refugio expressed appreciation for L.A. Care's efforts in assisting homeless people and suggested creating a program to prevent individuals and families from becoming homeless due to current living difficulties, where parents are struggling despite working. Member Refugio requested an update on the number of individuals benefiting from L.A. Care's homeless assistance program. She asked for clarity on the duration of assistance provided to these individuals. She also suggested collaboration with mayors and councils to address homelessness more broadly and questioned L.A. Care's goals regarding the complete elimination of homelessness and related issues. Dr. Amin noted L.A. Care's commitment to preventing homelessness. He mentioned existing programs aimed at assisting individuals on the verge of homelessness, such as enhanced care management programs. Dr. Amin expressed willingness to discuss these initiatives further during future engagements.	
FUTURE AGENDA ITEM SUGGESTIONS		
	Ms. Gonzalez asked for a presentation about the Call The Car application.	

	Member Salazar asked it the presentation from Call The Car can be moved up, because she uses the service and sometime is not able to get a hold of the driver. She normally has to wait until the call center calls her. Member Lebron noted the need to sleep slow so that the interpreters can properly interpret. suggested making the meeting time longer so they can take advantage of speaking to L.A. Care leadership. **PUBLIC COMMENT** *Andria McFerson from RCAC 5 proposed future agenda items. She emphasized the need for Dr. Amin to regularly update the committee on L.A. Care's homeless services progress. She suggested implementing surveys for homeless individuals receiving services to ensure accountability and ethics, including feedback on services provided by subcontractors like doctors or shelters. McFerson also advocated for empathy training based on peer-to-peer insights from those experiencing homelessness to better support their needs.*	
	PUBLIC COMMENTS	
	There were no public comments.	
	ADJOURNMENT	
ADJOURNMENT	The meeting was adjourned at 1:21 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 7/10/2024

BOARD OF GOVERNORS

Children's Health Consultant Advisory Committee

Meeting Summary – March 26, 2024

1055 W. Seventh Street, Los Angeles, CA 90017

Members

Tara Ficek, *MPH, Chair*
Felix Aguilar-Henriquez
Sameer Amin, *MD*
Edward Bloch, *MD**
Maria Chandler, *MD, MBA*
Rebecca Dudovitz, *MD, MS*
Rosina Franco, *MD**
Toni Frederick, *PhD*
Gwendolyn Ross Jordan
Lynda Knox, *PhD*
Nayat Mutafyan*
Hilda Perez
Maryjane Puffer, *BSN, MPH*
Diana Ramos, *MD**
Ilan Shapiro, *MD, FAAP**

Management

Alex Li, *MD, Chief Health Equity Officer*
Elaine Sadocchi-Smith, *Director, Population Health Management, Population Health*
Laura Gunn, *Quality Improvement Project Manager II, Quality Improvement*
Tamara Ataiwi, *RN, Quality Management Nurse Specialist RN II, Quality Improvement*

**Absent **Present, but not quorum*

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Tara Ficek, *MPH, Chairperson*, called the meeting to order at 8:35 A.M.	
APPROVAL OF MEETING AGENDA	The Agenda for today's meeting was approved as submitted.	**Approved Unanimously. 10 AYES (Aguilar-Hernandez, Amin, Chandler, Dudovitz, Ficek, Frederick, Jordan, Knox, Perez, Puffer)**

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
PUBLIC COMMENT	*No public comment was submitted.*	
APPROVAL OF THE MEETING MINUTES	The December 5, 2023 meeting minutes and January 16, 2024 meeting summary were approved as submitted.	**Approved Unanimously.**
CHAIRPERSON'S REPORT	Chairperson Ficek presented information about the 2024 L.A. CARE CHCAC Member Survey *(a copy of the presentation can be obtained from Board Services).*	

	Content	Structure (Group and Meetings)	Process
Working Well	Really interesting; well delivered; very informative; L.A. Care staff are impressive	Membership seems solid	Well organized
		Virtual/hybrid	Good communication with/from L.A. Care (scheduling, attendance)
Areas of Improvement		Hybrid meetings impacting (attendance & engagement), revisit meeting time and room set-up	
	Most pressing issues impacting pediatrics not being discussed (e.g. pediatric specialist shortages); recommend members submit info/items for future agendas	More engagement vs. report out; share questions in advance and facilitate to promote more discussion	
	L.A. Care partners presenting work together with L.A. Care	Expand group membership to include additional Regional Center representation	

Chairperson Ficek summarized feedback from four members regarding the effectiveness and areas for improvement of their meetings. The feedback was categorized into content, structure, and process. Members

APPROVED

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	appreciated the informative and well-delivered content of the meetings, with L.A. Care staff being particularly impressive. It was noted that some pressing issues, such as pediatric specialist shortages, were not being addressed. A recommendation was made to allow members to submit topics for future agendas and to include L.A.Care partners in presentations to offer diverse perspectives. Membership was considered solid, and the hybrid meeting format was praised for increasing access. Suggestions were made to revisit meeting times, room setups, and potentially moving to a more intimate conference room to enhance participation. The process was generally seen as well-organized, with good communication from La Care regarding scheduling and attendance. She noted that there was a desire for more interactive discussions rather than one-way presentations. There was a recommendation to expand group membership to include more regional center representatives to better reflect the diverse regions of Los Angeles County. Member Chandler and Member Knox thanked staff for their quick responses and turnaround time in getting messages out to the committee. Member Puffer asked for feedback from more Committee Members, she noted that the committee is not fully represented in the survey. Member Knox stated that the committee has a great Chair that is very well organized. Chairperson Ficek asked if it was necessary to apply the Brown Act at CHCAC meetings considering they are not part of the governing body. Linda Merkens, *Senior Manager, Board Services*, responded that it is in the L.A. Care bylaws that the committee must abide by the Brown Act.	
L.A. CARE MEMBERSHIP UPDATE	Matthew Pirritano, *Director, Population Health Informatics, Population Health,* gave an L.A. Care Membership Update *(a copy of the full presentation can be obtained from Board Services).* Mr. Pirritano provided an update on descriptive statistics for children and women of childbearing age, following a request made in the January meeting. He reviewed basic data, while noting that more detailed information is available upon request. The analysis included only medical members, with children defined as ages 0 to 17, and women of childbearing age as 18 to 44. For children, 30.46% of the population fell within the 0 to 17 age group, with the categories of infant/young child, children, and adolescents/teens. The data showed an even gender split at 51% male. Racially, a large portion was identified as White or Caucasian, including Hispanic. The largest proportion of children was found in Compton, Inglewood, and nearby areas, followed by Van Nuys, Antelope Valley, and Pomona. The top healthcare providers for this group were Healthcare, Preferred, Kaiser, Community Family Care, and AltaMed. For women of childbearing age, the analysis highlighted the 18 to 44 age brackets, with 41.83% of the female population falling into this category. The distribution across regions and racial demographics was similar to that of the children. Mr. Pirritano concluded by mentioning that he would revise the age range for women of childbearing age to 15 to 44 and provide an updated report, including a key for the codes used in the analysis. He invited further questions and offered to provide additional details as needed.	

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AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Chairperson Ficek raised questions and comments regarding the impact of Kaiser's new contractual relationship with the state on the membership of L.A. Care. She inquired if the expected shift would result in 100,000 members no longer being part of L.A. Care and where these members would be moved—specifically, if they would transition directly to Kaiser. She also asked how the current numbers compare to previous years, considering the ongoing population shifts due to Kaiser's new contract and the redetermination process. Ficek acknowledged that the situation is still in flux for 2024, with outcomes dependent on the redetermination process and the Kaiser movement. Mr. Pirritano responded that the proportions of L.A. Care's membership have remained consistent from year to year, despite potential differences in the actual counts. He noted that the profiles created annually show similar trends in terms of race, membership distribution across regions, and other demographics. Chairperson Ficek followed up by asking whether the overall percentage of L.A. Care's insured population is changing, particularly if there is a trend toward insuring more older adults or the adult population compared to the maternal and child population. She inquired if this shift is noticeable. Mr. Pirritano stated that the shift is pretty consistent. Dr. Li expressed his appreciation for the demographic data presented and suggested that the committee might benefit from a deeper breakdown of the information. He proposed further analysis by specific conditions, such as teenage pregnancy or CCS (California Children's Services), to help identify relevant topics or issues for future discussions. Dr. Li believes that a more detailed exploration of health outcomes and population specifics could provide valuable insights for the committee's work. Member Puffer emphasized the importance of drilling down into specific health conditions, such as asthma, in the data presentations. She noted that this detailed information is critical for service distribution and program development. Ms. Sadocchi-Smith stated that those breakouts are done annually into accreditation through the population health management assessment. Mr. Pirritano stated that they could extract and share detailed information and go over it briefly. He suggested focusing on children with special healthcare needs rather than just CCS, given the small population size, and also mentioned including data on teenage pregnancy and behavioral health, broken down by Service Planning Areas (SPA).	
CHIEF MEDICAL OFFICER REPORT	Sameer Amin, *MD*, *Chief Medical Officer*, gave a Chief Medical Officer update. Dr. Amin discussed the organizational structure at L.A. Care, noting that when he joined, the Health Services division had a complex, matrixed structure that hindered communication between operations and medical teams. To address this, he implemented a "dyad partnership" model where each department is co-led by clinical and operational leaders, ensuring unified strategy and clear accountability. He then outlined the four major departments under Health Services: Pharmacy, Quality Improvement, Case Management and Utilization Management, and Community Health. Each department has specific leaders and functions aimed at improving healthcare quality, managing complex cases, and addressing community health needs. Dr. Amin also spoke about the placement of maternal and child health programs within the organization. These programs primarily fall under Case Management (especially for high-risk cases), Health Education within the Quality Improvement	

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AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	department, and the core quality improvement efforts aimed at enhancing care metrics. He emphasized the integration of these programs across various departments to ensure comprehensive care and support for maternal and child health. Dr. Amin offered to provide more detailed organizational charts and paused to invite questions before moving on to discuss Change Healthcare.	
INITIAL HEALTH ASSESSMENT	Elaine Sadocchi-Smith, *Director, Facility Site Review, Director, Population Health Management*, gave an Initial Health Assessment (IHA) update *(a copy of the full presentation can be obtained from Board Services).* • The Initial Health Appointment (IHA) is a Medi-Cal requirement for newly enrolled Medi-Cal members to complete with their provider within 120 days of enrollment (based on APL 22-030). • PCPs are responsible to cover and ensure the provision of an IHA within the provider's office. (Some components can be completed virtually). • The IHA is not a single assessment form, but includes the following important components that allow a provider and patient to establish a relationship as a starting point for prevention and improved health outcomes. - Physical and mental medical history - Identification of risks - Assessment of need for preventive screens or services (e.g. Immunizations) - Health Education - Diagnosis and plan for treatment of any diseases Assessments in the IHA The requirement for an IHA to include the completion of the age-appropriate Individual Health Education Behavioral Assessment (IHEBA), often the Staying Healthy Assessment (SHA) was retired as of January 1, 2023. While no specific form is required, the IHA must still include documentation in the medical record of a comprehensive age-appropriate identification of risks and assessment of screenings and appropriate services. All screenings and assessments must be culturally and linguistically appropriate and look at member's needs, preferences, health goals and priorities. Examples of age appropriate screenings include, but are not limited to: - Adverse Childhood Experiences (ACEs) - Developmental progress and autism; vision and hearing - Lead Screening - Brief emotional/behavioral assessments and health behavior assessments and interventions; SABIRT, depression, substance use disorder (SUD) - Postpartum mood disorder screening	

APPROVED

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	- Tobacco cessation counseling - Screening for referral to the Diabetic Prevention Program - Cognitive assessment	
ADJOURNMENT	The meeting was adjourned at 9:55 a.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:
Tara Ficek, *MPH*, *Chairperson* DocuSigned by: Tara Ficek 5AC61982BA4D494...

Date Signed: 8/28/2024 | 9:10 AM PDT

APPROVED

BOARD OF GOVERNORS
Technical Advisory Committee
Meeting Summary – April 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 2:03 p.m. without a quorum. *The committee reached a quorum at 2:09 p.m.*	
APPROVAL OF MEETING AGENDA	The Agenda for today's meeting was approved.	**Approved Unanimously by roll call. 6 AYES (Amin, Chung, Davis, Li, Manchanda, Shultz)**
PUBLIC COMMENT	There were no public comments.	
APPROVAL OF MEETING MINUTES	The January 11, 2024 meeting minutes were approved as submitted.	**Approved Unanimously by roll call. 6 AYES**

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CHAIRPERSON'S REPORT • **Chief Health Equity Update**	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).* <u>Cyber Attack-Change Healthcare</u> In late February, Change Healthcare, a subsidiary of UnitedHealth Group was hacked. Change Healthcare not only offers providers and payors an Information Technology (IT) solution to submit and receive claims, it is also greatly impacted pharmacies ability to check co-pay when they went to pick up their medications from pharmacies. Due to Change Healthcare's large market presence, this attack was significant and impacted nearly every sector of the health care ecosystem. Unfortunately, L.A. Care used Change Healthcare as its tool to receive claims from providers. For the most parts, providers who receive capitation payments were not impacted. However, for hospitals, skilled nursing facilities (SNFs), durable medical equipment (DME) suppliers and other health care providers who bill L.A. Care through the fee for service format, were impacted by this attack. L.A. Care's team have been working diligently with UnitedHealth Group to stand up an alternative process. In the meantime, the provider network team have sent out regular communications and conducted town hall meetings to keep the network appraised. L.A. Care has also advanced over $20 million to those providers who expressed hardship. Moving forward, L.A. Carewill modify its business processes to increase resiliency and redundancy. <u>National Commission on Quality Assurance (NCQA) Health Equity Accreditation</u> On March 11, 2024, L.A. Care received a notification from NCQA that it achieved the NCQA Health Equity Accreditation status, with 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. Nationally, there were around 170+ health plans out of around 1,100 health plans nationally that have received the NCQA Health Equity Accreditation status. <u>Equity Practice Transformation Program Update</u> The 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 were selected to participate in the program. On March 7, 2024, L.A. Care hosted its first session.	

Type of Practice	Total Number of Practices	Total in Direct Network	Medi-Cal Members (LA Care and HealthNet) Impacted
Private	24	8	100,938

APPROVED

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

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 QWIP. 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.

ARTIFICIAL INTELLIGENCE AND HEALTH EQUITY

Ankoor Shah, *MD, MBA, MPH, Chief Medical Officer, Radiant Services, Principal Director, Healthcare Strategy & Consulting Accenture,* and Brandon Shelton, *Senior Director, Advanced Analytics Lab,* provided a presentation on Artificial Intelligence (AI) and Health Equity.

Dr. Shah's report on AI in healthcare addresses several key points regarding the current state and future implications of AI in the healthcare industry. He highlighted the fundamental supply and demand mismatch in healthcare, with an aging population and fewer workers, particularly physicians and nurses, projected for the future. This creates pressure on the healthcare system, necessitating the exploration of technological solutions to augment human capabilities. Dr. Shah discussed rising consumer expectations, with patients expecting more from healthcare providers, leading to increased pressure on the system. This occurs within the context of escalating healthcare costs, further complicating the delivery of care. He delved into the role of AI in healthcare and questions whether it has effectively reduced disparities and advanced health equity at scale.

Dr. Shah cited examples from the past two decades, such as electronic health records (EHRs) and wearable technology, highlighting their limitations and unintended consequences, including physician burnout and disparities in risk scoring algorithms. Dr. Shah noted the impact of AI on care management solutions, noting instances where algorithms have disproportionately affected certain patient populations, exacerbating disparities in care delivery. He discussed the concept of generative AI, which focuses on output creation without necessarily understanding the underlying logic. Dr. Shah emphasized the potential of generative AI but also underscored its significant limitations and risks, including the creation of inaccurate recommendations and concerns about data security and privacy. Dr. Shah encouraged critical reflection on the risks and concerns associated with AI in healthcare, seeking input from the audience to understand their

APPROVED

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	perspectives and considerations regarding AI implementation and its implications for health equity. Member Chung raised several concerns regarding security risks and intellectual property (IP) protection in the context of AI technology in healthcare. He noted that security risks tend to rise to the top of discussions, particularly issues related to protecting both model inputs and outputs. Member Chung highlighted the importance of discussing the basic aspect, which involves the degree to which globally applicable tools can be customized at individual or institutional levels. He questioned who owns the customization rights and how customization occurs on top of existing platforms. Member Chung acknowledged the challenges surrounding training and customization in the rapidly evolving field of AI in healthcare, noting that many are "making it up as they go along." He mentioned concerns about model hallucinations but emphasizes that those working with AI understand that models simply execute their programming based on the quality of the underlying data and prompts. Despite potentially alarming outputs from AI models, Member Chung suggested that the focus should be on the quality of data and interrogation rather than solely on the outputs themselves. He indicated that most people are likely focusing on the latter three concerns raised, although he acknowledged some uncertainty in this assumption. Mr. Limperis draws parallels between the historical adoption of electronic health records (EHRs) and the current trajectory of AI in healthcare. He highlighted the early adoption by institutions like Kaiser Permanente in 2002, noting that the floodgates truly opened in 2009 with the passage of the High Tech Act, which accelerated the modernization and widespread implementation of EHR systems. Mr. Limperis inquired whether Dr. Shah sees a similar path for AI in healthcare and how government regulation might influence this trajectory, particularly in the context of how EHRs were integrated into the industry. By referencing the regulatory framework that accompanied the adoption of EHRs, Mr. Limperis prompted Dr. Shah to consider how regulatory measures may shape the implementation and evolution of AI technologies in healthcare. Dr. Shah acknowledged the significant regulatory changes underway, emphasizing the need for both regulatory adaptation and innovative solutions beyond regulatory frameworks. He drew a parallel between the proliferation of electronic health records (EHRs) following the High Tech Act and the potential trajectory of AI in healthcare, highlighting interoperability as a crucial aspect that could either facilitate or hinder progress. Dr. Shah expressed optimism about the transformative potential of AI in addressing healthcare challenges, particularly in diagnosis, drug discovery, and addressing disparities. He cited examples such as AI-aided detection of	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	precancerous conditions and ambient listening technology for administrative tasks, which could enhance efficiency and expand capacity in healthcare delivery. Addressing concerns about fairness and transparency in AI deployment, Dr. Shah outlined principles for responsible AI use, including human-centered design, fairness, transparency, and accountability. He stressed the importance of continuous monitoring and audit systems to address biases that may emerge over time. Regarding regulation, Dr. Shah highlighted various initiatives aimed at defining core principles and criteria for AI developers and users. He emphasized the complexity of the regulatory landscape, with multiple agencies and organizations contributing to rulemaking and compliance standards. Dr. Shah advised organizations to establish governance structures, conduct risk assessments, and prioritize responsible AI practices to navigate the evolving regulatory environment effectively. He also provided four key questions for organizations to assess their readiness and accountability in implementing responsible AI practices. Sameer Amin, MD, *Chief Medical Officer*,expressed concern regarding the discourse surrounding AI in healthcare, noting that much of the discussion has focused on branding rather than practical applications. He highlighted the confusion between predictive AI and generative AI and the need for clarity on how AI will be utilized in healthcare. Dr. Amin raised skepticism about the success of AI initiatives, citing past experiences where technological promises failed to materialize. He referenced instances such as clinical decision-making tools built into glasses and natural language software, which ultimately resulted in cumbersome pop-up screens rather than meaningful advancements. Drawing parallels to science fiction portrayals of AI, Dr. Amin emphasized the importance of realistic expectations and timelines for AI implementation. He urged caution in discussing AI and advocated for a more pragmatic approach to assessing its potential benefits and usability in clinical settings. Dr. Shah acknowledged Dr. Amin's concerns about the branding-centric discourse surrounding AI in healthcare, noting the prevalence of startups using AI as a buzzword without clear application. He highlighted the need for a more thoughtful approach, focusing on identifying real problems that AI can effectively address rather than pursuing flashy but superficial solutions. Dr. Shah emphasized the importance of deploying AI in back-office administrative tasks to reduce burdens and demonstrate tangible value to healthcare organizations. He stressed the significance of systematic deployment strategies to ensure meaningful integration and avoid superficial implementations driven solely by marketing appeal. Acknowledging the diversity of approaches across the market, Dr. Shah expressed agreement with Dr. Amin's concerns and offered to continue the discussion on this topic.	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	In response to Member Batchlor's question about principals, Dr. Shah responded by emphasizing the importance of integrating technology to enhance rather than replace human tasks, advocating for a "human plus machine" approach. He underscored the need to prioritize human-centric goals in the design and deployment of technology, such as enabling more meaningful interactions between healthcare providers and patients. Dr. Shah urged a mindset shift towards building solutions around human needs and functions, rather than pursuing technology for its own sake. Member Batchlor enquired whether the human-centric approach advocated for in their discussion was a novel concept gaining traction. Member Batchlor acknowledged the historical emphasis on technology over human considerations and shared a personal anecdote about their son pursuing a graduate program in human factor engineering, indicating a personal interest in understanding the concept better. Dr. Shah noted that the current emphasis on human-centric approaches in AI implementation differs from previous waves, largely due to past experience with less thoughtful implementations. He observed a recent increase in discussion around ethical AI and responsible use, but noted that practical implementation still lags behind the discourse. Member Manchanda commented with three interrelated points regarding AI implementation: use cases, approach, and accountability. He applauded the acknowledgment of potential harms associated with AI, particularly from an equity standpoint, emphasizing the importance of considering harm as a default assumption in use case prioritization. Member Manchanda noted AI-enabled prior authorization and utilization management as an example of a use case with inherent risks. Member Manchanda spoke about the approach aspect, noting that while terms like "fairness" and "inclusiveness" are positive, they can be ambiguous and subject to co-optation. He advocated for explicit and inclusive framework that involves community and patient engagement from the outset, rather than as an afterthought. Member Manchanda discussed the necessity of ethical oversight throughout the implementation process, drawing parallels to the film industry's use of advisors for sensitive scenes. He stressed the need for ethical observers to ensure equitable application and mitigate the heightened risk of harm, particularly due to potential biases in large language models and datasets. Member Manchanda also underscored the importance of accountability and governance structures, pointing out the challenge faced by many plans in aligning internal systems with equity goals. He emphasized the need for involvement from those most impacted by AI implementation and highlighted the risk of bias in large datasets. Member Manchanda expressed curiosity about how the presented strategies would translate into actionable healthcare strategies.	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Dr. Shah responded with several considerations regarding the discussion on AI implementation and its potential harms. He expressed agreement with Member Manchanda while highlighting the opportunity costs of inaction. Dr. Shah acknowledged the risk of harm but emphasized comparing it to the alternative of human-only approaches, which have their own shortcomings. Dr. Shah stressed the importance of considering scalability in mitigating harm, particularly in solutions like care management. He suggested that smaller-scale iterative approaches could allow for better harm mitigation and responsible scaling compared to traditional methods reliant solely on human resources. Regarding prior authorization systems, Dr. Shah indicated his limited involvement in that area but noted the regulatory safeguards in place, such as requiring medical approval for care denials. He expressed hope that regulatory barriers would prevent the misuse of technology to deny care, although he acknowledged the potential for circumvention. Member Manchanda emphasized the importance of acknowledging the high risk of harm associated with AI, comparing it to drugs with a narrow therapeutic window. He clarified that recognizing this risk does not negate the consideration of potential benefits, which vary depending on specific use cases. Member Manchanda highlighted the discrepancy between the comprehensive expertise and strategic overview provided in the discussion and the more limited approaches taken by point solution vendors. He noted that many vendors pitch their technologies to healthcare plans without adequately addressing potential harms or providing necessary safeguards, thereby increasing overall risk.	
APPROVE THE TECHNICAL ADVISORY COMMITTEE CHARTER (TAC 100)	Chairperson Li, presented the following motion *(a copy of the materials can be obtained from Board Services)*: **To approve the revised Technical Advisory Committee Charter.** Member Manchanda moved to approve the committee charter with requested changes. He stated that while the Charter is well-crafted and logical, it lacks clarity on how the Technical Advisory Committee will enhance the existing work in engaging members and patients, such as community advisory committees. He suggested that the Charter should explicitly include ways to incorporate member voices and community engagement efforts. Member Manchanda noted the importance of integrating technical expertise on community engagement within the committee and stressed the need for communication to be a focal point in these discussions. Chairperson Li responded that that language can be included in the Charter. He added that the approval of the Charter can be postponed for another meeting. Member Manchanda responded that the Charter can be approved as long as there is a vehicle to elevate communication with	**proved Unanimously by roll call. 6 AYES (Amin, Chung, Davis, Li, Manchanda, Shultz)**

APPROVED

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	technical expertise. He trusted Chairperson Li to guide the committee and elevate that process and moved to approve the Charter as is. Member Davis seconded the motion, but asked that the committee incorporate other work and how the community will be involved.	
MEDI-CAL REDETERMINATIONS UPDATE	Karla Lee Romero, *Director, Medi-Cal Product Management,* gave an update on Medi-Cal Redetermination of eligibility *(a copy of the presentation can be obtained from Board Services).* Ms. Romero reviewed the end of the continuous coverage requirement in March 2023 and the subsequent unwinding period starting in April 2023, affecting beneficiaries with eligibility renewals in June and terminations beginning in July. Ms. Romero noted California's flexible approach during the unwinding, which improved engagement rates. She discussed a recent DHCS survey showing significant gaps in member awareness and engagement, with many members unaware of the renewal requirements or the process to restart coverage. She spoke about the need for continued outreach, noting that 32% of those who lost coverage were unaware of the renewal necessity, 37% wanted to restart coverage but did not know how, and 45% claimed they never received the renewal packet. As the unwinding period concludes in May, L.A. Care estimates about 330,000 members still need redetermination. Despite the unwinding ending, monthly redeterminations will continue. Ms. Romero noted that close to 2 million members have undergone renewal processing, with 73% maintaining coverage. She stressed the importance of consistent messaging to ensure members complete their renewal packets and maintain coverage. The update included details on L.A. Care's ongoing and planned outreach efforts to support members through the redetermination process.	
ADJOURNMENT	The meeting was adjourned at 4:01 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* 8/28/2024 | 8:56 AM PDT

Date Signed

APPROVED

EXECUTIVE COMMITTEE

BOARD OF GOVERNORS
Executive Committee
Meeting Minutes – June 26, 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**
*Absent

Management/Staff

John Baackes, *Chief Executive Officer**
Sameer Amin, MD, *Chief Medical Officer*
Augustavia J. Haydel, Esq., *General Counsel*
Todd Gower, *Interim Chief Compliance Officer*
Linda Greenfeld, *Chief Products Officer*
Darren Lee, *Deputy Chief of Human Resources*
Alex Li, MD, *Chief Health Equity Officer*
Noah Paley, *Chief of Staff*
Acacia Reed, *Chief Operating Officer*
Afzal Shah, *Chief Financial Officer*

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 2:25 p.m. The meetings were held simultaneously. He welcomed everyone to the meetings. He provided information on how to submit public comments.	
APPROVE MEETING AGENDA	The Agenda for today's meeting was approved.	**Approved unanimously. 3 AYES (Ballesteros, Booth and Shapiro)**
PUBLIC COMMENT	*Public Comment* *Elizabeth Cooper came here on a very, very serious matter. The members of the Executive Committee will discuss some very serious issues. She will speak on each item because she is very concerned about the issue. She appreciates the members of the Board who will make some tough decisions. She is here to give her point of view. She appreciates the time they spend but what she is concerned, she hopes they involve the Department of Managed Care and Department of Health Services. She wanted to give her comments before this important decision. She appreciates the comments that were made. She reserves the right to communicate with the Department of Managed Care and the Department of Health and Human Services. She knows the Board members are doing a fantastic job. But she's deeply concerned since she wasn't able, due to family issues, to come in and comment. She didn't get the agenda today so that's why she's in a rush. She would respectfully like to speak on all items on the Agenda for which she has requested.*	

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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
APPROVE MEETING MINUTES	The minutes of the May 22, 2024 meeting were approved.	**Approved unanimously.** **3 AYES**
CHAIRPERSON'S REPORT	*The Chairperson noted that public comment after this item will be limited to two minutes.* *<u>Public Comment</u>* *Elizabeth Cooper commented that she appreciates the courtesy, but this is a very serious matter and it affects members of L.A. Care. She's concerned regarding decisions the Committee will make today. Since she didn't have the agenda in a timely manner, she wasn't able to give her comments. She has to look at each agenda item. Because she reads the agenda and she wants to give public comment. It's very important her as a member of L.A. Care to give her public comments. The chairperson's report is important. The CEO report is going to be very important to her. She comes here to give her point of view because it's so important, health care is not something that she takes lightly. She will listen and give her comment. She thinks Mr. Baackes has done a beautiful job, but she has to respectfully have public comment. When those motions come up and that, because she didn't have time to read this. They didn't get from their ECAC members, as members of the RCAC, they didn't get much comment from the Chairs and it would have been possible if they had spoken to them. So she thanks the Chair for that public comment.* There was no report from the Chairperson.	
CHIEF EXECUTIVE OFFICER REPORT	*<u>Public Comment</u>* *Elizabeth Cooper commented on Mr. Baackes' report, she thinks he does the best he can but she has a point of view on a more serious note. She appreciates the ECAC and all what they have done, but she thinks they have not, in her opinion, addressed the issues if this motion goes through. They have not communicated with the members. They think of them as unimportant, but they are the ones who keep the engine going. They do not communicate with them. And if this motion goes through, she hopes this helps make sure that the Chairs communicate with the members, and they don't look at them as someone not important. All of these issues could have been discussed more freely if they had been more communication with the members, some don't even talk to the members, and that's why she's here. They are here to represent the people in their district.*	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	John Baackes, *Chief Executive Officer,* reported: The California Budget impacts a subject of great importance to L.A. Care, the managed care organization (MCO) tax. The Legislature reached an agreement on a Budget that includes a feature that the proceeds from the MCO tax, earmarked for about $2.6 billion this year, were swept by the Governor into the General Fund to help plug the budget deficit. This will have a negative impact for L.A. Care and all of the Medi-Cal providers. The Governor and the Legislature agreed that payments that would have gone to Medi-Cal in 2025 are pushed out to 2026. That's a meaningless gesture since the current Legislature cannot approve a budget provision for a future fiscal year. That has to be approved by the subsequent Legislature, so they will have to do it all over again next year. The MCO tax on managed care health plans like L.A. Care and our competitors, has been around for years. The money collected by the tax draws down a matching amount of dollars from the federal government. In the first nine years through 2021, the proceeds of that tax went to the general fund. None of the money went to Medi Cal. The tax was allowed to expire in 2023 because California had a one hundred billion dollar surplus. The health plan and provider community formed the Los Angeles Safety Net Coalition to try to get an increase in Medi-Cal funding to deal with financial impacts of COVID, the increased cost of nursing, and so forth. The Los Angeles County coalition, which consisted of hospitals, doctors, clinics, labor unions, and L.A. Care's competitor health plans, came up with the idea to have the tax reinstated with the proceeds earmarked specifically to increase MediCal reimbursement to providers. Surprisingly, the Coalition was able to get the Governor and Legislature to agree to implement it in last year's State Budget. The tax went into effect last July. It was supposed to be a three-year tax that would generate $19 billion in federal funding, with $8 billion going into the General Fund and $11 billion into Medi-Cal to increase payments to providers. By the Governor's action this year that funding is gone. It was assumed that when the tax was adopted last year that a ballot initiative was needed, which, if approved by the voters, would make the proceeds of the tax go to where it was originally intended. Sufficient signatures have been collected and the initiative has been certified by the Secretary of State. A ballot initiative number will be issued by July 3, and it will appear on the November ballot in California. If approved, it only takes a simple majority, the tax proceeds would begin to flow to increase Medi-Cal provider reimbursement and it will create another budget hole for the state next year to deal with. The coalition remains strong, everybody wants to proceed with this as planned. Local organizations have been part of the Coalition and it's really remarkable to have the various groups agree on the same thing. This is the number one issue right now.	

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• Government Affairs Update	Cherie Compartore, *Senior Director, Government Affairs*, reported: With regard to the California Budget, a directed payment program was approved for children's hospitals that brings in new funding of $230 million annually. The Governor issued a press release on another type of payment program for children's hospitals that may be in addition to that funding. Additional funding for the Equity and Practice Transformation payments for providers was removed from the Budget, leaving approximately $113 million believed for this year's program. Government Affairs staff is seeking information on next steps for that program. L.A. Care has 46 enrolled practices in that program. The Legislature and Governor agreed to funding for the: • Medi-Cal acupuncture benefit for adults, • benefits for In Home Supportive Services workers for undocumented seniors, • backup provider services for IHSS. Beneficiaries are eligible for approximately 80 hours per year, • Medi-Cal Continuous Eligibility program for children ages from birth through four years of age. Those are the main budget items. An updated State Budget review will be included in the next board meeting packet. Ms. Compartore reported that the main budget bill and the health budget trailer bill have been approved by the Governor and the Legislature, but there will be many budget trailer bills occurring through the summer and will be reported at a future Board meeting.	
COMMITTEE ISSUES		
Ratify L.A. Care Chief Executive Officer's, John Baackes, execution of Amendment A04 to L.A. Care's Exclusively Aligned Enrollment (EAE) D-SNP Contract Number 22-20236 with the Department of	*Public Comment* *Elizabeth Cooper commented that a few years back when she was a member of the RCAC, they got the RCAC involved, and all these motions that she listens to, it is very important what she was saying and what Mr. Baackes said. Chairperson, she does pay attention to what is said and what the legislation is. But what she's concerned about is that she doesn't hear anything coming to the RCACs about going out and supporting with one's Legislator. L.A. Care has a large membership, and it's very important for them to hear from their constituency regarding this legislation, about Medi-Cal and what Governor Newsom has done. Some of those issues impact her as a consumer. As a member and in trying to be an informed person, she*	

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Health Care Services (DHCS)	*would hope, Chairperson and Members of the Board that you sort of encourage members to be more involved, not politically involved, but involved on those issues. So the Legislators can hear from the people who vote for them and who their constituency is. That is most important and she appreciates what she was discussing today and she appreciates what Mr. Baackes was saying, about what they tried to do. But one final thing, the voter's going to decide and those who write to their Legislator will be important to Governor Newsom. She writes to him.* Augustavia J. Haydel, Esq., *General Counsel*, introduced Nadia Grochowski, *Associate Counsel,* and she presented a motion for an amendment to the Dual-eligible Special Needs Plan (DSNP) agreement that L.A. Care currently has with the California Department of Health Care Services (DHCS). This is an amendment extending the term of the contract from December 31, 2024 to December 31, 2025. When the amendment was received from DHCS, L.A. Care was asked to sign by June 20 2024. Ms. Grochowski asked approval of a motion to ratify the execution of the amendment by Mr. Baackes. **Motion EXE 100.0724** **To ratify L.A. Care Chief Executive Officer's, John Baackes, execution of Amendment A04 to L.A. Care's Exclusively Aligned Enrollment (EAE) D-SNP Contract Number 22-20236 with the Department of Health Care Services (DHCS).**	**Approved unanimously.** **3 AYES**
Approve the revisions to the Operating Rules of the Consumer Advisory Committee, and related changes, in accordance to the delegated authority from the Board of Governors as outlined in Motion BOG 104.0624	**Public Comment** *Estela Lara, a former Chair of Regional Community Advisory Committee (RCAC) 2 in the San Fernando Valley, and a member of RCAC 4 in Metro LA. She would like the Committee to approve the Operating Rules and the modifications that were made. She thinks it will be really beneficial for RCAC members with just one little modification. The stipend will be increased to $100. She suggests to increase the stipend to $200 because they have not had one in a very long time, and since there are modifications it is better to include it right now. Demares Hernandez de Cordero, has been here for 24 years, Ms. Lara has been here for eight years. Fatima Vazquez has been here for 13 years. There was one more on the list and between just the four of them they have 50 years of experience. There are many more members on all RCACs. She thinks their experience is under utilized. L.A. Care pays consultants but should just pay them the additional stipend because they can tell you specifically what will improve the plan and what needs to be done to have it go forward. She asked for that change in the modifications.*	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Elizabeth Cooper commented that she understands comments are two minutes. She can talk fast, but sometimes she cannot. Chairperson, this is one of the most important things or issues before the Board, the changes in the operating rules. Although she didn't have a chance to vote on them. She only had a brief time. But this has not been explained. The money is important too, and it is a help, she concurs with the money, but she was concerned about some of the changes. What will happen? Who will be the ones who select under the operating rules, and what about the ECAC? Will they have terms where they do not have to go through the changes that the members go through? You need to think about this motion, how it is going to affect the members, because we did hear this, but where the members did not have a vote on this operating rules before the ECAC voted on it. If we did not get the final say, the ECAC members did not communicate with the chair. That's why I'm speaking. But on these operating rules, I wonder who would make that decision on selection, who be on the committee? Would that be a prejudicial thing? It should be consideration of who would make those decisions. She appreciates the leadership that Mr. Baackes has shown members and she thinks he's been very sensitive to some of the concerns. But she's concerned about the operating rules because it's going to make changes. For the record, in the enabling legislation SB 2092, there was no term limits in the legislation for term limits. She doesn't matter because even if she's termed out, she still has a voice. But please take notice SB 2092, the enabling legislation, does not set term limits. It's alright with her because she will go to any meeting. But please take notice, Board, SB 2092, the enabling legislation, and legislators will have to agree to term limits, she believes. That's her point. But please take notice how you vote on the operating rules, making sure the RCACs are able to sustain themselves. *(This comment from Ms. McLain was read at the end of the meeting because it was received via email after this topic was discussed, but it is included here for relevancy.)* *Deaka McLain, ECAC Member at Large (Representative for Senior and People w/ Disabilities(SPD), TTECAC Vice-Chair. I would like to thank the executive committee for assisting the advisory committees with this process. I am in support of the changes as long as it's written and clear what was promised by Mr. Baakes and that if we are unhappy with any aspect of the changes, the ECAC has the ability to make amendments as necessary to ensure the RCACs are meeting the needs of members. Deaka McClain*	

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Mr. Baackes responded that it is a new requirement in the Medi-Cal contract with the DHCS that Medi-Cal managed care plans have consumer advisory committees. L.A. Care has always had them, and that makes L.A. Care an outlier from other managed care plans in California. For most plans, this is a new issue being addressed from scratch. L.A. Care worked to bring the long-standing RCACs and ECAC in alignment with the new DHCS requirements. A principal new requirement was that plans have a selection committee for community advisory committees, and that a report is sent annually on the composition of the community advisory committees. The members of the advisory committees must match the composition of membership in the health plan. L.A. Care has multiple RCACs while most other health plans will have only one. L.A. Care took this opportunity to create a selection committee and after listening to RCAC member concerns that the selection committee would be made up of members of the staff, the new operating rules call for a selection committee of six, consisting of three RCAC chairs selected by the ECAC, two members of the L.A. Care community based organization advisory group, and one staff member, the Chief Health Equity Officer, Dr. Alex Li. The committee of six will select the members of the eight RCACs. The eight RCACs (instead of the current eleven) will align with LA County Service Planning Areas (SPAs). This will enable L.A. Care to provide the members of those eight committees with current data from Los Angeles County about the health status of the community they live in. The data can be used in making recommendations to L.A. Care. Members will have two 4-year terms, which matches the term limits of the Board of Governors. L.A. Care reviewed the issue that was raised about no term limits and cannot find any substantiation, so the term limits are allowed. The structure was presented to the ECAC, and as the previous speaker mentioned, ECAC approved it. There was significant discussion about, what if we don't approve, what if it doesn't work out the way we think it can. So there is an opportunity in the operating rules for the ECAC to revisit the operating rules and make recommendations if things aren't working, so it can be adjusted going forward. Those are the highlights of what the operating rules contain. On the behalf of staff, Mr. Baackes stated they are anxious to get this implemented and over with and start meetings again on the new basis. Assuming it is approved, two meetings are planned in August including all RCAC members meeting together to go over the new operating rules, the new configurations and the new agendas. The Agendas we'll use will encourage more participation by the members. There will be a two-day training sessions	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	held two weeks apart in August and then the regular schedule will start in September. There will be six meetings annually for each RCAC. Mr. Baackes noted that is a quick summary of discussions, and topics were discussed many times. In the last round of RCAC meetings, Sameer Amin, MD, *Chief Medical Officer,* and Mr. Baackes tried to attend every RCAC meeting. Each of them attended four and there were three they couldn't get to that other staff attended. Modifications were made after listening to the members in those meetings. One concern was that they didn't like the idea of only four meetings, and the number of meetings was raised to six meetings annually. Another was that they really didn't like the idea of roundtable meetings, so that was eliminated. L.A. Care will incorporate member focused discussion in the agendas of the RCAC meetings. The purpose of the proposed roundtables was to have topic specific items on every agenda. Mr. Baackes asked that the Executive Committee consider a motion to adopt the operating rules. Board Member Booth noted there are typos and some grammar that needs to change and would not affect the document. She asked specifically about the wording on page 11, described as "substantial" violation of the Code of Conduct. She recommends the language be revised to indicate a CAC member is removed for violation of the Code of Conduct, without the word substantial. The section is about eligibility to re-apply for membership, the word substantial should not be there because it gives the appearance that there could be violations that are not substantial. She thinks a violation of the Code of Conduct is substantial. She was told that the word fighting just under that section as a one of the potential reasons for action taken against a CAC member. She thinks that's pretty unclear and was told that it could be better defined in the CAC member handbook, which also has conduct rules. Also on page 9, she noted the intention for 25 members in a group, this includes a maximum membership of 35. She suggested discussing whether 35 or 25 should be the maximum. She recommended aiming for a maximum of 25 because she is a member of committees with 35 members and it is way too many to get anything done. She noted there are a couple of other places with some inconsistencies that should be fixed. Mr. Baackes noted that the original operating rules included things about fighting and so forth, so that wording has been in the document for some time. The reason for the maximum of 35 members is because one RCAC will have 32 members in the new structure. Those 32 members will carry over into the new RCAC. L.A. Care agreed that	

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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	current RCAC members would be "grandfathered in" and wouldn't need to go through the selection process. Board Member Booth agreed that is fine to start the process, but as people leave they should not be replaced the RCAC membership is down to 25. She doesn't think the maximum needs to be described if it will be 25. Augustavia Haydel, *General Counsel*, noted that the enabling legislation sets the maximum number of each RCAC at 35, so this language reflects the number that was in the legislation, which is 35. The operating rules should not contain language that contradicts the enabling legislation. Mr. Baackes noted that the stipend is being raised to $140 per meeting, which is doubling the previous stipend. A proposal to make certain revisions to the Operating Rules for the Consumer Advisory Committees (CAC) was presented at the June 12, 2024 Temporary Transitional Executive Community Advisory Committee (TTECAC) meeting. The members of the TTECAC endorsed the revisions to the Operating Rules that included changes to CAC operations previously approved by the TTECAC at its meeting on May 12, 2024. The most substantive revisions to the Operating Rules are summarized below: 1. Section II – Function and Role – Additional subject areas added to align with new language in L.A. Care's contract with the Department of Health Care Services (DHCS) to provide Medi-Cal services. 2. Section III – Membership, Paragraph A – Selection Committee – A new section added describing the structure and role of a new CAC Member Selection Committee. The section also adds language referring to the submission of an Annual CAC Membership Demographic report by April 1 of each year. 3. Section III – Membership, Paragraph F – CAC Member Term – Language added describing term limits for CAC members (a maximum of two, four-year terms) and the setting of a target membership of 25 members for each CAC. 4. Section III – Membership, Paragraph H – Replacement of Members – Language added to specify that L.A. Care intends to replace CAC members who resign or are removed within 60 days. 5. Section VII – CAC Meetings, Paragraph D - Additional Meeting Guidelines – Additional language referring to posting of CAC meeting summaries, the deadline for submission of meeting summaries to DHCS and the length of the meeting summary record retention period.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	At its meeting of June 12, 2024, the TTECAC requested an additional revision to the Operating Rules: 1. Section V – Role and Term of ECAC Leadership – Sections A and B – In subparagraph e in each section, the TTECAC has requested that only unexcused absences be considered when determining if an ECAC Chairperson or Vice-Chairperson is considered to have resigned from their position due to missed meetings. In addition, the TTECAC asked that language that staff would consider each situation of this type on a case-by-case basis be added. Staff is in agreement with these additional revisions to the Operating Rules. Other non-substantive edits to the Operating Rules to remove mention of the CCI Council CAC that no longer exists and several minor corrections are also noted. **Motion EXE A.0624** **To authorize the Executive Committee of the Board of Governors to approve revisions to the Operating Rules for the Consumer Advisory Committees of L.A. Care Health Plan as presented during the June 12, 2024 meeting of the Temporary Transitional Executive Community Advisory Committee.** On behalf of the staff who have been working on this issue for a long time, Mr. Baackes thanked the Board Members and RCAC and ECAC members who have participated in the meetings, and he looks forward to a regular cadence of community advisory committee meetings to discuss issues that are important to the to the RCAC members and will help inform L.A. Care on how the organization can add value for members and providers. He thanked everyone extending patience through this process. Board Member Booth also thanked Francisco Oaxaca for his response to her questions even though he is out of the office. Mr. Baackes recognized the work by Auleria Eakins, a senior member of the staff who has been extremely helpful in this process. He also thanked the public for being involved in the discussion.	**Approved unanimously, with non-substantive edits.** **3 AYES**

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Discussion/ Recommendation on Temporary Transitional Executive Community Advisory Committee's tabled motions from May 2, 2024 Board of Governors meeting	*Public Comments* *Estela Lara from RCAC four asked the Committee to please approve the motion.* *Elizabeth Cooper commented that she approves this motion, with one correction. She knows it's out of order, Chairperson, when she speaks, she refers to the point of authority, the enabling legislation. Anything that she has spoken about is referred to in the enabling legislation, just like Counselor Haydel. So she hopes everything is going. She approves this, she doesn't object to this motion, she just wanted to say, you might say she's out of order, but Elizabeth Cooper referred to the enabling legislation that was signed by Governor Wilson and the legislature approved it. So that's when she's speaking.*	
• Placement of Closed session on the Board Meeting Agenda	Ms. Haydel noted that this motion was brought forward by the TTECAC in response to changing the closed session from the end to the beginning of the Board meeting Agenda. TTECAC brought this motion forward and it was tabled by the Board at the May meeting, and delegated by the Board to the Executive Committee for further discussion about whether the public portion of the Board meeting could be moved back up to the beginning of the Board meeting. Chairperson Ballesteros asked Executive Committee members about their thoughts on reverting back a closed session at the end of the Board meeting. The Board heard from the public in recent meetings that having the closed session at the beginning of the meeting has been problematic for their schedule. Board Member Booth commented that the closed session was moved to the beginning of the Board meeting because the members present for the quorum goes down near the end of the meeting and action could not be taken without quorum. Action items were then placed in the early part of the meeting and the more informational items were moved to the end. The Board members are here to do the business of L.A. Care. She acknowledges the issue expressed in public comment, and the Board also needs to accomplish the action items on the Agenda. Board Member Shapiro agreed with Board Member Booth and noted it is a balance of making sure that the public can participate and the Board can do its business. He suggested a shorter 30 minute closed session at the beginning of the meeting as a compromise, understanding that it would be the middle ground between what we have and what we can offer. That way the Board can vote on action items. Board Chairperson talked to consumers. He has a general sense that the Board wants to	

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	make meetings as accessible to the public as possible. The Board members do not want the public to get the impression that they are not considered as the agenda is structured. A main concern is that Board Members did not want the public to feel as if they were not important, and that might appear to be reflected in the fact that the closed session was moved to the beginning of the meeting. There are also some issues around meeting management that we need to think of: when many public comments come forward and there are many agenda items on the Agenda, he has been willing to move public comment from 3 to 2 minutes. There is a set amount of time for the meeting. He is also comfortable with pointing out to the speakers before the Board when the topic that they want to speak to in their comments are not germane to the Agenda topic. He suggested these additional meeting management tools be used. He has no issue with moving the closed session to the end of the agenda. He advised Board Members and the public that he will have to exercise those options to bring public comment from 3 to 2 minutes, perhaps to 1 minute if the agenda's cramped. He thinks that if the public is aware of that he will be okay with moving the closed session item back to the end of the agenda given that we're going to begin exercising more of the meeting management tools. He recommended going back to having the closed session to the end of the meeting. **MOTION TTECA 100.0524** **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.** Chairperson Ballesteros directed staff that starting at the next board meeting, the closed session will be held at the end of the meeting.	**Approved unanimously.** **3 AYES**
• Consider the placement of push buttons on any door accessible to the public at any site used by L.A. Care for public meetings	Darren Lee, *Deputy Chief Human Resources Officer*, noted that in a previous session, the Board Members requested additional information about adding automatic opening doors to L.A. Care Community Resource Centers and sites visited by the public. The request was reviewed, and it was determined that L.A. Care is in compliance with state and federal regulations with regard to those doors already in all public meeting spaces and larger forums. A review included researching any industry practice or standards for installation of automatic doors on bathrooms. It is noted that installing these automatic doors can create additional problems with blocking hallways and passageways as well as privacy issues when the doors stay open. He referred Board Members to the meeting	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	materials which include positive and negative potential issues with regard to the automatic doors. There are maintenance costs included in the meeting materials. He also noted that if the power goes out, the automatic doors are more difficult to manage. Industry standard and practice for regular clinics is that they generally do not have automatic doors. Looking at the cost for installation, which was one of the concerns the Board asked about, would be somewhere between $25 and $30,000 per door. That number is closer to $40,000 to retrofit. Retrofitting all of L.A. Care's doors at Community Resource Centers would cost somewhere in the neighborhood of $500,000. If that is something the Board would like to consider, additional information is included with regard to the time remaining on each lease. Board Member Shapiro asked Mr. Lee to confirm that the information indicates L.A. Care is doing all the legal things that it needs to be doing and is compliant, and this would be something extra. Mr. Baackes noted the staff recommendation in the meeting materials. Board Member Booth asked about the difference in cost from a regular door. Mr. Lee noted that there is a different door and framing, electrical and switches. A retrofit would include the deconstruction of the old door as well as installation of the automatic door. Board Member Booth commented that she has worked in hospitals that have a lot of these doors, and there seems to always be work on them or they get stuck. She hasn't found them to be reliable. Mr. Lee noted there would be a cost for regular maintenance as well as parts to repair them. **<u>Motion TTECA 101.0524</u>** **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.** Board Member Booth commented to the members present that this is the input the Board would like to see. This is wonderful. She thanked the members for bringing it forward.	**Not approved.** **2 NAYS,** **1 ABSTENTION** **(Ballesteros)**
Approve Human Resources Policies HR 306 (Equal	*<u>Public Comment</u>* *Elizabeth Cooper thanked the Chair and Board Members. This issue of human resource policy that's the employment is very important. She knows as member of*	

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<tr><th>AGENDA ITEM/PRESENTER</th><th>MOTIONS / MAJOR DISCUSSIONS</th><th>ACTION TAKEN</th></tr>
<tr><td>Employment Opportunity) and HR 603 (Overtime Pay)</td><td>

the public, and she hopes board members will listen to their concerns. She is concerned because when she first came here she saw a lack of Afro Americans employed here, and this is the employment issue. Also Afro Americans and others not given high positions. So she would like to know how does equal opportunity fit because I see some Afro Americans now who are in very high academic, but they are not getting elevated to top positions. And she also would like to see disabled members, which she hopes you do, but on the equal opportunity they hire and they fire, and they also recommend. She would also like to see diversity which she appreciates, she works with all groups, but she does like this board to consider diversity. As the one who has preached this since she's been a member of L.A. Care on the RCACs. She appreciates all cultures, but she finds that there's been a lack of elevation of Afro Americans in top positions. She's not saying others aren't just as important, but she would like to see the human relations department start elevating some. That doesn't mean they are all right or all wrong, but she's seen African Americans with high position and they're still in the same position. They don't get a chance. They go to the family resource centers, they don't get those positions. So she would like the human resources department to be more proactive on that. She appreciates all the employees. In fact, she has supported all the employees, but she sees a lack of Afro Americans in high positions.

Mr. Lee presented a motion requesting approval of the revised Human Resources Policies 306 (Equal Employment Opportunity) and HR 603 (Overtime Pay).

Policy Number	Policy	Section	Description of Modification
HR-306	Equal Employment Opportunity	Employment	Including recommended verbiage to meet NCQA Health Equity HE1A Factor 1
HR-603	Overtime Pay	Benefits	Transferred Policy to new template and made minor changes

<u>Motion EXE B.0624</u>
To approve the Human Resources Policies HR 306 (Equal Employment Opportunity) and HR 603 (Overtime Pay), as presented.

</td><td>**Approved unanimously.**
3 AYES</td></tr>
</table>

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Mr. Baackes commented that the changes approved were suggested as part of the accreditation process whereby L.A. Care achieved Health Equity Accreditation from the National Committee on Quality Assurance.	
Approve Consent Agenda	Approve the list of items that will be considered on a Consent Agenda for July 25, 2024 Board of Governors Meeting. • June 6, 2024 meeting minutes • Ratify L.A. Care Chief Executive Officer's, John Baackes, execution of Amendment A04 to L.A. Care's Exclusively Aligned Enrollment (EAE) D-SNP Contract Number 22-20236 with the Department of Health Care Services (DHCS)	**Approved unanimously.** **3 AYES**
PUBLIC COMMENTS		
ADJOURN TO CLOSED SESSION	The Joint Powers Authority Executive Committee meeting adjourned at 3:30 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 3:30 pm. 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: *June 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*, and Gene Magerr, *Chief Information Security 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	

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: Chief Executive Officer Agency Designated Representative: Alvaro Ballesteros, MBA Unrepresented Employee: John Baackes	
RECONVENE IN OPEN SESSION	The meeting reconvened in open session at 3:50 pm. No reportable actions were taken during the closed session.	
ADJOURNMENT	The meeting adjourned at 3:50 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

FINANCE
&
BUDGET
COMMITTEE

Board of Governors Meeting

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

July YTD Financials & FY 2024-25 Budget

September 5, 2024

Agenda

FY 2023-24 Performance

- July 2024 Membership & Financials

FY 2024-25 Budget

- Membership Assumptions & Projections
- Financial Assumptions – Revenue & Healthcare Costs
- Financial Performance vs FY 2023-24 4+8 Forecast
- Operating Margin by Segment
- Opportunities and Risks
- Balance Sheet Comparison
- Board Designated Funds
- TNE & Days of Cash On-Hand Comparison

FY 2024-25 Capital Projects and Programs

Informational Items

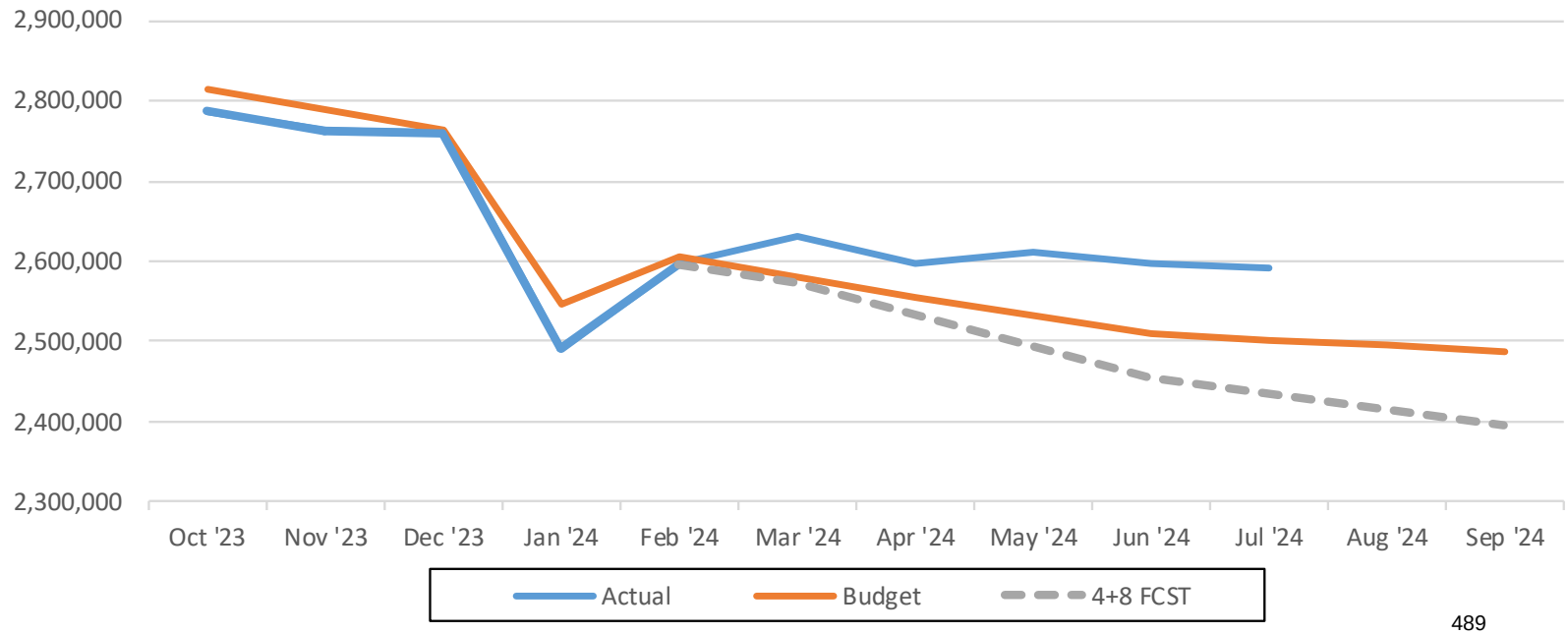
- Monthly Investment Transactions
- Quarterly Internal Policy Reports

Membership

for the 10 months ended July 2024

	July 2024			Year-to-Date		
Sub-Segment	**Actual**	**4+8 FCST**	**Variance**	**Actual**	**4+8 FCST**	**Variance**
Medi-Cal	2,354,148	2,217,445	136,703	24,305,499	23,830,006	475,493
D-SNP	19,703	19,591	112	191,618	190,709	909
LACC	186,954	170,284	16,670	1,636,313	1,578,610	57,703
PASC	49,327	47,636	1,691	486,744	480,905	5,839
***Elimination**	(19,703)	(19,591)	(112)	(191,618)	(190,709)	(909)
Consolidated	**2,590,429**	**2,435,365**	**155,064**	**26,428,556**	**25,889,521**	**539,035**

***D-SNP members included in MCLA membership under CCI.**



Consolidated Financial Performance – July 2024

	Actual	4+8 FCST	Variance
Member Months	2,590,429	2,435,365	155,064
Total Revenues	$925,910	$868,036	$57,874
Total Healthcare Expenses	$909,440	$827,182	($82,257)
Operating Margin	$16,471	$40,854	($24,383)
Operating Margin (excl HHIP/IPP)	$29,083	$32,825	($3,742)
Total Admin Expenses	$57,164	$56,796	($368)
Income/(Loss) from Operations	($40,693)	($15,942)	($24,751)
Non-Operating Income/(Expense)	$20,190	$11,238	$8,952
Net Surplus	**($20,503)**	**($4,704)**	**($15,799)**
Net Surplus (excl HHIP/IPP)	***($7,559)***	***($12,528)***	***$4,969***

Consolidated Financial Performance – July YTD 2024

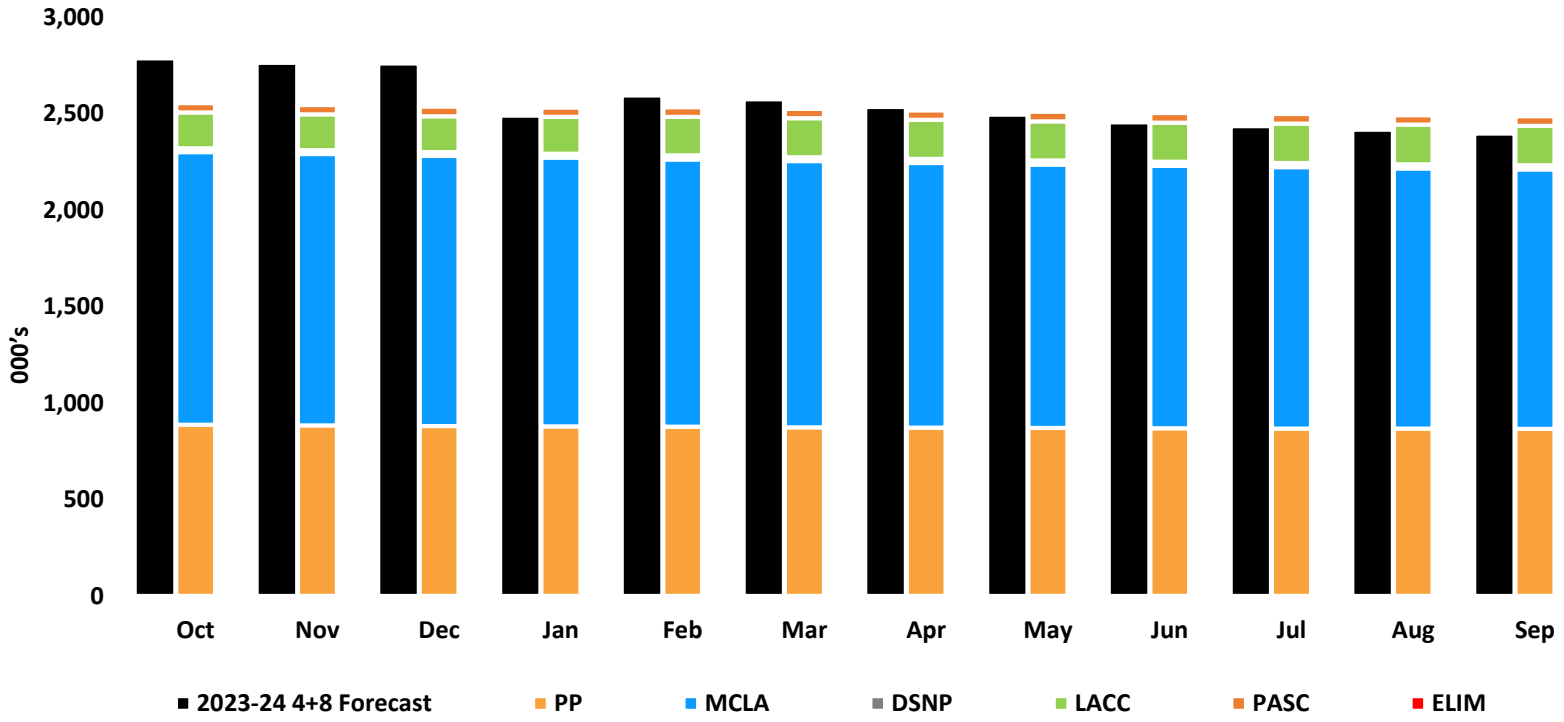
	Actual	4+8 FCST	Variance
Member Months	26,428,556	25,889,521	539,035
Total Revenues	$9,094,089	$8,971,923	$122,166
Total Healthcare Expenses	$8,244,122	$8,270,696	$26,574
Operating Margin	$849,967	$701,227	$148,740
Operating Margin (excl HHIP/IPP)	$735,228	$614,805	$120,423
Total Admin Expenses	$535,373	$524,067	($11,306)
Income/(Loss) from Operations	$314,595	$177,160	$137,434
Non-Operating Income/(Expense)	$165,937	$142,587	$23,350
Net Surplus	**$480,531**	**$319,747**	**$160,784**
Net Surplus (excl HHIP/IPP)	***$368,276***	***$235,466***	***$132,810***

FY 2024-25 Budget

FY 2024-25 Budget Assumptions - Membership

- FY 2024-25 Budget assumes 3.9% annual decline in Medi-Cal membership from previous year (0.33% p/month). This accounts for post unwinding activity after the end of the redetermination period as well as ongoing renewal processing delays.
- D-SNP assumes 6% member growth from previous year. This takes into account sales and retention efforts.
- LACC assumes growth of 11% over previous year. This assumes #1 price position and retention rate of 90%.
- The projected membership gain for FY 2024-25 Budget vs FY 2023-24 4+8 Forecast is expected to be 69,000 members or 2.9 percent, with member months falling approximately 720,000 or 2.3 percent.

FY 2024-25 Budget – Membership Projections



LOB	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Total	YoY Var
TOTAL MEDI-CAL	2,300,883	2,290,742	2,281,398	2,272,160	2,263,027	2,253,998	2,245,072	2,236,251	2,229,766	2,223,368	2,217,058	2,210,837	**27,024,560**	**(3.9%)**
DSNP	20,264	20,195	20,209	21,084	21,146	21,206	21,265	21,322	21,378	21,432	21,485	21,536	**252,522**	**6.28%**
LACC	185,220	185,402	185,078	189,593	200,003	200,853	201,677	202,475	203,248	203,997	204,724	205,328	**2,367,598**	**10.86%**
PASC	49,172	49,172	49,172	49,172	49,172	49,172	49,172	49,172	49,172	49,172	49,172	49,172	**590,068**	**0.00%**
ELIM	*(20,264)*	*(20,195)*	*(20,209)*	*(21,084)*	*(21,146)*	*(21,206)*	*(21,265)*	*(21,322)*	(21,378)	(21,432)	(21,485)	(21,536)	**(252,522)**	**6.28%**
Total	**2,535,275**	**2,525,316**	**2,515,649**	**2,510,926**	**2,512,202**	**2,504,023**	**2,495,921**	**2,487,898**	**2,482,186**	**2,476,538**	**2,470,954**	**2,465,337**	**29,982,226**	**(2.8%)**
MoM		(9,959)	(9,667)	(4,723)	1,277	(8,179)	(8,102)	(8,023)	(5,712)	(5,648)	(5,583)	(5,617)		
MoM %		-0.39%	-0.38%	-0.19%	0.05%	-0.33%	-0.32%	-0.32%	-0.23%	-0.23%	-0.23%	-0.23%		
Var to 4+8	(251,386)	(238,232)	(244,972)	20,491	(82,580)	(70,040)	(38,573)	(6,921)	27,454	41,172	54,594	**68,705**	**(720,287)**	
Var %	(9.0%)	(8.6%)	(8.9%)	0.8%	(3.2%)	(2.7%)	(1.5%)	(0.3%)	1.1%	1.7%	2.3%	**2.9%**	**(2.3%)**	

FY 2024-25 Budget – Revenue Assumptions

- **Medi-Cal**
  - CY2024 aligned with current DHCS rates
  - CY2025 based on preliminary actuarial assumptions: pending DHCS draft release
- **LACC & D-SNP**
  - CY2024 consistent with CY2024 rates
  - CY2025 aligns with respective bids
- **PASC**
  - CY2025 are assumed to continue at current rates

FY 2024-25 Budget – Healthcare Costs Assumptions

- **Global Sub Capitation**
  - CY2024 in line with current draft rates
  - CY2025 rate methodology based on preliminary actuarial assumptions
- **Capitation**
  - Medi-Cal:
    - CY2024 aligns with June ‘24 capitation
    - CY2025 trend consistent with historical increases
  - LACC
    - RAF of 0.64
    - CY2024 uses June ‘24 rates
    - CY2025 trend consistent with historical increases
  - D-SNP
    - Aligns with June ‘24 Capitation
- **Fee-for-Service (FFS) Cost**
  - IBNR files from May 2024 and CY2023 trends
  - FFS trends were developed using a base period of CY2023 and projected using actuarial assumptions

FY24-25 Budget vs. FY23-24 4+8 Forecast P&L – Total L.A. Care

excl. HHIP/IPP

	FY 2024-25 Budget	PMPM	FY 2023-24 4+8 Forecast	PMPM	Budget Fav/(Unfav)	PMPM
Membership						
Member Months	29,982,226		30,702,513		(720,287)	
Revenue						
Capitation Revenue	$ 10,719,517	$ 357.53	$ 10,441,716	$ 340.09	$ 277,800	$ 17.44
Total Revenues	**$ 10,719,517**	**$ 357.53**	**$ 10,441,716**	**$ 340.09**	**$ 277,800**	**$ 17.44**
Healthcare Expenses						
Capitation	$ 4,999,234	$ 166.74	$ 5,397,474	$ 175.80	$ 398,240	$ 9.06
Inpatient Claims	$ 1,522,804	$ 50.79	$ 1,322,142	$ 43.06	$ (200,662)	$ (7.73)
Outpatient Claims	$ 1,356,298	$ 45.24	$ 1,218,305	$ 39.68	$ (137,994)	$ (5.56)
Skilled Nurse Facility	$ 1,353,892	$ 45.16	$ 1,177,024	$ 38.34	$ (176,868)	$ (6.82)
CBAS	$ 232,076	$ 7.74	$ 222,497	$ 7.25	$ (9,579)	$ (0.49)
Multipurpose Senior Services Program	$ -	$ -	$ (16)	$ (0.00)	$ (16)	$ (0.00)
Pharmacy	$ 234,838	$ 7.83	$ 179,862	$ 5.86	$ (54,976)	$ (1.97)
Shared Risk	$ 34,695	$ 1.16	$ 33,074	$ 1.08	$ (1,621)	$ (0.08)
Provider Incentive	$ 118,230	$ 3.94	$ 136,668	$ 4.45	$ 18,437	$ 0.51
Medical Administrative Expenses	$ 143,628	$ 4.79	$ 140,042	$ 4.56	$ (3,585)	$ (0.23)
Total Healthcare Expenses	**$ 9,995,695**	**$ 333.39**	**$ 9,827,070**	**$ 320.07**	**$ (168,625)**	**$ (13.31)**
MCR (%)	*93.2%*		*94.1%*		*+86bps*	
Operating Margin	**$ 723,822**	**$ 24.14**	**$ 614,646**	**$ 20.02**	**$ 109,176**	**$ 4.12**

FY24-25 Budget vs. FY23-24 4+8 Forecast P&L – Total L.A. Care cont.

excl. HHIP/IPP

	FY 2024-25 Budget	PMPM	FY 2023-24 4+8 Forecast	PMPM	Budget Fav/(Unfav)	PMPM
Operating Expenses						
Salaries and Benefits	$ 397,920	$ 13.27	$ 361,976	$ 11.79	$ (35,944)	$ (1.48)
Temporary Labor and Recruitment	$ 8,989	$ 0.30	$ 2,777	$ 0.09	$ (6,212)	$ (0.21)
Professional Fees	$ 29,499	$ 0.98	$ 32,377	$ 1.05	$ 2,878	$ 0.07
Purchased Services	$ 177,091	$ 5.91	$ 171,511	$ 5.59	$ (5,580)	$ (0.32)
Advertising and Promotions	$ 8,406	$ 0.28	$ 14,540	$ 0.47	$ 6,134	$ 0.19
Business Fees and Insurance	$ 71,870	$ 2.40	$ 60,235	$ 1.96	$ (11,635)	$ (0.44)
Occupancy and Leases	$ 14,102	$ 0.47	$ 8,045	$ 0.26	$ (6,057)	$ (0.21)
Supplies and Other	$ 47,229	$ 1.58	$ 55,172	$ 1.80	$ 7,943	$ 0.22
Medical Administration Expenses - Admin	$ (138,651)	$ (4.62)	$ (133,842)	$ (4.36)	$ 4,810	$ 0.27
Depreciation and Amortization	$ 75,800	$ 2.53	$ 59,108	$ 1.93	$ (16,692)	$ (0.60)
Corporate Allocation	$ (0)	$ (0.00)	$ 0	$ 0.00	$ 0	$ 0.00
Total Operating Expenses	**$ 692,255**	**$ 23.09**	**$ 631,900**	**$ 20.58**	**$ (60,355)**	**$ (2.51)**
Admin Ratio (%)	*6.5%*		*6.1%*		*(41bps)*	
Income (Loss) from Operations	**$ 31,567**	**$ 1.05**	**$ (17,254)**	**$ (0.56)**	**$ 48,821**	**$ 1.61**
Margin before Non-Operating Inc/(Exp) Ratio (%)	*0.3%*		*(0.2%)*		*+46bps*	
Interest Income, Net	$ 180,371	$ 6.02	$ 184,649	$ 6.01	$ (4,278)	$ 0.00
Other Income (Expense), Net	$ (50,784)	$ (1.69)	$ (34,453)	$ (1.12)	$ (16,331)	$ (0.57)
Realized/Unrealized Gain/(Loss), Net	$ -	$ -	$ 13,928	$ 0.45	$ (13,928)	$ (0.45)
Total Non-Operating Income/(Expense)	**$ 129,587**	**$ 4.32**	**$ 164,124**	**$ 5.35**	**$ (34,537)**	**(1.02)**
Net Surplus/(Deficit)	**$ 161,155**	**$ 5.38**	**$ 146,870**	**$ 4.78**	**$ 14,285**	**$ 0.59**
Margin (%)	*1.5%*		*1.4%*		*+9bps*	
Net Surplus/(Deficit) excl. Interest Income, Net	**$ (19,216)**	**$ (0.64)**	**$ (37,779)**	**$ (1.23)**	**$ 18,563**	**$ 0.59**
Margin (%)	*(0.2%)*		*(0.4%)*		*+18bps*	

FY 2024-25 Budget – Margin by Segment

($ in Thousands)

	Medi-Cal	D-SNP	LACC	PASC	Other	Total	Total *(excl HHIP/IPP)*
Revenue	$9,393,011	$415,035	$725,018	$186,453	$93,440	$10,812,957	$10,719,517
Healthcare Exp.	$8,855,961	$369,397	$584,102	$186,235	$51,595	$10,047,290	$9,995,695
Operating Margin	$537,050	$45,638	$140,916	$218	$41,845	$765,667	$723,822
FY 24-25 Budget MCR %	94.3%	89.0%	80.6%	99.9%	N/A	92.9%	93.2%
FY 23-24 4+8 FCST MCR%	95.0%	90.6%	79.0%	100.7%	N/A	93.2%	94.1%

FY 2024-25 Budget – Opportunities

- ✓ **CY 2025 Revenue Rates:** Continued rate advocacy efforts with DHCS related to a safety net adjustment and acknowledging acuity of remaining members post redeterminations.

- ✓ **Membership:** Reduce dis-enrollment rates, increase renewals along with overall higher new sales growth for LACC and DSNP segments.

- ✓ **Business Transformation/Sunset Legacy Systems & Processes:** Driving cost savings via administrative value based procurement, selective workforce conversions and realizing efficiency gains due to new systems and processes.
- ✓ **Headcount Management:** Evaluate the effectiveness of incremental staffing on operational metrics and expected cost savings. Resource management relative to like-sized plans, accounting for percentage of delegation.

FY 2024-25 Budget – Risks

- **CY 2025 Rates:** Additional pressure due to overall acuity assumptions, risk adjustment, county-wide averaging, administrative adjustments and/or negative economic development adding pressure to CA general fund.
- **Medi-Cal TRI Rates:** TRI Rates from DHCS less than what LA Care's obligations for payment. There is also a risk of providers not agreeing to the Medi-Cal TRI payments, provider disputes, and LA Care not able to attest by Dec 31, 2024.
- **Covid Testing:** Covid Testing costs are continuing to increase this summer with an uptick in covid cases.
- **Utilization and Unit Cost Trends:** FFS and Capitation trends higher than what is assumed in the budget.
- **Admin Costs:** Exceeding budgetary assumptions due to unplanned/uncontrolled cost.

FY 2024-25 Budget – Balance Sheet Comparison

($ in thousands)	FY 2023-24 4+8 Forecast	FY 2024-25 Budget	Variance
Current Assets			
Cash & cash equivalents	$ 1,517,855	$ 1,207,185	$ (310,670)
Investments, at fair value	2,484,160	2,983,356	499,196
Other current assets	2,832,940	2,844,365	11,425
Total current assets	**6,834,955**	**7,034,906**	**199,951**
Capital and non-current assets	188,473	216,273	216,273
Total Assets	**7,023,428**	**7,251,179**	**416,224**
Current Liabilities			
Medical and providers payable	3,660,903	3,693,809	32,906
Reserves for claims	734,127	736,127	2,000
Other current liabilities	379,464	370,916	(8,548)
Total current liabilities	**4,774,494**	**4,800,852**	**26,358**
Non-Current Liabilities	35,108	35,108	-
Total Liabilities	**4,809,602**	**4,835,960**	**26,358**
Fund Equity			
Invested in Capital Assets	184,044	212,444	28,400
Board Designated Funds	136,266	102,266	(34,000)
Unrestricted Net Assets	1,648,889	1,827,263	178,373
TNE (130% of Required)	244,627	273,247	28,620
Total Fund Equity	**2,213,826**	**2,415,219**	**201,393**
Total Liabilities and Fund Equity	**$ 7,023,428**	**$ 7,251,179**	**$ 227,751**

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Board Designated Funds – Forecast as of Sept. 30, 2024

($ in thousands)

Prior to 2014	Contribution	Expenditure	Estimated Balance at 9/30/2024
Total	225,624	(225,624)	(0)
2014 - Present			
I. Community Health Investment			
CHIF Ad Hoc	8,705	19,480	28,185
Accessible Equipment Fund	450		450
Oral Health Initiative	5,800	(5,745)	55
Tranquada	9,550	(8,950)	600
Safety Net	15,225	(15,225)	-
Access to Service/Close Health Disparities Gap	13,000	(6,270)	6,730
Social/Health determinants	18,200	(16,699)	1,501
Empower/Invest in Health Orgs	2,150	(2,000)	150
LACDHC Flex housing subsidy	20,000	(20,000)	-
Total	93,080	(55,409)	37,671
II. Workforce Development Initiative			
Medical School Scholarship	26,562	(26,562)	-
Medical School Loan Repayment	26,641	(26,641)	-
Primary Care Leadership Program	8,260	(8,260)	-
Residency Support Program	12,232	(12,232)	-
Health Careers Intern and Fellowship Program	800	(800)	-
Provider Recruitment Programs	29,760	(29,760)	-
Elevating the Safety Net	2,000	(2,000)	-
Undesignated	98,595	-	98,595
Total	204,850	(106,255)	98,595
III. CRC Maintenance and Expansion	76,300	(76,300)	(0)
Grand Total	**$ 599,854**	**$ (463,588)**	**$ 136,266**

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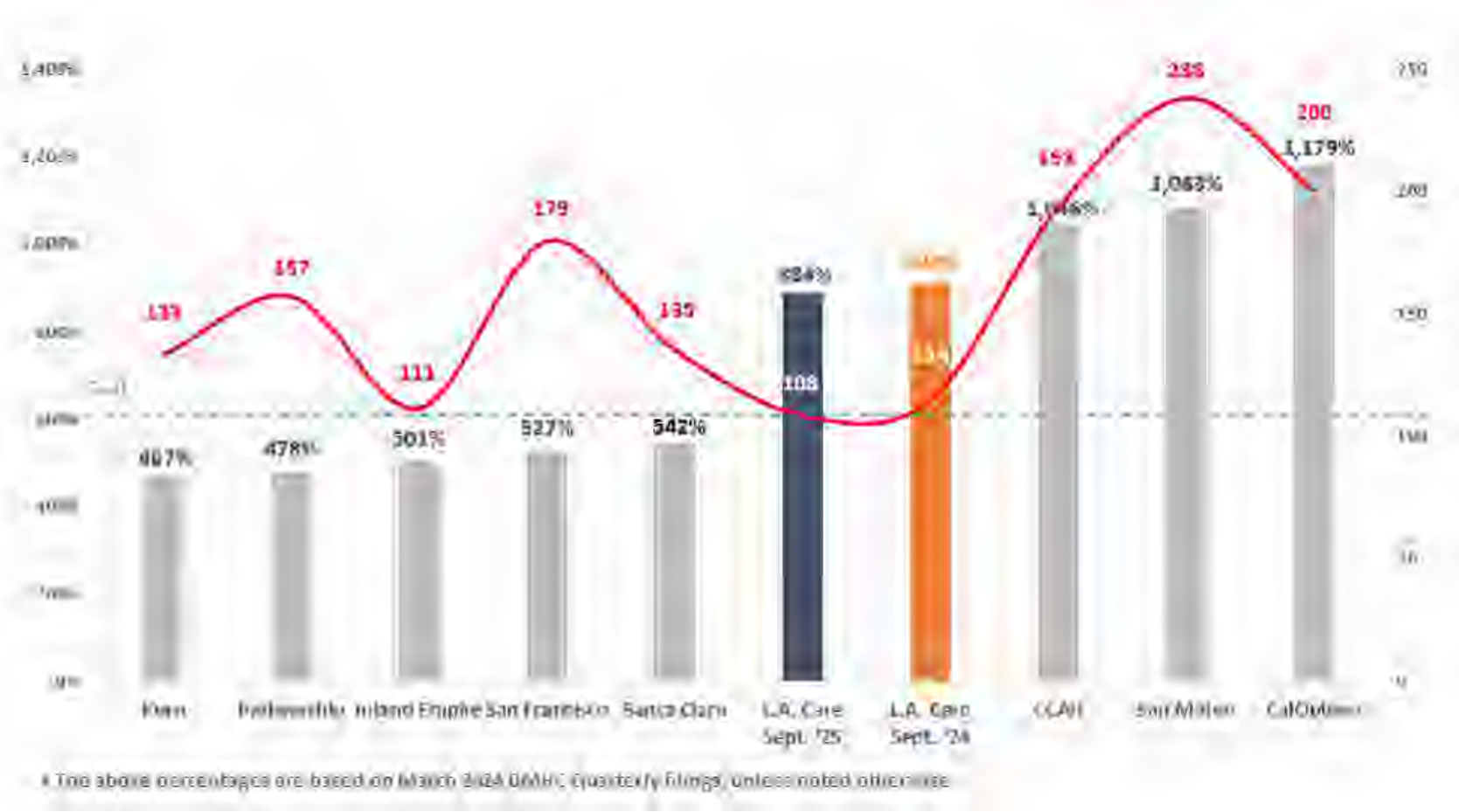
Tangible Net Equity & Days of Cash On-Hand



* The above percentages are based on March 2024 GAAP, quarterly filings, unless noted otherwise

FY 2024-25 Capital Projects and Programs

FY 2024-25 Capital Projects and Programs

L.A. Care Health Plan
Capital Projects
Fiscal Year 2024-25
(In thousands)

Project Description	Business Unit	Capital Expense	Operating Expense	Total
A&G System Replacement	Customer Service	$ 920	$ 230	$ 1,150
Care Catalyst - New HS Clinical System	Health Services	250	250	500
CDR Phase 2	I.T.	1,382	608	1,990
Clinic Based Assignment and FQHC APM	Provider	200	50	250
CMS Interoperability Mandate	I.T.	960	240	1,200
Edifecs Enhancements	Finance	5,348	1,352	6,700
MAPD Product Launch	Product	4,014	1,003	5,017
PQI System Replacement	Health Services	530	163	693
Provider Roadmap	Provider	3,216	920	4,136
SAP/ERP	Finance	1,511	361	1,872
VOICE - CRM & Telecom	I.T. & Operations	9,137	804	9,941
I.T. Member Experience Program	I.T.	7,297	1,804	9,101
Performance Optimization Program (Enterprise & Network)	Compliance	1,820	437	2,257
QNXT Upgrade & Transformation	I.T.	3,263	2,179	5,443
Leasehold Improvements	Facilities	38,415	-	38,415
Total Capital Projects		**$ 78,263**	**$ 10,401**	**$ 88,664**

Portfolio Program Descriptions

A&G System Replacement

The current A&G legacy system (PCT) is outdated, resulting in inefficiencies and reliability issues. To address these challenges, the initiative replaces PCT with a new system that will automate A&G processes, integrate with UM and Claims systems, comply with DMHC, DHCS, and CMS requirements, and eliminate manual processes deficiencies. The new system will enhance workflow controls, productivity, and monitoring, improve information accuracy and timeliness, and support better case intake, letter configuration, and reporting.

Care Catalyst – New Health Services Clinical System

This final component of the Care Catalyst program focuses on ensuring the continued accessibility of historical data from the SyntraNet Utilization Management platform for operational, compliance, audit, and reporting uses. These investments complement functionality being deployed in the QNXT Upgrade & Transformation effort (below), which transform L.A. Care's Utilization Management tools and processes.

Clinical Data Repository (CDR) Phase 2

CDR Phase 2 will be a continued investment in modern data exchange functionality to include Continuity of Care Document (CCD) data. The objective is to develop a real-time CCD data ingestion pipeline from LANES and HIEs to meet regulatory compliance, enhance health plan performance, and improve quality of care for members.

Portfolio Program Descriptions

Clinic Based Assignment and FQHC APM

With the recent, successful implementation of Clinic Based Assignment, L.A. Care can not only assign members directly to specific categories of community clinics, but also gained the necessary infrastructure to participate in the DHCS-mandated Alternative Payment Methodology (APM). Under APM, L.A. Care will change how it pays participating FQHC community clinics to include the Prospective Payment System (PPS) rate for Medi-Cal services that has previously been paid to clinics by the State.

CMS Interoperability Mandate

L.A. Care continues its multi-phase investment in electronic provider and member data portability in accordance with CMS requirements. Investments in 2025 and 2026 focus on payer-to-payer interfaces to ensure timely and efficient benefits coordination and transitions, as well as functionality for electronic prior authorizations.

Edifecs Enhancements

L.A. Care is continuing its iterative improvements of the Edifecs platform, which enables the organization's encounter data management and related regulatory reporting, and that supports risk adjustment activities. Upcoming enhancements target both operational optimizations, as well as compliance with evolving regulatory requirements. Planned investments include the processing of chart review records in Edifecs that do not have correlates in our electronic encounter data received from trading partners; the ability to unbundle mother/infant claims and encounters for the LACC line of business; processing of supplemental dental, vision, chiropractic, and acupuncture data for submission to CMS; inclusion of pharmacy data in outbound encounter reports to CMS; and enhancing the ability to process multi-payer encounter data. The organization is also exploring changes to the hosting arrangement for Edifecs software to maximize operational savings. 508

Portfolio Program Descriptions

Medicare Advantage Prescription Drug (MA-PD) Product Launch

L.A. Care will be offering a new Medicare Advantage Prescription Drug (MA-PD) Plan, with enrollment starting in the fall of 2025, and plan benefits starting January 1, 2026. The MA-PD Product aims to provide continuity of managed care services for members transitioning into Medicare, as well as provide an option for Medicare beneficiaries in L.A. County who do not qualify for the D-SNP Plan. L.A. Care's business and technical teams will be preparing technology systems and business processes throughout the FY 24-25 fiscal year to ensure operational readiness.

PQI System Replacement for Provider Quality Review

The team responsible for Provider Quality Review has lacked a central repository and modern system to support its work. L.A. Care has been building system with modern workflow controls to improve productivity and monitoring of the review process; to reduce delayed, lost, or incongruent information between teams; and to ensure integration with other enterprise systems. With the initial deployment targeted for fall 2024, L.A. Care intends to iteratively enhance the system's capabilities through FY 24-25 to meet the needs of Health Services.

Provider Roadmap

This multi-year initiative centers on the implementation of a holistic provider network management system for L.A. Care's provider business functions. The scope includes improved provider data ingestion, validation, and management, as well as workflow tools and refined business processes. The initiative will enable improved provider data quality, and more efficient operations in contracting, credentialing, network management, provider relations, member assignment, and regulatory reporting.

Portfolio Program Descriptions

SAP/ERP

L.A. Care is continuing its implementation of SAP for financial management functions. The upcoming phase will concentrate on finalizing the deployment of Callidus, a commission software solution that manages incentives and compensation programs for brokers. Additionally, the program will implement Arriba, a spend management tool designed to integration seamlessly with existing SAP procurement solutions. Arriba will enhance electronic order and invoice routing, user and role management functionalities, and contract and vendor management processes.

VOICE - CRM & Telecom

This multi-year program aims to create a robust and integrated Enterprise Customer Relationship Management (CRM) solution that improves the experience of L.A. Care's members and providers. Recent investments have focused on the implementation of a new agent console ('intelligent desktop') for the Call Center and other enterprise users; a new member portal with self-service capabilities; and a new prover portal with self-service capabilities. Following this implementation a subsequent phase will add enhancements across the CRM platform, including the integration of the agent console with our telephony systems, and the onboarding of additional areas of the organization with tailored CRM tools. These tools are expected to include Provider Dispute Resolution (PDR), Quality Improvement, and Pharmacy medication management. The initiative is also making investments in capturing and managing member demographic data aligned with regulatory requirements, such as Race and Ethnicity, Sexual Orientation and Gender Identity, and Alternative Format Selection.

Portfolio Program Descriptions

I.T. Member Experience Program

This initiative is composed of two multi-year, cross-functional programs to modernize data systems and I.T. tools to support an optimized member experience. These foundational technology efforts enable L.A. Care to more proactively manage the member life cycle (from enrollment through care delivery). Work streams in this initiative include Data Architecture Modernization, which improves how enterprise data is organized, managed, and stored; and a Clinical Data Repository (CDR) to better organize clinical experience data in support of care coordination, operational planning, and regulatory reporting. These continued investments will enable L.A. Care to deliver future technology initiatives more effectively, and significantly improve the ability of business areas inside L.A. Care to serve member needs.

Performance Optimization Program (Enterprise & Network)

This multi-year initiative is building data management tools and dashboard reporting tailored to L.A. Care's oversight activities. These investments improve improves monitoring of the performance of non-delegated enterprise functions, as well as entities in L.A. Care's extended service delivery model across lines of business. This initiative is improving data sources and reporting for numerous Key Performance Indicators (KPIs) for L.A. Care.

Portfolio Program Descriptions

QNXT Upgrade & Transformation

L.A. Care is making progressive investments in its core claims platform (QNXT), with current work focused on the implementation of new UM capabilities, as well as meeting Transparency in Coverage requirements. L.A. Care is also laying the foundation for a future move to a cloud implementation, with related efforts to reduce dependence on custom code, as well as completing an incremental upgrade of the software to meet business needs.

Leasehold Improvements

The capital budget includes funds to support construction associated with two Community Resource Centers (CRC), Lincoln Heights (new), Palmdale (relocation), miscellaneous upgrades to existing CRCs and a budget for the build-out of the 1200 W. 7th Street lease space to support the return to work/hybrid office configuration effective January 2025.

Questions & Considerations

Motion

- To accept the Financial Report for the ten months ended July 31, 2024.

Motion

- To recommend the draft FY 2024-25 Operating and Capital Budget for Board consideration.

Informational Items

Investment Transactions

- As of July 31, 2024, L.A. Care's total investment market value was $3.7B
  - $3.6 billion managed by Payden & Rygel and New England Asset Management (NEAM)
  - $88 million in BlackRock Liquidity T-Fund
  - $11 million in Los Angeles County Pooled Investment Fund
  - $6 million in Local Agency Investment Fund

Quarterly Internal Policies Report

L.A. Care
HEALTH PLAN

Board of Governors
MOTION SUMMARY

Date: September 5, 2024 **Motion No. FIN 102.0924**

Committee: Finance & Budget **Chairperson:** Stephanie Booth, MD

Requesting Department: Accounts & Finance Services

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

Issue: Acceptance of the Financial Reports as of July 2024.

Background: N/A

Member Impact: N/A

Budget Impact: N/A

Motion: To accept the Financial Reports as of July 2024, as submitted.

Financial Performance
July 2024
(Unaudited)

Financial Performance Highlights - Year-to-Date

July 2024

Overall (incl. HHIP/IPP)

L.A. Care total YTD combined member months are 26.4M, +539K favorable to forecast. July YTD financial performance resulted in a surplus of +$481M or 5.3% margin and is +$161M/+172bps favorable to forecast. The YTD favorability is driven by higher revenue +$122.2M, lower capitation expense +$104.3M, timing of provider incentives and shared risk +$29.7M, higher net other income +$14.0M, and higher interest income +$6.0M; partially offset by higher skilled nursing ($54.2M), inpatient ($40.0M) and outpatient ($18.2M) claims, and higher operating expenses ($11.3M).

Medi-Cal

Medi-Cal consists of members through our contracted providers and our contracted health plans ("Plan Partners"). July YTD member months are 24.3M, +475K favorable to forecast. July YTD financial performance resulted in a surplus of +$403M or 5.0% margin, +$175.1M/+214bps favorable to forecast. The YTD favorability is driven by lower capitation expense +$103.5M, higher revenue +$92.6M, lower operating expenses +$27.0M, timing of provider incentives and shared risk +$16.0M, higher interest income +$14.7M, and higher other income +$11.1M; partially offset by higher skilled nursing ($49.3M), and outpatient ($32.4M) and inpatient claims ($20.5M).

D-SNP

Effective January 1, 2023, members enrolled in CMC have been transitioned to our D-SNP plan. July YTD member months are 192K, +909 favorable to forecast. July YTD financial performance resulted in a surplus of +$11.9M or 4.1% margin, +$4.4M/+139bps favorable to forecast. The YTD favorability is driven by higher revenue +$13.2M, lower outpatient +$7.5M and inpatient claims +$5.8M, and pharmacy claims +$1.2M; partially offset by timing of provider incentives and shared risk ($7.5M), higher skilled nursing claims ($4.5M), and higher capitation expense ($4.2M).

Commercial

L.A. Care Commercial consists of LACC and PASC-SEIU. July YTD member months are 2.1M, favorable +64K to forecast. July YTD financial performance resulted in a deficit of ($20.6M) or (3.3%) margin, ($45.8M)/(744bps) unfavorable to forecast. The YTD unfavorability is driven by higher operating expenses ($29.0M), higher inpatient ($25.6M) and pharmacy claims ($8.1M), lower net interest income ($7.2M), and timing of provider incentives and shared risk ($3.0M); partially offset by higher revenue +$18.6M, lower capitation expense +$3.1M, and lower outpatient claims +$1.9M.

Incentive Programs

L.A. Care Incentive Programs consist of CalAIM Incentive Payment Program (IPP) and Housing and Homelessness Incentive Program (HHIP). July YTD financial performance resulted in a surplus of +$112.3M, +$28.0M favorable to forecast, primarily driven by the timing of healthcare expenses +$28.4M.

Consolidated Operations Income Statement ($ in thousands)

July 2024

Current Actual	PMPM	Current 4+8 Forecast	PMPM	Current Fav/(Unfav)	PMPM		YTD Actual	PMPM	YTD 4+8 Forecast	PMPM	YTD Fav/(Unfav)	PMPM
						Membership						
2,590,429		2,435,366		155,063		Member Months	26,428,556		25,889,521		539,035	
						Revenue						
$ 925,910	$ 357.44	$ 868,036	$ 356.43	$ 57,874	$ 1.01	Capitation Revenue	$ 9,094,089	$ 344.10	$ 8,971,923	$ 346.55	$ 122,166	$ (2.45)
$ 925,910	**$ 357.44**	**$ 868,036**	**$ 356.43**	**$ 57,874**	**$ 1.01**	**Total Revenues**	**$ 9,094,089**	**$ 344.10**	**$ 8,971,923**	**$ 346.55**	**$ 122,166**	**$ (2.45)**
						Healthcare Expenses						
$ 476,921	$ 184.11	$ 445,920	$ 183.10	$ (31,001)	$ (1.01)	Capitation	$ 4,509,258	$ 170.62	$ 4,613,581	$ 178.20	$ 104,323	$ 7.58
$ 122,707	$ 47.37	$ 116,978	$ 48.03	$ (5,730)	$ 0.66	Inpatient Claims	$ 1,134,063	$ 42.91	$ 1,094,026	$ 42.26	$ (40,037)	$ (0.65)
$ 148,669	$ 57.39	$ 114,788	$ 47.13	$ (33,880)	$ (10.26)	Outpatient Claims	$ 1,135,857	$ 42.98	$ 1,117,672	$ 43.17	$ (18,185)	$ 0.19
$ 108,195	$ 41.77	$ 100,929	$ 41.44	$ (7,266)	$ (0.32)	Skilled Nurse Facility	$ 1,038,622	$ 39.30	$ 984,400	$ 38.02	$ (54,223)	$ (1.28)
$ 18,885	$ 7.29	$ 15,352	$ 6.30	$ (3,533)	$ (0.99)	Pharmacy	$ 155,555	$ 5.89	$ 148,668	$ 5.74	$ (6,887)	$ (0.14)
$ 22,618	$ 8.73	$ 21,229	$ 8.72	$ (1,390)	$ (0.01)	Provider Incentive and Shared Risk	$ 164,840	$ 6.24	$ 194,588	$ 7.52	$ 29,748	$ 1.28
$ 11,444	$ 4.42	$ 11,987	$ 4.92	$ 543	$ 0.50	Medical Administrative Expenses	$ 105,927	$ 4.01	$ 117,762	$ 4.55	$ 11,835	$ 0.54
$ 909,440	**$ 351.08**	**$ 827,182**	**$ 339.65**	**$ (82,257)**	**$ (11.42)**	**Total Healthcare Expenses**	**$ 8,244,122**	**$ 311.94**	**$ 8,270,696**	**$ 319.46**	**$ 26,574**	**$ 7.52**
98.2%		*95.3%*		*(2.9%)*		*MCR (%)*	*90.7%*		*92.2%*		*1.5%*	
$ 16,471	**$ 6.36**	**$ 40,854**	**$ 16.78**	**$ (24,383)**	**$ (10.42)**	**Operating Margin**	**$ 849,967**	**$ 32.16**	**$ 701,227**	**$ 27.09**	**$ 148,740**	**$ 5.08**
$ 57,164	**$ 22.07**	**$ 56,796**	**$ 23.32**	**$ (368)**	**$ 1.25**	**Total Operating Expenses**	**$ 535,373**	**$ 20.26**	**$ 524,067**	**$ 20.24**	**$ (11,306)**	**$ (0.01)**
6.2%		*6.5%*		*0.4%*		*Admin Ratio (%)*	*5.9%*		*5.8%*		*(0.0%)*	
$ (40,693)	**$ (15.71)**	**$ (15,942)**	**$ (6.55)**	**$ (24,751)**	**$ (9.16)**	**Income (Loss) from Operations**	**$ 314,595**	**$ 11.90**	**$ 177,160**	**$ 6.84**	**$ 137,434**	**$ 5.06**
(4.4%)		*(1.8%)*		*(2.6%)*		*Margin before Non-Operating Inc/(Exp) Ratio (%)*	*3.5%*		*2.0%*		*1.5%*	
$ 16,734	$ 6.46	$ 15,774	$ 6.48	$ 960	$ (0.02)	Interest Income,Net	$ 159,060	$ 6.02	$ 153,100	$ 5.91	$ 5,960	$ 0.10
$ (2,488)	$ (0.96)	$ (4,536)	$ (1.86)	$ 2,048	$ 0.90	Other Income (Expense),Net	$ (10,486)	$ (0.40)	$ (24,451)	$ (0.94)	$ 13,965	$ 0.55
$ 304	$ 0.12	$ -	$ -	$ (304)	$ (0.12)	Realized Gain/Loss	$ 2,373	$ 0.09	$ 987	$ 0.04	$ (1,387)	$ (0.05)
$ 6,249	$ 2.41	$ -	$ -	$ 6,249	$ 2.41	Unrealized Gain/Loss	$ 19,716	$ 0.75	$ 14,904	$ 0.58	$ 4,812	$ 0.17
$ 20,190	**$ 7.79**	**$ 11,238**	**$ 4.61**	**$ 8,952**	**3.18**	**Total Non-Operating Income/(Expense)**	**$ 165,937**	**$ 6.28**	**$ 142,587**	**$ 5.51**	**$ 23,350**	**$ 0.77**
$ (20,503)	**$ (7.91)**	**$ (4,704)**	**$ (1.93)**	**$ (15,799)**	**$ (5.98)**	**Net Surplus/(Deficit)**	**$ 480,531**	**$ 18.18**	**$ 319,747**	**$ 12.35**	**$ 160,784**	**$ 5.83**
(2.2%)		*(0.5%)*		*(1.7%)*		*Margin (%)*	*5.3%*		*3.6%*		*1.7%*	

Total Medi-Cal Income Statement ($ in thousands)

July 2024

Current Actual	PMPM	Current 4+8 Forecast	PMPM	Current Fav/(Unfav)	PMPM		YTD Actual	PMPM	YTD 4+8 Forecast	PMPM	YTD Fav/(Unfav)	PMPM
						Membership						
2,354,148		2,217,445		136,703		Member Months	24,305,499		23,830,006		475,493	
						Revenue						
$ 817,556	$ 347.28	$ 755,786	$ 340.84	$ 61,769	$ 6.45	Capitation Revenue	$ 8,038,763	$ 330.74	$ 7,946,114	$ 333.45	$ 92,649	$ (2.71)
$ 817,556	**$ 347.28**	**$ 755,786**	**$ 340.84**	**$ 61,769**	**$ 6.45**	**Total Revenues**	**$ 8,038,763**	**$ 330.74**	**$ 7,946,114**	**$ 333.45**	**$ 92,649**	**$ (2.71)**
						Healthcare Expenses						
$ 443,193	$ 188.26	$ 416,376	$ 187.77	$ (26,817)	$ (0.49)	Capitation	$ 4,231,679	$ 174.10	$ 4,335,152	$ 181.92	$ 103,473	$ 7.82
$ 103,152	$ 43.82	$ 98,263	$ 44.31	$ (4,889)	$ 0.50	Inpatient Claims	$ 955,854	$ 39.33	$ 935,367	$ 39.25	$ (20,487)	$ (0.08)
$ 135,007	$ 57.35	$ 99,004	$ 44.65	$ (36,003)	$ (12.70)	Outpatient Claims	$ 1,016,392	$ 41.82	$ 983,996	$ 41.29	$ (32,396)	$ (0.53)
$ 107,551	$ 45.69	$ 100,929	$ 45.52	$ (6,622)	$ (0.17)	Skilled Nurse Facility	$ 1,030,446	$ 42.40	$ 981,116	$ 41.17	$ (49,330)	$ (1.22)
$ 4	$ 0.00	$ -	$ -	$ (4)	$ (0.00)	Pharmacy	$ 176	$ 0.01	$ 141	$ 0.01	$ (36)	$ (0.00)
$ 6,754	$ 2.87	$ 9,956	$ 4.49	$ 3,203	$ 1.62	Provider Incentive and Shared Risk	$ 98,625	$ 4.06	$ 114,642	$ 4.81	$ 16,017	$ 0.75
$ 10,159	$ 4.32	$ 10,673	$ 4.81	$ 515	$ 0.50	Medical Administrative Expenses	$ 97,232	$ 4.00	$ 106,170	$ 4.46	$ 8,938	$ 0.45
$ 805,819	**$ 342.30**	**$ 735,201**	**$ 331.55**	**$ (70,618)**	**$ (10.74)**	**Total Healthcare Expenses**	**$ 7,430,405**	**$ 305.71**	**$ 7,456,584**	**$ 312.91**	**$ 26,179**	**$ 7.20**
98.6%		*97.3%*		*(1.3%)*		*MCR (%)*	*92.4%*		*93.8%*		*1.4%*	
$ 11,737	**$ 4.99**	**$ 20,585**	**$ 9.28**	**$ (8,848)**	**$ (4.30)**	**Operating Margin**	**$ 608,359**	**$ 25.03**	**$ 489,530**	**$ 20.54**	**$ 118,829**	**$ 4.49**
$ 41,376	**$ 17.58**	**$ 43,447**	**$ 19.59**	**$ 2,071**	**$ 2.02**	**Total Operating Expenses**	**$ 390,178**	**$ 16.05**	**$ 417,217**	**$ 17.51**	**$ 27,039**	**$ 1.45**
5.1%		*5.7%*		*0.7%*		*Admin Ratio (%)*	*4.9%*		*5.3%*		*0.4%*	
$ (29,640)	**$ (12.59)**	**$ (22,862)**	**$ (10.31)**	**$ (6,778)**	**$ (2.28)**	**Income (Loss) from Operations**	**$ 218,181**	**$ 8.98**	**$ 72,313**	**$ 3.03**	**$ 145,867**	**$ 5.94**
(3.6%)		*(3.0%)*		*(0.6%)*		*Margin before Non-Operating Inc/(Exp) Ratio (%)*	*2.7%*		*0.9%*		*1.8%*	
$ 16,347	$ 6.94	$ 14,191	$ 6.40	$ 2,156	$ 0.54	Interest Income,Net	$ 155,313	$ 6.39	$ 140,634	$ 5.90	$ 14,680	$ 0.49
$ 1,536	$ 0.65	$ (1,470)	$ (0.66)	$ 3,006	$ 1.32	Other Income (Expense),Net	$ 12,520	$ 0.52	$ 1,419	$ 0.06	$ 11,101	$ 0.46
$ 297	$ 0.13	$ -	$ -	$ (297)	$ (0.13)	Realized Gain/Loss	$ 2,318	$ 0.10	$ 940	$ 0.04	$ (1,378)	$ (0.06)
$ 6,104	$ 2.59	$ -	$ -	$ 6,104	$ 2.59	Unrealized Gain/Loss	$ 19,267	$ 0.79	$ 14,460	$ 0.61	$ 4,807	$ 0.19
$ 23,690	**$ 10.06**	**$ 12,721**	**$ 5.74**	**$ 10,969**	**4.33**	**Total Non-Operating Income/(Expense)**	**$ 184,802**	**$ 7.60**	**$ 155,592**	**$ 6.53**	**$ 29,210**	**$ 1.07**
$ (5,950)	**$ (2.53)**	**$ (10,141)**	**$ (4.57)**	**$ 4,191**	**$ 2.05**	**Net Surplus/(Deficit)**	**$ 402,983**	**$ 16.58**	**$ 227,905**	**$ 9.56**	**$ 175,077**	**$ 7.02**
(0.7%)		*(1.3%)*		*0.6%*		*Margin (%)*	*5.0%*		*2.9%*		*2.1%*	

DSNP Income Statement ($ in thousands) **July 2024**

Current Actual	PMPM	Current 4+8 Forecast	PMPM	Current Fav/(Unfav)	PMPM		YTD Actual	PMPM	YTD 4+8 Forecast	PMPM	YTD Fav/(Unfav)	PMPM
						Membership						
19,703		19,591		112		Member Months	191,618		190,709		909	
						Revenue						
$ 32,108	$ 1,629.59	$ 28,387	$ 1,448.98	$ 3,721	$ 180.62	Capitation Revenue	$ 287,880	$ 1,502.36	$ 274,639	$ 1,440.09	$ 13,241	$ 62.27
$ 32,108	**$ 1,629.59**	**$ 28,387**	**$ 1,448.98**	**$ 3,721**	**$ 180.62**	**Total Revenues**	**$ 287,880**	**$ 1,502.36**	**$ 274,639**	**$ 1,440.09**	**$ 13,241**	**$ 62.27**
						Healthcare Expenses						
$ 14,411	$ 731.41	$ 10,701	$ 546.22	$ (3,710)	$ (185.19)	Capitation	$ 106,667	$ 556.67	$ 102,501	$ 537.47	$ (4,166)	$ (19.19)
$ 7,666	$ 389.09	$ 7,645	$ 390.21	$ (21)	$ 1.13	Inpatient Claims	$ 60,741	$ 316.99	$ 66,546	$ 348.94	$ 5,805	$ 31.95
$ 3,744	$ 190.01	$ 4,868	$ 248.46	$ 1,124	$ 58.45	Outpatient Claims	$ 33,333	$ 173.96	$ 40,848	$ 214.19	$ 7,515	$ 40.24
$ 539	$ 27.35	$ -	$ -	$ (539)	$ (27.35)	Skilled Nurse Facility	$ 7,265	$ 37.91	$ 2,808	$ 14.73	$ (4,456)	$ (23.19)
$ 528	$ 26.78	$ 1,253	$ 63.96	$ 725	$ 37.18	Pharmacy	$ 11,715	$ 61.14	$ 12,948	$ 67.90	$ 1,234	$ 6.76
$ 2,135	$ 108.37	$ 2,315	$ 118.15	$ 180	$ 9.78	Provider Incentive and Shared Risk	$ 25,741	$ 134.34	$ 18,235	$ 95.62	$ (7,506)	$ (38.72)
$ 363	$ 18.40	$ 188	$ 9.61	$ (174)	$ (8.79)	Medical Administrative Expenses	$ 3,427	$ 17.89	$ 2,286	$ 11.98	$ (1,142)	$ (5.90)
$ 29,385	**$ 1,491.41**	**$ 26,969**	**$ 1,376.62**	**$ (2,416)**	**$ (114.79)**	**Total Healthcare Expenses**	**$ 248,890**	**$ 1,298.88**	**$ 246,173**	**$ 1,290.83**	**$ (2,717)**	**$ (8.05)**
91.5%		*95.0%*		*3.5%*		*MCR (%)*	*86.5%*		*89.6%*		*3.2%*	
$ 2,723	**$ 138.19**	**$ 1,418**	**$ 72.36**	**$ 1,305**	**$ 65.82**	**Operating Margin**	**$ 38,990**	**$ 203.48**	**$ 28,466**	**$ 149.26**	**$ 10,525**	**$ 54.22**
$ 620	**$ 31.44**	**$ 2,886**	**$ 147.30**	**$ 2,266**	**$ 115.86**	**Total Operating Expenses**	**$ 31,277**	**$ 163.22**	**$ 24,957**	**$ 130.86**	**$ (6,320)**	**$ (32.36)**
1.9%		*10.2%*		*8.2%*		*Admin Ratio (%)*	*10.9%*		*9.1%*		*(1.8%)*	
$ 2,103	**$ 106.74**	**$ (1,468)**	**$ (74.94)**	**$ 3,571**	**$ 181.68**	**Income (Loss) from Operations**	**$ 7,714**	**$ 40.26**	**$ 3,509**	**$ 18.40**	**$ 4,205**	**$ 21.86**
6.6%		*(5.2%)*		*11.7%*		*Margin before Non-Operating Inc/(Exp) Ratio (%)*	*2.7%*		*1.3%*		*1.4%*	
$ 387	$ 19.62	$ 385	$ 19.66	$ 1	$ (0.05)	Interest Income,Net	$ 3,743	$ 19.53	$ 3,665	$ 19.22	$ 78	$ 0.31
$ 1	$ 0.07	$ -	$ -	$ 1	$ 0.07	Other Income (Expense),Net	$ 16	$ 0.08	$ 0	$ 0.00	$ 16	$ 0.08
$ 7	$ 0.36	$ -	$ -	$ (7)	$ (0.36)	Realized Gain/Loss	$ 56	$ 0.29	$ 23	$ 0.12	$ (33)	$ (0.17)
$ 144	$ 7.33	$ -	$ -	$ 144	$ 7.33	Unrealized Gain/Loss	$ 449	$ 2.34	$ 344	$ 1.81	$ 104	$ 0.54
$ 525	**$ 26.66**	**$ 385**	**$ 19.66**	**$ 140**	**6.99**	**Total Non-Operating Income/(Expense)**	**$ 4,152**	**$ 21.67**	**$ 3,988**	**$ 20.91**	**$ 165**	**$ 0.76**
$ 2,628	**$ 133.40**	**$ (1,083)**	**$ (55.28)**	**$ 3,711**	**$ 188.68**	**Net Surplus/(Deficit)**	**$ 11,866**	**$ 61.92**	**$ 7,496**	**$ 39.31**	**$ 4,370**	**$ 22.62**
8.2%		*(3.8%)*		*12.0%*		*Margin (%)*	*4.1%*		*2.7%*		*1.4%*	

Commercial Income Statement ($ in thousands)

July 2024

Current Actual	PMPM	Current 4+8 Forecast	PMPM	Current Fav/(Unfav)	PMPM		YTD Actual	PMPM	YTD 4+8 Forecast	PMPM	YTD Fav/(Unfav)	PMPM
						Membership						
236,281		217,921		18,360		Member Months	2,123,057		2,059,515		63,542	
						Revenue						
$ 76,246	$ 322.69	$ 67,306	$ 308.86	$ 8,940	$ 13.84	Capitation Revenue	$ 626,074	$ 294.89	$ 607,502	$ 294.97	$ 18,572	$ (0.08)
$ 76,246	**$ 322.69**	**$ 67,306**	**$ 308.86**	**$ 8,940**	**$ 13.84**	**Total Revenues**	**$ 626,074**	**$ 294.89**	**$ 607,502**	**$ 294.97**	**$ 18,572**	**$ (0.08)**
						Healthcare Expenses						
$ 19,317	$ 81.76	$ 18,843	$ 86.47	$ (475)	$ 4.71	Capitation	$ 172,548	$ 81.27	$ 175,678	$ 85.30	$ 3,130	$ 4.03
$ 11,890	$ 50.32	$ 11,070	$ 50.80	$ (820)	$ 0.48	Inpatient Claims	$ 118,608	$ 55.87	$ 92,963	$ 45.14	$ (25,645)	$ (10.73)
$ 9,943	$ 42.08	$ 10,084	$ 46.27	$ 140	$ 4.19	Outpatient Claims	$ 86,062	$ 40.54	$ 87,981	$ 42.72	$ 1,919	$ 2.18
$ 105	$ 0.45	$ -	$ -	$ (105)	$ (0.45)	Skilled Nurse Facility	$ 1,122	$ 0.53	$ 581	$ 0.28	$ (542)	$ (0.25)
$ 18,348	$ 77.65	$ 14,099	$ 64.70	$ (4,249)	$ (12.96)	Pharmacy	$ 143,300	$ 67.50	$ 135,225	$ 65.66	$ (8,076)	$ (1.84)
$ 1,117	$ 4.73	$ 1,263	$ 5.80	$ 146	$ 1.07	Provider Incentive and Shared Risk	$ 12,816	$ 6.04	$ 9,796	$ 4.76	$ (3,019)	$ (1.28)
$ 923	$ 3.91	$ 1,126	$ 5.17	$ 202	$ 1.26	Medical Administrative Expenses	$ 5,267	$ 2.48	$ 9,306	$ 4.52	$ 4,039	$ 2.04
$ 61,644	**$ 260.89**	**$ 56,484**	**$ 259.19**	**$ (5,160)**	**$ (1.70)**	**Total Healthcare Expenses**	**$ 539,724**	**$ 254.22**	**$ 511,530**	**$ 248.37**	**$ (28,193)**	**$ (5.85)**
80.8%		*83.9%*		*3.1%*		*MCR (%)*	*86.2%*		*84.2%*		*(2.0%)*	
$ 14,602	**$ 61.80**	**$ 10,823**	**$ 49.66**	**$ 3,780**	**$ 12.14**	**Operating Margin**	**$ 86,351**	**$ 40.67**	**$ 95,972**	**$ 46.60**	**$ (9,621)**	**$ (5.93)**
$ 14,027	**$ 59.36**	**$ 10,019**	**$ 45.98**	**$ (4,007)**	**$ (13.39)**	**Total Operating Expenses**	**$ 106,631**	**$ 50.23**	**$ 77,619**	**$ 37.69**	**$ (29,012)**	**$ (12.54)**
18.4%		*14.9%*		*(3.5%)*		*Admin Ratio (%)*	*17.0%*		*12.8%*		*(4.3%)*	
$ 575	**$ 2.44**	**$ 803**	**$ 3.69**	**$ (228)**	**$ (1.25)**	**Income (Loss) from Operations**	**$ (20,280)**	**$ (9.55)**	**$ 18,353**	**$ 8.91**	**$ (38,633)**	**$ (18.46)**
0.8%		*1.2%*		*(0.4%)*		*Margin before Non-Operating Inc/(Exp) Ratio (%)*	*(3.2%)*		*3.0%*		*(6.3%)*	
$ 1	$ 0.00	$ 1,198	$ 5.50	$ (1,198)	$ (5.50)	Interest Income,Net	$ 4	$ 0.00	$ 7,184	$ 3.49	$ (7,180)	$ (3.49)
$ (17)	$ (0.07)	$ (17)	$ (0.08)	$ -	$ 0.01	Other Income (Expense),Net	$ (279)	$ (0.13)	$ (279)	$ (0.14)	$ -	$ 0.00
$ -	$ -	$ -	$ -	$ -	$ -	Realized Gain/Loss	$ -	$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -	$ -	Unrealized Gain/Loss	$ -	$ -	$ -	$ -	$ -	$ -
$ (17)	**$ (0.07)**	**$ 1,181**	**$ 5.42**	**$ (1,198)**	**(5.49)**	**Total Non-Operating Income/(Expense)**	**$ (275)**	**$ (0.13)**	**$ 6,905**	**$ 3.35**	**$ (7,180)**	**$ (3.48)**
$ 558	**$ 2.36**	**$ 1,984**	**$ 9.10**	**$ (1,425)**	**$ (6.74)**	**Net Surplus/(Deficit)**	**$ (20,555)**	**$ (9.68)**	**$ 25,258**	**$ 12.26**	**$ (45,813)**	**$ (21.95)**
0.7%		*2.9%*		*(2.2%)*		*Margin (%)*	*(3.3%)*		*4.2%*		*(7.4%)*	

Incentive Programs Income Statement ($ in thousands)

July 2024

Current Actual	PMPM	Current 4+8 Forecast	PMPM	Current 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	$ 143,226	$ -	$ 143,337	$ -	$ (110)	$ -
$ -	**$ -**	**$ 16,556**	**$ -**	**$ (16,556)**	**$ -**	**Total Revenues**	**$ 143,226**	**$ -**	**$ 143,337**	**$ -**	**$ (110)**	**$ -**
						Healthcare Expenses						
$ -	$ -	$ -	$ -	$ -	$ -	Capitation	$ -	$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -	$ -	Inpatient Claims	$ -	$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ 833	$ -	$ 833	$ -	Outpatient Claims	$ -	$ -	$ 5,000	$ -	$ 5,000	$ -
$ -	$ -	$ -	$ -	$ -	$ -	Skilled Nurse Facility	$ -	$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -	$ -	Pharmacy	$ -	$ -	$ -	$ -	$ -	$ -
$ 12,612	$ -	$ 7,694	$ -	$ (4,918)	$ -	Provider Incentive and Shared Risk	$ 28,487	$ -	$ 51,914	$ -	$ 23,427	$ -
$ -	$ -	$ -	$ -	$ -	$ -	Medical Administrative Expenses	$ -	$ -	$ -	$ -	$ -	$ -
$ 12,612	**$ -**	**$ 8,528**	**$ -**	**$ (4,084)**	**$ -**	**Total Healthcare Expenses**	**$ 28,487**	**$ -**	**$ 56,914**	**$ -**	**$ 28,427**	**$ -**
0.0%		*51.5%*		*51.5%*		*MCR (%)*	*19.9%*		*39.7%*		*19.8%*	
$ (12,612)	**$ -**	**$ 8,029**	**$ -**	**$ (20,641)**	**$ -**	**Operating Margin**	**$ 114,739**	**$ -**	**$ 86,422**	**$ -**	**$ 28,317**	**$ -**
$ 332	**$ -**	**$ 205**	**$ -**	**$ (127)**	**$ -**	**Total Operating Expenses**	**$ 2,484**	**$ -**	**$ 2,141**	**$ -**	**$ (343)**	**$ -**
0.0%		*1.2%*		*1.2%*		*Admin Ratio (%)*	*1.7%*		*1.5%*		*(0.2%)*	
$ (12,944)	**$ -**	**$ 7,824**	**$ -**	**$ (20,768)**	**$ -**	**Income (Loss) from Operations**	**$ 112,255**	**$ -**	**$ 84,281**	**$ -**	**$ 27,975**	**$ -**
0.0%		*47.3%*		*(47.3%)*		*Margin before Non-Operating Inc/(Exp) Ratio (%)*	*78.4%*		*58.8%*		*19.6%*	
$ -	$ -	$ -	$ -	$ -	$ -	Interest Income,Net	$ -	$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -	$ -	Other Income (Expense),Net	$ -	$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -	$ -	Realized Gain/Loss	$ -	$ -	$ -	$ -	$ -	$ -
$ -	$ -	$ -	$ -	$ -	$ -	Unrealized Gain/Loss	$ -	$ -	$ -	$ -	$ -	$ -
$ -	**$ -**	**$ -**	**$ -**	**$ -**	**-**	**Total Non-Operating Income/(Expense)**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
$ (12,944)	**$ -**	**$ 7,824**	**$ -**	**$ (20,768)**	**$ -**	**Net Surplus/(Deficit)**	**$ 112,255**	**$ -**	**$ 84,281**	**$ -**	**$ 27,975**	**$ -**
0.0%		*47.3%*		*(47.3%)*		*Margin (%)*	*78.4%*		*58.8%*		*19.6%*	

Balance Sheet ($ in thousands)

Fiscal Year 2023-24

	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Assets										
Cash and Cash Equivalents	$ 1,215,928	$ 1,164,685	$ 1,050,823	$ 1,300,559	$ 1,457,922	$ 1,724,269	$ 1,543,191	$ 1,159,185	$ 867,797	$ 880,576
Short Term Investments, at fair value	$ 1,858,223	$ 2,006,373	$ 2,298,594	$ 2,203,165	$ 2,494,863	$ 2,799,085	$ 2,568,822	$ 2,555,603	$ 2,799,586	$ 2,675,073
Capitation Receivable	$ 3,182,445	$ 3,233,165	$ 3,152,661	$ 2,907,187	$ 3,022,046	$ 2,587,481	$ 2,525,481	$ 2,587,709	$ 2,693,894	$ 2,690,751
Interest and Non-Operating Receivables	$ 40,813	$ 6,752	$ 423,494	$ 472,216	$ 515,539	$ 567,924	$ 239,392	$ 110,212	$ 104,680	$ 87,213
Prepaids and Other Current Assets	$ 18,325	$ 16,145	$ 27,978	$ 33,486	$ 33,847	$ 63,688	$ 63,007	$ 43,180	$ 43,476	$ 33,730
Current Assets	**$ 6,315,735**	**$ 6,427,120**	**$ 6,953,551**	**$ 6,916,612**	**$ 7,524,217**	**$ 7,742,447**	**$ 6,939,893**	**$ 6,455,888**	**$ 6,509,433**	**$ 6,367,344**
Capitalized Assets - net	$ 168,137	$ 166,800	$ 163,264	$ 160,379	$ 161,628	$ 161,758	$ 160,634	$ 157,917	$ 156,927	$ 157,512
Non-Current Assets	$ 3,071	$ 2,901	$ 2,744	$ 1,744	$ 1,765	$ 2,917	$ 2,769	$ 5,229	$ 27,725	$ 27,495
Total Assets	**$ 6,486,942**	**$ 6,596,822**	**$ 7,119,560**	**$ 7,078,735**	**$ 7,687,611**	**$ 7,907,122**	**$ 7,103,296**	**$ 6,619,034**	**$ 6,694,086**	**$ 6,552,351**
Liabilities & Equity										
Liabilities										
Accounts Payable and Accrued Liabilities	$ 175,928	$ 187,262	$ 551,099	$ 598,049	$ 489,004	$ 398,097	$ 316,924	$ 241,720	$ 285,992	$ 205,098
Subcapitation Payable	$ 3,110,125	$ 3,153,507	$ 3,258,876	$ 3,194,511	$ 3,214,279	$ 3,130,550	$ 3,009,663	$ 2,978,540	$ 2,925,553	$ 2,941,454
Accts Receivable - PP	$ 2	$ 2	$ 1	$ 1	$ 1	$ 1	$ 1	$ 1	$ 1	$ 1
Reserve for Claims	$ 819,965	$ 827,368	$ 867,307	$ 851,802	$ 809,922	$ 829,146	$ 769,022	$ 733,127	$ 788,631	$ 718,477
Accrued Medical Expenses	$ 271,671	$ 266,999	$ 269,172	$ 211,542	$ 212,239	$ 199,114	$ 188,898	$ 195,703	$ 185,086	$ 190,115
Deferred Revenue	$ 69,446	$ 64,958	$ 38,107	$ 76,179	$ 138,196	$ 131,722	$ 156,957	$ 123,676	$ 71,999	$ 92,004
Reserve for Provider Incentives	$ 109,889	$ 114,474	$ 78,126	$ 67,785	$ 60,283	$ 60,905	$ 68,956	$ 99,527	$ 108,272	$ 115,768
Non-Operating Payables	$ 33,097	$ 29,341	$ 9,667	$ (19,112)	$ 645,902	$ 998,941	$ 379,332	$ 46,155	$ 44,440	$ 27,469
Grants Payable	$ 18,094	$ 16,769	$ 17,968	$ 17,443	$ 16,955	$ 17,855	$ 17,143	$ 18,381	$ 16,318	$ 16,232
Deferred Rent	$ 48,456	$ 45,243	$ 43,553	$ 41,868	$ 40,104	$ 38,434	$ 36,768	$ 35,108	$ 33,467	$ 31,909
Total Current Liabilities	**$ 4,656,673**	**$ 4,705,923**	**$ 5,133,874**	**$ 5,040,067**	**$ 5,626,885**	**$ 5,804,764**	**$ 4,943,664**	**$ 4,471,938**	**$ 4,459,759**	**$ 4,338,527**
Equity										
Invested in Capital Assets, Net of related dep	$ 99,218	$ 99,259	$ 97,349	$ 99,507	$ 103,953	$ 105,544	$ 105,848	$ 104,546	$ 104,659	$ 106,745
Restricted Equity	$ 600	$ 600	$ 600	$ 600	$ 600	$ 600	$ 600	$ 600	$ 23,327	$ 23,327
Minimum Tangible Net Equity	$ 235,945	$ 235,089	$ 238,050	$ 236,840	$ 238,550	$ 240,896	$ 242,796	$ 240,282	$ 238,065	$ 243,760
Board Designated Funds	$ 143,902	$ 142,476	$ 147,962	$ 145,172	$ 143,248	$ 141,795	$ 140,281	$ 136,265	$ 134,842	$ 131,525
Unrestricted Net Assets	$ 1,350,604	$ 1,413,475	$ 1,501,725	$ 1,556,550	$ 1,574,375	$ 1,613,522	$ 1,670,106	$ 1,665,402	$ 1,733,435	$ 1,708,467
Total Equity	**$ 1,830,268**	**$ 1,890,899**	**$ 1,985,685**	**$ 2,038,668**	**$ 2,060,725**	**$ 2,102,358**	**$ 2,159,631**	**$ 2,147,096**	**$ 2,234,328**	**$ 2,213,824**
Total Liabilities & Equity	**$ 6,486,942**	**$ 6,596,822**	**$ 7,119,560**	**$ 7,078,735**	**$ 7,687,611**	**$ 7,907,122**	**$ 7,103,296**	**$ 6,619,034**	**$ 6,694,086**	**$ 6,552,351**
Solvency Ratios										
Working Capital Ratio	1.37	1.38	1.37	1.38	1.35	1.34	1.41	1.46	1.47	1.48
Cash to Claims Ratio	0.78	0.80	0.81	0.87	0.98	1.14	1.09	1.00	0.99	0.97
Tangible Net Equity Ratio	7.76	8.04	8.34	8.61	8.64	8.73	8.89	8.94	9.39	9.08

Cash Flows Statement ($ in thousands)

July 2024

	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	YTD
Cash Flows from Operating Activities:											
Capitation Revenue	$ 841,537	$ 878,375	$ 1,020,197	$ 1,056,193	$ 814,382	$ 1,358,785	$ 951,617	$ 816,743	$ 767,921	$ 954,143	$ 9,459,893
Other Income (Expense), net	$ 19,423	$ 8,321	$ 3,604	$ 13,760	$ 11,212	$ 8,470	$ 24,067	$ 14,830	$ 10,554	$ 13,754	$ 127,995
Healthcare Expenses	$ (846,331)	$ (796,846)	$ (739,718)	$ (808,174)	$ (835,771)	$ (935,164)	$ (949,577)	$ (906,580)	$ (801,437)	$ (956,252)	$ (8,575,850)
Operating Expenses	$ (36,472)	$ (29,715)	$ (75,466)	$ (48,204)	$ (51,472)	$ (83,534)	$ (48,528)	$ (35,942)	$ (49,877)	$ (40,567)	$ (499,777)
Net Cash Provided By Operating Activities	**$ (21,843)**	**$ 60,135**	**$ 208,617**	**$ 213,575**	**$ (61,649)**	**$ 348,557**	**$ (22,421)**	**$ (110,949)**	**$ (72,839)**	**$ (28,922)**	**$ 512,261**
Cash Flows from Investing Activities											
Purchase of investments - Net	$ (67,389)	$ (137,165)	$ (285,931)	$ 96,186	$ (295,798)	$ (303,696)	$ 226,577	$ 16,064	$ (264,816)	$ 130,457	$ (885,511)
Purchase of Capital Assets	$ (3,065)	$ (2,368)	$ (161)	$ (4,646)	$ (5,605)	$ (4,599)	$ (3,071)	$ (1,554)	$ (2,771)	$ (4,476)	$ (32,316)
Net Cash Provided By Investing Activities	**$ (70,454)**	**$ (139,533)**	**$ (286,092)**	**$ 91,540**	**$ (301,403)**	**$ (308,295)**	**$ 223,506**	**$ 14,510**	**$ (267,587)**	**$ 125,981**	**$ (917,827)**
Cash Flows from Financing Activities:											
Lease Payment - Capital & ROU	$ (1,546)	$ (1,377)	$ (1,505)	$ (1,502)	$ (1,367)	$ (1,462)	$ (1,428)	$ (1,415)	$ (1,389)	$ (1,520)	$ (14,511)
SBITA Liabilty Increase / (Decrease)	$ -	$ -	$ -	$ -	$ 188	$ 29	$ 26	$ 23	$ 21	$ 19	$ 306
Gross Premium Tax (MCO Sales Tax) - Net		$ 33,288	$ (15,208)	$ (25,099)	$ (143,420)	$ (125,521)	$ 238,848	$ 47,001	$ 52,121	$ (82,437)	$ (20,427)
Pass through transactions (AB 85, IGT, etc.)	$ (269,155)	$ (3,756)	$ (19,674)	$ (28,779)	$ 665,014	$ 353,039	$ (619,609)	$ (333,176)	$ (1,715)	$ (414)	$ (258,225)
Net Cash Provided By Financing Activities	**$ (270,701)**	**$ 28,155**	**$ (36,387)**	**$ (55,380)**	**$ 520,415**	**$ 226,085**	**$ (382,163)**	**$ (287,567)**	**$ 49,038**	**$ (84,352)**	**$ (292,857)**
Net Increase in Cash and Cash Equivalents	**$ (362,998)**	**$ (51,243)**	**$ (113,862)**	**$ 249,735**	**$ 157,363**	**$ 266,347**	**$ (181,078)**	**$ (384,006)**	**$ (291,388)**	**$ 12,707**	**$ (698,423)**
Cash and Cash Equivalents, Beginning	$ 1,578,927	$ 1,215,929	$ 1,164,686	$ 1,050,824	$ 1,300,559	$ 1,457,922	$ 1,724,269	$ 1,543,191	$ 1,159,185	$ 867,797	$ 1,578,927
Cash and Cash Equivalents, Ending	**$ 1,215,929**	**$ 1,164,686**	**$ 1,050,824**	**$ 1,300,559**	**$ 1,457,922**	**$ 1,724,269**	**$ 1,543,191**	**$ 1,159,185**	**$ 867,797**	**$ 880,504**	**$ 880,504**
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**	**$ 41,633**	**$ 57,273**	**$ (12,536)**	**$ 87,232**	**$ (20,503)**	**$ 480,531**
Adjustments to Excess of Revenues Over Expenses:											
Depreciation	$ 4,181	$ 3,715	$ 3,697	$ 7,531	$ 4,356	$ 4,469	$ 4,196	$ 4,271	$ 3,760	$ 3,892	$ 44,068
Realized and Unrealized (Gain)/Loss on Investments	$ 868	$ (7,749)	$ (6,291)	$ (756)	$ 4,099	$ (525)	$ 3,685	$ (3,146)	$ (1,593)	$ (5,944)	$ (17,352)
Deferred Rent	$ 50	$ (6)	$ 50	$ 50		$ -	$ -			$ -	$ 144
Gross Premium Tax provision	$ (1)	$ (2)	$ 2	$ (1,187)	$ (1,765)	$ (2,330)	$ (2,339)	$ (1,559)	$ (1,531)	$ (1,460)	$ (12,172)
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**	**$ 1,614**	**$ 5,542**	**$ (434)**	**$ 636**	**$ (3,512)**	**$ 14,678**
Changes in Operating Assets and Liabilities:											
Capitation Receivable	$ (92,525)	$ (53,272)	$ (1,340,639)	$ 1,635,640	$ (120,052)	$ 445,473	$ 38,669	$ (56,954)	$ (102,379)	$ 6,986	$ 360,947
Interest and Non-Operating Receivables	$ 4,753	$ (2,462)	$ (7,465)	$ 1,386	$ 321	$ (8,149)	$ 8,342	$ 359	$ (3,479)	$ 1,055	$ (5,339)
Prepaid and Other Current Assets	$ 4,508	$ 4,901	$ (12,882)	$ (5,512)	$ 4,812	$ (41,969)	$ 24,161	$ 12,094	$ (3,913)	$ 6,132	$ (7,668)
Accounts Payable and Accrued Liabilities	$ 4,634	$ 9,503	$ (12,961)	$ 4,877	$ (8,089)	$ (7,463)	$ 2,245	$ 8,208	$ 2,159	$ 2,729	$ 5,842
Subcapitation Payable	$ (13,634)	$ 43,487	$ 105,367	$ (30,666)	$ 19,768	$ (83,730)	$ (120,887)	$ (31,123)	$ (52,987)	$ 15,900	$ (148,505)
MediCal Adult Expansion Payable		$ (104)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1	$ (103)
Deferred Capitation Revenue	$ (18,967)	$ (3,952)	$ 1,377,508	$ (1,366,774)	$ 62,024	$ (6,481)	$ 25,242	$ (32,779)	$ (52,211)	$ 21,246	$ 4,856
Accrued Medical Expenses	$ 6,124	$ (5,208)	$ 2,656	$ (57,626)	$ 690	$ (13,118)	$ (10,223)	$ 6,303	$ (10,083)	$ 3,788	$ (76,697)
Reserve for Claims	$ (22,643)	$ 7,403	$ 39,939	$ (15,505)	$ (41,880)	$ 19,225	$ (60,124)	$ (35,896)	$ 55,504	$ (70,154)	$ (124,131)
Reserve for Provider Incentives	$ 5,038	$ 4,586	$ (36,349)	$ (10,341)	$ (7,502)	$ 622	$ 8,051	$ 30,571	$ 8,745	$ 7,496	$ 10,917
Grants Payable	$ (1,205)	$ (1,325)	$ 1,199	$ (525)	$ (488)	$ 900	$ (712)	$ 1,238	$ (2,063)	$ (86)	$ (3,067)
Net Changes in Operating Assets and Liabilities	**$ (123,917)**	**$ 3,557**	**$ 116,373**	**$ 154,954**	**$ (90,396)**	**$ 305,310**	**$ (85,236)**	**$ (97,979)**	**$ (160,707)**	**$ (4,907)**	**$ 17,052**
Net Cash Provided By Operating Activities	**$ (21,843)**	**$ 60,135**	**$ 208,617**	**$ 213,575**	**$ (61,649)**	**$ 348,557**	**$ (22,421)**	**$ (110,949)**	**$ (72,839)**	**$ (28,922)**	**$ 512,261**

L.A. Care
HEALTH PLAN

Board of Governors
MOTION SUMMARY

Date: September 5, 2024 **Motion No. FIN 103.0924**

Committee: Finance & Budget **Chairperson:** Stephanie Booth, MD

Issue: Recommend the draft FY 2024-25 Operating and Capital Budget for Board consideration.

Background: Please see the Budget documents for detailed information.

Member Impact: The annual Capital and Operating Budget outlines the appropriate use of revenue 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.

Budget Impact: Not applicable.

Motion: **To approve the Fiscal Year 2024-25 Operating and Capital Budget, as submitted.**

L.A. Care
HEALTH PLAN®

OPERATING AND CAPITAL BUDGET

FISCAL YEAR 2024-25

Board of Governors

September 5, 2024

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EXECUTIVE SUMMARY

Environmental Overview

General
The health care landscape in the coming year will be greatly impacted by the federal presidential election in November. Should the Democratic candidate be elected, we can expect "business as usual". If the Republican candidate is successful, it is likely that there will be pressure on all lines of business, as the previous administration challenged the Affordable Care Act and expansions and budgets for Medicaid (Medi-Cal in California).
On the state level, California is gradually phasing in a new health care cost growth cap, with 2025 being the first year that spending data will be submitted to the state. The cap for 2025 is 3.5%, although the 2025 target will not be enforceable. It is unclear what impacts this will have on the broader landscape at this time, although there is concern regarding the unintended consequences of this action, given the tight budget for Medi-Cal across the state. Additionally, California's budget pressures persist, and as the state is facing a multi-billion dollar deficit. Budget cuts impacting social services, provider payment, and health care workforce are among those that have threatened. Many budget issues will be resolved via the trailer bill process later in 2024.

Medi-Cal
This year was the first year that L.A. Care had two prime plans to compete with in the Medi-Cal market: Kaiser and Health Net (which subcontracts with Molina). In January 2024, we lost 260,000 members and experienced an expected drop in market share due to Kaiser entering the market as a direct competitor. While many of the members who have retained Medi-Cal during the public health emergency have gone through the redetermination process, we have experienced a loss in membership through this process. In this next year, we will be working on growth for new members by increasing our choice rate and auto assignment rate as assigned by DHCS. Despite budget challenges, California did preserve core Medi-Cal expansion funding for coverage to all Californians regardless of immigration status. January 2025 marks the first full year that Medi-Cal has been available to anyone in the state regardless of immigration status, and we gained membership for this group. However, there still needs to be messaging to the community to help them understand eligibility and dispel fears about joining Medi-Cal.

CalAIM is the state's transformational initiative which began in FY 2021-22. CalAIM's goals are to manage member risk while addressing social determinants of health, reduce complexity and increase flexibility of Medi-Cal, and improve quality outcomes and the delivery system. L.A. Care has launched all required programs under CalAIM, and is focused on continued operationalization of services, expanding provider networks for CalAIM services, and ensuring that members receive all new services they are eligible for.

L.A. Care Covered
L.A. Care Covered (LACC) was the lead health plan enroller and Los Angeles County's only public option in 2024, and L.A. Care hopes to continue this lead role in 2025. The expanded premium assistance from the Inflation Reduction Act remains in place until the end of 2025. Legislation from 2019, SB 260, created a process where people who lose Med-Cal coverage are automatically enrolled into Covered California qualified health plans. L.A. Care has also been successfully enrolling those who lose Medi-Cal coverage into LACC, as the lowest cost plan in the region, per SB 260.

Covered California has implemented the Quality Transformation Initiative, which sets financial incentives for meeting specific quality metrics. Failure to meet goals will result in a financial penalty. We continue to work towards improved quality metrics, as well as improving our risk scores, as both have been important to the fiscal sustainability of LACC.

Medicare
This year was successful for our Dual Eligible Special Needs Plan (D-SNP), with our membership growth stabilizing for the program after the transition from Cal Medi-Connect to our D-SNP. We have since maintained a consistent growth rate, even amongst competition in the market.

L.A. Care will need to adapt to multiple regulatory changes in the fiscal year, with many starting in January 2025. Impacts of these new regulations will change some of the ways L.A. Care interacts with members and may also increase utilization of some supplemental benefits. While the market remains robust for D-SNP, the regulations may encourage dual eligible members to enroll in D-SNPs, which will provide L.A. Care with opportunities to recruit and retain new and existing membership.

Early in the upcoming fiscal year, CMS will release star ratings, and L.A. Care will receive its first rating for D-SNP. This will have an impact on our 2026 benefit year, which we will be planning for in 2025.

Membership

L.A. Care has approximately 2.47 million members budgeted for FY 2024-25, 2.21 million of which are Medi-Cal. With the redetermination period ending last fiscal year, our product team has a heightened focus to work on strategies to promote member retention, outreach, and engagement including enhancing member informing materials and collaborating with County partners to explore opportunities to retain the maximum number of eligible members as possible.

Overall, the projected membership increase between FY 2023-24 4+8 Forecast and FY 2024-25 Budget is expected to be 68,705 members or 2.9 percent, with member months decreasing by 720,287 or -2.3 percent. Combined segment membership is projected to be at 2,465,337 by September 30, 2025.

L.A. Care Health Plan
Membership by Fiscal Year

	Membership		Change		Member Months		Change	
(# in thousands)	FY 2023-24 4+8 Forecast	FY 2024-25 Budget	Membership [1]	Percent	FY 2023-24 4+8 Forecast	FY 2024-25 Budget	Member Months	Percent
Total Medi-Cal [2]	2,178	2,211	33	1.5%	28,205	27,025	(1,181)	(4.2%)
D-SNP	20	22	2	8.4%	230	253	22	9.6%
Commercial	219	255	36	16.2%	2,497	2,958	460	18.4%
Elimination [3]	(20)	(22)	(2)	8.4%	(230)	(253)	(22)	9.6%
Total	**2,397**	**2,465**	**69**	**2.9%**	**30,703**	**29,982**	**(720)**	**(2.3%)**

Note:
1. Membership is at Fiscal Year end
2. Plan Partners - Kaiser ended on December 31, 2023
3. Beginning January 2023, D-SNP members are included in both D-SNP & CCI under Total Medi-Cal since the funding comes from CMS & DHCS

L.A. Care Health Plan
Membership by Line of Business
Fiscal Year 2024-25 Budget

	Total Medi-Cal	Commercial	D-SNP	Elimination*	Total
Oct-24	2,300,883	234,392	20,264	(20,264)	2,535,275
Nov-24	2,290,742	234,574	20,195	(20,195)	2,525,316
Dec-24	2,281,398	234,251	20,209	(20,209)	2,515,649
Jan-25	2,272,160	238,766	21,084	(21,084)	2,510,926
Feb-25	2,263,027	249,176	21,146	(21,146)	2,512,202
Mar-25	2,253,998	250,026	21,206	(21,206)	2,504,023
Apr-25	2,245,072	250,849	21,265	(21,265)	2,495,921
May-25	2,236,251	251,647	21,322	(21,322)	2,487,898
Jun-25	2,229,766	252,420	21,378	(21,378)	2,482,186
Jul-25	2,223,368	253,170	21,432	(21,432)	2,476,538
Aug-25	2,217,058	253,896	21,485	(21,485)	2,470,954
Sep-25	2,210,837	254,500	21,536	(21,536)	2,465,337
Total	**27,024,560**	**2,957,666**	**252,522**	**(128,416)**	**29,982,226**

**Beginning January 2023, D-SNP members are included in both D-SNP & CCI under Total Medi-Cal since the funding comes from CMS & DHCS*

Combined Operations & Financials

Combined operations are budgeted to produce a net surplus of $201.4 million, which includes $56.7 million in support of community investments and $40.2 million in Incentive Programs. Adjusted net surplus excluding the Incentive Payment Program (IPP) and Homeless and Housing Incentive Program (HHIP) is expected to be $161.2 million, or a 1.5% margin ratio.

L.A. Care Health Plan
Consolidated Statement of Operations
Fiscal Year 2024-25 Budget

($ in millions)	Total Medi-Cal	Commercial	D-SNP	Community Programs [1]	Incentive Programs [2]	Total
Revenue	$9,393.0	$911.5	$415.0	$0.0	$93.4	$10,813.0
Healthcare Expenses	8,856.0	770.3	369.4	-	51.6	10,047.3
MCR %	*94.3%*	*84.5%*	*89.0%*	*n/a*	*n/a*	*92.9%*
Operating Margin	**537.1**	**141.1**	**45.6**	**-**	**41.8**	**765.7**
Operating Expenses	507.7	137.8	43.8	3.0	1.6	693.9
Administrative Ratio %	*5.4%*	*15.1%*	*10.5%*	*n/a*	*n/a*	*6.4%*
Gain/(Loss) from Operations	**29.3**	**3.4**	**1.9**	**(3.0)**	**40.2**	**71.8**
Provision for Community Investments	-	-	-	(53.7)	-	(53.7)
Managed Care Tax, net	2.9	-	-	-	-	2.9
Investment Income, net	157.8	15.5	7.1	-	-	180.4
Net Surplus/(Deficit)	**$190.0**	**$18.9**	**$9.0**	**($56.7)**	**$40.2**	**$201.4**
Margin Ratio %	***2.0%***	***2.1%***	***2.2%***	*n/a*	*n/a*	***1.9%***

Note:

1. Includes Community Resource Centers & Blue Shield Promise Grant

2. Includes Incentive Payment Program (IPP) & Housing and Homelessness Incentive Program (HHIP)

Revenue

Medi-Cal Capitation Rates (Classic Rating & Duals Categories)

The revenue rates are based on CY 2024 rates from the California Department of Health Care Services (DHCS). The CY 2025 rates assume a rate decrease across all categories of aid.

D-SNP

D-SNP revenue is based on the CY 2024 rates. The CY 2025 revenue is based on the bid submitted to CMS.

L.A. Care Covered

L.A. Care Covered revenue is based on the CY 2024 rates and the CY 2025 rates submitted to Covered California.

Healthcare Expenses

Consistent with a maturing health care delivery network, the utilization growth and the health care services delivery have become more complex. L.A. Care's management team remains focused on utilization management processes, provider contracting, and claims payment management. The fundamental goal is guided by the Institute for Healthcare Improvement's (IHI) Triple Aim Framework, (1) improve patient experience, (2) improve health outcomes, and (3) reduce unnecessary health care expenses.

L.A. Care has been building a direct network of contracted doctors. This initiative will allow us to have a more direct dialogue with the physicians who are critical to our mission. Our goal is to support the physicians with actionable data to help them improve the quality outcomes for our members. Key leaders from multiple departments have been involved in building the infrastructure in order to support more members through the direct network.

Capitation

L.A. Care contracts with, and in many cases delegates specific services to, various Risk Bearing Organizations (RBOs) like Independent Practice Associations (IPAs) and Medical Groups, safety-net providers, Federally Qualified Health Centers, and Community Clinics to provide health care services to enrolled members. The risk arrangements with the RBOs vary between shared, dual, and full risk, which define different level of capitation arrangements based on the division of financial responsibility between the RBO and L.A Care. L.A. Care continues to develop our Direct Network, contracting directly with primary care physicians, specialty care physicians and provider groups either on a capitated or fee-for-service basis. The variety of network arrangements allows us to create alternatives to fit the unique needs of our members.

In addition to what is listed above, L.A. Care also contracts with three other Knox-Keene licensed health plans, referred to as Plan Partners (Anthem, Blue Shield Promise, and Kaiser), to which all managed care services are delegated. The Plan Partners are reimbursed on a capitated PMPM fee basis for each enrolled Medi-Cal member. Furthermore, both Anthem and Blue Shield Promise participate in the plan partner incentive program which rewards plan partners for performance based on targeted metrics. Kaiser will no longer be a Plan Partner in 2024 as they will have a direct contract with the state.

Shared Risk | Provider Incentives

Shared Risk

This healthcare expense category consists of the risk pool tied to the shared risk arrangements mentioned in the capitation section above. The shared risk pools are established to encourage appropriate levels of hospital service utilization. L.A. Care enters into a capitation agreement to delegate professional services, but retains the hospital services. Per member per month (PMPM) targets are established with each contracted provider group and the risk pool is calculated based on membership. At the end of each calendar year, L.A. Care compares the actual claims experience to the target pools and surplus amounts are split between the contracted provider groups and L.A. Care.

L.A. Care Health Plan Provider Incentive Fiscal Year 2024-25 Budget					
Incentive Level Programs ($ in thousands)	**Plan Partners**	**Total MCLA [1]**	**Commercial**	**D-SNP**	**Total [2]**
Plan Partners	$11,135	$0	$0	$0	$11,135
Hospital	-	24,891	2,809	300	28,000
Skilled Nurse Facility	-	12,446	1,405	150	14,000
PPG	9,100	14,542	4,688	-	28,330
Physician	10,579	13,338	47	3,506	27,471
Member	-	1,381	832	463	2,677
Total	**$30,814**	**$66,599**	**$9,781**	**$4,419**	**$111,613**

Note:

1. CCI members are not eligible for Incentive Level Programs

2. Provider Incentive excludes Incentive Payment Program (IPP), Housing and Homelessness Incentive Program (HHIP) & Student Behavioral Health Incentive Program (SBHIP)

L.A. Care Quality Score Investments (Incentives)

Provider incentives are an essential part of L.A. Care's interventions strategy to advance provider performance, enhance the quality of clinical care and increase member satisfaction. They are designed to augment L.A. Care's collaboration with key industry partners, and to align the quality improvement goals of plan partners, IPAs and medical groups, clinics, physicians, and healthcare facilities. These programs use standard metrics such as Healthcare Effectiveness Data and Information Set (HEDIS) to reward excellent performance and year-over-year improvement. The programs aim to create a business case for provider investment in quality improvement, and to promote accountability and value.

Plan Partner Quality Score Investments (Incentives)

The Plan Partner Incentive Program aligns the efforts of L.A. Care with those of its strategic partners as a critical point for improving the outcomes and satisfaction of members. The program rewards plan partners with a broad set of metrics, including HEDIS clinical quality, utilization management, encounter data and member experience. The Plan Partner Incentive Program is fully aligned with the IPA-level program, which provides a strong platform for performance measurement and promotes shared quality improvement strategies between health plans and IPAs.

IPA Quality Score Investments (Incentives)

The Value Initiative for IPA Performance + Pay-for-Performance (VIIP+P4P) Program aims to improve the quality of care for L.A. Care members by measuring, reporting and rewarding IPAs for performance in multiple domains that affect quality of care, including HEDIS, utilization management, care/medication management, encounter data, and member experience. The VIIP+P4P program also encourages and supports lower performing IPAs to develop action plans, which are performance improvement projects with measurable goals on priority measures. These IPA action plans are reviewed by L.A. Care and will be discussed at quarterly webinars with the goal of reviewing trends seen, discussing barriers and sharing best practices.

Physician Quality Score Investments (Incentives)

The Physician Pay-for-Performance (P4P) Program provides financial rewards to eligible physicians and community clinics for outstanding performance and year-over-year improvement on multiple HEDIS measures, as well as physician- and clinic-level utilization management and member experience. The program is closely aligned with incentives available to IPAs and plan partners and is designed to improve provider encounter data submission.

Hospital/SNF Quality Score Investments (Incentives)

L.A. Care launched two new P4P programs in 2024 for Hospitals and Skilled Nursing Facilities (SNFs), respectively. A broad set of metrics were selected based on relevance to the quality of care that members receive at Hospitals and SNFs. These include measures and data related to associated infections, readmissions, follow-up visits post-discharge, percent of residents experiencing major injury and many more. The first payments will be sent to providers in late 2025 that meet performance targets.

L.A. Care also operates a provider incentive in support of completing Medicare Annual Wellness Exams, with the goal of getting pertinent patient medical history to assess wellness and develop preventive care plans. A new incentive for Health Information Exchange (HIE) adoption and use was launched this year to support technological advancements amongst L.A. Care's provider network. Additionally, L.A. Care operates member incentives to support the priorities related to obtaining vital medical services, to promote health education, and to increase positive member experiences.

Fee-for-Service Claims

L.A. Care's second largest healthcare expense type, behind capitation, is fee-for-service (FFS) expenses. The category includes inpatient, outpatient, skilled nursing facility, and community-based adult services related to TANF-MCE, SPD-CCI, D-SNP, LACC, and PASC-SEIU segments. The FY 2024-25 budget is based on CY 2023 (Jan-23 to Dec-23) cost levels. These costs were trended forward to the budget period with trends observed in the past year varying from zero to medium positives (e.g. 0 percent to 10 percent). Various adjustments were made to account for differences from the base period to budget period, including new programs. FFS costs continue to be difficult to predict due to the constantly changing healthcare landscape affected by COVID-19, and any significant COVID developments could have an impact on FFS trends across all categories of service. There is additional uncertainty this year from the impact of the end of Medi-Cal redeterminations, as well as large payment reform programs like Targeted Rate Increases (TRI).

Pharmacy

In 2023, drug expenditures in the United States grew 13.6%, which is a higher rate than the year before, according to the American Journal of Health-System Pharmacy (AJHP). For 2024, the AJHP projects a similar trend of a 10-20% increase, primarily driven by specialty, endocrine (e.g., weight loss GLP-1 agonists) and cancer drugs.

Mercer Government's Pharmacy team has identified a similar trend for 2024-2025 projections, where traditional drugs will account for a 7% to 8% increase and specialty drugs will account for a 6% to 10% increase. Pharmacy spend for traditional drugs are significantly higher than previous year estimates, boosted by new therapies, manufacturer price increases, and steady utilization gains in top categories like diabetes. Specialty drug spend as a percentage of total drug cost will continue to grow, accounting for over half of drug spend so far. L.A. Care Health Plan's pharmaceutical drug spend is expected to follow a similar overall trend. There is an increase in utilization of antidiabetic, weight loss, and specialty categories as well as price inflation across all brand name drugs.

L.A. Care's largest drug spend category is antidiabetics, which has high brand-name utilization rates. Antidiabetic drug spend has soared over the past several years. The majority of the antidiabetic cost increase is due to newer drugs in the incretin mimetic agents (GLP-1 receptor agonists) and Sodium-Glucose co-Transporter 2 (SGLT2) classes. The rise in antidiabetic utilization is also expected to correlate with increased efforts to improve medication adherence and quality metrics, such as STAR ratings.

Administrative Expenses

L.A. Care Health Plan
General Administrative Cross-Walk
Fiscal Year 2024-25 Budget

($ in thousands)	FY 2023-24 4+8 Forecast	Additions/ (Reductions)	FY 2024-25 Budget
Base Line Operations	$634,687		
Salaries and Benefits			
Increase due to higher budgeted FTEs before Vacancy Factor		41,674	
Vacancy Factor of 11.9%		(5,447)	
Temporary Labor and Recruitment		6,212	
Professional Fees & Purchased Services			
Increase in printing & other contracted services		2,912	
Increase in broker commissions		2,892	
Increase in Pharmacy & Behavioral Health admin fees		1,104	
Decrease in IT strategic projects & staff augmentation		(5,672)	
Advertising and Promotions			
Decrease in advertising expenses		(6,134)	
Business Fees & Occupancy and Leases			
Increase in DMHC Assessment & LACC participation fees		11,356	
Increase in software licenses & maintenance expenses		6,335	
Supplies and Other			
Increase in external postage, fulfillment, and other expense		5,691	
Decrease in internet and web-based services		(13,632)	
Depreciation and Amortization			
Increase in SBITA assets		15,000	
Increase in other assets that are not fully depreciated		1,692	
Medical Administrative Expenses			
Increase in Health Services programs		(4,810)	
Total Administrative Expenses*	**$634,687**	**$59,174**	**$693,861**

**Total Administrative Expenses include Incentive Payment Program (IPP) & Housing and Homelessness Incentive Program (HHIP)*

Comparative Administrative Cost – FY 2023-24 vs. FY 2024-25

L.A. Care continues to focus on administrative costs needed to support the evolving CalAIM Initiatives and to transform and upgrade our infrastructure. L.A. Care strives to efficiently manage the delivery of health care services and to comply with regulatory changes for the products we offer.

The following is a summary of the administrative forecast and budget between the fiscal years:

L.A. Care Health Plan
Administrative Expenses
Comparative Statement

($ in thousands)	FY 2023-24 4+8 Forecast	PMPM	FY 2024-25 Budget	PMPM
FTEs (at year end)	2,789		2,872	
Salaries and Benefits	$362,847	$11.82	$399,074	$13.31
Temporary Labor and Recruitment	2,777	0.09	8,989	0.30
Professional Fees	34,294	1.12	29,633	0.99
Purchased Services	171,511	5.59	177,407	5.92
Advertising and Promotions	14,540	0.47	8,406	0.28
Business Fees and Insurance	60,235	1.96	71,870	2.40
Occupancy and Leases	8,045	0.26	14,102	0.47
Supplies and Other	55,172	1.80	47,231	1.58
Depreciation and Amortization	59,108	1.93	75,800	2.53
Medical Administration Expenses	(133,842)	(4.36)	(138,651)	(4.62)
Total*	**$634,687**	**$20.67**	**$693,861**	**$23.14**
Admin Ratio %	***6.0%***		***6.4%***	

**Total includes Incentive Payment Program (IPP) & Housing and Homelessness Incentive Program (HHIP)*

For FY 2023-24, L.A. Care established a budget target of a $17.90 PMPM for administrative expenditures. The budget was increased to $20.67 PMPM as part of the 4+8 Forecast to account for additional investments in headcount and strategic projects.

FY 2024-25 administrative PMPM target is set at $23.14 PMPM, which is $2.47 higher than the FY 2023-24 4+8 Forecast and $5.24 higher compared to the FY 2023-24 Budget. The increase in PMPM is attributable to an increase in administrative expenses as well as the decrease in enrollments tied to redeterminations. Total administrative expenses are expected to increase by $59.2 million primarily due to an increase in Salaries & Benefits, increased print and mailing efforts related to redetermination outreach efforts, increased fees related to DMHC and LACC, and Depreciation & Amortization related to GASB 96 as well as increased capital projects completed and placed in service. We will continue to seek opportunities to limit the administrative spending and implement cost-reduction activities, including re-negotiating vendor contracts and re-deploying FTEs. We will also continue to focus on areas to improve efficiencies to manage administrative expenses below the target. However, it is important to continue investing in technology in order to improve operational efficiencies. We aspire to continue

to be a good partner to L.A. County and the State in driving efficiency now that cost pressures have intensified. Our preparation and continued investments in our infrastructure position us well to achieve that goal.

Staffing and Total Cost of Labor

For FY 2023-24, the budgeted FTE totaled to 2,499, which included a 15.7 percent vacancy factor with an increase in FTE of 219 year-over-year. For FY 2024-25, the budgeted FTE totaled to 2,872, which includes actual vacancy factor at the department level but caps at a maximum of 11.9 percent. For FY 2024-25, budgeted Salaries & Benefits totaled to $399.1 million compared to FY 2023-24 4+8 Forecast of $362.8 million, an increase of $36.2 million due to higher budgeted headcounts. The budgets for FY 2023-24 and FY 2024-25 include a 4.5 percent merit increase for eligible staff. In an effort to focus employees on organizational goals and objectives, L.A. Care will reward bonus incentives based on criteria established in its Organizational Incentive Program. The incentive program is not a guaranteed bonus for employees, but rather a reward for excellent performance, at the organizational level as well as at the individual level. Incentive compensation earned by an employee is paid as a lump sum and does not become a part of the employee's base pay rate.

The chart below shows the details of our budgeted staffing:

L.A. Care Health Plan
Full Time Employees

	Budgeted Fiscal Year (at year-end)		
	2022-23	**2023-24**	**2024-25**
Beginning Total	1,911	2,280	2,499
Unfilled positions	669	566	585
Vacancy factor	(300)	(347)	(212)
Total added positions	369	219	373
Ending Total*	**2,280**	**2,499**	**2,872**

**Total includes CRCs, Incentive Payment Program (IPP) & Housing Homelessness Incentive Program (HHIP)*

L.A. Care Health Plan Full Time Employees Fiscal Year Trend		
	at year-end	
Fiscal Year	Total FTEs [1]	FTEs per Membership in thousands
2020-21 Actual	1,902	0.77
2021-22 Actual	2,046	0.75
2022-23 Actual	2,361	0.82
2023-24 Forecast [2]	2,789	1.16
2024-25 Budget	2,872	1.16

Note:

1. FTEs include CRCs, Community Benefits & Incentive Payment Program (IPP) & Housing Homelessness Incentive Program (HHIP)

2. Fiscal Year 2023-24 4+8 Forecast

L.A. Care Segments

Medi-Cal Segments & Plans

Medi-Cal is California's Medicaid program. It is a public health program which provides comprehensive, no cost/low cost health care services for qualifying low-income children, adults, families, seniors, persons with disabilities, children in foster care, pregnant women, and unsatisfactory immigration status populations, as well as other aid and risk categories. Beginning on January 1, 2024, all residents regardless of immigration status became eligible for Medi-Cal.

Segments

TANF

Temporary Assistance for Needy Families (TANF) – TANF is a State-based federal cash assistance program for low-income families. TANF replaces the former program known as Aid to Families with Dependent Children (AFDC). CalWORKs is the name of California's TANF program. TANF programs are designed to help low income families with children achieve economic self-sufficiency. This segment consists primarily of members in family-adult, family-child, and Breast and Cervical Cancer Treatment Program aid categories.

MCE

Medicaid or Medi-Cal Expansion (MCE) – Starting January 2014, the Affordable Care Act expanded Medi-Cal coverage to adults (age 19-64 years) without children. MCE eligibility is based on modified adjusted gross income (MAGI) and is available to those with an annual income lower than 138 percent of the federal poverty level. MCE also allows coverage for parents who would have lost coverage under current rules if their income slightly exceeds the federal poverty level.

SPD

Seniors and Persons with Disabilities (**SPD)** – As of June 1, 2011, Seniors and Persons with Disabilities (SPD) were transitioned from Medi-Cal fee-for-service into managed care. Individuals 65 years and older, and/or a person of any age with a disability may qualify for Medi-Cal under this category. SPD eligible members must meet one of the following requirements:

- Aged: Persons 65 years and older
- Blind: Persons who have been declared legally blind by the Social Security Administration or the State Programs – Disability and Adult Programs Division (SP-DAPD)
- Disabled: Persons who have been declared disabled by SP-DAPD

Individuals determined to be disabled under SP-DAPD are considered disabled under Medi-Cal. SPDs may be full scope or partial dual members. Partial dual eligibility means a person qualifies for a Medicare Savings Program (MSP), and a person who qualifies for partial dual eligibility may also qualify for a Dual Special Needs Plan (D-SNP).

Plans

MCLA

The MCLA budget consists of the operating revenue and costs required to support all aid categories under Medi-Cal for members assigned to a PPG or direct network within the L.A. Care network. Assignment is based first on member choice. If no choice is made, assignment is based on the member assignment algorithm, which contains various rules, accounting for segment, PCP time and distance standards, and other variables. Auto assignment is also made to the Plan Partners.

Plan Partners

The Plan Partners' budget consists of the operating revenue and costs required to support all aid categories under Medi-Cal, delivered through subcontracted Plan Partners' (Anthem Blue Cross and Blue Shield of California Promise Health Plan) health care networks.

The fully delegated contracts with the two Plan Partners reflect both capitation rates for the Medi-Cal benefit and a performance incentive program. The agreements with Anthem and Blue Shield Promise were extended to September 2035. However, due to AB 2724, as of January 1, 2024, DHCS has contracted directly with Kaiser for Medi-Cal managed care across the state. Therefore, L.A. Care's contract with Kaiser ended effective January 1, 2024.

Plan Partners will be eligible for an incentive program based on measurement year 2024 (payable in 2025). The incentive is designed to align quality goals among L.A. Care and its subcontracted health plans and target specific performance measures that impact the managed care accountability set (MCAS), health care outcomes and patient satisfaction. Plan Partners are eligible for an annual per member per month financial incentive for meeting eligibility and performance criteria.

L.A. Care Health Plan Total Medi-Cal Income Statement*						
($ in thousands)	**FY 2023-24 4+8 Forecast**	**PMPM**	**% of Revenue**	**FY 2024-25 Budget**	**PMPM**	**% of Revenue**
Member Months	28,205,156			27,024,560		
Revenue						
Capitation	$9,366,623	$332.09	100.0%	$9,393,011	$347.57	100.0%
Total Revenues	**$9,366,623**	**$332.09**	**100.0%**	**$9,393,011**	**$347.57**	**100.0%**
Healthcare Expenses						
Capitation	$5,059,609	$179.39	54.0%	$4,612,995	$170.70	49.1%
Inpatient Claims	$1,126,426	$39.94	12.0%	$1,266,755	$46.87	13.5%
Outpatient Claims	$1,279,975	$45.38	13.7%	$1,386,626	$51.31	14.8%
Skilled Nurse Facility	$1,173,740	$41.61	12.5%	$1,353,892	$50.10	14.4%
Pharmacy	$141	$0.00	0.0%	$14	$0.00	0.0%
Provider Incentives & Shared Risk	$134,555	$4.77	1.4%	$113,285	$4.19	1.2%
Medical Administrative Expenses	$125,978	$4.47	1.3%	$122,395	$4.53	1.3%
Total Healthcare Expenses	**$8,900,425**	**$315.56**	**95.0%**	**$8,855,961**	**$327.70**	**94.3%**
Operating Margin	$466,198	$16.53	5.0%	$537,050	$19.87	5.7%

**Total Medi-Cal consists of Plan Partners and Total MCLA*

Dual Eligible Special Needs Plan (D-SNP)

The state of California implemented California Advancing and Innovating Medi-Cal (CalAIM), requiring Medi-Cal Managed Care Organizations to establish Dual Eligible Special Needs Plans (D-SNP) effective January 1, 2023. D-SNPs are a type of Medicare Advantage Plan with Part D (MAPD) and are available to those who are eligible for both Medicare and Medi-Cal services. These D-SNP Plans are Exclusively Aligned Enrollment (EAE) plans, where beneficiaries enrolled in the D-SNP for Medicare services will be aligned with the same parent organization to also receive their Medi-Cal services.

The Plan is designed to offer dual eligible beneficiaries (Medicare and Medicaid eligible) comprehensive, preventive, quality care through access to contracted health care providers and clinical care teams who are trained and experienced in caring for healthy individuals and individuals with chronic conditions or disabilities.

The plan covers all Medicare-covered Part A and B services, includes Part D benefits, and also offers supplemental benefit coverage, including fitness, an allowance for over-the-counter medication and supplies, a personal emergency response system, dental, vision, acupuncture, chiropractic services and worldwide emergency coverage, which are not available through traditional Fee-For-Service Medicare. Part D cost share will be $0 for LIS eligible members.

L.A. Care Health Plan
D-SNP Income Statement

($ in thousands)	FY 2023-24 4+8 Forecast	PMPM	% of Revenue	FY 2024-25 Budget	PMPM	% of Revenue
Member Months	230,321			252,522		
Revenue						
Capitation	$332,035	$1,441.62	100.0%	$415,035	$1,643.56	100.0%
Total Revenues	**$332,035**	**$1,441.62**	**100.0%**	**$415,035**	**$1,643.56**	**100.0%**
Healthcare Expenses						
Capitation	$124,136	$538.97	37.4%	$136,753	$541.55	32.9%
Inpatient Claims	$81,738	$354.89	24.6%	$94,610	$374.66	22.8%
Outpatient Claims	$51,263	$222.57	15.4%	$56,626	$224.24	13.6%
Skilled Nurse Facility	$2,808	$12.19	0.8%	$0	$0.00	0.0%
Pharmacy	$15,507	$67.33	4.7%	$49,593	$196.39	11.9%
Provider Incentives & Shared Risk	$22,864	$99.27	6.9%	$23,668	$93.73	5.7%
Medical Administrative Expenses	$2,650	$11.51	0.8%	$8,146	$32.26	2.0%
Total Healthcare Expenses	**$300,967**	**$1,306.73**	**90.6%**	**$369,397**	**$1,462.83**	**89.0%**
Operating Margin	$31,068	$134.89	9.4%	$45,638	$180.73	11.0%

California Advancing and Innovating Medi-Cal (Cal AIM) Initiative - Duals
Under CalAIM, the Department of Health Care Services (DHCS) transitioned Cal MediConnect (CMC) to an integrated Exclusively Aligned Enrollment (EAE) D-SNP program, managed by the same health plans. Having Medicare and Medi-Cal benefits managed by the same organization is an important component of CalAIM and aligns with the DHCS's Managed Long Term Services and Supports (MLTSS) strategy. Starting 2023, CalAIM policies will provide a more robust Medi-Cal managed care delivery system for dual eligible beneficiaries statewide, including mandatory Medi-Cal managed care enrollment statewide, Medi-Cal managed care carve-in of Skilled Nursing Facility care, Enhanced Care Management for populations needing Long Term Services and Supports, and Medi-Cal Community Supports provided by Medi-Cal plans.

Commercial Products

PASC-SEIU program provides health care for the In-Home Supportive Services (IHSS) workers in Los Angeles County. Among the administrative services provided are claims processing, member services, and COBRA/Cal-COBRA billing and information technology services. The PASC-SEIU Homecare Workers Health Care Plan (PASC-SEIU Plan) transitioned from Community Health Plan (CHP) to L.A. Care in February 2012.

L.A. Care Covered (LACC) program started in January 2014, L.A. Care Health Plan is one of many health plans designated to offer health insurance on the California State Exchange known as Covered California. L.A. Care Covered offers all metal coverage levels (Platinum, Gold, Silver, and Bronze) and a Catastrophic Plan for enrollees within Los Angeles County in Regions 15 and 16 on the Exchange. Consistent with its mission, L.A. Care focuses on outreach and enrollment activities to communities that are at or below 250 percent of the Federal Poverty Level (FPL).

Because of our number-one, price position on the Covered CA exchange for the fourth year in a row and coupled with our proactive management of our member experience throughout the year we have had several accomplishments in 2023:

- Enrolled nearly 49,000 new L.A. Care Covered members
- Renewed over 96% of our existing membership
- LACC membership for FY 2023-24 totaled over 171,000 members, the largest L.A. Care Covered membership enrollment since the inception of the product
- L.A. Care is the now largest managed care health plan in region 15 & 16, with 34% of the total enrollment among all seven plans offered in Los Angeles County

On August 16, 2022, President Biden signed an extension to the enhanced subsidies, which were first introduced under the American Rescue Plan (ARP) of 2021 and will remain in effect through December 31, 2025. The enhanced subsidies allow 50% of the existing LACC membership to have a zero monthly premium.

L.A. Care Health Plan
Commercial Income Statement

($ in thousands)	FY 2023-24 4+8 Forecast	PMPM	% of Revenue	FY 2024-25 Budget	PMPM	% of Revenue
Member Months	2,497,365			2,957,666		
Revenue						
Capitation	$742,728	$297.40	100.0%	$911,471	$308.17	100.0%
Total Revenues	**$742,728**	**$297.40**	**100.0%**	**$911,471**	**$308.17**	**100.0%**
Healthcare Expenses						
Capitation	$213,463	$85.48	28.7%	$249,486	$84.35	27.4%
Inpatient Claims	$114,828	$45.98	15.5%	$161,439	$54.58	17.7%
Outpatient Claims	$109,718	$43.93	14.8%	$145,122	$49.07	15.9%
Skilled Nurse Facility	$581	$0.23	0.1%	$0	$0.00	0.0%
Pharmacy	$163,860	$65.61	22.1%	$185,231	$62.63	20.3%
Provider Incentives & Shared Risk	$12,322	$4.93	1.7%	$15,972	$5.40	1.8%
Medical Administrative Expenses	$11,414	$4.57	1.5%	$13,087	$4.42	1.4%
Total Healthcare Expenses	**$626,185**	**$250.74**	**84.3%**	**$770,337**	**$260.45**	**84.5%**
Operating Margin	$116,543	$46.67	15.7%	$141,133	$47.72	15.5%

Non-Travel Meeting, Food, and Other Expenses

L.A. Care Health Plan Non-Travel Meals and Catering and Other Expenses Fiscal Year 2024-25				
#	Proposed Program	Non-Travel Food Expenses	Other	Total
1	Provider Continuing Education (PCE) Program	$ 43,700	$ 116,300	$ 160,000
2	New Employee Orientation	$ 16,848	$ -	$ 16,848
3	Quarterly HR Job Fairs	$ 2,311	$ -	$ 2,311
4	Veteran's Day Recognition Event - HR	$ 1,725	$ 2,175	$ 3,900
5	Behavioral Health Month	$ 1,311	$ 1,825	$ 3,136
6	Social Work Month	$ 3,335	$ 4,025	$ 7,360
7	Admin Day 2025	$ 3,450	$ 4,150	$ 7,600
8	Dedicated Service Awards 2025	$ 8,533	$ 500	$ 9,033
9	Retirement Recognition Events	$ 5,184	$ 2,330	$ 7,514
10	Nurses Week	$ 4,600	$ 5,000	$ 9,600
11	Management Certification Program Ceremony	$ 5,180	$ -	$ 5,180
12	HR and Facilities Team Building	$ 2,024	$ 3,380	$ 5,404
13	Catering for Health Promoters Program	$ 31,000	$ -	$ 31,000
14	Catering for LA Care Consumer Advisory Council (CAC) Member Engagement Sessions	$ 1,380	$ 2,000	$ 3,380
15	Catering for LAC Medicare Plus and Enrollee Advisory Committee (EAC) member meeting	$ 1,380	$ 4,800	$ 6,180
16	CEO Business Development	$ 3,000	$ 3,000	$ 6,000
17	Catering for Board & Committee Meetings	$ 50,000	$ -	$ 50,000
18	Board of Governors Offsite Meetings - June and September 2025	$ 30,000	$ -	$ 30,000
19	Board Consumer Representative Election Refreshments	$ 10,000	$ -	$ 10,000
20	Health Equity Collaborators Meetings	$ 2,289	$ -	$ 2,289
21	Equality and Quality at Independent Practices - EQuIP-LA	$ 1,080	$ -	$ 1,080
22	Physician Advisory Collaborative Meetings - QI PE&O Workgroup	$ 1,700	$ -	$ 1,700
23	Transform LA Program - Direct Network (DN) Practice Engagement	$ 9,360	$ -	$ 9,360
24	Customer Service and QI Performance Improvement Project (PIP) Trainings	$ 15,300	$ -	$ 15,300
25	QI Improvement and Provider Education	$ 15,300	$ -	$ 15,300
26	Community Benefit Grant Review Committee Meetings	$ 4,730	$ 39,200	$ 43,930
27	Catering for LA Care Consumer Members (RCAC/ECAC/BOG)*	$ 150,200	$ 398,640	$ 548,840
28	Legislative Office Educational Briefing	$ 1,240	$ 1,600	$ 2,840
29	Government Affairs Business Meetings	$ 400	$ -	$ 400
	Proposed Program Total	**$ 426,559**	**$ 588,925**	**$ 1,015,484**

Proposed Programs:

Provider Continuing Education (PCE) Program

L.A. Care Provider Continuing Education (PCE) Program is an accredited educational program with Continuing Medical Education (CME) for L.A. Care providers and other physicians, and Continuing Education (CE) for nursing staff and other healthcare professionals.

L.A. Care is an accredited CME Provider with commendation by the California Medical Association (CMA) for MDs, DOs, PAs, and also an accredited CE Provider by the California Board of Registered Nursing for NPs and RNs, and an accredited CE Provider by the California Association of Marriage and Family Therapists (CAMFT) for LCSWs, LMFTs, LPCCs, and LEPs. The PCE Program CME/CE activities and events specifically target the low performing primary care physicians related to their HEDIS scores and Star Performance to improve quality of patient care and physician-patient relationships. Other target audiences are high performing providers, new L.A. Care providers, L.A. Care staff, and other healthcare professionals.

The PCE Program will hold CME/CE activities throughout the year, with emphasis on the identified needs of L.A. Care providers and other healthcare professionals through conducted surveys and ongoing feedback. The PCE Program will coordinate four full-day CME/CE Conferences for in-depth content related to quality improvement of patient care, partnerships and best practices. It will also provide three evening CME/CE events to target Quality Improvement, HEDIS and other clinical improvement topics. There will also be eight online courses/webinars to reach hard-to-target L.A. Care network providers in L.A. County.

In addition, the program will offer online activities/online courses on content areas that are important for improving providers' competency, performance and patient outcomes. CME/CE Event expenses will include venue and food costs, and stipends for guest speakers to cover preparatory costs.

Meetings with Providers and Other External Stakeholders

Various mandatory, regulatory, and advisory meetings are held at L.A. Care's facilities, including committee meetings, trainings, and educational conferences. The goals of which are to support and strengthen L.A. Care's ability to provide a safety net for the communities we serve. The budget for FY 2024-25 is similar to FY 2023-24. Actual spending may be impacted as more meetings continue to be held in person.

Such meetings include:

- Board of Governors and other Governing Committees
- Behavioral Health Quality Committee (BHQC)
- Community Benefit Grant Review
- Quality Initiative trainings for PPGs and other clients to improve performance
- Equality and Quality at Independent Practices (EQuIP-LA)
- Physician Advisory Collaborative Meetings – QI Dept. Provider Engagement & Outreach Workgroup
- Transform LA Program – Direct Network Engagement

Business Development

Many community events are held annually to strengthen L.A. Care's relationship with its members. L.A. Care representatives are engaged in business development activities related to the sales and promotion of the various products offered. Collaborative meetings with sister health plans, the L.A. County Department of Health Services, providers, and members all contribute to the expansion of L.A. Care's Safety Net Initiatives. Continuation of these development activities are an integral part of the messaging and branding strategy in relationship building with providers, members, and external stakeholders. Planning anticipates that some of these events may be held in person, but most will be held virtually or will be suspended as the COVID-19 pandemic guidance updates.

Events and programs include:

- CEO Business Development
- Annual Strategic Planning Meeting
- L.A. Care Medicare Plus and Enrollee Advisory Committee (EAC) member meetings
- L.A. Care Consumer Advisory Council (CAC) member engagement sessions
- Health Promoters Program
- Community Outreach & Engagement Events including RCAC & ECAC meetings and RCAC Conferences

Staff Training, Recognition and Retention, and Extenuating Circumstances

Programs designed to support L.A. Care's staff have resumed after being suspended during the COVID-19 pandemic.

Such programs include:

- New Employee Orientations
- Quarterly Job Fairs
- Dedicated Service Awards
- Social Work Month
- Admin Day 2025
- Departmental Team Building and Training events

Meals may be provided to employees working mandatory overtime in extenuating circumstances such as the Yearly Disaster Recovery Test, department moves/relocation, or in-person usability testing where employees work over the weekend.

Advertising, Marketing, and Sales Strategies

Advertising and Promotions

Advertising and Promotions	
Fiscal Year	**Total****
FY 2023-24 4+8 Forecast	$13,318
FY 2024-25 Budget	$6,706

**Total $ in thousands*

***Total excludes Sponsorships*

For FY 2024-25, the Marketing team will begin the first phase of our Brand refresh with focus groups and expanded research, with the intent to understand our brand positioning; thus, expanding on the strategy to interconnect all other campaigns in market, with enhance targeting. We will introduce a new layer of strategic tactics that will be driven by this new layer of data and market analysis. We will also continue advertising our products, CRCs, and Plan Partner campaigns. We will maximize tactical media elements with a goal of growing our consumer voice in the market and impact choice enrollment. We will enhance D-SNP tactical campaigns to be more tailored for direct and personalized engagement for AEP. Research and focus group will also be conducted for our co-marketing Plan Partner, Medi-Cal program and for the new MAPD set to launch in 2026. For our CRCs, due to the significant expansion/growth, Marketing will now approach the campaign efforts to be more targeted by region and center. In addition to traditional and digital media campaigns tasked with creating growth opportunities, marketing will also expand on the leveraging market data for more efficient advertising to support growth and retention. Marketing will continue to factor in miscellaneous advertising campaigns required for FY 2024-25.

The Marketing team will roll out three campaigns in the Fall which will aim at driving enrollment for the Medi-Cal, D-SNP, and L.A. Care Covered products. Our Plan Partner digital co-marketing program is set to begin in August 2024, carrying through to the end of the year, as an effort to continue growth in 2025. For our Medi-Cal line of business (including Plan Partners), we will factor in Redetermination impacts and market dynamics. Our Covered California Open Enrollment Campaign for L.A. Care Covered will begin in October 2024 and ramp up through January 2025. Our campaign efforts will employ traditional elements like Outdoor, Radio and TV, but will be paralleled by tactical digital programs. Marketing will then look to roll out a Spring and Summer campaign post the Fall/Winter period to refocus our advertising on our corporate Brand campaign, D-SNP, Medi-Cal, and the

Community Resource Centers. Marketing will continue to leverage its Channel Performance reporting process that has helped us monitor and manage our Marketing Channels for optimization and performance improvement through a newly launched response dashboard. In spring of 2025 Marketing is set to begin focus groups to support the new MAPD product's brand development, to finalize the new product's brand personality. Lastly, Marketing has added BAA language to our advertising vendor's MSA, allowing us to expand on our KPIs and providing a new layer of campaign reporting that ties our campaigns to new membership.

Printing and Mailing

Printing & Mailing	
Fiscal Year	**Total***
FY 2023-24 4+8 Forecast	$31,616
FY 2024-25 Budget	$39,622

**Total $ in thousands*

With the restructuring of the Marketing department, Marketing is now driving all product and Sales OEP and AEP efforts from start to end, essentially, assuming responsibility for what product teams have driven prior. With this change, Marketing will serve as the center of material development, printing, and distribution through our relationships with local print and fulfillment vendors. The critical focuses in FY 2024-25 we will continue to enhance the tracking of all charges by cost center and to reflect those charges against each cost center's budget. This includes us getting more granular on how we track budgets, by accounting for each project spend. This Marketing budget management will continue to include a level of transparency for all budget owners, allowing them to have a clear line of sight to their spending in real-time. The objective is to provide a clear understanding of all the projects produced annually and to understand their financial impact, and assess any gaps, inefficiencies, and redundancies in member communications.

Marketing will continue the effort of reducing costs through competitive bidding and leverage digital tools to enhance our current member communication. Marketing is also looking at opportunities to transition print communications to digital, resulting a significant financial saving. The project management system, Podio, continues to archive print estimates and invoices, which allows us to reference historical jobs to better bid and price projects for business units. In addition, the Marketing and Sales teams will leverage vendor portals for efficient print production workflows. We will continue to partner with the Member Services team to help grow our digital communications tools (Portal, Email, text messaging) so we can switch to these communication touchpoints upon regulatory approvals being granted. Marketing will also work with Strategic Planning and our vendors to find a way to bring our member journey experience to an actionable and potentially automated outcome.

Additionally, Marketing will continue the vendor diversity exploration effort, in preparation for the 2026 RFP planning.

Broker Fees

Broker Commissions			
Fiscal Year	**D-SNP**	**LACC**	**Total***
FY 2023-24 4+8 Forecast	$4,297	$27,356	$31,652
FY 2024-25 Budget	$5,834	$28,710	$34,544

**Total $ in thousands*

Our broker partners continue to be instrumental in establishing net membership growth for our LACC and D-SNP products. We have steadily grown our D-SNP Certified Broker Agents to include over 1,000 agents, to serve as an extension of our Sales team, whom have contributed to 65% of our production, supporting our net membership growth over 18,000. As part of the CMS Commission Rate requirements and aligning to the CMS Final Rule, L.A. Care will continue to pay residuals for Broker book of business beginning January 1, 2025.

The L.A. Care Covered broker network to include over 3,000 agents, has also proved to be very valuable, helping us grow our product to over 100,000 members, whom are trending to contribute 55% of our entire membership. For CY 2025, commission will continue the same, with no changes. Our focus will continue to be on partnerships, training, education and business development for the Broker Community, insuring we can give our agents the tools they need to benefit our providers, community-based organizations, members and prospective members. Being able to demonstrate the value of these partnerships is critical to the success of our sales strategy and tactics.

Community Health Improvement Programs

The proposed Community Health Improvement Program budget for FY 2024-25 allocates $56.7 million of L.A. Care's financial reserves for selected projects to be funded throughout the fiscal year. Community Health Improvement Programs include the Community Health Investment Fund (CHIF), Elevating the Safety Net, Blue Shield Promise Grant, Community Resource Centers, and Community Programs (which includes Community Clinic Program, Community Benefits Program, Promotoras and Sponsorships).

L.A. Care Health Plan Community Health Improvement Programs Fiscal Year 2024-25 Budget						
($ in millions)	**CHIF**	**Elevating the Safety Net**	**Blue Shield Promise Grant**	**Community Resource Centers**	**Community Programs***	**Total**
Revenue						
Community Investments - Revenue	$0.0	$0.0	$7.9	$0.0	$0.0	$7.9
Expense						
Community Investments - Expense	$10.0	$11.9	$7.9	$31.0	$0.0	$60.8
Administrative Expenses	$0.0	$0.0	$0.0	$0.0	$3.8	$3.8
Net Surplus/(Deficit)	**($10.0)**	**($11.9)**	**$0.0**	**($31.0)**	**($3.8)**	**($56.7)**

**Community Programs include Community Clinic Program, Community Benefits Program, Promotoras & Sponsorships*

L.A. Care Health Plan
Community Health Improvement Programs
Comparative Statement - Expenses Only

($ in thousands)	FY 2023-24 4+8 Forecast	FY 2024-25 Budget
Community Health Investment Fund	**$11,142**	**$10,000**
Elevating the Safety Net	**10,576**	**11,900**
Blue Shield Promise Grant	**4,478**	**7,941**
Community Resource Centers	**23,615**	**30,992**
First 5 L.A. Grant	**303**	**-**
Community Programs	**2,895**	**3,779**
SCOPE Plan	250	500
Community Benefits Program	976	1,399
Promotoras/Health Promoters Program	338	180
Sponsorships/In-Kind	1,331	1,700
Total	**$53,008**	**$64,612**

Community Health Investment Fund (CHIF) $10.0 Million

The Board of Governors established the Community Health Investment Fund (CHIF) program to improve access and quality of care by filling gaps and supporting infrastructure to benefit the underserved and the safety net that serves them. CHIF is managed by the Community Benefits Department. Its proposed overarching funding goals for FY 2024-25 include:

1. Support the health care safety net to improve infrastructure and address disparities,
2. Advance solutions for social determinants of health to reduce inequities,
3. Close pervasive health disparities gaps, and
4. Empower and invest in health and health related social service organizations that address systemic racism.

Each year, staff presents to the Board a recommended budget allocation for CHIF grantmaking, which is divided between funds for predetermined initiatives and for those in response to external requests known as ad-hoc. The CHIF budget for FY 2023-24 was $10 million, and at least $10 million is recommended for FY 2024-25.

A total of $10 million is recommended to be invested in initiatives that improve community and public health, expand equitable access to healthcare, and strengthen whole person care, with a focus on rectifying health conditions frequently experienced at a disproportionately higher rate among under-resourced communities, including those in which our members live, work and pray. This may include projects that improve clinical delivery systems, such as care coordination and integration of medical, behavioral health, and oral healthcare, in addition to projects that address social determinants of health, and attempt to stem their root causes, namely systemic racism. All CHIF strategies will be designed to improve health and health related issues that are evidenced to critically impact physical, social, and/or behavioral health to enable individuals and communities to experience optimal health.

Workforce Development Initiative/Elevating the Safety Net (ESN) $ 11.9 Million

L.A. Care's Elevating the Safety Net (ESN) initiative is a long-term initiative to recruit highly qualified primary care physicians into the Los Angeles County safety net. Since FY 2017-18, and in alignment with our mission to care for the most vulnerable people in Los Angeles County, the ESN initiative has invested over $100 million of the $155 million across various programs to recruit, train and retain highly qualified primary care physicians who commit to practicing in our safety net. On October 5, 2023, L.A. Care's Board of Governors approved adding $50 million for a new total budget of $205 million to support ongoing workforce investments through FY 2026-27 across the key programs listed below and other emerging priorities.

Medical School Scholarship Program $ 3.9 Million

Offers full-tuition scholarships for eight (8) students admitted to the Charles R. Drew University of Medicine and Science (four students) and the David Geffen School of Medicine at UCLA (four students). 'L.A. Care Scholars' are identified by each school based on their diversity and ethnic background, desire to work with vulnerable populations and demonstration of financial need.

Provider Loan Repayment Program $ 4.0 Million

Supports physicians who commit to serving our Medi-Cal members and vulnerable communities for at least three (3) years by awarding them up to $5,000 per month to assist with student loan debt repayment. This program will be administered by a nonprofit organization, Uncommon Good, and physicians will be awarded based on a competitive application process.

Provider Recruitment Program $ 4.0 Million

Awards grants of up to $125,000 to eligible clinics and practices. Grant awards cover salary subsidies, sign-on bonuses, and/or relocation costs for new physicians or primary care psychiatrists recruited into the safety net. Clinics and practices will apply to the program through a competitive application process based on their need and history with L.A. Care.

Blue Shield Promise Grant $7.9 Million

L.A. Care Health Plan and Blue Shield of California Promise Health Plan have committed a combined $146 million over five years, to expand Resource Centers across Los Angeles County, both in terms of geographic footprint and services. Over five years, L.A. Care and Blue Shield Promise jointly opened five new Resource Centers, remodeled four existing centers and relocated three centers to larger locations, for a total of 12 centers. Two additional new centers will open in early FY 2024-25. The co-branded facilities are called Community Resource Centers. A new 5-year operating partnership agreement with Blue Shield Promise is expected to be take effect on October 1, 2024.

The Resource Centers will enhance community connections, address social needs and improve overall health outcomes for members and the entire community through free health screenings and on-site enrollment support for social service programs. Each jointly operated Resource Center will serve as a one-stop community destination, providing classes and services that will help keep center visitors active, healthy and informed.

While the Resource Centers are open to the public, L.A. Care and Blue Shield members will be able to access personalized health and wellness programs and services. The Resource Centers will serve as platforms to introduce health care technology such as telemedicine and health care mobile application support to help build L.A. Care and Blue Shield Promise members' capacity to manage their own health.

Community Resource Centers $31.0 Million

The Community Resource Centers are aimed at addressing health disparities by creating a single point of service where the community can turn to for help with health education, assistance with navigating the health care delivery system and available programs and resources. Dedicated L.A. Care staff and contracted health education vendors provide a number of activities for health plan members and other community residents including health education, disease prevention, promotion of self-management tools and education on establishing or maintaining health coverage. Twelve Community Resource Centers have successfully been launched in Boyle Heights, East L.A., Inglewood, Lynwood, Panorama City, Palmdale, Pomona, Metro L.A., Wilmington, El Monte, Norwalk and Long Beach and are operated jointly with Blue Shield of California Promise Health Plan.

Since the opening of the first Community Resource Center in November 2007, the initiative has been successful in delivering well-integrated health education resources and services that address important health topics such as asthma, diabetes, and obesity. A larger location in Lincoln Heights and a new location in South L.A. are expected to be completed in FY 2024-25.

Strengthening Clinical Operations and Patient Experience (SCOPE) Fund $0.5 Million

In 2022, the SCOPE Fund was reassigned to the Community Benefits Department transitioning from offering contracts to providing grants. The SCOPE Plan's three main objectives are to (1) improve patient experience, (2) improve health outcomes and (3) reduce unnecessary health care costs. To achieve these objectives, SCOPE grant partners focus on addressing the following strategic areas:

A. Clinic Workforce Training and Leadership Development
B. Improved Patient Experience
C. Enhanced Operations and Sustainability

The fund helps advance healthcare quality and innovation, the safety net workforce, and efficient care coordination through workforce training and leadership development, technical assistance, and policy development. Community Benefits will partner with organizations of significant experience in driving policy decisions to ensure providers in the Medi-Cal program and other L.A. Care products, and their members have equitable access to all forms of health care, and service delivery models that are evidence-based, high quality, and affordable for and valued by clients. Ultimately, this fund maximizes learning and leadership opportunities for contracted clinic partners through policy solutions, as well as assessment and advocacy for the refinement of statewide regulation for Medi-Cal plans.

Community Benefit Programs' Administration $1.4 Million

The Community Benefits Department staff has been responsible for managing all aspects of L.A. Care's CHIF grant making activities for over 25 years. The departments grew in 2018 when it began overseeing the Provider Recruitment Program on behalf of the Elevating the Safety Net. In 2023, the department experienced its most significant growth with added responsibility for grant initiatives related to the Housing and Homelessness Incentive Program (HHIP) and the SCOPE fund and three additional staff, two of which are supported as ALD's through HHIP funding.

The 2024-25 budget planning process has allowed the department to thoroughly consider how best to meet the administrative need of our growing team and operations. Administrative funds will continue to support the subscription for Community Benefits' grants management system called Blackbaud. Funding will also be used to pay stipends to external subject matter experts participating on a review committee panels, in addition to supporting the cost of food for review committee meetings. All costs will be within GSA allowable guidelines. Community Benefits will host up to seven grant review committee meetings to evaluate requests for grant and make funding recommendations. The department also conducts about 10 review committees comprised of internal staff from various L.A. Care departments for the various fund programs. While those committees do not require inclusion on the food and project budget, it is noted here in the event the department would like to access Employee Morale funds.

Administrative funds for 2024-25 have also been allocated to consultants to facilitate training, technical assistance, and need assessments, or community investment planning convenings. Community Benefits grantee partner requiring technical assistance beyond the department's resources are provided consultants to advise them on specialized and technical topics that build their capacity to fulfil the grant's purposes. Typically, these consultants are provided for a cohort of grantees within an initiative, but consultants may be requested for a specific effort being implemented by a single grantee entity, like the California Association of Food Banks.

Consultants will also be engaged in FY 2025, as Community Benefits anticipates the need to conduct up to four community provider convenings to develop priorities for community investments due to the changing landscape for Medi-Cal Plans' giving under the State Medi-Cal contract, expected budget shortfalls bringing new demands on philanthropy, and our periodic strategic planning session with community providers and other philanthropies. Lastly, the department will require technical operational or administrative consultation to support its grantmaking procedures/workflows, systems utilization, grants management or evaluation, and/or report development.

Administrative funds are also allocated for staff professional development, including potential travel at an average rate up to $2,000 per staff person. Given the change in workflows and staff roles, professional development is essential at this juncture. It was also identified as an area of improvement in our divisions Employee Engagement Survey results since 2022. The department is making professional development more accessible by renewing or establishing memberships with three entities; Southern California Grantmakers (SCG), PEAK Grantmaking, and Non-profit Sustainability Initiative (NSI), which provide benefits of free or low-cost access to workshops and trainings, subject matter funder groups, certification courses, and conferences. These organizations also make available to their members online networking/forums and professional resource directories, including highly rated consultant entities.

Capital Expenditures and Other Projects

The list reflects projects proposed and may include amounts to be spent over multiple fiscal years. Projects primarily support infrastructure and systems improvements while allowing L.A. Care the flexibility to achieve Strategic Goals.

L.A. Care Health Plan
Capital Projects
Fiscal Year 2024-25
($ in thousands)

Project Description	Business Owner	Capital Expense	Operating Expense	Total
A&G System Replacement	Customer Service	$ 920	$ 230	$ 1,150
Care Catalyst - New HS Clinical System	Health Services	250	250	500
CDR Phase 2	I.T.	1,382	608	1,990
Clinic Based Assignment and FQHC APM	Provider	200	50	250
CMS Interoperability Mandate	I.T.	960	240	1,200
Edifecs Enhancements	Finance	5,348	1,352	6,700
MAPD Product Launch	Product	4,014	1,003	5,017
PQI System Replacement	Health Services	530	163	693
Provider Roadmap	Provider	3,216	920	4,136
SAP/ERP	Finance	1,511	361	1,872
VOICE - CRM & Telecom	I.T. & Operations	9,137	804	9,941
I.T. Member Experience Program	I.T.	7,297	1,804	9,101
Performance Optimization Program (Enterprise & Network)	Compliance	1,820	437	2,257
QNXT Upgrade & Transformation	I.T.	3,263	2,179	5,443
Leasehold Improvements	Facilities	38,415	-	38,415
Total Capital Projects		**$ 78,263**	**$ 10,401**	**$ 88,664**

A&G System Replacement

The current A&G legacy system (PCT) is outdated, resulting in inefficiencies and reliability issues. To address these challenges, the initiative replaces PCT with a new system that will automate A&G processes, integrate with UM and Claims systems, comply with DMHC, DHCS, and CMS requirements, and eliminate manual processes deficiencies. The new system will enhance workflow controls, productivity, and monitoring, improve information accuracy and timeliness, and support better case intake, letter configuration, and reporting.

Care Catalyst – New Health Services Clinical System

This final component of the Care Catalyst program focuses on ensuring the continued accessibility of historical data from the SyntraNet Utilization Management platform for operational, compliance, audit, and reporting uses. These investments complement functionality being deployed in the QNXT Upgrade & Transformation effort (below), which transform L.A. Care's Utilization Management tools and processes.

Clinical Data Repository (CDR) Phase 2

CDR Phase 2 will be a continued investment in modern data exchange functionality to include Continuity of Care Document (CCD) data. The objective is to develop a real-time CCD data ingestion pipeline from LANES and HIEs to meet regulatory compliance, enhance health plan performance, and improve quality of care for members.

Clinic Based Assignment and FQHC APM

With the recent, successful implementation of Clinic Based Assignment, L.A. Care can not only assign members directly to specific categories of community clinics, but also gained the necessary infrastructure to participate in the DHCS-mandated Alternative Payment Methodology (APM). Under APM, L.A. Care will change how it pays participating FQHC community clinics to include the Prospective Payment System (PPS) rate for Medi-Cal services that has previously been paid to clinics by the State.

CMS Interoperability Mandate

L.A. Care continues its multi-phase investment in electronic provider and member data portability in accordance with CMS requirements. Investments in 2025 and 2026 focus on payer-to-payer interfaces to ensure timely and efficient benefits coordination and transitions, as well as functionality for electronic prior authorizations.

Edifecs Enhancements

L.A. Care is continuing its iterative improvements of the Edifecs platform, which enables the organization's encounter data management and related regulatory reporting, and that supports risk adjustment activities. Upcoming enhancements target both operational optimizations, as well as compliance with evolving regulatory requirements. Planned investments include the processing of chart review records in Edifecs that do not have correlates in our electronic encounter data received from trading partners; the ability to unbundle mother/infant claims and encounters for the LACC line of business; processing of supplemental dental, vision, chiropractic, and acupuncture data for submission to CMS; inclusion of pharmacy data in outbound encounter reports to CMS; and enhancing the ability to process multi-payer encounter data. The organization is also exploring changes to the hosting arrangement for Edifecs software to maximize operational savings.

Medicare Advantage Prescription Drug (MA-PD) Product Launch

L.A. Care will be offering a new Medicare Advantage Prescription Drug (MA-PD) Plan, with enrollment starting in the fall of 2025, and plan benefits starting January 1, 2026. The MA-PD Product aims to provide continuity of managed care services for members transitioning into Medicare, as well as provide an option for Medicare beneficiaries in L.A. County who do not qualify for the D-SNP Plan. L.A. Care's business and technical teams will be preparing technology systems and business processes throughout the FY 24-25 fiscal year to ensure operational readiness.

PQI System Replacement for Provider Quality Review

The team responsible for Provider Quality Review has lacked a central repository and modern system to support its work. L.A. Care has been building system with modern workflow controls to improve productivity and monitoring of the review process; to reduce delayed, lost, or incongruent information between teams; and to ensure integration with other enterprise systems. With the initial deployment targeted for fall 2024, L.A. Care intends to iteratively enhance the system's capabilities through FY 24-25 to meet the needs of Health Services.

Provider Roadmap

This multi-year initiative centers on the implementation of a holistic provider network management system for L.A. Care's provider business functions. The scope includes improved provider data ingestion, validation, and management, as well as workflow tools and refined business processes. The initiative will enable improved provider data quality, and more efficient operations in contracting, credentialing, network management, provider relations, member assignment, and regulatory reporting.

SAP/ERP

L.A. Care is continuing its implementation of SAP for financial management functions. The upcoming phase will concentrate on finalizing the deployment of Callidus, a commission software solution that manages incentives and

compensation programs for brokers. Additionally, the program will implement Arriba, a spend management tool designed to integration seamlessly with existing SAP procurement solutions. Arriba will enhance electronic order and invoice routing, user and role management functionalities, and contract and vendor management processes.

VOICE - CRM & Telecom

This multi-year program aims to create a robust and integrated Enterprise Customer Relationship Management (CRM) solution that improves the experience of L.A. Care's members and providers. Recent investments have focused on the implementation of a new agent console ('intelligent desktop') for the Call Center and other enterprise users; a new member portal with self-service capabilities; and a new prover portal with self-service capabilities. Following this implementation a subsequent phase will add enhancements across the CRM platform, including the integration of the agent console with our telephony systems, and the onboarding of additional areas of the organization with tailored CRM tools. These tools are expected to include Provider Dispute Resolution (PDR), Quality Improvement, and Pharmacy medication management. The initiative is also making investments in capturing and managing member demographic data aligned with regulatory requirements, such as Race and Ethnicity, Sexual Orientation and Gender Identity, and Alternative Format Selection.

I.T. Member Experience Program

This initiative is composed of two multi-year, cross-functional programs to modernize data systems and I.T. tools to support an optimized member experience. These foundational technology efforts enable L.A. Care to more proactively manage the member life cycle (from enrollment through care delivery). Work streams in this initiative include Data Architecture Modernization, which improves how enterprise data is organized, managed, and stored; and a Clinical Data Repository (CDR) to better organize clinical experience data in support of care coordination, operational planning, and regulatory reporting. These continued investments will enable L.A. Care to deliver future technology initiatives more effectively, and significantly improve the ability of business areas inside L.A. Care to serve member needs.

Performance Optimization Program (Enterprise & Network)

This multi-year initiative is building data management tools and dashboard reporting tailored to L.A. Care's oversight activities. These investments improve improves monitoring of the performance of non-delegated enterprise functions, as well as entities in L.A. Care's extended service delivery model across lines of business. This initiative is improving data sources and reporting for numerous Key Performance Indicators (KPIs) for L.A. Care.

QNXT Upgrade & Transformation

L.A. Care is making progressive investments in its core claims platform (QNXT), with current work focused on the implementation of new UM capabilities, as well as meeting Transparency in Coverage requirements. L.A. Care is also laying the foundation for a future move to a cloud implementation, with related efforts to reduce dependence on custom code, as well as completing an incremental upgrade of the software to meet business needs.

Leasehold Improvements

The capital budget includes funds to support construction associated with two Community Resource Centers (CRC), Lincoln Heights (new), Palmdale (relocation), miscellaneous upgrades to existing CRCs and a budget for the build-out of the 1200 W. 7th Street lease space to support the return to work/hybrid office configuration effective January 2025.

L.A. Care Health Plan
Comparative Income Statement
Fiscal Year 2024-25

($ in thousands)	FY 2022-23 Actual	FY 2023-24 Forecast [1]	FY 2024-25 Budget
Member Months	34,248,474	30,702,521	29,982,226
Revenue			
Capitation	$11,290,839	$10,618,166	$10,812,957
Total Revenues	11,290,839	10,618,166	10,812,957
Healthcare Expenses			
Capitation	5,824,298	5,397,458	4,999,234
Inpatient Claims	1,444,767	1,322,142	1,522,804
Outpatient Claims	1,414,662	1,447,468	1,588,374
Skilled Nurse Facility	1,109,176	1,177,024	1,353,892
Pharmacy	145,181	179,862	234,838
Provider Incentives & Shared Risk	138,963	237,045	204,521
Medical Administrative Expenses	105,805	140,042	143,628
Total Healthcare Expenses	10,182,852	9,901,040	10,047,290
MCR %	*90.2%*	*93.2%*	*92.9%*
Operating Margin	1,107,987	717,126	765,667
Total Operating Expenses	531,360	634,687	693,861
Administrative Ratio %	*4.7%*	*6.0%*	*6.4%*
Income (Loss) from Operations	576,627	82,438	71,806
Margin before Non-Operating Inc (Exp) %	*5.1%*	*0.8%*	*0.7%*
Non-Operating Income/(Expense)			
Provision for Community Investments	(48,925)	(31,503)	(53,692)
Managed Care Tax, net	16,352	(2,950)	2,908
Investment Income, net	101,885	198,577	180,371
Net Surplus/(Deficit) [2]	**$645,939**	**$246,562**	**$201,393**
Margin %	*5.7%*	*2.3%*	*1.9%*

Note:

1. Fiscal Year 2023-24 Forecast is based on 4 months of actual financial results through January 2024 & 8 months of forecast through September 2024

2. Net Surplus/(Deficit) includes Incentive Payment Program (IPP) & Housing and Homelessness Incentive Program (HHIP)

L.A. Care Health Plan
Balance Sheet
Fiscal Year 2024-25

($ in thousands)	Actual as of September 30, 2023	Forecast as of September 30, 2024	Budget as of September 30, 2025
Combined Balance Sheet			
Current Assets			
Cash & cash equivalents	$1,578,927	$1,517,855	$1,207,185
Investments, at fair value	1,794,938	2,484,160	2,983,356
Other current assets	3,154,911	2,832,940	2,844,365
Total current assets	6,528,776	6,834,955	7,034,906
Capital Assets, net	169,253	160,717	189,117
Other Assets			
Non-current Assets	3,243	27,756	27,156
Total Assets	**$6,701,272**	**$7,023,428**	**$7,251,179**
Current Liabilities			
A/P and accrued liabilities	$172,607	$283,361	$298,237
Subcapitation payable	3,426,014	3,267,155	3,263,555
Reserves for Provider Incentives	104,851	147,890	180,396
Reserves for claims	842,608	734,127	736,127
Deferred Revenue	57,426	74,052	29,298
Other accrued medical expenses	265,546	245,858	249,858
Grants payable	19,299	22,051	43,381
Total current liabilities	4,888,351	4,774,494	4,800,852
Non-Current Liabilities	79,627	35,108	35,108
Total Liabilities	4,967,978	4,809,602	4,835,960
Fund Equity			
Invested in Capital Assets	98,910	160,717	189,117
Restricted	600	23,327	23,327
Designated by Board of Governors			
Board Designated Funds	84,624	136,266	102,266
Unrestricted Net Assets	1,313,667	1,648,889	1,827,263
TNE (130% of Required)	235,493	244,627	273,247
Total Fund Equity	1,733,294	2,213,826	2,415,219
Total Liabilities and Fund Equity	**$6,701,272**	**$7,023,428**	**$7,251,179**

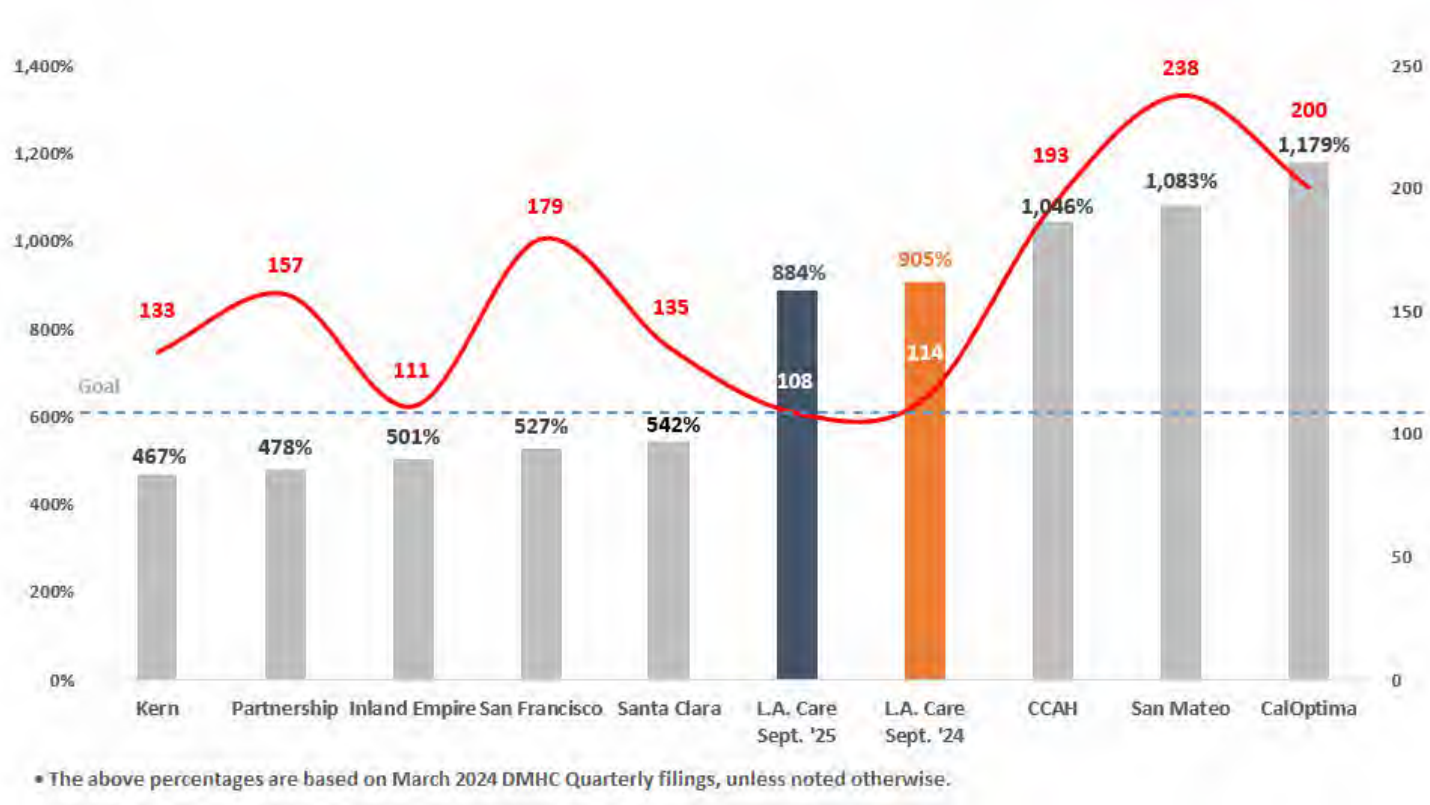
L. A. Care Health Plan
Statement of Cash Flows
Fiscal Year 2024-25

($ in thousands)	Forecast for the FYE September 30, 2024	Budget for the FYE September 30, 2025
Combined Statement of Cash Flows		
Operating activities		
Net Surplus (Deficit)	$480,531	$201,393
Add: Depreciation/Amortization, Investment Loss, and Tax Provision	42,231	81,708
(Increase) Decrease in:		
Other current assets	321,971	(11,425)
Non-current Assets	(24,513)	600
Increase (Decrease) in:		
Accounts payable	110,754	14,876
Subcapitation payable	(227,345)	(3,600)
Reserves for provider incentives	43,039	32,506
Reserves for claims	(108,481)	2,000
Deferred revenue	16,626	(44,754)
Other accrued medical expenses	(19,688)	4,000
Grants payable	2,753	21,330
Non-current liabilities	(44,519)	-
Cash provided (used) by operating activities	593,359	298,635
Investing activities		
Sell (purchase) of investments	(675,295)	(499,196)
Capital assets (investment)	(50,572)	(107,200)
Cash (used) provided by investing activities	(725,867)	(606,396)
Cash provided (used) by Pass Through activities	71,436	(2,908)
Net increase (decrease) in unrestricted cash & equivalents	(61,072)	(310,670)
Unrestricted cash & equivalents - beginning of period	1,578,927	1,517,855
Unrestricted cash & equivalents - end of period	**$1,517,855**	**$1,207,185**

L. A. Care Health Plan
Required Tangible Net Equity Calculation
Fiscal Year 2024-25

($ in thousands)	**Budget as of September 30, 2025**
Tangible Net Equity (TNE) Calculation	
Healthcare expenses:	
1. 8% of first $150 million of annualized healthcare expenses, except those paid on a capitated or managed hospital basis	$12,000
2. 4% of the annualized health care expenses, except those paid on a capitated or managed hospital basis	79,729
3. 4% of the annualized hospital expenditures paid on a managed hospital basis	118,461
Calculated TNE based on healthcare expenses	210,190
TNE (at 130% of State Required Level)	273,247
Fund equity	2,415,219
Excess equity over required TNE	**$2,141,973**

TNE Chart and Days of Cash Comparison



• The above percentages are based on March 2024 DMHC Quarterly filings, unless noted otherwise.

Due to the volume of the documents, the March, April, May, June, and July 2024 Monthly Investments Reports will be sent in a separate file.

DATE: May 22, 2024

TO: Finance & Budget Committee

FROM: Afzal Shah, *Chief Financial Officer*

SUBJECT: Monthly Investment Portfolio Securities Transaction Report for March, 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 March 1 to March 31, 2024.

L.A. Care's investment market value as of March 31, 2024, was $4.7 billion. This includes our funds invested with the government pooled funds and the Bank of America money market sweep account fund. L.A. Care has approximately $5 million invested with the statewide Local Agency Investment Fund (LAIF), and approximately $81 million invested with the Los Angeles County Pooled Investment Fund (LACPIF). L.A. Care also has approximately $109M invested with the BlackRock Liquity T-Fund.

The remainder as of March 31, 2024, of $4.46 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.

DATE: June 26, 2024

TO: Finance & Budget Committee

FROM: Afzal Shah, *Chief Financial Officer*

SUBJECT: Monthly Investment Portfolio Securities Transaction Report for April, 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 April 1 to April 30, 2024.

L.A. Care's investment market value as of April 30, 2024, was $4.1 billion. This includes our funds invested with the government pooled funds and the Bank of America money market sweep account fund. L.A. Care has approximately $6 million invested with the statewide Local Agency Investment Fund (LAIF), and approximately $11 million invested with the Los Angeles County Pooled Investment Fund (LACPIF). L.A. Care also has approximately $108M invested with the BlackRock Liquity T-Fund.

The remainder as of April 30, 2024, of $4 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.

DATE: August 28, 2024

TO: Finance & Budget Committee

FROM: Afzal Shah, *Chief Financial Officer*

SUBJECT: Monthly Investment Portfolio Securities Transaction Report for May, 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 May 1 to May 31, 2024.

L.A. Care's investment market value as of May 31, 2024, was $3.7 billion. This includes our funds invested with the government pooled funds and the Bank of America money market sweep account fund. L.A. Care has approximately $6 million invested with the statewide Local Agency Investment Fund (LAIF), and approximately $11 million invested with the Los Angeles County Pooled Investment Fund (LACPIF). L.A. Care also has approximately $117M invested with the BlackRock Liquidity T-Fund.

The remainder as of May 31, 2024, of $3.6 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.

DATE: August 28, 2024

TO: Finance & Budget Committee

FROM: Afzal Shah, *Chief Financial Officer*

SUBJECT: Monthly Investment Portfolio Securities Transaction Report for June, 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 June 1 to June 30, 2024.

L.A. Care's investment market value as of June 30, 2024, was $3.7 billion. This includes our funds invested with the government pooled funds and the Bank of America money market sweep account fund. L.A. Care has approximately $6 million invested with the statewide Local Agency Investment Fund (LAIF), and approximately $11 million invested with the Los Angeles County Pooled Investment Fund (LACPIF). L.A. Care also has approximately $125 million invested with the BlackRock Liquidity T-Fund.

The remainder as of June 30, 2024, of $3.6 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.

DATE: August 28, 2024

TO: Finance & Budget Committee

FROM: Afzal Shah, *Chief Financial Officer*

SUBJECT: Monthly Investment Portfolio Securities Transaction Report for July, 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 July 1 to July 31, 2024.

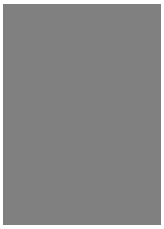
L.A. Care's investment market value as of July 31, 2024, was $3.7 billion. This includes our funds invested with the government pooled funds and the Bank of America money market sweep account fund. L.A. Care has approximately $6 million invested with the statewide Local Agency Investment Fund (LAIF), and approximately $11 million invested with the Los Angeles County Pooled Investment Fund (LACPIF). L.A. Care also has approximately $88 million invested with the BlackRock Liquidity T-Fund.

The remainder as of July 31, 2024, of $3.6 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.



May 13, 2024

TO: Finance & Budget Committee

FROM: Afzal Shah, *Chief Financial Officer*

SUBJECT: AFS-006 (Authorization and Approval Limits) and AFS-007 (Procurement Policy) 2nd Quarter Report for FY 2024

The below Accounting & Financial Services (AFS) policies are required to be reported to the Finance & Budget Committee:

1. Policy AFS-006 (Authorization and Approval Limits) requires reports for executed vendor contracts for all expenditures.

2. Policy AFS-007 (Procurement Policy) requires reports for all sole source purchases over $250,000.

Attached are the reports for 2nd Quarter Report for FY 2024.

L.A. Care Health Plan
AFS-006 Authorization and Approval Limits Quarterly Report
January 2024 - March 2024

New POs and Contracts	
Vendor Name	**PO and Contract Total**
A&M Healthcare Industry Group, LLC (a Wholly Owned Subsidiary of A&M Holdings, LLC)	$ 617,000.00
ABF Data Systems, Inc	$ 37,680.00
Absolute Ops LLC	$ 70,757.50
AdhereHealth Solutions LLC	$ 2,990,000.00
Advanced Healthcare Administration	$ 68,600.00
Advent Advisory Group LLC	$ 117,454.20
Affordable Living for The Aging (Grantee)	$ 300,000.00
AHN Foundation	$ 25,200.00
Alexandra Rodriguez	$ 11,240.00
Amazon Capital Services, Inc.	$ 30,469.68
Amtex Delivery Systems	$ 31,320.00
Ana Maria Delgado	$ 21,100.00
Angela P. Ahmu	$ 4,160.00
Antelope Valley Partners for Health	$ 57,140.00
Anthony Peter Lopez, Jr.	$ 103,363.34
Arent Fox LLP	$ 850,000.00
Ascencia (Grantee)	$ 250,000.00
Asian Pacific Health Care Venture, Inc. (Grantee)	$ 125,000.00
ATTAC Consulting Group, LLC	$ 59,560.00
Aunt Flow Corp.	$ 1,187.50
Bahareh Rabii	$ 12,000.00
Bearing on Health Inc	$ 176,000.00
Best Best & Krieger LLP	$ 200,000.00
Birthworkers of Color Collective	$ 16,000.00
Blackbaud, Inc.	$ 18,112.50
BrandFuse, inc.	$ 52,055.00
Brent Powell	$ 57,600.00
Cahaba Consulting Group, LLC	$ 695,450.00
Canon Solutions America Inc	$ 523,052.00
Center for the Study of Services	$ 1,588,316.30
Chinatown Service Center (Grantee)	$ 125,000.00
Cognizant TriZetto Software Group, Inc.	$ 4,827,645.99
Comcast Holdings Corporation	$ 15,000.00
Community Partners (Grantee)	$ 75,000.00
Competiscan, LLC	$ 12,485.00
Corodata Shredding, Inc.	$ 90,000.00
Costas Healthcare Solutions, LLC	$ 23,100.00
Critical Care Training Center	$ 67,200.00
Cynthia ReedCarmona	$ 91,000.00
Daponde Simpson Rowe PC	$ 1,225,000.00
Datavail Corporation	$ 306,564.00
Deloitte LLP	$ 7,500,000.00
Dewey Pest Control	$ 4,317.00
Digicert, Inc.	$ 8,890.00
Downtown Women's Center (Grantee)	$ 250,000.00
Earth Print, Inc.	$ 225,960.22

New POs and Contracts	
Vendor Name	**PO and Contract Total**
East Valley Community Health Center, Inc. (Grantee)	$ 125,000.00
Edmund Jung & Associates, Inc.	$ 90,000.00
El Sol Neighborhood Educational Center	$ 433,000.00
EPI-USE Labs, LLC.	$ 6,789.92
ePlus Technology, inc.	$ 4,302,100.08
Expert Plant Care, Inc.	$ 45,920.00
Fariborz Satey, MD, Inc. (Grantee)	$ 125,000.00
Fierce Software Corporation	$ 125,039.47
Fitness International, LLC	$ 1,000.00
Freeman-Thomas Early Education Consulting, LLC	$ 13,912.00
Galan Cultural Center Inc.	$ 38,000.00
God's Pantry	$ 98,448.00
Green Management Consulting Group, Inc.	$ 286,875.00
HALO BRANDED SOLUTIONS, INC.	$ 99,226.61
Hanson Bridgett LLP	$ 50,000.00
Health Access for All Inc. (Grantee)	$ 125,000.00
Health Management Associates Inc.	$ 968,480.00
Healthy Cooking LLC	$ 122,160.00
Hogan Lovells US LLP	$ 200,000.00
Homeboy Industries	$ 8,386.20
HRRP Garland LLC	$ 125,000.00
I Color Printing & Mailing Inc	$ 8,769,599.79
I.D. Systems & Supplies, Inc.	$ 10,000.00
Imagine Los Angeles, Inc. (Grantee)	$ 250,000.00
Instant InfoSystems	$ 2,114,550.62
Isaacs | Friedberg LLP	$ 200,000.00
Jack Nadel Inc	$ 9,000.00
JeffersonLarsonSmith LLC	$ 307,500.00
Jemmott Rollins Group	$ 100,000.00
Jennifer Baez	$ 49,920.00
Karen Perez	$ 24,700.00
Khavarian Enterprises, Inc.	$ 3,520.00
Kinema Fitness, Inc.	$ 30,000.00
Lakeshore Equipment Company	$ 13,050.68
Lands' End, Inc	$ 4,190.68
Larson LLP	$ 500,000.00
Luxor Printing Inc.	$ 1,224.09
M. Arthur Gensler, Jr. & Associates, Inc	$ 1,415,661.50
Majestic Marketing, Inc.	$ 891.72
Manhattan Telecommunications Corporation LLC	$ 100,000.00
Mazars USA LLP	$ 299,542.00
Michael Moldofsky	$ 9,499.50
Moss Adams LLP	$ 112,676.00
mPulse Mobile, Inc.	$ 493,482.00
Musick, Peeler & Garrett LLP	$ 100,000.00
New Tangram, LLC	$ 8,600.00
NICE Systems Inc	$ 585,280.35
Nielsen Merksamer Parrinello Gross & Leoni, LLP	$ 136,707.20
North Star Alliances, LLC	$ 2,878,200.00
Nossaman LLP	$ 100,000.00
NTT America, Inc.	$ 193,785.96

New POs and Contracts	
Vendor Name	**PO and Contract Total**
Office Ally, Inc	$ 360,000.00
Office Depot, Inc.	$ 37,548.56
Ollivier Corporation	$ 29,607.58
Optiv Security, Inc.	$ 2,409,331.95
Optum360 LLC	$ 14,234.25
Oracle America, Inc.	$ 4,800,000.00
Pack4U, Inc	$ 6,750.00
Paradise Signs, Inc.	$ 2,640.00
Pediatric & Family Medical Center (Grantee)	$ 125,000.00
PhotoShelter, Inc.	$ 10,499.00
Pomona Community Health Center (Grantee)	$ 150,000.00
Proaxys, Inc.	$ 300,000.00
Providence Little Company of Mary Foundation	$ 45,600.00
Purchaser Business Group on Health	$ 140,000.00
Q-PERIOR Inc.	$ 1,540,000.00
Quest Analytics, Inc. (Parent Company of Quest Analytics L.L.C.)	$ 654,740.00
Rapid7 LLC	$ 8,262.00
Resources Connection Inc.	$ 836,100.00
Rita Lisa Sinkoski	$ 3,900.00
Rubi Ruiz	$ 41,060.00
Safe and Sound Surveillance Solutions Inc	$ 9,680.00
Safety Net Connect Inc.	$ 1,180,000.00
SAP America, Inc.	$ 1,500,917.74
Sculpt Fitness Long Beach LLC	$ 40,950.00
Sheppard Mullin Richter & Hampton LLP	$ 1,300,000.00
SHI International Corp	$ 2,422,318.27
SKKN, INC.	$ 202,104.59
SonBern LLC.	$ 102,960.00
Sonia P. Guzman	$ 51,500.00
Tangoe US, Inc.	$ 132,768.00
The Anti-Recidivism Coalition (Grantee)	$ 250,000.00
The Children's Clinic, Serving Children and Their Families (Grantee)	$ 250,000.00
The Prophet Corporation	$ 5,240.14
The R.O.A.D.S. Foundation, Inc. (Grantee)	$ 125,000.00
Toney HealthCare Consulting, LLC	$ 3,763,584.00
Training Connection LLC	$ 14,320.00
TRI Ventures, Inc.	$ 6,000.00
Uline, Inc.	$ 14,215.18
Unidos Por La Musica	$ 87,840.00
Venice 2000 dba HELPER Foundation	$ 24,700.00
Via Care Community Health Center (Grantee)	$ 125,000.00
Vicki Bolsega	$ 7,800.00
VideoGuard, LLC	$ 52,200.00
Virginia Medina	$ 8,320.00
W Why W Enterprises, Inc.	$ 300,000.00
WestLA Homeless	$ 84,700.00
WW North America Holdings LLC	$ 3,600.00
Zipari, Inc.	$ 1,590,223.52
Zoll Medical Corp	$ 519.00
Zones, LLC (Wholly Owned by Zones IT Solutions Inc.)	$ 86,903.16
Total	**$ 75,426,536.54**

New POs and Contracts	
Vendor Name	**PO and Contract Total**

L.A. Care Health Plan
AFS-006 Authorization and Approval Limits Quarterly Report
January 2024 - March 2024

Amended Vendor Contracts

Vendor Name	Current Contract Total	Amendment	New Contract Total	Term Date
Advize Health LLC	$ 146,000.00	$ 146,000.00	$ 292,000.00	8/24/2025
Brent Powell	$ 52,500.00	$ 9,750.00	$ 62,250.00	6/30/2025
Change Healthcare Resources Holdings Inc.	$ 6,100,000.00	$ 300,000.00	$ 6,400,000.00	12/31/2024
Cognizant Technology Solutions U.S. Corporation	$ 740,264.00	$ 147,080.00	$ 887,344.00	12/31/2024
Cognizant TriZetto Software Group, Inc.	$ 439,488.00	$ 371,512.00	$ 811,000.00	8/29/2028
Cognizant TriZetto Software Group, Inc.	$ 4,586.72	$ 2,878.40	$ 7,465.12	5/1/2024
Collective Medical Technologies, Inc.	$ 5,100,096.00	$ (2,367,618.00)	$ 2,732,478.00	9/29/2024
County of Los Angeles	$ 50,000,000.00	$ 30,000,000.00	$ 80,000,000.00	12/31/2028
Franklin Covey Client Sales, Inc.	$ 87,023.73	$ 55,366.00	$ 142,389.73	9/30/2026
Health Management Associates Inc.	$ 189,225.00	$ 249,685.00	$ 438,910.00	7/31/2024
Health Management Associates, Inc. (dba Leavitt Partners	$ 187,800.00	$ 33,000.00	$ 220,800.00	12/31/2024
I Color Printing & Mailing Inc	$ 4,090,200.00	$ 4,600,000.00	$ 8,690,200.00	6/30/2025
Infocrossing, LLC	$ 3,462,949.00	$ 1,200,000.00	$ 4,662,949.00	12/31/2025
Infosys Limited	$ 8,000,000.00	$ 3,172,709.00	$ 11,172,709.00	9/30/2024
Integrated Healthcare Association	$ 362,425.35	$ 88,370.00	$ 450,795.35	No Expiration Date
Language Line Services, Inc.	$ 12,600,000.00	$ 7,800,000.00	$ 20,400,000.00	4/30/2026
Los Angeles Network for Enhanced Services-Health Inform	$ 8,100,000.00	$ 350,000.00	$ 8,450,000.00	No Expiration Date
Milliman Inc	$ 1,599,000.00	$ 400,000.00	$ 1,999,000.00	12/31/2024
Milliman Inc	$ 1,650,000.00	$ 400,000.00	$ 2,050,000.00	12/31/2024
NetFile, Inc.	$ 30,000.00	$ 15,919.00	$ 45,919.00	1/11/2027
Oliver Tate Brooks	$ 840,000.00	$ 150,000.00	$ 990,000.00	12/31/2025
Pack4U, Inc	$ -	$ 6,750.00	$ 6,750.00	6/30/2024
Panhealth Inc.	$ 395,000.00	$ 275,000.00	$ 670,000.00	12/31/2024
Payspan, Inc.	$ 3,875,000.00	$ 400,000.00	$ 4,275,000.00	12/31/2024
Therapeutic Bridges Inc.	$ 19,000.00	$ 21,000.00	$ 40,000.00	12/31/2024
Toney HealthCare Consulting, LLC	$ 2,026,000.00	$ 360,000.00	$ 2,386,000.00	12/31/2024
Toney HealthCare Consulting, LLC	$ 1,400,000.00	$ 600,000.00	$ 2,000,000.00	10/31/2024
Traliant Holdings, LLC	$ 59,015.00	$ 21,000.00	$ 80,015.00	2/17/2025
Traliant Holdings, LLC	$ 75,015.00	$ 5,100.00	$ 80,115.00	2/17/2025
UptoDate, Inc.	$ 160,434.33	$ 184,882.00	$ 345,316.33	2/28/2027
Well Rounded Fitness LLC	$ 23,390.00	$ (2,750.00)	$ 20,640.00	6/30/2024
WestLA Homeless	$ 84,700.00	$ (14,400.00)	$ 70,300.00	12/31/2024
Total			**$ 160,880,345.53**	

L.A. Care Health Plan
-006 Authorization and Approval Limits Quarterly Report
April 2024 - June 2024

New POs and Contracts	
Vendor Name	**PO and Contract Total**
Sierra Pacific Constructors, Inc.	$ 22,742,836.00
SHI International Corp	$ 15,786,716.75
I Color Printing & Mailing Inc	$ 8,031,258.51
New Tangram, LLC	$ 4,386,800.00
ePlus Technology, inc.	$ 4,288,555.36
Resources Connection Inc.	$ 3,757,800.00
Sheppard Mullin Richter & Hampton LLP	$ 2,976,636.45
Momentum Telecom, Inc.	$ 2,039,698.08
Avalon Medical Development Corporation (Grantee)	$ 2,000,000.00
Arent Fox LLP	$ 1,350,000.00
Daponde Simpson Rowe PC	$ 1,250,000.00
salesforce.com, inc.	$ 884,787.13
SAP America, Inc.	$ 780,198.46
Greater Rochester Independent Practice Association,	$ 780,000.00
Earth Print, Inc.	$ 752,552.03
Center for the Study of Services	$ 747,296.50
Saviynt, Inc.	$ 746,873.07
Hyland Software, Inc.	$ 706,660.12
Skillsoft Corporation	$ 616,399.91
Optiv Security, Inc.	$ 602,596.83
Larson LLP	$ 600,000.00
Toney HealthCare Consulting, LLC	$ 600,000.00
Cato Networks, Inc.	$ 572,126.38
AArete, LLC	$ 495,000.00
Prevalent, Inc.	$ 475,605.27
Best Best & Krieger LLP	$ 400,000.00
Fisher & Phillips, LLP	$ 400,000.00
Isaacs | Friedberg LLP	$ 400,000.00
Meyers, Nave, Riback, Silver & Wilson	$ 400,000.00
Morgan, Lewis & Bockius, LLP	$ 400,000.00
Cequel Data Centers, L.P.	$ 390,612.86
NTT America, Inc.	$ 358,805.89
Andrues/Podberesky, APLC	$ 300,000.00
Gartner Inc.	$ 295,930.20
Fierce Software Corporation	$ 276,548.09
Worksite Wellness LA	$ 254,176.00
LA Net Community Health Research and Resource N	$ 222,000.00
Carl Andrew Botterud	$ 200,000.00
Mansfield, Bronstein & Stone, LLP	$ 200,000.00
Parsons Behle & Latimer A Professional Corporation	$ 200,000.00

New POs and Contracts	
Vendor Name	**PO and Contract Total**
Procopio, Cory, Hargreaves, & Savitch, LLP	$ 200,000.00
Redwood Public Law, LLP	$ 200,000.00
Richards, Watson & Gershon A Professional Corpora	$ 200,000.00
GHA Technologies Inc	$ 192,642.33
SKKN, INC.	$ 186,157.99
Center for Health Care Strategies Inc. (Grantee)	$ 180,000.00
Dentons Global Advisors Government Relations LLC	$ 180,000.00
Health Management Associates, Inc. (dba Wakely Co	$ 180,000.00
Mckesson Medical-Surgical Inc.	$ 177,355.39
AltaMed Health Services Corporation (Grantee)	$ 150,000.00
STEM to the Future (Grantee)	$ 150,000.00
Edifecs, Inc.	$ 145,280.00
SAS Institute, Inc.	$ 142,177.98
Henry Schein, Inc.	$ 133,628.99
Central City Community Health Centers (Grantee)	$ 125,000.00
Northeast Community Clinic (Grantee)	$ 125,000.00
PIH Health Physicians (Grantee)	$ 125,000.00
Sonia P. Guzman	$ 122,425.00
MG Dance Foundation	$ 115,120.00
Rebecca E. Lynch	$ 114,400.00
BrandFuse, inc.	$ 111,259.34
Wavestone Consulting US Inc.	$ 111,000.00
Crowell & Moring LLP	$ 100,000.00
Canon Solutions America Inc	$ 92,064.00
Med-Mizer Inc	$ 84,000.00
Rockstar Music, Inc.	$ 83,600.00
God's Pantry	$ 82,350.00
HALO Branded Solutions, Inc.	$ 76,543.60
Anthony Peter Lopez, Jr.	$ 76,074.82
ALCO Sales & Service Co	$ 75,049.89
California Community Foundation (Grantee)	$ 75,000.00
City of Long Beach	$ 68,783.00
Healthy Cooking LLC	$ 66,260.00
Maria J. Davila	$ 63,040.00
Gloria S. Nuestro	$ 62,400.00
Informatica LLC	$ 60,626.69
PPT Holdings I, LLC	$ 60,477.84
Absolute Ops LLC	$ 59,805.25
SonBern LLC.	$ 50,160.00
Angie Gomez	$ 49,920.00
Herald Christian Health Center	$ 49,920.00
California Hospital Assessment and Reporting Task F	$ 45,000.00
Critical Care Training Center	$ 38,400.00
IBISWorld, Inc.	$ 36,900.00
Office Depot, Inc.	$ 36,057.67

New POs and Contracts	
Vendor Name	**PO and Contract Total**
SALVA	$ 35,220.00
Miriam Patricia Perez	$ 35,120.00
Watts Healthcare Corporation	$ 34,580.00
TRI Ventures, Inc.	$ 32,000.00
Melissa Data Corporation	$ 30,645.00
Advantage Mailing, LLC	$ 30,513.13
mPulse Mobile, Inc.	$ 30,000.00
Jennifer Baez	$ 28,380.00
Ollivier Corporation	$ 28,019.24
VideoGuard, LLC	$ 27,600.00
ABF Data Systems, Inc	$ 27,360.00
Motherhood Together	$ 26,200.00
Axis Technology, LLC	$ 25,000.00
Tania Hernandez	$ 22,800.00
Lands' End, Inc	$ 22,291.50
Amazon Capital Services, Inc.	$ 21,666.16
Khavarian Enterprises, Inc.	$ 21,520.00
Ana Maria Delgado	$ 21,000.00
Aurora Systems Consulting, Inc	$ 20,443.50
Parent, Family Engagement and Community Services	$ 19,960.00
Bhive Holdings, LLC	$ 19,750.00
Health Literacy Innovations, LLC	$ 19,740.00
Integrity Marketing Group, LLC (Parent Company of D	$ 19,300.00
Lucero Cuevas-Moreno	$ 19,000.00
Harbor Community Clinic, Inc.	$ 18,000.00
Environmental Systems Research Institute, Inc.	$ 17,940.00
Elisa Urbano	$ 17,160.00
Purchaser Business Group on Health	$ 15,755.20
Smartsheet.com, Inc.	$ 15,066.00
Comcast Holdings Corporation	$ 15,000.00
Articulate Global, Inc.	$ 14,503.03
Sandra De Jesus	$ 14,000.00
Dewey Pest Control	$ 12,900.00
Iron Mountain Inc	$ 12,300.00
Uline, Inc.	$ 12,172.44
GOANIMATE, INC.	$ 12,037.00
Zoom Video Communications, Inc.	$ 11,294.00
Plunet Inc.	$ 10,178.76
Training Connection LLC	$ 9,450.00
LifeLabs Group, Inc.	$ 8,550.00
Quadient, Inc.	$ 8,067.60
Kimberley Carruthers	$ 7,800.00
Bootstrap Software Partners, LLC	$ 7,415.48
RightStar, Inc.	$ 7,280.00
Blue Ribbon Technologies, LLC	$ 7,020.00

New POs and Contracts	
Vendor Name	**PO and Contract Total**
America's Health Insurance Plans, Inc.	$ 7,000.00
Digicert, Inc.	$ 6,874.20
Ryan Gonzalez	$ 5,150.00
Omar Ureta	$ 5,000.00
B&H Foto & Electronics, Corp.	$ 4,288.87
Samuel Roman	$ 3,789.53
Lakeshore Equipment Company	$ 3,788.39
Homeboy Industries	$ 3,702.50
Metalcraft, Inc	$ 3,375.20
Acquia, Inc	$ 2,900.00
The Prophet Corporation	$ 2,833.63
Live Art Plantscapes, Inc.	$ 2,036.87
Your Glass Connection, Inc.	$ 1,500.00
Altec Products, Inc.	$ 1,337.00
Norm's Refrigeration, LLC.	$ 772.50
Aunt Flow Corp.	$ 700.00
Luxury Glass Tinting Inc.	$ 185.00
Zones, LLC (Wholly Owned by Zones IT Solutions In	$ 40.00
Total	**$ 88,454,621.40**

L.A. Care Health Plan
AFS-007 Authorization and Approval Limits Quarterly Report
January 2024 - March 2024

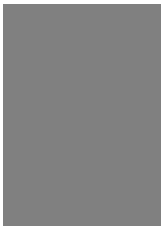
Vendor Selection - Sole Source

Vendor Name	Contract Total	Paid As Of 5/6/24	Vendor Selection
Green Management Consulting Group, Inc.	$ 286,875.00	$ 64,150.00	Sole Source
Proaxys, Inc.	$ 300,000.00	$ -	Sole Source
W Why W Enterprises, Inc.	$ 300,000.00	$ 43,846.93	Sole Source
Cahaba Consulting Group, LLC	$ 695,450.00	$ 228,000.00	Sole Source
Centauri Health Solutions Inc	$ 3,600,000.00	$ 1,129,748.12	Sole Source
Language Line Services, Inc.	$ 20,400,000.00	$ 13,397,392.59	Sole Source

L.A. Care Health Plan
AFS-007 Authorization and Approval Limits Quarterly Report
April 2024 - June 2024

Vendor Selection - Sole Source

Vendor Name	Contract Total	Paid As Of 8/16/24	Vendor Selection	For Internal Use: Description
AArete, LLC	$ 495,000.00	$ 482,625.00	Sole Source	Vendor provides third-party review of L.A. Care's end-to-end encounter process and proposes solutions to address process gaps. Vendor performs advisory and consulting services in connection with end-to-end encounter process analysis and other related matters.
FAIR Health, Inc.	$ 1,497,560.00	$ 199,040.00	Sole Source	Vendor provides healthcare benchmark data to L.A. Care on a quarterly basis which will assist L.A. Care's payment out-of-network claims and keep in compliance with DMHC regulations and the Gould Criteria.
Actum II, LLC	$ 1,200,000.00	$ 200,000.00	Sole Source	Vendor is providing lobbying and consulting services to L.A. Care's CEO for the purpose of increasing funding for safety net providers.
Applied Research Works, Inc.	$ 1,176,000.00	$ 196,000.00	Sole Source	Vendor provides licensing for the "Cozeva" SaaS Bridge module following pilot continued under SOW's 1, 2 and 3.
NexTec Operating Corp.	$ 500,000.00	$ 220,813.26	Sole Source	Vendor provides ongoing maintenance and support for finance department Solomon (MS Dynamics) system through 6/1/25.
Fierce Software Corporation	$ 276,548.09	$ 276,548.09	Sole Source	Vendor provides Cloudera data science services.
Connecting for Better Health	$ 250,000.00	$ -	Sole Source	Vendor provides a community focused virtual testing environment (Sandbox Project) for health and social data exchange and support local providers of CalAIM initiatives.



DATE: May 22, 2024

TO: Finance & Budget Committee

FROM: Afzal Shah, *Chief Financial Officer*

SUBJECT: AFS-027 Travel and Other Expenses Report

L.A. Care's internal policies, AFS-027 Travel and Other Expenses, for business related travel and non-travel expenses incurred by employees, members of the Board of Governors, Stakeholder Committees, and members of the Public Advisory Committees (PACs), require that all expenditures covered under these policies are to be reported to the Board of Governors on a quarterly basis.

Travel Related Expenses covered under the policy:

Travel and training expenditures, such as:

- Airlines
- Out-of-Town Lodging
- Parking
- Mileage
- Rental Cars
- Taxis and Other Public Transportation
- Meals Related to Business Travel

Other Expenses covered under the policy:

Any lunch, event, or gathering at which stakeholders are in attendance, such as:

- Board of Governors' meetings
- Stakeholder relationship events and outreach
- Education events

Any lunch, event, or gathering for internal staff only, such as:

- Recruitment, On-boarding, Training, or Orientation Events
- In-person Staff meetings, Teambuilding evens or other on-site meetings
- Business Lunches in support of Developing External Relationships
- Extenuating circumstances
- Discretionary staff spending for recognition and retention efforts

In order to keep the Committee apprised of L.A. Care's necessary expenditures and to comply with the internal policy, presented herein are the travel and non-travel related expenses for the second quarter of Fiscal Year 2023-2024, January through March 2024.

AFS-027 Travel Expense Report Q2 FY 2023-24

Division	Jan - Mar 2024	Description
Chief Product Officer	$ 22,461	Expenses are related to attendance of American Public Health Association (APHA) 2023 conference and L.A. Care staff mileage reimbursement.
Clinical Operations	$ 16,936	Expenses are related to L.A. Care Community Health Worker (CHW) staff mileage reimbursement.
Compliance	$ 10,978	Expenses are related to attendance of 2024 Managed Care conference, Institute of Internal Auditors (IIA) 2024 conference, California Association of Health Plans (CAHP) conference, Health Industry Collaboration Effort (HICE) 2023 conference, and staff mileage reimbursement.
Executive Services	$ 11,786	Expenses are related to attendance of America's Health Insurance Plans (AHIP) CEO and Board meetings, Cabinet Secretary meeting, Local Health Plans of California (LHPC) Strategic Planning Retreat, 2024 Health Care Compliance Association (HCCA) conference, Department of Health Care Services (DHCS) CEO meeting, and Promise Leadership Conference.
Finance Services	$ 6,415	Expenses are related to attendance of Government Investment Officers Association (GIOA) conference, 2024 All Rise (RISE) national conference, All Plan CFO meeting, and approved L.A. Care staff education and travel.
Health Services	$ 26,307	Expenses are related to attendance of American Pharmacists Association (APHA) conference, Stars Master Class Summit, 2024 HCCA Conference, 2023 Cozeva Annual User Group meeting, RISE National conference and L.A. Care staff mileage reimbursement.
Human Resources	$ 925	Expenses are related to attendance of University of California-Santa Barbara (UCSB) job fair and L.A Care staff mileage reimbursement.
Information Technology	$ 2,782	Expenses are related to attendance of LHPC Opportunity in Person meeting and L.A Care staff mileage reimbursement for CRC visits.
Legal Services	$ 1,588	Expenses are related to attendance of American Health Law Organization (AHLA) conference and L.A. Care staff mileage reimbursement.
Operations	$ 4,075	Expenses are related to approved L.A. Care staff education, travel, and mileage reimbursement.
Strategic Services	$ 22,050	Expenses are related to attendance of LHPC Board meeting and Strategic Planning Retreat, Association of Community Affiliated Plans (ACAP) legislative fly-in, support fees for CRC workshops and Outreach events, and approved L.A. Care staff transportation for site visits and meetings.
Total Travel Expenses	**$ 125,806**	

AFS-027 Other Expense Report Q2 FY 2023-24

Division	Jan - Mar 2024	Description
Chief Product Officer	$ 2,382	Expenses are related to Covered CA Semi-Annual meeting.
Compliance	$ 3,142	Expenses are related to Governance All-Hands meeting.
Executive Services	$ 762	Expenses are related to CMS Roundtable meeting and L.A. County Health Equity Officers meeting.
Finance Services	$ 815	Expenses are related to on-site meetings to support strategy development and team building.
Health Services	$ 58,361	Expenses are related to refreshments for CME/CE events for Asthma Management in Primary Care, Cancer Screenings Conference, Opioid Use Disorder Conference and Behavioral Health Conference, and Quarterly Appreciation Days for Transform LA, Help Me Grow/First 5LA, and EQuIP-LA.
Human Resources	$ 9,767	Expenses are related to refreshments for Management Certification Program events, New Hire Orientation events, and Product, Sales, Strategy, and Marketing (PSSM) Leadership team building meeting, .
Legal Services	$ 6,428	Expenses are related to refreshments for the committee meetings.
Strategic Services	$ 7,300	Expenses are related to refreshments for ECAC meetings.
Total Other Expenses	**$ 88,956**	

BOARD OF GOVERNORS

Finance & Budget Committee

Meeting Minutes – June 26, 2024

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

Members

Stephanie Booth, MD, *Chairperson*
Alvaro Ballesteros, MBA
G. Michael Roybal, MD **
Nina Vaccaro **

**Absent ** Via Teleconference*

Management/Staff

John Baackes, *Chief Executive Officer*
Sameer Amin, MD, *Chief Medical Officer*
Terry Brown, *Chief of Human Resources*
Augustavia Haydel, *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*

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Stephanie Booth, MD*, Committee Chairperson*, called the L.A. Care and JPA Finance & Budget Committee meetings to order at 1:06 p.m. The meetings were held simultaneously. She welcomed everyone and summarized the process for public comment during this meeting.	
APPROVE MEETING AGENDA	The Agenda for today's meeting was approved.	**Approved unanimously by roll call. 4 AYES (Ballesteros, Booth, Roybal, and Vaccaro)**
PUBLIC COMMENTS	There were no public comments.	
APPROVE MINUTES OF PREVIOUS MEETING	The minutes of May 22, 2024 meeting were approved as submitted.	**Approved unanimously by roll call. 4 AYES**
CHAIRPERSON'S REPORT	There was no Chairperson report.	
CHIEF EXECUTIVE OFFICER'S REPORT	John Baackes, *Chief Executive Officer,* reported that the impact of the California State Budget is important to L.A. Care, especially with respect to the managed care organization (MCO) tax. The Legislature reached an agreement on a Budget with the Governor, that includes a provision that the proceeds from the MCO tax, earmarked for about $2.6 billion this year, were swept into the State's General Fund to help plug the deficit. This will have a negative	

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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	impact for L.A. Care and all Medi-Cal providers. The Governor and the Legislature agreed that payments that would have gone to Medi-Cal in 2025 will be pushed out to 2026. That is a meaningless gesture, since the current Legislature cannot approve a budget provision for a future fiscal year and the legislature will have to approve it again next year. The MCO tax on managed care health plans like L.A. Care and its competitors has been around for years. The money collected by the tax draws down matching funding from the federal government. In the first nine years through 2021 the proceeds of the tax went to the General Fund. None of the money went to Medi_Cal. The tax was allowed to expire in 2023 because California had a $100 billion surplus. The Los Angeles Safety Net Coalition was formed by health plans and providers to increase Medi-Cal funding due to the financial impacts of COVID, the increased costs for nursing, and other cost increases. The Coalition, (consisting of hospitals, doctors, clinics, labor unions and L.A. Care's competitor health plans) came up with the idea to have the MCO tax reinstated, and proceeds earmarked specifically to increase Medi-Cal reimbursement to providers. Surprisingly, the Coalition was able to get the Governor and Legislature to agree to implement the tax in last year's State Budget, and the tax went into effect last July. It was supposed to be a three-year tax that would generate $19 billion in federal funding, with $8 billion going into the General Fund and $11 billion into Medi-Cal to increase payments to providers. Through the Governor's action this year, that funding is gone. It was assumed that when the tax was adopted last year, a ballot initiative was needed which, if approved by the voters, would make the proceeds of the tax go to where it was originally intended. Sufficient signatures have been collected and the initiative has been certified by the Secretary of State. A ballot initiative number will be issued by July 3, and it will appear on the November ballot in California. If it is approved by a simple majority the tax proceeds would begin to flow to increase Medi-Cal provider reimbursement and it will create another budget hole for the state to deal with next year. The Coalition has broadened to statewide representation, and it remains strong. Local organizations have been part of the Coalition and it is remarkable to have the various groups agree on the same thing.	
COMMITTEE ITEMS		
Chief Financial Officer's Report • Financial Report	Jeffrey Ingram, *Deputy Chief Financial Officer,* reported on the April 2024 Financial Performance *(a copy of the report can be obtained by contacting Board Services).* <u>Membership</u> April 2024 membership was 2.6 million, approximately 64,000 favorable to the 4+8 forecast. The favorability continues to be impacted by retro-enrollments. Staff reports	

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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	membership on a reported basis, which means any retroactivity for prior months is posted in the current reporting month. L.A. Care Covered (LACC) is favorable to forecast by 6,000 consistent with prior month. Year-to-Date (YTD) membership was 18.6 million, 125,000 favorable to the forecast. <u>April 2024 Consolidated Financial Performance</u> There was a net loss of $40.7 million for April 2024; $45.4 million unfavorable to the forecast when Housing and Homelessness Incentive Program (HHIP) and Incentive Payment Program (IPP) are excluded. Revenue was $8.3 million unfavorable to forecast; $91 million unfavorable excluding HHIP/IPP, primarily driven by the Calendar Year (CY) 2023 rate adjustment or ($118 million) with an offset in Medical Expense. The other unfavorable driver was $3 million in Risk Corridors; primarily the Unsatisfactory Immigration Status (UIS) Revenue Corridor. Offsetting that unfavorability were: • +$82.7M in HHIP/IPP (received $99 million HHIP payment) • +$21M due to membership • +$4M Maternity Kick with small offset in Capitation • +$4MCY 2024 Rates Medical Expense was favorable$50.9 million. The biggest driver is the offset to the CY 2023 rate adjustment +$37 million. Other drivers include: • +$21M in Capitation favorability • +$8.3M in HHIP/IPP • +5M in Shared Risk Expense excluding CY 2023 true-up • +$5M in Provider Incentives excluding Student Behavioral Health Incentive Program (SBHIP) & IPP • +$3M Targeted Rate Increase (TRI) Adjustment • +$2M CY 2024 rates • These items are offset by Membership impact ($20 million), Incurred Claims ($9 million), and CY23 Shared Risk True-Up ($3 million) Operating Expense was flat to forecast. Non-Operating expense was +$2.1 million. Favorability driven by interest income and timing of grant spending.	

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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	<u>YTD Consolidated Financial Performance</u> There was $298 million net surplus YTD; $22.9 million favorable to the forecast when HHIP and IPP are excluded: 4.8% | 3.0% less investment income. Revenue was $6.5 million unfavorable or $56.1 million unfavorable without HHIP/IPP, primarily driven by CY 2023 ($118 million) rate adjustment with offset in Medical Expense. Other driver was ($4 million) due to Cal MediConnect (CMC) CY2021 Disenrollment Penalty. Offsetting that unfavorability were: • +$49.6M HHIP/IPP • +$38M due to membership • +$13M Maternity Kick with small offset in Capitation • +$5M in Risk Corridors • +$5M in Long-Term Care (LTC)/INST revenue • +$4M Equity Payment & Transformation Incentive Revenue (CalAIM) Medical Expense was $95.6 million favorable, +$78 million favorable excluding HHIP/IPP • +$72M Capitation favorability • +$44M CY 2023 rate adjustment offset • +$25M Pay for Performance (P4P) & Value Initiative for IPA Performance (VIIP) provider incentives • +$17.6M HHIP/IPP • +$7M SBHIP favorable • +$4M Enhanced Care Management (ECM)/Homeless Housing and Support Services (HHSS) Membership Cleanup • +$3M CMC Disenrollment penalty offset • Offset by Membership ($37 million), Incurred Claims ($34 million) and CY 2023 Shared Risk True-Up ($20 million) Operating Expense was ($2 million) unfavorable. Unfavorability driven by higher contract spend in Purchased Services; partially offset by timing favorability in Supplies & Other. Non-Operating Expenses +$2.8 million favorable. <u>Operating Margin by Segment</u> • Overall Medical Care Ratio (MCR) is 91.2% vs the forecasted 91.6% excluding HHIP/IPP	

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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

	• Medi-Cal performing at 91.7%, slightly ahead of forecast
	• Duals Special Needs Plan (DSNP) is aligned with forecast 87.2% vs 87.0%
	• LACC is at 81.4% vs the 78.3%
	  o Slight improvement from March at 81.4%
	• PASC running at 100.8%, almost aligned with the 99.9% forecast
	
	<u>Key Financial Ratios</u>
	• Administrative Ratio was 5.8%, slightly ahead of forecast.
	• Balance sheet metrics all healthy again this month.
	• Cash to claims is a bit higher than prior months at 1.09 (vs .90), not impacted by pass-through payments.
	  o There have been decreases to sub capitation payable and reductions to Incurred but Not Reported (IBNR). L.A. Care pay down inventory and speed up cycle times.
	  o There was $110 million in YTD interest income. This continues to build cash and cash equivalents.
	
	<u>Tangible Net Equity (TNE)</u>
	There was 889% of TNE with days of cash on-hand at 118 days.
	
	<u>Motion FIN 100.0624</u>
	To accept the Financial Reports for April 2024, as submitted.
	
	Chairperson Booth suggested that the Finance & Budget Committee could consider a quarterly reporting to the Board, to help reduce the length of Board meetings. She asked Finance & Budget Committee members to provide feedback to Board Services. Board Services staff will check financial reporting requirements to the Board of Governors.
		Approved unanimously by roll call. 4 AYES

• Monthly Investment Transactions Reports	Mr. Ingram referred to the investment transactions reports included in the meeting materials (*a copy of the report is available by contacting Board Services)*. This report is to comply with the California Government Code as an informational item. L.A. Care's total investment market value as of April 30, 2024 was $4.1 billion. • $4 billion managed by Payden & Rygel and New England Asset Management (NEAM) • $108 million in BlackRock Liquidity T-Fund • $11 million in Los Angeles County Pooled Investment Fund • $6 million in Local Agency Investment Fund	

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Public Comments on the Closed Session agenda items.	There were no public comments.	
ADJOURN TO CLOSED SESSION	The Joint Powers Authority Finance & Budget Committee meeting adjourned at 1:25 p.m. Augustavia J. Haydel, Esq., *General Counsel*, announced the items that the Committee will discuss in closed session. There was no public comment on the Closed Session items, and the meeting adjourned to closed session at 1:26 p.m. REPORT INVOLVING TRADE SECRET Pursuant to Welfare and Institutions Code Section 14087.38(n) Discussion Concerning New Service, Program, Technology, Business Plan Estimated date of public disclosure *June 2026* CONTRACT RATES Pursuant to Welfare and Institutions Code Section 14087.38(m) • Plan Partner Rates • Provider Rates • DHCS Rates CONFERENCE WITH REAL PROPERTY NEGOTIATORS Section 54956.8 of the Ralph M. Brown Act Property: 1055 W. 7th St., Los Angeles Agency Negotiator: John Baackes Negotiating Parties: Jamison Services, Inc. Under Negotiation: Price and Terms of Payment	
RECONVENE IN OPEN SESSION	The meeting reconvened in open session at 2:09 pm. Ms. Haydel advised the public that no reportable action from the closed session.	
ADJOURNMENT	The meeting adjourned at 2:10 p.m.	

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:
Signed by:
Stephanie R. Booth, MD
084B48A20E5F499...
Stephanie Booth, MD, *Chairperson*
Date Signed 8/30/2024 | 9:37 AM PDT

APPROVED

COMPLIANCE & QUALITY COMMITTEE

BOARD OF GOVERNORS
Compliance & Quality Committee Meeting
Meeting Minutes – June 20, 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

Senior Management
Sameer Amin, *MD, Chief Medical Officer*
Terry Brown, *Chief of Human Resources*
Todd Gower, *Chief Compliance Officer*
Augustavia J. Haydel, *General Counsel*
Alex Li, *Chief Health Equity Officer*
Tom MacDougall, *Chief Information and Technology Officer, IT Executive Administration*
Noah Paley, *Chief of Staff*
Acacia Reed, *Chief Operations Officer*
Edward Sheen, MD, *Senior Quality, Population Health, and Informatics Executive*

** Absent ** Via Teleconference*

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.*	

APPROVED

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
APPROVAL OF MEETING MINUTES	**The April 18, 2024 meeting minutes were approved as submitted.**	**Approved unanimously.**
CHAIRPERSON REPORT	Chairperson Booth spoke about two main issues: the use of acronyms and the confusion between fiscal and calendar years. She stressed the need for a standardized approach to acronyms, suggesting either always spelling them out, adding an appendix to each presentation, or creating an acronym list, although she noted the difficulty of maintaining such a list, because acronyms she hasn't noticed in over three years show up rather regularly. She said has gathered two lists of acronyms, none of which was defined in the Board Welcome packet from LA Care. For the first list, she collected and, often with help from Board Services or the writer of the document, determined what the acronym meant to convey. She then alphabetized the list. She began collecting and defining a second list of new acronyms almost immediately. She noted each list is quite long. Chairperson Booth referred to an idea she has mentioned previously. She has been hoping LA Care could create a virtual library to serve as a source of reference for Board Members. This library could be where the three lists of acronyms, after being merged and alphabetized, could reside. Chairperson Booth next considered the confusion sometimes created by the way different departments at LA Care refer to a year's-worth of time. Most items coming to the Board are based on the calendar year — January through December. However, Finance and Budget items are always based on the fiscal year — October through the next September. She wonders if this is confusing to Board members, as it still occasionally is for her. She suggested labeling the year "CY" or "FY," as appropriate. Third, she addressed the drop in the readability of appeals and grievance letters. She stated the timeliness of responses to patients was prioritized. The A&G team put a great deal of work into fixing timeliness issues and she congratulated the team for the very nearly perfect scores they had been reporting. However, the readability of the letters declined in that same timeframe. She knows it is highly ambitious, but she challenged the team with finding a better balance of work to be put toward each issue requiring improvement at any given time. The perfection to strive for, she suggested, should be the best balance of progress in each underperforming process and maintenance of each adequately performing process. She stated the unfairness of external entities re-auditing as issue and expecting improvement without allowing sufficient time for corrective action implementation, does not go unnoticed by the Board. Finally, Chairperson Booth suggested that these should be interesting topics for discussion for incoming C&Q committee members. Mr. Gower responded that as Compliance is creating a 2025 Compliance Work Plan it will be a good idea to provide an educational piece on what is being done in 2025 regarding what is changing in Compliance.	

In Process

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AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
COMPLIANCE & QUALITY COMMITTEE CHARTER STATUS UPDATE	Todd Gower, *Chief Compliance Officer*, discussed the Compliance & Quality Committee Charter Process. He stated that he sent the committee Charter to Chairperson Booth for review and to get her comments and input. Once she provides her comments it will be sent to the rest of the committee for input. Chairperson Booth stressed the importance of the information being discussed. She proposed creating a document that includes relevant facts, opinions, and tasks. This document would serve as informal guidance for committee members, outlining important information and listing expected reports. Chairperson Booth suggested that this document be kept up-to-date and treated as unofficial guidance rather than a formal policy.	
CHIEF COMPLIANCE OFFICER REPORT	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).* Tara Nelson, *Senior Director, Utilization Management, Utilization Management,* presented information on Utilization Management (UM). Ms. Nelson reported on the overall compliance measures from January through April, noting that of over 180 measures, 179 were met with a rating between 95% and 100%. Four measures were between 90% and 95%, and one was below 90%. Direct network measures were above 95%. She explained that the few measures below 95% were due to past urgent decisions and notifications, which are being addressed. She highlighted that while extensions are being applied, the current reporting system does not account for the extensions, affecting the reported metrics. Ms. Nelson expressed confidence that these issues would be corrected in the next report. Chairperson Booth asked if the Direct Network metric" included measurements for UM services related only to Medi-Cal patients, and Ms. Nelson responded affirmatively. Ms. Nelson continued the report by focusing on specific compliance measures in April. She noted that 15 measures for the direct network were above 95%, and 45 measures for the rest of the population were similarly high, with one measure falling in the 90-95% range due to past urgent decisions. Nelson assured that this measure would improve by the next report. She then highlighted the current audits conducted by the quality team, focusing on internal review processes, regulatory compliance, and procedural consistency. These monthly audits cover various areas, including timeliness, decision-making, and template usage for doctors and outpatient clinical staff, ensuring proper prior authorization and intake processes. The audits also examine continuity of care for non-contracted requests, the accuracy and timeliness of letters, and the reasons behind overturned appeals to prevent future occurrences. Additionally, she mentioned that non-emergency medical transportation (NEMT) is audited to ensure proper processing of required Physician Certified Statement forms. Ms. Nelson offered to address any specific questions about	

In Process

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AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	the audits. Chairperson Booth asked what "AT Staff" refers to. Ms. Nelson responded that AT staff are Authorization Technicians, non-clinical intake staffs. She explained that when a provider faxes information, AT is the team that ingests that fax and creates the authorization. Ms. Nelson reviewed the detail involved in template audits. She explained that they examine whether the correct letter templates are used, including the presence of the Independent Medical Review form, appeal rates, peer-to-peer contact information, and the member's ability to request the criteria used. For denial reasons, the audits check if the doctor criteria and verbiage make sense and are correctly applied, ensuring clarity at a fifth-grade reading level. They also verify that the appropriate decision letters, such as those for extensions, are used. The audits assess peer-to-peer turnaround times and ensure that denials are made by the correct personnel, distinguishing between clinical and administrative denials. Nelson emphasized the importance of maintaining readability and health literacy throughout the process. Member Ballesteros asked Ms. Nelson for clarification on the continuity of care audit. He wanted to understand whether the audit examines the practical implementation of continuity of care processes for individual patients or if it focuses on the regulatory requirements as stated in the law. He questioned whether the audit reviews the actual procedures on the ground or the legal guidelines governing those procedures. Ms. Nelson responded by clarifying that the continuity of care (COC) audit focuses on eligibility rather than specific patient interactions with providers. It examines whether new members with established provider relationships within the past twelve months are appropriately managed according to regulatory requirements. This includes the issuance of various mandated letters, such as COC acknowledgment letters and notifications about the end of the COC period. She emphasized that these COC letters are different from standard process letters and are crucial for regulatory compliance. The audit ensures the correct letters are sent and the entire COC process is followed from start to finish. Member Ballesteros expressed his desire to understand the audit from the patient's perspective. He wanted to know if the audit assesses the patient experience, specifically whether patients received the necessary communications and how they perceived the process. He mentioned the potential disconnect between the procedural focus of the audit and the patient's understanding of the steps involved. Member Ballesteros highlighted that patients might simply perceive delays in moving from one step to another without grasping the detailed regulatory requirements, and he sought to understand how the audit addresses these immediate patient concerns. Member Vazquez would like to know when the results are expected for each of the categories. Ms. Nelson clarified that the audits shown are internal and process-related, remaining within the organization. They report the audits through UM and in monthly meetings with Sameer Amin, *MD, Chief Medical Officer*. The quality and education team conducts these assessments monthly, and	

In Process

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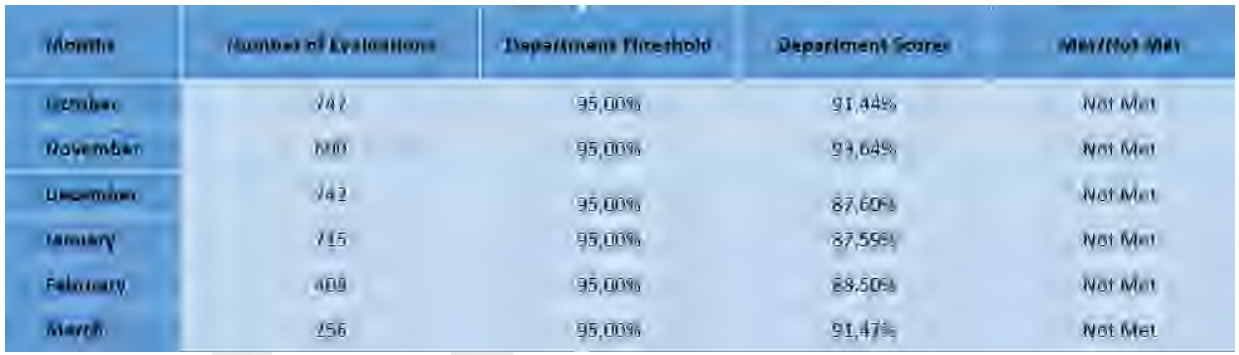
AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	any identified gaps or failures prompt staff education to correct issues. The audits are internal and managed in-house. Demetra Crandall, *Director, Customer Solution Center Appeals and Grievances, CSC Appeals & Grievances,* provided information about Appeals & Grievance (A&G). A&G Audit Score Results FY 2023-2024  • A&G staff conducts quality audits on appeal and grievance cases prior to resolution, post closure and focused audits to ensure that cases meet regulatory requirements. • The number of evaluations decreased over time due to the team being utilized to assist with other regulatory functions. • The A&G Leadership team is re-focusing efforts on audit results with associates to improve the department score. • Increased staffing will assist with improving this measure. It will allow for the associates to have adequate time to process cases thoroughly and for training/retraining to occur. A&G Audit Results A&G utilized existing quality audit questions to track improvement on identified areas in the DMHC/DHCS audits. Audit Questions • Does the system reflect that the case was resolved and the resolution letter mailed timely based on regulations?	

In Process

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AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

Months 2023/2024	Number of Evaluations	Evaluations Passed	Evaluations Failed	Department Threshold	Department Scores	Met/Not Met
October	607	599	8	95.00%	98.58%	Met
November	376	373	3	95.00%	99.20%	Met
December	No Audits	No Audits	No Audits	No Audits	No Audits	No Audits
January	166	165	1	95.00%	99.40%	Met
February	105	104	1	95.00%	99.05%	Met
March	81	81	2	95.00%	97.59%	Met

- Is the resolution letter written in clear and concise language?

Months 2023/2024	Number of Evaluations	Evaluations Passed	Evaluations Failed	Department Threshold	Department Scores	Met/Not Met
October	607	551	51	95%	91.53%	Not met
November	376	324	52	95%	86.17%	Not met
December	No Audits	No Audits	No Audits	No Audits	No Audits	No Audits
January	166	141	25	95.00%	84.94%	Not met
February	105	75	30	95.00%	71.43%	Not met
March	86	66	17	95	79.52%	Not met

A&G New Quality Audit Questions

In an effort to remediate specific identified areas of non-compliance, the A&G team created new quality audit questions. Based on Regulatory Audit Findings, the new questions were added to the audit scorecards effective March 1, 2024.

Was the AOR/ARD process followed correctly?

Month 2024	Number of Evaluations	Evaluations Passed	Evaluations Failed	Department Threshold	Department Scores	Met/Not Met
March	131	119	12	95%	90.84%	Not

Was the case classified correctly?

Month 2024	Number of Evaluations	Evaluations Passed	Evaluations Failed	Department Threshold	Department Scores	Met/Not Met
March	78	72	6	95%	92.31%	Not Met

Erik Chase, *Senior Director, Claims Integrity, Claims Integrity,* reported on Claims Integrity. Mr. Chase noted that the data presented had been previously shared with the Board of Governors on June 6, and would be updated before the next board meeting. His presentation focused on illustrating the trends and challenges in claims processing and the steps taken to address them. Mr. Chase discussed the total paid claims, including interest, highlighting that there had been a notable increase in paid claims due to issues with Change Healthcare and adjustments to retro rates for skilled nursing facilities (SNFs). Despite the increase in volume, the interest paid on claims decreased, indicating improved timeliness in claims payments. This was a positive outcome of the efficiency measures implemented. He discussed the percentage of first-pass auto adjudications, emphasizing the role of automation in reducing errors and increasing consistency compared to manual processing. The rise in auto adjudication rates reflected the improvements. Mr. Chase

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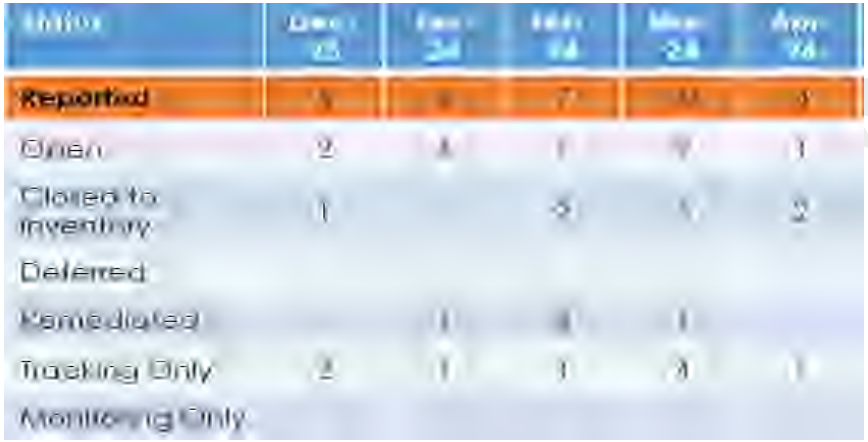
AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	addressed claims timeliness compliance. He noted that the processes put in place during late 2023 led to an increase in compliance rates, surpassing the standards set for 30 calendar days and 45 business days. Additionally, he pointed out a significant reduction in the time taken to process claims, further underscoring the effectiveness of the new efficiency measures. He reported a decrease in the denial rate, attributing the improvement to a proactive review of denials. A significant factor identified was the coordination of benefits, where claims were previously denied due to discrepancies between primary and secondary payments. Changes in policy now allowed for claims processed at zero to not be classified as denied, which reduced the denial rate and improved encounter crediting. Further efforts were being made to educate providers on proper claim submission to avoid future issues. Regarding adjustments, Mr. Chase highlighted increased volumes due to retro rate adjustments for SNFs and transportation vendors, which had impacted adjustment volumes. He noted that the large volume of retro rate adjustments in 2023 had contributed to this increase. The report also covered the rise in Provider Dispute Resolution (PDR) volumes, particularly in December, which was linked to an increase in the Coordination of Benefits volume. Efforts were made to address these delays, and a focus was placed on educating providers about reimbursement terms to align expectations and reduce disputes. Mr. Chase mentioned ongoing improvements in average data processing times and the development of a new platform to enhance workflow capabilities. This platform was expected to provide better technology support for the PDR process. He acknowledged the collaborative efforts of the Payment Integrity and Special Investigations Unit teams, expressing gratitude for their contributions to improving claims processing and ensuring the integrity of payments. Michael Sobetzko, *Senior Director, Risk Management and Operations Support, Compliance,* gave an update on L.A. Care's Risk Committee (RC) and Issues Inventory update. Internal Compliance Committee approved the Risk Committee charter on April 10, 2024. RC Purpose: To ensure that L.A. Care can fulfill its requirement with respect to management of the Company's risks and assist management in setting the tone from the top and in developing a strong risk and compliance culture at all levels in the Company that results in appropriate consideration of risk and compliance in key strategic and business decisions. RC Goals: The primary goals of the Risk Committee are to: • Identify the key risks that could affect the ability of the Company to achieve its strategies and meet its regulatory obligations. • Establish an Enterprise Risk Management program to identify, measure, monitor and report on the risks the Company faces • Oversee Management Action Plans to ensure risks are properly mitigated. • Periodically review enterprise level activities that tie into risk profiles (e.g. vendors)	

APPROVED

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	RC Report-Out: The Risk Committee meets semi-monthly (or more often if necessary) and will report out to ICC and the Compliance & Quality committee of the board. • These reports highlight critical risks, trends, and areas requiring attention. • Status of Management Action Plans (MAPs) • RC Composition: The Risk Committee is made up of Director+ level representatives from across the enterprise RC Decision Making: • They consider risk appetite, regulatory compliance, and strategic alignment. • Recommendations from the risk committee may influence resource allocation, risk tolerance, and policy adjustments. Issues Inventory Update  • Open – Issues confirmed by Compliance Risk Operations that require oversight and monitoring with business units. • Closed to Inventory – Issues in which business units' are seeking guidance about a regulation or best practice process. • Deferred – Issues in which regulatory guidance (Department of Health Care Services, Departmen of Managed Health Care, or Center for Medicare and Medicaid Services) is pending to resolve or issue resolution is dependent on another business units' implementation of a system or process. • Remediated – Issues that require formal or informal corrective action plans for resolution.	

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AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

- Tracking Only – Issues managed by other Compliance areas (such as Regulatory Affairs, Audits, Analysis, Communication and Internal Audit In which the risk management staff is following up for current status updates to closure.
- Monitoring Only – Issues in which corrective action plans are completed and monitoring is to be done by Compliance.

Issues Inventory Years 2019-2024

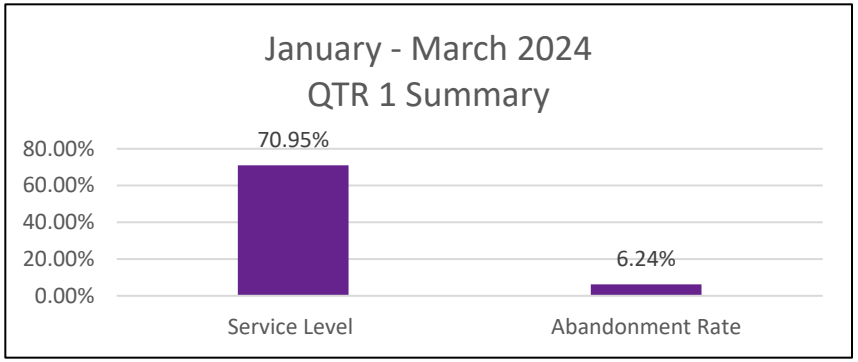
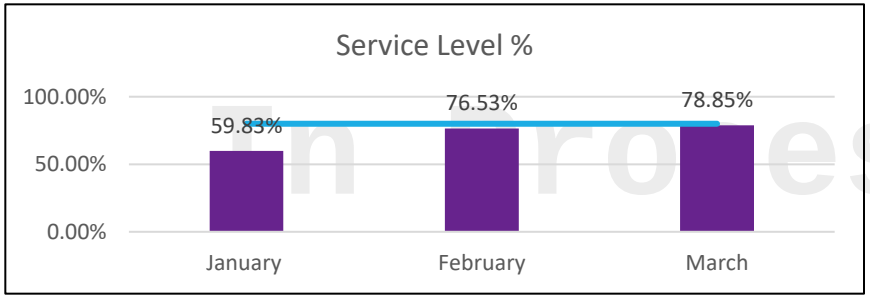
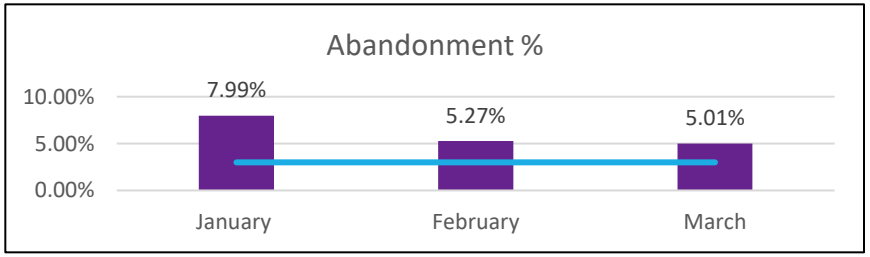
Year	2019	2020	2021	2022	2023	2024
Total	**6**	**134**	**32**	**105**	**212**	**27**
Open	**1**			**3**	**20**	**8**
Closed to Inventory					**126**	**7**
Deferred			**3**	**21**	**2**	
Remediated	**5**	**134**	**29**	**81**	**45**	**5**
Tracking Only					19	7
Monitoring Only						

Open

Issue Name and Description	Date Reported	Business Unit	Status
Call Center D-SNP Performance Metric Not Met Q12024 The plan did not meet the D-SNP internal enterprise performance target goals for call center service level >80% (January 59.83%, February 76.53% and March 78.85%) and abandonment <3% (January 7.99%, February 5.27% and March 5.01%) for the Q12024. (1569)	4/18/2024	Customer Solution Center	Open

Julie Valdivia, *Lead Customer Solution Center Workforce Management Analyst, Office of CSC Excellence*, gave a Customer Solution Center Call Center Corrective Action Plan Update.

APPROVED

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	D-SNP Call Center Performance    Root Cause and Corrective Action Plans Root Cause: • The call center was challenged with meeting Key Performance Indicators (KPI) in January, February and March due to the following factors: - Increase in AHT during Open Enrollment	

In Progress

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

- High attrition and shrinkage within Internal and Vendor staff impacting resource availability

Remediation Efforts:

- The WFM team implemented a Customer Solution Representatives shift bid change on March 11, 2024 to accommodate coverage for call arrival patterns
- The WFM team will continue to conduct a daily analysis of call volume trends and call arrival patterns in order to adjust staffing optimization
- A 6th work day for the Vendor staff has been and will continue to be scheduled during high call volume days. Overtime has also been and will continue to be implemented for internal phone staff, as an all-hands-on-deck (AHOD) approach with supplemental units to increase resource capability
- Three D-SNP classes were scheduled from January- March with a total of 21 CSRs, with added classes in April, May, June amounting in 20 CSRs.
- The Vendor was approved to increase their headcount as of May 2024, and have classes scheduled to onboard new staff
  - New hire training lasts approximately 6-10 weeks. After the training is completed, their average handle time will naturally be higher as they become familiarized with call handling and transition from a training environment to production

In Process

Michael Devine, *Director, Special Investigations Unit, Special Investigations Unit*, gave a Compliance SIU Update.

FY 2023-2024 Year to Date Recoveries & Savings Dashboard

	Mar – May 2024	FY Year-to-Date
Recoveries	$744K	$3.5M
Savings	$2.5M	$6.4M
Totals	$3.2M	$9.9M

Law Enforcement

Active Criminal Investigations (FBI, CA DOJ, LASD HALT)	48
Undercover Operations	0
Arrests	2
Pending Prosecution	11

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Convictions 3 Mr. Devine announced that he was a speaker at the Healthcare Payment & Revenue Integrity Congress in Boston, Massachusetts, speaking on the topic of Pharmacy Fraud Investigations. Marita Nazarian, *Director, Delegation Oversight*, gave a Delegation Oversight Audit update. 2023 Delegation Oversight Audits 24 Participating Physician Group (PPG)/Independent Physician Association (IPA) Audited Initial Health Assessment (IHA): 91% of PPGs audited had untimely IHAs Medi-Cal Specialty Referrals • 79% of PPGs audited could not demonstrate that the member was scheduled for requested services; and • 94% of PPGs audited could not evidence that there was a follow-up conducted on the referral if it remained open or unused. 2024 Delegation Oversight Audits Five PPGs Audits Completed (Trends as of June 2024); PPGs are not clear on IHA obligations for D-SNP members Priscilla Lopez, *Manager, Quality Improvement Accreditation, Quality Improvement,* provided information on Quality Improvement. She reported that LA Care's accreditation status has been updated on the NCQA website, acknowledging the successful efforts of the delegation oversight and compliance teams. While celebrating this achievement, Ms. Lopez emphasized the need for ongoing improvement and the development of a plan to prevent future issues. The QI team continues it's collaboration with delegation and compliance material review teams to address missing language in notice of action denial letters. The team is preparing for the next Los Angeles County Department of Health Services discretionary survey, scheduled for June 2026, and between now and then is monitoring changes to the e-consult process and denial file volume. Ms. Lopez also introduced a new process improvement initiative aimed at enhancing data accessibility for delegates. The shift from provider-level report cards to an interactive dashboard will allow delegates to view compliance areas, filter data by specialty and line of business, and track usage frequency. This tool will be rolled out in the coming months, incorporating feedback from the latest access to care survey conducted between October and December 2023.	

In Process

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AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CHIEF MEDICAL OFFICER REPORT	Edward Sheen, MD, *Senior Quality, Population Health, and Informatics Executive,* presented the June 2024 Chief Medical Officer report on behalf of Sameer Amin, *MD, Chief Medical Officer* (*a copy of the written report can be obtained from Board Services).* The Chief Medical Officer report focused on two main topics: provider engagement efforts and quality performance trends. In 2024, Dr. Sheen introduced a new system of Quality and Population Health Joint Operating Meetings (JOMs), designed to expand and deepen provider engagement. These monthly forums involve the ten largest practice groups accounting for up to 70% of the provider network and Plan Partners , aiming to improve collaboration, review performance data, design solutions, and address specific challenges. A JOM system for the Direct Network is also being developed. These systems represents a shift from infrequent engagements to a more consistent, structured, and interactive approach with deeper focus on provider voices. Dr. Sheen also provided an update on quality performance. The report indicated improvements in several metrics, with a notable decrease in MCAS sanctions from $890,000 to $300,000. For the measurement year 2023, 15 out of 18 measures showed performance improvements. Lack of reliable state data feeds for FUA and FUM measures remains a challenge. The 2024 performance trends are positive with many measures showing YTD improvement compared 2023. One headwind to keep in mind is impact of Kaiser plan partner exit which will have across the board impact on quality measure performance based on Kaiser's historical performance. t. Overall, the organization is seeing better performance compared to the previous year in quality, pharmacy, and operations domains.. Dr. Sheen highlighted ongoing efforts to maintain and enhance these improvements, emphasizing the collaborative efforts across teams to achieve better results.	
TRANSITIONAL CARE SERVICES (CalAIM)	*This agenda item was not discussed due to a lack of time.*	
PUBLIC COMMENT ON CLOSED SESSION ITEMS	*There was no public comment.*	
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 4:51 P.M. PEER REVIEW Welfare & Institutions Code Section 14087.38(o)	

In Process

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AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	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 THREAT TO PUBLIC SERVICES OR FACILITIES Government Code Section 54957 Consultation with: Magdalena Marchese, Senior Director, Audit Services, Executive Services 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 5:10 p.m. There was no report from closed session.	
ADJOURNMENT	The meeting adjourned at 5:15 p.m.	

In Process

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:

Signed by:
Stephanie R. Booth, MD
084B48A20E5F499...

Stephanie Booth, MD, *Chairperson*
Date Signed: 8/30/2024 | 9:34 AM PI

APPROVED

AUDIT COMMITTEE

APPROVEBOARD OF GOVERNORS

Audit Committee Meeting Minutes–December 21, 2023, 2:30 PM

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

Members
Hector De La Torre, *Chairperson*
George Greene, Esq. *
Layla Gonzalez

**Absent **Teleconference*

Management/Staff
John Baackes, *Chief Executive Officer*
Augustavia J. Haydel, Esq., *General Counsel*
Afzal Shah, *Chief Financial Officer*
Todd Gower, *Chief Compliance Officer*
Terry Brown, *Chief Human Resources Officer*

Guests
Rosie Procopio, *Audit & Assurance Managing Director, Deloitte & Touche (D&T)*
Justine Lee, *Manager, D&T*

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Committee Chairperson, Hector De La Torre, called to order the L.A. Care Audit Committee and the L.A. Care Joint Powers Authority Audit Committee meetings at 2:31 p.m. The meetings were held simultaneously. He welcomed everyone to the meetings. For those who provided public comment for this meeting by voice message or in writing, we are really glad that you provided input today. The Committee will hear your comments and we also have to finish the business on our Agenda today. If you have access to the internet, the materials for today's meeting are available at the lacare.org website. If you need information about how to locate the meeting materials, please let us know. Information for public comment is on the Agenda available on the web site. Staff will read the comment from each person for up to three minutes. The Chairperson will invite public comment before the Committee starts to discuss an item. If the comment submitted is related to the topic for a specific agenda item, it will be read at the general Public Comment item 2 on today's agenda. He provided information on how to submit a public comment live and directly using the "chat" feature.	
APPROVE MEETING AGENDA	Today's Agenda was approved as submitted.	**Approved unanimously 2 AYES (De La Torre, and Gonzalez)**
PUBLIC COMMENT	There was no public comment.	

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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
APPROVE MEETING MINUTES	The August 22, 2023 meeting minutes were approved as submitted.	**Approved unanimously 2 AYES**
CHAIRPERSON'S REPORT	There was no report from the Chairperson. Committee Chairperson De La Torre wished everyone Happy Holidays.	
CHIEF EXECUTIVE OFFICER/CHIEF FINANCIAL OFFICER REPORT	There was no CEO Report. Afzal Shah, *Chief Financial Officer*, provided an update on the Fiscal Year 2022-23 financial statement. Net surplus was $646.1 million, excluding $473.7 million for Unsatisfactory Immigration Status (UIS) programs. Some of the key reasons related to the surplus were rate increases for Medi-Cal Expansion for the UIS population membership increases. The redetermination period was delayed until July 2023. These numbers were consistent with what was presented to the Board for year end September 2023. Mr. Shah reported on the the treatment for Government Accounting Standards Board (GASB) Statement No. 96 Subscription-based Information Technology Arrangements which was adopted in the current year. These 80 arrangements were reflected on the balance sheet as capital assets similar to the right of use lease assets and the prior year related to GASB updates. On the P&L, transferring software license expense to additional amortization of the subscription assets. Interest will also be recorded the commitments recognizing these long term contracts greater than 1 year have not been previously recorded. Angela Bergman, *Director, Accounting Operations*, is currently working on an update for this. L.A. Care is currently evaluating its contracts because not all contracts would fall under GASB 96. Mr. Shah reported on the inflow of resources mentioned in the representation letter item number 6. It was an immaterial representation that was discovered during the Los Angeles County's financial audit. L.A. Care believes the effects of the uncorrected financial statement misstatements detected in the current year that relate to the prior year presented, when combined with those misstatements	

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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	aggregated during the prior year audit engagement and pertaining to the prior year presented, are immaterial, both individually and in the aggregate, to the financial statements for the year ended September 30, 2022. During the year ended September 30, 2023, the Organization identified $31.4 million of deferred inflow of resources of which $30.6 million should be classified as accounts payable and accrued expenses and $0.7 million should be classified as noncurrent liabilities with no impact to the Organization's net position as of September 30, 2022. Ms. Bergman added this is because of the long term nature of the program of the deferred revenue that L.A. Care were receiving so it is not a material difference, but there is a change in presentation on the balance sheet. Mr. Shah noted that for the 2024 related to claims payment process, this is with the SAP implementation. The claims process payment process was changed because L.A. Care was getting voided checks that were not posted to the expense account. Finance Department caught the error prior to the year end and corrected. For FY 2003-24, L.A. Care is currently working on implementing and executing COVID 19 provide settlement. This is both delegated providers as well as paying claims for Fee For Service (FFS). There is a large volume that L.A. Care needs to pay to providers and the expectation from that is that these payments will be done February 2024. Mr. Shah talked abut the medical targeted rate increases. The state recently did a webinar directly with providers on the impact of these increases for primary care, especially behavioral health and services with the Medicaid. Medi-Cal fee schedule is going to go up to roughly 287.5, sort of Medicare. There's a lot of work that all plans have to do to implement these changes and be able to pay FFS or capitative providers. The State is giving L.A. Care extra time. They are not expecting L.A. Care to implement this in January 2024. There is a staggered timeline starting with July onto October when L.A. Care have to make these payments, but the payments will be retroactive to January 2024. This will be a major undertaking by all plans to be able to implement this program successfully.	

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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Chairperson De La Torre asked if L.A. Care foresee any problems not being able to adhere to that timeline. Mr. Shah noted the issue is on the complicated contracts. L.A. Care have to figure out the additional value for every provider and negotiate with the providers. The State is going to come up with additional guidance on what plans can and cannot do, what base data to use, etc. Very time and resource intensive. L.A. Care have to re-negotiate and re-contract the entire metwork to be able to do this. On the capitation side, the challenge is that the State is expecting L.A. Care to pay Prop 56 payments to FFS providers when it comes in because the Prop 56 money has been absorbed into the rates. Again, administratively, this is going to take a lot of resources. Mr. Shah added from his perspective, this is going to be very confusing to the providers and L.A. Care will probably spend more time trying to explain what L.A. Care has done.	
COMMITTEE ISSUES • **Presentation of the Audited Financial Report for FY 2022-23**	Mr. Shah introduced Rosie Procopio, *Audit & Assurance Managing Director*, *Deloitte & Touche (D&T)* who presented the Audited Financial Report for FY 2022-23. Ms. Procopio noted that the Audited Financial Report for FY 2022-23 is consistent with prior year. The financial statements will be issued right after the holidays after D&T has completed some of the minor edits that staf talked about and D&T's quality checks. Ms. Procopio commented on what staff covered and did not anticipate any issues on the changes made in the current year, both with respect to the prior year. D&T's procedures are in accordance with the engagement letter issued in August 2023. D&T have looked and made sure the financial statements are materially free from statement. D&T calculate materiality amount. They do not test every transaction in the financial statements, but there are certain areas that they do due to systems and additional tools they use. D&T reviews internal controls with management every year to make sure there were no changes in internal controls.	

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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	D&T do not issue a separate opinion like they do with their public company audits, but D&T inquire to make sure controls were appropriately designed and implemented; and if there were any significant deficiencies for material weaknesses. Those policies that are significant to the financial statements are always going to be reflected in the Notes to the financial statements as well if there are certain GASB statements. One of which is the issue that Ms. Bergman reported earlier related to subscription based arrangements which is consistent to what was done last year. D&T also look every year to make sure there is no change in how significant policies are applied. If management changed the way they were accounting for, or processing any kind of transactions, D&T evaluate and make sure whether or not, they are still consistent with the policy. Ms. Procopio showed the accounting estimates. Accounting estimates are those estimates that D&T consider material to the financial statements the largest estimates that requires judgment in the financial statements, continues to be. For claims, the amounts that are recorded by management in both 2022 and 2023 between 784 last year and a $142 million. This year, D&T engaged their actuarial specialists to run an independent estimate. The team goes through all of the claims data, test that data. D&T make selections and make sure the data are appropriate. D&T's actuarial specialist range came in this year at $759 million to $855 million. L.A. Care is right within that range. L.A. Care is only about 4% higher than what D&T estimate was. Last year, D&T were approximately 1% lower. The recast came in a little bit more favorable than what management and D&T estimated again. They are both L.A. Care and D&T's estimates – they are never exactly correct but to be within 1% and 4%. To recap, Ms. Procopio thinks this a very good results. There were discussions with management and their actual team well before D&T start the audit to make sure D&T understands the changes to assumptions things that might be impacting the model to factor in. Again nothing unusual to report. <u>Uncorrected, misstatements and disclosure items</u>	

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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	D&T has not identified anything and agree with the items management covered, both were immaterial to the financial statements if there were any material corrected. D&T have no material corrections to the financial statements. There was no disagreements with management. D&T is not aware of any consultation management had with other accountants. Management always provides D&T full unrestricted access to all books and records. There were no difficulties encountered in performing the audit. Chairperson De La Torre expressed that he has commented many times before, he thinks this is one of the strengths of L.A. Care as organization based on D&T's comments about the estimates. Same thing on its annual estimates in terms of the fiscal reporting to the Board of Governors on medical loss ratio estimate. All of these things tend to come in right around where staff is projecting, and it is not easy because you were hitting a moving target. Chairperson De La Torre added that L.A. Care has almost doubled in size in terms of membership. Overall, with that kind of growth and yet staff are hitting the estimated targets very close to D&T's every year. Chairperson De La Torre acknowledged that he has has been away from the Audit Committee for many years. Now that he is back to the committee and getting the same kind of reporting, and thanked D&T and staff. The Committee members did not have a separate conversation with Deloitte & Touche.	
• **Accept Audited Financial Report for FY 2022-23**	**<u>Motion AUD A.1223</u>** **To accept the findings of the Deloitte & Touches' audit of L.A. Care's financial statements for the fiscal year ended September 30, 2023, as presented.**	**Approved unanimously** **2 AYES**
ADJOURNMENT	The Chair adjourned the meeting at 2:58 pm.	

APPROVED

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

APPROVED BY:

_____
Hector De La Torre, *Committee Chairperson*
Date Signed: _____

APPROVED

PROVIDER RELATIONS ADVISORY COMMITTEE

BOARD OF GOVERNORS

Provider Relations Advisory Committee

Meeting Minutes – May 15, 2024

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

Members

George Greene, Esq., *Chairperson* **
Richard Ayoub
Stephanie Booth, MD
Hector Flores, MD **
Monica Gutierrez-McCarthy *
Alice Kou, MD *
Sabra Matovsky
Ashkan Moazzez, MD, MPH, FACS, CHCQM *
Zahra Movaghar
John Raffoul
Amanda Ruiz, MD *
David Silver, MD
David Topper *
Michelle Tyson, MD
Haig Youredjian **

Absent* * Via Teleconference*

Management/Staff

John Baackes, *Chief Executive Officer*
Augustavia Haydel, Esq., *General Counsel*
Sameer Amin, MD, *Chief Medical Officer*
Noah Paley, *Chief of Staff*
Acacia Reed, *Chief Operating Officer*

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	George Greene, Esq., *Committee Chairperson*, welcomed everyone and called the L.A. Care and JPA Provider Relations Advisory Committee (PRAC) meetings to order at 9:38 A.M. The meetings were held simultaneously. Mr. Greene described the process for public comment.	
APPROVE MEETING AGENDA	The Agenda for today's meeting was approved.	**Approved unanimously by roll call. 10 AYES (Ayoub, Booth, Flores, Greene, Matovsky, Movaghar, Raffoul, Silver, Tyson and Youredjian)**
PUBLIC COMMENTS	There was no public comment.	
APPROVE MEETING MINUTES	The minutes of the February 21, 2024 meeting were approved as submitted.	**Approved unanimously by roll call. 10 AYES**
CHAIRPERSON'S REPORT	Chairperson Greene noted the dialogue and issues on which the Committee has focused. There are opportunities for improvement for L.A. Care, some vendors worked to improve	

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	their engagement with providers and relationships with providers. L.A. Care and its vendors share a goal of providing good patient care and patient services to the beneficiaries. Chairperson Greene expressed excitement about the update on metrics that L.A. Care is tracking. L.A. Care is listening to providers when issues are raised at this forum. Chairperson Greene added L.A. Care demonstrates leadership in wanting to collaborate with providers, and it demonstrates that the work that this committee is leaning into is and will make a positive impact. He expressed his appreciation to John Baackes, *Chief Executive Officer*, Sameer Amin, MD, *Chief Medical Officer,* and all of L.A. Care's team for listening to the comments that have been made, not just that this committee, but what they are hearing on an ad hoc basis from organizations like the Hospital Association of Southern California.	
CHIEF EXECUTIVE OFFICER'S REPORT	Mr. Baackes thanked Chairperson Greene for his comments about collaboration. Mr. Baackes expressed he was distressed to see in the last two weeks that the California Hospital Association was suing Anthem Health Plan over the very issues that have been discussed in this Committee about care around the complex and hard-to-place patients needing sub-acute hospital care. Mr. Baackes feels this is a step backward in light of the work of this Committee is doing by collaborating with the hospital association and the skilled nursing facilities. Last year, concerned parties from 30 hospitals and 80 skilled facilities were brought together by L.A. Care to discuss the issues in the system. It was not a problem that resides in the lap of any particular entity, and the main way to get a solution is by collaborating around and not by going to court. Mr. Baackes hoped that the example set here would be followed by others and avoid litigation of the kind that is now in process. Mr. Baackes provided an update on the Medi-Cal eligibility redetermination process. L.A. Care has completed twelve months. As of May 2024, L.A. Care has 2,331,000 Medi-Cal members. L.A. Care has added 51,352 new members who were released from "on-hold." These were people who had not completed their redetermination process which were put on hold for 90 days and 2,800 of them completed the process and eligibility was reestablished back to the effective date. L.A. Care lost 8,704 members, who were disenrolled because they no longer qualified for Medi-Cal. Most of these are people whose income exceeded the eligibility ceiling of 138% of the federal poverty level or may have moved out of Los Angeles County. L.A. Care had 52,800 people placed on hold for 90 days who did not complete the redetermination process and were disenrolled. This brings L.A. Care's current Medi-Cal enrollment to 2,324,000.	

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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	About 265,000 Kaiser members left L.A. Care because Kaiser signed a direct contract to serve Medi-Cal. This brought L.A. Care's membership down to about 2,450,000. Today, L.A. Care has about 2,350,000 Medi-Cal members. The loss of about 1000+ members is less than 4% of total enrollment. Behind the numbers, there was a lot of commotion and churning. L.A. Care took a deep dive into the data, and saw that about 42% of people re-enrolled. They were those that instead of going through the redetermination process just reapplied. There were a lot of people that did not renew. It is believed that most have moved and no longer reside in Los Angeles County. During this period, eligibility was expanded for undocumented residents between 26 and 49. At the beginning of 2024, L.A. Care added about 155,000 new members from that population. In terms of revenue, there has not been a big bump but enrollment is a little better than the 13% loss that L.A. Care forecast. L.A. Care lost about 4 or 5%. L.A. Care was involved in a coalition of hospitals and providers in getting the managed care organization (MCO) tax reinstated last year, with the bulk of the proceeds intended for Medi-Cal to improve provider reimbursement. In the Governor's announcement of the May State Budget revise this year, that was reversed, and the proceeds of tax will now be going to the State's general fund. This means the increased Medi-Cal funding projected in 2025 and 2026 is gone. The increases in the 2024 budget are protected, but that was the smallest amount of funding from the tax, and was only directed for primary care, behavioral health and OB-GYN providers. It is also clouded by imposing adjustments to aid codes with fees connected, while L.A. Care reimburses most providers through capitation, not fees. L.A. Care is discussing with regulators about how to equate the fee for service schedule increases with capitation rates. In some cases, L.A. Care may already be paying more than the increased amount. This will not get resolved in time to provide any money until December. The payments coming out of the MCO tax for 2024 will come out as another lump sum payment at the end of the year, for services that were provided during the year. L.A. Care hoped that the funding would appear in rates that providers received simultaneously with services being provided. There will be a ballot initiative in November to have the MCO tax permanently fund Medi-Cal. L.A. Care cannot take a position on the ballot initiative. The ballot initiative number will be announced shortly. Committee Member Raffoul asked when the ballot initiative would take effect, if it is approved. Mr. Baackes responded it should go into effect in 2026.	

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	Committee Member Matovsky asked if the ballot initiative is approved or not, will there be legal action and how is the coalition addressing the Governor's move to take those funds. Mr. Baackes responded that unfortunately, because it was done during the budget process, the Governor can do exactly what was done. There is no basis to sue for redirecting the funds, and it has to be reauthorized every year in the budget. The coalition managing the ballot initiative was contacted by the Governor's office in advance, offering that a withdrawal of the ballot initiative would result in funding for 2026. Unfortunately, the answer to that offer was no.	
COMMITTEE ISSUES		
Participating Physician Group (PPG) Scorecard and Internal Performance Metrics	Sameer Amin, MD, *Chief Medical Officer*, Tara Nelson, *Senior Director, Utilization Management*, Priti Golechha, *Senior Medical Director, Care Delivery*, Steven Chang, *Senior Director, Case Management,* and Suma Simcoe, *Deputy Chief Operating Officer*, provided information on the Participating Physician Group (PPG) Scorecard and Internal Performance Metrics. *(A copy of the report may be obtained by contacting Board Services.)* Dr. Amin expressed he is proud of L.A. Care's performance over the last 12 months. He added that when there is a change in performance, L.A. Care actively monitors the issues to ensure that remediation is effective to turn correct the metrics. He added that a report will be presented by staff who are doing the actual work. Committee Members can see their faces, hear their voices and see the quality of their work, so that they have confidence in the health plan and have open dialogue on the quality of the work. Staff wanted this Committee to understand that L.A. Care is in a position to collaborate with L.A. Care's network providers. L.A. Care wants to demonstrate openness that providers expect from the entire healthcare ecosystem and from other health plans. This Committee can advocate as a group with all health plans and work together for an open environment, see all the data on performance. L.A. Care wants to provide the same data about patient care and medical management. Ms. Nelson discussed the internal performance on processing authorizations, turnaround timelines and the recent status. • Urgent pre-service request decisions are made within 72 hours from the receipt of the request. L.A. Care has consistently been above 99%. L.A. Care's internal goal is to make	

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	decisions within the first 24 to 36 hours. L.A. Care prioritizes to make sure those decisions are not delaying any care for members. • Standard routine service request made within five business days of the receipt was in the upper 99% to 100%. Internal goal is five days, but staff try to process these by three to four days to ensure those decisions are made timely. • Expedited urgent, concurrent service request decisions made within 72 hours are timely at 98.99%. Staff wants to communicate with providers within 36 hours to meet regulatory requirement for completing the letters within 72 hours, including translation. • Post service requests decisions for both inpatient and outpatient is consistent at 99% to 100%. There was a drop in November due to an oddity with a couple of cases that were processed late. The issue was discovered through analysis and resolved quickly. Overall timely at 98.99% and above. Dr. Amin noted that over the course of last two years, L.A. Care has improved. He credited the Utilization Management team and Ms. Nelson's leadership. L.A. Care is consistent for two years with 99 to 100% compliance. Dr. Golechha presented the utilization data for hospital admissions, readmissions and related metrics, and developed a scorecard for L.A. Care's provider network. She reviewed L.A. Care's inpatient admissions and performance month over month from November 2022 to October 2023. There was a six-month lag in the claims and encounter results. She reviewed the performance for the last year for those months. There was improvement in total inpatient hospital admissions from the prior year. A lot of effort has gone into complex case management and transitions of care. Staff is monitoring performance and making sure the initiatives are working. L.A. Care's hospitalization rate decreased The improvement reflects the hard work by L.A. Care delegates. There was a significant decrease in inpatient hospital admissions from last year going into this year, compared to last year in the same period of time. Statistically from the largest providers, the confidence interval is going to be smaller because the membership is larger. They are affecting the network average. The providers with smaller membership will have a wider confidence interval. This is the normal variation of the network average. L.A. Care is focused on the delegated provider network which are falling outside of those network averages, working on networking and collaborative discussion to	

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	create strategies to decrease hospital admissions or readmissions to ensure that members are getting the care where they need it, without unnecessary hospitalization. Committee Member Hector Flores expressed that a lot of the Medi-Cal focused contracts with hospitals may not be as efficient as they need to be. Some hospitals expressed concerns that outpatient follow up is not well managed. This can lead to patients being readmitted or with an extended length of stay because of not connecting with the medical home that was supposed to receive the patient at discharge. There is a whole host of issues to address with that. Dr. Amin agreed and thanked Committee Member Flores. He added that L.A. Care is working on transitions of care through case management, and significant focus on the hand offs is critical in improving L.A. Care's performance. David Kagan, MD, *Senior Medical Director, Direct Network*, noted L.A. Care asked the hospitals for this data because hospitals have expressed concern with the variation in performance of the admitting position and how that affects the length of hospital stays. L.A. Care is working on the mechanics of hospital assignments for patients. Committee Member Zahra Movaghar asked if L.A. Care observed a difference between admission rates for full risk patients when there is a hospital physician relationship compared to shared risk. Dr. Golechha noted that L.A. Care is reviewing the risk profile with the data and not seeing significant differences, but will continue its review. L.A. Care looked at admissions and 30 day readmission rates to see how L.A. Care is performing compared to last year. Compared to last year, the trend looks better. L.A. Care is looking into the factors which might affect increased hospitalization, and is working with delegated network providers. L.A. Care is having collaborative discussions on how to make sure the members are properly transitioned between levels of care and the members visit their primary care physician (PCP) or telehealth, to avoid readmissions. L.A. Care reviewed emergency room (ER) utilization and it was found to be very similar year over year while slightly lower in some months. Dr. Amin proposed that L.A. Care educate members about other available urgent care resources. The inpatient hospital admission rate is hard to move, while readmissions and admissions are down, the data shows areas where L.A. Care can intervene to improve the rates. In response to a question if it is possible to separate between avoidable and non-avoidable re-admissions, Dr. Golechha noted L.A. Care staff specifically defined ambulatory, sensitive,	

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	acute and chronic conditions that could be managed well by the PCP level to avoid emergency room utilization. The conditions in this particular metric, compared with last year, had no significant difference. Dr. Amin noted this metric seems to be the most stubborn metric. The question has always been around access and education. The health care system was not built to deal with the queue, similarly, the primary care system was not built to deal with acute issues. The metrics are hard to move. Dr. Amin noted that when patients feel truly sick, they go to the urgent care, because the PCP office is not able to provide acute care. Committee Member Flores added that patients with Medi-Cal, except for relatively new members, were enrolled in Medi-Cal when they did not have access, and the default access was the emergency room (ER) where they would be seen quickly. These are old habits that are hard to break, and a lot of educational effort is needed when the patient is enrolled in Medi-Cal. For the previously uninsured, their only access point had been ER. Another aspect is educating patients about 24/7 access to a clinician. Because many of them are working, they do not have time and won't get paid if they take a day off to go see a doctor. ER is the only place to go after hours if there is no urgent care nearby. These are multi-faceted issues and it takes a lot of ongoing education, as well as transformation of the practices that serve them. Dr. Amin noted that there is a new utilization algorithm with more sensitivity to identify completely inappropriate utilization. When a chronic condition has flared, that patient needed ER, but if that chronic condition was managed better, they would not need to go to the ER. Committee Member Michelle Tyson asked if urgent care utilization is included in the utilization performance. Dr. Golechha responded this includes ER only and not urgent care. Dr. Golechha noted that staff plans to meet with the delegated provider network to review comprehensive integrated data sets on their performance to make sure that it is clear to providers what is happening and how it might affect the population health for members. Staff plans to also review member experience and access data along with quality data and metrics. L.A. Care reviews access and quality metrics with medical management metrics compared to network average, as well as PCP utilization. Dr. Amin noted that some of the issues that L.A. Care has been experiencing are related to different regulatory agencies giving different regulatory input as to what health plans are and	

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	are not allowed to do through the credentialing system. Dr. Amin added that mid-level organizations, like the physician assistant organization, verifies the hours and certifies they can practice independently. Dr. Amin suggested a presentation by credentialing staff at a future meeting. Dr. Amin presented a dashboard of performance metrics for community supports (CS) programs in Enhanced Care Management (ECM), a program under California Advancing and Improving Medi-Cal (CalAIM). L.A. Care reviews the dashboard regularly to monitor performance for recuperative care, medically tailored meals, environmental accessibility, adaptations, respite services, personal care services, centers for housing navigation, and housing deposits. The dashboard will be made available online. L.A. Care has implemented and has members enrolled every community support in ECM. In 2023, L.A. Care invested $80.01 million in these programs and L.A. Care is growing the ECM enrollment. Mr. Baackes noted that L.A. Care is currently working on payment methodologies to make sure that contracted providers are getting reimbursement in caring for these patients. L.A. Care will institute an incentive pool for new enrollees into the program and is in conversation with Department of Health Services about this. The current enrollment is 35,000 members, and continued increase is expected in 2024. Dr. Amin noted for the CS program, the data shows the benefit of the investment. Mr. Baackes noted that when CalAIM was originally announced, it was announced as if community supports would pay for themselves. That idea is no longer touted, but originally it was projected to save money by reducing hospitalizations and avoiding ER utilization. He pointed out that Medi-Cal does not cover the cost of the care being provided. Putting a roof over someone's head or whatever the cost that is, will not save enough money to pay for the program with medically tailored meals. Mr. Baackes expressed concern that health plans will be blamed for lack of cost savings. A study done in Camden, New Jersey for 10 years showed that providing a host of the CS to a group of mostly dually eligible for Medicare and Medicaid didn't save any money. The program was judged a failure, but the improvement in quality of life for the participants was not a metric in the evaluation. Dr. Amin noted there is no metric about quality of life and if none of the patients went to the hospital, the savings would only make up about 20% of the cost of CS benefits such as housing, supportive services and housing deposits. The likelihood that any further benefit in total cost of care can be found is unlikely. It would be great if there is some way to incorporate that into return on investment, but the assumption is that 5-10 years down the line, the beneficiaries will be in a better situation. Maybe the participant moved on to employer-based insurance,	

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	and does not have Medicaid. L.A. Care will continue to review the data, and initially advocated to regulators that if they want CalAIM to continue, it needs proper funding in the Medicaid rates. Mr. Chang clarified the numbers presented include L.A. Care plan partner enrollment and L.A. Care has about 70% of statewide enrollment. Committee Member Richard Ayoub noted Project Angel Food is L.A. Care's largest supplier for medically tailored meals in CS. With that contract and reimbursements, the analysis can compare 3-6 months of meals because there might be a difference in cost. Mr. Baackes agreed that extended data will show better returns in the long term for patients benefiting from medically tailored meals. Ms. Simcoe presented the Claims Operations dashboard. Five key incidents, since August 2023, have impacted claims payment timeliness and interest payments starting with the implementation of the coordination of benefit agreement (COBA). 1) In August, L.A. Care began receiving a very high volume of claims from Centers for Medicaid and Medicare Services (CMS), which affected our ability to process claims timely. 2) The Change Healthcare (CHC) cyberattack, in February 2024, impacted the volume of claims receipts. 3) The skilled nursing facility (SNF) fee schedules were updated four times, and each update impacted SNF claims. The rate change required an adjustment to the originally processed claims. 4) The retroactive Call The Car contract changes caused a high volume of claims to be reprocessed. 5) The SB 510 legislation required review and reprocessing of previously processed claims. The delay in the timely processing of claims resulted in a little bit of a higher interest payment than normal. We created new workflow process to focus on claims where L.A. Care is the primary payer and created a queue for secondary claims to mitigate the claims processing delays. In April claims volume was 1.5 million, with professional claims at the highest volume followed by Uniform Billing (UBO4) form used by the facilities for billing outpatient/home health/hospice etc., SNF and hospital inpatient claims. We interpreted this hike in claims receipts was due to the resolution of the CHC issue, as the percentage of claims submitted electronically was very high. Ms. Simcoe reviewed claims denial and adjustments. One of the reasons for the high denial rate was due to duplicate COB claims received by L.A. Care from CMS, while the providers are submitting the same claims to L.A. Care directly for payment consideration. Another	

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	reason was due to the COBA claims payment status, where claims paid at $0.00 were categorized as denied instead of paid. The system logic was updated in March to reflect $0.00 paid claims as paid rather than denied. Most of these claims were paid $0.00 because the primary insurer paid the eligible amount. Ms. Simcoe reviewed details about claims processing and mitigation work on improper claims processing. Ms. Simcoe talked about claims timeliness and noted the average turnaround time for claims processing has improved. The current running rate for claims processing is around 9 days. Ms. Simcoe reported that in December 2023, Provider Dispute Resolution (PDR) volume was high and the contract change with Call the Car is one of the issues that caused higher PDR volume. The turnaround time for PDR is now 39 days, and the goal is to reduce it to 20-25 days. Dr. Amin asked Committee Members for feedback on the data provided in the performance dashboard. Chairperson Greene noted it was a lengthy report and he thinks this is exactly the type of update for which this group was looking. There may be additional comments after closer review. He thanked the team for the work into putting this together and expressed his appreciation for the transparency. Dr. Amin thanked Acacia Reed, *Chief Operating Officer*. Ms. Reed oversees the Claims Department and has done an amazing job of working with Ms. Simcoe to get the claims data headed in the right direction. Dr. Amin asked the Committee Members if they would be interested in further discussion regarding over/under utilization as presented earlier around re-admissions, admissions, and avoidable ER use. Committee Member Movaghar asked about the target for admissions. Dr. Golecha noted that L.A. Care is currently looking at normalizing the network average, especially ER use and hospitalization. L.A. Care is stratifying by aid codes, because their SPD members are likely to have higher rates of utilization. L.A. Care is reviewing access to care because a network utilization average might not be the right target for all. L.A. Care is creating an internal average standard considering multiple factors for members. Dr. Amin added the expectation is 95% to 99%, which are the usual regulatory baselines.	

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OPEN FORUM	Dr. Amin noted that this section is for topics to discuss at future meetings, such as advocacy collaboration on how to get other health plans to publish a dashboard that has all the information that L.A. Care has provided. Chairperson Greene suggested a conversation about metrics related to Call The Car (CTC). Dr. Amin responded that Committee Member Tyson, CTC is on the line so she add her input as well. L.A. Care has worked collaboratively with CTC in the last year and a half and synced on the metrics that L.A. Care is tracking. L.A. Care has built a number of metrics into the contract with CTC, and is actively monitoring them. L.A. Care are collaborates with CTC in trying to meet those metrics and achieved the goals on a regular basis in 2023. During discussions with this Committee, L.A. Care learned that some facilities and some members still have some concerns, and that probably comes from a lag in experience versus a lag in the metrics. L.A. Care discuss corrective action process with CTC. Noah Paley, *Chief of Staff*, added that L.A. Care is carefully monitoring CTC's performance. When there are deficiencies below the agreed upon performance levels that are regulatory and contractual requirements, L.A. Care communicates immediately with CTC to discuss remediation and ensure that performance meets required service levels. AJ Lopez, *Director, Provider Relations* added that CTC was selected through request for proposal process and reaffirmed about nine months ago, after L.A. Care requested for information from the competitors. CTC conducts up to 250,000 rides per month, roughly 6,600 a day, which requires thousands of phone calls every day. Unfortunately it just takes one case to delay service. His team monitors the account regularly; in many cases, hour by hour for complex transports. Angela Pena, *Senior Manager, Provider Contracts and Relationship Management,* added that CTC works very closely with L.A. Care and is a good partner. CTC responded quickly and is working to implement corrective action plans. L.A. Care has seen improved service level throughout recent months. Committee Member Tyson thanked L.A. Care and Mr. Lopez' team. She noted that CTC's day to day operation is not as easy as it looks. It is a very robust program and CTC is getting better every day because L.A. Care is very responsive. CTC try to be as equally responsive to make certain these issues are covered. There are a number of issues in transportation that can escalate very quickly. CTC values and is trying to support a network of patients with transportation. CTC is aligned with L.A. Care in compliance. CTC is looking at every avenue possible down to the subcontracted vendors and all the way up and down every piece	

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	of this massive amount of information. Committee Member Tyson noted that transportation is a very complex delivery of care, CTC is making certain that it is utilized properly for the people in Los Angeles County. CTC will continue collaborating and moving forward. CTC appreciates and thank the L.A. Care team for their collaboration. Dr. Amin thanked Committee Member Tyson and reviewed indicators such as calls answered within 30 seconds, abandonment rate on incoming calls, scheduled on time performance, discharge on time performance, transfer on time performance, provider cancellations and/or provider missed pick-ups, member complaints and grievances. L.A. Care set benchmarks for each of these at 100% rate. Dr. Amin wanted to make sure that everybody sees that L.A. Care is tracking these very closely and monitoring compliance. Mr. Lopez provided context on transportation for a health plan and noted that other health plans, even outside of California, are looking to L.A. Care for the best industry practices. Chairperson Greene thanked everyone engaged on this issue. Chairperson Greene encouraged the Committee Members to reach out to him or any member of L.A. Care leadership with issues they would like to see discussed by this Committee. He expressed that the work that we all do is hard, meaningful and impactful, but we got to recharge ourselves in order to really lean in. He wished everyone a great summer.	
ADJOURNMENT	The meeting adjourned at 11:08 a.m.	

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:

_____
George Greene, Esq., *Chairperson*
Date Signed _____

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