BOARD OF GOVERNORS MEETING

May 4, 2023 • 1:00 PM

L.A. Care Health Plan

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

About L.A. Care Health Plan

Statement

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

Overview

Committed to the promotion of accessible, affordable and high quality health care, L.A. Care Health Plan (Local Initiative Health Authority of Los Angeles County) is an independent local public agency created by the State of California to provide health coverage to low-income Los Angeles County residents. Serving more than 2.8 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 Cal MediConnect Plan** – L.A. Care Cal MediConnect Plan provides coordinated care for Los Angeles County seniors and people with disabilities who are eligible for Medicare and Medi-Cal.

- **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 February 2023	
Medi-Cal	**2,678,030**
L.A. Care Covered	**127,051**
D-SNP	**17,801**
PASC-SEIU	**49,481**
Total membership	**2,872,363**
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 2021-2022 budget)	
Revenue	**$8.6B**
Fund Equity	**$1,143,510**
Net Operating Surplus	**($90,772)**
Administrative cost ratio	**5.2%**
Staffing highlights	
Full-time employees (Actual as of September 2021)	**1,911**
Projected full-time employees (FY 2021-2022 budget)	**1,945**

AGENDA
BOARD OF GOVERNORS MEETING
L.A. Care Health Plan
Thursday, May 4, 2023, 1:00 P.M.

L.A. Care Health Plan, 1055 W. 7th Street, Conference Rooms 1017-18, 10th Floor
Los Angeles, CA 90017

DRAFT

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

To listen to the meeting via videoconference please register by using the link below:
https://lacare.webex.com/lacare/j.php?MTID=m69e416cdcec908bea42a221d71d7a869

To listen to the meeting via teleconference please dial: +1-213-306-3065
English Meeting Access Number: 2498 036 8785 Password: lacare
Spanish Meeting Access Number: 2489 348 8869 Password: lacare

Hilda Perez
L.A. Care Community Resource Center
3200 E Imperial Hwy, Lynwood, CA 90262

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 in writing by e-mail to BoardServices@lacare.org, or by sending a text or voicemail to (213) 628-6420.

Attendees who log on to lacare.webex using the URL above will be able to use "chat" during the meeting for public comment. You must be logged into WebEx to use the "chat" feature. The log in information is at the top of the meeting Agenda. The chat function will be available 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 right of your screen for the icon that has the word, "chat" on it.
3. Click on the chat icon. It will open two small windows.
4. Select "Everyone" in the "To:" window,
5. The chat message 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.
6. Type your public comment in the box that says "Enter chat message here".
7. When you hit the enter key, your message is sent and everyone can see it.
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.

You can send your public comments by voicemail, email or text. If we receive your comments by 1:00 P.M., May 4, 2023, it will be provided to the members of the Board of Governors in writing at the beginning of the meeting. The chat message, text, voicemail, or email must indicate if you wish to be identified or remain anonymous, and must include the name of the item to which your comment relates.

Once the meeting has started, public comment submitted in writing must be received before the agenda item is called by the Chair. If your public comment is not related to any of the agenda item topics, it will be read in the general public comment agenda item.

Please note that there may be delay in the digital transmittal of emails, texts and voicemail. The Chair will announce when 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 prior to the board going to closed session.

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. These are extraordinary circumstances, and the process for public comment is evolving and may change at future meetings. We thank you for your patience.

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

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

Welcome — Al Ballesteros, MBA, *Chair*

1. Approve today's Agenda — *Chair*
2. Public Comment *(Please read instructions above.)* — *Chair*
3. Approve Consent Agenda Items — *Chair*
   - April 6, 2023 Board of Governors Meeting Minutes p.17
   - Ratify execution of Amendment to L.A. Care's Medi-Cal Contract No. 04-36069 with the Department of Health Care Services **(EXE 100)** p.48
   - Delegation of authority to negotiate and execute the delegation amendments to the Plan Partner Services Agreements with Kaiser Foundation Health Plan, Inc., and Blue Cross of California and Ratification of the execution of the delegation amendment to the Plan Partner Services Agreement with Blue Shield of California Promise Health Plan **(EXE 101)**p.95
   - Quarterly Investment Report **(FIN 100)** p.422
   - Health Dialog Contract Amendment **(FIN 101)** p.457
   - Health Integrated Association Contract Amendment **(FIN 102)** p.459
   - O'Neil Digital Solutions, LLC Contract Amendment **(FIN 103)** p.460
4. Chairperson's Report — *Chair*
5. Chief Executive Officer Report p.461 — John Baackes, *Chief Executive Officer*
   - Quarterly Vision Progress Report p.463
   - Department of Managed Health Care Enforcement Matter Report p.483
   - Monthly Grants & Sponsorship Reports p.485

Advisory Committee Reports

6. Executive Community Advisory Committee — Hilda Perez / Layla Gonzalez, *Consumer member and Advocate member*

Committee Reports

7. Executive Committee — *Chair*
   - Government Affairs Update p.500 — Cherie Compartore, *Senior Director, Government Affairs*
   - Authorization to establish a Provider Relations Advisory Committee **(EXE 102)** p.691
8. Finance & Budget Committee — Stephanie Booth, MD, *Committee Chair*

- Chief Financial Officer Report p.703 — Afzal Shah, *Chief Financial Officer*
  - Financial Report – February & March 2023 **(FIN 104)** p.714
  - Monthly Investment Transactions Reports – February & March 2023 p.733
  - Quarterly Internal Policy Reports *(Informational Item)* p.799

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

10. Public Comment on Closed Session Items *(Please read instructions above.)* — *Chair*

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

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

12. REPORT INVOLVING TRADE SECRET
Pursuant to Welfare and Institutions Code Section 14087.38(n)
Discussion Concerning new Service, Program, Marketing Strategy, Business Plan or Technology
Estimated date of public disclosure: *May 2025*

13. 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)

14. CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION
Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act
    - Glendale Adventist Medical Center dba Adventist Health Glendale v. Local Initiative Health Authority for Los Angeles dba L.A. Care Health Plan, JAMS 1220072271

15. CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION
Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act
    - PIH Whittier & PIH Downey v. L.A. Care (L.A.S.C. Case No. 19STCV18084, filed May 24, 2019), consolidated with:
    - PIH Whittier & PIH Downey v. L.A. Care (L.A.S.C. Case No. 21NWCV0052, filed Jan. 27, 2021)
    - PIH Whittier & PIH Downey v. L.A. Care (L.A.S.C. Case No. 22NWCV00596, filed Jul. 14, 2022)

16. 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

17. 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 — *Chair*

Adjournment *Chair*

The next meeting is scheduled on June 1, 2023 at 1 PM and 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.

NOTE: THE BOARD OF GOVERNORS CURRENTLY MEETS ON THE FIRST THURSDAY OF MOST MONTHS AT 1:00 P.M.

AGENDA and PRINTED MEETING MATERIALS ARE AVAILABLE FOR INSPECTION 72 HOURS BEFORE THE MEETING:

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

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

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

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

Schedule of Meetings May 2023

Monday	Tuesday	Wednesday	Thursday	Friday
1	2	3	4 ***Board of Governors Meeting*** ***1 pm*** *(for approx. 6 hours)*	5
8	9	10 ***ECAC Meeting*** *10 AM* *(for approx. 2 hours)*	11	12
15 ***RCAC 9*** *10 AM* *(for approx. 1-1/2 hours)*	16 ***RCAC 7*** *10 AM* *(for approx. 1-1/2 hours)*	17 ***RCAC 11*** *10 AM* *(for approx. 1-1/2 hours)*	18 ***RCAC 4*** *9:30 AM* *(for approx. 1-1/2 hours)* ***Compliance & Quality*** *2 PM* *(for approx. 2 hours)*	19 ***RCAC 8*** *10:30 AM* *(for approx. 1-1/2 hours)*
22	23	24 ***Finance & Budget Committee Meeting*** *1 PM* *(for approx. 1 hour)* ***Executive Committee Meeting*** *2 PM* *(for approx. 2 hours)*	25	26
29	30	31		

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

Prepared by mhbalones/printed on 04/25/23

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

BOARD OF GOVERNORS & PUBLIC ADVISORY COMMITTEES
2023 MEETING SCHEDULE / MEMBER LISTING

	MEETING DAY, TIME & LOCATION	MEETING DATES	BOARD MEMBERS / STAFF CONTACT
BOARD OF GOVERNORS	**1st Thursday** 1:00 PM *(for approximately 3 hours)* L.A. Care Health Plan 1055 W. 7th Street, 1st Floor, Los Angeles, CA 90017 (213) 694-1250 **Offsite meeting – location TBD* ***All Day Retreat – location TBD* ****Placeholder meeting*	May 4 June 1* July 27 *No meeting in August* September 7** October 5*** November 2 December 7	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. Hilda Perez G. Michael Roybal, MD, MPH Supervisor Hilda L. Solis Nina Vaccaro, MPH **Staff Contact:** John Baackes *Chief Executive Officer, x4102* Linda Merkens *Senior Manager, Board Services, x4050*
BOARD COMMITTEES			
EXECUTIVE COMMITTEE	**4th Wednesday of the month** 2:00 PM *(for approximately 2 hours)* L.A. Care Health Plan 1055 W. 7th Street, 1st Floor, Los Angeles, CA 90017 (213) 694-1250 **2nd Wednesday due to Thanksgiving holiday*	May 24 June 28 *No meeting in July* August 23 September 27 October 25 November 15* *No meeting in December*	Alvaro Ballesteros, MBA, *Chairperson* Ilan Shapiro, MD, *Vice Chairperson* Stephanie Booth, MD, *Treasurer* John G. Raffoul, *Secretary* Hilda Perez *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 2023 Meeting Schedule / Member Listing

	Meeting Day, Time & Location	Meeting Dates	Board Members / Staff Contact
Compliance & Quality Committee	**3rd Thursday of the month** 2:00 PM *(for approximately 2 hours)* L.A. Care Health Plan 1055 W. 7th Street, 1st Floor, Los Angeles, CA 90017 (213) 694-1250	May 18 June 15 *No meeting in July* August 17 September 21 October 19 November 16 *No meeting in December*	Stephanie Booth, MD, *Chairperson* Alvaro Ballesteros, MBA Hilda Perez G. Michael Roybal, MD, MPH **Staff Contact:** Victor Rodriguez *Board Specialist II, Board Services x 5214*
Finance & Budget Committee	**4th Wednesday of the month** 1:00 PM *(for approximately 1 hour)* L.A. Care Health Plan 1055 W. 7th Street, 1st Floor, Los Angeles, CA 90017 (213) 694-1250 **2nd Wednesday due to Thanksgiving holiday*	May 24 June 28 *No meeting in July* August 23 September 27 October 25 November 15* *No meeting in December*	Stephanie Booth, MD, *Treasurer* Al Ballesteros, MBA Hilda Perez G. Michael Roybal, MD, MPH Nina Vaccaro **Staff Contact:** Malou Balones *Board Specialist III, Board Services x4183*
Governance Committee	L.A. Care Health Plan 1055 W. 7th Street, 1st Floor, Los Angeles, CA 90017 (213) 694-1250 **MEETS AS NEEDED**		Hilda Perez, *Chairperson* Stephanie Booth, MD Layla Gonzalez Nina Vaccaro, MPH **Staff Contact:** Malou Balones *Board Specialist III, Board Services/x 4183*
Service Agreement Committee	L.A. Care Health Plan 1055 W. 7th Street, 1st Floor, Los Angeles, CA 90017 (213) 694-1250 **MEETS AS NEEDED**		Layla Gonzalez, *Chairperson* George W. Greene Hilda Perez **Staff Contact** Malou Balones *Board Specialist III, Board Services/x 4183*

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	MEETING DAY, TIME & LOCATION	MEETING DATES	BOARD MEMBERS / STAFF CONTACT
AUDIT COMMITTEE	L.A. Care Health Plan 1055 W. 7th Street, 1st Floor, Los Angeles, CA 90017 (213) 694-1250 **MEETS AS NEEDED**		Hector De La Torre Layla Gonzalez George Greene **Staff Contact** Malou Balones *Board Specialist III, Board Services, x 4183*

L.A. CARE COMMUNITY HEALTH PLAN	**Meets Annually or as needed** L.A. Care Health Plan 1055 W. 7th Street, 1st Floor, Los Angeles, CA 90017 (213) 694-1250		Alvaro Ballesteros, MBA, *Chairperson* Ilan Shapiro, MD, *Vice Chairperson* Stephanie Booth, MD, *Treasurer* John G. Raffoul, *Secretary* Jackie Contreras, PhD Hector De La Torre Christina R. Ghaly, MD Layla Gonzalez, George W. Greene, Esq. Hilda Perez G. Michael Roybal, MD, MPH Supervisor Hilda Solis Nina Vaccaro, MPH **Staff Contact:** John Baackes, *Chief Executive Officer, x4102* Linda Merkens, *Senior Manager, Board Services, x4050*
L.A. CARE JOINT POWERS AUTHORITY	L.A. Care Health Plan 1055 W. 7th Street, 1st Floor, Los Angeles, CA 90017 (213) 694-1250 **Offsite meeting – location TBD* ***All Day Retreat – location TBD* ****Placeholder meetings*	May 4 June 1* July 27 *No meeting in August* September 7** October 5*** November 2 December 7	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. Hilda Perez G. Michael Roybal, MD, MPH Supervisor Hilda Solis Nina Vaccaro, MPH **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 2023 Meeting Schedule / Member Listing

Public Advisory Committees			
Children's Health Consultant Advisory Committee General Meeting	**3rd Tuesday of every other month** 8:30 AM *(for approximately 2 hours)* L.A. Care Health Plan 1055 W. 7th Street, 1st Floor, Los Angeles, CA 90017 (213) 694-1250	May 16 *No meeting in July* August 15 September 19 November 21	**Tara Ficek, MPH,** *Chairperson* **Staff Contact:** Victor Rodriguez *Board Specialist II, Board Services/x 5214*
Executive Community Advisory Committee	**2nd Wednesday of the month** 10:00 AM *(for approximately 3 hours)* L.A. Care Health Plan 1055 W. 7th Street, 1st Floor, Los Angeles, CA 90017 (213) 694-1250	May 10 June 14 *No meeting in July* August 9 September 13 October 11 November 8 December 13	**Fatima Vasquez,** *Chairperson* **Staff Contact:** Idalia Chitica, *Community Outreach & Education, Ext. 4420*
Technical Advisory Committee	**Meets Quarterly** **2nd Thursday of meeting month** 2:00 PM *(for approximately 2 hours)* L.A. Care Health Plan 1055 W. 7th Street, 1st Floor, Los Angeles, CA 90017 (213) 694-1250	May 11 August 10 November 9	**Staff Contact:** Victor Rodriguez *Board Specialist II, Board Services/x 5214*

BOARD OF GOVERNORS, BOARD COMMITTEES, PUBLIC ADVISORY COMMITTEES AND REGIONAL COMMUNITY ADVISORY COMMITTEES
2023 MEETING SCHEDULE / MEMBER LISTING

REGIONAL COMMUNITY ADVISORY COMMITTEES			
REGION 1 **ANTELOPE VALLEY**	**3rd Friday of every other month** 10:00 AM *(for approximately 2-1/2 hours)* L.A. Care Family Resource Center 2072 E. Palmdale Blvd. Palmdale, CA 93550 (213) 438-5580	June 16 August 18 October 20 December 15	**Russel Mahler,** *Chairperson* **Staff Contact:** Kristina Chung, Field Specialist Cell Phone (213) 905-8502 *Community Outreach & Education*
REGION 2 **SAN FERNANDO VALLEY**	**3rd Monday of every other month** 10:00 AM *(for approximately 2-1/2 hours)* L.A. Care Family Resource Center 10807 San Fernando Rd. Pacoima, CA 91331 (844) 858-9942	June 26 * August 21 October 16 December 18 **Dates have changed due to holidays or L.A. Care Special events*	**Estela Lara,** *Chairperson* **Staff Contact:** Martin Vicente, Field Specialist Cell Phone (213) 503-6199 *Community Outreach & Education*
REGION 3 **ALHAMBRA, PASADENA AND FOOTHILL**	**3rd Tuesday of every other month** 10:00 AM *(for approximately 2-1/2 hours)* Robinson Park Recreation Center 1081 N. Fair Oaks Ave. Pasadena, CA 91103 (626) 744-7330	June 20 August 15 October 17 December 19	**Cynthia Conteas-Wood,** *Chairperson* **Staff Contact:** Frank Meza, Field Specialist Cell phone (323) 541-7900 *Community Outreach & Education*
REGION 4 **HOLLYWOOD-WILSHIRE, CENTRAL L.A. AND GLENDALE**	**3rd Wednesday of every other month** 9:30 AM *(for approximately 2-1/2 hours)* Community Resource Center Metro LA 1233 S. Western Ave. Los Angeles, CA 90006 (213) 428-1457	May 18 July 20 September 21 November 16	**Sylvia Poz,** *Chairperson* **Staff Contact:** Kristina Chung, Field Specialist Cell Phone (213) 905-8502 *Community Outreach & Education*

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REGION 5 **CULVER CITY, VENICE, SANTA MONICA, MALIBU, WESTCHESTER**	**3rd Monday of every other month** 2:00 PM *(for approximately 2-1/2 hours)* Veterans Memorial Bldg Multipurpose Room 4117 Overland Avenue Culver City, CA 90230 (310) 253-6625	June 26 * August 21 October 16 December 18	**Maria Sanchez,** *Chairperson* **Staff Contact:** Cindy Pozos, Field Specialist Cell phone (213) 545-4649 *Community Outreach & Education*
REGION 6 **COMPTON, INGLEWOOD, WATTS, GARDENA, HAWTHORNE**	**3rd Thursday of every other month** 10:00 AM *(for approximately 2-1/2 hours)* Community Resource Center Inglewood 2864 W. Imperial Highway Inglewood, CA 90303 (310) 330-3130	June 21 August 16 October 18 December 20	**Andria McFerson,** *Chairperson* **Staff Contact:** Frank Meza, Field Specialist Cell phone (323) 541-7900 *Community Outreach & Education*
REGION 7 **HUNTINGTON PARK, BELLFLOWER, NORWALK, CUDAHY**	**3rd Thursday of every other month** 10:00 AM *(for approximately 2-1/2 hours)* Community Resource Center Norwalk 11721 Rosecrans Ave. Norwalk, CA 90650 (562) 651-6060	May 16 July 18 September 19 November 21	**Fatima Vasquez,** *Chairperson* **Staff Contact:** Martin Vicente, Field Specialist Cell Phone (213) 503-6199 *Community Outreach & Education*
REGION 8 **CARSON, TORRANCE, SAN PEDRO, WILMINGTON**	**3rd Friday of every other month** 10:30 AM *(for approximately 2-1/2 hours)* Community Resource Center Wilmington 911 N. Avalon Ave. Wilmington, CA 90744 (213) 428-1490	May 19 July 21 September 15 November 17	**Ana Romo** – ***Chairperson*** **Staff Contact:** Hilda Herrera, *Field Specialist* Cell phone (213) 605-4197 *Community Outreach & Education*

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REGION 9 **LONG BEACH**	**3rd Monday of every other month** 10:00 AM *(for approximately 2-1/2 hours)* Community Resource Center Long Beach 5599 Atlantic Ave. Long Beach, CA 90805 (213) 905-8502	May 15 July 17 September 18 November 20	**Tonya Byrd**, *Chairperson* **Staff Contact:** Kristina Chung, Field Specialist Cell Phone (213) 905-8502 *Community Outreach & Education*
REGION 10 **EAST LOS ANGELES, WHITTIER AND HIGHLAND PARK**	**3rd Thursday of every other month** 2:00 PM *(for approximately 2-1/2 hours)* L.A. Care East L.A. Family Resource Center 4801 Whittier Blvd Los Angeles, CA 90022 (213) 438-5570	June 15 August 17 October 19 December 21	**Damares Hernández de Cordero,** *Chairperson* **Staff Contact:** Hilda Herrera, *Field Specialist* Cell phone (213) 605-4197 *Community Outreach & Education*
REGION 11 **POMONA AND EL MONTE**	**3rd Thursday of every other Month** 10:00 AM *(for approximately 2-1/2 hours)* Pomona Community Resource Center 696 W. Holt Street Pomona, CA 91768 (909) 620-1661	May 17 July 19 September 20 November 15	**Maria Angel Refugio,** *Chairperson* **Staff Contact:** Frank Meza, Field Specialist Cell phone (323) 541-7900 *Community Outreach & Education*

Board of Governors
Regular Meeting Minutes #316
April 6, 2023

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 *
Hector De La Torre *
Christina R. Ghaly, MD
Layla Gonzalez
George W. Greene, Esq.**
Supervisor Hilda Solis **
Hilda Perez **
G. Michael Roybal, MD, MPH
Nina Vaccaro, MPH **

Management

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

**Absent*
*** via teleconference*

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
WELCOME	Ilan Shapiro, MD, *Vice-Chairperson,* called to order 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 at 1:04 p.m. The meetings were held simultaneously. Al Ballesteros, *Chairperson,* joined the meeting. He announced that those attending the meeting in person who wish to submit a public comment should use the form provided. For those with access to the internet, the materials for today's meeting are available on the L.A. Care website. He welcomed everyone and thanked those who have submitted public comment by voice mail, text or email. He informed participants that for those using the video software during the meetings; the "chat" function will be available to provide live and direct public comment to everyone participating in the virtual meeting. The Chat feature will be open throughout the meeting for public comment. Board Members have received in writing the voice messages and written public comments sent before the meeting. All comments sent before and during the meeting were read for up to three minutes. All are welcome to provide input.	
APPROVAL OF MEETING AGENDA	The agendas were approved as presented.	**Unanimously approved by roll call.**

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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	(Board Member Gonzalez joined the meeting.)	**9 AYES (Ballesteros, Booth, Ghaly, Perez, Raffoul, Roybal, Shapiro, Solis, and Vaccaro)**
PUBLIC COMMENTS	*Andria McFerson, RCAC 6 Chair, asked the Board to please allow the ECAC Chairs and the public to speak like this, as well as the Regional Community Advisory Committees. There are pre-written Agendas from staff. It would be great if the committees could talk about better ways to speak about what affects the community the most. She has tried a lot to be able to have a voice and represent the public. That's how she wants it to be. She doesn't want it to be confrontational in general, she wants the community to have a voice. She has a lot of people asking her about what they are going through with their doctors. People that are homeless because they could not work anymore due to their medical condition. The suicide rates are going up and there is a lot of depression. According to their own medical illness they are not receiving proper healthcare and not even receiving the honor of <unintelligible audio due to technical issue> for their doctors. They are underdiagnosed, undiagnosed, misdiagnosed, it's all going to an auto mechanic - once one thing is fixed they make something else go wrong just so that one can go back. That's how they feel when they go to the doctor, so they are reluctant to even go. She asked to have a voice again, at the RCACs, at the ECAC, and also not allow staff to interrupt the Chairs as they are speaking. They are reluctant to say anything because they see me being disrupted, it's embarrassing. She wants to have the participation of RCAC members back showing love to each other. She loves everyone in the meeting no matter what. Whether people feels she is being abruptive or not, she is here for only one reason: for the people she represents and better health care.*	
APPROVE CONSENT AGENDA ITEMS	• March 2, 2023 Board of Governors Meeting Minutes • Resources Connection, LLC dba Resources Global Professionals **<u>Motion BOG 100.0423</u>** **To authorize staff to amend a contract in the amount of $700,000 with Resources Connection, LLC dba Resources Global Professionals (RGP) to provide Internal Audit services for the period of November 1, 2022 through December 31, 2023.** • Customer Motivators Contract Amendment **<u>Motion FIN 100.0423</u>**	**Unanimously approved by roll call. 10 AYES (Ballesteros, Booth, Ghaly, Gonzalez, Perez, Raffoul, Roybal, Shapiro, Solis, and Vaccaro)**

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	To authorize staff to amend an existing contract with Customer Motivators to provide member incentive fulfillment services for the period of July 1, 2023 to June 30, 2026, in the amount of $1,999,999 for a new total of $2,999,999 over a 5-year period. • Center for Caregiver Advancement Contract Amendment **Motion FIN 101.0423** **To authorize a contract renewal in the amount of $11,640,388 with Center for Caregiver Advancement (CCA) to provide education and training for In-Home Supportive Services (IHSS) providers for dual-eligible beneficiaries for the period of May 14, 2023 through May 13, 2026.**	
CHAIRPERSON'S REPORT	Al Ballesteros, *Chairperson,* announced that the Board of Supervisors has appointed Jackie Contreras, *Director of Los Angeles County Department of Public and Social Services*, to this Board. She was unfortunately not able to attend today. He welcomed Ms. Contreras to the L.A. Care Board of Governors. Chairperson Ballesteros reported that Gloria Molina, former Los Angeles County Supervisor and a past member of the L.A. Care Board has announced that she is battling terminal cancer. He knows that many people participating in today's meeting know former Supervisor Molina and have worked closely with her in the past. He thanked Board Member Supervisor Solis for her motion at the recent Board of Supervisors meeting to rename Grand Park in honor of Ms. Molina. He worked with Ms. Molina during the early stages of the AIDS epidemic in Los Angeles, and she was immensely helpful. Everything the community did in East LA, and especially for populations of people of color on the Eastside and how they were affected and were not properly addressed at that time. He will always have a lot of respect for Ms. Molina and how she helped that cause. Not only was she a champion of healthcare, she was on the L.A. Care Board and on the Board of Supervisors always championing the issues for individuals that are uninsured and individuals that did not access the health care system because of fear or lack of knowledge. She made a tremendous difference. Chairperson Ballesteros is thinking of her as she battles terminal cancer. He knows that many people feel the same way. He felt it is important to take this time to talk about Gloria Molina and her many accomplishments. Board Member Supervisor Solis thanked him for the comments. Gloria Molina, former Supervisor, City Councilwoman and Assemblywoman, has contributed in many, many ways to the advancement of our communities, especially in the healthcare arena. She fought very hard	

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	to establish the replacement project for the LAC+USC hospital. After the 1994 earthquake, services could not be provided in the old hospital building. It was a big job, a big lift for Ms. Molina to get the new hospital in place. Services are still available on the bottom floor of the old building, which is known as *The Wellness Center*. Many providers are located there, such as promotoras, and people receive assistance there in many different ways from non-profits and clinics. People can also enroll in coverage at the Wellness Center. It was through Ms. Molina's help that the basic services are provided there, and it remains a big part of her legacy. Board Member Supervisor Solis is proud to report, as she currently serves on the *Metro* Board that Ms. Molina also served on the Metro Board when it developed the Gold Line to East Los Angeles from Union Station. The work she did for the Gold Line continues to be part of her legacy, and that is the reason Board Member Supervisor Solis proposed renaming the Civic Center stop after Ms. Molina. Board Member Supervisor Solis urged those who knew her to send her notes, as she is sure Ms. Molina would welcome that. Board Member Supervisor Solis had the opportunity to meet with her, and Ms. Molina is very grateful for having been able to serve so many people, and that they remember her courage and heroism throughout her career, in fighting for the most vulnerable and the voiceless.	
CHIEF EXECUTIVE OFFICER REPORT	John Baackes, *Chief Executive Officer,* reported that as of April 1, 2023, the redetermination of eligibility for Medicaid, called Medi-Cal in California, has begun nationwide. California has submitted a plan to notify members, starting April 1, about redetermination effective in June. Medi-Cal coverage will terminate on July 1 for any beneficiaries that do not complete the redetermination process. L.A. Care's Medi-Cal members will continue to be reassessed for eligibility through June 2024. Details about L.A. Care's preparation for eligibility redetermination were presented at the February Board of Governors' meeting. Mr. Baackes summarized actions to support continued health care coverage for Medi-Cal members: • Training on renewal was conducted on April 4 for L.A. Care's health promoters to raise awareness in communities throughout L.A. County. • A Provider toolkit has been shared with all L.A. Care's contracted medical groups and with providers in the directly contracted network. • A separate version will be presented to L.A. Care's street medicine providers, a critical component in making sure that people who are unhoused can maintain access to health coverage. • L.A. Care will host a provider webinar on May 10 to increase awareness of the renewal process and outreach activities for providers to keep their patients enrolled.	

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	• L.A. Care has shared outreach materials in meetings with members of the Hospital Association of Southern California (HASC), SCAN, Community Clinic Association of Los Angeles County (CCALAC), and the L.A. County Office of Education. • By early May, every L.A. Care Community Resource Center (CRC) will have a direct contract with a certified application assistor to provide technical assistance with renewal paperwork to anyone who comes into the CRC. The twelfth CRC opened on March 23 in Norwalk. Jacey K. Cooper, the State Medicaid Director and Chief Deputy Director of Health Care Programs at California Department of Health Care Services (DHCS), attended the opening event. The CRCs will be valuable resources for the community and those needing technical assistance are welcome to bring the paperwork to a CRC for help. The paperwork must be transmitted to DPSS for processing. • An internal resource guide was developed for L.A. Care's member-facing staff so they can answer questions and direct members appropriately. • There is a reporting code for eligibility redetermination in the L.A. Care Call Center. Approximately 100-110 calls are usually received each month. The volume of calls doubled in March, and traffic continued to increase in the first few days of April. L.A. Care expects even great volume of calls related to redetermination as time goes on. Mr. Baackes thanked Ms. Contreras, the newest Board Member, for working with L.A. Care on a draft Memorandum of Understanding with DPSS. Once approved, the MOU will enable L.A. Care to receive information about the Medi-Cal renewal dates for L.A. Care members. The renewal information is not currently provided to L.A. Care. L.A. Care could do more direct messaging to members once the renewal date information is provided. L.A. Care is concerned about member information fatigue and the potential for lower attention paid to automated calls and messages. With the specific renewal information, L.A. Care can conduct targeted notifications. • L.A. Care began automated general awareness messages in April through calls and texts. It is hoped to replace those with more specific content. • DHCS has begun a public service announcement (PSA) campaign about redetermination on radio and television. • Media has reported on the PSA campaign, focusing on the potential number of people who may lose coverage. L.A. Care would like to make sure that every eligible L.A. Care member is requalified for Medi-Cal benefits. There may be members who have moved from Los Angeles County and will need to reapply in their current county of residence.	

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	• Medi-Cal members whose current income is higher than 138% of the federal poverty level can enroll in L.A. Care through Covered California. There are six health plans offering coverage in Los Angeles County through Covered California. L.A. Care offers the lowest premiums in all four metal tiers, so it should be a very attractive choice for them, and L.A. Care hopes to see members transition to L.A. Care Covered. The resumption of eligibility redetermination is the most important change in Medi-Cal in a long time. It is a return to normal, but because of the three-year hiatus in eligibility redetermination through the pandemic, L.A. Care is aware of the significant challenges involved in the process. Board Member Roybal asked about planning for patients who may be in the middle of a course of treatment or some course of therapy who may be no longer eligible. Mr. Baackes noted that knowing the renewal date would help health insurers track the renewal of eligibility and follow up to avoid interruptions in care. Board Member Roybal asked about those who may no longer qualify for Medi-Cal coverage and are in the middle of treatment or therapy. Sameer Amin, MD, *Chief Medical Officer,* responded that those Medi-Cal beneficiaries would fall under continuing care rules. Mr. Baackes explained that continuing care means that if one loses coverage, Medi-Cal will continue coverage until the course of coverage is completed. He is sure the DHCS is supportive of that. Mr. Baackes noted that there is a new process by which any Medi-Cal beneficiary can have their eligibility automatically renewed without completing paperwork. DPSS and DHCS can use information from databases under other public and social service programs to determine eligibility for Medi-Cal. DHCS estimates that 25-30% of Medi-Cal beneficiaries can be automatically renewed. Ms. Contreras is estimating more than 50% of Los Angeles County's Medi-Cal members can be automatically renewed. One way to make sure the automatic renewal happens as much as possible is for L.A. Care members to call and update their contact information, so the opportunity for a match can be easily made. Mr. Baackes described the yellow envelope for the Medi-Cal renewal packet. A member will receive the yellow envelope for either the paper renewal process or for the automatic renewal. For the automatic renewal, the yellow envelope will contain notice that the automatic renewal process is underway. For the paper renewal process, the Medi-Cal beneficiary will receive a packet of papers in the yellow envelope and must complete and return the packet to DPSS. Board Member Supervisor Solis noted that Ms. Contreras provided an update to the Board of Supervisors at the meeting on April 4. The Board of Supervisors is delighted that she has been appointed. There were questions from Supervisors about the collaboration just outlined, and	

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	Board Member Supervisor Solis and her staff are preparing the motion, hopefully for the next meeting of the Supervisors. Board Member Supervisor Solis noted that Supervisors asked Ms. Contreras to think about other Los Angeles County departments that also serve seniors that are in the eligible pool or may already be enrolled in other programs, such as the department of aging, department of parks and senior services. There may be other agencies to collaborate with beyond Los Angeles County departments. She wondered what role Metro can help play, perhaps through advertising as discussed at last month's meeting. She suggested that L.A. Care could have promotoras available at certain stations or in areas where community members tend to congregate. This could be arranged safely to help community members that otherwise may not have time or know where to call about the redetermination process. Mr. Baackes explained that once a beneficiary turns 65 years of age, Medicare becomes primary for coverage and Medi-Cal fills in the gaps in coverage, such as for home care or long-term care. Mr. Baackes noted that beneficiaries who are dually eligible for coverage with Medicare and Medi-Cal are likely to have coverage automatically renewed because they generally do not have any change in income. He thanked Board Member Supervisor Solis for the suggestion. L.A. Care's DSNP staff members are well aware of this and will be making sure the members complete the renewal paperwork. Mr. Baackes assured Board Members that L.A. Care is addressing the concerns in the letter from the Hospital Association of Southern California (HASC). A task force comprised of CEO Cabinet members will address each concern in the L.A. Care response on February 28, 2023, to contracted hospital executives. The progress on each metric are reviewed on a weekly basis. • Mr. Baackes is meeting personally with the CEOs of the contracted hospitals about the individual concerns. He is finding the meetings to be significant in learning the details of concerns for each hospital, and for continuing the relationships with the hospitals at the CEO level. Work on resolving the concerns is continuing with other levels of the organizations. • L.A. Care is hosting a brainstorming forum on April 27 to address the placement of clinically difficult Medi-Cal patients who are ready for discharge from an inpatient setting and a transfer to a skilled nursing facility (SNF) setting. Jonathan Freedman, of Health Management Associates, will facilitate the session. L.A. Care has invited representatives of 80 nursing facilities and 30 hospitals who actually do the transfer work. L.A. Care will invite representatives from two plan partners, Blue Shield Promise and Anthem, to participate. L.A. Care would like to produce a report from this forum that outlines how the community of providers and health plans can work together to speed up and facilitate the transfer process. The assertion was that the problem is with L.A. Care because it does not adequately pay nursing homes. Mr. Baackes assured Board Members that this assertion is	

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	exaggerated, but the perception is out there. The forum would allow participants to put the real issues on the table. Mr. Baackes referenced a letter from David S. Silver, MD, CEO of Rockport Health Services, the largest chain of SNFs in Los Angeles County. The unsolicited letter indicated that Rockport has found L.A. Care to be easy to work with and that claims are paid on time. This is contrary to the issues raised by HASC, so the forum will be an important place to expose real issues and identify where the difficulties are for providers. L.A. Care knows that part of the problem is that capacity for accepting clinically difficult patients varies among the SNFs. L.A. Care needs a better alignment to have successful transfers. Sameer Amin, MD, *Chief Medical Officer,* has had robust discussions with SNFs, which revealed that each has struggled in a different way. Difficulties are often with the population served, and often it is due to the general state of health care in Los Angeles County. Some SNFs have specific concerns with L.A. Care, which upon further scrutiny reveal a miscommunication, which is not always on L.A. Care's side. Last week, a situation arose with a SNF that was very upset with L.A. Care over late payment of claims and denial of coverage for a member. The SNF acknowledged that the claim had actually been paid, after L.A. Care provided information of timely payment. With regard to the patient denied admission to the SNF, it turned out that the SNFs own Nursing Supervisor had denied the transfer. The SNF representative acknowledged that it would accept the patient when provided with additional information about how the transfer was denied. The best way to resolve many of the problems is through better communication. Miscommunication occurs in many ways, within the facility itself, between the SNF and L.A. Care or between finance and medical staff. Dr. Amin will speak more about utilization management later in this meeting. The aim is not to just correct the record but to improve the member experience and get them the care they need. Board Member Booth noted that she has learned that SNFs may be short staffed and that some do not accept transfers after hours. Dr. Amin responded that SNFs have different capabilities. Some are able to take high-risk patients and manage complex issues that L.A. Care members often have, while others cannot. It is a matter of finding the right facility for the patient. L.A. Care is contracted with nearly all the SNFs in Los Angeles County and has strong relationships with a majority of them, including leadership conversations when patients are difficult to discharge from the hospital. That is often how the patients are placed. The SNF must have alignment in the capability to serve the patient's needs. At the same time, it is L.A. Care's job to find the right placement for the patient.	

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	Board Member Booth asked if that includes the timing of the transfer. L.A. Care begins the discharge planning when the patient is admitted to the hospital so there is not an urgency when the patient is ready for discharge. Situations that do not include pre-planning are indication of a gap in communication. Mr. Baackes noted that the contract between hospital and health plan include that the hospital is responsible for discharge planning, and the health plan becomes involved in situations where difficulties occur in the discharge. L.A. Care is called in situations when there is a difficult placement. • On March 1, L.A. Care sent a notice to hospitals that changes were made in the provider dispute resolution (PDR) process, with four steps to be followed by the hospitals to streamline claims disputes. One of the issues raised that there were many disputes filed. PDRs can take a long time to process, and L.A. Care is trying to simplify the process by eliminating a "bottle neck" that slows down the process. • It was asserted that L.A. Care is running antiquated systems, with the term "fax" used as evidence of an antiquated system. Current processing of faxed documents is electronic. Tom MacDougall, *Chief Information Officer,* reported that L.A. Care's incoming documents are digitized. All external information comes through the phone line to a digital facility, either through the cloud and into the Syntranet application for utilization management (UM), or through the Rightfax application that goes directly into email. There are no paper fax machines employed at L.A. Care, it is all done electronically. In some cases, the provider may feed a document into a paper-based fax machine, and on the L.A. Care receiving side, that document will be digitized and is electronically directed into the system. Mr. Baackes reported that L.A. Care has increased staffing as noted in the February 28 L.A. Care letter. At least 15 staff members have been added in utilization management (UM), and 15 in provider network management. Dr. Amin reported that L.A. Care is aggressively growing the UM team, to meet the demand for additional work. A PDR team is dedicated to support ongoing compliance and assist with a number of cases. Four positions have been filled, with two that started on March 13 and one position in the recruitment process. Dr. Amin has expanded the consulting agreement to get additional temporary nursing staff to augment the PDR team. L.A. Care has reestablished the admit team for post-stabilization requests, nine positions have been filled with two in recruitment. The processes and documentation are being revised to improve reporting and oversight of the PDR team. A discharge planning team has been added, dedicated to accelerate the process of authorizations needed for discharge and to provide more resources for members who are difficult to place due to complex medical and psycho-social situations. L.A. Care has a new nursing director, which has allowed restructure of the UM team into separate inpatient and outpatient teams and provide focused oversight on quality and process improvements. In	

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	addition, new audit tools and protocols have been developed and implemented, and there are additional positions that are specific to these functions. All the changes will be reported to the internal UM Committee and to the Compliance & Quality Committee. • Since the beginning of the COVID pandemic, L.A. Care has made payments in advance of directed payments available to any hospital. Since January, almost $30 million has been advanced, bringing the total in advance payments to $130 million. As mentioned in previous reports, there is no interest charged by L.A. Care on the advance payments. • L.A. Care is developing dashboards for individual hospitals and SNFs covering five areas: o complete monthly claims volume with adjudication timelines, o number of claims denied on first presentation (includes incomplete claims), o disputed claims volume and decision timeliness, and o transportation metrics including response timeliness. o dashboard for the website is under legal review for compliance and will be shown to the Board Members at a future meeting. • Mr. Baackes asked the Board Members to initiate a Provider Relations Advisory Committee that will not be limited to Board Members. The Board Chair has approved, and Board Member Greene has agreed to Chair the Committee. Board Member Supervisor Solis thanked Mr. Baackes for his update, which clarified a lot of the concerns she had, and other Board Members may have had the same concerns. Board Member Supervisor Solis proposed a motion: Motion It is moved that the L.A. Care Board of Governors establish an advisory committee designated as the "Provider Relations Advisory Committee" for the purposes of identifying and informing the Board of the challenges affecting providers in Los Angeles County, considering opportunities to mitigate those challenges, and making recommendations to the Board. It is further moved that the initial Chair of the Committee shall be George Greene and that membership of the Committee shall consist of Board members, Los Angeles County providers and others, as deemed appropriate by this Board. Augustavia Haydel, *General Counsel,* advised that the Agenda does not contain the appropriate posting for such an action today. However, the Board can direct staff as required to take certain actions. Board Member Supervisor Solis realizes it is not appropriately noticed to the public. Because there is no agenda item to take action in establishing an advisory committee today, she requested that the Board direct staff to review the process and requirements for the Board to establish this advisory committee designated as the "Provider Relations Advisory Committee". She requested that the committee's purposes would include identifying and informing the Board of the challenges affecting providers in Los Angeles County, considering opportunities to	

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	mitigate those challenges, and making recommendations to the Board. She further requested that staff review and make recommendations concerning the potential appointment of George Greene as Chair of the committee, and appointing other potential members to include other board members, Los Angeles County providers and other individuals, as appropriate. Staff recommendations should also include any other issues as designated in L.A. Care's bylaws and other applicable governing sources or law. Staff shall provide their recommendations to the Executive Committee at its April 26 meeting, and that Committee shall bring forward its recommendations to the full Board at the May 4 board meeting. Board Member Roybal asked that this committee would report to the Board on a regular basis so that Board Members are informed about any concerns. Mr. Baackes confirmed it would report regularly, in the same manner as the other committees report at the Board meetings, and there will be routine item on the Agenda. Board Member Ghaly suggested that the new committee could provide specific suggestions on the dashboard metrics to align the measurements with the needs of providers. Board Member Roybal asked about including plan partners. Mr. Baackes will include plan partners, and he is always glad to include Health Net, as L.A. Care has a very cordial and effective working relationship, especially with regard to CalAIM. Board Member Roybal asked that once the metrics are determined, that the Board receive regular reporting on the dashboard to learn more about some of the concerns from the hospitals and other providers. Chairperson Ballesteros suggested that part of the recommendation be a recommendation from staff on the resources that may be needed to support the work of the committee. Board Member Supervisor Solis agreed that this committee should be able to get things done, with full commitment from L.A. Care. Mr. Baackes agreed also, and he noted that the Committee is in line with the intent of the provider forum, which brings different providers together to resolve issues. He noted that L.A. Care's role includes collaboration across the spectrum of providers that serve L.A. Care's members, which is the philosophy behind his recommendation to form this committee. Board Member Supervisor Solis asked if Board Member Greene had any comment on this. Board Member Greene thanked Board Member Supervisor Solis for the opportunity, and he applauded Mr. Baackes for being open to the creation of the committee. He noted that everything that Mr. Baackes has shared demonstrates that he and L.A. Care's leadership team is listening. Part of improving and working in a collaborative manner to provide services to the beneficiaries of L.A. Care, and also support the providers who are providing health care to	

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	those beneficiaries, takes collaborative listening and then collaborative action. He is appreciative of the direction in which Mr. Baackes and the leadership team at L.A. Care seem to be moving. With regard to the areas in which Mr. Baackes is trying to make improvements, Board Member Greene is working with hospital leaders to provide feedback to Mr. Baackes, and will be happy to share with the Board, about those areas of improvement in L.A. Care's letter to the Board of Supervisors. There might be additional items for improvement suggested by HASC for consideration, and those might be substantive conversations for the new committee. Board Member Greene was not able to hear all the comments with regard to the dashboard metrics, he thought he heard Board Member Ghaly suggested, and he agrees with, gathering feedback on the metrics to be reported on the dashboard. It is important that the dashboards will be developed to recognize the nuances of the issues that individual providers and hospitals may have. It is also important for some version of that to be shared not only with the new committee, but also with the Board of Governors to ensure that we are progressing with regard to the organizational changes and improvements to which L.A. Care ultimately commits. Board Member Greene is honored that Mr. Baackes and Board Member Supervisor Solis have asked him to chair this committee, and he will have a field perspective in that role, and will try to continue to work collaboratively in order to support the mission of L.A. Care, which holds the beneficiaries at the center of everything it does. He believes that all Board Members keeps the beneficiaries at the center of everything even in times where feedback can start tense conversations. America was created through tense conversations that ultimately led it to be the greatest country in the world, as all are focused on the same things. He again noted he is appreciative that Mr. Baackes and the leadership team are listening, but obviously there is always opportunities for improvement. Board Member Greene noted the dialog will continue, and he will share responses to L.A. Care's letter next week. He will stand ready to take on the responsibility of being Chair of the Provider Relations Advisory Committee. Mr. Baackes thanked Board Member Greene for his comments and noted that Board Member Ghaly's comments were to ask that the committee provide input to what the metrics might be which aligns with the purpose of the committee. It is L.A. Care's desire to provide the information those providers need. There will be give and take, because some things may be considered proprietary and consideration will be made for L.A. Care's capacity to provide some metrics. Board Member Ghaly stated that, apart from payment claims issues with individual hospitals, there are two categories which put pressure on hospitals:	

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	o Escalating costs: nurse staffing, regulatory requirements for nurse staffing ratios, salary escalations, the new minimum wage bills, and other pressures on the cost side, in the setting of largely fixed base rates in the Medi-Cal program. Mr. Baackes is well aware of these issues. He advocates for changes in the base rates and challenges with countywide averaging complicate the issue on base rates. o The other category for hospitals is the placement issue. Board Member Ghaly agreed that hospital have responsibilities for discharge planning, but incentives are not aligned in this area. Hospitals have a role because the patient is in the hospital, but hospitals do not control: o the network for out of hospital placement, o there is no financial responsibility of which she is aware, hospitals don't have a financial relationships nor the financial responsibility to pay the SNFs, o hospitals don't have a contract with SNFs, o hospitals do not have regulatory authority over the SNFs, and o payment for administrative days are typically through contracts with health plans, and the administrative day rates do not in any way approach the actual fixed costs for the hospital. The vast majority of costs for hospitals are fixed. A patient that is subacute and requires a SNF level of care, the cost for that patient's care are not substantially different for patients who are acute, because of AB394 and because of all the regulatory requirements for how acute beds are staffed in California. When a hospital receives an administrative day payment, it creates a huge misalignment of incentives between the hospital and the health plan and the SNF. All of the risk falls to the hospital, all of the benefit falls to the health plan, and there is no risk or benefit to the SNF, as long as the SNF beds are full with patients from other payers. She thinks the misalignment puts too much responsibility on the hospitals to manage the payment and the patient placements. In addition, hospitals are adding more administrative staff to complete the paperwork involved in the process. There is an imbalance when too much responsibility has shifted to the hospitals to do the discharge planning. The rebalance could hopefully addressed in the new committee or in other forums to determine the right balance among the hospital, the health plan and the SNFs, and hopefully set up contracts in a fair way so there is alignment for hospitals in the fixed costs and administrative day payments. Board Member Ghaly is aware that SNFs decline a placement, stating that the patient is not suitable. That may be true in some cases, but in the overwhelming majority of cases, the patient placement is declined because the rate is not profitable for the SNF. A SNF may be able to get greater funding for a patient that has a better payer or a patient that is less complex, either behaviorally complex or clinically complex. She invited discussion of what is the right way to	

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	tier rates so that the financial responsibilities are aligned and patients can be moved out of the hospital. Hospitals are under immense pressure, and when hospital stays are measured in the number days or weeks or months, and in some cases years, waiting for a placement, it hurts the patient and the hospital. It does not hurt the health plans or the SNFs. It hurts the bottom line for hospitals, and hospitals have no way to move the patient to another more appropriate facility. She asked about how the contracts could be structured so all sides experience a win. There are many hospitals closing due to financial pressure, which jeopardizes the availability of hospital beds in a community. The health of the hospital community needs to be assessed, along with ways to preserve precious hospital resources and ensure that people in the hospital beds are acute. That is what the beds are there for, that is what the staff are trained for, and bed availability must be preserved in case of an emergency. There is a high number of patients in hospitals, and the hospitals are unable to discharge those patients. There are steps hospitals and health plans should take, and develop a joint advocacy agenda to take to state officials regarding lower level of care placements, which applies to SNF as well as custodial SNF. Mr. Baackes noted that the contractual relationships have been around for years and may need to be revisited. Discharge planning has always been with the hospitals, and the health plan supplements that work. There is a real issue with the payer mix for SNFs, because the Medi-Cal reimbursement is so low, compared with Medicare or commercial health plans. Yet, two–thirds of the beds in nursing homes are occupied by Medicaid patients, many of them custodial care patients. The forum on April 27 will be a good place to start this discussion, as many of the parties impacted will be there. From a regulatory standpoint, both hospitals and health plans are highly regulated but SNFs are not. SNFs have the discretion to decline a patient transfer. Dr. Amin noted that SNFs do choose which patients they take in. He wants to make sure there is confidence that it is not because L.A. Care wants to keep patients in acute care facilities. L.A. Care is actively trying to move the patients to appropriate levels of care. In one case, he observed about 200 calls from L.A. Care's UM staff in placing a patient, with L.A. Care leadership team members literally begging SNFs to take a patient. L.A. Care has a very high-risk group of patients who may be difficult to transfer. A majority of patients are discharged properly and easily, including transfers to other facilities depending on the care needed. There are patients who are difficult to discharge. L.A. Care knows that some patients who have behavioral health issues, or are younger and are not as mobile may be difficult to transfer. The difficulty is not for lack of trying or misaligned incentives. L.A. Care wants the level of care that is best for the member, and if that is in a SNF, L.A. Care will try to get them there. L.A. Care has made every effort to contract with SNFs, made multiple changes to the rates for care at SNFs. He is not sure it is a contractual issue nor a payment issue. L.A. Care's percentage of first pass claims payments to SNFs is very low. Some of the issues for transfers are regulatory	

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	and the low level of Medi-Cal reimbursement. Working together, hospitals and managed care plans can move forward in helping to make the transfers more efficient. Mr. Baackes hopes that the Board of Governors, particularly Supervisor Solis and Member Greene, understand that this is a complicated issue, and it will require new and unique collaboration and cooperation to resolve. When organizing the California Safety Net Coalition, he recognized that Medi-Cal health plans and providers must to act together, as an ecosystem, to solve issues, and not from silos. Board Member Raffoul commented that he runs a medium-sized hospital of 350 beds. The hospital has 35 case managers and social workers to do discharge planning. They do everything they can to manage the flow of patients coming in and going out. Invariably there are patients that are difficult to place. He thinks that increasing the size of L.A. Care's UM staff will go a long way to help. Discharges happen 24/7, and having access to immediate support at the health plan will be great. There were struggles in the past to get immediate action. The SNFs contract with the health plan, so hospitals have challenges in working with SNFs. The health plan has more weight in working with the SNFs. The additional staff and support from the health plan will go a long way in helping resolve potential a bottleneck and make beds available. He noted that 72 hours is too long to transfer a patient and free a hospital bed. Steps being taken by L.A. Care, with the new committee and working to speed up the transfer process, will go a long way in solving the problems, and he looks forward to working together to resolve the issues. Mr. Baackes noted that the transfer wait time can go no longer than 72 hours, and L.A. Care begins working on facilitating a transfer immediately. Dr. Amin noted that regulations require the transfer within 72 hours. He thanked Mr. Raffoul for acknowledging the steps being taken. Mr. Baackes noted that L.A. Care has access to data from DHCS that shows it is the better payer for SNFs in Los Angeles County.	
• Monthly Grants and Sponsorships Reports	*Mr. Baackes referred Board Members to the written reports included in the meeting materials.*	
CHIEF MEDICAL OFFICER REPORT	Dr. Amin referred to his written report in the meeting materials (*a copy of his report can be obtained by contacting Board Services*) and he highlighted some items: • Housing and Homelessness Incentive Program	

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	The Community Health department includes Behavioral Health, Social Services, Community Supports programs and Housing Initiatives. L.A. Care recently completed a report to DHCS on the Housing and Homelessness Incentive Program for measurement period 1, and expects to receive 318 out of 350 points. This is a remarkable result. A large portion of the available incentive money is expected to be received and will be redistributed to the community to help house L.A. Care members. At the February Board meeting, an additional $30 million investment was authorized for the L.A. County Homelessness Initiative, contingent on expected earnings of at least $40 million from measurement period 1. L.A. Care expects to exceed that target and will move forward with the allocation, on top of the $50 million already committed to the Unit Acquisition and Activities of Daily Living Expansion strategies. This will be a significant investment in housing for L.A. Care members. Mr. Baackes noted that the original request was made to the Board without knowing the results of the measurement period 1. As a result of L.A. Care successfully completing the first measurement period, there will be even more resources for members. He thanked the Board for support of the initial tranche of funding for this program. Dr. Amin agreed this would go far in helping to assuage the homelessness in Los Angeles County. • School Based Behavioral Health program On February 21, 2023, DHCS awarded L.A. Care $20.7 million for the School Based Behavioral Health program (SBBH). L.A. Care plans to be in the schools to provide better BH resources for students. The funds will be allocated to enhance behavioral health training, workforce capacity and IT infrastructure in partnership with Health Net and the Los Angeles County Office of Education. Additional funding was allocated for the completion of a SBHIP needs assessment that was completed on March 3, 2023. • Provider Quality Review There was a backlog from August 2021 and March 2022 and L.A. Care provider quality review (PQR) staff has been addressing the issues. There are three cases remaining: two are pending a peer review committee meeting in April and one is pending additional medical records. L.A. Care has remedied the problem that resulting in a group of cases that had not been correctly transferred from the Appeals & Grievances department. This smaller backlog is being addressed by PQR and will be closed by August. • NCQA Accreditation L.A. Care has completed a review with a consultant to prepare for the upcoming audit by National Committee on Quality Assurance (NCQA). There were a few corrections in	

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	"must pass" elements, particularly for UM denial letters. The changes have been implemented. • DHCS Audit recently completed Preliminary findings have not yet been received. L.A. Care staff is diligently following up on the discussions in the closing meeting with the auditors. Board Member Booth asked about the timing of the NCQA audit. Dr. Amin explained that this audit was scheduled as a result of the enforcement actions in 2022. The regular NCQA accreditation is not yet scheduled. L.A. Care has requested that the two audits be combined.	
ADVISORY COMMITTEE REPORTS		
Executive Community Advisory Committee (ECAC)	**PUBLIC COMMENT** *Andria McFerson stated that the last ECAC meeting was labeled as a listening session. She believes it was on March 27. It was a totally different day of the month after the routine meeting was purposely cancelled by staff for some reason. Restricting the public to participate routinely according to regular procedure dates practiced for many, many years. She asked Board Members to tell her if they have a right to say something about that. It's important because you know you have people that are seniors, people who have disabilities, people who have jobs, people who have families, and they are committed to that one day of the month where they can participate and tell their life stories. And other people from the community their stories about what ails them. And that's why they're here. She commented on if they have the right to speak and vote on better finances for L.A. Care, better community involvement and carrying out approved motions during the ECAC meeting. Like the survey that she had approved. The survey is to have a person build person-to-person data from the members to help make and vote on life-saving decisions that will positively affect and save lives of the community. She is not quite sure if the RCACs or ECAC are changing either. Now, as reported by Mr. Oaxaca, things are changing. She asked that they be informed at the next meeting, and all the RCACs and things like that, if the changes are effective immediately or can they vote on these decisions as a committee. Are they allowed to go ahead and vote? To make sure that every one of the members still work cohesively to better L.A. Care, the whole health plan first hand, according to their own communities' necessities. Like they used to, together for the betterment of all of the members, from their own perspectives, which is only right. From the members who have conditions that continue to worsen due to lack of things like oxygen. She asked how the Board can even know what people are going through when it comes to life*	

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	saving decisions that the Board is making today. How would they know? Like her, she hates to tell her story but the Board needs to know that she had brain surgery due to lack of medication and lack of courage from her doctors. She needs the Board to actually listen, and help, and make her feel like she is doing something substantial up here. She thanked the Board. *Fatima Vasquez, RCAC 7 Chair and ECAC Chair.(an interpreter translated her comments from Spanish to English) Today we hear from Chairs and members of ECAC and some members of RCACs. She would like to take the time to talk to the Board and say thanks to them. All the news that they give members month by month in the ECAC meetings, and all the information that members can get on different ways to look at the health plan. In 2020, was our last RCAC meeting together in person. On March 27 we had an informational ECAC meeting, our first opportunity to see each other in person again. And, we will be in person at our ECAC meeting next Wednesday. As Chair of ECAC, she is very excited because being in person they feel a lot different. They missed it a lot. And they had the opportunity to see each other again. She thanked the Board again for all the information and the work that they do for members. Because members are the next to Board Members and members are close to their communities throughout all of Los Angeles County. In her community, for example, people are already receiving the redetermination packets. And RCAC members are on top of all the services the community is receiving. The purpose to achieve their goal is to give the community the best services regarding their health. As a member of both ECAC and the RCAC, and as a member that receives services from L.A. Care because she is legally blind, she knows about the challenges as a member of the community. And all the challenges that they went through, she knows there is a lot of good things to come and that members will receive. And that is why members are here to work together with the health plan. As a volunteer she feels very appreciative to be here today.* Mr. Baackes thanked Ms. Vazquez for her steadfast leadership as Chairperson of ECAC. He is glad they are back in live settings. He would participate but he has to be in Sacramento next Wednesday, and he will participate virtually. *Estela Lara represents Regional Community Advisory Committee, Region 2, in the San Fernando Valley. There are many faces on the Board she hasn't seen before and wonderful faces she sees every time she comes. She is glad the board is here today. The Board sits in positions of power that can assist the members to have a*	

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	better, more improved plan. She was surprised to hear the discussion earlier about providers, because she thought that the members were the only ones having that type of discussion. That she heard the Board discussion, and disagreements and different areas that need to be improved with the providers. Members don't really think about providers until they don't give the services members want. In general members appreciate what the Board does. Each Board member is significant in how they improve the health of members and their lives and their families. As individual Board Members go forward with organizations, it is important for them to understand and bring a lot of feedback to this Board. Because the more feedback there is, the more changes will occur, and the more we will have a different plan moving forward. Every time Mr. Baackes tells the advisory committee members about different things that he has put forth, they make a significant difference in members' lives. It is not just the fact that members come to the meeting. There are more members here than were at the last board meeting. It is important that the Board realize there are 11 regional areas in Los Angeles County, although not all the areas are represented today. Members have a significant voice, and members have representatives on the board: Layla Gonzalez and Hilda Perez. She thinks they have done a wonderful job, and she thinks the members are better off having them serve. She thinks it behooves each one - members, providers and Board Members to bring even more improvement for the plan. She thanked the Members of the Board and Mr. Baackes and everybody here. Each person in their own way contributes to healthier lives. Mr. Baackes thanked Ms. Lara, Ms. McFerson and Ms. Vazquez for their service on the RCACs and ECAC. He hopes the conversation today between the Board and the providers illustrates that health care isn't rocket science, it's harder. It is very difficult to put all the pieces together in a satisfactory way so that the provide4rs aren't feeling burned out and can be more responsive to the needs of members. Whatever role L.A. Care can play as a convener, facilitator or collaborator, it will do. L.A. Care hears everything that was said, and he thanked them for being at the meeting. **Submitted on April 6, 2023 at 1:38 PM by Johnny Chua via chat box:** *Suggeston made by Supervisor Solis is very true, there may be some area that wil need assistance in the application for assistance with Medi-Cal and/or Medicare.*	

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	City of Walnut could be looked at for such assistance to be offered. I will welcome if my asistance to coordinate this outreach to call me. Thank you. **Submitted on April 6, 2023 at 2:09 PM by Elizabeth Cooper, RCAC 2 Member via voicemail:** *I would like to address Hilda Perez, Layla Gonzalez, and Board members who will be coming in. And I do hope as a member and one whose family members is a member of L.A. Care that they please take notice, to please be aware of their responsibility and their outreach for the Board seat because it's so important to have a Board member that is knowledgeable and caring for older members, their cultural and linguistics. I would also like to address to the chair and members of the Board to please take notice the new changes that are coming into L.A. Care. I'm sorry I wasn't able to hear most of the meeting today, there were some things I had to take care of. On behalf of my son and myself, Chairperson, I do hope that the information does get to the members impacted by the changes at L.A. Care. I think sometimes there is a lack of communication in the community outreach sometimes from the members in regards to information. That needs to be addressed. I would greatly appreciate that the Chairperson please take notice on the communications now that the COVID emergency is over. And also I was also concerned about the new changes that did not allow me to participate in meetings. That information should be given to members. Chairperson please make sure my concerns are heard.* Board Member Gonzalez thanked everyone listening to the meeting and the members attending in person, and welcomed the comments. She reported: • A Special Meeting of the ECAC was held on March 27 and the Board will receive a report after the April ECAC meeting. She thanked the Board and L.A. Care staff for pulling the meeting together in person once the public health emergency ended, and on a day people do not normally attend an ECAC meeting. Unfortunately, she was unable to attend that meeting. It is good to have everyone together to be informed of the changes. • CO&E and Board Services held an informational session for Board Seat candidates on April 3. Candidates had an opportunity to introduce themselves, review the election rules that were approved by ECAC and ask any questions they may have, review the timeline for the election, and receive assistance with filling out their applications. The informational session was held in person at L.A. Care headquarters.	

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	• She thanked the COE and other L.A. Care staff for holding a disability awareness meeting in March, that was an excellent meeting. Speakers were Felicia Ford, Ismael Maldonado, Gladis Alvarez, Richard Hernandez and Deaka McClain, who gave their perspective on what it is like to have a disability, how they would like to be addressed, and how they would like to be greeted. The presentation was great and she thanks the speakers for sharing that information. Board Member Perez thanked Board Member Gonzalez for asking COE and Board Services to provide the names of the RCAC members attending today's meeting. She could not stop getting emotional listening to the contributions of the members. She feels blessed to be here after the COVID health emergency. She personally loves when members express their voice because that is the reason members are here. Members are valuable as members of the community, as L.A. Care members and as patients. She thanked Board Member Raffoul for his comments about patients waiting; she thanked him for his empathy. She congratulated Board Member Shapiro, also known as "Dr. Shaps" for conquering the Mt. Everest base camp. As a Latina and Mexican woman she would like to congratulate him for everything he has done since he came on the Board. She follows him on social media and he is all over the place, putting the names of Latinos and Mexicans up high. Regarding the social media outreach at L.A. Care to members and members of the community, she noted that Board Member Shapiro has *Conversaciones Vitales*, which are live videos broadcast each week. The conversations allow members of the public to ask questions. Board Member Shapiro is the Health and Wellness Medical Director at AltaMed, and is well known in the community. He has celebrities and well-known individuals that her communities identify with and can relate to. Whenever health information is presented, the community members understand and can relate to it. She invited the Communications and Social Media departments to listen to the ideas. She does not know the day-to-day activities or operational parts of those departments. Board Member Perez is almost finished with her term and would like to leave this for the members: there are other organizations that are super far and beyond doing outreach to the community using social media. Social Media is huge. After the technology challenges, and that L.A. Care serves 2.7+ million members and will soon hit 3 million, the members are in vulnerable communities and may not have a computer or are computer knowledgeable, but most have a smart phone. Ms. Perez thanked the Communications and Health Promoters departments for making the health promoters part of the Medi-Cal redetermination outreach efforts. Health promoters received training and will be part of the outreach efforts in the community. L.A. Care's health promoter department began as an idea from Maria Guerrero, a RCAC 5 member.	

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	Board Member Perez reported that at the Special Meeting of ECAC on March 27, Francisco Oaxaca, *Chief of Communications and Community Relations,* provided information about changes to the advisory committee structure in a listening session. The changes will be implemented in January 2024. More information will be share at the April and May RCAC meetings. Members will have an opportunity to discuss the changes and provide feedback. Members would like to know the extent they can participate in the changes and provide feedback, or if it is only the organization letting members know about what will happen. Board Members Gonzalez and Perez will finish their terms on the Board this year. RCACs did not meet in person during the public health emergency, and information has been distributed to RCAC members throughout. Many RCACs do not have the same number of members as they did in 2019. She would like to be part of the conversations so L.A. Care can have a sufficient and efficient advisory committee model and organization, so members can provide the feedback that L.A. Care needs. That will help the Board to decide on policies that are effective and provide access to care. A virtual event was held on March 30 to recognize Disability Awareness month. Some RCAC members participated as panelists. Board Member Perez learned a lot from the session, and she thanked L.A. Care, the COE Department and Mr. Oaxaca. Board Member Perez reported that the information session was held for the election of nominees for the two consumer representative seats on the Board of Governors. Five candidates attending. Those who are interested in the position, the deadline to submit applications is April 12. Candidates can attend each RCAC to speak during the meeting and meet all the members. The voting will take place in June. The newly elected members will be appointed by the Board of Supervisors and will be seated on the L.A. Care Board in July or September, 2023. This election is for a partial term, which will end on October 31, 2024. ECAC will meet in person on April 12. Board Member Ghaly asked if the advisory committees are held under the Brown Act and if the changes mentioned are related to the end of the public health emergency. Ms. Haydel responded that the advisory committees are committees of the Board of Governors and meetings are held under the Brown Act. Board Member Gonzalez indicated that the changes mentioned are related to changes in the Brown Act following the end of the public health emergency.	
Children's Health Consultant Advisory Committee	Tara Ficek, *CHCAC Chairperson*, reported that the Children's Health Consultant Advisory Committee met on March 21 (*minutes can be obtained by contacting Board Services*).	

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- Mr. Baackes introduced Dr. Li as L.A. Care's new Chief Health Equity Officer. Dr. Li elevated his focus on moms and kids, and members experiencing homelessness.
- Dr. Amin presented the March 2023 Chief Medical Officer report. He introduced Dr. Felix Aguilar, L.A. Care's new Quality Medical Director, who will primarily focus on provider quality initiatives and accreditation.
- Dr. Amin highlighted performance, noting that L.A. Care did not meet 2021 Medi-Cal Managed Care Accountability Set (MCAS) measures tied to childhood immunization status combination 10 and well-child visits in the first 30 days of life. Given this, work is underway through a comprehensive quality strategy that includes new interventions designed to meet or exceed 2023 MCAS performance measures. Additionally, L.A. Care is increasing staffing to address this, including recruitment of a Quality Management Nurse Specialist.
- Dr. Brodsky gave an update on the DHCS Student Behavioral Health Incentive Program (SBHIP). The SBHIP is a three-year program that began January 1, 2022, and ends December 31, 2024. The program is focused on addressing behavioral health access barriers for students. The outcomes include:
  - strengthening behavioral health infrastructure in schools, benefitting both Medi-Cal and non-Medi-Cal students.
  - more managed care plans will have contracts with offices of education, county mental health departments and others to support Medi-Cal payment for behavioral health services in schools, and,
  - relationships are strengthened between Medi-Cal plans, county mental health departments and schools to support coordination of behavioral health services.
- The ultimate goal is to increase access to preventive, early intervention, and behavioral health services by school-affiliated behavioral health providers for children as young as 4 years participating in transitional kindergarten, through grade 12 in public schools.
- The four targeted interventions in Los Angeles County include:
  - Telehealth – potentially affects 1.4 million students
  - Behavioral Health Wellness Program
  - Behavioral Health Workforce Development
  - IT Enhancement

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<tr><td colspan="2">BOARD COMMITTEE REPORTS</td><td></td></tr>
<tr><td>Executive Committee</td><td>Chairperson Ballesteros reported that the Executive Committee met on March 22 (approved meeting minutes can be obtained by contacting Board Services and will be available on the website).</td><td></td></tr>
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• Government Affairs Update	Cherie Compartore, *Senior Director, Government Affairs,* reported: • Members of the California legislature return to Sacramento next week following the Spring Break. • Policy hearings on bills will also begin next week. • Governor Newsom will release the May Budget Revise around May 10. This is the budget update that matters, because it is based on updated revenue projection and program cost information that was not available when the budget was first released in January. A written update will be provided to the Board. • Two bills have been introduced related to hospital closures. Both bills would establish an emergency loan program for hospitals under threat of closing or have recently closed. Neither bill has been discussed in a hearing yet, so much of the detail and any amendments will emerge from committees. Government Affairs staff will monitor those bills. • There is also a managed care organization (MCO) tax bill which was introduced by Senator Caballero. This bill restates the MCO tax which expired last year during a budget surplus. There is not much information available but it is interesting to note that the declaration for the bill includes a statement that it will help rural hospitals. • There are two bills on health care universal single payer. The bill was introduced by State Assembly member Ash Kalra and the California Nursing Association is involved. There is another bill by State Senator Scott Wiener, directing the state to gather a committee to work toward getting a federal waiver. • Governor Newsome announced in March that California would no longer cover medical prescriptions filled at Walgreen's stores. This was because of Walgreen's decision to not dispense abortion medication nationwide. Since the announcement, the state learned that, by federal law, it cannot prevent Medi-Cal members from using Walgreen's to fill prescriptions. This was acknowledged by the Governor and Medi-Cal recipients can continue to use Walgreen's to fill prescriptions. Board Member Booth asked about AB55, related to reimbursements for ambulance services. Ms. Compartore noted that this bill has been introduced in the past and was not passed by the legislature. The bill changes the reimbursement to fee-for-service. It could translate to Medi-Cal managed care, but now it is specifically for fee-for-service. Ms. Compartore offered to look into in and provide additional information. Board Member Booth noted that she has learned that Medi-Cal pays only $111 for non-emergency ambulance service, which barely covers the cost. Medicare provides $350. She feels this would be important to support this and she would like to hear more about it.	

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	Mr. Baackes commented that with regard to the MCO tax bills, he reported earlier today that the California Safety Net Coalition will be organizing a ballot initiative to use the MCO tax for funding to supplementing Medi-Cal rates. The Governor's proposed legislation would use the fund to cover the shortfall in California's general fund. There will be more clarity on all of this before the Governors May Budget Revise is released. In the CSNC ballot initiative, ambulance services are recognized for additional funding. Mr. Baackes will provide more information for Board Member Booth following the meeting.	
Finance & Budget Committee	PUBLIC COMMENT *Andria McFerson, RCAC 6, requested that the Board approve food for the RCAC meetings. There are members that walk or that may catch three buses to get to the meetings and haven't eaten, but their main focus is not food, because there is none. She wants to speak for those members. She asked if the Board can allow members to have a portion of the food from the food banks that L.A. Care participates in. Some people in the community are down to one meal a day. She asked for empathy in some kind of way and allow for one meal a month for RCAC members. They have been a part of L.A. Care dating back 24 or 25 years. That would be awesome for people who may not be able to afford to have three meals a day.* **Submitted on April 6, 2023 at 2:13pm by Elizabeth Cooper, RCAC 2 Member, by voicemail:** *I would like to speak to Board Members and staff on MOTION FIN 102, Chief Financial Officer Report, for 4.6.2023, I would like to respectfully request to consider that all funds for the Community Outreach continue and they continue to operate for the RCACS. Now that the emergency is over please mention if there is funding for operation of the RCACs to continue for Fiscal Year 2023 to 2024.* Board Member Booth reported that the Finance & Budget Committee met on March 22 *(approved meeting minutes can be obtained by contacting Board Services and are available on the website)*. The Committee reviewed and approved motions at that meeting that were approved earlier today on the Consent Agenda.	
Chief Financial Officer Report	Afzal Shah, *Chief Financial Officer*, presented Financial Reports for January 2023 and the forecast update *(a copy of the presentation can be requested by contacting Board Services)*. <u>Membership</u> January 2023 membership is 2.8 million. This is the first month comparing to the 3+9 forecast so the forecasted membership is equal to the actual membership for the month and year-to-date	

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	(YTD). The forecast assumes a combined 76,000 new members enrolled in managed care January through March 2023. The 3+9 forecast is updated to be consistent with the end of the public health emergency and impact of eligibility redetermination for Medi-Cal starting in July 2023. There are 17,689 members eliminated in the change from CalMedi-Connect to the Dual Special Needs Program. The Medi-Cal component for those members is included in the Medi-Cal enrollment. <u>Consolidated Financial Performance</u> The January 2023 net surplus was $18 million, $27 million favorable to the forecast. The operating margin is favorable to the forecast by $11 million driven primarily by the incurred claims, which are favorable to the forecast by $13.7 million. The YTD net surplus was $57 million, $27 million favorable to the forecast. The variances are the same for the month and YTD since is the first month being compared to the 3+9 forecast. The HHIP and IPP programs combined include $30 million in revenue. The actual financial performance is slightly behind the 3+9 forecast. The YTD performance includes the $30 million in revenue, and excluding that revenue, the net surplus is about $3 million lower than the 3+9 forecast. <u>Operating Margin YTD</u> • Housing and Homelessness Incentive Program/ Incentive Payment Program (HHIP/IPP) – Staff is expecting that all funds received will be fully invested. It is a matter of timing. • Overall YTD Medical Cost Ratio (MCR) is 94.1% versus forecast of 94.5%. • Cal MediConnect (CMC) MCR is slightly unfavorable to the forecast, with one month's data. • Medi-Cal MCR is favorable to forecast due lower Fee for Service (FFS) and CBAS claims. <u>Reported vs Paid Claims Trend</u> The year-end reserve position is holding up with four months of experience. <u>Key Financial Ratios</u> • Medical Care Ratio was 94.1% • The administrative ratio was 4.8%, lower than the forecast of 5.0%. • Working Capital and Tangible Net Equity are ahead of benchmarks. • Cash to claims ratio is below the benchmark and will not recover fully until the In-Home Support Services balances is resolved with the Department of Health Care Services (DHCS).	

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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Tangible Net Equity (TNE) and Days of Cash on Hand L.A. Care has the lowest number of days' cash on hand compared to eight other Local Initiatives and County Organized Health Systems. January 2023 Fund Balance was $1.1 billion, which represents 538% of TNE. Board Member Raffoul asked if the cash to claims ratio was lower than projected because claims are being paid from a backlog or if there is higher claims reported than normal. Mr. Shah responded that L.A. Care has experienced somewhat of an increase in claims paid more quickly. The cash to claims ratio has been in this range for some time, and there are several reasons for that, including claims inventory. Doris Lai, *Senior Director, Accounting and Financial Services*, noted that the unpaid claims include claims for In-Home Support Services (IHSS), which has not been settled. Mr. Baackes noted that L.A. Care has contingent liabilities for IHSS and for Coordinate Care Initiative reclassification claims, totaling about $115 million. **Motion FIN 105.0323** **To accept the Financial Reports for December 2022 as submitted.**	**Unanimously approved by roll call. 10 AYES (Ballesteros, Booth, Ghaly, Gonzalez, Perez, Raffoul, Roybal, Shapiro, Solis, and Vaccaro)**
• Monthly Investments Transactions Report	Mr. Shah referred to the investment transactions reports included in the meeting materials (a *copy of the report can be obtained by contacting Board Services)*. This report is provided to comply with the California Government Code and is presented as an informational item. L.A. Care's total investment market value as of January 31, 2023 was $2 billion. • $1.79 billion managed by Payden & Rygel and New England Asset Management (NEAM) • $74 million in Local Agency Investment Fund • $157 million in Los Angeles County Pooled Investment Fund	
Compliance & Quality Committee	Board Member Booth, *Chairperson of* the Compliance & Quality Committee, reported that the committee met on March 16. • Mr. Mapp and the Compliance Department presented the March 2023 Chief Compliance Officer report. - 2023 Issue Inventory: o Issues that are remediated will be assessed to be included in the Internal Audit follow up review process. o 91 Issues are being tracked from 2022 and into 2023, 56 have been remediated, and 19 are in process of remediation. o The remaining items are still being reviewed with responsible areas. - 2023 Risk Assessment: o Three of the top ten risks have made significant progress to remediation and are included in the 2023 Internal Audit plan for validation.	

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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	o Two of the top ten risks are in process of remediation with plans for Internal Audit to review late in 2023 and as part of the 2024 work plan. - Audit Overview and Next Steps: o The onsite audit ended March 10, 2023 and DHCS will issue a draft report and schedule an exit conference within 60 to 90 days. o L.A. Care will have 15 days to submit any disputes prior to the issuance of the final report. - Five major themes from the onsite included that L.A. Care are: o Not involving appropriate decision makers and escalating issues; o Missing required processes; o Not collecting and tracking data and information; o Not making timely reports to regulators; o Inadequately overseeing network providers and delegates. - The Auditors shared 27 preliminary findings at the close of the onsite audit. o This list is not closed/exhaustive, as the Auditors are continuing to review. o In categories related to enforcement matters, the preliminary findings included three for Utilization Management/Prior Authorizations and seven for Appeals & Grievances. • Dr. Amin gave a Chief Medical Officer report earlier today. • Christine Chueh and Rhonda Reyes gave an annual Provider Quality Review update. The Quality Improvement (QI) Provider Quality Review (PQR) team manages the Potential Quality of care Issue (PQI) process, which is a regulatory requirement to identify clinical issues/concerns and ensure high quality patient care is delivered to L.A. Care members. The Quality Improvement PQR process evaluates an occurrence or occurrences in which there is a potential or suspected deviation from accepted standards of clinical care. For the 503 cases identified last October, the cause of the backlog was identified on January 5, 2023 as human error of an incorrect selection of delivery method when submitting the PQI referral. The 503 cases are from Appeals and Grievances that contained a PQI date from January 1, 2021 to December 31, 2022. A remediation plan to close these additional cases in a timely manner has been implemented. The PQR team received a backlog of 1560 cases from grievances from August 2021 to March 2022 and consequently it generated a backlog of untimely aging of 900+ PQI cases for clinical review. The 90 cases that remain open from this backlog were completed by end of March 2023. Designated staff will work additional cases with a goal of completing at least 100 cases or more each month.	

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Bettsy Santana presented the 2022 Quality Improvement Annual Evaluation and the 2023 Quality Improvement Program Description. She gave an overview of quality improvement activities and significant accomplishments during the past year such as Quality and Safety of Clinical Care, Quality of Service, Member Experience, and Access to Care. As part of its clinical initiatives, L.A. Care completed 31 interventions via social media, mailings, automated and live agent calls and text messaging. It held a total of 14 Patient Experience training webinars and 15 training sessions for 11 IPAs and clinics provided by the SullivanLuallin Group. L.A. Care also supported 12 participating physician groups with improving their HEDIS and CAHPS scores. Ms. Santana reviewed the 2023 Program Description revisions and changes and gave updates on the 2023 Quality Improvement Work Plan.	
PUBLIC COMMENT on Closed Session Items	*Maritza Lebron, RCAC 7, thanked the Board for the opportunity to speak. In December or January, she called the nurse advice line. It is very important to have empathy and understanding that it is difficult for some to speak in English about their health. If the nurse doesn't have the same language, and they are trying to help you, sometimes you don't connect no matter what. The ability to understand others is not always the same for everybody. Ms. Lebron tried to explain in English but the nurse didn't get it. The nurse called for translator but it might have been a computer trying to translate. She tried to speak to the translator but it didn't work. Ms. Lebron asked for a different nurse, she was trying but she gave up. She felt alone. She called back again and the other person working was able to understand. The first nurse didn't have the empathy to connect her with a co-worker. It is important to have cultural competency so we have a successful outcome.* *Andria McFerson, Chair of RCAC 6, asked if the original procedures could be brought back, allowing public comment to come after the agenda item being spoken about is described. And motions presented to the actual stakeholders so they can actually talk and cohesively come up with decisions about how it affects members and if they approve it or not. It can then go back to the wonderful chairs on the Board so they can vote accordingly to how they feel about it and how it affects members. That is how the process used to be. She is not quite sure if they can get that back, but that would be great. She asked that the L.A. Care site be allowed to actually let people know that the RCACs are back in action.* Chairperson Ballesteros will speak on the order of public comment at the next meeting.	
ADJOURN TO CLOSED SESSION	The Joint Powers Authority Board of Directors meeting adjourned at 3:56 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 3:57 pm. No report is anticipated from the closed session.	

<table>
<tr><th>AGENDA ITEM/PRESENTER</th><th>MOTIONS / MAJOR DISCUSSIONS</th><th>ACTION TAKEN</th></tr>
<tr><td></td><td colspan="2">CONTRACT RATES
Pursuant to Welfare and Institutions Code Section 14087.38(m)
• Plan Partner Rates
• Provider Rates
• DHCS Rates

REPORT INVOLVING TRADE SECRET
Pursuant to Welfare and Institutions Code Section 14087.38(n)
Discussion Concerning New Service, Program, Business Plan
Estimated date of public disclosure: April 2025

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)
L.A. Care Health Plan v. United States, (U.S. Court of Federal Claims Case No. 17-1542); (U.S. Court of Appeals for the Federal Circuit Case No. 20-2254)

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

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: April 2025

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</td></tr>
<tr><td>RECONVENE IN OPEN SESSION</td><td colspan="2">The Board reconvened in open session at 4:56 p.m. There was no report from closed session.</td></tr>
<tr><td>ADJOURNMENT</td><td>The meeting adjourned at 4:56 p.m.</td><td></td></tr>
</table>

Respectfully submitted by: APPROVED BY:

DRAFT

Linda Merkens, *Senior Manager, Board Services*
Malou Balones, *Board Specialist III*
Victor Rodriguez, *Board Specialist II*

____
John G. Raffoul, *Board Secretary*
Date Signed ___________________________

Board of Governors
MOTION SUMMARY

Date: May 4, 2023 **Motion No. EXE 100.0523**

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

Issue: Request to ratify execution of one Amendment to L.A. Care's Medi-Cal contract (contract number 04-36069) with the Department of Health Care Services (DHCS).

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

Background: L.A. Care received a revised A42 from DHCS following objections from health plans to various provisions, most of which have been removed in this revised amendment. The updates include:

- Updated references of the "PHM Program Guide" to the "PHM Policy Guide" throughout amendment
- Clarifying language updates made for PHM MIS, LTC, and Transitional Care Services
- Added an APL reference for IHAs
- Removed new MOU language from updates to Attachment 11
- Removed new language for LEA Services requiring MH/SUD coverage and Network Provider/Subcontractor Agreements
- Removed new AIHS language
- Removed new language for a "warm hand-off" to other public benefits programs
- Removed new language of providing Basic PHM resources to providers
- Removed new aid code 4C from "Eligible Beneficiary" aid code chart
- Removed the language in the LTC definition that would have been effective July 1, 2023

DHCS provided the Plan with a limited time to review the amendment; therefore, Staff is asking for approval of the executed amendment.

Member Impact: Member impact is under investigation.

Budget Impact: Business units have reviewed the amendment for any impact on relevant budgets.

Motion: **To approve execution by L.A. Care Chief Executive Officer, John Baackes, of one Amendment to Medi-Cal Contract (04-36069).**

IV. Exhibit A, Attachment 3, MANAGEMENT INFORMATION SYSTEM, is amended to read:

1. Management Information System (MIS) Capability

A. Contractor's Management and Information System (MIS) shall be fully compliant with 42 CFR section 438.242 requirements and have the capability to capture, edit, and utilize various data elements for both internal management use as well as to meet the data quality and timeliness requirements of DHCS's Encounter Data submission. All data related to this Contract shall be available to DHCS and to the Centers for Medicare and Medicaid Services (CMS) upon request. Contractor shall have and maintain a MIS that provides, at a minimum:

7) Financial information as specified in Exhibit A, Attachment 1, Provision 8. Administrative Duties/Responsibilities~~.~~, ~~and~~

8) Member and Member's authorized representative Alternative Format Selection(s) (AFS)**, and**

9) Data Sources specified in DHCS policies and guidance, including All Plan Letters (APLs), the Enhanced Care Management (ECM) Policy Guide, Community Supports Policy Guide, and the Population Health Management (PHM) Policy Guide.

D. Contractor's MIS must have the capability to transmit and consume data files with and from DHCS, Subcontractors and sub-Subcontractors, Network Providers, other State, federal, and local governmental agencies, and other sources as needed to support Care Coordination and the overall administration of the Medi-Cal program. Contractor must have processes in place for utilizing all data made available to meet the Care Coordination requirements and other administrative functions of this Contract. Data that Contractor's MIS must be able to transmit and consume to the greatest extent possible include, but are not limited to:

1) Encounter Data,

2) Medi-Cal Fee-For-Service (FFS) claims data,

3) Carved-out claims data, including state plan services carved out of the contract and data available from partner organizations, including but not limited to the Local Education

Agency Medi-Cal Billing Option Program (LEA BOP) and incarceration in-reach services,

4) Dental claims data,

5) Specialty mental health data,

6) Substance use disorder data,

7) Medi-Cal FFS treatment authorization request data

8) California Children's Services (CCS) program data

9) Targeted Case Management (TCM) data;

10) Pharmacy claims data;

11) Risk Tier assignment data;

12) Authorization and referral data; and

13) Electronic Health Record or Health Record information, including case notes.

V. Exhibit A, Attachment 9, ACCESS AND AVAILABILITY, is amended to read:

13. Cultural and Linguistic Program

Contractor shall have a Cultural and Linguistic Services Program that incorporates the requirements of Title 22 CCR Section 53876. Contractor shall monitor, evaluate, and take effective action to address any needed improvement in the delivery of culturally and linguistically appropriate services. ~~Contractor shall review and update their cultural and linguistic services consistent with the population needs assessment (PNA) requirements stipulated below.~~

C. Population Needs Assessment (PNA)

~~Contractor shall conduct a PNA, as specified below, to identify the health education and cultural and linguistic needs of its' Members; and utilize the findings for continuous development and improvement of contractually required health education and cultural linguistic programs and services. Contractor must use multiple reliable data sources, methodologies, techniques, and tools to conduct the PNA.~~

~~1) Contractor shall conduct an initial PNA within 12 months from the commencement of operations within a Service Area and at least annually thereafter. For Contracts existing at the time this provision becomes effective, the next PNA will be required at a time within five (5) years from the effective date of this provision, to be determined by DHCS.~~

~~2) Contractor shall submit a report to the DHCS that must include:~~

~~a) The objectives; methodology; data sources; survey instruments; findings and conclusions; program and policy implications; and references contained in the PNA.~~

~~b) The findings and conclusions must include the following information for Medi-Cal plan Members: 1) demographic profile; 2) related health risks, problems and conditions; 3) related knowledge, attitudes and practices including cultural beliefs and practices; 4) perceived health education needs including learning needs, preferred methods of learning and literacy level; and 5) culturally competent community resources.~~

~~3) Contractor shall demonstrate that PNA and summary report findings and conclusions in item 2) b) above are utilized for continuous development of its health education and cultural and linguistic services program. Contractor must maintain documentation of program priorities, target populations, and program goals/objectives as they are revised to meet the identified and changing needs of the Member population.~~

Contractor must review and update its cultural and linguistic services programs to align with the Population Needs Assessment (PNA). Contractor must ensure its Network Providers', Subcontractors', and sub-Subcontractors' cultural and Health Equity linguistic services programs also align with the PNA.

~~D. The results of the PNA shall be considered in the development of any Marketing or promotional materials prepared by Contractor.~~

~~E~~**D**. Cultural Competency Training

~~F~~**E**. Program Implementation and Evaluation

VI. Exhibit A, Attachment 10, SCOPE OF SERVICES, is amended to read:

3. Initial Health ~~Assessment~~ Appointment (IHA)

~~An Initial Health Assessment (IHA) consists of a history and physical examination and an Individual Health Education Behavioral Assessment (IHEBA) that enables a Provider of primary care services to comprehensively assess the Member's current acute, chronic and preventive health needs and identify those Members whose health needs require coordination with appropriate community resources and other agencies for services not covered under this contract.~~ **Contractor must ensure the provision of an Initial Health Appointment (IHA) in accordance with 22 CCR sections 53851(b)(1), and APL 22-030. An IHA, at a minimum, must include: a history of the Member's physical and mental health; an identification of risks; an assessment of the need for preventive screens, services, and health education; a physical examination; and the diagnosis and plan for treatment of any diseases. An IHA may be waived if the Member's Primary Care Provider determines that the Member's health record contains complete information, updated within the previous 12 months, consistent with the assessment requirements.**

A. Contractor shall cover and ensure the provision of an IHA ~~(complete history and physical examination) in conformance with Title 22 CCR Section 53851(b)(1) to~~ **for** each new Member within timelines stipulated in Provision ~~5~~**4, Services for Members under Twenty-One (21) Years of Age,** and Provision ~~6~~**5, Services for Adults,** below.

B. Contractor shall ensure that ~~the IHA includes an IHEBA as described in Exhibit A, Attachment 10, Provision 8, Paragraph A, 10) using an age appropriate DHCS-approved assessment tool. Contractor is responsible for assuring that arrangements are made for follow-up services that reflect the findings or risk factors discovered during the IHA and IHEBA~~ **a Member's completed IHA is documented in their Health Record and that appropriate assessments from the IHA are available during subsequent health visits**.

C. ~~Contractor shall ensure that Members' completed IHA and IHEBA tool are contained in the Members' medical record and available during subsequent preventive health visits.~~

~~D.~~ Contractor shall make reasonable attempts to contact a Member ~~and~~ **to** schedule an IHA. All attempts shall be documented. Documented attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and schedule an IHA shall be considered evidence in meeting this requirement. **Contractor may delegate these activities, but Contractor remains ultimately responsible for all delegated functions.**

~~**4. Health Risk Stratification and Assessment for SPD Beneficiaries**~~

~~Contractor shall apply a DHCS approved health risk stratification mechanism or algorithm to identify newly enrolled SPD beneficiaries with higher risk and more complex health care needs within 44 days of enrollment. Based on the results of the health risk stratification, Contractor shall also administer the DHCS approved health risk assessment survey within 45 days for SPD beneficiaries deemed to be at a higher health risk, and 105 days for those determined to be a lower health risk. The health risk stratification and assessment shall be done in accordance with W & I Code Sections 14182 (c)(11) to (13) and APL 17-013.~~

~~5~~<u>4</u>. Services for Members under Twenty-One (21) Years of Age

Contractor shall cover and ensure the provision of all screening, preventive and Medically Necessary diagnostic and treatment services for Members under 21 years of age required under the EPSDT benefit described in 42 USC Section 1396d(r), and W&I Code section 14132(v). The EPSDT benefit includes all Medically Necessary health care, diagnostic services, treatments and other measures listed in 42 USC Section 1396d(a), whether or not covered under the State Plan. All EPSDT services are Covered Services, unless excluded under this Contract.

A. Provision of IHAs for Members under Age 21

3) The initial IHA assessment must include, or arrange for provision of, all immunizations necessary to ensure that the child is up-to-date for **<u>their</u>** age, ~~and an age appropriate IHEBA. See PL 13-001 for specific IHEBA requirements~~ **<u>an Adverse Childhood Experiences (ACEs) screening, and any required age-specific screenings including developmental screenings</u>**.

B. Children's Preventive Services

2) Where a request is made for children's preventive services by the Member, the Member's parent(s) or guardian or through a referral ~~from the local Child Health and Disability Prevention (CHDP) program~~, an appointment shall be made for the Member to be examined within two (2) weeks of the request.

<u>H. Local Education Agency Services</u>

<u>Contractor must reimburse Local Education Agencies, as appropriate, for the provision of school-linked EPSDT services, including but not limited to BHT as specified in Paragraph E, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services, of this Provision.</u>

~~6~~**5.** Services for Adults

A. IHAs for Adults (Age 21 and older)

1) Contractor shall cover and ensure that an IHA for adult Members is performed within 120 calendar days of enrollment.

2) Contractor shall ensure that the ~~performance of the initial complete history and physical exam~~ **IHA** for adults includes, but is not limited to~~:~~**, an evaluation of applicable preventive services provided in accordance with the United States Preventive Services Taskforce (USPSTF) "A" and "B" recommendations.**

~~a) blood pressure,~~

~~b) height and weight,~~

~~c) total serum cholesterol measurement for men ages 35 and over and women ages 45 and over,~~

~~d) clinical breast examination for women over 40,~~

~~e) mammogram for women age 50 and over,~~

~~f) Pap smear (or arrangements made for performance) on all women determined to be sexually active,~~

~~g) Chlamydia screen for all sexually active females aged 21 and older who are determined to be at high-risk for chlamydia infection using the most current CDC guidelines. These guidelines include the screening of all sexually active females aged 21 through 25 years of age,~~

~~h) screening for TB risk factors including a Mantoux skin test on all persons determined to be at high risk, and,~~

~~i) IHEBA.~~

B. Adult Preventive Services

Contractor shall cover and ensure the ~~delivery~~ **provision** of all preventive services and Medically Necessary diagnostic and treatment services for adult Members~~.~~ **as follows:**

1) Contractor shall ensure ~~that~~ the ~~latest edition of the Guide to Clinical Preventive Services published by the U.S. Preventive~~

~~Services Task Force (USPSTF) is used to determine the provision of clinical preventive services to asymptomatic, healthy adult Members [age 21 or older]. A~~ **provision of a**ll **applicable** preventive services identified as USPSTF “A” and “B” recommendations ~~must be provided. For tobacco use prevention and cessation services, Contractor may use either the USPSTF recommendations or the latest edition of the US Public Health Service “Treating Tobacco Use and Dependence: A Clinical Practice Guideline.” As a result of the IHA or other examination, discovery of the presence of risk factors or disease conditions will determine the need for further follow-up, diagnostic, and/or treatment services. In the absence of the need for immediate follow-up, the core preventive services identified in the requirements for the IHA for adults described above shall be offered in the frequency required by~~ **in accordance with** the USPSTF Guide to Clinical Preventive Services.

~~7~~6. Pregnant Women

~~8~~7. Services for All Members

A. Health Education

6) Contractor shall maintain a health education system that provides educational interventions addressing ~~the following~~ health categories and topics~~:~~ **that align with Contractor’s Population Health Management (PHM) Strategy, in accordance with Exhibit A, Attachment 23, Provision 2, Population Health Management Strategy (PHMS) and Population Needs Assessment (PNA), including education regarding the appropriate use of health care services, risk-reduction and healthy lifestyles, and self-care and management of health conditions.**

~~a) Appropriate use of health care services – managed health care; preventive and primary health care; obstetrical care; health education services; and, complementary and alternative care.~~

~~b) Risk-reduction and healthy lifestyles – tobacco use and cessation; alcohol and drug use; injury prevention; prevention of sexually transmitted diseases; HIV and unintended pregnancy; nutrition, weight control, and physical activity; and, parenting.~~

~~c) Self-care and management of health conditions – pregnancy; asthma; diabetes; and, hypertension.~~

~~10) Contractor shall ensure that all new Members complete the IHEBA within 120 calendar days of enrollment as part of the IHA; and that all existing Members complete the IHEBA at their next non-acute care visit. Contractor shall ensure: 1) that Primary Care Providers use the DHCS standardized "Staying Healthy" assessment tools, or alternative approved tools that comply with DHCS approval criteria for the IHEBA; and 2) that the IHEBA tool is: a) administered and reviewed by the Primary Care Provider during an office visit, b) reviewed at least annually by the Primary Care Provider with Members who present for a scheduled visit, and c) re-administered by the Primary Care Provider at the appropriate age-intervals.~~

~~11) Contractor shall cover and ensure provision of comprehensive case management including coordination of care services as described in Exhibit A, Attachment 22.~~

~~12~~**10**) Contractor shall develop a referral policy to ensure the Member is seen by a dental Provider following an initial dental health screening. The Member shall be referred to a dental Provider to address any immediate dental needs and for comprehensive dental care which will include a comprehensive oral exam.

~~B. The Health Information Form (HIF)/Member Evaluation Tool (MET)~~

~~Contractor shall use data from a Health Information Form (HIF)/Member Evaluation Tool (MET) to help identify newly enrolled Members who may need expedited services. In accordance with 42 CFR section 438.208(b), Contractor shall, at a minimum, comply with the following:~~

~~1) Mail a DHCS-approved HIF/MET to all new Members as a part of Contractor's welcome packet and include a postage paid envelope for response.~~

~~2) Within 90 days of each new Member's effective date of enrollment:~~

~~a) Make at least two (2) telephone call attempts to remind new Members to return the HIF/MET and/or collect the HIF/MET information from new Members. This outreach can be done through head of household for Members under the care of parents, custodial parents, legal guardians, or other authorized representatives in accordance with applicable privacy laws.~~

~~b) Conduct an initial screening of the Member's needs as identified in the HIF/METs received. To meet this~~

~~requirement, Contractor may build upon any existing screening process currently used to meet requirements in Exhibit A, Attachment 10, Scope of Services, or Exhibit A, Attachment 11, Case Management and External Coordination of Care.~~

~~3) Upon a Member's disenrollment, Contractor shall make the HIF/MET assessment results available to their new Medi-Cal Managed Care Health Plan upon request.~~

~~C~~**B**. Hospice Care

~~D~~**C**. Vision Care – Lenses

~~E~~**D**. Behavioral Health Services

2) Contractor ~~shall~~ **must** cover and pay for all Medically Necessary Mental Health Covered Services for the Member, including the following services:

i) Dyadic Care Services and the Family Therapy Benefit for Members ages 0-20 years and/or their caregivers in an outpatient setting.

~~F~~**E**. Pharmaceutical Services

~~G~~**F**. Transportation

~~H~~**G**. Practice Guidelines

~~I~~**H**. Organ and Bone Marrow Transplant Surgeries

I. Asthma Prevention Services

J. Community Health Workers Services

K. CHW Provider Capacity

L. Identifying Members for CHW

M. Long-Term Care Services

Contractor must authorize and cover LTC. Contractor must ensure that Members in need of LTC services are placed in a health care facility that provides the level of care most appropriate to the

Member's medical needs, unless the Member has elected hospice care.

1) LTC services are covered under this Contract. Contractor must ensure that Members, other than Members requesting hospice services, in need of LTC services are placed in a LTC facility that provides the level of care most appropriate to the Member's medical needs. Contractor must make Member placement decisions based on the appropriate level of care, as set forth in the definitions in 22 CCR sections 51118, 51120, 51120.5, 51121, 51123, 51124, 51124.5, and 51124.6 and the criteria for admission set forth in 22 CCR sections 51335, 51335.5, 51335.6, and 51334 and related sections of the Manual of Criteria for Medi-Cal Authorization referenced in 22 CCR section 51003(e).

2) Hospice Services as defined in 22 CCR section 51180 rendered in a Skilled Nursing Facility or Intermediate Care Facility for the Developmentally Disabled are not LTC services consistent with 22 CCR section 51544(h).

3) Contractor must place Members in LTC facilities that are licensed and certified by the CDPH. Contractor must ensure that contracted LTC facilities have not been decertified by CDPH or otherwise excluded from participation in the Medi-Cal Program.

4) Contractor must provide continuity of care, as set forth in APL 18-008, to Members through continued placement in the LTC facility in which the Member is residing at time of Enrollment for up to 12 months. During this time, Contractor may attempt to place Members at LTC facilities within its Provider Network only with approval from the Member or individual authorized to make health care decisions on their behalf.

5) Contractor must cover a Member stay in a facility with availability regardless of Medical Necessity if placement in a Medically Necessary appropriate lower level of care is not available, unless otherwise provided by this Contract. Contractor must continue to attempt to place the Member in a facility with the appropriate level of care, including by offering to contract with facilities within and outside of the Service Area.

N. Care Management and Care Coordination

1) **Contractor must provide all Members with Care Coordination services as specified in Exhibit A, Attachment 23, Provision 8, Basic Population Health Management.**

2) **Contractor must provide care management services to all Members as specified in Exhibit A, Attachment 23, Provision 8, Basic Population Health Management, and Exhibit A, Attachment 23, Provision 7, Care Management Programs. Care management services include, Basic Population Health Management (Basic PHM), Complex Care Management (CCM), and Enhanced Care Management (ECM).**

VII. Exhibit A, Attachment 11, CASE MANAGEMENT AND EXTERNAL COORDINATION OF CARE, is amended to read:

1. Targeted Case Management Services

~~Contractor is responsible for determining whether a Member requires Targeted Case Management (TCM) services, and must refer Members who are eligible for TCM services to a Regional Center or local governmental health program as appropriate for the provision of TCM services.~~

~~If a Member is receiving TCM services as specified in Title 22 CCR Section 51351, Contractor shall be responsible for coordinating the Member's health care with the TCM Provider and for determining the Medical Necessity of diagnostic and treatment services recommended by the TCM Provider that are Covered Services under the Contract.~~

~~If Members under age 21 are not accepted for TCM services, Contractor shall ensure the Members' access to services are comparable to EPSDT TCM services per Exhibit A, Attachment 10, Scope of Services, Provision 5. Services for Members under Twenty-One (21) Years of Age.~~

A. Contractor must identify the target populations for Targeted Case Management (TCM) programs within their Service Area, and maintain procedures to refer Members to TCM services. If upon notification from DHCS that a Member is receiving TCM services and Contractor is not already aware, Contractor must reach out to Local Government Agencies (LGAs) to coordinate care, as appropriate.

B. Contractor must coordinate with LGAs to provide Care Coordination for all Medically Necessary Covered Services identified by TCM Providers in their Member care plans, including referrals and Prior Authorization for Out-of-Network medical services. Coordination with LGAs must continue for Members receiving TCM services until the

LGA notifies Contractor that TCM services are no longer needed for the Member.

C. Because TCM can be a direct duplication of services such as Basic PHM, CCM, ECM, and Community Supports, Contractor must have processes to ensure Members receiving TCM are not receiving duplicative services.

D. Contractor must designate a representative responsible for coordinating TCM services with LGAs for the Member. Contractor representative's responsibilities include, but are not limited to, sharing the appropriate Member Provider(s) information and PCP and/or Care Manager assignment with LGAs and resolving all related operational issues.

E. Contractor must also notify Members' PCPs and/or Care Managers when Members are receiving TCM services and provide them with the appropriate LGA contact information.

F. For Members under 21 years of age, Contractor must ensure that all Medically Necessary services are provided timely as required in Exhibit A, Attachment 10, Provision 5, Services for Members under Twenty-One (21) Years of Age. Notwithstanding medical services recommended in TCM care plans or arranged by LGAs or TCM providers for Members less than 21 years of age, Contractor remains responsible for the provision of the EPSDT benefit, as described in Exhibit A, Attachment 10, Provision 5, Paragraph F.

4. ~~Specialty~~ Mental Health Services

Contractor must use DHCS-approved screening tools as identified in DHCS guidance to ensure Members seeking mental health services, and who are not currently receiving Non-specialty Mental Health Services (NSMHS) or Specialty Mental Health Services (SMHS), receive referrals to the appropriate delivery system for mental health services, either in Contractor's Network or the county mental health plan network, in accordance with the No Wrong Door policies set forth in W&I Code section 14184.402(h) and specified in Exhibit A, Attachment 20, Provision 6, No Wrong Door for Mental Health Services.

A. Non-Specialty Mental Health Services

Contractor must provide timely NSMHS for Members consistent with the No Wrong Door policies, including under the following circumstances:

1) When NSMHS are provided in the following instances;

a) During the assessment process;

b) Prior to determination of a diagnosis; or

c) Prior to determination of whether NSMHS criteria set forth in W&I Code section 14184.402(b)(2) are met.

2) When NSMHS were not included in a Member's individual treatment plan;

3) When a Member has a co-occurring mental health condition and substance use disorder; or

4) When NSMHS are provided to a Member concurrently with SMHS, if those services are not duplicative and coordinated between Contractor and the county mental health plan.

~~A~~**B**. Specialty Mental Health Services

1) ~~All Specialty Mental Health Services (inpatient and outpatient) are excluded from this Contract.~~ **Contractor must maintain policies and procedures to refer Members who meet the criteria for SMHS to the MHP in accordance with the No Wrong Door policies.**

2) ~~Contractor shall make appropriate referrals for Members needing Specialty Mental Health Services as follows:~~ **If a Member receiving NSMHS is determined to meet the criteria for SMHS due to a change in the Member's condition, Contractor must use DHCS-approved standardized transition tools as specified by DHCS, and continue to provide NSMHS to the Member concurrently receiving SMHS when those services are not duplicative and coordinated between Contractor and the MHP.**

~~a) For those Members with a tentative psychiatric diagnosis which meets eligibility criteria for referral to the county mental health plan, as defined in PL 00-001 Revised and APL 13-021, the Member shall be referred to the county mental health plan in accordance with the Memorandum of Understanding (MOU) between Contractor and the county mental health plan and APL 13-018.~~

~~b) For those Members whose mental health diagnosis is not covered by the county mental health plan because the adult~~

~~Member's level of impairment is mild to moderate, or the recommended treatment for adult and child Members do not meet the criteria for Specialty Mental Health Services, the Member shall be referred to an appropriate Medi-Cal mental health Provider within Contractor's Provider Network. Contractor shall consult with the county mental health plan as necessary to identify other appropriate community resources and to assist the Member to locate available non-covered mental health services.~~

C. Mental Health Services Disputes

~~3~~**1)** Disputes between Contractor and the county mental health plan regarding this section shall be addressed collaboratively within the Contract as specified by the MOU to achieve a timely and satisfactory resolution. **Disputes between the Contractor and MHP shall not delay the provision of Medically Necessary services by the Contractor or MHP.**

2) If Contractor and the county mental health plan cannot agree **on the appropriate place of care**, **then** disputes shall be resolved pursuant to **APL 21-013** **and** ~~Title~~ 9~~,~~ CCR~~,~~ ~~S~~**s**ection 1850.505. ~~Any decision rendered by DHCS regarding a dispute between Contractor and the county mental health plan concerning provision of mental health services or Covered Services required under this Contract shall not be subject to the dispute procedures specified in Exhibit E, Attachment 2, Provision 18 regarding Disputes.~~ **Specifically, as set forth in APL 21-013, Contractor and county mental health plans must complete the plan-level dispute resolution process within 15 Working Days of identifying the dispute.**

3) Contractor and the county mental health plan may seek to enter into an expedited dispute resolution process if a Member has not received a disputed service(s) and Contractor and/or the county mental health plan determine that the routine dispute resolution process timeframe would result in serious jeopardy to the Member's life, health, or ability to attain, maintain, or regain maximum function. Under this expedited process, Contractor and the county mental health plan will have one (1) Working Day after identification of a dispute to attempt to resolve the dispute at the plan level. All terms and requirements established in APL 21-013 apply to disputes between Contractor and the county mental health plan.

~~B~~**D**. County Mental Health Plan Coordination

Contractor shall execute a Memorandum of Understanding (MOU) with the county mental health plan as stipulated in Exhibit A, Attachment 12, Local Health Department Coordination, Provision 3. County Mental Health Plan Coordination for the coordination of Specialty Mental Health Services to Members**, to ensure services for its Members are properly coordinated and provided in a timely and non-duplicative manner**.

5. Alcohol and Substance Use Disorder Treatment Services

Alcohol and substance use disorder treatment services available under Drug Medi-Cal program as defined in Title 22 CCR 51341.1, and outpatient heroin detoxification services defined in Title 22 CCR 51328 are excluded from this Contract. These Excluded Services include all medications used for the treatment of alcohol and substance use disorders covered by DHCS, as well as specific medications not currently covered by DHCS, but reimbursed through the Medi-Cal FFS Program.

A. Contractor shall identify ~~individuals~~ **Members** requiring alcohol and or substance use disorder treatment services and refer the ~~individuals~~ **Members** to the county department responsible for substance use treatment, or other community resources when services are not available through counties, and to outpatient heroin **and other opioid** detoxification Providers available through the Medi-Cal FFS program, ~~for~~ **as** appropriate ~~services~~. Contractor shall assist Members in locating available treatment service sites. To the extent that treatment slots are not available within Contractor's Service Area, Contractor shall ~~pursue placement~~ **coordinate with the county department responsible for substance use disorder treatment to refer Members to available treatment** outside the **Service** ~~a~~**A**rea. Contractor shall continue to cover and ensure the provision of primary care and other services unrelated to the alcohol and substance use disorder treatment and coordinate services between ~~the its~~ Network Providers and the treatment programs.

B. Contractor shall execute a MOU with ~~the~~ **each** county department **responsible** for alcohol and substance use disorder treatment services.

C. Prescribing and medication management of buprenorphine and other prescribed medications for substance use disorder treatment, also known as medication- assisted treatment or MAT, are the responsibility of Contractor when they are provided in Primary Care offices, departments, hospitals or other contracted medical Facilities.

7. California Children's Services (CCS)

Services provided by the CCS program are not covered under this Contract. Upon adequate diagnostic evidence that a Medi-Cal Member under 21 years of age may have a CCS-eligible condition, Contractor shall refer the Member to the local CCS office for determination of eligibility.

A. Contractor ~~shall develop and implement~~ **must maintain** written policies and procedures for identifying and referring ~~children~~ **Members** with CCS-eligible conditions to the local CCS program. The policies and procedures shall include, but not be limited, to those which:

2) ~~Assure that~~ **Instruct** Network Providers ~~understand~~ that CCS reimburses only CCS-paneled Providers and CCS-approved hospitals within Contractor's Network; and only from the date of referral;

3) ~~Enable~~ **Ensure that Network Providers complete the** initial referrals of Member~~'~~s with **suspected** CCS-eligible conditions **the same day** **using modalities accepted by** ~~to be made to~~ the local CCS program ~~by telephone, same-day mail or fax, if available~~. The initial referral shall be followed by submission of supporting medical documentation sufficient to allow for eligibility determination by the local CCS program~~.~~**;**

4) ~~Ensure that Contractor~~ **Instruct Network Providers of the requirement to** continue~~s to provide~~ **providing** all Medically Necessary Covered Services to the Member until CCS **program** eligibility is confirmed~~.~~**;**

5) Ensure that, once eligibility for the CCS program is established for a Member, Contractor shall continue to provide all Medically Necessary Covered Services that are not authorized by **the** CCS **program** and shall ensure the coordination of services and joint case management between ~~its~~ **the Member's** Primary Care Providers, the CCS ~~specialty~~ Providers, and the local CCS program. Contractor shall continue to provide case management services to ensure all ~~Medically Necessary treatment~~ **Covered Services** authorized through the CCS program ~~is~~ **are provided** timely ~~provided~~ as required in Exhibit A, Attachment 10, Scope of Services, Provision 5. Services for Members under Twenty-One (21) Years of Age. Without limitation, Contractor shall, as necessary, ~~or~~ **including** upon a Member's request, arrange for all in-home nursing hours authorized by the CCS program that a Member desires to utilize, as required by APL 20-012~~.~~**; and**

6) If the local CCS program does not approve eligibility, Contractor remains responsible for the provision of all Medically Necessary

Covered Services to the Member. If the local CCS program denies authorization for any service, Contractor remains responsible for ~~obtaining~~ **providing and reimbursing for the cost of** the service, if it is **determined to be** Medically Necessary~~, and paying for the service if it has been provided~~.

B. Contractor shall execute a Memorandum of Understanding (MOU) with the local CCS program as stipulated in Exhibit A, Attachment 12, Provision 2, for the coordination of CCS services to Members. **The MOU must delineate the roles and responsibilities of Contractor and the CCS Program for coordinating care and ensuring the non-duplication of services.**

C. The CCS program authorizes Medi-Cal payments to Network Providers who currently are members of the CCS panel and to other Network Providers who provided CCS-covered services to the Member during the CCS-eligibility determination period who are determined to meet the CCS standards for paneling. Contractor shall inform Network Providers, except as noted above, that CCS reimburses only CCS paneled Network Providers. Contractor shall submit information to the CCS program on all Providers who have provided services to a Member thought to have a CCS-eligible condition.

Authorization for payment shall be retroactive to the date the CCS program was informed about the Member through an initial referral by Contractor or a Network Provider~~, via telephone, fax, or~~ mail. In an emergency admission, Contractor or Network Provider shall be allowed until the next Working Day to inform the CCS program about the Member. Authorization shall be issued upon confirmation of panel status or completion of the process described above.

D. Contractor must maintain policies and procedures for identifying CCS-eligible Members who are aging out of the CCS program. Within 12 months of when a CCS Member will age out of the program, Contractor must develop a Care Coordination plan to assist the Member in transitioning out of the CCS Program. The policies and procedures must include, the following, at a minimum:

1) Identifying the Member's CCS-Eligible Condition;

2) Planning for the needs of the Member to transition from the CCS Program;

3) A communication plan with the Member in advance of the transition,

4) Identification and coordination of Primary Care and specialty care Providers appropriate to the Member's CCS qualifying condition(s); and

5) Continued assessment of the Member through first 12 months of the transition.

8. Services for Persons with Developmental Disabilities

A. Contractor shall develop and implement procedures for the identification of Members with developmental disabilities **(DD)**.

C. Contractor shall refer Members with ~~developmental disabilities~~ **DD** to a ~~Regional Center for the developmentally disabled~~ **regional center** for evaluation and for access to those non-medical services provided ~~\Regional Centers~~, such as but not limited to, respite, out-of-home placement, and supportive living. ~~Contractor shall participate with Regional Center staff in the development of the individual developmental services plan required for all persons with developmental disabilities, which includes identification of all appropriate services, including medical care services and Medically Necessary Outpatient Mental Health Services, which need to be provided to the Member.~~

E. Contractor shall execute a Memorandum of Understanding (MOU) with the local Regional Centers as stipulated in Exhibit A, Attachment 12, Provision 2, for the coordination of services for Members with ~~developmental disabilities~~ **DD to ensure the non-duplication of services and to coordinate and work with the regional centers in the development of the individual development services plan required for all Members with DD, which includes identification of the Member's medical needs and the provision of Medically Necessary services such as medical care, NSMHS, and Behavioral Health Treatment (BHT)**.

10. Local Education Agency Services

A. Local Education Agency (LEA**)** assessment services are services specified in Title 22, CCR Section 51360(b) and provided to students who qualify based on Title 22 CCR Section 51190.1. LEA services provided pursuant to an Individual Education Plan as set forth in Education Code, Section 56340 et seq. or Individual Family Service Plan as set forth in Government Code Section 95020 are not covered under this Contract. However, Contractor is responsible for providing a PCP and all Medically Necessary Covered Services for the Member, and shall ensure that the Member's PCP cooperates and collaborates in the development of the Individual Education Plan **(IEP)** or the Individual Family Service Plan **(IFSP)**. Contractor shall provide case management and care coordination

to the Member to ensure the provision of all Medically Necessary diagnostic, preventive and treatment services identified in the Individual Education Plan developed by the LEA, with Primary Care Provider participation.

B. Contractor must implement interventions that increase access to preventive, early intervention, and behavioral health services by school- affiliated behavioral health Providers for children in publicly funded childcare and preschool, and TK-12 children in public schools, in accordance with the interventions, goals, and metrics set forth in W&I Code section 5961.3(b).

12. Dental

A. Contractor shall cover and ensure that dental screenings/oral health assessments for all Members are included as a part of the IHA. ~~For Members under 21 years of age, Contractor is responsible for ensuring that a dental screening/oral health assessment shall be performed as part of every periodic assessment by a medical Provider or coordinated with a dental Provider, with annual dental referrals made with the eruption of the child's first tooth or at 12 months of age, whichever occurs first.~~ Contractor shall ensure that **all** Members are referred to appropriate Medi-Cal dental Providers. Contractor shall provide Medically Necessary Federally Required Adult Dental Services (FRADs) and fluoride varnish, **and** dental services that may be performed by a medical professional. Dental services that are exclusively provided by dental providers are not covered under this Contract.

B. For Members under 21 years of age, Contractor is responsible for ensuring that a dental screening or oral health assessment is performed as part of every periodic assessment by a medical Provider or coordinated with a dental Provider, with annual dental referrals made with the eruption of the child's first tooth or at 12 months of age, whichever occurs first.

C. Contractor shall ensure the provision of ~~covered medical services related to~~ **Medically Necessary** dental**-related Covered** ~~s~~**S**ervices that are not **exclusively** provided by dentists or dental anesthetists. **Contractor must also have an identified Contractor liaison available to Medi-Cal dental Providers to assist with referring Members to other Covered Services. Other** Covered ~~medical s~~**S**ervices include**, but are not limited to**: laboratory services; and, pre-admission physical examinations required for admission to an out-patient surgical service center or an in-patient hospitalization required for a dental procedure (including facility fees and anesthesia services for both inpatient and outpatient services). Contractor may require Prior Authorization for medical services required in support of

dental procedures.

D. If ~~the~~ Contractor requires Prior Authorization for ~~these~~ **dental procedures**, Contractor shall develop and publish the **policies and** procedures for obtaining Prior Authorization to ensure that services for the Member are not delayed. Contractor shall ~~submit such procedures to~~ **coordinate with the DHCS Dental Services Division in the development of their policies and procedures for Prior Authorization of dental services, and must submit them to** DHCS for review and approval.

13. Direct Observed Therapy (DOT) for Treatment of Tuberculosis (TB)

~~A. DOT is offered by LHDs and is not covered under this Contract.~~
Contractor shall assess the risk of noncompliance with drug therapy for each Member who requires placement on anti-tuberculosis drug therapy.

A. The following groups of individuals are at risk for non-compliance for the treatment of TB:

1) Members with demonstrated multiple drug resistance (defined as resistance to Isoniazid and Rifampin);

2) Members whose treatment has failed or who have relapsed after completing a prior regimen;

3) **Members with mental health conditions or substance use disorders;**

4) **Elderly,** children**,** and adolescent~~s~~ **Members;**

5) **Members with unmet housing needs;**

6) **Members with language and/or cultural barriers**; and,

7) ~~individuals~~ **Members** who have demonstrated noncompliance (those who failed to keep office appointments).

B. Contractor shall refer Members with active TB and who have ~~any of these~~ **treatment resistance or non-compliance issue** risks to the TB Control Officer of the LHD for DOT. ~~Contractor shall assess the following groups of Members for potential noncompliance and for consideration for DOT: substance users, persons with mental illness, the elderly, persons with unmet housing needs, and persons with language and/or cultural barriers.~~ If~~, in the opinion of Network~~ **a** Provider~~,~~ **finds that** a Member ~~with one (1) or more of these risk factors~~ is at risk for **treatment resistance or**

noncompliance, **Contractor must refer** the Member ~~shall be referred~~ to the LHD for DOT.

~~Contractor shall provide all Medically Necessary Covered Services to the Member with TB on DOT and shall ensure joint case management and coordination of care with the LHD TB Control Officer.~~

~~B~~**C**. Contractor shall execute a MOU with the LHD as stipulated in Exhibit A, Attachment 12, Provision 2, ~~for the provision of~~ **to ensure joint case management and Care Coordination with the LHD TB Control Officer. Contractor must provide all Medically Necessary Covered Services to Members with TB on** DOT.

14. Women, Infants, and Children (WIC) Supplemental Nutrition Program

B. Contractor, as part of its IHA of Members, or, as part of the initial evaluation of newly pregnant women, shall refer and document the referral of pregnant, breastfeeding, or postpartum women or a parent/guardian of a child under the age of five (5) to the WIC program as mandated by 42 CFR 431.635(c) **and PL 98-010**.

~~B~~**C**. Contractor shall execute a MOU with the WIC program as stipulated in Exhibit A, Attachment 12, Provision 2, for services provided to Members through the WIC program.

18. In-Home Support Services

Contractor must maintain policies and procedures for identifying and referring eligible Members to the county In-Home Support Services (IHSS) program. Contractor's procedures must address the following requirements, at a minimum:

A. Processes for coordinating with the county IHSS agency that ensures Members do not receive duplicative services through ECM, Community Supports, and other services;

B. Track all Members receiving IHSS and continue coordinating services with the county IHSS agency for Members until IHSS notifies Contractor that IHSS is no longer needed for the Member;

C. Outreach and coordinate with the county IHSS agency for any Members identified by DHCS as receiving IHSS;

D. Upon identifying Members receiving, referred to, or approved for IHSS, conduct a reassessment of Members' Risk Tier, per

<u>the population RSS and Risk Tiering requirements in this Section; and</u>

<u>E. Continue to provide Basic PHM and Care Coordination of all Medically Necessary services while Members receive IHSS.</u>

VIII. Exhibit A, Attachment 18, IMPLEMENTATION PLAN AND DELIVERABLES, is amended to read:

10. Scope of Services

L. Submit policies and procedures for the provision of:

<u>6) Long-Term Care</u>

IX. Exhibit A, New Attachment 23, POPULATION HEALTH MANAGEMENT AND COORDINATION OF CARE, adds the following language:

<u>Exhibit A, Attachment 23</u>
<u>POPULATION HEALTH MANAGEMENT AND COORDINATION OF CARE</u>

<u>1. Population Health Management (PHM) Program Requirements</u>

<u>A. Contractor must develop and maintain a Population Health Management (PHM) program that ensures all Members have equitable access to necessary wellness and prevention services, Care Coordination, and care management. Contractor must assess each Member's needs across the continuum of care based on Member preferences, data-driven risk stratification, identified gaps in care, and standardized assessment processes. Contractor must maintain a PHM program that seeks to improve the health outcomes of all Members consistent with the requirements set forth in this Section and DHCS guidance.</u>

<u>B. Contractor must ensure its PHM program meets all National Committee for Quality Assurance (NCQA) PHM standards, as well as applicable federal and State requirements. Contractor must conduct a Population Needs Assessment (PNA) as described in Provision 2 of this Attachment, and submit to DHCS for approval a Population Health Management Strategy (PHMS) that details all components of</u>

its PHM program activities in accordance with the requirements of this Attachment and the DHCS Comprehensive Quality Strategy.

C. Contractor must engage Local Health Departments (LHDs), Local Education Agencies (LEAs), Local Government Agencies (LGAs), and other stakeholders identified in Provision 2 of this Attachment to develop its PNA.

2. Population Health Management Strategy (PHMS) and Population Needs Assessment (PNA)

In accordance with 42 CFR sections 438.206(c)(2), 438.330(b)(4), and 438.242(b)(2), 22 CCR sections 53876(a)(4), 53876(c), 53851(b)(2), 53851(e), 53853(d), and 53910.5(a)(2), and applicable DHCS guidance, Contractor must conduct a PNA every three (3) years. The first submission under this new structure will be due to DHCS in Calendar Year 2025. Contractor must use the PNA to identify population-level health and social needs, including health disparities, and to provide and maintain culturally competent and linguistically appropriate services and translations. Contractor must implement health equity, health education, and continuous Quality Improvement (QI) programs and services, and determine relevant

subpopulations for targeted, person-centered interventions. Contractor must develop the PNA in accordance with the following requirements:

A. Contractor's PNA must evaluate, at a minimum, the following factors for its entire Member population:

1) General characteristics and health needs;

2) Health status, behaviors and utilization trends, including use of Emergency Services;

3) Health education, and cultural and linguistic needs;

4) Health disparities;

5) Social drivers of health (SDOH); and

6) Any gaps in services and resources even if they are not Covered Services under this Contract.

B. Contractor's PNA must consider all relevant data for its entire Member population, including, but not limited to:

1) Data from Subcontractors and sub-Subcontractors; and

2) Needs assessments conducted by other entities and community-based organizations within Contractor's Service Area.

C. Contractor must use reliable data sources, including Subcontractor and sub-Subcontractor level data, to conduct and update the PNA at least annually every three (3) years. Reliable data sources must include the most recent results from the Member satisfaction survey and DHCS Health Disparities data.

D. In order to assess Member needs in Contractor's Service Area, Contractor must conduct broad community engagement as specified in DHCS policies and guidance, including the PHM Policy Guide, and engage representatives of LHDs, LEAs, LGAs, Safety Net Providers, community based organizations, county mental health plans, Drug Medi-Cal and Drug Medi-Cal Organized Delivery System (DMC- ODS) plans, community mental health programs, PCPs, social service providers, regional centers, California Department of Corrections and Rehabilitation, county jails and juvenile facilities, Child Welfare Agencies as well as stakeholders from special needs groups,

including Seniors and Persons with Disabilities (SPD), Children with Special Health Care Needs (CSHCN), Members with Limited English Proficiency (LEP), and other Member subgroups from diverse cultural and ethnic backgrounds.

E. Contractor must produce its PNA in writing, make it available to the public, and post it on its website.

F. Contract must submit an annual PHM Strategy that is aligned with NCQA requirements and DHCS policies and guidance, including the PHM Policy Guide, and includes the following:

1) All components of the PHM Strategy and approach

2) Strategies and initiatives that address the Comprehensive Quality Strategy's Clinical Focus Areas and achieve the Bold Goals, in addition to specific health disparities and conditions identified in the PNA.

3. Data Integration and Exchange

In accordance with the CMS Interoperability and Patient Access final rule (CMS- 9115-F) and applicable federal and state data exchange requirements, Contractor must integrate its PHM data by expanding its Management Information System (MIS) capabilities outlined in Exhibit A, Attachment 3, Management Information Systems, as follows:

A. Integrate additional data sources in accordance with all NCQA PHM standards to ensure the ability to assess the needs and characteristics of all Members;

B. Enhance interoperability of its MIS to allow for data exchange with Health Information Technology (HIT) systems and Health Information Exchange (HIE) networks as specified by DHCS;

C. Enhance interoperability of the PHM Service, in support of population health principles, integrated care, and Care Coordination across delivery systems;

D. Provide DHCS with administrative, clinical, and other data requirements as specified by the DHCS; and

E. Comply with all data sharing agreements, including data exchange policies and procedures, as defined by the California Health and

Human Services Data Exchange Framework in accordance with Health & Safety Code section 130290.

4. PHM Service

Contractor must use the PHM Service in accordance with all applicable federal and State laws and regulations, and in a manner specified by DHCS, as follows:

A. Contractor must use the PHM Service, when applicable functionality is fully defined and deemed available by DHCS, at a minimum, to:

1) Perform Risk Stratification and Segmentation (RSS) activities using PHM Service's RSS methodologies, including identifying and assessing Member-level risks and needs through use of the PHM Service's Risk Tiering functionalities, which places Members into standardized tiers.

2) Inform and enable Member screening and assessment activities, including using pre-populating screening and assessment tools; and

3) Support Contractor's Basic PHM program, including wellness and prevention, Member engagement and health education activities.

5. Population Risk Stratification/Segmentation (RSS) and Risk Tiering

A. Contractor must meet all of the requirements for RSS listed in this Provision. Contractor must use the PHM Service, in a manner specified by DHCS, or their own RSS approach, to meet the requirements contained in this Provision, including:

1) Considering findings from the PNA and all Members' behavioral, developmental, physical, and oral health, Long-Term Services and Supports (LTSS) needs as well as health

risks, rising-risks, and health-related social needs due to SDOH;

2) Complying with NCQA PHM standards;

3) Risk stratify and/or segment all Members at least annually and during each of the following timeframes:

a) Upon each Member's Enrollment;

b) Annually after each Member's Enrollment;

c) Upon a significant change in the health status or level of care of the Member; and

d) Upon the occurrence of events or new information that Contractor determines as potentially changing a Member's needs, including but not limited to, referrals for Complex Care Management (CCM), Enhanced Care Management (ECM), and Transitional Care Services.

4) Submitting its processes to DHCS upon request regarding how it identifies significant changes in Members' health status or level of care and how it is monitoring appropriate re-stratification.

5) Use integrated data that includes data sources, specified in DHCS policies and guidance, including the PHM Policy Guide.

6) Avoid and reduce biases in its RSS approach by using evidence-based methods to prevent further exacerbation of Health Disparities. Only using utilization data would not meet standards to reduce bias.

B. Contractor must use RSS and PHM Service Risk Tiers, when available, to:

1) Connect all Members, including those with rising risk, to an appropriate Contractor-identified level of service within parameters outlined in Paragraph B.3) of this Provision, including but not limited to, care management programs, Basic PHM, and Transitional Care Services;

2) Monitor and improve the penetration rate of PHM programs and services, including, but not limited to, the percentage of Members who require additional assessments who complete

them as well as the connection of Members to the programs and services they are eligible for.

3) In line with NCQA PHM requirements, prior to PHM Service being deemed by DHCS to be operational, assess specific Members identified as High or Medium-Rising risk as outlined in DHCS guidance, including the PHM Policy Guide, to determine care management needs.

C. Contractor must ensure that its RSS and Risk Tiering approach is submitted to DHCS for review and approval in a form and method prescribed by DHCS, and includes the following element, at a minimum:

1) Description of its RSS and Risk Tiering approach;

2) Description of how RSS and Risk Tiers are used to connect Members to appropriate services;

3) The number of Members in each Risk Tier and the programs or services for which they are eligible;

4) The penetration rate of PHM programs or services by Risk Tier:

a) The number of Members, by Risk Tier, who needed further assessment and received it;

b) The number of Members, by Risk Tier who were enrolled in programs they were eligible for; and

5) Method(s) for discovering and reducing bias within the RSS and Risk Tiering approach.

6. Screening and Assessments

A. In accordance with 42 CFR section 438.208, Contractor must conduct an initial screening of each Member's needs within 90 days of Enrollment and share that information with DHCS and other managed care health plans or Providers serving the Member, to prevent duplication of those activities. Contractor must make at least three (3) attempts to contact a Member to conduct the initial screening using available modalities.

B. Contractor must conduct necessary screenings to gain timely information on the health and social needs of all Members, in

accordance with applicable State and federal laws and regulations, and NCQA PHM standards.

C. Contractor must abide by DHCS guidance for Member screening and assessment, including the PHM Policy Guide, which will include guidance for how to use the PHM Service for the screening and assessment process.

D. Contractor must monitor what percentage of required screenings and assessments are completed per the specifications above.

7. Care Management Programs

Contractor must maintain a PHM delivery infrastructure to ensure that the needs of its entire Member population are met across the continuum of care. The infrastructure must provide Members with the appropriate level of care management through person-centered interventions based on the intensity of health and social needs and services required. The care management interventions described in this Provision are intended for specific segments of the population that require more intensive engagement than the Basic PHM described in Provision 8 of this Attachment. Members receiving care management must have an assigned Care Manager and a Care Management Plan (CMP).

A. Enhanced Care Management (ECM) and Complex Care Management (CCM)

1) ECM is a whole-person, interdisciplinary approach to comprehensive care management that addresses the clinical and non-clinical needs of high need and/or high-cost Members through systematic coordination of services and consistently apply comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. This benefit is intended for the highest risk Medi-Cal managed care health plan Members who meet the Populations of Focus criteria. ECM is described further in Exhibit A, Attachment 22.

2) Complex Care Management, which equates to Complex Case Management as defined by NCQA and in this Contract, is an approach to comprehensive care management that meets differing needs of high and rising-risk Members through both ongoing chronic Care Coordination and interventions for episodic, temporary needs. The overall goal of CCM is to help

Members regain optimum health or improved functional capability, in the right setting, and in a cost-effective manner.

3) Contractor must consider CCM to be an opt-out program, i.e. all eligible Members have the right to participate or to decline to participate.

4) Both ECM and CCM are inclusive of Basic PHM, which Contractor must provide to all Members. Care Managers conducting ECM or CCM must integrate all elements of Basic PHM into their ECM or CCM approach.

B. Care Management Programs

Contractor must operate and administer ECM as described in Exhibit A, Attachment 22, and CCM as stated in this Paragraph.

1) Contractor must operate and administer CCM in accordance with all NCQA CCM standards and requirements, and coordinate services for high and medium-rising risk Members through Contractor's CCM approach. To the extent NCQA's standards are updated, Contractor must comply with the most recent standards. Contractor must maintain and provide DHCS with policies and procedures that, at a minimum, include the following details regarding its CCM program:

a) Must be designed and implemented to help Members gain or regain optimum health or improved functional capability in the right setting;

b) Must include comprehensive assessment of the Member's condition, determination of available benefits and resources, and development and implementation of a CMP with performance goals, monitoring and follow-up;

c) Must have an opt-out approach wherein Members meeting the criteria for CCM have the right to decline to participate;

d) Must include a variety of interventions for Members that meet the differing needs of high and medium-rising risk populations, including longer-term chronic care

coordination and interventions for episodic, temporary needs; and

e) **Must incorporate disease-specific management programs, including but not limited to asthma and diabetes, that include self-management support and health education.**

2) **Contractor must assess Members for the need for Community Supports as part of its CCM program and provide Community Supports, if available and medically appropriate and cost effective.**

C. **CCM Care Manager Role**

1) **Assignment of Care Manager**

a) **Contractor must identify and assign a Care Manager for every Member receiving CCM. PCPs may be assigned as Care Managers when they are able to meet all the requirements specified in this Paragraph C.**

b) **When a Care Manager other than the Member's PCP is assigned, Contractor must provide to the Member's PCP with the identity of the Member's assigned Care Manager and a copy of the Member's CMP.**

c) **When multiple Providers perform separate aspects of Care Coordination for a Member, Contractor must:**

i. **Identify a lead Care Manager and communicate that lead to all treating Providers and the Member; and**

ii. **Maintain policies and procedures to ensure compliance and non-duplication of Medically Necessary services, and the delegation of responsibilities between Contractor and the Member's Providers in meeting all care management requirements.**

2) **Care Manager Responsibilities**

a) **Contractor is responsible for ensuring Care Managers comply with all of the Basic PHM requirements in**

Provision 8 of this Attachment, and all NCQA CCM standards.

b) Contractor must ensure that the Care Manager performs the following duties:

i. Conduct Member assessments as needed to identify and close any gaps in care and address the Member's physical, mental health, substance use disorder, developmental, oral health, dementia, palliative care, chronic disease and LTSS needs as well as needs due to SDOH;

ii. Complete a CMP for all Members receiving CCM, consistent with the Member's goals in consultation with the Member. The CMP must:

a. Address a Member's health and social needs, including needs due to SDOH;

b. Be reviewed and updated at least annually, upon a change in Member's condition or level of care, or upon request of the Member;

c. Be in an electronic format and a part of the Member's Medical Record, and document all of the Member's services and treating Providers;

d. Be developed using a person-centered planning process that includes identifying, educating and training the Member's parents, family members, legal guardians, authorized representatives, caregivers, or authorized support persons, as needed; and

e. Include referrals to community-based social services and other resources even if they

are not Covered Services under this Contract.

iii. Ensure continuous information sharing and communication with the Member and their treating Providers; and

iv. Specify the responsibility of each Provider that provides services to the Member.

c) Ensure Members receive all Medically Necessary services, including Community Supports, to close any gaps in care and address the Member's mental health, substance use disorder, developmental, physical, oral health, dementia, and palliative care needs, as well as needs due to SDOH;

d) Support and assist the Member in accessing all needed services and resources, including across the physical and behavioral health delivery systems;

e) Communicate to Members' parents, family members, legal guardians, authorized representatives, caregivers, or authorized support persons all Care Coordination provided to Members, as appropriate;

f) Refer to Community Health Workers (CHWs), peer counselors, and other community-based social services including, but not limited to, personal care services, LTSS, Community Supports, and local community organizations;

g) Assess the Member's understanding of the referral instructions and follow-up to determine whether the referral instructions were completed or whether the

Member needs further assistance to access the services, and if so, provide such assistance;

h) Review and/or modification of Member's CMP, when applicable, to address unmet service needs;

i) Facilitate and encourage the Member's adherence to recommended interventions and treatment; and

j) Ensure timely authorization of services to meet the Member's needs in accordance with the Member's CMP.

8. Basic Population Health Management (PHM)

A. Contractor must provide Basic PHM to all Members, in accordance with 42 CFR section 438.208. Contractor must maintain policies and procedures that, at a minimum, meet the following Basic PHM requirements:

1) Ensure that each Member has an ongoing source of care that is appropriate, ongoing and timely to meet the Member's needs;

2) Ensure Members have access to needed services including Care Coordination, navigation and referrals to services that address Members' developmental, physical, mental health, SUD, dementia, LTSS, palliative care, and oral health needs;

3) Ensure that each Member is engaged with their assigned PCP and that the Member's assigned PCP plays a key role in the Care Coordination functions described in this Subsection, in partnership with the Contractor;

4) Ensure that each Member receives all needed preventive services in partnership with the Member's PCP;

5) Ensure efficient Care Coordination and continuity of care for Members who may need or are receiving services and/or programs from Out-of-Network Providers;

6) Review Member utilization reports to identify Members not using Primary Care; stratify such reports, at minimum, by race and ethnicity to identify Health Disparities that result from

differences in utilization of outpatient and preventive services; and develop strategies to address differences in utilization;

7) Facilitate access to care for Members by, at a minimum, helping to make appointments, arranging transportation, ensuring Member health education on the importance of Primary Care for Members who have not had any contact with their assigned Medical Home/PCP or have not been seen within the last 12 months, particularly Members less than 21 years of age;

8) Ensure all services are delivered in a culturally and linguistically competent manner in alignment with NCLAS standards that promotes health equity for all Members;

9) Coordinate health and social services between settings of care, across other Medi-Cal Managed Care Health Plans, delivery systems, and programs such asTargeted Case Management and SMHS, with external entities outside of Contractor's Network, and with Community Supports and other community-based resources, even if they are not Covered Services under this Contract, to address Members' needs and to mitigate impacts of SDOH;

10) Assist Members, Members' parents, family members, legal guardians, authorized representatives, caregivers, or authorized support persons with navigating health delivery systems, including Contractor's Subcontractor and sub-Subcontractor Networks, to access Covered Services as well as services not covered under this Contract.

11) Provide Members with resources to address the progression of disease or disability, and improve behavioral, developmental, physical, and oral health outcomes;

12) Communicate to Members' parents, family members, legal guardians, authorized representatives, caregivers, or authorized support persons all Care Coordination provided to Members, as appropriate;

13) Ensure that Providers furnishing services to Members maintain and share, as appropriate, Members' Medical

Records in accordance with professional standards and state and federal law;

14) Facilitate exchange of necessary Member information in accordance with any and all state and federal privacy laws and regulations, specifically pursuant to 45 CFR parts 160 and 164 subparts A and E, to the extent applicable;

15) Maintain processes to ensure no duplication of services occurs; and

16) Provide evidence-based disease management programs in line with NCQA requirements and DHCS Comprehensive Quality Strategy (CQS) Bold Goals, including, but not limited to, programs for diabetes, cardiovascular disease, asthma, and depression that incorporate health education interventions, target members for engagement, and seek to close care gaps for Members participating in these programs.

B. Wellness and Prevention Programs

Contractor must provide comprehensive wellness and prevention programs to all Members and in accordance with DHCS guidance.

1) Contractor must provide wellness and prevention programs that meet NCQA PHM standards, including for the provision of evidence-based self-management tools;

2) Contractor must ensure that the wellness and prevention programs align with the DHCS Comprehensive Quality Strategy;

C. Contractor must provide wellness and prevention programs in a manner specified by DHCS, and in collaboration with LGAs as appropriate, that include the following, at a minimum:

1) Identification of specific, proactive wellness initiatives and programs that address Member needs as identified in the PNA;

2) Initiatives, programs and evidence-based approaches to improving access to preventative health visits, developmental screenings and services for Members less than 21 years of

age, as described in Exhibit A, Attachment 10, Provision 4, Services for Members Under 21 Years of Age;

3) Initiatives, programs and evidence-based approaches on improving pregnancy outcomes for women, including through 12 months post-partum;

4) Initiatives, programs and evidence-based approaches on ensuring adults have access to preventive care, as described in Exhibit A, Attachment 10, Provision 5, Services for Adults, and in compliance with all applicable State and federal laws;

5) A process for monitoring the provision of wellness and preventive services by PCPs as part of Contractor's Site Review process, as described in Exhibit A, Attachment 4, Provision 10, Site Review;

6) Health education materials, in a manner that meets Members' health education and cultural and linguistic needs, in accordance with Exhibit A, Attachment 10, Provision 7, Services for All Members, and in alignment with NCLAs standards; and

7) Initiatives and programs that implement evidence-based best practices that are aimed at helping Members set and achieve wellness goals.

8) Special preventive services as required by EPSDT, in accordance with Exhibit A, Attachment 10, Provision 4, Services for Members Under 21 Years of Age.

D. Contractor must ensure that its wellness and prevention programs are submitted to DHCS for review and approval in a form and method prescribed by DHCS.

E. Contract must report annually through the PHMS on how community-specific information and stakeholder input from the PNA

is used to design and implement evidence-based wellness and prevention strategies.

9. Other Population Health Requirements for Children

For Members who are less than 21 years of age, Contractor must provide as part of care management and Basic PHM the following services for children:

A. EPSDT Case Management Responsibilities

1) Contractor must provide case management to assist Members under 21 years of age in gaining access to all Medically Necessary medical, behavioral health, dental, social, educational serves, and other services, as defined in 42 USC sections 1396d(a), 1396d(r), and1396n(g)(2), and W & I Code section 14059.5(b). Case management services for Members under 21 years of age also includes the data exchange necessary for the provision of services as well as the coordination of non-covered services such as social support services.

2) Contractor must also provide EPSDT case management services as Medically Necessary for Members less than 21 years of age, as required in Exhibit A, Attachment 10, Provision 4, Services for Members Under 21 Years of Age, and must ensure that all Medically Necessary services for Members under 21 years of age are initiated within timely access standards whether or not the services are Covered Services under this Contract.

B. Children with Special Health Care Needs (CSHCN)

Contractor must develop and implement policies and procedures to provide services for CSHCN. CSHCN are defined as having, or being at an increased risk for, a chronic physical, behavioral, developmental, or emotional condition, and who require health or related services of a type or amount beyond what is generally required by children. Contractor must ensure that the policies and procedures include the following information, at a minimum, to encourage CSHCN Member participation:

1) Methods for ensuring and monitoring timely access to pediatric Specialists, sub-Specialists, ancillary therapists, transportation Providers, and DME and supplies. These may

include assignment to a Specialist as a PCP, Standing Referrals, or other methods;

2) Methods for monitoring and improving the quality, health equity and appropriateness of care for CSHCN; and

3) Methods for ensuring Care Coordination with California Department of Developmental Services (DDS) and local CCS Programs, as appropriate.

C. Early Intervention Services

1) Contractor must develop and implement systems to identify Members who may be eligible to receive services from the Early Start program, and refer them to the local Early Start program. These Members include those with a condition known to lead to a developmental delay, those in whom a developmental delay is suspected, or whose early health history places them at risk for delay. Contractor must collaborate with the local regional center or local Early Start program in determining the Medically Necessary diagnostic and preventive services and treatment plans for such Members.

2) Contractor must provide case management and Care Coordination to the Member to ensure the provision of all Medically Necessary Covered Services identified in the Individualized Family Service Plan (IFSP) developed by the Early Start program, with PCP participation.

10. Transitional Care Services

A. Contractor must provide Transitional Care Services to Members transferring from one setting, or level of care, to another in accordance with 42 CFR section 438.208, other applicable federal and State laws and regulations, and DHCS guidance, including the phased implementation timeline outlined in the PHM Policy Guide. Transferring from one setting, or level of care, to another includes, but is not limited to, discharges from hospitals, institutions, acute care facilities, and SNFs to home or community-based settings, Community Supports, post-acute care facilities, or LTC settings.

B. If the Member is receiving CCM or ECM, Contractor must ensure that the Member's assigned Care Manager provides all Transitional Care Services. If the Member is not receiving CCM or ECM, the Contractor must assign a care manager who is required to ensure all transitional

care services are complete, including making appropriate referrals and ensuring no gaps in care.

C. Contractor must implement transitional care processes that meet the following requirements, at minimum:

1) Implement a standardized discharge risk assessment that is to be completed prior to discharge, to assess a Member's risk of re-institutionalization, re-hospitalization, and risk of mental health and/or substance use disorder relapse;

2) Obtain permission from Members, Members' parents, legal guardians, or authorized representatives, as appropriate, to share information with Providers to facilitate transitions, in accordance with federal and state privacy laws and regulations;

3) Ensure that medication reconciliation is conducted pre- and post-transition;

4) Refer to Community Supports and coordination with county social service agencies and waiver agencies for IHSS and other HCBS;

5) Ensure all Prior Authorizations required for the Member's discharge are processed within timeframes consistent with the urgency of the Member's condition, not to exceed five (5) Working Days for routine authorizations, or 72 hours for expedited authorizations, in accordance with Exhibit A, Attachment 5, Provision 3, Timeframes for Medical Authorization. This includes Prior Authorizations for therapy, home care, medical supplies, prescription medications for which Contractor is responsible, and DME that are processed in accordance with 42 CFR section 438.210, Health and Safety Code section 1367.01, and Exhibit A, Attachment 5, Provision 1, Utilization Management Program;

6) Ensure all Network Provider hospitals, institutions, and facilities educate their Discharge Planning staff on the services, supplies, medications, and DME needing Prior Authorization;

7) Ensure that mutually agreed upon policies and procedures for Discharge Planning and Transitional Care Services exist

between Contractor and each of its Network Provider and Out-of-Network Provider hospitals within its Service Area;

8) Prevent delayed discharges of a Member from a hospital, institution, or facility due to circumstances such as, but not limited to, Contractor authorization procedures or transitions to a lower level of care, by determining and addressing the root causes of why delays occur;

9) Ensure each Member is evaluated for all care settings appropriate to the Member's condition, needs, preferences and circumstances. Members must not be discharged to a setting that does not meet their medical and/or LTSS needs; and

10) Ensure Members with substance use disorder and mental health needs receive treatment for those conditions upon discharge.

D. Contractor must provide a Discharge Planning document to Members, Member's parents, legal guardians, or authorized representatives, as appropriate, when being discharged from a hospital, institution or facility. Contractor's Discharge Planning document must include the following information, at a minimum:

1) Pre-admission status, including living arrangements, physical and mental function, SUD needs, social support, DME uses, and other services received prior to admission;

2) Pre-discharge factors, including the Member's medical condition, physical and mental function, financial resources, and social supports at the time of discharge;

3) The hospital, institution or facility to which the Member was admitted;

4) Specific agency or home recommended by the hospital, institution or facility after the Member's discharge based upon Member needs and preferences; specific services needed after the Member's discharge; specific description of the type of placement preferred by the Member, specific description of type of placement agreed to by the Member, specific description of agency or Member's return to home agreed to by the Member, and recommended pre-discharge counseling;

5) Summary of the nature and outcome of participation of Member, Member's parents, legal guardians, or authorized

representatives in the Discharge Planning process, anticipated problems in implementing post-discharge plans, and further action contemplated by the hospital, institution or facility to be included in the Member's Medical Record;

6) Information regarding available care, services, and supports that are in the Member's community once the Member is discharged from a hospital, institution or facility, including the scheduled outpatient appointment or follow-up with the Member.

7) The name and contact information of the assigned care manager responsible for transitional care services.

E. Nursing Facility Transitions

When transitioning Members to and from SNFs, Contractor must ensure timely Member transitions that do not delay or interrupt any Medically Necessary services or care by meeting the following requirements, at a minimum:

1) Coordinate with facility discharge planners, care or case managers, or social workers to provide case management and transitional care services during all transitions;

2) Assist Members being discharged or Members' parents, legal guardians, or authorized representatives by evaluating all medical needs and care settings available including, but not limited to, discharge to a home or community setting, and referrals and coordination with IHSS, Community Supports, LTSS, and other HCBS;

3) Maintain contractual requirements for SNFs to share Minimum Data Set (MDS) Section Q, have appropriate systems to import and store MDS Section Q data and incorporate MDS Section Q data into transition assessments;

4) Ensure Member outpatient appointment(s) or other immediate follow-ups are scheduled prior to discharge;

5) Verify with facilities or at-home settings that Members arrive safely at the agreed upon care setting and have their medical needs met; and

6) Follow-up with Members, Members' parents, legal guardians, or authorized representatives, as appropriate, regarding the

new care setting to ensure compliance with transitional care services requirements.

X. Exhibit B, BUDGET DETAIL AND PAYMENT PROVISIONS, is amended to read:

16. Special Contract Provisions Related to Payment

A. Contractor must reimburse Network Providers pursuant to the terms of each applicable Directed Payment Initiative established in accordance with 42 CFR section 438.6(c), in a form and manner specified by DHCS through APLs or other technical guidance. For applicable Rating Periods, DHCS shall make the terms of each Directed Payment Initiative available on the ~~DHCS website~~ **DHCS website at www.dhcs.ca.gov**.

C. Contractor must comply with the terms of any Incentive Arrangements approved by CMS under 42 CFR section 438.6(b)(2), in a form and manner specified by DHCS through APLs or other technical guidance. For applicable Rating Periods, DHCS will make the terms of each approved Incentive Arrangement available on the ~~DHCS website~~ **DHCS website at www.dhcs.ca.gov**.

D. To participate in Member direct incentive programs approved in the Public Assistance Cost Allocation Plan (PACAP) by the U.S. Department of Health and Human Services Division of Cost Allocation Services, with CMS concurrence, Contractor must comply with the terms of those programs as set forth in the PACAP in a form and manner specified by DHCS through APLs or other technical guidance. For Rating Periods in which Member direct incentive programs are effective, commencing with the Rating Period starting January 1, 2021, DHCS shall make the terms of each approved Member direct incentive program available on the ~~DHCS website~~ **DHCS website at www.dhcs.ca.gov.**

E. Contractor must comply with the terms of any Risk Sharing Mechanisms instituted in accordance with 42 CFR section 438.6(b)(1), in a form and manner specified by DHCS through APLs or other technical guidance. For applicable Rating Periods, DHCS will make the terms of each approved Risk Sharing Mechanism available on the DHCS website at www.dhcs.ca.gov.

XI. Exhibit E, Attachment 1, DEFINITIONS, is amended to read:

Dyadic Care Services means a family and caregiver-focused model of care intended to address developmental and behavioral health conditions of children as soon as they are identified.

Eligible Beneficiary means any Medi-Cal beneficiary who is residing in Contractor's Service Area with one (1) of the following aid codes:

Aid Group	Mandatory Aid Codes	Non-Mandatory Aid Codes
Adult & Family/Optional Targeted Low-Income Child	01, 02, 08, 0A, 0E, 2C, 2V, 30, 32, 33, 34, 35, 38, 39, 3A, 3C, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 47, 54, 59, 72, 7A, 7J, 7S, 7W, 81, 82, 86, 8E, 8P, 8R, 8U, K1, M3, M7, M9, P5, P7, P9, 5C, 5D, 5V, E6, E7, H1, H2, H3, H4, H5, M5, R1, T1, T2, T3, T4, T5	03, 04, 06, 07, 2P, 2R, 2S, 2T, 2U, 40, 42, 43, 45, 46, 49, 4A, 4F, 4G, 4H, 4K, 4L, 4M, 4N, 4S, 4T, 4U, 4W, 5K, 5L, 76
Adult & Family/Optional Targeted Low- Income Child (Dual)	**0A,** 0E, 2V, 30, 32, 33, 34, 35, 38, 39, **3A, 3C,** 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 47, 54, 59, **5C, 5D,** 5V, 72, 8U, 7A, 7J, **7S,** 7W, 7X, 82, 8E, 8P, 8R, **E6, E7, H1, H2, H3, H4, H5,** K1, M3, **M5,** M7, M9, P5, P7, P9, R1, **T1, T2, T3, T4, T5**	03, 04, 06, 07, 40, 42, 43, 45, 46, 49, 86, 4A, 4F, 4G, 4H, 4K, 4L, 4M, 4N, 4S, 4T, 4U, 4W, 5K, 5L
SPD	10, 14, 16, 1E, 1H 20, 24, 26, 2E, 2H, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V, L6	
Adult Expansion	L1, M1, 7U	
Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N, 0P, 0R, 0T, 0U, 0W	
Long Term Care/Full Dual	13, 23, **53,** 63	
Long Term Care/ Non-Full Dual	13, 23, **53,** 63	
SPD /Dual	10, 14, 16, 1E, 1H, 1X, 20, 24, 26, 2E, 2H, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V, 6X,	

An Eligible Beneficiary may continue to be a Member following any redetermination of Medi-Cal eligibility that determines that the individual is eligible for, and the individual thereafter enrolls in, the BCCTP.

Long-Term Care (LTC) means **specialized rehabilitative services and care** provided in a ~~s~~**S**killed ~~n~~**N**ursing ~~f~~**F**acility and subacute care services that lasts longer than ~~60 days~~ **the remainder of the month of admission plus one (1) month**.

Long-Term Services & Supports (LTSS) means services and supports designed to allow a Member with functional limitations and/or chronic illnesses the ability to live or work in the setting of the Member's choice, which may include the Member's home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting, and includes both LTC and Home and Community Based Services, and carved-in and carved-out services.

XII. All rights, duties, obligations and liabilities of the parties hereto otherwise remain unchanged.

STATE OF CALIFORNIA

STANDARD AGREEMENT AMENDMENT

STD. 213A_DHCS (Rev. 06/16)

☒ Check here if additional pages are added: 45 Page(s)

Agreement Number	Amendment Number
04-36069	A42
Registration Number:	

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

   State Agency's Name (Also known as DHCS, CDHS, DHS or the State)

   Department of Health Care Services

   Contractor's Name (Also referred to as Contractor)

   L.A. Care Health Plan

2. The term of this Agreement is: April 1, 2005 through December 31, 2023

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:** January 1, 2023, or until approved by DGS (if DGS approval is required).

   II. **Purpose of amendment:** This amendment incorporates changes and new requirements for Population Health Management, Dyadic Care Services and the Family Therapy Benefit, Risk Sharing Mechanisms, and adds new aid codes.

   III. Certain changes made in this amendment are shown as: Text additions are displayed in **bold and underline**. Text deletions are displayed as strike through text (i.e., ~~Strike~~).

(Continued on next page)

All other terms and conditions shall remain the same.

IN WITNESS WHEREOF, this Agreement has been executed by the parties hereto.

CONTRACTOR		CALIFORNIA Department of General Services Use Only
Contractor's Name *(If other than an individual, state whether a corporation, partnership, etc.)* L.A. Care Health Plan		
By *(Authorized Signature)* ✍	Date Signed *(Do not type)*	
Printed Name and Title of Person Signing John Baackes, Chief Executive Officer		
Address 1055 West 7th Street, 10th Floor Los Angeles, CA 90017		
STATE OF CALIFORNIA		
Agency Name Department of Health Care Services		
By *(Authorized Signature)* ✍	Date Signed *(Do not type)*	
Printed Name and Title of Person Signing Michelle Retke, Chief Managed Care Operations Division		☒ Exempt per: W&I Code Section 14087.55(c)
Address 1501 Capitol Avenue, MS 4415, P.O. Box 997413 Sacramento, CA 95899-7413		

Board of Governors

MOTION SUMMARY

Date: May 4, 2023 | **Motion No.** **EXE 101.0523**

Committee: Executive | **Chairperson:** Al Ballesteros, MBA

Issue:

(a) Request to delegate authority to negotiate and execute the delegation amendments to the Plan Partner Services Agreements (PPSA) with Kaiser Foundation Health Plan, Inc. (Kaiser) (A41) and Blue Cross of California (Anthem Blue Cross) (A54).

(b) Request to ratify the execution of the delegation amendment to the PPSA with Blue Shield of California Promise Health Plan (Promise) (A48).

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

Background: The delegation standards exhibit of the PPSA is being revised to incorporate current National Committee for Quality Assurance criteria, among other revisions.

Member Impact: Members will benefit from these revised criteria.

Budget Impact: No budget impact.

Motion: **To approve and/or delegate authority to L.A. Care Chief Executive Officer, John Baackes, to negotiate and execute Amendments to Plan Partner Services Agreements between L.A. Care Health Plan and Kaiser, Anthem Blue Cross, and Promise, and to ratify any non-substantive changes to the associated Amendments which may be made or negotiated by the Chief Executive Officer and/or his designees.**

Amendment No. 4254
to
Services Agreement
between
Local Initiative Health Authority for Los Angeles County
and
Anthem Blue Cross

This Amendment No. 42 54 is effective as of July 1, 20212020, as indicated herein by and between the Local Initiative Health Authority for Los Angeles County, a local public agency operating as L.A. Care Health Plan ("Local Initiative") and ***Blue Cross of California dba Anthem Blue Cross***, a California health care service plan ("Plan").

RECITALS

WHEREAS, the State of California ("State") has, through statute, regulation, and policies, adopted a plan ("State Plan") for certain categories of Medi-Cal recipients to be enrolled in managed care plans for the provision of specified Medi-Cal benefits. Pursuant to this State Plan, the State has contracted with two health care service plans in Los Angeles County. One of these two health care service plans with which the State has a contract ("Medi-Cal Agreement") is a health care service plan locally created and designated by the County's Board of Supervisors for, among other purposes, the preservation of traditional and safety net providers in the Medi-Cal managed care environment ("Local Initiative"). The other health care service plan is an existing HMO which is selected by the State (the "Commercial Plan");

WHEREAS, the Local Initiative is licensed by the Department of Managed Health Care as a health care service plan under the California Knox-Keene Act (Health and Safety Code Sections 1340 *et seq*.) (the "Knox-Keene Act");

WHEREAS, Plan is duly licensed as a prepaid full service health care service plan under the Knox-Keene Act and is qualified and experienced in providing and arranging for health care services for Medi-Cal beneficiaries; and

WHEREAS, Local Initiative and Plan have entered into a prior agreement dated October 1, 2009, as amended ("Agreement"), for Plan to provide and arrange for the provision of health care services for Local Initiative enrollees as part of a coordinated, culturally and linguistically sensitive health care delivery program in accordance with the Medi-Cal Agreement and all applicable federal and state laws.

NOW, THEREFORE, in consideration of the foregoing and the terms and conditions set forth herein, the parties agree to amend the Agreement as follows:

IN WITNESS WHEREOF, the parties have entered into this Amendment No. 42 54 as of the date set forth below.

Local Initiative Health Authority for Los Angeles County operating as
L.A. Care Health Plan (Local Initiative)
A local public agency

By: ______________________________
John Baackes
Chief Executive Officer

Date: ___________________, 20232

By: ______________________________
Hector De La TorreAlvaro Ballesteros
Chairperson
L.A. Care Board of Governors

Date: ___________________, 20232

Blue Cross of California dba Anthem Blue Cross
A California health care services plan

By: ______________________________
Les Ybarra
President
Medicaid Health Plan for California

Date: ______________________, 20232

I. Exhibit 8 – Delegation Agreement, shall be revised as follows:

Exhibit 8
Delegation Agreement
[Attachment A]

Delegated Activities
Responsibilities of Plan and Local Initiative

The purpose of the following grid is to specify the activities delegated by Local Initiative ("L.A. Care") to Anthem Blue Cross (individually and collectively "Plan" and/or "Delegate") under the Delegation Agreement with respect to: (i) quality management and improvement, (ii) population health management, (iii) network management, (iv) utilization management, (v) credentialing and re-credentialing, (vi) member experience, and (vii) claims recovery, and (viii) claims processing.~~.~~ All Delegated Activities are to be performed in accordance with currently applicable NCQA accreditation standards and implementation timelines set and required by NCQA and State and Federal regulatory requirements, as modified from time to time. Anthem Blue Cross agrees to be accountable for all responsibilities delegated by L.A. Care and will not further delegate (sub-delegate) any such responsibilities without prior written approval by L.A. Care, except as outlined in the Delegation Agreement. Anthem is responsible for sub-delegation oversight of any sub-delegated activities. Anthem Blue Cross will provide periodic reports to L.A. Care as described elsewhere in the Delegation Agreement. L.A. Care will oversee the delegation to Anthem Blue Cross as described elsewhere in the Services Agreement. In the event deficiencies are identified through this oversight, Anthem Blue Cross will provide a specific corrective action plan acceptable to L.A. Care. If Anthem Blue Cross does not comply with the corrective action plan within the specified time frame, L.A. Care may revoke the delegation to Anthem Blue Cross, in whole or in part, in accordance with Exhibit 5, herein. Due to the Medi-Cal Rx Transition where the pharmacy benefit will be managed by DHCS~~-~~starting January 1, 2022~~in 2021~~, standard and reporting requirements as related to Pharmacy items will no longer be required for data period beginning the transition date identified by DHCS. This would apply to all standard requirements and reports listed under "Pharmacy". The final monitoring and quarterly reporting requirement would be up to the data period until the transition date. However, while the monitoring and quarterly reporting will discontinue after the transition date, any reports required for regulatory or NCQA purposes mainly as it relates to any data up to the actual transition date would be still required upon request.L.A. Care will provide Plan Partner with the data necessary to determine member experience and clinical performance, when requested and as applicable

Standard	Delegated Activities	Retained by L.A. Care
	QUALITY IMPROVEMENT	
Program Structure and Operations Applicable L.A. Care Policies: QI-003, QI-005, QI-006, QI-007, QI-0026 (NCQA ~~2020~~ QI 1)	~~**Element A:**~~ **QI Program Structure** The organization's QI program description specifies: 1. The QI Program Structure 2. The behavioral healthcare aspects of the program 3. Involvement of a designated physician in the QI program 4. Involvement of a behavioral healthcare practitioner in the behavioral aspects of the program 5. Oversight of QI functions of the organization by the QI Committee 6. Objectives for serving a culturally and linguistically diverse membership ~~**Element B:**~~ **Annual Work Plan**	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs, including review, evaluation, and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	The organization documents and executes a QI annual work plan that reflects ongoing activities throughout the year and addresses: 1. Yearly planned QI activities and objectives. 2. Time frame for each activity's completion. 3. Staff members responsible for each activity. 4. Monitoring of previously identified issues. 5. Evaluation of the QI program. ~~Element C:~~ **Annual Evaluation** The organization conducts an annual written evaluation of the QI program that includes the following information: 1. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service 2. Trending of measures to assess performance in the quality and safety of clinical care and quality of service 3. Analysis and evaluation of the overall effectiveness of the QI program and of its progress toward influencing network-wide safe clinical practices ~~Element D:~~ **QI Committee Responsibilities** The organization's QI Committee: 1. Recommends policy decisions 2. Analyzes and evaluates the results of QI activities 3. Ensures practitioner participation in the QI program through planning, design, implementation or review 4. Identifies needed actions 5. Ensures follow-up, as appropriate **Promoting Organizational Diversity, Equity and Inclusion** The organization: 1. Promotes diversity in recruiting and hiring. 2. Offers training to employees on cultural competency, bias or inclusion.	
Health Services Contracting Applicable L.A. Care Policy: QI-007 (NCQA ~~2020~~ QI 2)	~~Element A:~~ **Practitioner Contracts** Contracts with practitioners specifically require that: 1. Practitioners cooperate with QI activities; 2. Practitioners allow the organization to use their performance data ~~Element B:~~ **Provider Contracts**	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	Contracts with ~~organization providers~~practitioners specifically require that: 1. Providers cooperate with QI activities. ~~2.~~ Providers allow the plan to use their performance data. ~~3.~~ ~~As reference by NCQA, *"Use of practitioner manual or organization's policies. The organization may use its practitioner manual or policies as evidence of performance against this element in the following circumstances.*~~ ~~*• Practitioner contracts specify that the manual or policy is an extension of the contract and that practitioners must abide by the conditions set forth in the contract and in the manual or policy.*~~ ~~*• The manual or policy includes the requirements specified in factors 1 and 2. The organization includes an addendum addressing any factors not included in the contract."*~~ ~~4.~~2.	
Continuity and Coordination of Medical Care Applicable Policy QI-0026 (NCQA ~~2020~~ QI 3)	**~~Element A:~~ Identifying Opportunities** The organization annually identifies opportunites to improve coordination of medical care by: 1. Collecting data on member movement between practitioners 2. Collecting data on member movement across settings 3. Conducting quantitative and causal analysis of data to identify improvement opportunities 4. Identifying and selecting one opportunity for improvement 5. Identifying and selecting a second opportunity for improvement 6. Identifying and selecting a third opportunity for improvement 7. Identifying and selecting a fourth opportunity for improvement **~~Element B:~~ Acting on Opportunities** The organization annually acts to improve coordination of medical care by: 1. Taking action on the first opportunity identified in Element A, factor 4. 2. Taking action on the second opportunity identified in Element A, factor 5	

Standard	Delegated Activities	Retained by L.A. Care
	3. Taking action on the third opportunity identified in Element A, factor 6 ~~Element C:~~ **Measuring Effectiveness** The organization annually measures the effectiveness of improvement actions taken for: 1. The first opportunity 2. The second opportunity 3. The third opportunity ~~Element D:~~ **Transition to Other Care** Refer to Utilization Management Delegated Activities Section	

Standard	Delegated Activities	Retained by L.A. Care
Continuity and Coordination between Medical and Behavioral Healthcare Applicable L.A. Care Policy: QI-0026 (NCQA 2020 QI 4)	**Element A: Data Collection** The organization annually collects data about opportunities for collaboration between medical care and behavioral healthcare in the following areas: 1. Exchange of information 2. Appropriate diagnosis, treatment and referral of behavioral healthcare disorders commonly seen in primary care 3. Appropriate use of psychotropic medications 4. Management of treatment access and follow-up for members with coexisting medical and behavioral disorders 5. Primary or secondary preventive behavioral healthcare program implementation 6. Special needs of members with severe and persistent mental illness. **Element B: Collaborative Activities** The organization annually conducts activities to improve the coordination of behavioral healthcare and general medical care, including: 1. Collaborating with behavioral healthcare practitioners 2. Quantitative and causal analysis of data to identify improvement opportunities 3. Identifying and selecting one opportunity for improvement from Element A 4. Identifying and selecting a second opportunity for improvement from Element A 5. Taking collaborative action to address one identified opportunity for improvement from Element A. 6. Taking collaborative action to address a second identified opportunity for improvement from Element A. **Element C: Measuring Effectiveness** The organization annually measures the effectiveness of improvement actions taken for: 1. The first opportunity 2. The second opportunity 2.	

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Standards for Medical Record Documentation (DHCS)	Establishing medical record standards which require medical records to be maintained in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review, including: 1. Developing and distributing to practice sites: a. Policies and procedures for the confidentiality of medical records; b. Medical record documentation standards; c. Requirements for an organized medical record keeping system; ~~d.~~ Standards for the availability of medical records d.	
Sub-Delegation of QI Applicable L.A. Care Policy: QI-007 (NCQA ~~2020~~ QI 5)	**Sub-Delegation Agreement** **(LAC will ask Delegate of its sub-delegate during the annual audit)** The written sub-delegation agreement: 1. Is mutually agreed upon. 2. Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity. 3. Requires at least semiannual reporting by the sub-delegated entity to the delegate. 4. Describes the process by which the delegate evaluates the sub-delegated entity's performance. 5. Describes the process for providing member experience and clinical performance data to its delegates when requested. 6. Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **Predelegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the delegated entity evaluates sub-delegate capacity to meet NCQA requirements before sub-delegation begins. **Review of QI Program** For arrangements in effect for 12 months or longer, the delegate: 1. Annually reviews its sub-delegate's QI program. 2. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities.	~~**Element A: Delegation Agreement**~~ ~~The written delegation agreement:~~ ~~1. Is mutually agreed upon~~ ~~2. Describes the delegated activities and the responsibilities of the organization and the delegated entity~~ ~~3. Requires at least semiannual reporting by the delegated entity to the organization~~ ~~4. Describes the process by which the organization evaluates the delegated entity's performance~~ ~~5. Describes the process for providing member experience and clinical performance data to its delegates when requested.*~~ ~~6. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement~~ ~~**Element B: Predelegation Evaluation**~~ ~~For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation begins.~~ ~~**Element C: Review of QI Program**~~ ~~For arrangements in effect for 12 months or longer, the organization:~~ ~~1. Annually reviews its delegate's QI program~~ ~~2. Annually evaluates delegate performance against NCQA standards for delegated activities~~ ~~3. Semiannually evaluates regular reports, as specified in Element A~~ ~~**Element D: Opportunities for Improvement**~~

Standard	Delegated Activities	Retained by L.A. Care
	3. Semiannually evaluates regular reports, as specified in the sub-delegation agreement **Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable. ** L.A. Care will provide Plan Partner with the data necessary to determine member experience and clinical performance, when requested and as applicable. Request shall be sent to the L.A. Care business unit which maintains the data and/or L.A. Care's Plan Partner Business Unit. The request must be precise and contain sufficient details so it is clear what minimum data needs to be provided to fulfill the request. The L.A. Care business unit responsible for the requested data shall respond timely and ensure that data is sent in compliance with L.A. Care's Policies and Procedures securing PHI through applicable protections, e.g, encryption*
	POPULATION HEALTH MANAGEMENT	
PHM Strategy (NCQA 2020 PHM 1)	**Element A: Strategy Description** The strategy describes: 1. Goals and populations targeted for each of the four areas of focus 2. Programs or Services offered to members. 3. Activities that are not direct member interventions, 4. How member programs are coordinated. 5. How members are informed about available PHM programs. **Element B: Informing Members** The organization informs members eligible for programs that include interactive contact: 1. How members become eligible to participate. 2. How to use program services. 3. How to opt in or opt out of the program.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.
Population Identification (NCQA 2020 PHM 2)	**Element A: Data Integration** The organization integrates the following data to use for population health management functions: 1. Medical and Behavioral claims or encounters. 2. Pharmacy claims. 3. Laboratory results. 4. Health appraisal results. 5. Electronic health records.	

Standard	Delegated Activities	Retained by L.A. Care
	6. Health Services programs within the organization. 7. Advanced data sources. ~~Element B:~~ **Population Assessment** The organization annually: 1. Assesses the characteristics and needs, including social determinants of health, of its member population. 2. Identifies and assesses the needs of relevant member subpopulations. 3. Assesses the needs of child and adolescent members. 4. Asseses the needs of members with disabilities. 5. Assesses the needs of members with serious and persistent mental illness (SPMI). 6. Assesses the needs of of members racial or ethnic groups. ~~5.~~7. Assesses the needs of members with limited English proficiency ~~Element C:~~ **Activities and Resources** The organization annually uses the population assessment to: 1. Review and update its PHM activities to address member needs. 2. Review and update its PHM resources to address member needs. ~~2.~~3. Review and update activities or resources to address health care disparities for at least one identified population. ~~3.~~4. Review community resources for integration into program offerings to address member needs. ~~Element D:~~ **Segmentation** 1. ~~At least annually, the organization s~~Segments or stratifies its entire population into subsets for targeted intervention. 2. Assesses for racial bias in its segmentation or stratification methodology.	
Delivery System Supports (NCQA ~~2020~~ PHM 3)	~~Element A:~~ **Practitioner or Provider Support** The organization supports practitioners or providers in its network to achieve population health management goals by: 1. Sharing data. 2. Offering ~~evidence-based or~~ certified shared -decision-making aids.	~~Element B:~~ **Value-Based Payment Arrangements** The organization demonstrates that it has a value-based payment (VBP) arrangement(s) and reports the percentages of total payments tied to VBP.

Standard	Delegated Activities	Retained by L.A. Care
	3. Providing practice transformation support to primary care practitioners. 4. Providing comparative quality information on selected specialties. 5. Providing comparative pricing information for selected services. 6. One additional activity to support practitioners or providers in achieving PHM goals.	
Wellness and Prevention (NCQA ~~2020~~ PHM 4)	~~**Element A:**~~ **Frequency of Health Appraisal Completion** The organization has the capability to administer an HA annually. ~~**Element B:**~~ **Topics of Self-Management Tools** The organization offers self-management tools, derived from available evidence, that provide members with information on at least the following wellness and health promotion areas: 1. Healthy weight (BMI) maintenance. 2. Smoking and tobacco cessation. 3. Encouraging physical activity. 4. Healthy eating 5. Managing stress. 6. Avoiding at-risk drinking. ~~7.~~ Identifying depressive symptoms. 7.	
Complex Case Management (NCQA ~~2020~~ PHM 5)	~~**Element A:**~~ **Access to Case Management** The organization has multiple avenues for members to be considered for complex case management services, including: 1. Medical management program referral 2. Discharge planner referral 3. Member or caregiver referral 4. Practitioner referral. ~~**Element B:**~~ **Case Management Systems** The organization uses case management systems that support: 1. Evidence-based clinical guidelines or algorithms to conduct assessment and management; 2. Automatic documentation of staff ID, and the date and time of action on the case or when interaction with the member occurred; 3. Automated prompts for follow-up as required by the case management plan. ~~**Element C:**~~ **Case Management Process** The organization's complex case management procedures address the following:	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	1. Initial assessment of member health status, including condition-specific issues. 2. Documentation of clinical history, including medications. 3. Initial assessment of activities of daily living. 4. Initial assessment of behavioral health status, including cognitive functions. 5. Initial assessment of social determinants of health. 6. Initial assessment of life-planning activities. 7. Evaluation of cultural and linguistic needs, preferences or limitations. 8. Evaluation of visual and hearing needs, preferences or limitations. 9. Evaluation of caregiver resources and involvement. 10. Evaluation of available benefits. 11. Evaluation of community resources. 12. Development of an individualized case management plan, including prioritized goals that considers the member and caregiver goals, preferences and desired level of involvement in the case management plan. 13. Identification of barriers to the member meeting goals or complying. with the case management plan 14. Facilitation of member referrals to resources and follow-up process to determine whether members act on referrals. 15. Development of a schedule for follow-up and communication with members. 16. Development and communication of a member self-management plan. 17. A process to assess member progress against the case management plan. ~~Element D:~~ **Initial Assessment** An NCQA review of a sample of the organization's complex case mangagement files demonstrates that the organization follows its documented processes for: 1. Initial assessment of members' health status, including condition-specific issues. 2. Documentation of clinical history, including medications.	

Standard	Delegated Activities	Retained by L.A. Care
	3. Initial assessment of activities of daily living (ADL). 4. Initial assessment of behavioral health status, including cognitive functions. 5. Initial assessment of social determinants of health. 6. Evaluation of cultural and linguistic needs, preferences or limitations. 7. Evaluation of visual and hearing needs, preferences or limitations. 8. Evaluation of caregiver resources and involvement. 9. Evaluation of available benefits 10. Evaluation of available community resources. 11. Assessment of life planning activities. ~~Element E:~~ **Case Management: Ongoing Management** NCQA's review of a sample of the organization's complex case management files demonstrates that the organization follows its documented process for: 1. Development of case management plans that includeg prioritized goals, that take into account member and caregiver goals, preferences and desired level of involvement in the complex case management program 2. Identification of barriers to meeting goals and complying with the case management plan 3. Development of a schedule for follow-up and communication with members. 4. Development and communication of member self-management plans. ~~5.~~ Assessment of progress against case management plans and goals, and modification as needed. 5.	
Population Health Management Impact (NCQA ~~2020~~ PHM 6)	~~Element A:~~ **Measuring Effectiveness** At least annually, the organization conducts a comprehensive analysis of the impact of its PHM strategy that includes the following: 1. Quantitative results for relevant clinical, cost/utilization and experience measures. 2. Comparison of results with a benchmark or goal. 3. Interpretation of results. ~~Element B:~~ **Improvement and Action**	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	The organization uses results from the PHM impact analysis to annually: ~~1.~~7. Identify opportunities for improvement. ~~2.~~8. Act on one opportunity for improvement.	
Sub-Delegation of PHM (NCQA ~~2020~~ PHM 7)	**Sub-Delegation Agreement** **(LAC will ask Delegate of its sub-delegate during the annual audit)** The written sub-delegation agreement: 1. Is mutually agreed upon 2. Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity 3. Requires at least semiannual reporting by the sub-delegated entity to the delegate 4. Describes the process by which the delegate evaluates the sub-delegated entity's performance 5. Describes the process for providing member experience and clinical performance data to its delegates when requested. 6. Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **Predelegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the delegated entity evaluates sub-delegate capacity to meet NCQA requirements before sub-delegation begins. **Review of PHM Program** For arrangements in effect for 12 months or longer, the delegate: 1. Annually reviews its sub-delegate's PHM program 2. Annually audits complex case management files against NCQA standards for each year that sub-delegation has been in effect, if applicable 3. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities 4. Semiannually evaluates regular reports, as specified in the sub-delegation agreement **Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-	~~**Element A: Delegation Agreement**~~ ~~The written delegation agreement:~~ ~~1. Is mutually agreed upon~~ ~~2. Describes the delegated activities and the responsibilities of the organization and the delegated entity~~ ~~3. Requires at least semiannual reporting by the delegated entity to the organization~~ ~~4. Describes the process by which the organization evaluates the delegated entity's performance~~ ~~5. Describes the process for providing member experience and clinical performance data to its delegates when requested*~~ ~~6. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement~~ ~~**Element B: Predelegation Evaluation**~~ ~~For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation begins.~~ ~~**Element C: Review of PHM Program**~~ ~~For arrangements in effect for 12 months or longer, the organization:~~ ~~1. Annually reviews its delegate's PHM program~~ ~~2. Annually audits complex case management files against NCQA standards for each year that delegation has been in effect, if applicable~~ ~~3. Annually evaluates delegate performance against NCQA standards for delegated activities~~ ~~4. Semiannually evaluates regular reports, as specified in Element A~~ ~~**Element D: Opportunities for Improvement**~~ ~~For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable.~~ ~~** L.A. Care will provide Plan Partner with the data necessary to determine member experience and clinical performance, when requested and as applicable. Request shall be sent to the L.A. Care business unit which maintains the data and/or L.A.*~~

Standard	Delegated Activities	Retained by L.A. Care
	delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	~~Care's Plan Partner Business Unit. The request must be precise and contain sufficient details so it is clear what minimum data needs to be provided to fulfill the request. The L.A. Care business unit responsible for the requested data shall respond timely and ensure that data is sent in compliance with L.A. Care's Policies and Procedures securing PHI through applicable protections, e.g, encryption~~
	NETWORK MANAGEMENT	
Availability of Practitioners (NCQA ~~2020~~ NET 1)	**~~Element A:~~ Cultural Needs and Preferences** The organization: 1. Assesses the cultural, ethnic, racial and linguistic needs of its members. 2. Adjusts the availability of practitioners within its network, if necessary. **~~Element B:~~ Practitioners Providing Primary Care** To evaluate the availability of practitioners who provide primary care services, including general medicine or family practice, internal medicine, and pediatrics, the organization: 1. Establishes measurable standards for the number of each type of practitioners providing primary care. 2. Establishes measurable standards for the geographic distribution of each type of practitioner providing primary care. 3. Annually analyzes performance against the standards for the number of each type of practitioner providing primary care. 4. Annually analyzes performance against the standards for the geographic distribution of each type of practitioner providing primary care. **~~Element C:~~ Practitioners Providing Specialty Care** To evaluate the availability of specialists in its delivery system, the organization: 1. Defines the type of high volume and high-impact specialists 2. Establishes measurable standards for the number of each type of high volume specialists	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	3. Establishes measurable standards for the geographic distribution of each type of high-volume specialists 4. Establish measureable standards for the geographic distribution of each type of high-impact specialist 5. Analyzes its performance against the established standards at least annually **~~Element D:~~ Practitioners Providing Behavioral Healthcare** To evaluate the availability of high-volume behavioral healthcare practitioners in its delivery system, the organization: 1. Defines the types of high volume behavioral healthcare practitioners 2. Establishes measurable standards for the number of each type of high volume behavioral healthcare practitioner 3. Establishes measurable standards for the geographic distribution of each type of high-volume behavioral healthcare practitioner 4. Analyzes performance against the standards annually	
Accessibility of Services (NCQA ~~2020~~ NET 2)	**~~Element A:~~ Access to Primary Care** Using valid methodology, the organization collects and performs an annual analysis of data to measure its performance against its standards for access to: 1. Regular and routine care appointments; 2. Urgent care appointments; 3. After-hours care **~~Element B:~~ Access to Behavioral Healthcare** Using valid methodology, the organization annually collects and analyzes data to evaluate access to appointments for behavioral healthcare for: 1. Care for a non-life-threatening emergency within 6 hours. 2. Urgent care within 48 hours. 3. Initial visit for routine care within 10 business days. 4. Follow-up routine care. **~~Element C:~~ Access to Specialty Care**	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	Using valid methodology, the organization annually collects and analyzes data to evaluate access to appointments for: 1. High-volume specialty care 2. High-impact specialty care	
Assessment of Network Adequacy (NCQA ~~2020~~ NET 3)	~~Element A:~~ **Assessment of Member Experience Accessing the Network** The organization annually identifies gaps in networks specific to geographic areas or types of practitioners or providers by: 1. Using analysis results related to member experience with network adequacy for nonbehavioral healthcare services from ME 7, Element C and Element D 2. Using analysis results related to member experience with network adequacy for behavioral healthcare services from Behavioral Healthcare and Services.ME 7, Element E 3. Compiling and analyzing requests for and utilization of out-of-network services 4. Compiling and analyzing behavioral healthcare requests for and utilization of out-of-network services. ~~Element B:~~ **Opportunities to Improve Access to Nonbehavioral Healthcare Services** The organization annually: 1. Prioritizes opportunities for improvement identified from analyses of availability (NET 1, Elements B and C), accessibility,(NET 2, Elements A and C), and member experience accessing the network (NET 3, Element A, factors 1 and 3) 2. Implements interventions on at least one opportunity, if applicable. 3. Measures the effectiveness of interventions if applicable. ~~Element C:~~ **Opportunities to Improve Access to Behavioral Healthcare Services** The organization annually: ~~1.~~ Prioritizes opportunities for improvement ~~opportunities~~ identified from analyses of availability(NET 1, Element D), accessibility (NET 2, Element B), and member experience accessing the network (NET 3, Elements A and D, factor 2 and 4)	

Standard	Delegated Activities	Retained by L.A. Care
	1. Implements interventions on at least one opportunity, if applicable. 2. Measures the effectiveness of the interventions, if applicable.	
Continued Access to Care (NCQA ~~2020~~ NET 4)	**~~Element A:~~ Notification of Termination** Refer to Utilization Management Delegated Activities Section. The organization notifies members affected by the termination of a practitioner or practice group in general, family or internal medicine or pediatrics, at least 30 calendar days prior to the effective terminaton date, and helps them select a new practitioner. **~~Element B:~~ Continued Access to Practitioners** Refer to Utilization Management Delegated Activities Section If a practitioner's contract is discontinued, the organization allows affected member continued access to the practitioner, as follows: 1. Continuation of treatment through the current period of active treatment, or up to 90 calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition. 2. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy. *~~L. A. Care combined NCQA Standard NET 4, Continued Access to Care, Element A and B under NCQA Standard, QI 3 Element D, Coordination of Medical Care.~~*	
Physician and Hospital Directories (NCQA ~~2020~~ NET 5)	**~~Element A:~~ Physician Directory Data** The organization has a web-based physician directory that includes the following physician information: 1. Name. 2. Gender. 3. Specialty. 4. Hospital affiliations. 5. Medical group affiliations. 6. Board certification. 7. Accepting new patients. 8. Language spoken by the physician or clinical staff. 9. Office locations and phone numbers.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	~~Element B:~~ Physician Directory Updates The organization updates its web-based physician directory within 30 calendar days of receiving new information from the network physician. **~~Element C:~~ Assessment of Physician Directory Accuracy** Using valid methodology, the organization performs an annual evaluation of its physician directories for: 1. Accuracy of office locations and phone numbers. 2. Accuracy of hospital affiliations. 3. Accuracy of accepting new patients. 4. Awareness of physician office staff of physician's participation in the organization's networks. **~~Element D:~~ Identifying and Acting on Opportunities** ~~1.~~ Based on results of the analysis performed in Element C, at least annually, the organization: ~~2.~~1. ~~3.~~ Identifies opportunities to improve the accuracy of the information in its physician directories. 2. ~~4.~~3. Takes action to improve the accuracy of the information in its physician directories. **~~Element E:~~ Searchable Physician Web-Based Directory** The organization's web-based physician directory includes search functions with instructions for finding the following physician information: 1. Name. 2. Gender. 3. Specialty. 4. Hospital affiliations. 5. Medical group affiliations. 6. Accepting new patients. 7. Languages spoken by the physician or clinical staff. 8. Office locations. **~~Element F:~~ Hospital Directory Data**	

Standard	Delegated Activities	Retained by L.A. Care
	The organization has a web-based hospital directory that includes the following information: 1. Hospital name. 2. Hospital location and phone number. 3. Hospital accreditation status. 4. Hospital quality data from recognized sources. ~~**Element G:**~~ **Hospital Directory Updates** The organization updates its web-based hospital directory information within 30 calendar days of receiving new information from the hospital. ~~**Element H:**~~ **Searchable Hospital Web-Based Directory** The organization's web-based directory includes search functions for specific data types and instructions for searching for the following information: 1. Hospital name. 2. Hospital location. ~~**Element I:**~~ **Usability Testing** The organization evaluates its web-based physician and hospital directories for understandability and usefulness to members and prospective members at least every three years, and considers the following: 1. Reading level. 2. Intuitive content organization, 3. Ease of navigation. 4. Directories in additional languages, if applicable to the membership. ~~**Element J:**~~ **Availability of Directories** The organization makes web-based physician and hospital directory information available to members and prospective members through alternative media, including: 1. Print. 2. Telephone.	
Sub-Delegation of NET (NCQA ~~2020~~ NET 6)	**Sub-Delegation Agreement** The written sub-delegation agreement: 1. Is mutually agreed upon 2. Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity 3. Requires at least semiannual reporting by the sub-delegated entity to the delegate	~~**Element A: Delegation Agreement**~~ ~~The written delegation agreement:~~ ~~1. Is mutually agreed upon~~ ~~2. Describes the delegated activities and the responsibilities of the organization and the delegated entity~~ ~~3. Requires at least semiannual reporting by the delegated entity to the organization~~

Standard	Delegated Activities	Retained by L.A. Care
	4. Describes the process by which the delegate evaluates the sub-delegated entity's performance 5. Describes the process for providing member experience and clinical performance data to its delegates when requested. 6. Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **Predelegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the organization evaluated sub-delegate capacity to meet NCQA requirements before sub-delegation begins. **Review of Sub-Delegated Activities** For arrangements in effect for 12 months or longer, the delegate: 1. Annually reviews its sub-delegate's network management procedures 2. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities 3. Semiannually evaluates regular reports, as specified in the sub-delegation agreement **Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	4. Describes the process by which the organization evaluates the delegated entity's performance 5. Describes the process for providing member experience and clinical performance data to its delegates when requested * 6. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement **Element B: Predelegation Evaluation** For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began. **Element C: Review of Delegated Activities** For arrangements in effect for 12 months or longer, the organization: 1. Annually reviews its delegate's network management procedures 2. Annually evaluates delegate performance against NCQA standards for delegated activities 3. Semiannually evaluates regular reports, as specified in Element A **Element D: Opportunities for Improvement** For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable. ** L.A. Care will provide Plan Partner with the data necessary to determine member experience and clinical performance, when requested and as applicable. Request shall be sent to the L.A. Care business unit which maintains the data and/or L.A. Care's Plan Partner Business Unit. The request must be precise and contain sufficient details so it is clear what minimum data needs to be provided to fulfill the request. The L.A. Care business unit responsible for the requested data shall respond timely and ensure that data is sent in compliance with L.A. Care's Policies and Procedures securing PHI through applicable protections, e.g, encryption*
UTILIZATION MANAGEMENT		
	UTILIZATION MANAGEMENT	
Continued Access to Care (NCQA NET 4) and Continuity and Coordination of Medical Care	**NET 4 Element A: Notification of Termination** The organization notifies members affected by the termination of a practitioner or practice group in general, family and internal medicine or pediatrics, at least thirty (30) calendar days	

Standard	Delegated Activities	Retained by L.A. Care
-(NCQA Net 4 and QI 3)	prior to the effective termination date and helps them select a new practitioner. ~~NET 4 Element B:~~ **Continued Access to Practitioners** If a practitioner's contract is discontinued, the organization allows affected members continued access to the practitioner, as follows: 1. Continuation of treatment through the current period of active treatment, or for up to 90 calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition. 2. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy. ~~QI 3 Element D:~~ **Transition to Other Care** The organization helps with members' transition to other care when their benefit ends, if necessary]	
Program Structure (NCQA ~~2020~~ UM 1)	~~Element A:~~ **Written Program Description** The organization's UM program description includes the following: 1. A written description of the program structure. 2. The behavioral healthcare aspects of the program. 3. Involvement of a designated senior-level physician in UM program implementation. 4. Involvement of a designated behavioral healthcare practitioner in the implementation of the behavioral healthcare aspects of the UM program. 5. The program scope and processes to determine benefit coverage and medical necessity. 6. Information sources used to determine benefit coverage and medical necessity. ~~Element B:~~ **Annual Evaluation** The organization annually evaluates and updates the UM Program, as necessary.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.
Clinical Criteria for UM Decisions (NCQA ~~2020~~ UM 2)	~~Element A:~~ **UM Criteria** The organization: 1. Has written UM decision-making criteria that are objective and based on medical evidence. 2. Has written policies for applying the criteria based on individual needs.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	3. Has written policies for applying the criteria based on an assessment of the local delivery system. 4. Involves appropriate practitioners in developing, adopting and reviewing criteria. 5. Annually reviews the UM criteria and the procedures for applying them, and updates the criteria when appropriate. ~~Element B:~~ **Availability of Criteria** The organization: 1. States in writing how practitioners can obtain the UM criteria. ~~2.~~ Makes the criteria available to its practitioners upon request. 2. ~~Element C:~~ **Consistency in Applying Criteria** At least annually, the organization: 1. Evaluates the consistency with which health care professionals involved in UM apply criteria in decision making 2. Acts on opportunities to improve consistency, if applicable.	
Communication Services (NCQA ~~2020~~ UM 3)	~~Element A:~~ **Access to Staff** The organization provides the following communication services for members and practitioners: 1. Staff are available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues. 2. Staff can receive inbound communication regarding UM issues after normal business hours. 3. Staff are identified by name, title, and organization name when initiating or returning calls regarding UM issues. 4. TDD/TTY services for members who need them. 5. Language assistance for members to discuss UM issues.	
Appropriate Professionals (NCQA ~~2020~~ UM 4)	~~Element A:~~ **Licensed Health Professionals** The organization has written procedures: 1. Requiring appropriately licensed professionals to supervise all medical necessity decisions 2. Specifying the type of personnel responsible for each level of UM decision-making. ~~Element B:~~ **Use of Practitioners for UM Decisions**	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	The organization has a written job description with qualifications for practitioners who review denials of care based on medical necessity. Practitioners are required to have: 1. Education, training,or professional experience in medical or clinical practice 2. A current clinical license to practice or an administrative license to review UM cases. ~~Element C:~~ **Practitioner Review of Nonbehavioral Healthcare Denials** The organization uses a physician or other healthcare professional as appropriate, to review any non-behavioral healthcare denial based on medical necessity. ~~Element D:~~ **Practitioner Review of Behavioral Healthcare Denials** The organization uses a physician or appropriate behavioral healthcare practitioner, as appropriate, to review any behavioral healthcare denial of care based on medical necessity. ~~Element E:~~ **Practitioner Review of Pharmacy Denials** The organization uses a physician or pharmacist to review pharmacy denials based on medical necessity. ~~Element F:~~ **Use of Board-Certified Consultants** The organization: 1. Has written procedures for using board certified consultants to assist in making medical necessity determinations. ~~2.~~ Provides evidence that it uses board-certified consultants are used for medical necessity determinations. 2.	
Timeliness of UM Decisions (NCQA ~~2020~~ UM 5)	~~Element A:~~ **Notification of Nonbehavioral Decisions** The organization adheres to the following time frames for notification of non-behavioral healthcare UM decisions: 1. N/A Marketplace 2. For Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners ~~and members~~ within 72 hours of the request. 3. For Medicaid urgent preservice decisions, the organization gives electronic or written notification of	

Standard	Delegated Activities	Retained by L.A. Care
	the decision to members and practitioners ~~and members~~ within 72 hours of the request. 4. For non-urgent Medicaid preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners ~~and members~~ within 14 calendar days of the request. 5. For post-service decsions, the organization gives electronic or written notification of the decision to practitioners and members within 30 calendar days of the request. ~~5.~~6. For postservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 30 calendar days of the request. **~~Element B:~~ Notification of Behavioral Healthcare Decisions** The organization adheres to the following time frames for notification of behavioral healthcare UM decisions: 1. N/A (Marketplace) 2. For Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to practitioners and members within 72 hours of the request. 3. For urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners ~~and members~~ within 72 hours of the request. 4. For Medicaid non-urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners ~~and members~~ within 14 calendar days of the request. 5. For Medicaid postservice decisions, the organization gives electronic or written notification of the decision to members and practitioners ~~and members~~ within 30 calendar days of the request. **~~Element C: Notification of Pharmacy Decisions~~**	

Standard	Delegated Activities	Retained by L.A. Care
	~~The organization adheres to the following time frames for notifying members and practitioners of pharmacy UM decisions:~~ ~~1. For urgent concurrent decisions, electronic or written notification of the decision to members and practitioners within 24 hours of the request.~~ ~~2. For urgent preservice decisions, electronic or written notification of the decision to members and practitioners within 72 hours of the request.~~ ~~3. For nonurgent preservice decisions, electronic or written notification of the decision to members and practitioners within 15 calendar days of the request.~~ ~~4. For postservice decisions, electronic or written notification of the decision to members and practitioners within 30 calendar days of the request.~~ **Element D: UM Timeliness Report** The organization monitors and submits a report for timeliness of: 1. Nonbehavioral UM decision making. 2. Notification of nonbehavioral UM decisions. 3. Behavioral UM decision making. 4. Notification of behavioral UM decisions. ~~4.~~ ~~5. Pharmacy UM decision making.~~ ~~6. Notification of pharmacy UM decisions.~~ ***Note: L.A. Care and Plan must adhere to the applicable standards identified in the California Health and Safety Code and DHCS Contract, all current regulatory notifications (such as APLs), as well as the most recent NCQA HP Standards*** Note: This only applies to pharmaceuticals covered under the medical benefit.	
Clinical Information (NCQA ~~2020~~ UM 6)	**~~Element A:~~ Relevant Information for Nonbehavioral Healthcare Decisions** There is documentation that the organization gathers relevant clinical information consistently to support nonbehavioral healthcare UM decision making. **~~Element B:~~ Relevant Information for Behavioral Healthcare Decisions** There is documentation that the organization gathers relevant clinical information	

Standard	Delegated Activities	Retained by L.A. Care
	consistently to support behavioral healthcare UM decision making. ~~Element C:~~ **Relevant Information for Pharmacy Decisions** The organization documents that it consistently gathers relevant information to support pharmacy UM decision making. Note: This only applies to pharmaceuticals covered under the medical benefit.	
Denial Notices (NCQA 2020 UM 7)	~~Element A:~~ **Discussing a Denial With a Reviewer** The organization gives practitioners the opportunity to discuss nonbehavioral healthcare UM denial decisions with a physician or other appropriate reviewer. ~~Element B:~~ **Written Notification of Nonbehavioral Healthcare Denials** The organization's written notification of nonbehavioral healthcare denials, provided to members and their treating practitioners, contains the following information: 1. The specific reasons for the denial, in easily understandable language. 2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based. 3. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision is based, upon request. ~~Element C~~ **Written Notification of Nonbehavioral Healthcare Notice of Appeal Rights/Process** The organization's written nonbehavioral denial notifications to members and their treating practitioners contain the following information: 1. A description of appeal rights, including the right to submit written comments, documents or other information relevant the appeal. 2. An explanation of the appeal process, including members' rights to representation and appeal time frames. 3. A description of the expedited appeal process for urgent preservice or urgent concurrent denials 4. Notification that expedited external review can occur concurrently with	

Standard	Delegated Activities	Retained by L.A. Care
	the internal appeals process for urgent care. ~~Element D:~~ **Discussing a Behavioral Healthcare Denial With a Reviewer** The organization provides practitioners with the opportunity to discuss any behavioral healthcare UM denial decision with a physician, appropriate behavioral healthcare reviewer or pharmacist reviewer ~~Element E:~~ **Written notification of Behavioral Healthcare Denials** The organization's written notification of behavioral healthcare denials, that it provided to members and their treating practitioners, contains: 1. The specific reasons for the denial, in easily understandable language 2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based 3. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision is based, upon request. **Writen Notification of**~~Element F:~~ **Behavioral Healthcare Notice of Appeal Rights/Process** The organization's written notification of behavioral healthcare denials, which it provides to members and their treating practitioners, contains the following information: 1. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal 2. An explanation of the appeal process, including the right to member representation and time frames for deciding appeals 3. A description of the expedited appeals process for urgent pre-service or urgent concurrent denials 4. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care ~~Element G:~~ **Discussing a Pharmacy Denial With a Reviewer**	

Standard	Delegated Activities	Retained by L.A. Care
	The organization gives practitioners the opportunity to discuss pharmacy UM denials decisions with a physician or pharmacist. ~~Element H:~~ **Written Notification of Pharmacy Denials** The organization's written notification of pharmacy denials to members and their treating practitioners contains the following information: 1. The specific reasons for the denial in language that is easy to understand 2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based. 3. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or similar criterion on which the denial decision was based, upon request. ~~Element I:~~ **Pharmacy Notice of Appeals Rights/Process** The organization's written notification of pharmacy denials to members and their treating practitioners contains the following information: 1. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal 2. An explanation of the appeal process, including the right to member representation and time frames for deciding appeals 3. A description of the expedited appeals process for urgent pre-service or urgent concurrent denials 4. Notification that expedited external review can occur concurrently with the internal appeal process for urgent care Note: This only applies to pharmaceutical covered under the medical benefit.	
Policies for Appeals (NCQA ~~2020~~ UM 8)	~~Element A:~~ **Internal Appeals** The organization's written policies and procedures for registering and responding to written internal appeals include the following: 1. Allowing at least 60 calendar days after notification of the denial for the member to file the appeal 2. Documenting the substance of the appeal and any actions taken	Members have the option to appeal directly to L.A. Care. Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	3. Fully investigating the substance of the appeal, including any aspects of clinical care involved 4. The opportunity for the member to submit written comments, documents or other information relating to the appeal. 5. Appointment of a new person to review the appeal, who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination 6. Appointment of at least one person to review an appeal who is a practitioner in the same or similar ~~(defined as a practitioner with similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal) or a similar (defined as a practitioner who has experience treating the same problems as those in question in the appeal, in addition to experience treating similar complications of those problems)~~ specialty. 7. The decision for a preservice appeal and notification to the member within 30 calendar days of receipt of the request. 8. The decision for a post service appeal and notification to the member within 30 calendar days of receipt of the request. 9. The decision for an expedited appeal and notification to the member within 72 hours of receipt of the request. 10. Notification to the member about further appeal rights 11. Referencing the benefit provision, guideline, protocol or other similar criterion on which the appeal decision is based. 12. Giving the member reasonable access to and copies of all documents relevant to the appeal, free of charge, upon request. 13. Including a list of titles and qualifications, including specialties, of individuals participating in the appeal review.	

Standard	Delegated Activities	Retained by L.A. Care
	14. Allowing an authorized representative to act on behalf of the member 15. Providing notices of the appeals process to members in a culturally and linguistically appropriate manner. 16. Continued coverage pending the outcome of an appeal.	
Appropriate Handling of Appeals (NCQA ~~2020~~ UM 9)	~~**Element A:**~~ **Preservice and Postservice Appeals** An NCQA review of the organization's appeal files indicates that they contain the following information: 1. Documention of the substance of appeals 2. Investigation of appeals 3. Appropriate response to the substance of the appeal. ~~**Element B:**~~ **Timeliness of the Appeal Process** Timeliness of the organization's preservice, postservice, and expedited appeal process is within the specified time frames: 1. The organization resolves preservice appeals within 30 calendar days of receipt of the request 2. The organization resolves postservice appeals within 30 calendar days of receipt of the request 3. The organization resolves expedited appeals within 72 hours of receipt of the request ~~**Element C:**~~ **Appeal Reviewers** The organization provides nonsubordinate reviewers who were not involved in the previous determination and same-or-imilar specialist review, as appropriate. ~~**Element D:**~~ **Notification of Appeal Decision/Rights** An NCQA review of the organization's internal appeal files indicates notification to members of the following: 1. Specific reasons for the appeal decision in easily understandable language 2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based 3. Notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or	Members have the option to appeal directly to L.A. Care. Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	other similar criterion on which the appeal decision was based, upon request. 4. Notification that the member is entitled to receive reasonable access to, and copies of all documents relevant to their appeal, free of charge, upon request. 5. A list of titles and qualifications, including specialties, of individuals participating in the appeal review ~~6.~~ A description of the next level of appeal within the organization or to an independent external organization, as applicable, along with relevant written procedures. 6.	
Evaluation of New Technology (NCQA ~~2020~~ UM 10)		**~~Element A:~~ Written Process** The organization's written process for evaluating new technology and the new application of existing technology for inclusion in its benefits plan includes an evaluation of the following: 1. Medical procedures. 2. Behavioral healthcare procedures. 3. Pharmaceuticals. 4. Devices This element is NA: • For Medicaid product lines if the state mandates all benefits and new technology determinations. – The organization provides the state's language. • If the organization does not determine which technologies, pharmaceuticals, devices, procedures or other services are included in benefits plans it offers to members. – For example, when these determinations are made by all purchasers of the organization's services. **Element B: Description of the Evaluation Process** This element is NA for Medicaid product lines if the state mandates all benefits and new technology determinations. The organization must produce documentation that demonstrates this. This element is NA if the organization does not determine which technologies, pharmaceuticals, devices, procedures or other services are included in benefits plans it offers to members. For example, when these determinations are made by all purchasers of the organization's services.

Standard	Delegated Activities	Retained by L.A. Care
Procedures for Pharmaceutical Management (NCQA ~~2020~~ UM 11)	**<u>Element A: Pharmaceutical Management Procedures</u>** The organization's policies and procedures for pharmaceutical management include the following: 1. The criteria used to adopt pharmaceutical management procedures 2. A process that uses clinical evidence from appropriate external organizations 3. A process to include pharmacists and appropriate practitioners in the development of procedures 4. A process to provide procedures to practitioners annually and when it makes changes. **<u>Element B: Pharmaceutical Restrictions/Preferences</u>** Annually and after updates, the organization communicatesto members and prescribing practitioners: 1. A list of pharmaceuticals including restrictions and preferences. 2. How to use the pharmaceutical management procedures 3. An explanation of limits or quotas 4. How prescribing practitioners must provide information to support an exception request 5. The organization's process for generic substitution, therapeutic interchange and step-therapy protocols. **SB1052**: Anthem shall post formulary on its Internet website and update that posting with changes on a monthly basis. **<u>Element C: Pharmaceutical Patient Safety Issues</u>** The organization's pharmaceutical procedures include: 1. Identifying and notifying members and prescribing practitioners affected by Class II recalls or voluntary drug withdrawals from the market for safety reasons within 30 calendar days of the FDA notification. 2. An expedited process for prompt identification and notification of members and prescribing practitioners affected by a Class I recall. **<u>Element D: Reviewing and Updating Procedures</u>**	

Standard	Delegated Activities	Retained by L.A. Care
	With the participation of physicians and pharmacists, the organization annually: 1. Reviews the procedures. 2. Reviews the list of pharmaceuticals. 3. Updates the procedures as appropriate. 4. Update the list of pharmaceuticals as appropriate. SB1052: Anthem shall post the formulary list with changes on its Internet website on a monthly basis. . **Element E: Considering Exceptions** Implementing policies and procedures for considering exceptions when a closed formulary is used, which include: 1. Making an exception requests based on medical necessity 2. Obtaining medical necessity information from prescribing practitioners 3. Using appropriate pharmacists and practitioners to consider exception requests 4. Timely handling of exception requests ~~5.~~ Communicating the reason for a denial and an explanation of the appeal process when it does not approve an exception request. 5.	
UM System Controls (NCQA ~~2020~~ UM 12)	**Element A: UM Denial System Controls** The organization has policies and procedures describing its system controls specific to UM denial notification dates that: 1. Define the date of receipt consistent with NCQA requirements. 2. Define the date of written notification consistent with NCQA requirements. 3. Describe the process for recording dates in systems. 4. Specify staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate. 5. Specify how the system tracks modified dates. 6. Describe system security controls in place to protect data from unauthorized modification. 7. Describe how the organization audits the processes and procedures in factors 1-6. **Element B: UM Appeal System Controls**	

Standard	Delegated Activities	Retained by L.A. Care
	The organization has policies and procedures describing its system controls specific to UM appeal dates that: 1. Define the date of receipt consistent with NCQA requirements. 2. Define the date of written notification consistent with NCQA requirements. 3. Describe the process for recording dates in systems. 4. Specify staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate. 5. Specify how the system tracks modified dates. 6. Describe system security controls in place to protect data from unauthorized modification. ~~7.~~ Describe how the organization audits the processes and procedures in factors 1-6. 7.	
Sub Delegation of UM (NCQA ~~2020~~ UM 13)		**Element A: Delegation Agreement** The written delegation agreement: 1. Is mutually agreed upon 2. Describes the delegated activities and responsibilities of organization and delegated entity 3. Requires at least semiannual reporting by the delegated entity to the organization 4. Describes the process by which the organization evaluates the delegated entity's performance 5. Describes the process for providing member experience and clinical performance data to its delegates when requested* 6. Describes the remedies available to organization . if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement. **Element B: Predelegation Evaluation** For new delegation agreements initiated in the look-back period, the delegate evaluates delegate capacity to meet NCQA requirements before delegation began. **Element C: Review of the UM Program** For arrangements in effect for 12 months or longer, the organization: 1. Annually reviews its delegate's UM program 2. Annually audits UM denials and appeals files against regulatory guidelines and NCQA standards for each year that delegation has been in effect

Standard	Delegated Activities	Retained by L.A. Care
		3. Annually evaluates delegate performance against NCQA standards for delegated activities 4. Semiannually evaluates regular reports as specified in Element A. **Element D: Opportunities for Improvement** For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years the organization identified and followed up on opportunities for improvement, if applicable. ** L.A. Care will provide Plan Partner with the data necessary to determine member experience and clinical performance, when requested and as applicable. Request shall be sent to the L.A. Care business unit which maintains the data and/or L.A. Care's Plan Partner Business Unit. The request must be precise and contain sufficient details so it is clear what minimum data needs to be provided to fulfill the request. The L.A. Care business unit responsible for the requested data shall respond timely and ensure that data is sent in compliance with L.A. Care's Policies and Procedures securing PHI through applicable protections, e.g, encryption*
	~~CREDENTIALING~~	
	CREDENTIALING	
Credentialing Policies (NCQA ~~2020~~ CR1) DHCS 6.5.4.2 DHCS APL 19-004	The organization has well-defined credentialing and recredentialing process for evaluating and selecting licensed independent practitioners to provide care to its members. **Element A: Practitioner Credentialing Guidelines** The organization specifies: 1. The types of practitioners to credential and re-credential [*State Contract 6.5.4.2: include all administrative physician reviewers responsible for making medical decisions*] 2. The verification sources it uses. 3. The criteria for credentialing and re-credentialing. 4. The process for making credentialing and recredentialing decisions. 5. The process for managing credentialing files that meet organization's established criteria. • Credentialing policies and procedures describe the process used to determine and approve files that meet criteria (i.e., clean files). The organization may present all practitioner files to the Credentialing Committee or may designate	L.A. Care retains the right based on quality issues to approve, suspend and terminate individual practitioners, providers and sites at all times. Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' credentialing activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	approval authority of clean files to the medical director or to an equally qualified practitioner. 6. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. a. Credentialing policies and procedures: ▪ State that the organization does not base credentialing decisions on an applicant's race, ethnic/national identity, gender, age, sexual orientation or patient type (e.g., Medicaid) in which the practitioner specializes. ▪ Specify the process for preventing discriminatory practices.-Preventing involves taking proactive steps to protect against discrimination occurring in the credentialing and recredentialing processes. ▪ Specify how the organization monitors the credentialing and recredentialing processes. for discriminatory practices, at least annually. – Monitoring involves tracking and identifying discrimation in credentialing and recredentialing processes. 7. The process for notifying practitioners if information obtained during the organization's credentialing process varies substantially from the information they provided to the organization. 8. The process for notifying practitioners of the credentialing and recredentialing decision within 60 calendar days of the committee's decision. 9. The medical director or other designated physician's direct responsibility and participation in the credentialing program. 10. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law. 11. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data,	

Standard	Delegated Activities	Retained by L.A. Care
	including education, training, board certification and specialty. **Element B: Practitioner Rights** The organization notifies practitioners about their right to: 1. Review information submitted to support their credentialing application. 2. Correct erroneous information. • The timeframe for making corrections. • The format for submitting corrections. • Where to submit corrections. 3. Receive the status of their credentialing or recredentialing application, upon request. **Element C: Credentialing System Controls** The organization's credentialing process describes: 1. How primary source verification information is received, dated and stored. 2. How modified information is tracked and dated from its initial verification. 3. Staff who are authorized to review, modify and delete information, and circumstances when modification or deletion is appropriate. 4. The security controls in place to protect the information from unauthorized modification. • If the organization contracts with an external entity to outsource storage of credentialing information, the contract describes how the contracted entity ensures the security of the stored information . 5. How the organization audits the processes and procedures in factors 1–4. **Medi-Cal FFS Enrollment *** Developing and implementing policies and procedures for Medi-Cal enrollment. Policy must clearly specify enrollment process including, but not limited to: 1. All practitioners that have a FFS enrollment pathway must enroll in the Medi-Cal program. 2. The process for ensuring and verifying Medi-Cal enrollment. 3. The process for practitioners whose enrollment application is in process. 4. The process for monitoring between recredentialing cycles to validate continued enrollment.	

Standard	Delegated Activities	Retained by L.A. Care
	5. Process for practitioners not currently enrolled in the Medi-Cal program. 6. Process for practitioners deactivated or suspended from the Medi-Cal program *Anthem supports this requirement under its Network Management operations.	
Credentialing Committee (NCQA ~~2020~~ CR 2)	The organization designates a Credentialing Committee that uses a peer-review process to make recommendations regarding credentialing decisions. **<u>Element A: Credentialing Committee</u>** The organization's Credentialing Committee: 1. Uses participating practitioners to provide advice and expertise for credentialing decisions. • The Credentialing Committee is a peer-review body with members from the range of practitioners participating in the organization's network. • The organization may have separate review bodies for each practitioner type (e.g., physician, oral surgeon, psychologist), specialty or multidisciplinary committee, with representation from various specialties. • If the organization is part of a regional or national organization, a regional or national Credentialing Committee that meets the criterion may serve as the peer review committee for the local organization. 2. Reviews credentials for practitioners who do not meet established thresholds. The Credentialing Committee: • Reviews the credentials of practitioners who do not meet the organization's criteria for participation in the network. • Gives thoughtful consideration to credentialing information. • Documents discussions about credentialing in meeting minutes. 3. Ensures that files meet established criteria are reviewed and approved by a medical director or designated physician. Has a process for medical director or qualified physician review and approve clean files.	

Standard	Delegated Activities	Retained by L.A. Care
Credentialing Verification (NCQA ~~2020~~ CR 3) DHCS 6.5.4.2 APL 19-004	The organization verifies credentialing information through primary sources, unless otherwise indicated. The organization conducts timely verification of information to ensure that practitioners have legal authority and relevant training and experience to provide quality care. **Element A: Verification of Credentials** The organization verifies that the following are within the prescribed time limits: 1. A current, valid license to practice. (Develop a process to ensure providers licenses are kept current at all times). 2. A valid DEA or CDS certificate and must able to dispense schedules 2 through 5 or schedules applicable to the provider's speciality. • Pending DEA certificates and practitioners who do not have schedules 2 through 5, if applicable: The organization may credential a practitioner whose DEA certificate is pending or missing schedules if it has a documented process for allowing a practitioner with a valid DEA certificate to write all prescriptions requiring a DEA number for the prescribing practitioner whose DEA is pending or missing schedules until the practitioner has a valid DEA certificate and able to dispense schedules appropriate to the practitioners specialty type. 3. Education and training as specified in the explanation. • The organization verifies the highest of the following three levels of education and training obtained by the practitioner as appropriate: Board certification • Residency • Graduation from medical or professional school. 4. Board certified status, if applicable. • The organization verifies current certification status of practitioners who state that they are board certified. The organization documents the expiration date of the board certification in the credentialing file. If a practitioner has a certification that does not expire (e.g., a lifetime certification status), the organization verifies that board certification is current and documents the date of verification. 5. Work history. The organization obtains a minimum of the most recent five years of work history as a health professional through	

Standard	Delegated Activities	Retained by L.A. Care
	the practitioner's application or CV. If the practitioner has fewer than five years of work history, the time frame starts at the initial licensure date. Gaps in work history. The organization documents its review of the practitioner's work history and any gaps on the application, CV, checklist or other identified documentation methods 6. A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner. • The organization obtains confirmation of the past five years of malpractice settlements from the malpractice carrier or queries the National Practitioner Databank (NPDB). The five-year period may include residency or fellowship years. The organization is not required to obtain confirmation from the carrier for practitioners who had a hospital insurance policy during a residency or fellowship • DHCS APL 19-004: Medi-Cal FFS enrollment. [*Anthem supports this requirement under its Network Management operations.]* • Verification of practioner enrollment of DHCS FFS. • Each MCP network provider must maintain good standing in the Medicare and Medicaid/Medi-Cal programs. Any provider terminated from the Medicare or Medicaid/Medi-Cal program may not participate in the MCP's provider network. All certifications and expiration dates must be made part of the practitioner's file and kept current. The Delegate must notify L.A. Care immediately when a practitioner's license has expired for removal from the network	
Sanction Information (NCQA ~~2020~~ CR 3) State Contract 6.5.4.2	**Element B: Sanction Information** The organization verifies the following sanction information for credentialing: 1. State sanctions, restrictions on licensure, and limitations on scope of practice. 2. Medicare and Medicaid sanctions. The Delegate must notify L.A. Care immediately when practitioners are identified on any sanctions or reports for removal from the network.	
CR Application	**Element C: Credentialing Application**	

Standard	Delegated Activities	Retained by L.A. Care
(NCQA ~~2020~~ CR 3) State Contract 6.5.4.2	Applications for credentialing include the following: 1. Reasons for inability to perform the essential functions of the position 2. Lack of present illegal drug use. 3. History of loss of license and felony convictions. 4. History of loss or limitation of privileges or disciplinary action. 5. Current malpractice insurance coverage. ~~6.~~ Current and signed attestation confirming the correctness and completeness of the application. 6.	
Re-credentialing Cycle Length (NCQA ~~2020~~ CR 4) State Contract 6.5.4.2	**Element A: Recredentialing Cycle Length** Recredentialing all practitioners at least every 36-months.	
Ongoing Monitoring and Interventions (NCQA ~~2020~~ CR 5) State Contract 6.5.4.2	The organization Develops and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identifies occurrences of poor quality. **Element A: Ongoing Monitoring and Interventions** The organization implements ongoing monitoring and makes appropriate interventions by: 1. Collecting and reviewing Medicare and Medicaid sanctions. 2. Collecting and reviewing sanctions or limitations on licensure. 3. Collecting and reviewing complaints. 4. Collecting and reviewing information fromidentified adverse events. 5. Implementing appropriate interventions when it identifies instances of poor quality related to factors 1-4. The Delegate's Credentialing committee may vote to flag a practitioner for ongoing monitoring. The Delegate must make clear the types of monitoring it imposes, the timeframe used, the intervention, and the outcome, which must be fully demonstrated in the Delegate's credentialing committee minutes.	Upon notification of any Adverse Event, L.A. Care will notify the Delegate of their responsibility with respect to delegation of credentialing/re-credentialing activity. The notification will clearly delineate what is expected from the Adverse Event that has been identified. The notice will include, but is not limited to: a. Requesting what actions will be taken by the delegate b. What type of monitoring is being performed c. What interventions are being implemented including closing panel, moving members, or removal of practitioner from the network d. The notification will include a timeframe for responding to L.A. Care to ensure L.A. Care's members receive the highest level of quality care

Standard	Delegated Activities	Retained by L.A. Care
	The Delegate's credentialing committee can: • Request a practitioner be placed on a watch list. Any list must be clearly defined and monitored. • Request that the practitioner demonstrate compliance with probation that has been imposed by the State and monitor completion. • Impose upon the practitioner to demonstrate steps they have taken to improve processes and/or chart review, if applicable. Delegated entities who fail to comply with the requested information within the specified timeframe are subject to sanctions as described in L.A. Care's policies and proceduresThe Plan will clearly delineate what is expected from the Delegate regarding the Adverse Event that has been identified. The notification may include performing the following:Requesting what action will be taken by the DelegateWhat type of monitoring is being performedWhat interventions are being implemented, including closing panel, moving members, or removal of practitioner from the networkThe notification will include a timeframe for responding to L.A. Care to ensure L.A. Care members receive the highest level of quality care. In the event that the Delegate fails to respond as required, L.A. Care will perform the oversight functions of the Adverse Event and the Delegate will be subject to L.A. Care's credentialing committee's outcome of the adverse events The Delegate must notify L.A. Care immediately when practitioners are identified on any sanctions or reports for removal from the network The above are samples, but not limited to, the steps the Delegate can take.	
Notification to Authorities and Practitioner Appeal Rights (NCQA ~~2020~~ CR 6) State Contract 6.5.4.2	The organization uses objective evidence and patient-care consideration when deciding on a course of action for dealing with a practitione who does not meet its quality standards. **Element A: Actions Against Practitioners** The organization has policies and procedures for: 1. The range of actions available to organization.	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation and annual oversight review and more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards.

Standard	Delegated Activities	Retained by L.A. Care
	• Specify that the organization reviews participation of practitioners whose conduct could adversely affect members' health or welfare. • Specify the range of actions that may be taken to improve practitioner performance before termination. • Specify that the organization reports its actions to the appropriate authorities. 2. Making the appeal process known to practitiones. Within 14 days from criminal action taken against any contracted practitioner, Delegate shall notify L.A. Care in writing.	
CR Assessment of Organizational Providers (NCQA ~~2020~~ CR 7) State Contract 6.5.4.2	**Element A: Review and Approval of Provider** The organization's policy for assessing a health care delivery provider specifies that before it contracts with a provider, and for at least every 36 months thereafter, it: 1. Confirms that the provider is in good standing with state and federal regulatory bodies. 2. Confirms that the provider has been reviewed and approved by an accrediting body. acceptable to Delegate, including which accrediting bodies are acceptable; 3. Conducts an onsite quality assessment is conducted if the provider is not accredited. by an accrediting body acceptable to Delegate, including which accredited bodies are acceptable; 4. At least every three years that the provider continues to be in good standing with state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body acceptable to Delegate; Maintaining a tracking log that includes names of the organization, type of organization, a prior validation date, a current validation date for licensure, accreditation status (if applicable), CMS or state reviews conducted within 3 years at time of verification (if applicable), CLIA certificate (if applicable), NPI number for each organizational provider. **Element B: Medical Providers**	

Standard	Delegated Activities	Retained by L.A. Care
	The Delegate includes at least the following medical providers in its assessment: 1. Hospitals. 2. Home health agencies. 3. Skilled nursing facilities. 4. Free-standing surgical centers. *Hospices. *Clinical Laboratories (A CMS issued CLIA certificate or a hospital based exemption from CLIA). *Comprehensive Rehabilitation Facilities (CORFs). *Outpatient Physical Therapy and Speech Pathology Providers. *Providers of end-stage renal disease services. *Providers of outpatient diabetes self-management training . *Portable X-Ray Suppliers. *Rural Health Clinic (RHCs). Federally Qualified Health Center (FQHCs). **Element C: Behavioral Healthcare Providers** The Delegate includes behavioral health care facilities providing mental health or substance abuse services in the following settings: 1. Inpatient. 2. Residential. 3. Ambulatory. **Element D: Assessing Medical Providers** The Delegate assesses contracted medical health care providers. **Element E: Assessing Behavioral Healthcare Providers** The Delegate assesses contracted behavioral healthcare providers.	
Sub-Delegation of CR (NCQA ~~2020~~ CR 8) State Contract 6.5.4.2	**Element A: Delegation Agreement** If the organization (Anthem) sub-delegates any NCQA required credentialing activities, there must be evidence of oversight of the delegated activities, including written sub-delegation agreement: 1. Is mutually agreed upon. 2. Describes the sub-delegated activities and the responsibilities of the organization and the delegated entity. 3. Requires at least quarterlyreporting to Delegate	L.A. Care retains the right to perform a pre-delegation audit of any entity to which the Plan sub-delegates delegated credentialing activities and approve any such sub-delegation audit of any sub-delegate. Prior to entering into an agreement to sub-delegate delegated credentialing activities, Plan shall provide L.A. Care with reasonable prior notice of Plan's intent to sub-delegate.

Standard	Delegated Activities	Retained by L.A. Care
	4. Describes the process by which Delegate evaluates Sub-delegated entity's performance. 5. Specifies that the delegate retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making. 6. Describes the remedies available to Delegate if Sub-delegate does not fulfill its obligations, including revocation of the sub-delegation agreement. Retention of the right by Delegate and L.A. Care, based on quality issues, to approve, suspend, and terminate individual practitioners, providers, and sites. **Element B: Predelegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the Delegate evaluated sub-delegate capacity to meet NCQA requirements before sub-delegation begins. **Element C: Review of Delegate's Credentialing Activities** For sub-delegation arrangements in effect for 12 months or longer, the Delegate: 1. Annually reviews its sub-delegate's credentialing policies and procedures. 2. Annually audits credentialing and recredentialing files against NCQA standards for each year that sub-delegation has been in effect. 3. Annually evaluates the Sub-delegate's performance against relevant regulatory requirements; NCQA standards and Delegate's expectations annually. 4. Evaluates regular reports from Sub-delegate at least quarterly or more frequently based on the reporting schedule described in the sub-delegation document. **Element D: Opportunities for Improvement** For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identifies and follows up on opportunities for improvement, if applicable	

Standard	Delegated Activities	Retained by L.A. Care
	If a Delegate fails to complete the corrective action plan and has gone through the exigent process which results in de-delegation, the Delegate cannot appeal and must wait one year to reapply for a pre-delegation audit. If the pre delegation audit reveals deficiencies identified that are the same as those from previous audits, delegation will be at the sole discretion of the Credentialing Committee regardless of score.	
	MEMBER EXPERIENCE	
Statement of Members' Rights and Responsibilities (NCQA 2020 ME 1)	~~Element B.~~ **Distribution of Rights Statement** The organization distributes its member rights and responsibilities statement to the following groups: 1. New members, upon enrollment. 2. Existing members, if requested. 3. New practitioners, when they join the network. 4. Existing practitioners, if requested.	~~Element A:~~ **Rights and Responsibilites Statement** The organization's member rights and responsibilities statement specifies that members have: 1. A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities 2. A right to be treated with respect and recognition of their dignity and right to privacy 3. A right to participate with practitioners in making decisions about their health care 4. A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage 5. A right to voice complaints or appeals about the organization or the care it provides 6. A right to make recommendations regarding the organization's member rights and responsibilities policy 7. A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care 8. A responsibility to follow plans and instructions for care that they have agreed to with their practitioners 9. A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goal, to the degree possible L.A. Care adheres to the most current NCQA standards to comply with these requirements.
Subscriber Information (NCQA 2020 ME 2)		**Element A: Subscriber Information** The organization provides each subscriber with the information necessary to understand benefit coverage and obtain care. **Element B: Interpreter Services** Based on linguistic need of its subscribers, the organization provides interpreter or bilingual services in its Member Services department and telephone functions.

Standard	Delegated Activities	Retained by L.A. Care
		L.A. Care adheres to the most current NCQA standards to comply with these requirements.
Marketing Information (NCQA 2020 ME 3)		**Element A: Materials and Presentations** All organizational materials and presentations accurately describe the following information: 1. Covered benefits. 2. Noncovered benefits. 3. Practitioner and provider availability. 4. Key UM procedures the organization uses. 5. Potential network, service or benefit restrictions. 6. Pharmaceutical management procedures. **Element B: Communicating with Prospective Members** The organization uses easy-to-understand language in communications to prospective members about its policies and practices regarding collection, use and disclosure of PHI: 1. In routine notification of privacy practices 2. The right to approve the release of information (use of authorizations) 3. Access to Medical Records 4. Protection of oral, written, and electronic information across the organization 5. Information for employers **Element C: Assessing Member Understanding** **The organization systematically takes the following steps:** 1. Assesses how well new members understand policies and procedures. 2. Implements procedures to maintain accuracy of marketing communication. 3. Acts on opportunities for improvement, if applicable.
Functionality of Claims Processing (NCQA 2020 ME 4)	**Element B: Functionality-Telephone Requests** Members can track the status of their claims in the claims process and obtain the following information over the telephone in one attempt or contact: 1. The stage in the process. 2. The amount approved. 3. The amount paid. 4. Member cost. 5. The date paid 5.	
Pharmacy Benefit Information (NCQA 2020 ME 5)	**Element A: Pharmacy Benefit Information-Website** Members can complete the following actions on the organization's website in one attempt or contact: 1. Determine their financial responsibility for a drug, based on the pharmacy benefit.	

Standard	Delegated Activities	Retained by L.A. Care
	2. Initiate the exceptions process 4. Find the location of an in-network pharmacy. 5. Conduct a pharmacy proximity search based on zip code. 6. Determine the availability of generic substitutes. SB1052: Anthem shall post the formulary on its internet website and update that posting on a monthly basis. **Element B: Pharmacy Benefit Information Telephone** Members can complete the following actions via telephone in one attempt or contact: 1. Determine their financial responsibility for a drug, based on the pharmacy benefit. 2. Initiate the exceptions process. 4. Find the location of an in-network pharmacy. 5. Conduct a proximity search based on zip code. 6. Determine the availability of generic substitutes. **Element C: QI Process on Accuracy of Information** The organization's quality improvement process for pharmacy benefit information: 1. Collects data on quality and accuracy of pharmacy benefit information. 2. Analyze data results. 3. Act to improve identified deficiencies. **Element D: Pharmacy Benefit Updates** The organization updates member pharmacy benefit information on its website and in materials used by telephone staff, as of the effective date of a formulary change and as new drugs are made available or are recalled.	
Personalized Information on Health Plan Services (NCQA ~~2020~~ ME 6)	**Element A: Functionality – Website** Members can complete each of the following activities on the organization's website in one attempt or contact: 1. Change a primary care practitioner, as applicable. 2. Determine how and when to obtain referrals and authorizations for specific services, as applicable **Element B: Functionality Telephone** To support financial decision making, members can complete each of the following	

Standard	Delegated Activities	Retained by L.A. Care
	activities over the telephone within one business day: 1. Determine how and when to obtain referrals and authorizations for specific services, as applicable. 2. Determine benefit and financial responsibility for a specific service or treatment from a specified provider or institution. **Element C: Quality and Accuracy of Information** At least annually, the organization must evaluate the quality and accuracy of the information it provides to its members via the webs and telephone, by: 1. Collecting data on quality and accuracy of information provided. 2. Analyzing data against standards or goals. 3. Determining causes of deficiencies, as applicable. 4. Acting to improve identified deficiencies, as applicable. **Element D: E-mail Response Evaluation** The organization: 1. Has a process for responding to member e-mail inquiries within one business day of submission. 2. Has a process for annually evaluating the quality of e-mail responses. 3. Annually collects data on email turnaround time. 4. Annually collects data on the quality of email responses. 5. Annually analyzes data. 6. Annually act to improve identified deficiencies.	
Member Experience Applicable L.A. Care Policy: QI-0031 (NCQA ~~2020~~ ME 7)	**~~Element A:~~ Policies and Procedures for Complaints** The organization has policies and procedures for registering and responding to oral and written complaints that include: 1. Documenting the substance of complaints and actions taken. 2. Investigating of the substance of complaints 3. Notification to members of the resolution of complaint and, if there is an adverse decision, the right to appeal. 4. Standards for timeliness including standards for urgent situations.	Members have the option to complain and appeal directly to L.A. Care. L.A. Care retains the right to perform a pre-delegation audit of any entity to which the Plan sub-delegates delegated activities and approve any such sub-delegation audit of any sub-delegate. Prior to entering into an agreement to sub-delegate Delegated Activities, Plan shall provide L.A. Care with reasonable prior notice of Plan's intent to sub-delegate. **~~Element D:~~ Nonbehavioral Opportunities for Improvement** The organization annually identifies opportunities for improvement, sets priorities and decides which

Standard	Delegated Activities	Retained by L.A. Care
	5. Provision of language services for the complaint process. ~~Element B:~~ **Policies and Procedures for Appeals** The organization has policies and procedures for registering and responding to oral and written appeals which include: 1. Documentation of the substance of the appeals and actions taken. 2. Investigation of the substance of the appeals. 3. Notification to members of the disposition of appeals and the right to further appeal, as appropriate. 4. Standards for timeliness including standards for urgent situations. 5. Provision of language services for the appeal process. ~~Element C:~~ **Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals** Using valid methodology, the organization annually analyzes nonbehavioral complaints and appeals for each of the five required categories. ~~Element E:~~ **Annual Assessment of Behavioral Healthcare and Services** Using valid Methodology, the organization annually: 1. Evaluates behavioral healthcare member complaints and appeals for each of the five required categories. 2. Conducts a member experience survey. ~~Element F:~~ **Behavioral Healthcare Opportunities for Improvement** The organization works to improve members' experience with behavioral healthcare and service by annually: 1. Assessing data from complaints and appeals or from member experience surveys. 2.Identifying opportunities for improvement. 3.Implementing interventions, if applicable. 4.Measuring effectiveness of interventions, if applicable.	opportunities to pursue based on analysis of the following information: 1. Member complaint and appeal data from the Member Experience standard for Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals. 2. CAHPS survey results and/or QHP Enrollee Experience Survey results.
Sub-Delegation of ME (NCQA ~~2020~~ ME 8)	**Sub-Delegation Agreement** The written sub-delegation agreement: 1. Is mutually agreed upon 2. Describes the delegated activities and the responsibilities of the organization and the delegated entity and the delegated activities.	~~**Element A: Delegation Agreement**~~ ~~The written delegation agreement:~~ ~~1. Is mutually agreed upon.~~ ~~2. Describes the delegated activities and the responsibilities of the organization and the delegated entity and the delegated activities.~~ ~~3. Requires at least semiannual reporting by the delegated entity to the organization.~~

Standard	Delegated Activities	Retained by L.A. Care
	3. Requires at least semiannual reporting by the delegated entity to the organization. 4. Describes the process by which the organization evaluates the delegated entity's performance. 5. Describes the process for providing member experience and clinical performance data to its delegates when requested. 6. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement. **Predelegation Evaluation** For new delegation agreements initiated in the look-back period, the organization evaluates delegate capacity to meet NCQA requirements before delegation began. **Review of Performance** For delegation arrangements in effect for 12 months or longer, the organization: 1. Semiannually evaluates regular reports as specified in the sub-delegation agreement. 2. Annually evaluates delegate performance against NCQA standards for delegated activities. **Opportunities for Improvement** For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years the organization identified and followed up on opportunities for improvement, if applicable.	~~4. Describes the process by which the organization evaluates the delegated entity's performance~~ ~~5. Describes the process for providing member experience and clinical performance data to its delegates when requested *~~ ~~6. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement~~ ~~**Element B: Predelegation Evaluation**~~ ~~For new delegation agreements initiated in the look-back period, the organization evaluates delegate capacity to meet NCQA requirements before delegation begins.~~ ~~**Element C: Review of Performance**~~ ~~For delegation arrangements in effect for 12 months or longer, the organization:~~ ~~1. Semiannually evaluates regular reports, as specified in Element A.~~ ~~2. Annually evaluates delegate performance against NCQA standards for delegated activities.~~ ~~**Element D: Opportunities for Improvement**~~ ~~For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that organization identified and followed up on opportunities for improvement, if applicable.~~ ~~** L.A. Care will provide Plan Partner with the data necessary to determine member experience and clinical performance, when requested and as applicable. Request shall be sent to the L.A. Care business unit which maintains the data and/or L.A. Care's Plan Partner Business Unit. The request must be precise and contain sufficient details so it is clear what minimum data needs to be provided to fulfill the request. The L.A. Care business unit responsible for the requested data shall respond timely and ensure that data is sent in compliance with L.A. Care's Policies and Procedures securing PHI through applicable protections, e.g, encryption*~~
Nurse Advice Line (Title 28 California Code of Regulations Section 1300.67.2.2 Knox-Keene 1348.8)	Plan shall provide telephone medical advice services to its enrollees and subscribers. The staff hold a valid California license as a registered nurse or a valid license in the state within which they provide telephone medical advice services as a physician and surgeon or physician assistant, and are operating in compliance with the laws governing their respective scopes of practice.	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation and annual oversight review and more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards.

Standard	Delegated Activities	Retained by L.A. Care
	A Nurse Advice Line is offered to members to assist members with wellness and prevention **A. Access to Nurse Advice Line** A Nurse Advice Line that is staffed by licensed nurses or clinicians and meets the following factors (Knox-Keene, 1348.8; 1. Is available 24 hours a day, 7 days a week by telephone. (Title 28 CA Code of Regulations; 1300.67.2.2) 2. Provides secure transmission of electronic communication, with safeguards, and a 24-hour turnaround time. 3. Provides interpretation services for members by telephone. (Knox-Keene; 1367.04) 4. Provide telephone triage or screening services in a timely manner appropriate to the enrollee's condition. The triage and screening wait time shall not exceed 30 minutes. (1300.67.2.2) **B. Nurse Advice Line Capabilities** The nurse advice line gives staff the ability to: 1. Follow up on specified cases and contact members. ~~2.~~ Link member contacts to a contact history. 2. **C. Monitoring the Nurse Advice Line** The following shall be conducted: 1. Track telephone and website statistics at least quarterly. 2. Track member use of the nurse advice line at least quarterly. 3. Evaluate member satisfaction with the nurse advice line at least annually. 4. Monitors call periodically. 5. Analyze data at least annually and, if applicable, identify opportunities and establish priorities for improvement. 1. Establish and maintain an operational policy for operating and maintaining a Telephone Nurse Advice Service. **E. Promotion (1300.67.2.2)** 1. Promote the availability of Nurse Advice Line services in materials that are approved in accordance with the Pan Partner Services Agreement	

Standard	Delegated Activities	Retained by L.A. Care
	and L.A. Care policies and procedures. 2. In the form of, but not limited to: a. Flyers b. Informational mailers c. ID Cards d. Evidence of Coverage (EOC)	
Potential Quality of Care Issue Review (Title 28 California Code of Regulations Section 1300.70)	The Quality Improvement program must document that the quality of care is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated. The Quality Improvement program must include continuous review of the quality of care provided; quality of care problems are identified and corrected for all provider entities.	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation and annual oversight review and more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards.
~~Quality Assurance Program~~ ~~(Title 28 California Code of Regulations Section 1300.70)~~	~~The Quality Improvement program must document that the quality of care is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.~~ ~~The Quality Improvement program must include continuous review of the quality of care provided; quality of care problems are identified and corrected for all provider entities.~~	~~L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation and annual oversight review and more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards.~~
Quality Improvement Performance DHCS APL 19-017 Applicable L.A. Care Policy: QI-008~~DHCS~~ APL ~~Supplement to All Plan Letter~~ 19-017 *	1. Annually measures performance and meets the NCQA 25th percentile benchmark for the Medi-Cal Managed Care Accountability Set established by DHCS and NCQA required Medi-Cal accreditation measures. 2. Opportunity for Improvement When the 25th percentile is not met the plan will identify and follow up on opportunities for improvement. ~~* DHCS supplement to All Plan Letter (APL) 19-017 is to provide Medi-Cal managed care health plans (MCPs) with adjustments to quality and performance improvement requirements as a result of the current public health emergency resulting from COVID-19. These adjustments are consistent with recent allowances from the National Committee for Quality Assurance (NCQA).~~	L.A. Care will retain the PIP and PDSA reporting process with DHCS for the Medi-Cal line of business.

Standard	Delegated Activities	Retained by L.A. Care
Blood Lead Screening of Young Children Applicable L.A. Care Policy: QI-048 APL 20-016	1. Ensure network providers follow the blood lead anticipatory guidance and screening requirements in accordance with APL 20-016. 2. Identify, on at least a quarterly basis (i.e. January-March, April-June, July-September, October-December), all child members under the age of six years (i.e. 72 months) who have any record of receiving a blood lead screening test as required, *L.A. Care will send delegate CLPPB data when they receive from DHCS on a quarterly basis.	
	HEALTH EDUCATION	
DHCS Policy Letter 02-004 DHCS Policy Letter 16-014 DHCS Policy Letter 18-018 DHCS Policy Letter 13-001 DHCS Policy Letter 10-012 DHCS Policy Letter 16-005	1. Maintenance of a health education program description and work plan 2. Availability and promotion of member health education services in DHCS language and topic requirements including implementation of a closed-loop referral process. 3. Implementation of comprehensive tobacco cessation/prevention services including: a. individual, group, and telephone counseling b. Provider tobacco cessation trainings c. Tobacco user identification system d. Tracking individual utilization data of tobacco cessation interventions 4. Availability of a diabetes prevention program (DPP) that complies with CDC DPP guidelines and is delivered by a CDC recognized provider 5. Availability of written member health education materials in English and Spanish in DHCS required health topics including: a. a system for providers to order materials and informing providers how to do so b. Adherence to all regulatory requirements as dictated per the Readability & Suitability Checklist 6. Implementation of an Individual Health Education Behavioral Assessment (IHEBA), preferably the Staying Healthy Assessment (SHA) including a method of making the assessments available to providers and provider education 7. Employment of a full-time Health Education Director, or the equivalent, with	L.A. Care retains responsibility for providing written health education materials in DHCS required health topics for non-English/Spanish threshold languages. L.A. Care retains responsibility for conducting the Health Education, Cultural & Linguistics Population Needs Assessment (PNA) annually but retains the right to request Plan Partner assistance as needed.

Standard	Delegated Activities	Retained by L.A. Care
	a Master's Degree in Public Health (MPH) responsible for the direction, management and supervision of the health education system. 8. Integration between health education activities and QI activities 9. Provision of provider education on health education requirements and resources 10. Adherence to all requirements regarding Non-Monetary Member Incentives including submission of Request for Approval and Annual Update/End of Program Evaluation forms to L.A. Care's Compliance Unit on an on-going basis.\ Should Plan Partner delegate any or all health education requirements to a sub-delegate, Plan Partner must monitor sub-delegate's performance and ensure continued compliance.	
CULTURAL & LINGUISTIC SERVICES		
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 28, §1300.67.04(c) CCR, Title 22, §53876 DHCS Agreement Exhibit A Attachment 9, (12)& (13)(A) Federal Guidelines: OMH CLAS Standards, Standards 1-4 & 9	**Cultural & Linguistic Program Description and Staffing** 1. Plan maintains an approved written program description of its C&L services program that complies with all applicable regulations. It must includes, at minimum, the following elements (or its equivalent): a. Organizational commitment to deliver culturally and linguistically appropriate health care services. b. Goals and objectives with timetable for implementation. c. Standards and performance requirements for the delivery of culturally and linguistically appropriate health care services. 2. Plan centralizes coordination and monitoring of C&L services. The department and/or staff responsible for such services are documented in an organizational chart. 3. Plan has written description(s) of position(s) and qualifications of the staff involved in the C&L services program.	
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 22, §53876 CCR, Title 28, §1300.67.04, (c)(2)(G) & (H)	**Access to Interpreting Services** 1. Plan has approved policies and procedures which include, at minimum, the following items: a. Provision of timely 24-hour, 7 days a week interpreting services from a qualified interpreter at all key points of contact, in any language requested,	

Standard	Delegated Activities	Retained by L.A. Care
Code of Federal Regulations (CFR), Title28, §35.160-25.164 CFR, Title 45 §92.4 & §92.201 DHCS Agreement Exhibit A, Attachment 9(12) & (14) DHCS All Plan Letter 21-004 Federal Guidelines: OMH CLAS Standards, Standard 5-7	including American Sign Language, at no cost to members. b. Discouraging use of friends, family, and particularly minors as interpreters, unless specifically requested by the member after she/he was being informed of the right and availability of no-cost interpreting services. c. Availability of auxiliary aids and services, such as TTY, video relay services, remote interpreting services, etc., to ensure effective communication with individuals with disabilities. 2. Plan has a sound method to ensure qualifications of interpreters and quality of interpreting services. Qualified interpreter must have demonstrated: a. Proficiency in speaking and understanding both spoken English and at least one other spoken language; and b. Ability to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using necessary specialized vocabulary and a fundamental knowledge in both languages of health care terminology and phraseology concepts relevant to health care delivery systems. c. Adherence to generally accepted interpreter ethics principles, including client confidentiality (such as the standards promulgated by the California Healthcare Interpreters Association and the National Council on Interpreting in Healthcare) 3. Plan makes available translated signage (tagline) on availability of no-cost language assistance services and how to access such services to providers. Tagline must be in English and all 18 non-English languages specified by DHCS 4. Plan posts non-discrimination notice and translated taglines in English and 18 non-English languages specified by DHCS at	

Standard	Delegated Activities	Retained by L.A. Care
	physical location where the plan interacts with the public and on Plan's website. 5. Plan maintains utilization reports for face-to-face and telephonic interpreting services.	
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 28, §1300.67.04(c)(2)(H) Code of Federal Regulations (CFR), Title 45 §92.4 & §92.201(e)(4) DHCS Agreement Exhibit A, Attachment 9(13)(B) & (F) DHCS All Plan Letter 22-04 Federal Guidelines: OMH CLAS Standards, Standards - 7	**Assessment of Linguistic Capabilities of Bilingual** 1. Plan has approved policies and procedures related to identifying, assessing, and tracking oral and/or written language proficiency of clinical and non-clinical bilingual employees who communicate directly with members in a language other than English. 2. Plan has a sound method to assess bilingual employees' oral and/or written language proficiency, including appropriate criteria for ensuring the proficiency. Qualified bilingual staff must have demonstrated: a. Proficiency in speaking and understanding both spoken English and at least one other spoken language, including any necessary specialized vocabulary, terminology, and phraseology. b. Ability to effectively, accurately, and impartially communicate directly with Limited English Proficiency Members in their preferred language. 3. Plan maintains a current list of assessed and qualified bilingual employees, who communicate directly with members, including the following information at minimum, name, position, department, language, level of proficiency.	
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 28, §1300.67.04(d)(9) DHCS Agreement Exhibit A, Attachment 6(11)(B)(2) & Attachment 18 (6)(K) DHCS Policy Letter 98-12	**Linguistic Capabilities of Provider Network** 1. Plan has approved policies and procedures related to identifying and monitoring language capabilities of providers and provider staff ensuring provider network is reflective of membership demographics. 2. Plan lists language spoken by providers and provider staff in the provider directory. 3. Plan updates language spoken by providers and provider staff in the provider directory.	

Standard	Delegated Activities	Retained by L.A. Care
Federal Guidelines: OMH CLAS Standards, Standard 7	4. Plan annually assesses the provider network language capabilities to meet the members' needs.	
California Health and Safety Code, §1367.04(b)(1)(A)-(C) Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 22, §53876 (a)(2)&(3) CCR, Title 28, §1300.67.04, (b)(7), (c)(2)(F) & (e)(2)(i)-(ii) Code of Federal Regulations (CFR), Title28, §35.160-25.164 CFR, Title 45 §92.4 & §92.8 DHCS Agreement, Exhibit A, Attachment 9(14)(B)(2), (14)(C), Attachment 13(4)(C) DHCS All Plan Letter 21-011 DHCS All Plan Letter 21-004 DHCS All Plan Letter 22-002 Federal Guidelines: OMH CLAS Standards, Standard 5-8	**Access to Written Member Informing Materials in Threshold Languages & Alternative Formats** 1. Plan has approved policies and procedures documenting the process to: a. Translate Written Member Informing Materials, including the non-template individualized verbiage in Notice of Action (NOA) letters, accurately using a qualified translator in all Los Angeles County threshold languages and alternative formats (large print 20pt, audio, Braille, accessible data) according to the required timelines. b. Track member's standing requests for Written Member Informing Materials in their preferred threshold language and alternative format. c. Submit newly captured members' alternative format selection data directly to the DHCS Alternate Format website. d. Distribute fully translated Written Member Informing Materials in their identified Los Angeles County threshold language and alternative format to members on a routine basis based on the standing requests and DHCS alternative format selection (AFS) data. e. Attach the appropriate non-discrimination notice and translated tagline (a written language assistance notice) in English and 18 non-English required by DHCS to Member Informing Materials. Threshold Languages for Los Angeles County: English, Spanish, Arabic, Armenian, Chinese, Farsi, Khmer, Korean, Russian, Tagalog, and Vietnamese. Taglines (Language assistance notice) Languages: English, Spanish, Arabic, Armenian, Chinese, Farsi, Khmer, Korean,	

Standard	Delegated Activities	Retained by L.A. Care
	Russian, Tagalog, Vietnamese, Hindi, Hmong, Japanese, Lao, Mien, Punjabi, Thai and Ukrainian. 2. Plan has a sound method to ensure qualifications of translators and quality of translated Written Member Informing Materials. Qualified translators must have demonstrated: a. Adherence to generally accepted translator ethics principles, including client confidentiality to protect the privacy and independence of LEP Members. b. Proficiency reading, writing, and understanding both English and the other non-English target language. c. Ability to translate effectively, accurately, and impartially to and such language(s) and English, using necessary specialized vocabulary, terminology and phraseology. Plan maintains: a. Translated Written Member Informing materials on file along with attestations which affirm qualifications of the translators and translated document is an accurate rendition of the English version. b. Evidence of the distribution of Written Member Informing Materials to members in their identified Los Angeles County threshold language and alternative format on a routine basis. c. Evidence of reporting newly captured AFS data to DHCS	
Code of California Regulations (CCR), Title 28, §1300.67.04(c)(2)(C) DHCS Agreement, Exhibit A, Attachment 13(1)(A) DHCS All Plan 21-004	**Member Education** 1. Plan informs members annually of their right to no-cost interpreting services 24-hour, 7 days a week, including American Sign Language and axillary aids/services and how to access these services. 2. Plan informs members annually about the importance of not using friends, family members and particularly minors, as interpreters.	

Standard	Delegated Activities	Retained by L.A. Care
Federal Guidelines: OMH CLAS Standards, Standard 6	3. Plan informs members annually of their right to receive Written Member Informing Materials in their preferred language and alternative format at no cost and how to access these services. 4. Plan informs members annually of their right to file complaints and grievances if their cultural or linguistic needs are not met and how to file them. 5. Plan informs members annually that Plan does not discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability or identification with any other persons or group identified in Penal Code 422.56 in its health programs and activities.	
Code of California Regulations (CCR), Title 28, §1300.67.04(c)(2)(E) & (3) DHCS Agreement Exhibit A, Attachment 7(5)(B), Attachment 9 (13)(E), Attachment 18(7)(F) & (9)(M) DHCS All Plan Letter 99-005 Federal Guidelines: OMH CLAS Standards, Standard 4	**Provider Education & Training** 1. Plan has approved policies and procedures related to education/training on C&L requirements, cultural competency, sensitivity or diversity training for providers. 2. Plan provides initial and annual education/training on cultural and linguistic requirements to providers, which includes the following items: a. Availability of no-cost language assistance services, including: i) 24-hour, 7 days a week interpreting services, including American Sign Language. ii) Written Member Informing Materials in their identified Los Angeles threshold language and preferred alternative format. iii) Auxiliary aids and services, such as TTY, video relay services, remote interpreting services, etc. b. How to access language assistance services. c. Discouraging the use of friends, family, and particularly minors as interpreters. d. Not relying on staff other than qualified bilingual staff to communicate directly in a non-English language with members.	

Standard	Delegated Activities	Retained by L.A. Care
	e. Documenting the member's language and the request/refusal of interpreting services in the medical record. f. Posting translated taglines in English and 18 non-English languages required by DHCS at key points of contact with members. g. Working effectively with members using in-person or telephonic interpreters and using other media such as TTY and remote interpreting services. h. Referring members to culturally and linguistically appropriate community services. 3. Plan provides initial and annual cultural competency, sensitivity or diversity training to providers, which includes topics that are relevant to the cultural groups in Los Angeles County, such as: a. Promote access and the delivery of services in a culturally competent manner to all Members, regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental, disability, or identification with any other persons or groups defined in Penal Code 422. b. Awareness that culture and cultural beliefs may influence health and health care delivery. c. Knowledge about diverse attitudes, beliefs, behaviors, practices, and methods regarding preventive health, illnesses, diseases, traditional home remedies, and interaction with providers and health care systems. d. Skills to communicate effectively with diverse populations e. Language and literacy needs.	
Code of California Regulations (CCR), Title 28, §1300.67.04(c)(3) DHCS Agreement Exhibit A, Attachment	**Plan Employee Education & Training** 1. Plan has approved policies and procedures related to education/training on C&L requirements, cultural competency sensitivity or diversity training for Plan employees.	

Standard	Delegated Activities	Retained by L.A. Care
9(13)(E) DHCS All Plan Letter 99-005 Federal Guidelines: OMH CLAS Standards, Standard 4	2. Plan provides initial and annual education/training on cultural and linguistic requirements and language assistance services to plan staff, which includes the following items: a. The availability of Plan's no-cost language assistance services to members, including: i. 24-hour, 7 days a week interpreting services, including American Sign Language. ii. Written Member Informing Materials in their identified Los Angeles threshold language and preferred alternative format. iii. Auxiliary aids and services, such as TTY, video relay services, remote interpreting services, etc. b. How to access these language assistance services. c. Discouraging the use of friends, family, and particularly minors, as interpreters. d. Not relying on staff other than qualified bilingual staff to communicate directly in a non-English language with members. e. Working effectively with members using in-person or telephonic interpreters and using other media such as TTY and remote interpreting services f. Referring members to culturally and linguistically appropriate community services. 3. Plan has cultural competency, sensitivity or diversity training material(s) for Plan employees, which includes topics that are relevant to the cultural groups in Los Angeles County, such as: a. Promote access and the delivery of services in a culturally competent manner to all Members, regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental, disability, or identification with any other per-sons or groups defined in Penal Code 422.	

Standard	Delegated Activities	Retained by L.A. Care
	b. Knowledge about diverse attitudes, beliefs, behaviors, practices, and methods regarding preventive health, illnesses, diseases, traditional home remedies, and interaction with providers and health care system. c. Skills to communicate effectively with diverse populations. d. Language and literacy needs.	
DHCS Agreement Exhibit A, Attachment 9(13)(F) DHCS All Plan Letter 99-005 Federal Guidelines: OMH CLAS Standards, Standard 10	**C&L and Quality Improvement** 1. Plan has approved policies and procedures related to C&L program evaluation, at minimum, including: a. Review and monitoring of C&L program that has a direct link to Plan's quality improvement processes. b. Procedures for continuous evaluation. 2. Plan analyzes C&L services performance and evaluates the overall effectiveness of the C&L program to identify barriers and deficiencies. For example: a. Grievances and complaints regarding C&L issues b. Trending of interpreting and translation utilization c. Member satisfaction with the quality and availability of language assistance services and culturally competent care d. Plan staff and providers' feedback on C&L services 3. Plan takes actions to correct identified barriers and deficiencies related to C&L services.	
Code of California Regulations (CCR), Title 28, §1300.67.04 (c)(4) DHCS Agreement, Exhibit A, Attachment 4(6)(A), (B) & Attachment 6(14)(B) DHCS All Plan Letter 99-005 DHCS All Plan Letter	**Oversight of Subcontractors for Cultural & Linguistic Services and Requirements** 1. Plan has a contract and/or other written agreement with its network providers and subcontractor(s) regarding: a. C&L requirements (e.g., documentation of preferred language and refusal/request for interpreting services in the medical record, posting of translated tagline in English and 18 non-English languages) b. Delegated C&L services (e.g., language assistance services)	

Standard	Delegated Activities	Retained by L.A. Care
17-004DHCS All Plan Letter 21-004	2. Plan has approved policies and procedures related to oversight and monitoring of its network providers and subcontractors to ensure compliance with the contract/agreement terms and applicable federal and state laws and regulations that are related to C&L requirements and/or delegated C&L services. 3. Plan has a mechanism to monitor network providers and subcontractors to ensure compliance with the contract terms and applicable federal and state laws and regulations that are related to C&L requirements and/or delegated C&L services. 4. Plan monitors network providers and subcontractors with regular frequency to ensure compliance with the contract terms and applicable federal and state laws and regulations that are related to C&L requirements and/or delegated C&L services.	
Code of California Regulations (CCR), Title 22, §53876 DHCS Agreement Exhibit A, Attachment 9(5) & (14)(B)(3)	**Cultural & Linguistic Service Referral** 1. Plan has approved policies and procedures related to referring members to culturally and linguistically appropriate community services and providers who can meet the members' religious and ethical needs. 2. Plan has a process and/or mechanism to refer members to culturally and linguistically appropriate community services. 3. Plan informs providers of the availability of culturally and linguistically appropriate community service programs for members and how to access them.	

CLAIMS PROCESSING REQUIREMENTS		
Claims Processing (Title 28 California Code of Regulations Section 1300.71)	**Timely Claims Processing** 1. Process at a minimum ninety percent (90%) of claims within 30 calendar days of the claim receipt date, 2. Process at a minimum ninety-five percent (95%) of claims within 45 working days of the claim receipt date, **and** 3. Process at a minimum ninety-nine percent (99%) of claims within 90 calendar days of the claim receipt date. **Accurate Claims Payments** 1. Pay claims at the Medi-Cal rates or contracted rates at a minimum of 95% of the time. 2. All modified claims are reviewed and approved by a physician and medical records are reviewed. 3. Calculate and pay interest automatically for claims paid beyond 45 workings days from date of receipt at a minimum 95% of the time. a. **Emergency services claims:** Late payment on a complete claim which is not contested or denied will automatically include the greater of $15 or 15% rate per annum applied to the payment amount for the time period the payment is late. b. **All other service claims:** Late payments on a complete claim will automatically include interest at a 15% rate per annum applied to the payment amount for the time period payment is late. c. **Penalty:** Failure to automatically include the interest due on the late claims regardless of service is $10 per late claim in addition to the interest amount. **Forwarding of Misdirected Claims** Forward misdirected claims within 10 working days of the claim receipt date at a minimum of 95% of the time. **Acknowledgement of Claims** Acknowledge the receipt of electronic claims within 2 working days and paper claims within 15 working days at a minimum of 95% of the time. **Dispute Resolution Mechanism** Provide written notice of a dispute resolution mechanism for all denied and modified claims at a minimum of 95% of the time. **Accurate and Clear Written Explanation**	

	Provide written notice of a dispute resolution mechanism for all denied and modified claims at a minimum of 95% of the time. **Deadline for Claims Submission** Shall not impose a claims filing deadline less than 90 days after the date of service for contracted providers and less than 180 days after the date of service for non-contracted providers on three or more occasions. **Request for Reimbursement of Overpayment** Reimbursement for overpayment request shall be in writing and clearly identifying the claim and reason why the claim is believed to be overpaid within 365 days from the payment date, for at least 95% of the time. **Rescind or Modify an Authorization** An authorization shall not be rescinded or modified for health care services after the provider renders the service in good faith and pursuant to the authorization on three (3) or more occasions over the course of any three-month period. **Request for Medical Records** 1. **Emergency services claims:** Medical records shall not be requested more frequently than twenty percent (20%) of the claims submitted by all providers for emergency services over any 12-month period. 2. **All other claims:** Medical records shall not be requested more frequently than three percent (3%) of the claims submitted by all providers, excluding claims involving unauthorized services over any 12-month period. **Exception:** The thresholds and limitations on requests for medical records as stated above should not apply to claims where reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices are being demonstrated.	
Provider Dispute Resolution (PDR) Processing and Payments requirement. (Title 28 California Code of Regulations Section 1300.71.38)	**Acknowledgement of Provider Disputes** Acknowledgement of received disputes is performed in a timely manner at a minimum of 95% of the time. a. 15 working days for paper disputes. b. 2 working days for electronic disputes. **Timely Dispute Determinations** Dispute determinations are made in a timely manner, at a minimum of 95% of the time. a. 45 working days from receipt of the dispute.	

	b. 45 working days from receipt of additional information. **Clear Explanation of NOA Letter** Rationale for decision is clear, accurate and specific in NOA Letter, at a minimum of 95% of the time. a. Written determination stating the pertinent facts and explaining the reasons for the determination **Accurate Provider Dispute Payments** 1. Appropriately paying any outstanding monies determined to be due if the dispute is determined in whole or in part in favor of the provider. 2. Interest payments are paid correctly when dispute determination is in favor of provider, at a minimum of 95% of the time. Accrual of interest of payment on resolved provider disputes begin on the day after the expiration of forty-five (45) working days from the original claim receipt date. **Acceptance of Late Claims** The organization must accept and adjudicate disputes that were originally filed beyond the claim filing deadline and the provider was able to demonstrate good cause for the delay, at a minimum of 95% of the time.	

Exhibit 8
NCQA Delegation Agreement
[Attachment B]

Plan's Reporting Requirements

Report	Due Date	Submit To	Required Format
PHARMACY			
Pharmacy Reporting requirements for additional delegated activities 1. NCQA UM related [Part 1] a. **UM 4E:** Practitioner Review of Pharmacy Denials b. **UM 5:** Timeliness of Pharmacy UM Decision Making c. **UM 5C:**Notification of Pharmacy Decisions d. **UM 6C:** Relevant Information for Pharmacy Decisions e. **UM 7G:** Discussing a Pharmacy Denial with a Reviewer f. **UM 7H:** Written Notification of Pharmacy Denials 2. NCQA UM related [Part 2] a. **UM 7I:** Pharmacy Notice of Appeals Rights/Process b. **UM 9A** Preservice and Postservice Pharmacy Appeals c. **UM 9B:** Timeliness of the Pharmacy Appeal Process d. **UM 9C:** Pharmacy Appeal Reviewers e. **UM 9D:** Notification of Appeal Decision/Rights for Pharmacy f. **UM 12A:** UM Denial System Controls 3. NCQA UM related [Part 3] a. **UM 5G(factors5&6)**: UM Timeliness Report (Pharmacy) 4. DHCS Related a. Decision timeliness rate for all PA requests according DHCS contractual agreement = PA decisions within 24 hours of receipt/Total PAs .- includes approval and denials, <u>excludes all</u>	1-4. Quarterly 1st Qtr – May 30 2nd Qtr – Aug 30 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) – Compliance Folder. Plan will also have the option to submit via email to remain compliant with due date.	1-3. L.A. Care Reporting Format with data elements as defined in the Anthem Pharmacy Report Templates workbook, and 4. Policy and Procedure PHRM-041: Plan Partner Pharmacy Reporting Requirements

early close and administrative denials b. Notification timeliness rate for all PA requests according DHCS contractual agreement = PA notifications within 24 hours of receipt/Total PAs .- includes approval and denials, excludes all early close and administrative denials 5. Pharmacy Activities Summary Reports a. Denial per 1000 = (Pharmacy Denials/1000 members) - all early close and administrative denials should be excluded. b. Appeal per 1000 = (Pharmacy Appeals/ 1000 members) - withdrawn appeals should be excluded **c.** Overturn Rate = (Pharmacy Overturned Appeals/ Total Pharmacy Appeals) - withdrawn appeals should be excluded. 6. Pharmacy Utilization Reports a. Top fifty drugs by number of Prescriptions b. Top fifty Drugs by Aggregate Cost c. Non-Formulary Medication d. Prior Authorization Report e. Summary Report of L.A. Care member Prescription Utilization.			
NCQA Pharmacy ME related reporting requirements 1. **ME:** Quality and accuracy (QI process) of pharmacy benefit information provided on website and telephone a. Collects data on quality and accuracy of pharmacy benefit information b. Analyzes data results c. Acts to improve identified deficiencies 2. **ME:** Pharmacy benefit updates for: a. Member information on its website and in materials used by telephone staff, as the effective date of a formulary change and as new drugs are made available.	1 - 2. Quarterly 1st Qtr – May 30 2nd Qtr – Aug 30 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) – Compliance folder. Plan will also have the option to submit via email to remain compliant with due date.	1 – 2. Compliant with NCQA in accordance to Plan's accreditation submission

~~**APPEALS & GRIEVANCES**~~

~~APPEALS & GRIEVANCES~~ ~~Member complaints and Appeals Log~~	~~Monthly~~ ~~12th Calendar Day of Each Month~~	~~L.A. Care's Secure File Transfer Protocol (SFTP) Compliance folder~~ ~~Plan will also have the option to submit via email to remain compliant with due date.~~	~~Format as defined in the L.A. Care Technical Bulletin MS 005~~
~~**ME 7 A, B, C, E, F**~~ ~~1. **Analysis of Member Experience, if delegated, to include:** Policies and Procedures for Complaints~~ ~~2. Policies and Procedures for Appeals~~ ~~3. Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals for each of 5 categories along with oppurtunities for improvement:~~ ~~a. Quality of Care~~ ~~b. Access~~ ~~c. Attitude and Service~~ ~~d.~~ ~~e. Quality of Practitioner Office Site~~ ~~4. Annual Assessment of Behavioral Healthcare Complaints and Appeals and Services for each of 5 categories along with oppurtunities for improvement:~~ ~~a. Quality of Care~~ ~~b. Access~~ ~~c. Attitude and Service~~ ~~d.~~ ~~e. Quality of Practitioner Office Site~~	~~Annually during PP audit~~	~~L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder /~~ ~~Plan will also have the option to submit via email to remain compliant with due date.~~	~~Compliant with NCQA in accordance to Plan's accreditation submission~~
QUALITY IMPROVEMENT			
NET 1A **Cultural Needs and Preferences Assessment** 1. Assess the cultural, ethnic, racial and linguistic needs of its members 2. Adjust the availability of practitioners within its network, if necessary	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder Plan will also have the option to submit via email to remain compliant with due date.	Compliant with NCQA in accordance to Plan's accreditation submission

NET 1B **Availability of Practitioners, if delegated:** Formal assessment of primary care, behavioral healthcare and specialty care practitioners (SCP) availability to include: 1. Adjustment of practitioners availability within its network to meet the cultural, ethnic, racial and linguistic needs of its members 2. Quantifiable and Measurable Standards for the number of each type of practitioner providing primary care. 3. Quantifiable and Measurable Standards for Geographic Distribution of each type of practitioner providing primary care. 4. Analysis of Performance against Standards	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder Plan will also have the option to submit via email to remain compliant with due date.	Compliant with NCQA in accordance to Plan's accreditation submission
NET 1C **Formal assessment of Practitioners Providing Specialty Care, if delegated, to include:** 1. Identification of High Volume Specialty Providers, one of which must be OB/GYN; and Identification of High Impact Specialty Providers, one of which must be Oncology 2. Quantifiable and Measurable Standards for the number of each type of high-volume specialists. 3. Quantifiable and Measurable Standards and Distribution by Geographic Distribution of High Volume SCPs and High Impact SCPs; and 4. Analysis of Performance against Standards	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder Plan will also have the option to submit via email to remain compliant with due date.	Compliant with NCQA in accordance to Plan's accreditation submission
NET 1D **Assessment of Practitioners Providing Behavioral Healthcare, if delegated, to include:** 1. Identification of High-Volume behavioral healthcare practitioners 2. Quantifiable and Measurable Standards for the number of each type of High-Volume behavioral healthcare practitioner. 3. Quantifiable and Measurable Standards for the geographic distribution of each type of High-Volume behavioral healthcare practitioners. 4. Analysis of Performance against Standards	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder Plan will also have the option to submit via email to remain compliant with due date.	Compliant with NCQA in accordance to Plan's accreditation submission

<table>
<tr><td>NET 2A
Access to Primary Care, if delegated:
Analysis of data that measures:
1. Regular and Routine Care Appointments
2. Urgent Care Appointments
3. After-Hours Care</td><td>Annually during PP audit</td><td>L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder

Plan will also have the option to submit via email to remain compliant with due date.</td><td>Compliant with NCQA in accordance to Plan's accreditation submission</td></tr>
<tr><td>NET 2B
Access to Behavioral Healthcare, if delegated:
Analysis of data that evaluate access to appointments for behavioral healthcare for:
1. Care for a non-life-threatening emergency within 6 hours
2. Urgent Care within 48 hours
3. Initial visit for routine care within 10 business days
4. Follow-up routine care within a time frame defined by the organization</td><td>Annually during PP audit</td><td>L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder

Plan will also have the option to submit via email to remain compliant with due date.</td><td>Compliant with NCQA in accordance to Plan's accreditation submission</td></tr>
<tr><td>NET 2C
Access to Specialty Care, if delegated:
Analysis of data that evaluate access to appointments for :
1. High-Volume specialty care.
2. High-Impact specialty care.</td><td>Annually during PP audit</td><td>L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder

Plan will also have the option to submit via email to remain compliant with due date.</td><td>Compliant with NCQA in accordance to Plan's accreditation submission</td></tr>
<tr><td>NET 3
Assessment of Network Adequacy
1. Assessment of Member Experience Accessing the Network by:
a. Analyzing data from complaints and appeals about network adequacy for non-behavioral and behavioral healthcare services
b. Using aspects of analysis from (b) to determine if there are issues specific to particular geographic areas or types of practitioners or providers
2. Analyze opportunities to improve access to non-behavioral healthcare services by:
a. Prioritizing opportunities for improvement from analysis of availability, accessibility and</td><td>Annually during PP audit</td><td>L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder

Plan will also have the option to submit via email to remain compliant with due date</td><td>Compliant with NCQA in accordance to Plan's accreditation submission</td></tr>
</table>

CAHPS survey results and member complaints and appeals b. Implement interventions on at least one opportunity, if applicable c. Measure the effectiveness of interventions, if applicable 3. Analyze opportunities to improve access to behavioral healthcare services by: a. Prioritizing improvement opportunities identified from analyses of availability, accessibility, complaints and appeals, or member experience b. Implementing interventions on at least on opportunity, if applicable c. Measures the effectiveness of the interventions, if applicable			
QI 2A Practitioner Contracts	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ubcsc/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
QI 3A Identifying Opportunites **QI 3B** Acting on Opporunities **QI 3C** Measuring Effectiveness ~~**QI 3 A-C & 4 A-C Annual Assessment and Improvement Actions taken for Continuity and Coordination of Care across the health care network**~~ ~~1. Continuity and Coordination of Medical Care analysis~~ ~~2. Continuity and Coordination Between Medical Care and Behavioral Healthcare analysis.~~	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder home/ubcsc/infile/Quality Improvement/ Plan will also have the option to submit via email to remain compliant with due date to quality@lacare.org ..	Annual data collection analysis that identify and acts on opportunities for improvement for Continuity of Care as outlined by NCQA guidelines for Continuity Coordination of Care of Medical Care and Continuity and Coordination Between Medical Care and Behavioral HealthCare
QI 4A Data Collection **QI 4B** Collaborative Activites **QI 4C** Measuring Effectiveness	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder: home/ubcsc/infile/Quality Improvement/ Plan will also have the option to submit via email to remain compliant with due date to quality@lacare.org .	Compliant with NCQA in accordance to Plan's accreditation submission.

QI 5A **Sub-Delegation Agreement** **QI 5B** Sub- Delegation Predelegation Evaluation **QI 5C** Sub-Delegation Review of QI Program **QI 5D** **Sub-Delegation** Opportunities for Improvement	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder home/ubcsc/infile/Quality Improvement/ Plan will also have the option to submit via email to remain compliant with due date to quality@lacare.org .	Compliant with NCQA in accordance to Plan's accreditation submission.
Quality Improvement Quarterly reporting requirements 1. **QI Workplan Update** 1. Workplan updates should goals, objectives, QI activities and responsible party related to the MCAS MPL measures. 2. **Potential Quality of Care Issues (PQIs)** a. Number of PQIs b. Number of closed PQIs c. Number of closed PQIs within 6 months d. PQI Detail Report with final PQI severity level	1 – 2. Quarterly 1st Qtr – April June 30 2nd Qtr – July 25Sep 30 3rd Qtr – Oct 25Dec 30 4th Qtr – Jan 25Mar 30 2.Quarterly PQI Report 1st Qtr – April 25 2nd Qtr – July 25 3rd Qtr – Oct 25 4th Qtr – Jan 25	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Compliance folder home/ubcsc/infile/Quality Improvement/ . Plan will also have the option to submit via email to remain compliant with due date to quality@lacare.org.	1 – 3. Acceptable formats: • Quarterly Workplan Updates • ICE Reporting Format
Quality Improvement Annual reporting requirements 1. **QI 1A:** QM Program Description 2. **QI 1C:** QM Program Evaluation 3. QI Workplan 4. PHM Workplan *(if the activities are not included in the QI Workplan)*	1 – 4. Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder home/ubcsc/infile/Quality Improvement/ Plan will also have the option to submit via email to remain compliant to quality@lacare.org. The PHM reporting element is part of Anthem's UM operations – copy of its UM Workplan will be shared with LA Care's Quality Improvement Team during the annual PP audit.	Acceptable formats: • ICE Reporting Format

ME 1B: Distribution of Member Rights & Responsibilities Statement to New Practitioners	Semi-Annually: Jan 15th (Reporting period Q3 & Q4) July 15th (Reporting period Q1 & Q2)	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Compliance folder home/ubcsc/infile/Quality Improvement/ Plan will also have the option to submit via email to remain compliant to quality@lacare.org.	Mutually agreed upon format
PHM 1A: PHM Strategy Element A: Strategy Description **PHM 1B** Informing Members	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder home/ubcsc/infile/Quality Improvement/ Plan will also have the option to submit via email to remain compliant to quality@lacare.org	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 2A Data integration **PHM 2B: Population Identification** Element B: Population Assessment **PHM 2C** Activites and Resources **PHM 2D** Element D: Segmentation	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder Plan will also have the option to submit via email to remain compliant to quality@lacare.org	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 6A : Population Health Management Impact Element A: Measuring Effectiveness **Element BPHM6B:** -Improvement and Action	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder home/ubcsc/infile/Quality Improvement/ Plan will also have the option to submit via email to remain compliant to quality@lacare.org .	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 7A Sub-Delegation Agreement **PHM 7B** Sub-Delegate Pre-Delegation Agreement	Annually during PP audit	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder	Compliant with NCQA in accordance to Plan's accreditation submission

PHM 7C Sub-Delegate Review of PHM Program **PHM 7D** Opportunities for Improvement		home/ubcsc/infile/Quality Improvement/ Plan will also have the option to submit via email to remain compliant to quality@lacare.org .	
Title 28 California Code of Regulations Section 1300.67.2.2 **Assessment of Nurse Advice Line** 1. Nurse Advice Line monitoring for: a. Telephone statistics at least quarterly • Average abandonment rate within 5 percent • Average speed of answer within 30 seconds 2. Annual analysis of Nurse Advice Line statistics (website, telephone, use, and calls), identify opportunities and establish priorities for improvement.	1. Quarterly 1st Qtr – April 25 2nd Qtr – July 25 3rd Qtr – Oct 25 4th Qtr – Jan 25 2. Annually during PP Audit	1. L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Regulatory Reports/ Plan will also have the option to submit via email to remain compliant with due date. 2. L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder Plan will also have the option to submit via email to remain compliant.	Mutually agreed upon format
Quality Improvement Performance A PDSA tool will be required when the plan does not meet the 25th percentile for the Managed Care Accountability Set and the 25th percentile for the Medicaid NCQA Accreditation Measures as established by both regulatory entities. ~~* DHCS supplement to All Plan Letter (APL) 19-017 is to provide Medi-Cal managed care health plans (MCPs) with adjustments to quality and performance improvement requirements as a result of the current public health emergency resulting from COVID-19. These adjustments are consistent with recent allowances from the National Committee for Quality Assurance (NCQA).~~	Annually during PP Audit. The PDSA tool is due 90 calendar days after findings are received.	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Audit folder home/ubcsc/infile/Quality Improvement/. Plan will also have the option to submit via email to remain compliant to quality@lacare.org	The PDSA tool provided by DHCS
UTILIZATION MANAGEMENT			
Service Authorizations and Utilization Review			

UM 1 1. UM Program Description 2. UM Program Evaluation 3. UM Program Work Plan	1. Annually during PP audit 2-3. May 31	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Compliance folder Plan will also have the option to submit via email to remain compliant with due date.	1. Narrative 2. HICE Quarterly Reporting format 3. HICE Quarterly Format
Quarterly UM Activity Report **All elements outlined within L.A. Care Annual and Quarterly UM Activity (HICE) report including but not limited to:** 1. UM Summary – Inpatient Activity a. Average monthly membership b. Acute Admissions/K c. Acute Bed days/K d. Acute LOS e. Acute Readmits/K f. SNF Admissions/K g. SNF Bed days/K h. SNF LOS i. SNF Readmits/K 2. UM Activities Summary a. Referral Management Tracking of the number of Approvals/Modifications/Denials/ Deferrals (Routine/Urgent) b. Referral Denial Rate c. Appeals/K d. Overturn Rate 3. **PHM 5:** CCM Complex Case Management CM Reports and Statistics	Annual 2022 Evaluation and 2023 Work Plan – February 15, 2023 Quarterly 1st Qtr – May ~~31~~ 2nd Qtr – Aug ~~31~~ 3rd Qtr – Nov ~~30~~ 4th Qtr – Feb ~~28~~	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Compliance folder. Plan will also have the option to submit via email to remain compliant with due date.	ICE Quarterly Reporting Format
NET 4B: Continued Access to Care 1. Continued Access to Practitioners If a practitioner's contract is discontinued, the organization allows affected members continued access to the practitioner, as follows: a. Continuation of treatment through the current period of active treatment for members undergoing active treatment for a chronic or acute medical condition b. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy	Quarterly 1st Qtr – May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Compliance folder. Plan will also have the option to submit via email to remain compliant with due date.	L.A. Care Quarterly Reporting Format

PHM 5: CCM Log of Case Management Cases (CCM) for members who have been in CCM for at least 60 days to include both open and closed cases.	Quarterly 1st Qtr – May 25 2nd Qtr – Aug 25 3rd Qtr – Nov 25 4th Qtr – Feb 25	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) (Compliance folder.) Plan will also have the option to submit via email to remain compliant with due date.	Acceptable formats: L.A. Care Format
Medi-Cal Provider Preventable Reportable Conditions	Monthly	Anthem supports its compliance via its encounter submission	Acceptable formats: DHCS Required Reporting Format
QI 3D: Transition to Other Care**--**member transition to other care, **a.** When their benefits end. **b.** During transition from pediatric care to adult care. (MM 22 Element D)	Quarterly 1st Qtr – May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Compliance folder Plan will also have the option to submit via email to remain compliant with due date.	L.A. Care TOC Reporting Document and COC Log Template Format
	CREDENTIALING		
1. Initial Credentialed practitioner list containing Credentialing Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. 2. Re-credentialed practitioner list containing Re-credentialing Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. 3. Voluntary Practitioner Termination list containing Termination Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. 4. Involuntary Practitioner Termination list containing Termination Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name	Quarterly 1st Qtr – May15 2nd Qtr – Aug 15 3rd Qtr – Nov 15 4th Qtr – Feb 15	L.A. Care Reports via its Secure File Transfer Protocol (SFTP) Compliance folder Plan will also have the option to submit via email to Credinfo@lacare.org to remain compliant with due date.	Current L.A. Care Health Plan Delegated Credentialing Quarterly Credentialing Submission Form (HICE Format)
	DMHC Survey		
1. DMHC Timely Access and Network Reporting (TAR) a. Exhibit A-1 Timely Access Time-Elapsed Standards	Annually - March	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	

b. Exhibit A-2 Alternative Access Timely Access Time-Elapsed Standards (if applicable) c. Exhibit A-3 Timely Access Monitoring Policies and Procedures related to subdivision (c)(5) d. Exhibit A-4 Timely Access Monitoring policies and Procedures related to all other standards e. Exhibit C-1 Methodology f. Exhibit C-2 Incidents of Non-Compliance with Rule 1300.67.2.2 g. Exhibit C-3 Patterns of Non-Compliance with rule 1300.67.2.2 h. Exhibit D-1 Methodology for Verification of Advanced Access Program (if applicable) i. Exhibit D-2 List of Advanced Access Providers (if applicable) j. Exhibit E-1 Triage k. Exhibit E-2 Telemedicine l. Exhibit E-3 Health I.T. m. Exhibit F-1 Provider Satisfaction Survey Methodology (a) Policy & Procedures n. Exhibit F-1 Provider Satisfaction Survey Methodology (b) Survey Tool o. Exhibit F-1 Provider Satisfaction Survey Methodology (c) Detailed Explanation p. Exhibit F-2 Provider Satisfaction Survey Results q. Exhibit F3- Enrollee Satisfaction Survey Methodology (a) Policy and Procedures r. Exhibit F3- Enrollee Satisfaction Survey Methodology (b) Survey Tool s. Exhibit F3- Enrollee Satisfaction Survey Methodology (c) Detailed Explanation t. Exhibit F4- Enrollee Satisfaction Survey Results u. Quality Assurance Report			

v. Annual Provider Network Report Forms i. PCP ii. Specialists iii. Other Contracted iv. Hospitals and Clinics v. Telehealth vi. Service and Enrollment vii. Mental Health viii. Grievances			
1. DMHC Provider Appointment Availability Survey (PAAS) a. Provider Contact Lists i. PCP ii. Specialists iii. Psychiatry iv. Non-Physician Mental Health v. Ancillary	Annually - July	L.A. Care's Secure File Transfer Protocol (SFTP)/ home/ucfst/infile/Quality Improvement/	
COMPLIANCE			
1. 274 EDI File Mandated by APL 16-019	Monthly – Due to L.A. Care by the 4th of each month	L.A. Care's Secure File Transfer Protocol (SFTP) 274 folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS required formatting.
2. Data Certification Statements Mandated by APL 17-005	Monthly – Due to L.A. Care 3 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder Plan will also have the option to submit via email to remain compliant with due date.	No specific template. All DHCS reports submitted to L.A. Care within the month must be listed and signed by Plan Partner President
3. Non-Medical Transportation & Non-Emergency Medical Transportation (NMT-NEMT) Report Mandated by APL 17-010	Monthly - Due to L.A. Care ~~5~~ 7 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder. Plan will also have the option to submit via email to remain	DHCS approved template

		compliant with due date.	
4. AB1455 Quarterly Reporting: Claims Timeliness Reports 4. Provider Dispute Resolution (PDR) Disclosure of Emerging Claims Payment Deficiencies	Quarterly – Due to LA Care 45 calendar days after quarter *The effective date will be based on the last date signed by the parties to support the full execution of this delegation agreement.	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports Plan will also have the option to submit via email to remain compliant with due date.	DMHC HICE approved template
5. Call Center Report Mandated by APL 14-012 *DHCS retired effective December 31, 2019. However, Anthem to continue its submission directly to LA Care.	Quarterly – Due 30 days after quarter end	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Compliance folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS approved templates
6. Community Based Adult Services (CBAS) Report	Quarterly - Due to L.A. Care 75 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder. Plan will also have the option to submit via email to remain compliant with due date.	DHCS approved template
7. Dental General Anesthesia Report Mandated by APL 15-012	Quarterly - Due to L.A. Care 5 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder. Plan will also have the option to submit via email to remain compliant with due date.	DHCS approved template
8. Coordinated Care Initiative – Long-Term Services & Supports (CCI – LTSS)	Quarterly - Due to L.A. Care 5 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder. Plan will also have the option to submit via email to remain compliant with due date.	DHCS approved template

9. Encounter Data Letters – CAP response	Quarterly - Due to L.A. Care 30 business days after receipt of CAP request	L.A. Care Regulatory Reporting via email	No specific template
10. Grievance Report Mandated by APL 14-013	Quarterly - Due to L.A. Care 5 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports Plan will also have the option to submit via email to remain compliant with due date.	DHCS approved template
11.9. Medi-Cal Managed Long-Term Services & Supports (MLTSS) Report Mandated by APL 17-012APL 14-010	Quarterly - Due to L.A. Care 57 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports Plan will also have the option to submit via email to remain compliant with due date.	DHCS approved template
12. Out-of-Network (OON) Report	Quarterly - Due to L.A. Care 5 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports Plan will also have the option to submit via email to remain compliant with due date.	DHCS approved template
13.10. Medi-Cal Managed Care Survey – Disproportionate State Hospitals (MMCS-DSH) Survey	Annually – contingent of DHCS notice	DHCS SFTP with copy to LA Care Medical Payment Systems and Services Reporting	DHCS approved template
14. Pharmacy Formulary Changes Reports	Annually - Due to L.A. Care 5 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS approved template

~~15.~~11. Health Homes Program DHCS Required Reporting **DHCS retired effective December 31, 2021*	Due to L.A. Care 5 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS approved template
12. Enhanced Care Management DHCS Required Reporting	Quarterly, Bi-Annually, & Annually, according to schedule in DHCS template -Due to L.A. Care 5 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder	DHCS approved template, plus attestation of data and brief written summary of oversight and monitoring activity for the reporting period
13. Community Supports DHCS Required Reporting	Quarterly, Bi-Annually, & Annually, according to schedule in DHCS template -Due to L.A. Care 5 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder	DHCS approved template, plus attestation of data and brief written summary of oversight and monitoring activity for the reporting period
~~16.~~14. CBAS Monthly Wavier Report	Monthly -Due to L.A. Care 5 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS approved template
15. MOT Post Transitional Monitoring	Quarterly -Due to L.A. Care 5 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template
~~17.~~16. Prop 56 Directed Payment for Physician Services (APL 19-015)	Quarterly-Due to L.A. Care 5 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS Template based on APL reporting requirements

~~18.~~17. Prop 56 Hyde Reimbursement Requirements for specific Services (APL 19-013)	Quarterly-Due to L.A. Care 5 business days prior to submission to DHCS	LA Care Regulatory via its Secure File Transfer Regulatory Reports folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS Template based on APL reporting requirements
~~19.~~18. Prop 56 Directed Payments for Developmental Screening Services (APL 19-016)	Quarterly-Due to L.A. Care 5 business days prior to submission to DHCS	LA Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS Template based on APL reporting requirements
~~20.~~19. Prop 56 Directed Payments for Valued Base Payment Program (APL 20-014)	Quarterly-Due to L.A. Care 5 business days prior to submission to DHCS	LA Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS Template based on APL reporting requirements
~~21.~~20. Prop 56 Directed Payments for Family Planning (APL 20-013)	Quarterly-Due to L.A. Care 5 business days prior to submission to DHCS	LA Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS Template based on APL reporting requirements
~~22.~~21. Prop 56 Directed Payment for Adverse Childhood Experiences Screening Services (AP-19-018)	Quarterly-Due to L.A. Care 5 business days prior to submission to DHCS	LA Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder Plan will also have the option to submit via email to remain	DHCS Template based on APL reporting requirements

		compliant with due date.	
~~23.~~22. MMDR MER Exemption Review Denial Report	Monthly - Due to L.A. Care 5 business days prior to submission to DHCS This deliverable is contingent of receiving a member list from L.A Care to support monthly report.	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS Reporting template
~~24.~~23. MCPD and PCPA Managed Care Program Date (MCPD) and Primary Care Provider Alignment (PCPA) The Managed Care Program Data (MCPD) report is a consolidated reporting requirement which DHCS introduced through APL 20-017. The MCPD file replaces the following reporting requirements, as this data is now incorporated into the MCPD file in .json format: • Grievances and appeals data in an Excel template, as specified in APL 14-013 ***(previously submitted by your plan as the Grievance Report Mandated by APL 14-013)*** • Monthly MERs and other continuity of care records data in an Excel template, as specified in Attachment B of APL 17-007 ***(previously submitted by your plan as the MMDR Report)*** • Other types of continuity of care data in ad-hoc Excel templates Out-of-Network request data in a variety of ad-hoc Excel templates ***(previously submitted by your plan as the OON Report***	Monthly - Due to L.A. Care 5 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS Template based on APL reporting requirements
~~25. Third Party Liability~~	~~Due 25 days from the date LA Care submits case file.~~	~~L.A. Care Regulatory via its Secure File Transfer Protocal (SFTP) TPL folder~~	~~DHCS approved templates~~

		Plan will also have the option to submit via email to remain compliant with due date.	
24. Acute Care at Home Hospital Report APL 20-021	Monthly – Due to LA Care the last day of every month	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder	DHCS Reporting Template
25. Cost Avoidance & Post Payment (CAPP) Recovery Mandated by APL 21-002	Quarterly - Due to L.A. Care 45 days after the quarter ends	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	Regulatory Reports provided Template based on APL reporting requirements
26. Provider Network Termination Mandated by APL 21-003	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	DHCS Approved Template
27. Third Party Liability	Due 25 days from the date LA Care submits case file.	L.A. Care Regulatory via its Secure File Transfer Protocal (SFTP) TPL folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS approved templates
28. ECM and Community Supports Quarterly Report	Report due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder	DHCS Reporting Template
26.29. New and or revised reports as released by DHCS	Due to L.A. Care 7 business days prior to submission to DHCS *The effective date will be based on the last date signed by the parties to support the full execution of this delegation agreement.	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder Plan will also have the option to submit via email to remain compliant with due date.	DHCS approved templates
27.30. Disaster and Recovery Plan / Test Results L.A. Care will communicate all data elements as outlined by DHCS due to an	Contingent of DHCS notice	L.A. Care Regulatory via its Secure File Transfer Protocol (SFTP) Regulatory Reports folder	DHCS template Word Document, Non-Specific template

emergency declared by the Governor. below including but not limited to: LA Care may require additional information on Business Continuity efforts based off current event. In the event there are any additional requests from regulators for individual instances, such as, an emergency declared by the governor; L.A. Care will send out an ad hoc written request asking to respond with the requested information should it be an element outside of what is already being requested and another mobile contact mechanism when outside of regular business hours.	Annually during PP audit and ad-hoc Contingent on government notice; Ad-hoc	Plan will also have the option to submit via secure email to remain compliant with due date. EnterpriseRiskManagement@lacare.org home/PPName/infile/Regulatory Reports/ EnterpriseRiskManagement@lacare.org ; RegulatoryReports@lacare.org	Template may change upon regulators request.
FINANCIAL COMPLIANCE			
1. PPG Solvency Report 627	Quarterly - Due to L.A. Care 75 calendar days after each quarter end	L.A. Care via its Secure File Transfer Protocol (SFTP) Compliance folder Plan will also have the option to submit via secure email to remain compliant with due date.	Excel/PDF
2. Annual Audit Report 628	Quarterly – Due to L.A. Care 60 calendar days after each calendar quarter end for the delegate audits conducted in the reporting quarter	L.A. Care via its Secure File Transfer Protocol (SFTP) Compliance folder Plan will also have the option to submit via secure email to remain compliant with due date.	Excel/PDF
DELEGATION OVERSIGHT			
1. New Member Welcome Kit Mailing Reports	Due to L.A. Care by the 15th of each month	L.A. Care via its Secure File Transfer Protocol (SFTP) Compliance folder Plan will also have the option to submit via email to remain compliant with due date.	

CULTURAL & LINGUISTIC SERVICES			
1. C&L Program Description and Work Plan	Annually – due to L.A. Care January 31st of each year	L.A. Care's Secure File Transfer Protocol (SFTP) *OR* Via email to CulturalandLinguisticServices_Mailbox@lacare.org	Plan Partner can submit their own format of C&L program description and work plan.
2. C&L Program Evaluation NCQA HE Standard 7	Annually – due to L.A. Care January 31st of each year	L.A. Care's Secure File Transfer Protocol (SFTP) *OR* Via email to CulturalandLinguisticServices_Mailbox@lacare.org	Plan Partner can submit their own format of C&L program evaluation
3. Bilingual Staff List NCQA HE Standard 7	Annually – due to L.A. Care January 31st of each year	L.A. Care's Secure File Transfer Protocol (SFTP) *OR* Via email to CulturalandLinguisticServices_Mailbox@lacare.org	L.A. Care report template *OR* Mutually agreed upon report format
4. Translated Documents / Alternative Formats Tracking Log NCQA HE Standard 7	Quarterly – Due to L.A. Care the 25th day of the month following the end of the quarter: • Q1 due 4/25 • Q2 due 7/25 • Q3 due 10/25 • Q4 due 1/25	L.A. Care's Secure File Transfer Protocol (SFTP) *OR* Via email to CulturalandLinguisticServices_Mailbox@lacare.org	L.A. Care report template *OR* Mutually agreed upon report format
5. Interpreting Utilization Report (Face-to-face and Telephonic interpreting) NCQA HE Standard 7	Quarterly – Due to L.A. Care the 25th day of the month following the end of the quarter: • Q1 due 4/25 • Q2 due 7/25 • Q3 due 10/25 • Q4 due 1/25	L.A. Care's Secure File Transfer Protocol (SFTP) *OR* Via email to CulturalandLinguisticServices_Mailbox@lacare.org	L.A. Care report template *OR* Mutually agreed upon report format
6. C&L Referral Report	Quarterly – Due to L.A. Care the 25th day of the month following the end of the quarter:	L.A. Care's Secure File Transfer Protocol (SFTP)	L.A. Care report template

	• Q1 due 4/25 • Q2 due 7/25 • Q3 due 10/25 • Q4 due 1/25	*OR* Via email to CulturalandLinguisticServices_Mailbox@lacare.org	*OR* Mutually agreed upon report format

HEALTH EDUCATION			
1. Health Education Referral Report	Quarterly – Due to L.A. Care the 25th day of the month following the end of the quarter: • Q1 due 4/25 • Q2 due 7/25 • Q3 due 10/25 • Q4 due 1/25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Health Education/	Format as specified by LA. Care or mutually agreed upon per Plan Partner process.
2. Health Education Material Distribution Report	Quarterly – Due to L.A. Care the 25th day of the month following the end of the quarter: • Q1 due 4/25 • Q2 due 7/25 • Q3 due 10/25 • Q4 due 1/25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Health Education/	Format as specified by LA. Care or mutually agreed upon per Plan Partner process.
3. Health Education Program Description and jtWork Plan	Annually – due to L.A. Care January 31st of each year	Via email to designated Health Education contact	As appropriate per Plan Partner model.

All other non-conflicting rights and duties, obligations and liabilities of the parties to the Agreement shall remain unchanged.

IN WITNESS WHEREOF, the parties have entered into this Amendment as of the date set forth below.

Local Initiative Health Authority for Los Angeles County d.b.a. L.A. Care Health Plan (L.A. Care)
A local government agency

By: ________________________
John Baackes
Chief Executive Officer

Date: ______________________, 202~~2~~3

By: ________________________
~~Hector De La Torre~~Alvaro Ballesteros
Chairperson,
L.A. Care Board of Governors

Date: _____________________, 202~~2~~3

Blue Cross of California dba Anthem Blue Cross
A California health care services plan

By: ___________________________
Les Ybarra
President,
Medicaid Health Plan for California

Date: _______________________, 202~~2~~3

Amendment No. 48
to
Services Agreement
between
Local Initiative Health Authority for Los Angeles County
and
Blue Shield of California Promise Health Plan

This Amendment No. 48 is effective as of July 1, 2021, as indicated herein by and between the Local Initiative Health Authority for Los Angeles County, a local public agency operating as L.A. Care Health Plan ("Local Initiative") and ***Blue Shield of California Promise Health Plan***, a California health care service plan ("Plan").

RECITALS

WHEREAS, the State of California ("State") has, through statute, regulation, and policies, adopted a plan ("State Plan") for certain categories of Medi-Cal recipients to be enrolled in managed care plans for the provision of specified Medi-Cal benefits. Pursuant to this State Plan, the State has contracted with two health care service plans in Los Angeles County. One of these two health care service plans with which the State has a contract ("Medi-Cal Agreement") is a health care service plan locally created and designated by the County's Board of Supervisors for, among other purposes, the preservation of traditional and safety net providers in the Medi-Cal managed care environment ("Local Initiative"). The other health care service plan is an existing HMO which is selected by the State (the "Commercial Plan");

WHEREAS, the Local Initiative is licensed by the Department of Managed Health Care as a health care service plan under the California Knox-Keene Act (Health and Safety Code Sections 1340 *et seq*.) (the "Knox-Keene Act");

WHEREAS, Plan is duly licensed as a prepaid full service health care service plan under the Knox-Keene Act and is qualified and experienced in providing and arranging for health care services for Medi-Cal beneficiaries; and

WHEREAS, Local Initiative and Plan have entered into a prior agreement dated October 1, 2009, as amended ("Agreement"), for Plan to provide and arrange for the provision of health care services for Local Initiative enrollees as part of a coordinated, culturally and linguistically sensitive health care delivery program in accordance with the Medi-Cal Agreement and all applicable federal and state laws.

NOW, THEREFORE, in consideration of the foregoing and the terms and conditions set forth herein, the parties agree to amend the Agreement as follows:

I. <u>Exhibit 8 – Delegation Agreement, shall be revised as is set forth in Exhibit 8, below.</u>

IN WITNESS WHEREOF, the parties have entered into this Amendment No. 48 as of the date set forth below.

Local Initiative Health Authority for Los Angeles County operating as L.A. Care Health Plan (Local Initiative)
A local public agency

By: ______________________________
John Baackes
Chief Executive Officer

Date: ___________________, 2023

By: ______________________________
Alvaro Ballesteros
Chairperson
L.A. Care Board of Governors

Date: __________________, 2023

Blue Shield of California Promise Health Plan,
A California health care services plan

By: ______________________________
Kristen Cerf
President and Chief Executive Officer

Date: ______________________, 2023

II. Exhibit 8 – Delegation Agreement, shall be revised as follows:

Exhibit 8
Delegation Agreement
[Attachment A]

Delegated Activities Effective July 1, 2021-June 30, 2022
Responsibilities of Plan and Local Initiative

The purpose of the following grid is to specify the activities delegated by Local Initiative ("L.A. Care") to Blue Shield of California Promise Health Plan (individually and collectively "Plan" and/or "Delegate") under the Delegation Agreement with respect to: (i) quality management and improvement, (ii) population health management (iii) network management, (iv) utilization management, (v) credentialing and re-credentialing, (vi) member experience, (vii) claims recovery., and (viii) claims processing. All Delegated Activities are to be performed in accordance with currently applicable NCQA accreditation standards and State and Federal regulatory requirements, as modified from time to time. Blue Shield of California Promise Health Plan agrees to be accountable for all responsibilities delegated by L.A. Care and will not further delegate (sub-delegate) any such responsibilities without prior written approval by L.A. Care, except as outlined in the Delegation Agreement. Blue Shield of California Promise Health Plan is responsible for sub-delegation oversight of any sub-delegated activities. Blue Shield of California Promise Plan will provide periodic reports to L.A. Care as described elsewhere in the Delegation Agreement. L.A. Care will oversee the delegation to Blue Shield of California Promise Health Plan as described elsewhere in the Services Agreement. In the event deficiencies are identified through this oversight, Blue Shield of California Promise Health Plan will provide a specific corrective action plan acceptable to L.A. Care. If Blue Shield of California Promise Health Plan does not comply with the corrective action plan within the specified time frame, L.A. Care may revoke the delegation to Blue Shield of California Promise Health Plan, in whole or in part, in accordance with Exhibit 5, herein. Due to the Medi-Cal Rx Transition where the pharmacy benefit will be managed by DHCS starting January 1, 2022, standard and reporting requirements as related to Pharmacy items will no longer be required for data period beginning the transition date identified by DHCS. This would apply to all standard requirements and reports listed under "Pharmacy". The final monitoring and quarterly reporting requirement would be up to the data period until the transition date. However, while the monitoring and quarterly reporting will discontinue after the transition date, any reports required for regulatory or NCQA purposes mainly as it relates to any data up to the actual transition date would be still required upon request. *L.A. Care will provide* ***delegate with Member Experience data: complaints, CAHPS, survey results or other data collected on members' experience with the delegate's services. In addition, will also provide Clinical performance data: HEDIS measures, claims and other clinical data collected by the organization. L.A. Care may provide data feeds for relevant claims data or clinical performance measure results*** *when requested and as applicable. Request shall be sent to the L.A. Care business unit which maintains the data and/or L.A. Care's delegate Business Unit. The request must be precise and contain sufficient details so it is clear what minimum data needs to be provided to fulfill the request. The L.A. Care business unit responsible for the requested data shall respond timely and ensure that data is sent in compliance with L.A. Care's Policies and Procedures securing PHI through applicable protections, e.g., encryption.*

Standard	Delegated Activities	Retained by L.A. Care
	QUALITY MANAGEMENT AND IMPROVEMENT	
Program Structure and Operations: Applicable L.A. Care Policies: QI-003, QI-005, QI-006, QI-007, QI-0026	**QI Program Structure** The organization's QI program description specifies: 1. The QI Program Structure 2. The behavioral healthcare aspects of the program. 3. Involvement of a designated physician in the QI program	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs, including review, evaluation, and approval of its Delegates'

Standard	Delegated Activities	Retained by L.A. Care
(NCQA QI 1)	4. Involvement of a behavioral healthcare practitioner in the behavioral aspects of the program 5. Oversight of QI functions of the organization by the QI Committee 6. Objectives for serving a culturally and linguistically diverse membership **Annual Work Plan** The organization documents and executes a QI annual work plan that reflects ongoing activities throughout the year and addresses: 1. Yearly planned QI activities and objectives. 2. Time frame for each activity's completion. 3. Staff members responsible for each activity. 4. Monitoring of previously identified issues. 5. Evaluation of the QI program. **Annual Evaluation** The organization conducts an annual written evaluation of the QI program that includes the following information: 1. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service 2. Trending of measures of performance in the quality and safety of clinical care and quality of service 3. evaluation of the overall effectiveness of the QI program and of its progress toward influencing network-wide safe clinical practices **QI Committee Responsibilities** The organization's QI Committee: 1. Recommends policy decisions. 2. Analyzes and evaluates the results of QI activities. 3. Ensures practitioner participation in the QI program through planning, design, implementation or review. 4. Identifies needed actions. 5. Ensures follow-up, as appropriate. **Promoting Organizational Diversity, Equity and Inclusion** The organization: 1. Promotes diversity in recruiting and hiring. 2. Offers training to employees on cultural competency, bias or inclusion.	activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.
Health Services Contracting : Applicable L.A. Care Policy: QI-007 (NCQA QI 2)	**Practitioner Contracts** Contracts with practitioners specifically require that: 1. Practitioners cooperate with QI activities 2. Practitioners allow the organization to use their performance data.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and

Standard	Delegated Activities	Retained by L.A. Care
	Provider Contracts This standard is required for the first survey under NCQA guidelines. Plans are still required to maintain compliance with this standard. NCQA only removed this requirement to submit documentation for renewal surveys. Contracts with practitioners specifically require that: 1. Practitioners cooperate with QI activities. 2. Practitioners allow the organization to use their performance data.	approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.
Continuity and Coordination of Medical Care: Applicable L.A. Care Policy: QI-0026 (NCQA QI 3)	**Identifying Opportunities** The organization annually identifies opportunities to improve continuity and coordination of medical care across the network by: 1. Collecting data on member movement between practitioners. 2. Collecting data on member movement across settings. 3. Conducting quantitative and analysis of data to identify improvement opportunities. 4. Identifying and selecting one opportunity for improvement. 5. Identifying and selecting a second opportunity for improvement. 6. Identifying and selecting a third opportunity for improvement. 7. Identifying and selecting a fourth opportunity for improvement. **Acting on Opportunities** The organization annually acts to improve coordination of medical care by: 1. Acting on the first opportunity identified in Element A, factor 4-7 2. Acting on the second opportunity identified in Element A, factor 4-7 3. Acting on the third opportunity identified in Element A, factor 4-7. **Measuring Effectiveness** The organization annually measures the effectiveness of improvement actions taken for: 1. The first opportunity identified in Element B. 2. The second opportunity identified in Element B. 3. The third opportunity identified in Element B. **Transition to Other Care** Refer to Utilization Management Delegated Activities Section	

Standard	Delegated Activities	Retained by L.A. Care
Continuity and Coordination Between Medical Care and Behavioral Healthcare: Applicable L.A. Care Policy: QI-0026 (NCQA QI 4)	**<u>Data Collection</u>** The organization annually collects data about opportunities for collaboration between medical care and behavioral healthcare in the following areas: 1. Exchange of information. 2. Appropriate diagnosis, treatment and referral of behavioral healthcare disorders commonly seen in primary care. 3. Appropriate use of psychotropic medications. 4. Management of treatment access and follow-up for members with coexisting medical and behavioral disorders. 5. Primary or secondary preventive behavioral healthcare program implementation. 6. Special needs of members with severe and persistent mental illness. **<u>Collaborative Activities</u>** The organization annually conducts activities to improve the coordination of behavioral healthcare and general medical care including: 1. Collaborating with behavioral healthcare practitioners. 2. Quantitative and causal analysis of data to identify improvement opportunities 3. Identifying and selecting one opportunity for improvement from Element A. 4. Identifying and selecting a second opportunity for Improvement from Element A. 5. Taking collaborative action to address one identified opportunity for improvement from Element A. 6. Taking collaborative action to address a second identified opportunity for improvement from Element A **<u>Measuring Effectiveness</u>** The organization annually measures the effectiveness of improvement actions taken for: 1. The first opportunity in Element B. 2. The second opportunity in Element B.	

Standard	Delegated Activities	Retained by L.A. Care
Standards for Medical Record Documentation (DHCS)	Establishing medical record standards which require medical records to be maintained in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review, including: 1. Developing and distributing to practice sites: a. Policies and procedures for the confidentiality of medical records; b. Medical record documentation standards; c. Requirements for an organized medical record keeping system; d. Standards for the availability of medical records	

Standard	Delegated Activities	Retained by L.A. Care
Sub-Delegation of QI: Applicable L.A. Care Policy: QI-007 (NCQA QI 5)	**<u>Sub-Delegation Agreement</u>** **(LAC will ask Delegate of its sub-delegate during the annual audit)** The written sub-delegation agreement: 1. Is mutually agreed upon. 2. Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity. 3. Requires at least semiannual reporting by the sub-delegated entity to the delegate. 4. Describes the process by which the delegate evaluates the sub-delegated entity's performance. 5. Describes the process for providing member experience and clinical performance data to its delegates when requested. 6. Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **<u>Predelegation Evaluation</u>** For new sub-delegation agreements initiated in the look-back period, the delegated entity evaluates sub-delegate capacity to meet NCQA requirements before sub-delegation begins. **<u>Review of QI Program</u>** For arrangements in effect for 12 months or longer, the delegate: 1. Annually reviews its sub-delegate's QI program. 2. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities. 3. Semiannually evaluates regular reports, as specified in the sub-delegation agreement **<u>Opportunities for Improvement</u>** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	
	POPULATION HEALTH MANAGEMENT	
PHM Strategy (NCQA PHM 1)	**<u>Strategy Description</u>** The strategy describes: 1. Goals and populations targeted for each of the four areas of focus. 2. Programs or Services offered to members. 3. Activities that are not direct member interventions,	

Standard	Delegated Activities	Retained by L.A. Care
	4. How member programs are coordinated. 5. How members are informed about available PHM programs. 6. How the organization promotes health equity. **<u>Informing Members</u>** The organization informs members eligible for programs that include interactive contact: 1. How members become eligible to participate 2. How to use program services. 3. How to opt in or opt out of the program	
Population Identification (NCQA PHM 2)	**<u>Data Integration</u>** The organization integrates the following data to use for population health management functions: 1. Medical and Behavioral claims or encounters 2. Pharmacy claim (Jul 1, 2021-Dec 31,2021) 3. Physician Administered Drugs (PAD) claim 4. Laboratory results 5. Health appraisal results 6. Electronic health records 7. Health Services programs within the organization 8. Advanced data sources **<u>Population Assessment</u>** The organization annually: 1. Assesses the characteristics and needs, including social determinants of health, of its member population. 2. Assesses the needs of child and adolescent members. 3. Assesses the needs of members with disabilities. 4. Assesses the needs of members with serious and persistent mental illness (SPMI). 5. Assesses the needs of members of racial or ethnic groups. 6. Assesses the needs of members with limited English proficiency. 7. Identifies and assesses the needs of relevant member subpopulations. **<u>Activities and Resources</u>** The organization annually uses the population assessment to: 1. Review and update its PHM activities to address member needs 2. Review and update its PHM resources to address member need 3. Review and update activities or resources to address health care disparities for at least one identified population. 4. Review community resources for integration into program offerings to address member needs.	

Standard	Delegated Activities	Retained by L.A. Care
	Segmentation 1. segments or stratifies its entire population into subset for targeted intervention. 2. Assesses for racial bias in its segmentation or stratification methodology.	
Delivery System Supports (NCQA PHM 3)	**Practitioner or Provider Support** The organization supports practitioners or providers in its network to achieve population health management goals by: 1. Sharing data 2. Offering certified shared-decision making aids 3. Providing practice transformation support to primary care practitioners 4. Providing comparative quality information on selected specialties 5. Providing comparative pricing information for selected services 6. One additional activity to support practitioners or providers in achieving PHM goals	**Value-Based Payment Arrangements** The organization demonstrates that it has a value-based payment (VBP) arrangement(s) and reports the percentages of total payments tied to VBP.
Wellness and Prevention (NCQA PHM 4)	**Frequency of Health Appraisal Completion** This standard is required for the first survey under NCQA guidelines. Plans are still required to maintain compliance with this standard. NCQA only removed this requirement to submit documentation for renewal surveys. The organization has the capability to administer a health appraisal (HA) annually. **Topics of Self-Management Tools** The organization offers self-management tools derived from available evidence, that provide members with information on at least the following wellness and health promotion areas: 1. Healthy weight (BMI) maintenance. 2. Smoking and tobacco cessation. 3. Encouraging physical activity. 4. Healthy eating. 5. Managing stress. 6. Avoiding at-risk drinking. 7. Identifying depressive symptoms.	

Standard	Delegated Activities	Retained by L.A. Care
Complex Case Management (NCQA PHM 5)	**<u>Access to Case Management</u>** The organization has multiple avenues for members to be considered for complex case management services, including: 1. Medical management program referral 2. Discharge planner referral 3. Member or caregiver referral 4. Practitioner referral. **<u>Case Management Systems</u>** The organization uses case management systems that support: 1. Evidence-based clinical guidelines or algorithms to conduct assessment and management; 2. Automatic documentation of the individual ID and date and time of action on the case when interaction with the member occurred; and 3. Automated prompts for follow-up as required by the case management plan. **<u>Case Management Process</u>** This standard is required for the first survey under NCQA guidelines. Plans are still required to maintain compliance with this standard. NCQA only removed this requirement to submit documentation for renewal surveys. The organization's complex case management procedures address the following: 1. Initial assessment of member health status, including condition-specific issues 2. Documentation of clinical history, including medications 3. Initial assessment of activities of daily living 4. Initial assessment of behavioral health status, including cognitive functions 5. Initial assessment of social determinants of health 6. Initial assessment of life planning activities 7. Evaluation of cultural and linguistic needs, preferences or limitations 8. Evaluation of visual and hearing needs, preferences or limitations 9. Evaluation of caregiver resources and involvement 10. Evaluation of available benefits 11. Evaluation of community resources 12. Development of an individualized case management plan, including prioritized goals and considers member and caregiver goals, preferences and desired level of involvement in the case management plan	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	13. Identification of barriers to the member meeting goals or complying with the case management plan 14. Facilitation of member referrals to resources and follow-up process to determine whether members act on referral 15. Development of a schedule for follow-up and communication with the member 16. Development and communication of self-management plans. 17. A process to assess members' progress against case management plans for members. **<u>Initial Assessment</u>** An NCQA review of a sample of the organization's complex case management files demonstrates that the organization follows its documented processes for: 1. Initial assessment of members' health status, including condition-specific issues 2. Documentation of clinical history, including medications 3. Initial assessment of activities of daily living (ADL) 4. Initial assessment of behavioral health status, including cognitive functions 5. Initial assessment of social determinants of health 6. Evaluation of cultural and linguistic needs, preferences or limitations 7. Evaluation of visual and hearing needs, preferences or limitations 8. Evaluation of caregiver resources and involvement 9. Evaluation of available benefits 10. Evaluation of available community resources 11. Assessment of life planning activities. 12. Beginning the assessment for at least one factor within 30 calendar days of identifying a member for complex case management. **<u>Case Management Ongoing Management</u>** The NCQA review of a sample of the organization's case management files that demonstrates the Plan Partner follows its documented processes for: 1. Development of case management plans, including prioritized goals, that take into account member and caregiver goals, preferences and desired level of involvement in the complex case management program 2. Identification of barriers to meeting goals and complying with the plan 3. Development of a schedule for follow-up and communication with members.	

Standard	Delegated Activities	Retained by L.A. Care
	4. Development and communication of member self-management plans. 5. Assessment of progress against case management plans and goals and modification as needed.	
Population Health Management Impact (NCQA PHM 6)	**<u>Measuring Effectiveness</u>** At least annually, the organization conducts a comprehensive analysis of the impact of its PHM strategy that includes the following: 1. Quantitative results for relevant clinical, cost/utilization and experience measures. 2. Comparison of results with a benchmark or goal. 3. Interpretation of results. **<u>Improvement and Action</u>** The organization uses results from the PHM impact analysis to annually: 1. Identify opportunities for improvement. 2. Act on one opportunity for improvement.	
Sub-Delegation of PHM (NCQA PHM 7)	**<u>Sub-Delegation Agreement</u>** **(LAC will ask Delegate of its sub-delegate during the annual audit)** The written sub-delegation agreement: 1. Is mutually agreed upon 2. Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity 3. Requires at least semiannual reporting by the sub-delegated entity to the delegate 4. Describes the process by which the delegate evaluates the sub-delegated entity's performance 5. Describes the process for providing member experience and clinical performance data to its delegates when requested.	

Standard	Delegated Activities	Retained by L.A. Care
	6. Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **Predelegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the delegated entity evaluates sub-delegate capacity to meet NCQA requirements before sub-delegation begins. **Review of PHM Program** For arrangements in effect for 12 months or longer, the delegate: 1. Annually reviews its sub-delegate's PHM program 2. Annually audits complex case management files against NCQA standards for each year that sub-delegation has been in effect, if applicable 3. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities 4. Semiannually evaluates regular reports, as specified in the sub-delegation agreement **Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	
	NETWORK MANAGEMENT	
Availability of Practitioners (NCQA NET 1)	**Cultural Needs and Preferences** The organization: 1. Assessing the cultural, ethnic, racial, and linguistic needs of members 2. Adjusts the availability of practitioners within its network if necessary. **Practitioners Providing Primary Care** To evaluate the availability of practitioners who provide primary care services, including general medicine or family practice, internal medicine and pediatrics, the organization: 1. Establishes measurable standards for the number of each type of practitioners providing primary care 2. Establishes measurable standards for the geographic distribution of each type of practitioner providing primary care.	

Standard	Delegated Activities	Retained by L.A. Care
	3. Annually analyzes performance against the standards for the number of each type of practitioner providing primary care 4. Annually analyzes performance against the standards for the geographic distribution of each type of practitioner providing primary care. **<u>Practitioners Providing Specialty Care</u>** To evaluate the availability of specialists in its delivery system, the organization: 1. Defines the types of high-volume and high-impact specialists 2. Establishes measurable standards for the number of each type of high volume specialists. 3. Establishes measurable standards for the geographic distribution of each type of high-volume specialists. 4. Establishes measureable standards for the geographic distribution of each type of high-impact specialist. 5. Analyzes its performance against the established standards at least annually. **<u>Practitioners Providing Behavioral Healthcare</u>** To evaluate the availability of high-volume behavioral healthcare practitioners in its delivery system, the organization: 1. Defines the types of high-volume behavioral healthcare practitioners 2. Establishes measureable standards for the number of each type of high-volume behavioral healthcare practitioner 3. Establishes measureable standards for the geographic distribution of each type of high-volume behavioral healthcare practitioner 4. Analyzes performance against standards annually	

Standard	Delegated Activities	Retained by L.A. Care
Accessibility of Services (NCQA NET 2)	**<u>Access to Primary Care</u>** Using valid methodology, the organization collects and performs an annual analysis of data to measure its performance against its standards for access to: 1. Regular and routine care appointments; 2. Urgent care appointments; 3. After-hours care **<u>Access to Behavioral Healthcare</u>** Using valid methodology, the organization annually collects and analyzes data to evaluate access to appointments for behavioral healthcare for: 1. Care for a non-life-threatening emergency within 6 hours 2. Urgent care within 48 hours 3. Initial visit for routine care within 10 business days 4. Follow-up routine care. **<u>Access to Specialty Care</u>** Using valid methodology, the organization annually collects and analyzes data to evaluate access to appointments for: 1. High-volume specialty care 2. High-impact specialty care	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
Assessment of Network Adequacy (NCQA NET 3)	**<u>Assessment of Member Experience Accessing the Network</u>** The organization annually identifies gaps in networks specific to geographic areas or types of practitioners or providers by: 1. Using analysis results related to member experience with network adequacy for nonbehavioral healthcare services from ME 7, Element C and Element D. 2. Using analysis results related to member experience with network adequacy for behavioral healthcare services from ME 7, Element C and Element E. 3. Compiling and analyzing non-behavioral requests for and utilization of out-of-network services 4. Compiling and analyzing behavioral healthcare requests for and utilization of out-of-network services. **<u>Opportunities to Improve Access to Nonbehavioral Healthcare Services</u>** The organization annually: 1. Prioritizes opportunities for improvement from analyses of availability (NET 1, Elements A, B and C), accessibility (NET 2, Elements A and C) and member experience accessing the network (NET 3, Element A, factors 1 and 3). 2. Implements interventions on at least one opportunity, if applicable. 3. Measures the effectiveness of interventions, if applicable. **<u>Opportunities to Improve Access Behavioral Healthcare Services</u>** The organization annually: 1. Prioritizes opportunities for improvement identified from analyses of availability (NET 1, Elements A and D), accessibility (NET 2, Element B) and member experience accessing the network (NET 3, Element A, factors 2 and 4). 2. Implements interventions on at least one opportunity, if applicable. 3. Measures the effectiveness of the interventions, if applicable.	

Standard	Delegated Activities	Retained by L.A. Care
Continued Access to Care (NCQA NET 4)	**Notification of Termination** Refer to Utilization Management Delegated Activities Section **Continued Access to Practitioners** Refer to Utilization Management Delegated Activities Section Note: Review process is managed by L.A. Care Utilization Management team.	
Physician and Hospital Directories (NCQA NET 5)	**<u>Physician Directory Data</u>** The organization has a web-based physician directory that includes the following physician information: 1. Name 2. Gender 3. Specialty 4. Hospital affiliations 5. Medical group affiliations 6. Board certification 7. Accepting new patients 8. Language spoken by the physician or clinical staff 9. Office locations and phone numbers **<u>Physician Directory Updates</u>** The organization updates its web-based physician directory within 30 calendar days of receiving new information from the network physician. **<u>Assessment of Physician Directory Accuracy</u>** Using valid methodology, the organization performs an annual evaluation of its physician directories for: 1. Accuracy of office locations and phone numbers 2. Accuracy of hospital affiliations 3. Accuracy of accepting new patients 4. Awareness of physician office staff of physician's participation in the organization's networks. **<u>Identifying and Acting on Opportunities</u>** Based on results of the analysis performed in Element C, at least annually the organization: 1. Identifies opportunities to improve the accuracy of the information in its physician directories.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	2. Takes action to improve the accuracy of the information in its physician directory. **<u>Searchable Physician Web Based Directory</u>** The organization's web-based physician directory includes search functions with instructions for finding the following physician information: 1. Name 2. Gender 3. Specialty 4. Hospital affiliations 5. Medical group affiliations 6. Accepting new patients 7. Languages spoken by the physician or clinical staff 8. Office locations **<u>Hospital Directory Data</u>** The organization has a web-based hospital directory that includes the following: 1. Hospital name 2. Hospital location and phone number 3. Hospital accreditation status 4. Hospital quality data from recognized sources **<u>Hospital Directory Updates</u>** The organization updates its web-based hospital directory information within 30 calendar days of receiving new information from the network hospital. **<u>Searchable Hospital Web-Based Directory</u>** The organization's web-based directory includes search functions for specific data types and instructions for searching for the following information: 1. Hospital name 2. Hospital location **<u>Usability Testing</u>** The organization evaluates its web-based physician and hospital directories for understandability and usefulness to members and prospective members at least every three years, and considers the following: 1. Reading level 2. Intuitive content organization	

Standard	Delegated Activities	Retained by L.A. Care
	3. Ease of navigation 4. Directories in additional languages, if applicable to the membership **<u>Availability of Directories</u>** The organization makes web-based physician and hospital directory information available to members and prospective members through alternative media, including: 1. Print 2. Telephone	
Sub-Delegation of NET (NCQA NET 6)	**<u>Sub-Delegation Agreement</u>** The written sub-delegation agreement: 1. Is mutually agreed upon 2. Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity 3. Requires at least semiannual reporting by the sub-delegated entity to the delegate 4. Describes the process by which the delegate evaluates the sub-delegated entity's performance 5. Describes the process for providing member experience and clinical performance data to its delegates when requested. 6. Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **<u>Predelegation Evaluation</u>** For new sub-delegation agreements initiated in the look-back period, the organization evaluated sub-delegate capacity to meet NCQA requirements before sub-delegation begins. **<u>Review of Sub-Delegated Activities</u>** For arrangements in effect for 12 months or longer, the delegate: 1. Annually reviews its sub-delegate's network management procedures 2. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities 3. Semiannually evaluates regular reports, as specified in the sub-delegation agreement **<u>Opportunities for Improvement</u>**	

Standard	Delegated Activities	Retained by L.A. Care
	For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	
	UTILIZATION MANAGEMENT	
Continued Access to Care and Continuity and Coordination of Medical Care (NCQA NET 4 and QI 3)	**<u>Notification of Termination (NET4)</u>** The organization notifies members affected by the termination of a practitioner or practice group in general, family or internal medicine or pediatrics, at least thirty (30) calendar days prior to the effective termination date and helps them select a new practitioner. **<u>Continued Access to Practitioners</u>** If a practitioner's contract is discontinued the organization allows affected members continued access to practitioner, as follows: 1. Continuation of treatment through the current period of active treatment or for up to ninety (90) calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition. 2. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy. **<u>Transition to Other Care</u>** The organization helps with members' transition to other care when their benefits end, if necessary.	
Program Structure (NCQA UM 1)	**<u>Written Program Description</u>** The organization's UM program description includes the following: 1. A written description of the program structure 2. The behavioral healthcare aspects of the program 3. Involvement of a designated senior physician in UM program implementation 4. Involvement of a designated behavioral healthcare practitioner in the implementation of the behavioral healthcare aspects of the UM program. 5. The program scope and processes used to make determinations of benefit coverage and medical necessity. 6. Information sources used to determine benefit coverage and medical necessity. **<u>Annual Evaluation</u>** The organization annually evaluates and updates the UM program, as necessary.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
Clinical Criteria for UM Decisions (NCQA UM 2)	**<u>UM Criteria</u>** The organization: 1. Has written UM decision-making criteria that are objective and based on medical evidence 2. Has written policies for applying the criteria based on individual needs 3. Has written policies for applying the criteria based on an assessment of the local delivery system 4. Involves appropriate practitioners in developing, adopting and reviewing criteria. 5. Annually reviews UM criteria and the procedures for applying them based on individual needs and assessment of the local delivery system, and updating as necessary. **<u>Availability of Criteria</u>** The organization: 1. States in writing how practitioners can obtain the UM criteria 2. Makes the criteria available to practitioners upon request. **<u>Consistency in Applying Criteria</u>** At least annually, the organization: 1. Evaluates the consistency with which health care professionals involved in UM apply criteria in decision making 2. Acts on opportunities to improve consistency, if applicable.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.
Communication Services (NCQA UM 3)	**<u>Access to Staff</u>** The organization provides the following communication services for members and practitioners: 1. Staff are available at least eight (8) hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues 2. Staff can receive inbound communication regarding UM issues after normal business hours 3. Staff are identified by name, title, and organization name when initiating or returning calls regarding UM issues 4. TDD/TTY services for members who need them 5. Language assistance for members to discuss UM issues.	

Standard	Delegated Activities	Retained by L.A. Care
Appropriate Professionals (NCQA UM 4)	**<u>Licensed health Professionals</u>** The organization has written procedures: 1. Requiring appropriately licensed professionals to supervise all medical necessity decisions 2. Specifying the type of personnel responsible for each level of UM decision-making. **<u>Use of Practitioners for UM Decisions</u>** The organization has a written job description with qualifications for practitioners who review denials of care based on medical necessity. Practitioners are required to have: 1. Education, training and professional experience in medical or clinical practice 2. A current license to practice or an administrative license to review UM cases without restriction. **<u>Practitioner Review of Nonbehavioral healthcare Denials</u>** The organization uses a physician, or other healthcare professional as appropriate, reviews any non-behavioral healthcare denial of coverage based on medical necessity. **<u>Practitioner Review of Behavioral Healthcare Denials</u>** The organization uses that a physician or appropriate behavioral healthcare practitioner, to review any behavioral healthcare denial of care based on medical necessity. . **<u>Practitioner Review of Pharmacy Denials</u>** The organization uses a physician or a pharmacist reviews pharmacy denials based on medical necessity. Note: This only applies to pharmaceuticals (Physician Administered Drugs) covered under the medical benefit. **<u>Use of Board Certified Consultants</u>** The organization: 1. Has written procedures for using board certified consultants to assist in making medical necessity determinations 2. Provides evidence that it uses board-certified consultants for medical necessity determinations	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.
Timeliness of UM Decisions (NCQA UM 5)	**<u>Notification of Nonbehavioral Decisions</u>** The organization adheres to the following time frames for notification of non-behavioral healthcare UM Decisions: 1. N/A Marketplace	

Standard	Delegated Activities	Retained by L.A. Care
	2. For Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request. 3. For Medicaid urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request. 4. For Medicaid nonurgent preservice decisions the organization gives electronic or written notification of the decision to members and practitioners within 14 calendar days of the request. 5. For Medicaid postservice decisions the organization gives electronic or written notification of the decision to members and practitioners within 30 calendar days of the request. 6. For postservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 30 calendar days of the request. **Notification of Behavioral Healthcare Decisions** The organization adheres to the following time frames for notification of behavioral healthcare UM decisions: 1. N/A (Marketplace) 2. For Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request. 3. For Medicaidurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 15 calendar days of the request. 4. For Medicaid nonurgent preservice decisions the organization gives electronic or written notification of the decision to members and practitioners within 14 calendar days of the request. 5. For Medicaid post service decisions, the organization gives electronic or written notification of the decision to practitioners and members within 30 calendar days of the request. **Notification of Pharmacy Decisions**	

Standard	Delegated Activities	Retained by L.A. Care
	The organization adheres to the following time frames for notifying members and practitioners of pharmacy UM decisions: 1. For Medicaid urgent concurrent decisions electronic or written notification of the decision to members and practitioners within 24 hours of the request. 2. For Medicaid urgent preservice decisions electronic or written notification of the decision to members and practitioners within 72 hours of the request. 3. For Medicaid nonurgent preservice decisions electronic or written notification of the decision to members and practitioners within 15 calendar days of the request. 4. For Medicaid postservice decisions electronic or written notification of the decision to members and practitioners within 30 calendar days of the request. 5. N/A (Medicare and Marketplace) **Timeliness Report** The organization monitors and submits a report for timeliness of: 1. 1. Non-behavioral UM decision making 2. 2. Notification of non-behavioral UM decisions 3. 3.Behavioral UM decision making 4. 4.Notification of behavioral UM decisions 5. Pharmacy UM decision making 6. Notification of pharmacy UM decisions Note: This only applies to pharmaceuticals (Physician Administered Drugs) covered under the medical benefit. ***Note: L.A. Care and Plan must adhere to the applicable standards identified in the California Health and Safety Code and DHCS Contract, all current regulatory notifications (such as APLs), as well as the most recent NCQA HP Standards***	
Clinical Information (NCQA UM 6)	**Relevant Information for Nonbehavioral Healthcare Decisions** There is documentation that the organization gathers relevant clinical information consistently to support nonbehavioral healthcare UM decision making.	

	<u>Relevant Information for Behavioral Healthcare Decisions</u> There is documentation that the organization gathers relevant clinical information consistently to support behavioral healthcare UM decision making. **<u>Relevant Information for Pharmacy Decisions</u>** The organization documents that it consistently gathers relevant information to support pharmacy UM decision making. Note: This only applies to pharmaceuticals (Physician Administered Drugs) covered under the medical benefit.	
Denial Notices (NCQA UM 7)	**<u>Discussing a Denial With a Reviewer</u>** The organization gives practitioners the opportunity to discuss nonbehavioral healthcare UM denial decisions with a physician or other appropriate reviewer. **<u>Written Notification of Nonbehavioral healthcare Denials</u>** The organization's written notification of each non-behavioral denials, provided to members and their treating practitioners contains the following information: 1. The specific reason for denial, in easily understandable language 2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based 3. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision is based, upon request. **<u>Written Notification of Nonbehavioral Healthcare Notice of Appeal Rights/Process</u>** The organization's written non-behavioral denial notification to members and their treating practitioners contains the following information: 1. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal 2. An explanation of the appeal process, including the members' rights to representation and appeal time frames 3. A description of the expedited appeal process for urgent pre-service or urgent concurrent denials 4. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care.	

	<u>Discussing a Behavioral Healthcare Denial With a Reviewer</u> The organization provides practitioners with the opportunity to discuss any behavioral healthcare UM denial decisions with a physician appropriate behavioral healthcare reviewer or pharmacist reviewer. **<u>Written Notification of Behavioral Healthcare Denials</u>** The organization's written notification of behavioral healthcare denials that it provided to members and their treating practitioners contains: 1. The specific reasons for the denial, in easily understandable language. 2. A reference to the benefit provision, guideline, protocol or similar criterion on which the denial decision is based 3. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or similar criterion on which the denial decision was based, upon request **<u>Written Notification of Behavioral Healthcare Notice of Appeal Rights/Process</u>** The organization's written notification of behavioral healthcare denials which it provides to members and their treating practitioners contains the following information: 1. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal 2. An explanation of the appeal process, including members' right to representation and appeal time frames 3. A description of the expedited appeal process for urgent pre-service or urgent concurrent denials 4. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care. **<u>Discussing a Pharmacy Denial with a Reviewer</u>** The organization gives practitioners the opportunity to discuss pharmacy UM denial decisions with a physician or pharmacist **<u>Written Notifications of Pharmacy Denials</u>** The organization's written notification of pharmacy denials to members and their treating practitioners contains the following information: 1. The specific reasons for the denial in language that is easy to understand.	

	2. A reference to the benefit provision guidelines protocol or similar criterion on which the denial decision is based. 3. A statement that members can obtain a copy of the actual benefit provision guideline protocol or similar criterion on which the denial decision was based, upon request. **<u>Pharmacy Notice of Appeals Rights/Process</u>** The organization's written notification of pharmacy denials to members and their treating practitioners contains the following information: 1. A description of appeal rights including the member's right to submit written comments documents or other information relevant to the appeal. 2. An explanation of the appeal process including the member's right to representation and the appeal time frames. 3. A description of the expedited appeal process for urgent preservice or urgent concurrent denials. 4. Notification that expedited external review can occur concurrently with the internal appeal process for urgent care Note: This only applies to pharmaceuticals (Physician Administered Drugs) covered under the medical benefit.	
Policies for Appeals (NCQA UM 8)	**<u>Internal Appeals</u>** The organization's written policies and procedures for registering and responding to written internal appeals include the following: 1. Allowing at least sixty (60) calendar days after notification of the denial for the member to file the appeal. 2. Documenting the substance of the appeal and any actions taken 3. Full investigation of the substance of the appeal, including any aspects of clinical care involved 4. The opportunity for the member to submit written comments, documents or other information relating to the appeal 5. Appointment of a new person to review an appeal, who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination 6. Appointment of at least one person to review an appeal who is a practitioner in the same or similar specialty The decision for a pre-service appeal and notification to the member within 30 calendar days of receipt of the request.	Members have the option to appeal directly to L.A. Care. Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

	7. The decision for a post-service appeal and notification to the member within 60 calendar days of receipt of the request. For Medicaid only, decisions for postservice appeals and notifications to members must be within 30 calendar days of receipt of the request. 8. The decision for an expedited appeal and notification to the member within 72 hours of receipt of the request. 9. Notification to the member about further appeal rights. 10. Referencing the benefit provision, guideline, protocol or other similar criterion on which the appeal decision is based 11. Giving members reasonable access to and copies of all documents relevant to the appeal, free of charge, upon request. 12. Including a list of titles and qualifications, including specialties, of individuals participating in the appeal review 13. Allowing an authorized representative to act on behalf of the member 14. Providing notices of the appeals process to members in a culturally and linguistically appropriate manner. 15. Continued coverage pending the outcome of an appeal.	
Appropriate Handling of Appeals (NCQA UM 9)	**<u>Preservice and Postservice Appeals</u>** An NCQA review of the organization's appeal files indicates that they contain the following information: 1. Documenting the substance of appeals 2. Investigating appeals 3. Appropriate response to the substance of the appeal. **<u>Timeliness of the Appeal Process</u>** Timeliness of the organization's preservice, postservice and expedited appeal processes is within the specified time frames: 1. For preservice appeals, the organization gives electronic or written notification within thirty (30) calendar days of receipt of the request 2. For Medicaid postservice appeals, the organization gives electronic or written notification within thirty (30) calendar days of receipt of the request 3. For expedited appeals, the organization gives electronic or written notification within seventy-two (72) hours of receipt of the request. **<u>Appeal Reviewers</u>**	Members have the option to appeal directly to L.A. Care. Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

	The organization provides non-subordinate reviewers who were not involved in the previous determination and same or similar specialist review, as appropriate. **Notification of Appeal Decision/Rights** An NCQA review of the organization's internal appeal files indicates notification to members of the following: 1. Specific reasons for the appeal decision in easily understandable language 2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based 3. Notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based, upon request. 4. Notification that the member is entitled to receive reasonable access to and copies of all documents free of charge upon request. 5. The list of titles and qualifications, including specialties, of individuals participating in the appeal review 6. A description of the next level of appeal, either within the organization or to an independent external organization, as applicable, along with relevant written procedures. **Final Internal and External Appeal Files** N/A **Appeals Overturned by the IRO** N/A	
Evaluation of New Technology (NCQA UM 10)		**Written Process** Evaluates the inclusion of new technology and the new application of existing technology in the benefits plan, including medical and behavioral health procedures, physician administered drugs effective January 2022 and devices. This element is Not Applicable for Medicaid product lines if the state mandates all benefits and new technology determinations. L.A. Care will provide the state's language. **Description of the Evaluation Process**

		This element is Not Applicable for Medicaid product lines if the state mandates all benefits and new technology determinations. L.A. Care will produce documentation that demonstrates this.
Procedures for Pharmaceutical Management (NCQA UM 11)	**<u>Pharmaceutical Management Procedures</u>** The organization's policies and procedures for pharmaceutical management include the following: 1. The criteria used to adopt pharmaceutical management procedures 2. A process that uses clinical evidence from appropriate external organizations 3. A process to include pharmacists and appropriate practitioners in the development of procedures 4. A process to provide procedures to practitioners annually and when it makes changes. **<u>Pharmaceutical Restrictions/Preferences</u>** Annually and after updates, the organization communicate to members and prescribing practitioners: 1. A list of pharmaceuticals including restrictions, updates and preferences to post on its Internet website and update that posting with changes on a monthly basis (SB1052) 2. How to use the pharmaceutical management procedures 3. An explanation of limits or quotas 4. How prescribing practitioners must provide information to support an exception request 5. The process for generic substitution, therapeutic interchange and step-therapy protocols. **<u>Pharmaceutical Patient Safety Issues</u>** The organization's pharmaceutical procedures include: 1. Identifying and notifying members and prescribing practitioners affected by Class II recalls or voluntary drug withdrawals from the market for safety reasons within thirty (30) calendar days of the FDA notification 2. An expedited process for prompt identification and notification of members and prescribing practitioners affected by a Class I recall. **<u>Reviewing and Updating Procedures</u>** With the participation of physicians and pharmacists the organization annually: 1. Reviews the procedures 2. Reviews the list of pharmaceuticals	

	3. Updates the procedures as appropriate 4. Updates the list of pharmaceuticals, as appropriate, and 5. Post the list with changes on its Internet website on a monthly basis. (SB1052) **Considering Exceptions** The organization has exceptions policies and procedures that describe the process for: 1. Making exception requests based on medical necessity 2. Obtaining medical necessity information from prescribing practitioners 3. Using appropriate pharmacists and practitioners to consider exception requests 4. Timely handling of request 5. Communicating the reason for denial and explanation of the appeal process when it does not approve an exception request. Note: This only applies to pharmaceuticals (Physician Administered Drugs) covered under the medical benefit.	
UM System Controls (NCQA UM 12)	**UM Denial System Controls** The organization has policies and procedures describing its system controls specific to UM denial notification dates that: 1. Define the date of receipt consistent with NCQA requirements. 2. Define the date of written notification consistent with NCQA requirements. 3. Describe the process for recording dates in systems. 4. Specify titles or roles of staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate. 5. Specify how the system tracks modified dates. 6. Describe system security controls in place to protect data from unauthorized modification. 7. Describe how the organization monitors its compliance with the policies and procedures in factors 1–6 at least annually and takes appropriate action, when applicable. **UM Denial System Controls Oversight** **At least annually, the organization demonstrates that it monitors compliance with its UM denial controls, as described in Element A, factor 7, by:** **1. Identifying all modifications to receipt and decision notification dates that did not meet**	

	the organization's policies and procedures for date modifications. **2. Analyzing all instances of date modifications that did not meet the organization's policies and procedures for date modifications.** **3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters.**	
Sub-Delegation of UM (NCQA UM 13)	**<u>Sub-Delegation Agreement</u>** The written delegation agreement: 1. Is mutually agreed upon 2. Describes the delegated activities and the responsibilities of the organization and the delegated entity. 3. Requires at least semiannual reporting by the delegated entity to the organization. 4. Describes the process by which the organization evaluates the delegated entity's performance. 5. Describes the process for providing member experience and clinical performance data to its delegates when request. 6. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations including revocation of the delegation agreement. **<u>Predelegation Evaluation</u>** For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began. **<u>Review of the UM Program</u>** For arrangements in effect for 12 months or longer, the organization: 1. Annually reviews its delegate's UM program. 2. Annually audits UM denials and appeals files against NCQA standards for each year that delegation has been in effect. 3. Annually evaluates delegate performance against NCQA standards for delegated activities. 4. Semiannually evaluates regular reports, as specified in Element A. 5. Annually monitors the delegate's UM denial and appeal system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures at least annually. 6. Annually acts on all findings from factor 5 for each delegate and implements a quarterly	

	monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters. **Opportunities for Improvement** For delegation arrangements that have been in effect for more than 12 months at least once in each of the past 2 years the organization identified and followed up on opportunities for improvement if applicable.	
	CREDENTIALING	
Credentialing Policies (NCQA CR 1) DMHC, DHCS, CMS	The Delegate has a well-defined credentialing and recredentialing process for evaluating licensed independent practitioners to provide care to its members by developing and implementing credentialing policies and procedures which specify: 1. The types of practitioners to credential and re-credential, to also include all administrative physician reviewers responsible for making medical decisions. 2. The verification sources used. 3. The criteria for credentialing and re-credentialing. 4. The policies must explicitly define the process and criteria used for making credentialing and re-credentialing decisions. 5. The process for managing credentialing files that meet Delegate's established criteria. Policies must describe the process it uses to determine and approve clean files or the Delegate may present all files to the Credentialing Committee, including clean files, or it may designate approval authority to the medical director or to an equally qualified practitioner. 6. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. Policies must specify that the Delegate does not base credentialing decisions on an applicant's race, ethnic/national identity, gender, age, sexual orientation or patient type in which the practitioner specializes. Has a process for preventing and monitoring discriminatory practices and monitors the credentialing and recredentialing processes for discriminatory practices, at least annually and maintain a heterogeneous credentialing committee to sign a statement affirming that they do not discriminate when they make decisions. 7. The process for notifying practitioners about any information obtained during the credentialing process that varies substantially from the	L.A. Care retains the right based on quality issues to approve, suspend and terminate individual practitioners, providers and sites at all times. Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' credentialing activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

	information provided to Delegate by the practitioner. 8. The process to ensure that practitioners are notified of initial and recredentialing decisions within sixty (60) calendar days of the committee's decision. 9. The medical director or other designated physician's direct responsibility for, and participation in, the credentialing program. 10. The process for securing the confidentiality of all information obtained in the credentialing process except as otherwise provided by law. 11. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data including education training board certification and specialty. The organization notifies practitioners about: 1. The right of practitioners to review information submitted to support their credentialing or recredentialing application 2. The right of practitioners to correct erroneous information and: • The timeframe for making corrections. • The format for submitting corrections. • The person to whom the corrections must be submitted. 3. The right of practitioners to be informed of the status of their credentialing or re-credentialing application, upon request. The Delegate must have policies and procedures for its CR system security controls. If the Organization outsources storage of credentialing information to an external entity, the contract between the Delegate and the external entity will be part of the oversight review. The organization's credentialing process describes: 1. How primary source verification information is received, dated and stored. 2. How modified information is tracked and dated from its initial verification. 3. Titles or roles of staff who are authorized to review, modify and delete information, and circumstances when modification or deletion is appropriate. 4. The security controls in place to protect the information from unauthorized modification. 5. How the organization monitors its compliance with the processes and procedures in factors 1–4 at	

(DHCS APL 19-004)	least annually and takes appropriate action when applicable. **Medi-Cal FFS Enrollment** Developing and implementing policies and procedures for Medi-Cal enrollment. Policy must clearly specify enrollment process including, but not limited to: 1. All practitioners that have a FFS enrollment pathway must enroll in the Medi-Cal program.process for ensuring and verifying Medi-Cal enrollment prior to contracting. 2. The process for practitioners whose enrollment application is in process. 3. The process for monitoring between recredentialing cycles to validate continued enrollment. 4. Process for practitioners not currently enrolled in the Medi-Cal program. 5. Process for practitioners deactivated, suspended or denied from the Medi-Cal program. During the annual oversight review, the Delegate is subject to a CAP (Corrective Action Plan) if their documented process does not align with policies. In addition, if the Delegate demonstrates reoccurring deficiencies that were identified in previous audits, the Delegate is subject to additional point deductions.	
Credentialing Committee (NCQA CR 2) DHCS, DMHC, CMS	Designating a credentialing committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions such that: The committee:	

	a. Includes representation from a range of participating practitioners to provide advice and expertise for credentialing decisions. b. Has the opportunity to review the credentials of all practitioners being credentialed or re-credentialed who do not meet Delegate's established criteria and to offer advice, which Delegate considers appropriate under the circumstances. c. The Medical Director, designated physician or credentialing committee reviews and approves files that meet the Delegate's established criteria.	
Credentialing Verification (NCQA CR 3) DHCS, DMHC, CMS	Primary source verification and credentialing and recredentialing decision-making, which includes verification of information to ensure that practitioners have the legal authority and relevant training and experience to provide quality care, within the NCQA prescribed time limits, through primary or other NCQA-approved sources prior to credentialing and recredentialing by: Verifying that the following are within the prescribed time limits: 1. Current, valid license to practice (develop a process to ensure providers licenses are kept current at all times). 2. A valid DEA or CDS, with schedules 2 thru 5, if applicable; or the Delegate has a documented process for practitioners: • Allowing a practitioner with a valid DEA certificate to write all prescriptions for a practitioner with a pending DEA certificate. • Require an explanation from a qualified practitioner who does not prescribe medications and provide arrangements for the practitioner's patients who need prescriptions for medications. 3. Verification of the highest of the following three levels of education and training obtained by the practitioners as appropriate: • Board certification if practitioner stated on the application that he/she is board certified, as well as expiration date of certification. • Completion of a residency program. • Graduation from medical or professional school. 4. Work history. 5. Current malpractice insurance coverage ($1 million/$3 million).	

	6. A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner. 7. Clinical Privileges in good standing at a Plan contracted facility designated by the physician as the primary admitting facility. 8. Current, valid FSR/MRR of primary care physician (PCP) offices within 3 years prior to credentialing decision. 9. CLIA Certifications, if applicable. 10. NPI number. 11. Medi-Cal FFS enrollment. All certifications and expiration dates must be made part of the practitioner's file and kept current. The Delegate must notify L.A. Care immediately when a practitioner's license has expired for removal from the network.	
CR Sanction Information (NCQA CR 3) DHCS, DMHC, CMS	Primary source verification and credentialing and recredentialing decision-making, which includes verifying, within the NCQA prescribed time limits, through primary or other NCQA-approved sources, the following prior to credentialing and recredentialing. a. State sanctions, restrictions on licensure, or limitations on scope of practice. b. Medicare and Medicaid sanctions. c. *Medicare Opt-out. d. SAM. e. CMS Preclusion. The Delegate must notify L.A. Care immediately when practitioners are identified on any sanctions or reports for removal from the network.	
CR Application and Attestation (NCQA CR 3) DHCS, DMHC, CMS	Applications for credentialing and recredentialing include the following: a. Reasons for inability to perform the essential functions of the position, with or without accommodation. b. Lack of present illegal drug use. c. History of loss of license and felony convictions. d. History of loss or limitation of privileges or disciplinary action. e. Current malpractice insurance coverage. f. Current and signed attestation confirming the correctness and completeness of the application.	

Re-credentialing Cycle Length (NCQA CR 4) DHCS, DMHC, CMS	Recredentialing all practitioners at least every 36 months. For PCPs only, must confirm provider has a valid FSR at least every 36 months as part of the recredentialing process.	
CR Ongoing Monitoring and Interventions (NCQA CR 5) DHCS, DMHC, CMS	Developing and implementing policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues and takes appropriate action against practitioners when it identifies occurrences of poor quality between recredentialing cycles by: 1. Collecting and reviewing Medicare and Medicaid sanctions. 2. Collecting and reviewing sanctions or limitations on licensure. 3. Collecting and reviewing complaints. 4. Collecting and reviewing information from identified adverse events. 5. Implementing appropriate interventions when delegate identifies instances of poor quality. a. The Delegate's Credentialing committee may vote to flag a practitioner for ongoing monitoring. b. The Delegate must make clear the types of monitoring it imposes, the timeframe used, the intervention, and the outcome, which must be fully demonstrated in the Delegate's credentialing committee minutes. c. The Delegate's credentialing committee can: • Request a practitioner be placed on a watch list. Any list must be clearly defined and monitored. • Request that the practitioner demonstrate compliance with probation that has been imposed by the State and monitor completion. • Impose upon the practitioner to demonstrate steps they have taken to improve processes and/or chart review, if applicable. d. Delegated entities who fail to comply with the requested information within the specified timeframe are subject to sanctions as described in L.A. Care's policies and procedures. e. The Plan will clearly delineate what is expected from the Delegate regarding the Adverse Event that has been identified. The notification may include performing the following:	Upon notification of any Adverse Event, L.A. Care will notify the Delegate of their responsibility with respect to delegation of credentialing/re-credentialing activity. The notification will clearly delineate what is expected from the Adverse Event that has been identified. The notice will include, but is not limited to: a. Requesting what actions will be taken by the Delegate. b. What type of monitoring is being performed. c. What interventions are being implemented including closing panel, moving members, or removal of practitioner from the network. d. The notification will include a timeframe for responding to L.A. Care to ensure L.A. Care's members receive the highest level of quality care.

	• Requesting what action will be taken by the Delegate. • What type of monitoring is being performed. • What interventions are being implemented, including closing panel, moving members, or removal of practitioner from the network. • The notification will include a timeframe for responding to L.A. Care to ensure L.A. Care members receive the highest level of quality care. 6. In the event that the Delegate fails to respond as required, L.A. Care will perform the oversight functions of the Adverse Event and the Delegate will be subject to L.A. Care's credentialing committee's outcome of the adverse events. 7. The Delegate must notify L.A. Care immediately when practitioners are identified on any sanctions or reports for removal from the network. 8. The above are samples, but not limited to, the steps the Delegate can take.	
Notification to Authorities and Practitioner Appeal Rights (NCQA CR 6) DHCS, DMHC, CMS	The Delegate uses objective evidence and patient care considerations when deciding on a course of action for dealing with a practitioner who does not meet its quality standards, including: 1. Developing and implementing policies and procedures that specify: a. The range of actions available to Delegate. b. That the Delegate reviews participation of practitioners whose conduct could adversely affect members' health or welfare. c. The range of actions that may be taken to improve practitioner performance before termination. d. That the Delegate reports its actions to the appropriate authorities. e. Making the appeal process known to practitioners. 2. Within 14 days from criminal action taken against any contracted practitioner, Delegate shall notify L.A. Care in writing.	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation, routine monitoring and annual oversight review or more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards.
CR Assessment of Organizational Providers (NCQA CR 7) DHCS, DMHC, CMS	The Delegate's policy for assessing a health care delivery provider specifies that before it contracts with a provider, and for at least every 36 months thereafter it: 1. Confirms that the provider is in good standing with state and federal regulatory bodies. 2. Confirms that the provider has been reviewed and approved by an accrediting body acceptable	

	to Delegate, including which accrediting bodies are acceptable. 3. Conducts an onsite quality assessment if the provider is not accredited. 4. At least every three years that the provider continues to be in good standing with state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body acceptable to Delegate. Maintaining a tracking log that includes names of the organization, type of organization, a prior validation date, a current validation date for licensure, accreditation status (if applicable), CMS or state reviews conducted within 3 years at time of verification (if applicable), CLIA certificate (if applicable), NPI number for each organizational provider. The Delegate includes at least the following medical providers in its assessment: a. Hospitals. b. Home health agencies. c. Skilled nursing facilities. d. Freestanding surgical centers. e. Federally Qualified Health Center (FQHCs). The Delegate includes behavioral healthcare facilities providing mental health or substance abuse services in the following setting: a. Inpatient. b. Residential. c. Ambulatory. The Delegate assesses contracted medical health care providers. The Delegate assesses contracted behavioral healthcare providers.	
Sub-Delegation of CR (NCQA CR 8) DHCS, DMHC, CMS	If Delegate sub-delegates any NCQA required credentialing activities, there must be evidence of oversight of the delegated activities, including a written sub-delegation agreement that: a. Is mutually agreed upon. b. Describes the sub-delegated activities and the responsibilities of the organization and the delegated entity. c. Requires at least quarterly reporting to Delegate. d. Describes the process by which Delegate evaluates sub-delegate's performance. e. Specifies that the delegate retains the right to approve, suspend and terminate individual	L.A. Care retains the right to perform a pre-delegation audit of any entity to which the Plan sub-delegates delegated credentialing activities and approve any such sub-delegation audit of any sub-delegate. Prior to entering into an agreement to sub-delegate delegated credentialing activities, Delegated Plan shall provide L.A. Care with reasonable prior notice of Plan's intent to sub-delegate.

	practitioners, providers and sites, even if the organization delegates decision making. f. Describes the remedies available to Delegate if sub-delegate does not fulfill its obligations, including revocation of the delegation agreement. Retention of the right by Delegate and LA Care, based on quality issues, to approve, suspend, and terminate individual practitioners, providers, and sites. For new sub-delegation agreements initiated in the look-back period, the Delegate evaluated sub-delegate capacity to meet NCQA requirements before sub-delegation begins For sub-delegation arrangements in effect for 12 months or longer, the Delegate: a. Annually reviews its sub-delegate's credentialing policies and procedures. b. Annually audits credentialing and recredentialing files against NCQA standards for each year that sub-delegation has been in effect. c. Annually evaluates the sub-delegate's performance against relevant regulatory requirements; NCQA standards and Delegate's expectations annually d. Evaluates regular reports from sub-delegate at least quarterly or more frequently based on the reporting schedule described in the sub-delegation document. e. Annually monitors the delegate's credentialing system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures at least annually. f. Annually acts on all findings from factor 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters. For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identifies and follows up on opportunities for improvement, if applicable. If a Delegate fails to complete the corrective action plan and has gone through the exigent process which results in de-delegation, the Delegate cannot appeal and must wait one year to reapply for a pre-delegation audit. If the pre-delegation audit reveals	

	deficiencies identified are the same as those from previous audits, delegation will be at the sole discretion of the Credentialing Committee regardless of score.	
MEMBER EXPERIENCE		
Statement of Members' Rights and Responsibilities (NCQA ME 1)	**<u>Distribution of Rights Statement</u>** The organization distributes its member rights and responsibilities statement to the following groups: 1. New members, upon enrollment. 2. Existing members, if requested. 3. New practitioners, when they join the network. 4. Existing practitioners, if requested.	**<u>Rights and Responsibilities Statement</u>** The organization's member rights and responsibilities statement specifies that members have: 1. A right to receive information about the organization its services its practitioners and providers and member rights and responsibilities. 2. A right to be treated with respect and recognition of their dignity and their right to privacy. 3. A right to participate with practitioners in making decisions about their health care. 4. A right to a candid discussion of appropriate or medically necessary treatment options for their conditions regardless of cost or benefit coverage. 5. A right to voice complaints or appeals about the organization or the care it provides. 6. A right to make recommendations regarding the organization's member rights and responsibilities policy. 7. A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care. 8. A responsibility to follow plans and instructions for care that they have agreed to with their practitioners. 9. A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.

		L.A. Care adheres to the most current NCQA standards to comply with these requirements.
Subscriber Information (NCQA ME 2)		**Subscriber Information** L.A. Care informs its subscribers upon enrollment and annually thereafter about benefits and access to medical services. **Interpreter Services** L.A. Care provides interpreter or bilingual services in its Member Services Department and telephone functions based on linguistic needs of its subscribers. L.A. Care adheres to the most current NCQA standards to comply with these requirements.
Marketing Information (NCQA ME 3)		**Materials and Presentations** L.A. Care's prospective members receive an accurate description of the organization's benefits and operating procedures. L.A. Care adheres to the most current NCQA standards to comply with these requirements. **Communicating with Prospective Members** The organization uses easy-to-understand language in communications to prospective members about its policies and practices regarding collection, use and disclosure of PHI: 1. In routine notification of privacy practices 2. The right to approve the release of information (use of authorizations) 3. Access to Medical Records 4. Protection of oral, written, and electronic information across the organization 5. Information for employers **Assessing Member Understanding** 1. Assesses how well new members understand policies and procedures. The right to approve

<table>
<tr><td></td><td></td><td>the release of information (use of authorizations)
2. Implements procedures to maintain accuracy of marketing communication. Protection of oral, written, and electronic information across the organization
3. Acts on opportunities for improvement, if applicable.</td></tr>
<tr><td>Functionality of Claims Processing
(NCQA ME 4)</td><td><u>Functionality-Website</u>
Members can track the status of their claims in the claims process and obtain the following information on the organization’s website in one attempt or contact:
1. The stage in the process.
2. The amount approved.
3. The amount paid.
4. Member cost.
5. The date paid

<u>Functionality-Telephone Requests</u>
Members can track the status of their claims in the claims process and obtain the following information over the telephone in one attempt or contact:
1. The stage in the process.
2. The amount approved.
3. The amount paid.
4. Member cost.
5. The date paid</td><td></td></tr>
<tr><td>Pharmacy Benefit Information
(NCQA ME 5)</td><td><u>Pharmacy Benefit Information-Website</u>
Members can complete the following actions on the website in one attempt or contact:
1. Determine their financial responsibility for a drug, based on the pharmacy benefit.
2. Initiate the exceptions process
3. Order a refill for an existing, unexpired mail-order prescription.
4. Find the location of an in-network pharmacy.
5. Conduct a pharmacy proximity search based on zip code.
6. Determine the availability of generic substitutes.

*According to SB1052 Blue Shield shall post the formulary on its internet website and update that posting on a monthly basis.

<u>Pharmacy Benefit Information Telephone</u>
Members can complete the following actions via telephone in one attempt or contact:</td><td></td></tr>
</table>

	1. Determine their financial responsibility for a drug, based on the pharmacy benefit. 2. Initiate the exceptions process. 3. Order a refill for an existing, unexpired, mail-order prescription. 4. Find the location of an in-network pharmacy. 5. Conduct a proximity search based on zip code. 6. Determine the availability of generic substitutes. **<u>QI Process on Accuracy of Information</u>** The organization's quality improvement process for pharmacy benefit information: 1. Collects data on quality and accuracy of pharmacy benefit information. 2. Analyze data results. 3. Act to improve identified deficiencies. **<u>Pharmacy Benefit Updates</u>** The organization updates member pharmacy benefit information on its website and in materials used by telephone staff, as of the effective date of a formulary change and as new drugs are made available or are recalled.	
Personalized Information on Health Plan Services (NCQA ME 6) 	**<u>Functionality-Website</u>** Members can complete each of the following activities on the organization's website in one attempt or contact: 1. Change a primary care practitioner, as applicable. 2. Determine how and when to obtain referrals and authorizations for specific services, as applicable 3. Determine benefit and financial responsibility for a specific service or treatment from a specified provider or institution, if applicable. **<u>Functionality Telephone</u>** To support financial decision making, members can complete each of the following activities over the telephone within one business day: 1. Determine how and when to obtain referrals and authorizations for specific services, as applicable. 2. Determine benefit and financial responsibility for a specific service or treatment from a specified provider or institution. **<u>Quality and Accuracy of Information</u>** At least annually, the organization must evaluate the quality and accuracy of the information provided to members via the website and telephone must be evaluated by:	

	1. Collecting data on quality and accuracy of information provided. 2. Analyzing data against standards or goals. 3. Determining causes of deficiencies, as applicable. 4. Acting to improve identified deficiencies, as applicable. **<u>E-mail Response Evaluation</u>** The organization: 1. Has a process for responding to member e-mail inquiries within one business day of submission. 2. Has a process for annually evaluating the quality of e-mail responses. 3. Annually collects data on email turnaround time. 4. Annually collects data on the quality of email responses. 5. Annually analyzes data. 6. Annually act to improve identified deficiencies.	
Member Experience Applicable L.A. Care Policy: QI-031 (NCQA ME 7) 	**<u>Policies and Procedures for Complaints</u>** The organization has policies and procedures for registering and responding to oral and written complaints that include: 1. Documenting the substance of complaints and actions taken. 2. Investigating of the substance of complaints and actions taken. 3. Notification to members of the resolution of complaints and, if there is an adverse decision, the right to appeal. . 4. Standards for timeliness including standards for urgent situations. 5. Provision of language services for the complaint process. **<u>Policies and Procedures for Appeals</u>** The organization has policies and procedures for registering and responding to oral and written appeals which include: 1. Documentation of the substance of the appeals and actions taken. 2. Investigation of the substance of the appeals 3. Notification to members of the disposition of appeals and the right to further appeal, as appropriate 4. Standards for timeliness including standards for urgent situations. 5. Provision of language services for the appeal process. **<u>Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals</u>**	Members have the option to complain and appeal directly to L.A. Care. L.A. Care retains the right to perform a pre-delegation audit of any entity to which the Plan sub-delegates delegated activities and approve any such sub-delegation audit of any sub-delegate. Prior to entering into an agreement to sub-delegate Delegated Activities, Plan shall provide L.A. Care with reasonable prior notice of Plan's intent to sub-delegate. **<u>Nonbehavioral Opportunities for Improvement</u>** The organization annually identifies opportunities for improvement, sets priorities and decides which opportunities to pursue based on analysis of the following information: 1. Member complaint and appeal data from Member Experience standard for Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals. 2. CAHPS survey results and/or QHP Enrollee Experience Survey results.

	Using valid methodology, the organization annually analyzes nonbehavioral complaints and appeals for each of the five required categories. **Annual Assessment of Behavioral Healthcare and Services** Using valid methodology, the organization annually: 1. Evaluates behavioral healthcare member complaints and appeals for each of the five required categories. 2. Conducts a member experience survey. **Behavioral Healthcare Opportunities for Improvement** The organization works to improve members' experience with behavioral healthcare and service by annually: 1. Assessing data from complaints and appeals or from member experience surveys. 2. Identifying opportunities for improvement. 3. Implementing interventions, if applicable. 4. Measuring effectiveness of interventions, if applicable.	
Sub-Delegation of ME (NCQA ME 8)	**Sub-Delegation Agreement** The written sub-delegation agreement: 1. Is mutually agreed upon 2. Describes the delegated activities and the responsibilities of the organization and the delegated entity and the delegated activities. 3. Requires at least semiannual reporting by the delegated entity to the organization. 4. Describes the process by which the organization evaluates the delegated entity's performance. 5. Describes the process for providing member experience and clinical performance data to its delegates when requested. 6. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement. **Predelegation Evaluation** For new delegation agreements initiated in the look-back period, the organization evaluates delegate capacity to meet NCQA requirements before delegation began. **Review of Performance** For delegation arrangements in effect for 12 months or longer, the organization: 1. Semiannually evaluates regular reports as specified in the sub-delegation agreement.	

	2. Annually evaluates delegate performance against NCQA standards for delegated activities. **<u>Opportunities for Improvement</u>** For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years the organization identified and followed up on opportunities for improvement, if applicable.	
Nurse Advice Line (Title 28 California Code of Regulations Section 1300.67.2.2)	A Nurse Advice Line is offered to members to assist members with wellness and prevention **A. Access to Nurse Advice Line** A Nurse Advice Line that is staffed by licensed nurses or clinicians and meets the following factors: 1. Is available 24 hours a day, 7 days a week, by telephone. 2. Provides secure transmission of electronic communication, with safeguards, and a 24-hour turnaround time. 3. Provides interpretation services for members by telephone. 4. Provide telephone triage or screening services in a timely manner appropriate to the enrollee's condition. The triage and screening wait time shall not exceed 30 minutes. **B. Nurse Advice Line Capabilities** The nurse advice line gives staff the ability to: 1. Follow up on specified cases and contact members. 2. Link member contacts to a contact history. **C. Monitoring the Nurse Advice Line** The following shall be conducted: 1. Track telephone statistics at least quarterly 2. Track member use of the nurse advice line at least quarterly. 3. Evaluate member satisfaction with the nurse advice line at least annually. 4. Monitors call periodically. 5. Analyze data at least annually and, if applicable, identify opportunities and establish priorities for improvement. **D. Policies and Procedures** 1. Establish and maintain an operational policy for operating and maintaining a Telephone Nurse Advice Service. **E. Promotion** 1. Promote the availability of Nurse Advice Line services in materials that are approved in accordance with the Plan Partner Services	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation and annual oversight review and more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards.

	Agreement and L.A. Care policies and procedures. 2. In the form of, but not limited to: a. Flyers b. Informational mailers c. ID Cards d. Evidence of Coverage (EOC)	
Potential Quality of Care Issue Review (Title 28 California Code of Regulations Section 1300.70)	The Quality Improvement program must document that the quality of care is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated. The Quality Improvement program must include continuous review of the quality of care provided; quality of care problems are identified and corrected for all provider entities.	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation and annual oversight review and more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards.
Quality Improvement Performance: Applicable L.A. Care Policy: QI-0008 APL 19-017	1. Annually measures performance and meets the NCQA 50th percentile benchmark for the Medi-Cal Managed Care Accountability Set established by DHCS and NCQA required Medi-Cal accreditation measures. 2. Opportunity for Improvement When the 50th percentile is not met the plan will identify and follow up on opportunities for improvement.	L.A. Care will still retain the PIP and PDSA reporting process with DHCS for the Medi-Cal line of business.
Blood Lead Screening of Young Children Applicable L.A. Care Policy: QI-048 APL 20-016	1. Ensure network providers follow the blood lead anticipatory guidance and screening requirements in accordance with APL 20-016 2. Identify, on at least a quarterly basis (i.e. January – March, April – June, July – September, October – December), all child members under the age of six years (i.e. 72 months) who have any record of receiving a blood lead screening test as required Note: L.A. Care will send delegate CLPPB data when they receive from DHCS on a quarterly basis.	Annual Submission to DHCS data for all child members under the age of six years (i.e. 72 months) who have no record of receiving a blood lead screening
HEALTH EDUCATION		
DHCS Policy Letter 02-004 DHCS Policy Letter 16-014 DHCS Policy Letter 18-018 DHCS Policy Letter 13-001 DHCS Policy Letter 10-012 DHCS Policy Letter 16-005	1. Maintenance of a health education program description and work plan 2. Availability and promotion of member health education services in DHCS language and topic requirements including implementation of a closed-loop referral process. 3. Implementation of comprehensive tobacco cessation/prevention services including: a. individual, group, and telephone counseling b. Provider tobacco cessation trainings c. Tobacco user identification system	L.A. Care retains responsibility for providing written health education materials in DHCS required health topics for non-English/Spanish threshold languages. L.A. Care retains responsibility for conducting the Health Education, Cultural & Linguistics Population Needs Assessment (PNA) annually but retains the right to

	d. Tracking individual utilization data of tobacco cessation interventions 4. Availability of a diabetes prevention program (DPP) that complies with CDC DPP guidelines and is delivered by a CDC recognized provider 5. Availability of written member health education materials in English and Spanish in DHCS required health topics including: a. a system for providers to order materials and informing providers how to do so b. Adherence to all regulatory requirements as dictated per the Readability & Suitability Checklist 6. Implementation of an Individual Health Education Behavioral Assessment (IHEBA), preferably the Staying Healthy Assessment (SHA) including a method of making the assessments available to providers and provider education 7. Employment of a full-time Health Education Director, or the equivalent, with a Master's Degree in Public Health (MPH) responsible for the direction, management and supervision of the health education system. 8. Integration between health education activities and QI activities 9. Provision of provider education on health education requirements and resources 10. Adherence to all requirements regarding Non-Monetary Member Incentives including submission of Request for Approval and Annual Update/End of Program Evaluation forms to L.A. Care's Compliance Unit on an on-going basis.\ 11. Should Plan Partner delegate any or all health education requirements to a sub-delegate, Plan Partner must monitor sub-delegate's performance and ensure continued compliance.	request Plan Partner assistance as needed.
	CULTURAL & LINGUISTIC REQUIREMENTS	
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 28, §1300.67.04(c) CCR, Title 22, §53876 DHCS Agreement Exhibit A Attachment 9, (12)& (13)(A) Federal Guidelines: OMH CLAS Standards, Standards 1-4 & 9	**Cultural & Linguistic Program Description and Staffing** 1. Plan maintains an approved written program description of its C&L services program that complies with all applicable regulations, includes, at minimum, the following elements (or its equivalent): a. Organizational commitment to deliver culturally and linguistically appropriate health care services. b. Goals and objectives with timetable for implementation. c. Standards and performance requirements for the delivery of culturally and linguistically appropriate health care services.	

	2Plan centralizes coordination and monitoring of C&L services. The department and/or staff responsible for such services are documented in an organizational chart. 3. Plan has written description(s) of position(s) and qualifications of the staff involved in the C&L services program.	
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 22, §53876 CCR, Title 28, §1300.67.04, (c)(2)(G) & (H) Code of Federal Regulations (CFR), Title28, §35.160-25.164 CFR, Title 45 §92.4 & §92.201 DHCS Agreement Exhibit A, Attachment 9(12) & (14) DHCS All Plan Letter 21-004 Federal Guidelines: OMH CLAS Standards, Standard 5-7	**Access to Interpreting Services** 1. Plan has approved policies and procedures which include, at minimum, the following items: a. Provision of timely 24-hour, 7 days a week interpreting services from a qualified interpreter at all key points of contact, in any language requested, including American Sign Language, at no cost to members. b. Discouraging use of friends, family, and particularly minors as interpreters, unless specifically requested by the member after she/he was being informed of the right and availability of no-cost interpreting services. c. Availability of auxiliary aids and services, such as TTY, video relay services, remote interpreting services, etc., to ensure effective communication with individuals with disabilities. Plan has a sound method to ensure qualifications of interpreters and quality of interpreting services. Qualified interpreter must have demonstrated: 2. a. Proficiency in speaking and understanding both spoken English and at least one other spoken language; and b. Ability to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using necessary specialized vocabulary and a fundamental knowledge in both languages of health care terminology and phraseology concepts relevant to health care delivery systems. c. Adherence to generally accepted interpreter ethics principles, including client confidentiality (such as the standards promulgated by the California Healthcare Interpreters Association and the National Council on Interpreting in Healthcare) 3. Plan makes available translated signage (tagline) on availability of no-cost language assistance services and how to access such services to	

	providers. Tagline must be in English and all 18 non-English languages specified by DHCS 4. Plan posts non-discrimination notice and translated taglines in English and 18 non-English languages specified by DHCS at physical location where the plan interacts with the public and on plan's website. 5. Plan maintains utilization reports for face-to-face and telephonic interpreting services.	
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 28, §1300.67.04(c)(2)(H) Code of Federal Regulations (CFR), Title 45 §92.4 & §92.201(e)(4) DHCS Agreement Exhibit A, Attachment 9(13)(B) & (F) DHCS All Plan Letter 22-04 Federal Guidelines: OMH CLAS Standards, Standards - 7	**Assessment of Linguistic Capabilities of Bilingual** 1. Plan has approved policies and procedures related to identifying, assessing, and tracking oral and/or written language proficiency of clinical and non-clinical bilingual employees who communicate directly with members in a language other than English. 2. Plan has a sound method to assess bilingual employees' oral and/or written language proficiency, including appropriate criteria for ensuring the proficiency. Qualified bilingual staff must have demonstrated: a. Proficiency in speaking and understanding both spoken English and at least one other spoken language, including any necessary specialized vocabulary, terminology, and phraseology. b. Ability to effectively, accurately, and impartially communicate directly with Limited English Proficiency Members in their preferred language. 3. Plan maintains a current list of assessed and qualified bilingual employees, who communicate directly with members, including the following information at minimum, name, position, department, language, level of proficiency.	
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 28, §1300.67.04(d)(9) DHCS Agreement Exhibit A, Attachment 6(11)(B)(2) & Attachment 18 (6)(K) DHCS Policy Letter 98-12 Federal Guidelines: OMH CLAS Standards, Standard 7	**Linguistic Capabilities of Provider Network** 1. Plan has approved policies and procedures related to identifying and monitoring language capabilities of providers and provider staff ensuring provider network is reflective of membership demographics. 2. Plan lists language spoken by providers and provider staff in the provider directory. 3. Plan updates language spoken by providers and provider staff in the provider directory. 4. Plan annually assesses the provider network language capabilities meet the members' needs.	

California Health and Safety Code, §1367.04(b)(1)(A)-(C) Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 22, §53876 (a)(2)&(3) CCR, Title 28, §1300.67.04, (b)(7), (c)(2)(F) & (e)(2)(i)-(ii) Code of Federal Regulations (CFR), Title28, §35.160-25.164 CFR, Title 45 §92.4 & §92.8 DHCS Agreement, Exhibit A, Attachment 9(14)(B)(2), (14)(C), Attachment 13(4)(C) DHCS All Plan Letter 21-011 DHCS All Plan Letter 21-004 DHCS All Plan Letter 22-002 Federal Guidelines: OMH CLAS Standards, Standard 5- 	**Access to Written Member Informing Materials in Threshold Languages & Alternative Formats** 1. Plan has approved policies and procedures documenting the process to: a. Translate Written Member Informing Materials, including the non-template individualized verbiage in Notice of Action (NOA) letters, accurately using a qualified translator in all Los Angeles County threshold languages and alternative formats (large print 20pt, audio, Braille, accessible data) according to the required timelines. b. Track member's standing requests for Written Member Informing Materials in their preferred threshold language and alternative format. c. Submit newly captured members' alternative format selection data directly to the DHCS Alternate Format website d. Distribute fully translated Written Member Informing Materials in their identified Los Angeles County threshold language and alternative format to members on a routine basis based on the standing requests and DHCS alternative format selection (AFS) data. e. Attach the appropriate non-discrimination notice and translated tagline (a written language assistance notice) in English and required all 18 non-English required by DHCS to Member Informing Materials publications). Threshold Languages for Los Angeles County: English, Spanish, Arabic, Armenian, Chinese, Farsi, Khmer, Korean, Russian, Tagalog, and Vietnamese. Taglines (Language assistance notice) Languages: English, Spanish, Arabic, Armenian, Chinese, Farsi, Khmer, Korean, Russian, Tagalog, Vietnamese, Hindi, Hmong, Japanese, Lao, Mien, Punjabi, Thai and Ukrainian. 2. Plan has a sound method to ensure qualifications of translators and quality of translated Written Member Informing Materials. Qualified translators must have demonstrated: a. Adherence to generally accepted translator ethics principles, including client	L.A. Care provides Plan with: 1. Any changes to threshold and tagline languages. 2. Weekly DHCS alternative format selection data

	confidentiality to protect the privacy and independence of LEP Members. b. Proficiency reading, writing, and understanding both English and the other non-English target language. c. Ability to translate effectively, accurately, and impartially to and such language(s) and English, using necessary specialized vocabulary, terminology and phraseology. Plan maintains: a. Translated Written Member Informing materials on file along with attestations which affirm qualifications of the translators and translated document is an accurate rendition of the English version. b. Evidence of the distribution of Written Member Informing Materials to members in their identified Los Angeles County threshold language and alternative format on a routine basis. c. Evidence of reporting newly captured AFS data to DHCS	
Code of California Regulations (CCR), Title 28, §1300.67.04(c)(2)(C) DHCS Agreement, Exhibit A, Attachment 13(1)(A) DHCS All Plan 21-004 Federal Guidelines: OMH CLAS Standards, Standard 6	**Member Education** 1. Plan informs members annually of their right to no-cost interpreting services 24-hour, 7 days a week, including American Sign Language and axillary aids/services and how to access these services. 2. Plan informs members annually about the importance of not using friends, family members and particularly minors, as interpreters. 3. Plan informs members annually of their right to receive Written Member Informing Materials in their preferred language and alternative format at no cost and how to access these services. 4. Plan informs members annually of their right to file complaints and grievances if their cultural or linguistic needs are not met and how to file them. 5. Plan informs members annually that Plan does not discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability or identification with any other persons or group identified in Penal Code 422.56 in its health programs and activities.	

Code of California Regulations (CCR), Title 28, §1300.67.04(c)(2)(E) & (3) DHCS Agreement Exhibit A, Attachment 7(5)(B), Attachment 9 (13)(E), Attachment 18(7)(F) & (9)(M) DHCS All Plan Letter 99-005 Federal Guidelines: OMH CLAS Standards, Standard 4	**Provider Education & Training** 1. Plan has approved policies and procedures related to education/training on C&L requirements, cultural competency, sensitivity or diversity training for providers. 2. Plan provides initial and annual education/training on cultural and linguistic requirements to providers, which includes the following items: a. Availability of no-cost language assistance services, including: i) 24-hour, 7 days a week interpreting services, including American Sign Language\ ii) Written Member Informing Materials in their identified Los Angeles threshold language and preferred alternative format iii) Auxiliary aids and services, such as TTY, video relay services, remote interpreting services, etc. b. How to access language assistance services. c. Discouraging the use of friends, family, and particularly minors as interpreters. d. Not relying on staff other than qualified bilingual staff to communicate directly in a non-English language with members. e. Documenting the member's language and the request/refusal of interpreting services in the medical record. f. Posting translated taglines in English and 18 non-English languages required by DHCS at key points of contact with members. g. Working effectively with members using in-person or telephonic interpreters and using other media such as TTY and remote interpreting services. h. Referring members to culturally and linguistically appropriate community services. 3. Plan provides initial and annual cultural competency, sensitivity or diversity training to providers, which includes topics that are relevant to the cultural groups in Los Angeles County, such as: a. Promote access and the delivery of services in a culturally competent manner to all Members, regardless of race, color, national origin, creed, ancestry, religion, language,	

	age, marital status, sex, sexual orientation, gender identity, health status, physical or mental, disability, or identification with any other persons or groups defined in Penal Code 422. 4. a. Awareness that culture and cultural beliefs may influence health and health care delivery. b. Knowledge about diverse attitudes, beliefs, behaviors, practices, and methods regarding preventive health, illnesses, diseases, traditional home remedies, and interaction with providers and health care systems. c. Skills to communicate effectively with diverse populations d. Language and literacy needs.	
Code of California Regulations (CCR), Title 28, §1300.67.04(c)(3) DHCS Agreement Exhibit A, Attachment 9(13)(E) DHCS All Plan Letter 99-005 Federal Guidelines: OMH CLAS Standards, Standard 4	**Plan Employee Education & Training** 1. Plan has approved policies and procedures related to education/training on C&L requirements, cultural competency sensitivity or diversity training for Plan employees. 2. Plan provides initial and annual education/training on cultural and linguistic requirements and language assistance services to plan staff, which includes the following items: a. The availability of Plan's no-cost language assistance services to members, including: i. 24-hour, 7 days a week interpreting services, including American Sign Language. ii. Written Member Informing Materials in their identified Los Angeles threshold language and preferred alternative format. iii. Auxiliary aids and services, such as TTY, video relay services, remote interpreting services, etc. b. How to access these language assistance services. c. Discouraging the use of friends, family, and particularly minors, as interpreters. d. Not relying on staff other than qualified bilingual staff to communicate directly in a non-English language with members. e. Working effectively with members using in-person or telephonic interpreters and using other media such as TTY and remote interpreting services	

	f. Referring members to culturally and linguistically appropriate community services. 3. Plan has cultural competency, sensitivity or diversity training material(s) for Plan employees, which includes topics that are relevant to the cultural groups in Los Angeles County, such as: a. Promote access and the delivery of services in a culturally competent manner to all Members, regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental, disability, or identification with any other per-sons or groups defined in Penal Code 422. b. c. Knowledge about diverse attitudes, beliefs, behaviors, practices, and methods regarding preventive health, illnesses, diseases, traditional home remedies, and interaction with providers and health care system. d. Skills to communicate effectively with diverse populations. e. Language and literacy needs	
DHCS Agreement Exhibit A, Attachment 9(13)(F) DHCS All Plan Letter 99-005 Federal Guidelines: OMH CLAS Standards, Standard 10	**C&L and Quality Improvement** 1. Plan has approved policies and procedures related to C&L program evaluation, at minimum, including: a. Review and monitoring of C&L program that has a direct link to Plan's quality improvement processes. b. Procedures for continuous evaluation. 2. Plan analyzes C&L services performance and evaluates the overall effectiveness of the C&L program to identify barriers and deficiencies. For example: a. Grievances and complaints regarding C&L issues b. Trending of interpreting and translation utilization c. Member satisfaction with the quality and availability of language assistance services and culturally competent care d. Plan staff and providers' feedback on C&L services 3. Plan takes actions to correct identified barriers and deficiencies related to C&L services.	

Authority: Code of California Regulations (CCR), Title 28, §1300.67.04 (c)(4) DHCS Agreement, Exhibit A, Attachment 4(6)(A), (B) & Attachment 6(14)(B) DHCS All Plan Letter 99-005 DHCS All Plan Letter 17-004DHCS All Plan Letter 21-004	**Oversight of Subcontractors for Cultural & Linguistic Services and Requirements** 1. Plan has a contract and/or other written agreement with its network providers and subcontractor(s) regarding: a. C&L requirements (e.g., documentation of preferred language and refusal/request for interpreting services in the medical record, posting of translated tagline in English and 18 non-English languages) b. Delegated C&L services (e.g., language assistance services) 2. Plan has approved policies and procedures related to oversight and monitoring of its network providers and subcontractors to ensure compliance with the contract/agreement terms and applicable federal and state laws and regulations that are related to C&L requirements and/or delegated C&L services. 3. Plan has a mechanism to monitor network providers and subcontractors to ensure compliance with the contract terms and applicable federal and state laws and regulations that are related to C&L requirements and/or delegated C&L services. 4. Plan monitors network providers and subcontractors with regular frequency to ensure compliance with the contract terms and applicable federal and state laws and regulations that are related to C&L requirements and/or delegated C&L services.	
Code of California Regulations (CCR), Title 22, §53876 DHCS Agreement Exhibit A, Attachment 9(5) & (14)(B)(3)	**Cultural & Linguistic Service Referral*** 1. Plan has approved policies and procedures related to referring members to culturally and linguistically appropriate community services and providers who can meet the members' religious and ethical needs. 2. Plan has a process and/or mechanism to refer members to culturally and linguistically appropriate community services. 3. Plan informs providers of the availability of culturally and linguistically appropriate community service programs for members and how to access them.	
CLAIMS PROCESSING REQUIREMENTS		

Claims Processing (Title 28 California Code of Regulations Section 1300.71) Blood Lead Screening of Young Children APL 20-016 	**Timely Claims Processing** 1. Process at a minimum ninety percent (90%) of claims within 30 calendar days of the claim receipt date, 2. Process at a minimum ninety-five percent (95%) of claims within 45 working days of the claim receipt date, **and** 3. Process at a minimum ninety-nine percent (99%) of claims within 90 calendar days of the claim receipt date. **Accurate Claims Payments** 1. Pay claims at the Medi-Cal rates or contracted rates at a minimum of 95% of the time. 2. All modified claims are reviewed and approved by a physician and medical records are reviewed. 3. Calculate and pay interest automatically for claims paid beyond 45 workings days from date of receipt at a minimum 95% of the time. a. **Emergency services claims:** Late payment on a complete claim which is not contested or denied will automatically include the greater of $15 or 15% rate per annum applied to the payment amount for the time period the payment is late. b. **All other service claims**: Late payments on a complete claim will automatically include interest at a 15% rate per annum applied to the payment amount for the time period payment is late. **Penalty:** Failure to automatically include the interest due on the late claims regardless of service is $10 per late claim in addition to the interest amount. **Forwarding of Misdirected Claims** Forward misdirected claims within 10 working days of the claim receipt date at a minimum of 95% of the time. **Acknowledgement of Claims** Acknowledge the receipt of electronic claims within 2 working days and paper claims within 15 working days at a minimum of 95% of the time. **Dispute Resolution Mechanism** Provide written notice of a dispute resolution mechanism for all denied and modified claims at a minimum 95% of the time. **Accurate and Clear Written Explanation**	

	Provide written notice of a dispute resolution mechanism for all denied and modified claims at a minimum 95% of the time. **Deadline for Claims Submission** Shall not impose a claims filing deadline less than 90 days after the date of service for contracted providers and less than 180 days after the date of service for non-contracted providers on three or more occasions. **Request for Reimbursement of Overpayment** Reimbursement for overpayment request shall be in writing and clearly identifying the claim and reason why the claim is believed to be overpaid within 365 days from the payment date, for at least 95% of the time. **Rescind or Modify an Authorization** An authorization shall not be rescinded or modified for health care services after the provider renders the service in good faith and pursuant to the authorization on three (3) or more occasions over the course of any three-month period. **Request for Medical Records** 1. **Emergency services claims:** Medical records shall not be requested more frequently than twenty percent (20%) of the claims submitted by all providers for emergency services over any 12-month period. 2. **All other claims:** Medical records shall not be requested more frequently than three percent (3%) of the claims submitted by all providers, excluding claims involving unauthorized services over any 12-month period. **Exception:** The thresholds and limitations on requests for medical records as stated above should not apply to claims where reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices are being demonstrated.	
Provider Dispute Resolution (PDR) Processing and Payments requirement. (Title 28 California Code of Regulations Section 1300.71.38)	**Acknowledgement of Provider Disputes** Acknowledgement of received disputes is performed in a timely manner at a minimum of 95% of the time. a. 15 working days for paper disputes. b. 2 working days for electronic disputes. **Timely Dispute Determinations** Dispute determinations are made in a timely manner, at a minimum of 95% of the time.	

	a. 45 working days from receipt of the dispute. b. 45 working days from receipt of additional information. **Clear Explanation of NOA Letter** Rationale for decision is clear, accurate and specific in NOA Letter, at a minimum of 95% of the time. a. Written determination stating the pertinent facts and explaining the reasons for the determination **Accurate Provider Dispute Payments** 1. Appropriately paying any outstanding monies determined to be due if the dispute is determined in whole or in part in favor of the provider. 2. Interest payments are paid correctly when dispute determination is in favor of provider, at a minimum of 95% of the time. Accrual of interest of payment on resolved provider disputes begin on the day after the expiration of forty-five (45) working days from the original claim receipt date. **Acceptance of Late Claims** The organization must accept and adjudicate disputes that were originally filed beyond the claim filing deadline and the provider was able to demonstrate good cause for the delay, at a minimum of 95% of the time.	

Exhibit 8
Delegation Agreement
[Attachment B]

Plan's Reporting Requirements
(Pharmacy reporting requirements are only applicable from July 1, 2021 to December 31, 2021)

Report	Due Date	Submit To	Required Format
	PHARMACY		
Pharmacy Reporting requirements for additional delegated activities 1. NCQA UM related a. **UM 4E:** Practitioner Review of Pharmacy Denials	1-4. Quarterly 1st Qtr – May 30 2nd Qtr – Aug 30 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Pharmacy/	1-3. L.A. Care Reporting Format with data elements as defined in the Blue Shield Pharmacy Report Templates workbook, and

b. **UM 5:** Timeliness of Pharmacy UM Decision Making**UM 5C:** Notification of Pharmacy Decisions c. **UM 5D (factors 5&6):** UM Timeliness Report (Pharmacy) d. **UM 6C:** Relevant Information for Pharmacy Decisions e. **UM 7G:** Discussing a Pharmacy Denial with a Reviewer f. **UM 7H:** Written Notification of Pharmacy Denials g. **UM 7I:** Pharmacy Notice of Appeals Rights/Process h. **UM 9A** Preservice and Postservice Pharmacy Appeals i. **UM 9B:** Timeliness of the Pharmacy Appeal Process j. **UM 9C**: Pharmacy Appeal Reviewers k. **UM 9D**: Notification of Appeal Decision/Rights for Pharmacy l. **UM 12A:**UM Denial System Controls **2. DHCS Related** a. Decision timeliness rate for all PA requests according DHCS contractual agreement = PA decisions within 24 hours of receipt/Total PAs. - includes approval and denials, excludes all early close and administrative denials b. Notification timeliness rate for all PA requests according DHCS contractual agreement = PA notifications within 24 hours of receipt/Total PAs. - includes approval and denials, excludes all early close and administrative denials 3. Pharmacy Activities Summary Reports a. Denial per 1000 = (Pharmacy Denials/1000 members) - all early close and administrative denials should be excluded.			4. Policy and Procedure PHRM-041: Plan Partner Pharmacy Reporting Requirements

b. Appeal per 1000 = (Pharmacy Appeals/ 1000 members) - withdrawn appeals should be excluded c. Overturn Rate = (Pharmacy Overturned Appeals/ Total Pharmacy Appeals) - withdrawn appeals should be excluded. 4. Pharmacy Utilization Reports a. Top fifty drugs by number of Prescriptions b. Top fifty Drugs by Aggregate Cost c. Non-Formulary Medication d. Prior Authorization Report e. Summary Report of L.A. Care member Prescription Utilization			
NCQA ME Pharmacy related reporting requirements 1. **ME :** Quality and accuracy (QI process) of pharmacy benefit information provided on website and telephone a. Collects data on quality and accuracy of pharmacy benefit information b. Analyzes data results c. Acts to improve identified deficiencies 2. **ME :** Pharmacy benefit updates for: a. Member information on its website and in materials used by telephone staff, as the effective date of a formulary change and as new drugs are made available.	1 – 2. Quarterly 1st Qtr – May 30 2nd Qtr – Aug 30 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Pharmacy/	1 – 2. Compliant with NCQA in accordance to Plan's accreditation submission
QUALITY IMPROVEMENT			
NET 1A **Cultural Needs and Preferences Assessment** **NET 1B** Practitioners Providing Primary Care **NET 1C** Practitioners Providing Specialty Care **NET 1D** Practitioners Providing Behavioral Healthcare	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission

NET 2A **Access to Primary Care** **NET 2B** Access to Behavioral Healthcare **NET 2C** Access to Specialty Care	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
NET 3A Assessment of Member Experience Accessing the Network **NET 3B** Opportunities to Improve Access to Nonbehavioral Healthcare Services **NET 3C** Opportunities to Improve Access to Behavioral Healthcare Services	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
QI 2A Practitioner Contracts	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
QI 3A Identifying Opportunities **QI 3B** Acting on Opportunities **QI 3C** Measuring Effectiveness	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Annual data collection analysis that identify and acts on opportunities for improvement for Continuity of Care as outlined by NCQA guidelines for Continuity Coordination of Care of Medical Care and Continuity and Coordination Between Medical Care and Behavioral HealthCare

QI 4A Data Collection **QI 4B** Collaborative Activities **QI 4C** Measuring Effectiveness	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
QI 5A **Sub-Delegation Agreement** **QI 5B** Sub- Delegation Predelegation Evaluation **QI 5C** Sub-Delegation Review of QI Program **QI 5D** **Sub-Delegation** Opportunities for Improvement	Annually during PP audit	home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
<u>Quality Improvement Quarterly reporting requirements</u> 1. **QI Workplan Update** 2. **Potential Quality of Care Issues (PQIs)** a. Number of PQIs b. Number of closed PQIs c. Number of closed PQIs within 6 months d. PQI Detail Report with final PQI severity level	QI Workplan Quarterly 1st Qtr – Jun 30 2nd Qtr – Sep 30 3rd Qtr – Dec 30 4th Qtr – Mar 30 2. Quarterly PQI Report 1st Qtr – April 25 2nd Qtr – July 25 3rd Qtr – Oct 25 4th Qtr – Jan 25	1-3. L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	1 – 3. Acceptable formats: • Quarterly Workplan Updates • ICE Reporting Format
<u>Quality Improvement Annual reporting requirements</u> 1. **QI 1A:** QM Program Description 2. **QI 1C:** QM Program Evaluation 3. QI Workplan 4. PHM Work plan (if the activities are not included in the QI Workplan)	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Acceptable formats: • Quarterly • ICE Reporting Format
ME 1B: Distribution of Member Rights & Responsibilities Statement	Semi-Annually: Jan 15th (Reporting period Q3 & Q4)	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Mutually agreed upon format

	July 15th (Reporting period Q1 &Q2)		ME 1B_Distribution of Rights Statement
ME 7C Element C: Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals **ME 7E** Element E: Annual Assessment of Behavioral Healthcare and Services **ME 7F** Element F: Behavioral Healthcare Opportunities	Annually during PP audit	home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 1A Strategy Description **PHM 1B** Informing Members	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 2A Data Integration **PHM 2B** Population Assessment **PHM 2C** Activities and Resources **PHM 2D** Segmentation	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 3 A Practitioner or Provider Support	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 6A Measuring Effectiveness **PHM 6B** Improvement and Action	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 7A Sub-Delegation Agreement **PHM 7B** Sub-Delegate Pre-Delegation Agreement	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission

PHM 7C Sub-Delegate Review of PHM Program **PHM 7D** Opportunities for Improvement			
Title 28 California Code of Regulations Section 1300.67.2.2 **California Health and Safety Code Section 1348.8** **Assessment of Nurse Advice Line** 1. Nurse Advice Line monitoring for: a. Telephone statistics at least quarterly • Average abandonment rate within 5 percent • Average speed of answer within 30 seconds 2. Annual analysis of Nurse Advice Line statistics (telephone, use, and calls), identify opportunities and establish priorities for improvement.	1. Quarterly 1st Qtr – May 18 2nd Qtr – August 18 3rd Qtr – November 18 4th Qtr – February 18 2. Annually during PP Audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Health Education/ Plan will also have the option to submit via email to remain compliant with due date.	Mutually agreed upon format
Quality Improvement Performance A PDSA tool will be required when the plan does not meet the 50th percentile for the Managed Care Accountability Set and the 50th percentile for the Medicaid NCQA Accreditation Measures as established by both regulatory entities.	Annually during PP Audit. The PDSA tool is due 90 calendar days after findings are received.	L.A. Care's Secure File Transfer Protocol (SFTP)/ home/ucfst/infile/Quality Improvement/ Plan will also have the option to submit via email to remain compliant	The PDSA tool provided by DHCS or L.A. Care
UTILIZATION MANAGEMENT			
APPEALS & GRIEVANCES Member complaints and Appeals Log	Monthly 15th Calendar Day of Each Month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/grievance/	Format as defined in the L.A. Care Technical Bulletin MS 005
ME 7 A, B, C, E, F **Analysis of Member Experience, if delegated, to include:** 1. Policies and Procedures for Complaints 2. Policies and Procedures for Appeals 3. Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals for each of 5 categories: a. Quality of Care	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/greivance/	Compliant with NCQA in accordance to Plan's accreditation submission

b. Access c. Attitude and Service d. Billing and Financial Issues e. Quality of Practitioner Office Site 4. Annual Assessment of Behavioral Healthcare Complaints and Appeals and Services for each of 5 categories along with opportunities for improvement: a. Quality of Care b. Access c. Attitude and Service d. Billing and Financial Issue e. Quality of Practitioner Office Site			
Service Authorizations and Utilization Review			
UM 1 1. UM Program Description 2. UM Program Evaluation 3. UM Program Work Plan	1. Delegation Oversight to review. Annually during PP audit 2-3. Due to Clinical Assurance on May 31st via the SFTP Site	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	1. Narrative 2. ICE Quarterly Reporting format 3. ICE Quarterly Format
Quarterly UM Activity Report **All elements outlined within L.A. Care Quarterly UM Activity (ICE) report including but not limited to:** 1. UM Summary – Inpatient Activity a. Average monthly membership b. Acute Admissions/K c. Acute Bed days/K d. Acute LOS e. Acute Readmits/K f. SNF Admissions/K g. SNF Bed days/K h. SNF LOS i. SNF Readmits/K 2. UM Activities Summary a. Referral Management Tracking of the number of Approvals/Modifications/Denials/ Deferrals (Routine/Urgent) b. Referral Denial Rate c. Appeals/K d. Overturn Rate 3. **PHM 5:** CCM Complex Case Management CM Reports and Statistics	Quarterly 1st Qtr –May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	ICE Quarterly Reporting Format

NET 4B: Continued Access to Care 1. Continued Access to Practitioners If a practitioner's contract is discontinued, the organization allows affected members continued access to the practitioner, as follows: a. Continuation of treatment through the current period of active treatment for members undergoing active treatment for a chronic or acute medical condition b. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy	Quarterly 1st Qtr – May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	L.A. Care Quarterly Reporting Format
PHM 5: CCM Log of Case Management Cases (CCM) for members who have been in CCM for at least 60 days to include both open and closed cases.	Quarterly 1st Qtr – May 25 2nd Qtr – Aug 25 3rd Qtr – Nov 25 4th Qtr – Feb 25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	Acceptable formats: L.A. Care Format
Medi-Cal Provider Preventable Reportable Conditions	Quarterly 1st Qtr – May 25 2nd Qtr – Aug 25 3rd Qtr – Nov 25 4th Qtr – Feb 25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	Acceptable formats: DHCS Required Reporting Format
QI 3D: Transition to Other Care**--**member transition to other care, **a.** When their benefits end, if necessary **b.** During transition from pediatric care to adult care.	Quarterly 1st Qtr – May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	L.A. Care TOC Reporting Format
	CREDENTIALING		
1. Initial Credentialed practitioner list containing Credentialing Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. 2. Re-credentialed practitioner list containing Re-credentialing Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. 3. Voluntary Practitioner Termination list containing Termination Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. 4. Involuntary Practitioner Termination list containing Termination Date, Last Name,	Quarterly 1st Qtr – May15 2nd Qtr – Aug 15 3rd Qtr – Nov 15 4th Qtr – Feb 15	credinfo@lacare.org	Current L.A. Care Health Plan Delegated Credentialing Quarterly Credentialing Submission Form (ICE Format)

First Name, MI, Title, Address, City, State, Zip, Group Name			
DMHC SURVEYS			
1. DMHC Timely Access and Network Reporting (TAR) a. Exhibit A-1 Timely Access Time-Elapsed Standards b. Exhibit A-2 Alternative Access Timely Access Time-Elapsed Standards (if applicable) c. Exhibit A-3 Timely Access Monitoring Policies and Procedures related to subdivision (c)(5) d. Exhibit A-4 Timely Access Monitoring policies and Procedures related to all other standards e. Exhibit C-1 Methodology f. Exhibit C-2 Incidents of Non-Compliance with Rule 1300.67.2.2 g. Exhibit C-3 Patterns of Non-Compliance with rule 1300.67.2.2 h. Exhibit D-1 Methodology for Verification of Advanced Access Program (if applicable) i. Exhibit D-2 List of Advanced Access Providers (if applicable) j. Exhibit E-1 Triage k. Exhibit E-2 Telemedicine l. Exhibit E-3 Health I.T. m. Exhibit F-1 Provider Satisfaction Survey Methodology (a) Policy & Procedures n. Exhibit F-1 Provider Satisfaction Survey Methodology (b) Survey Tool o. Exhibit F-1 Provider Satisfaction Survey Methodology (c) Detailed Explanation p. q. Exhibit F3- Enrollee Satisfaction Survey Methodology (a) Policy and Procedures	Annually - March	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	

r. Exhibit F3- Enrollee Satisfaction Survey Methodology (b) Survey Tool s. Exhibit F3- Enrollee Satisfaction Survey Methodology (c) Detailed Explanation t. u. Quality Assurance Report v. Annual Provider Network Report Forms i. PCP ii. Specialists iii. Other Contracted iv. Hospitals and Clinics v. vi. Service and Enrollment vii. Mental Health viii. Grievances			
2. DMHC Provider Appointment Availability Survey (PAAS) a. Provider Contact Lists i. PCP ii. Specialists iii. Psychiatry iv. Non-Physician Mental Health v. Ancillary	Annually - July	L.A. Care's Secure File Transfer Protocol (SFTP)/ home/ucfst/infile/Quality Improvement/	
COMPLIANCE			
1. 274 EDI File Mandated by APL 16-019	Monthly – Due to L.A. Care by the 4th of each month	L.A. Care's Secure File Transfer Protocol (SFTP) /home/ucfst/infile/274	DHCS required formatting.
2. Data Certification Statements Mandated by APL 17-005	Monthly – Due to L.A. Care 3 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	Word Document, Non-specific template. Utilize own template; however, all state reports submitted to L.A. Care within the month MUST be listed and CEO MUST sign off attesting to ALL data submissions.

3. Non-Medical Transportation & Non-Emergency Medical Transportation (NMT-NEMT) Report Mandated by APL 17-010	Monthly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template
4. **Health Industry Collaboration Effort** AB1455 Quarterly Reports M/Q Medi-Cal Claims Timeliness Report AB1455 Pharmacy Claims Timeliness Reports Quarterly Provider Dispute Resolution (PDR) Report Disclosure of Emerging Claims Payment Deficiencies	Quarterly – Due to L.A. Care within specified deadline set by L.A. Care	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	HICE Approved Documents
5. Call Center Report	Quarterly – Due to L.A. care 30 days after the end of each quarter of the calendar year. When due date falls on the weekend (Sunday or Saturday, data must be submitted by COB on the Friday before the due date. • Q1 – January, February, and March • Q2 – April, May, and June • Q3 – July, August, and September • Q4 – October, November, and December	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	Format as specified by L.A. Care
6. Community Based Adult Services (CBAS) Report	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved templates
7. Dental General Anesthesia Report Mandated by APL 15-012	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved templates

8. Coordinated Care Initiative – Long- Term Services & Supports (CCI – LTSS)	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved templates
9. Medi-Cal Managed Long-Term Services & Supports (MLTSS) Report Mandated by APL 17-012	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved templates
10. Medi-Cal Managed Care Survey – Disproportionate State Hospitals (MMCS-DSH) Survey	Annually - Due to L.A. Care 7 business days prior to submission to DHCS	BSCPHP has the option to submit report directly to DHCS Or Via L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved templates
11. Health Homes Program DHCS Required Reporting (Sunset CY 2022)	Quarterly, Bi-Annually, & Annually, according to schedule in DHCS template -Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template, plus attestation of data and brief written summary of oversight and monitoring activity for the reporting period
12. Enhanced Care Management DHCS Required Reporting	Quarterly, Bi-Annually, & Annually, according to schedule in DHCS template -Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template, plus attestation of data and brief written summary of oversight and monitoring activity for the reporting period
13. Community Supports DHCS Required Reporting	Quarterly, Bi-Annually, & Annually, according to schedule in DHCS template -Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template, plus attestation of data and brief written summary of oversight and monitoring activity for the reporting period
14. CBAS Monthly Wavier Report	Monthly - Due to L.A. Care every 4th day of the month	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template

15. MOT Post Transitional Monitoring	Quarterly -Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template
16. Prop 56 Directed Payment for Physician Services Mandated by APL 19-015	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	Financial Compliance provided Template based on APL reporting requirements
17. Prop 56 Hyde Reimbursement Requirements for specific Services Mandated by APL 19-013	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ucfst/infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements
18. Prop 56 Directed Payments for Developmental Screening Services Mandated by APL 19-016	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ucfst/infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements
Prop 56 Directed Payments for Valued Base Payment Program Mandated by APL 20-014	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ucfst/infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements
19. Prop 56 Directed Payments for Family Planning Mandated by APL 20-013	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ucfst/infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements
20. Prop 56 Directed Payment for Adverse Childhood Experiences Screening Services Mandated by AP-19-018	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ucfst/infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements
21. MCPD and PCPA Managed Care Program Date (MCPD) and Primary Care Provider Alignment (PCPA) Mandated by APL 20-017 The Managed Care Program Data (MCPD) report is a consolidated reporting requirement which DHCS introduced	Monthly - Due to L.A. Care every 4th day of the month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	Regulatory Reports provided Template based on APL reporting requirements

through APL 20-017. The MCPD file replaces the following reporting requirements, as this data is now incorporated into the MCPD file in .json format: • Grievances and appeals data in an Excel template, as specified in APL 14-013 ***(previously submitted by your plan as the Grievance Report Mandated by APL 14-013)*** • Monthly MERs and other continuity of care records data in an Excel template, as specified in Attachment B of APL 17-007 ***(previously submitted by your plan as the MMDR Report)*** • Other types of continuity of care data in ad-hoc Excel templates • Out-of-Network request data in a variety of ad-hoc Excel templates ***(previously submitted by your plan as the OON Report)***			
22. Acute Care at Home Hospital Report Mandated by APL 20-021	Monthly – Due to LA Care the last day of every month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	**DHCS Reporting Template**
23. Blood Lead Screening Mandated by APL 20-016	Quarterly - Due to L.A. Care 45 days after the quarter ends	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	**Regulatory Reports provided Template based on APL reporting requirements**
24. Cost Avoidance & Post Payment (CAPP) Recovery Mandated by APL 21-002	Monthly – Due to L.A. Care 6th business day of every month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	DHCS Approved Template
25. Provider Network Termination Mandated by APL 21-003	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	DHCS Approved Template

26. Third Party Liability	15 days from the date LA Care submits case file.	L.A. Care via its Secure File Transfer Protocol (SFTP) – home/ucfst/infile/Regulatory Reports/	DHCS approved templates
27. New and or revised reports as released by DHCS	Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved templates
28. Disaster and Recovery Plan Disaster Recovery Test Results L.A. Care will request all elements outlined below including but not limited to: LA Care may require additional information on Business Continuity efforts based off current event. In the event there are any additional requests from regulators for individual instances, such as, an emergency declared by the governor; 29. L.A. Care will send out an ad hoc written request asking to respond with the requested information should it be an element outside of what is already being requested and another mobile contact mechanism when outside of regular business hours.	Annually during PP audit and ad-hoc; Ad-Hoc	L.A. Care's Secure File Transfer Protocol (SFTP) EnterpriseRiskManagement@lacare.org home/PPName/infile/Regulatory Reports/ EnterpriseRiskManagement@lacare.org ; RegulatoryReports@lacare.org	Word Document, Non-Specific template Template may change upon regulators request.
DELEGATED FINANCIAL AND DELEGATED CLAIMS COMPLIANCE			
1. a) Oversight Summary on Financial Solvency Monitoring of Delegates' Quarterly Unaudited Financial Statements b) Data elements that are from Claims Delegates' Quarterly Timeliness Reporting will be included in 1(a) above – Oversight Report on Financial Solvency Monitoring of Delegates' Quarterly Unaudited Financial Statements) Note: Delegates consist of PPGs and capitated hospitals.		L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Financial_Compliance/ Plan will also have the option to submit via email to remain compliant	Excel/PDF

2. Oversight Summary on Financial Solvency Monitoring of Delegates' Annual Independent Audited Financial Statements ***Note: 2) does not apply to Oversight reporting of claims processing audits of delegates***	Annually – Due to L.A. Care 180 calendar days after delegates' fiscal year end	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Financial_Compliance Plan will also have the option to submit via email to remain compliant	Excel/PDF
3. a) Oversight Summary on Annual Financial Solvency Audits of Delegates. b) Oversight Summary on Annual & Follow-Up Claims Processing Audit of Delegates Note: Delegates consist of PPGs and capitated hospitals.	Quarterly – Due to L.A. Care 60 calendar days after each calendar quarter end for the delegate audits conducted[1] in the reporting quarter [1]the date of delegate audit is based on the first date of fieldwork conducted by BSC PHP.	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Financial_Compliance Plan will also have the option to submit via email to remain compliant	Excel/PDF
4. Policy 2305 Medi-Cal Allocation	Annually – Due to L.A. Care 120 calendar year end (April 30)	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Financial_Compliance Plan will also have the option to submit via email to remain compliant	
DELEGATION OVERSIGHT			
New Member Welcome Kit Mailing Reports	Quarterly – Due to L.A. Care the 15th day of each quarter end	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Delegation Oversight	Format as specified by L.A. Care
HEALTH EDUCATION			
1. Health Education Referral Report	Quarterly – Due to L.A. Care the 25th day of the month following the end of the quarter: • Q1 due 4/25 • Q2 due 7/25 • Q3 due 10/25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Health Education/	Format as specified by LA. Care or mutually agreed upon per Plan Partner process.

	• Q4 due 1/25		
2. Health Education Material Distribution Report	Quarterly – Due to L.A. Care the 25th day of the month following the end of the quarter: • Q1 due 4/25 • Q2 due 7/25 • Q3 due 10/25 • Q4 due 1/25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Health Education/	Format as specified by LA. Care or mutually agreed upon per Plan Partner process.
3. Health Education Program Description and Work Plan	Annually – due to L.A. Care January 31st of each year	Via email to designated Health Education contact	As appropriate per Plan Partner model.
CULTURAL AND LINGUISTC SERVICES			
1. C&L Program Description and Work Plan	Annually – due to L.A. Care January 31st of each year	L.A. Care's Secure File Transfer Protocol (SFTP) *OR* Via email to CL_Reports_Mailbox@lacare.org	Plan Partner can submit their own format of C&L PD and work Plan. Requirement is in reference to Policy and Procedure CL-008 and C&L Program Description delegated Subcontractor.
2. C&L Referral Report	Quarterly – Due to L.A. Care the 25th day of the month following the end of the quarter: • Q1 due 4/25 • Q2 due 7/25 • Q3 due 10/25 • Q4 due 1/25	L.A. Care's Secure File Transfer Protocol (SFTP) *OR* Via email to CL_Reports_Mailbox@lacare.org	Format as specified by LA. Care or mutually agreed upon per Plan Partner process.

All other non-conflicting rights and duties, obligations and liabilities of the parties to the Agreement shall remain unchanged.

IN WITNESS WHEREOF, the parties have entered into this Amendment as of the date set forth below.

Local Initiative Health Authority for Los Angeles County d.b.a. L.A. Care Health Plan (L.A. Care)
A local government agency

By: ________________________
John Baackes
Chief Executive Officer

Date: __________________________, 2023

By: ________________________
Alvaro Ballesteros
Chairperson,
L.A. Care Board of Governors

Date: _______________________, 2023

Blue Shield of California Promise Health Plan
A California health care services plan

By: ___________________________
Kristen Cerf
President and Chief Executive Officer

Date: _______________________, 2023

~~NHao~~Amendment No. ~~36~~41

to

Services Agreement

between

Local Initiative Health Authority for Los Angeles County

and

Kaiser Foundation Health Plan, Inc.

This Amendment No. ~~36~~ 41 is effective as of July 1, 2021~~20202021 2020202020210~~, as indicated herein by and between the Local Initiative Health Authority for Los Angeles County, a local public agency operating as L.A. Care Health Plan ("Local Initiative") and ***Kaiser Foundation Health Plan, Inc.,*** a California health care service plan ("Plan").

RECITALS

WHEREAS, the State of California ("State") has, through statute, regulation, and policies, adopted a plan ("State Plan") for certain categories of Medi-Cal recipients to be enrolled in managed care plans for the provision of specified Medi-Cal benefits. Pursuant to this State Plan, the State has contracted with two health care service plans in Los Angeles County. One of these two health care service plans with which the State has a contract ("Medi-Cal Agreement") is a health care service plan locally created and designated by the County's Board of Supervisors for, among other purposes, the preservation of traditional and safety net providers in the Medi-Cal managed care environment ("Local Initiative"). The other health care service plan is an existing HMO which is selected by the State (the "Commercial Plan");

WHEREAS, the Local Initiative is licensed by the Department of Managed Health Care as a health care service plan under the California Knox-Keene Act (Health and Safety Code Sections 1340 *et seq*.) (the "Knox-Keene Act");

WHEREAS, Plan is duly licensed as a prepaid full service health care service plan under the Knox-Keene Act and is qualified and experienced in providing and arranging for health care services for Medi-Cal beneficiaries; and

WHEREAS, Local Initiative and Plan have entered into a prior agreement dated October 1, 2009, as amended ("Agreement"), for Plan to provide and arrange for the provision of health care services for Local Initiative enrollees as part of a coordinated, culturally and linguistically sensitive health care delivery program in accordance with the Medi-Cal Agreement and all applicable federal and state laws.

NOW, THEREFORE, in consideration of the foregoing and the terms and conditions set forth herein, the parties agree to amend the Agreement as follows:

I. Exhibit 8 – Delegation Agreement, shall be revised as is set forth in Exhibit 8, below.

IN WITNESS WHEREOF, the parties have entered into this Amendment No. ~~36~~ 41 as of the date set forth below.

Local Initiative Health Authority for Los Angeles County operating as L.A. Care Health Plan (Local Initiative)
A local public agency

By: ______________________________
John Baackes
Chief Executive Officer

Date: ___________________, 2022~~1~~

By: ______________________________
Hector De La Torre
Chairperson
L.A. Care Board of Governors

Date: ___________________, 2022~~1~~

Kaiser Foundation Health Plan, Inc.,
A California health care services plan

By: ______________________________
Marcus J. Hoffman
Senior Vice President, Chief Financial Officer, Southern California and Hawai'i Market~~Region (Interim)~~

Date: ______________________, 2022~~1~~

II. Exhibit 8 – Delegation Agreement, shall be revised as follows:

Exhibit 8
Delegation Agreement
[Attachment A]

Delegated Activities
Responsibilities of Plan and Local Initiative

The purpose of the following grid is to specify the activities delegated by Local Initiative ("L.A. Care") to Kaiser Foundation Health Plan (individually and collectively "Plan" and/or "Delegate") under the Delegation Agreement with respect to: (i) quality management and improvement, (ii) population health management, (iii) network management, (iv) utilization management, (v) credentialing and re-credentialing, (vi) member experience, and (vii) claims recovery, and (viii) claims processing.. All Delegated Activities are to be performed in accordance with currently applicable NCQA accreditation standards and State and Federal regulatory requirements, as modified from time to time. Kaiser Foundation Health Plan agrees to be accountable for all responsibilities delegated by L.A. Care and will not further delegate (sub-delegate) any such responsibilities without prior written approval by L.A. Care, except as outlined in the Delegation Agreement. Kaiser Foundation Health Plan is responsible for sub-delegation oversight of any sub-delegated activities. Kaiser Foundation Health Plan will provide periodic reports to L.A. Care as described elsewhere in the Delegation Agreement. L.A. Care will oversee the delegation to Kaiser Foundation Health Plan as described elsewhere in the Services Agreement. Due to the Medi-Cal Rx Transition where the pharmacy benefit will be managed by DHCS in 2021starting January 1,-2022 2021, standard and reporting requirements as related to Pharmacy items will no longer be required for data period beginning the transition date identified by DHCS. This would apply to all standard requirements and reports listed under "Pharmacy". The final monitoring and quarterly reporting requirement would be up to the data period until the transition date. However, while the monitoring and quarterly reporting will discontinue after the transition date, any reports required for regulatory or NCQA purposes mainly as it relates to any data up to the actual transition date would be still required upon request. In the event deficiencies are identified through this oversight, Kaiser Foundation Health Plan will provide a specific corrective action plan acceptable to L.A. Care. If Kaiser Foundation Health Plan does not comply with the corrective action plan within the specified time frame, L.A. Care may revoke the delegation to Kaiser Foundation Health Plan, in whole or in part, in accordance with Exhibit 5, herein. L.A. Care will provide Plan Partner with the data necessary to determine member experience and clinical performance, when requested and as applicable. Request shall be sent to the L.A. Care business unit which maintains the data and/or L.A. Care's Plan Partner BusinessBusiness Unit. The request must be precise and contain sufficient details so it is clear what minimum data needs to be provided to fulfill the request. The L.A. Care business unit responsible for the requested data shall respond timely and ensure that data is sent in compliance with L.A. Care's Policies and Procedures securing PHI through applicable protections, e.g., encryption

Standard	Delegated Activities	Retained by L.A. Care
	QUALITY	
Program Structure and Operations (NCQA 20210-20222020 QI 1) QI	**QI Program Structure** The organization's QI program description specifies: 1. The QI Program Structure 2. The behavioral healthcare aspects of the program 3. Involvement of a designated physician in the QI program 4. Involvement of a behavioral healthcare practitioner in the behavioral aspects of the program 5. Oversight of QI functions of the organization by the QI Committee	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs, including review, evaluation, and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	~~6. Objectives for serving a culturally and linguistically diverse membership~~ **Annual Work Plan** The organization documents and executes a QI annual work plan that reflects ongoing activities throughout the year and addresses: 1. Yearly planned QI activities and objectives. 2. Time frame for each activity's completion. 3. Staff members responsible for each activity. 4. Monitoring of previously identified issues. 5. Evaluation of the QI program. **Annual Evaluation** The organization conducts an annual written evaluation of the QI program that includes the following information: 1. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service 2. Trending of measures of ~~to assess~~ performance in the quality and safety of clinical care and quality of service 3. ~~Analysis and~~ evaluation of the overall effectiveness of the QI program and of its progress toward influencing network-wide safe clinical practices **QI Committee Responsibilities** The organization's QI Committee: 1. Recommends policy decisions. 2. Analyzes and evaluates the results of QI activities. 3. Ensures practitioner participation in the QI program through planning, design, implementation or review. 4. Identifies needed actions. 5. Ensures follow-up, as appropriate.	
Health Services Contracting (NCQA 2021~~0~~-2022~~2020~~ QI 2)	**Practitioner Contracts** Contracts with practitioners specifically require that: 1. Practitioners cooperate with QI activities; 2. Practitioners allow the organization to use their performance data. ~~**Provider Contracts**~~ ~~Contracts with organization providers specifically require that:~~ ~~1. Providers cooperate with QI activities;~~ ~~2. Providers allow the plan to use their performance data~~	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs, including review, evaluation, and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
Continuity and Coordination of Medical Care (NCQA 20210-20222020 QI 3)	**Continuity and Coordination of Medical Care** The organization annually identifies opportunities to improve coordination of medical care by: 1. Collecting data on member movement between practitioners 2. Collecting data on member movement across settings 3. Conducting quantitative and causal analysis of data to identify improvement opportunities 4. Identifying and selecting one opportunity for improvement 5. Identifying and selecting a second opportunity for improvement 6. Identifying and selecting a third opportunity for improvement 7. Identifying and selecting a fourth opportunity for improvement **Acting of Opportunities** The organization annually acts to improve coordination of medical care by: 1. Acting on the first opportunity identified in Element A, factorsfactor 4-7 2. Acting on the second opportunity identified in Element A, factorsfactor 5 4-7 3. Acting on the third opportunity identified in Element A, factorsfactor 6 4-7 **Measuring Effectiveness** The organization annually measures the effectiveness of improvement actions taken for: 1. The first opportunity in Element B. 2. The second opportunity in Element B. 3. The third opportunity in Element B. **Transition to other care** Refer to Utilization Management Delegated Activities Section	
Continuity and Coordination between Medical and Behavioral Healthcare (NCQA 20210-20222020 QI 4)	**Data Collection** The organization annually collects data about opportunities for collaboration between medical care and behavioral healthcare in the following areas: 4.1. Exchange of information 5.2. Appropriate diagnosis, treatment and referral of behavioral healthcare disorders commonly seen in primary care 6. Appropriate use of psychotropic medications 3.	

Standard	Delegated Activities	Retained by L.A. Care
	~~1.~~4. Management of treatment access and follow-up for members with coexisting medical and behavioral disorders. ~~7.~~ Primary or secondary preventive behavioral healthcare program implementation. 5. ~~2.~~6. Special needs of members with severe and persistent mental illness. **Collaborative Activities** The organization annually conducts activities to improve the coordination of behavioral healthcare and general medical care including: 1. Collaborating with behavioral healthcare practitioners 2. Quantitative and ~~causal~~ qualitative analysis of data to identify improvement opportunities ~~3.~~ Identifying and selecting one opportunity for improvement from Element A 3. ~~1.~~4. Identifying and selecting a second opportunity for improvement from Element A ~~4.~~ Taking collaborative action to address one identified opportunities for improvement from Element A 5. ~~2.~~6. Taking collaborative action to address a second identified opportunity for improvement from Element A. **Measuring Effectiveness** The organization annually measures the effectiveness of improvement actions taken for: ~~III.~~1. The first opportunity in Element B. ~~IV.~~2. The second opportunity in Element B.	

Standard	Delegated Activities	Retained by L.A. Care
Standards for Medical Record Documentation (DHCS)	Establishing medical record standards which require medical records to be maintained in a manner that is current, detailed, and organized, and which permits effective and confidential patient care and quality review, including: ~~a.~~1. Developing and distributing to practice sites: a. Policies and procedures for the confidentiality of medical records b. Medical record documentation standards ~~a.~~i. Requirements for an organized medical record c. Standards for the availability of medical records	

Sub-Sub-delegation Delegation of QI (NCQA 20210-20222020 QI 57	**Element A: Sub-delegation Delegation Agreement** The written sub-delegation agreement: 1. Is mutually agreed upon 2. Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity 3. Requires at least semiannual reporting by the sub-delegated entity to the delegate 3. 1.4. Describes the process by which the delegate evaluates the sub-delegated entity's performance 4. Describes the process for providing member experience and clinical performance data to its sub-delegates when requested 5. 2.6. Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **Element B: Predelegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the delegated entity evaluates sub-delegate capacity to meet NCQA requirements before sub-delegation begins. **Element C: Review of QI Program** For arrangements in effect for 12 months or longer, the organization: 1. Annually reviews its sub-delegate's QI program 2. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities 3. Semiannually evaluates regular reports, as specified in Element Athe sub-delegation agreement. **Element D: Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	

Standard	Delegated Activities	Retained by L.A. Care
	POPULATION HEALTH MANAGEMENT	
PHM Strategy (NCQA 20210-20222020 PHM 1)	**Strategy Description** The strategy describes: 1. Goals and populations targeted for each of the four areas of focus 2. Programs or Services offered to members. 3. Activities that are not direct member interventions, 3. 1.4. How member programs are coordinated. 5. How members are informed about available PHM programs. 6. How the organization promotes health equity. **Informing Members** The organization informs members eligible for programs that include interactive contact: 1. How members become eligible to participate 2. How to use program services 3. How to opt in or opt out of the program	

Population Identification (NCQA 2021~~0~~-2022~~2020~~ PHM 2)	**Data Integration** The organization integrates the following data to use for population health management functions: 1. Medical and Behavioral claims or encounters 2. Pharmacy claims ~~3.~~ Laboratory results 3. ~~1.~~4. Health appraisal results ~~4.~~ Electronic health records 5. ~~2.~~6. Health Services programs within the organization ~~5.~~7. Advanced data sources **Population Assessment** The organization annually: 1. Assesses the characteristics and needs, including social determinants of health, of its member population ~~2. Identifies and assesses the needs of relevant member subpopulations~~ ~~3.~~ Assesses the needs of child and adolescent members 2. ~~1.~~3. Assesses the needs of members with disabilities 4. Needs of members with serious and persistent mental illness (SPMI) 5. Assesses the needs of members of racial or ethnic groups. 6. Assesses the needs of members with limited English proficiency. 7. Identifies and assesses the needs of relevant member subpopulations **Activities and Resources** The organization annually uses the population assessment to: 1. Review and update its PHM activities to address member needs 2. Review and update its PHM resources to address member needs 3. Review and update activities or resources to address health care disparities for at least one identified populations. ~~2.~~4. Review community resources for integration into program offerings to address member needs **Segmentation** 1. At least annually, the organization segments or stratifies its entire population into subset for targeted intervention.	

Standard	Delegated Activities	Retained by L.A. Care
	2. Assesses for racial bias in its segmentation or stratification methodology.	
Delivery System Supports (NCQA 2021~~0~~-2022~~2020~~ PHM 3)	~~**Practitioner or Provider Support**~~ ~~The organization supports practitioners or providers in its network to achieve population health management goals by:~~ ~~1. Sharing Data~~ ~~2. Offering certified shared-decision making aids~~ ~~3. Providing practice transformation support to primary care practitioners~~ ~~4. Providing comparative quality information on selected specialties~~ ~~5. Providing comparative pricing information for selected services~~ ~~6.~~ ~~1. Sharing data~~ ~~7. Offering certified shared-decision making aids~~ ~~2. Providing practice transformation support to primary care practitioners~~ ~~1. Providing comparative quality information on selected specialties~~ ~~8. Providing comparative pricing information for selected services~~ ~~2. One additional activity to support practitioners or providers in achieving PHM goals~~ **Practitioner or Provider Support** The organization supports practitioners or providers in its network to achieve population health management goals by: 1. Sharing data 2. Offering evidence-based or certified decision making aids 3. Providing practice transformation support to primary care practitioners 4. Providing comparative quality information on selected specialties 5. Providing comparative pricing information for selected services 6. Providing training on equity, cultural competency, bias, diversity and inclusion. 1.	**Value-Based Payment Arrangements** The organization demonstrates that it has a value-based payment (VBP) arrangement(s) and reports the percentages of total payments tied to VBP.

Standard	Delegated Activities	Retained by L.A. Care
Wellness and Prevention (NCQA 2020 PHM 4)	**Frequency of Health Appraisal Completion** The organization has the capability to administer an HA annually **Topics of Self-Management Tools** The organization offers self-management tools, derived from available evidence, that provides members with information on at least the following wellness and health promotion areas: 1. Healthy weight (BMI) maintenance. 2. Smoking and tobacco cessation. 3. Encouraging physical activity. ~~1.~~ Healthy eating. 4. ~~4.~~5. Managing stress. ~~2.~~ Avoiding at-risk drinking. 6. ~~5.~~7. Identifying depressive symptoms.	
Complex Case Management (NCQA 2020 PHM 5)	**Access to Case Management** The organization has multiple avenues for members to be considered for complex case management services, including: ~~a.~~1. Medical management program referral ~~b.~~2. Discharge planner referral ~~c.~~3. Member or caregiver referral ~~1.~~a. Practitioner referral. **Case Management Systems** The organization uses case management systems that support: ~~a.~~1. Evidence-based clinical guidelines or algorithms to conduct assessment and management; ~~b.~~2. Automatic documentation of staff ID, and the date and time of action on the case or when interaction with the member occurred ~~c.~~3. Automated prompts for follow-up, as required by the case management plan.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Case Management Process
The organization's complex case management procedures address the following:

~~a.~~1. Initial assessment of member health status, including condition-specific issues
~~b.~~2. Documentation of clinical history, including medications
~~c.~~3. Initial assessment of activities of daily living
    ~~1.~~a. Initial assessment of behavioral health status, including cognitive functions
~~d.~~4. Initial assessment of social determinants of health
    ~~2.~~b. Initial assessment of life planning activities
~~e.~~5. Evaluation of cultural and linguistic needs, preferences or limitations
~~f.~~6. Evaluation of visual and hearing needs, preferences or limitations
    ~~3.~~c. Evaluation of caregiver resources and involvement
~~g.~~7. Evaluation of available benefits
~~h.~~8. Evaluation of community resources
    ~~4.~~d. Development of an individualized case management plan, including prioritized goals that considers the member's and caregiver's goals, preferences and desired level of involvement in the case management plan
    ~~5.~~e. Identification of barriers to a member meeting goals or complying with the case management plan
    ~~6.~~f. Facilitation of member referrals to resources and follow-up process to determine whether members act on referrals
    ~~7.~~g. Development of a schedule for follow-up and communication with members
    ~~8.~~h. Development and communication of a member self-management plan
    ~~9.~~i. A process to assess member progress against case management plan

Initial Assessment
An NCQA review of a sample of the organization's complex case management files demonstrates that the organization follows its documented processes for:
~~a)~~1. Initial assessment of members' health status, including condition-specific issues

Standard	Delegated Activities	Retained by L.A. Care
	~~b)~~2. Documentation of clinical history, including medications ~~c)~~3. Initial assessment of activities of daily living ~~1.~~a) Initial assessment of mental health status, including cognitive functions ~~d)~~4. Initial assessment of social determinants of health ~~2.~~b) Evaluation of cultural and linguistic needs, preferences or limitations ~~e)~~5. Evaluation of visual and hearing needs, preferences or limitations ~~f)~~6. Evaluation of caregiver resources and involvement ~~3.~~c) Evaluation of available benefits ~~g)~~7. Evaluation of available community resources ~~4.~~d) Assessment of life planning activities. **Case Management Ongoing Management** The NCQA review of a sample of the organization's case management files that demonstrates the Plan Partner follows its documented processes for: ~~a)~~1. Development of case management plans, including prioritized goals, that take into account member and caregiver goals, preferences and desired level of involvement in the complex case management program ~~b)~~2. Identification of barriers to meeting goals and complying with the plan ~~c)~~3. Development of a schedule for follow-up and communication with members. ~~2.~~a) Development and communication of member self-management plans; and ~~d)~~4. Assessment of progress against the case management plans and goals and modification as needed.	

Standard	Delegated Activities	Retained by L.A. Care
Population Health Management Impact (NCQA 2020 PHM 6)	**Measuring Effectiveness** At least annually, the organization conducts a comprehensive analysis of the impact of its PHM strategy that includes the following: 1. Quantitative results for relevant clinical, cost/utilization and experience measures. 2. Comparison of results with a benchmark or goal. 3. Interpretation of results. **Improvement and Action** The organization uses results from the PHM impact analysis to annually: 1. Identify opportunities for improvement. 2. Act on one opportunity for improvement.	

Standard	Delegated Activities	Retained by L.A. Care
Sub-delegation Delegation of PHM (NCQA 20210-20222020 PHM 7)	**Sub-delegation Delegation Agreement** The written sub-delegation agreement: 1. Is mutually agreed upon 2. Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity 2. 3. Requires at least semiannual reporting by the sub-delegated entity to the delegate 3. 1.4. Describes the process by which the delegate evaluates the sub-delegated entity's performance 4. Describes the process for providing member experience and clinical performance data to its sub-delegates when requested 5. 2.6. Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **Predelegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the delegated entity evaluates sub-delegate capacity to meet NCQA requirements before sub-delegation begins. **Review of PHM Program** For arrangements in effect for 12 months or longer, the organization: 1. Annually reviews its sub-delegate's PHM program 2. Annually audits complex case management files against NCQA standards for each year that sub-delegation has been in effect, if applicable 3. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities 3. 1.4. Semiannually evaluates regular reports, as specified in Element Athe sub-delegation agreement. **Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	

Standard	Delegated Activities	Retained by L.A. Care
	NETWORK MANAGEMENT	
Availability of Practitioners (NCQA 20210-20222020 NET 1)	**Cultural Needs and Preferences** The organization: 2.1. Assesses the cultural, ethnic, racial, and linguistic needs of its members 3.2. Adjusts the availability of practitioners within its network, if necessary. **Practitioners Providing Primary Care** To evaluate the availability of practitioners who provide primary care services, including general medicine or family practice, internal medicine and pediatrics by: •1. Establishes measurable standards for the number of each type of practitioner providing primary care •2. Establishes measurable standards for the geographic distribution of each type of practitioner providing primary care •3. Annually analyzes performance against the standards for the number of each type of practitioner providing primary care 1.• Annually analyzes performance against the standards for the geographic distribution of each type of practitioner providing primary care. **Practitioners Providing Specialty Care** To evaluate the availability of specialists in its delivery system, the organization: 1. Defines the type of practitioners who serve as high volume and high impact specialists 2. Establishes measurable standards for the number of each type of high volume specialists 3. Establishes measurable standards for the geographic distribution of each type of high-volume specialist 3. 1.4. Establishes measureable standards for the geographic distribution of each type of high-impact specialist 4.5. Analyzes its performance against the established standards at least annually **Practitioners Providing Behavioral Healthcare** To evaluate the availability of high-volume behavioral healthcare practitioners in its delivery system, the organization:	

Standard	Delegated Activities	Retained by L.A. Care
	~~1.~~a. Defines the types of high volume behavioral healthcare practitioners ~~2.~~b. Establishes measurable standards for the number of each type of high volume behavioral healthcare practitioner ~~3.~~c. Establishes measurable standards for the geographic distribution of each type of high-volume behavioral healthcare practitioner ~~4.~~d. Analyze performance against the standards at least annually	
Accessibility of Services (NCQA 2021~~0~~-2022~~2020~~ NET 2)	**Access to Primary Care** Using valid methodology, the organization collects and performs an annual analysis of data to measure its performance against its standards for access to: ~~2.~~1. Regular and routine care appointments ~~3.~~2. Urgent care appointments ~~4.~~3. After-hours care. **Access to Behavioral Healthcare:** Using valid methodology, the organization annually collects and analyzes data to evaluate access to appointments for behavioral healthcare for: 1. Care for a non-life-threatening emergency within 6 hours 2. Urgent care within 48 hours 3. Initial visit for routine care within 10 business days 4. Follow-up routine care **Access to Specialty Care** Using valid methodology, the organization annually collects and analyzes data to evaluate access to appointments for: 1. High-volume specialty care 2. High-impact specialty care	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs, including review, evaluation, and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.
Assessment of Network Adequacy (NCQA 2021~~0~~-2022~~2020~~ NET 3)	**Assessment of Member Experience Accessing the Network** The organization annually identifies gaps in networks specific to geographic areas or types of practitioners or providers by: 1. Using analysis results related to member experience with network adequacy for nonbehavioral healthcare services from ~~Member Experience standards for Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals and Nonbehavioral Opportunities for Improvement.~~ ME 7, Element C and Element D.	

Standard	Delegated Activities	Retained by L.A. Care
	2. Using analysis results related to member experience with network adequacy for behavioral healthcare services from ~~the Member Experience standard for Annual Assessment of Behavioral Healthcare and Services.~~ ME 7, Element C and Element D. ~~3.~~ Compiling and analyzing non-behavioral requests for and utilization of out-of-network services 3. ~~3.~~4. Compiling and analyzing behavioral healthcare requests for and utilization of out-of-network services. **Opportunities to Improve Access to Nonbehavioral Healthcare Services** The organization annually: 1. Prioritizes opportunities for improvement identified from analyses of availability, ~~accessibility and member experience accessing the network.~~ **(NET 1, Elements A, B and C), accessibility (NET 2, Elements A and C) and member experience accessing the network (NET 3, Element A, factors 1 and 3).** 2. Implements interventions on at least one opportunity, if applicable. 3. Measures the effectiveness of interventions, if applicable. **Opportunities to Improve Access to Behavioral Healthcare Services** The organization annually: ~~1. Prioritizes improvement opportunities for improvement identified from analyses of availability, accessibility, and member experience accessing the network.~~ 1. 1. Prioritizes opportunities for improvement identified from analyses of availability (NET 1, Elements A, B and C), accessibility (NET 2, Elements A and C) and member experience accessing the network (NET 3, Element A, factors 1 and 3). 2. Implements interventions on at least one opportunity, if applicable. 3. Measures the effectiveness of interventions, if applicable.	
Continued Access to Care	**Notification of Termination**	

Standard	Delegated Activities	Retained by L.A. Care
(NCQA 2020 NET 4)	Refer to Utilization Management Delegated Activities Section **Continued Access to Practitioners** Refer to Utilization Management Delegated Activities Section	
Physician and Hospital Directories (NCQA 2020 NET 5)	**Physician Directory Data** The organization has a web-based physician directory that includes the following physician information: ~~a.~~1. Name ~~b.~~2. Gender ~~c.~~3. Specialty ~~1.~~a. Hospital affiliations ~~d.~~4. Medical group affiliations ~~2.~~b. Board certification ~~e.~~5. Accepting new patients ~~f.~~6. Language spoken by the physician or clinical staff ~~3.~~c. Office locations and phone numbers **Physician Directory Updates** The organization updates its web-based physician directory within 30 calendar days of receiving new information from the network physician. **Assessment of Physician Directory Accuracy** Using valid methodology, the organization performs an annual evaluation of its physician directories for: ~~a.~~1. Accuracy of office locations and phone numbers ~~b.~~2. Accuracy of hospital affiliations ~~c.~~3. Accuracy of accepting new patients ~~1.~~a. Awareness of physician office staff of physician's participation in the organization's network **Identifying and Acting on Opportunities** Based on results of the analysis performed in Element C, at least annually, the organization: ~~a.~~1. Identifies opportunities to improve the accuracy of the information in its physician directories ~~b.~~2. Takes action to improve the accuracy of the information in its physician directories	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	Searchable Physician Web-Based Directory The organization's web-based physician directory includes search functions with instructions for finding the following physician information: ~~a.~~1. Name ~~b.~~2. Gender ~~c.~~3. Specialty ~~1.~~a. Hospital affiliations ~~d.~~4. Medical group affiliations ~~2.~~b. Accepting new patients ~~e.~~5. Languages spoken by the physician or clinical staff ~~f.~~6. Office locations **Hospital Directory Data** The organization has a web-based hospital directory that includes the following information: 1. Hospital name 2. Hospital location and phone number ~~3.~~ Hospital accreditation status 3. ~~1.~~4. Hospital quality data from recognized sources **Hospital Directory Updates** The organization updates its web-based hospital directory information within 30 calendar days of receiving new information from the network hospital. **Searchable Hospital Web-Based Directory** The organization's web-based directory includes search functions for specific data types and instructions for searching for the following information: 1. Hospital name 2. Hospital location **Usability Testing** The organization evaluates its web-based physician and hospital directories for understandability and usefulness to members and prospective members at least every three years, and considers the following: ~~a.~~1. Reading level ~~b.~~2. Intuitive content organization ~~c.~~3. Ease of navigation	

Standard	Delegated Activities	Retained by L.A. Care
	~~4.~~a. Directories in additional languages, if applicable to membership **Availability of Directories** The organization makes web-based physician and hospital directory information available to members and prospective members through alternative media, including: ~~a.~~1. Print ~~b.~~2. Telephone	
Sub-Delegation of NET (NCQA 2020 NET 67	**Sub-delegation Delegation Agreement** The written sub-delegation agreement: 1. Is mutually agreed upon 2. Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity ~~3.~~ Requires at least semiannual reporting by the sub-delegated entity to the delegate 3. 4. Describes the process by which the delegate evaluates the sub-delegated entity's performance ~~4.~~ Describes the process for providing member experience and clinical performance data to its sub-delegates when requested 5. ~~5.~~6. Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **Predelegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the delegated entity evaluates sub-delegate capacity to meet NCQA requirements before sub-delegation begins. **Review of Sub-Delegated Activities** For arrangements in effect for 12 months or longer, the organization: ~~I.~~ Annually reviews its sub-delegate's network management procedures 1. ~~II.~~2. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities	

Standard	Delegated Activities	Retained by L.A. Care
	~~III.~~1. Semiannually evaluates regular reports, as specified in Element Athe sub-delegation agreement. **Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	
	UTILIZATION MANAGEMENT	
Continued Access to Care and Continuity and Coordination of Medical Care (NCQA 2020 NET 4and QI 3)	**Notification of Termination** The organization notifies members affected by the termination of a practitioner or practice group in general, family, and internal medicine or pediatrics, at least thirty (30) calendar days prior to the effective termination date and helping the member select a new practitioner. **Continued Access to Practitioners** If a practitioner's contract is discontinued, the organization allows affected members continued access to the practitioner, as follows: 1. Continuation of treatment through the current period of active treatment or for up to ninety (90) calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition 2. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy. **Transition to Other Care** The organization helps with members' transition to other care when their benefits end, if necessary.	
Program Structure (NCQA 2020 UM 1)	**Written Program Description** The organization's UM program description includes the following: 1. A written description of the program structure 2. The behavioral healthcare aspects of the program ~~3.~~ Involvement of a designated senior-level physician in UM program implementation 3. ~~1.~~4. Involvement of a designated behavioral healthcare practitioner in the implementation of the behavioral healthcare aspects of the UM program	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs, including review, evaluation, and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	~~4.~~ The program scope and processes to determine benefit coverage and medical necessity 5. ~~2.~~6. Information sources used to determine benefit coverage and medical necessity. **Annual Evaluation** The organization annually evaluates and updates the UM program, as necessary.	
Clinical Criteria for UM Decisions (NCQA 2020 UM 2)	**UM Criteria** The organization: 1. Has written UM decision-making criteria that are objective and based on medical evidence 2. Has written policies for applying the criteria based on individual needs ~~3.~~ Has written policies for applying the criteria based on an assessment of the local delivery system 3. ~~1.~~4. Involves appropriate practitioners in developing, adopting, and reviewing criteria ~~4.~~5. Annually reviews the UM criteria and the procedures for applying them, and updates the criteria when appropriate **Availability of Criteria** The organization: 1. States in writing how practitioners can obtain the UM criteria 2. Makes the criteria available to practitioners upon request. **Consistency in Applying Criteria** At least annually, the organization: 1. Evaluates the consistency with which health care professionals involved in UM apply criteria in decision making 2. Acts on opportunities to improve consistency, if applicable.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs, including review, evaluation, and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.
Communication Services (NCQA 2020 UM 3)	**Access to Staff** The organization provides the following communication services for members and practitioners including: 1. Staff are available at least eight (8) hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues 2. Staff can receive inbound communication regarding UM issues after normal business hours	

Standard	Delegated Activities	Retained by L.A. Care
	3. Staff are identified by name, title, and organization name when initiating or returning calls regarding UM issues 4. TDD/TTY services for members who need them 5. Language assistance for members to discuss UM issues.	
Appropriate Professionals* (NCQA 2020 UM 4)	**Appropriate Professionals** The organization has written procedures: 1. Requiring appropriately licensed professionals to supervise all medical necessity decisions 2. Specifying the type of personnel responsible for each level of UM decision-making **Use of Practitioners for UM Decisions** The organization has a written job description with qualifications for practitioners who review denials of care based on medical necessity. Practitioners are required to have: ~~b.~~1. Education, training, or professional experience in medical or clinical practice ~~c.~~2. A current clinical license to practice or an administrative license to review UM cases **Practitioner Review of Nonbehavioral Healthcare Denials** The organization uses a physician or other healthcare professional, as appropriate, to review any non-behavioral healthcare denial based on medical necessity. **Practitioner Review of Behavioral Healthcare Denials** The organization uses a physician, appropriate behavioral healthcare practitioners, as appropriate, to review any behavioral healthcare denial of care based on medical necessity. **Practitioner Review of Pharmacy Denials** The organization uses a physician or a pharmacist to review pharmacy denials based on medical necessity. **Use of Board-Certified Consultants** The organization: 1. Has written procedures for using board-certified consultants to assist in making medical necessity determinations 2. Provides evidence that it uses board-certified consultants for medical necessity determinations.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs, including review, evaluation, and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
Timeliness of UM Decisions (NCQA 2020 UM 5)	**Notification of Nonbehavioral Decisions** The organization adheres to the following time frames for notification of non-behavioral healthcare UM decisions: 1. N/A (Marketplace) 1.2. For Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to practitioners and members within seventy-two (72) hours of the request 2. For Medicaid urgent pre-service decisions, the organization gives electronic or written notification of the decision to practitioners and members within seventy-two (72) hours of the request 3. 3.4. For Medicaid non-urgent pre-service decisions, the organization gives electronic or written notification of the decision to practitioners and members within fourteen (14) calendar days of the request 3.5. For Medicaid postservice decisions, the organization gives electronic or written notification of the decision to practitioners and members within thirty (30) calendar days of the request. **Notification of Behavioral Healthcare Decisions** The organization adheres to the following time frames for notification of behavioral healthcare UM decisions: 1. N/A (Marketplace) 1. 1.2. For Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to practitioners and members within seventy-two (72) hours of the request 2. For Medicaid urgent pre-service decisions, the organization gives electronic or written notification of the decision to practitioners and members within seventy-two (72) hours of the request 3. 3.4. For Medicaid non-urgent pre-service decisions, the organization gives electronic or written notification of the decision to	

Standard	Delegated Activities	Retained by L.A. Care
	practitioners and members within fourteen (14) calendar days of the request ~~3.~~5. For Medicaid postservice decisions, the organization gives electronic or written notification of the decision to practitioners and members within thirty (30) calendar days of the request. **Notification of Pharmacy Decisions** The organization adheres to the following time frames for notifying members and practitioners of pharmacy UM decisions: 1. For Medicaid urgent concurrent decisions, electronic or written notification of the decision to members and practitioners within twenty-four (24) hours of the request 2. For Medicaid urgent preservice decisions, electronic or written notification of the decision to members and practitioners within seventy-two (72) hours of the request ~~3.~~ For Medicaid non-urgent pre-service decisions, electronic or written notification of the decision to members and practitioners within fifteen (15) calendar days of the request 3. ~~8.~~4. For Medicaid post service decisions, electronic or written notification of the decision to members and practitioners within thirty (30) calendar days of the request. ~~4.~~ N/A (Medicare and Marketplace) 5. ~~9.~~6. N/A (Medicare and Marketplace) ~~5.~~7. N/A (Medicare and Marketplace) **UM Timeliness Report** The organization monitors and submits a report for timeliness of: 1. Non-behavioral UM decision making 2. Notification of non-behavioral UM decisions ~~3.~~ Behavioral UM decision making 3. ~~1.~~4. Notification of behavioral UM decisions ~~4.~~ Pharmacy UM decision making 5. ~~2.~~6. Notification of pharmacy UM decisions. ***Note: L.A. Care and Plan must adhere to the applicable standards identified in the California***	

Standard	Delegated Activities	Retained by L.A. Care
	Health and Safety Code and DHCS Contract, all current regulatory notifications (such as APLs), as well as the most recent NCQA HP Standards	
Clinical Information (NCQA 2020 UM 6)	**Relevant Information for Nonbehavioral Healthcare Decisions** There is documentation that the organization gathers relevant clinical information consistently to support nonbehavioral healthcare UM decision making. **Relevant Information for Behavioral Healthcare Decisions** There is documentation that the organization gathers relevant clinical information consistently to support behavioral healthcare UM decision-making. **Relevant Information for Pharmacy Decisions** The organization documents that it consistently gathers relevant information to support pharmacy UM decision-making.	
Denial Notices (NCQA 2020 UM 7)	**Discussing a Denial With a Reviewer** The organization gives practitioners the opportunity to discuss nonbehavioral healthcare UM denial decisions with a physician or other appropriate reviewer **Written Notification of Nonbehavioral Healthcare Denials** The organization's written notification of nonbehavioral healthcare denials, provided to members and their treating practitioners, contains the following information: 1. The specific reasons for the denial, in easily understandable language 2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based 3. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision is based, upon request. **Nonbehavioral Healthcare Notice of Appeal Rights/Process** The organization's written non-behavioral healthcare denial notifications to members and their treating practitioners contains the following information:	

Standard	Delegated Activities	Retained by L.A. Care
	1. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal 2. An explanation of the appeal process, including the right to member representation and time frames for deciding appeals 3. A description of the expedited appeals process for urgent pre-service or urgent concurrent denials 4. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care **Discussing a Behavioral Healthcare Denial With a Reviewer** The organization provides practitioners with the opportunity to discuss any behavioral healthcare UM denial decision with a physician, appropriate behavioral healthcare reviewer or pharmacist reviewer **Written notification of Behavioral Healthcare Denials** The organization's written notification of behavioral healthcare denials, that it provided to members and their treating practitioners, contains: ~~A.~~1. The specific reasons for the denial, in easily understandable language ~~A.~~2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based ~~A.~~3. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision is based, upon request. **Behavioral Healthcare Notice of Appeal Rights/Process** The organization's written notification of behavioral healthcare denials, which it provides to members and their treating practitioners, contains the following information: ~~I.~~1. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal ~~I.~~2. An explanation of the appeal process, including the right to member	

Standard	Delegated Activities	Retained by L.A. Care
	representation and time frames for deciding appeals II. A description of the expedited appeals process for urgent pre-service or urgent concurrent denials 3. 4. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care **Discussing a Pharmacy Denial With a Reviewer** The organization gives practitioners the opportunity to discuss pharmacy UM denial decisions with a physician or pharmacist. **Written Notification of Pharmacy Denials** The organization's written notification of pharmacy denials to members and their treating practitioners contains the following information: a.1. The specific reasons for the denial, in language that is easy to understand b.2. A reference to the benefit provision, guideline, protocol or similar criterion on which the denial decision is based A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or similar criterion on which the denial decision was based, upon request. **Pharmacy Notice of Appeals Rights/Process** The organization's written notification of pharmacy denials to members and their treating practitioners contains the following information: 2.1. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal 3.2. An explanation of the appeal process, including the right to member representation and time frames for deciding appeals 4.3. A description of the expedited appeals process for urgent pre-service or urgent concurrent denials 5.4. Notification that expedited external review can occur concurrently with the internal appeal process for urgent care	

Standard	Delegated Activities	Retained by L.A. Care
Policies for Appeals (NCQA 2020 UM 8)	**Internal Appeals** The organization's written policies and procedures for registering and responding to written internal appeals must follow all current regulations and include but not limited toto~~include~~ the following: 1. Allowing at least sixty (60) calendar days after notification of the denial for the member to file the appeal 2. Documenting the substance of the appeal and any actions taken ~~3.~~ Full investigation of the substance of the appeal, including any aspects of clinical care involved 3. ~~1.~~4. The opportunity for the member to submit written comments, documents or other information relating to the appeal ~~4.~~ Appointment of a new person to review an appeal, who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination 5. ~~2.~~6. Appointment of at least one person to review an appeal who is a practitioner in the same (defined as a practitioner with similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal) or a similar (defined as a practitioner who has experience treating the same problems as those in question in the appeal, in addition to experience treating similar complications of those problems) specialty. ~~5.~~7. The decision for a pre-service appeal and notification to the member within thirty (30) calendar days of receipt of the request. ~~6.~~ The decision for a post-service appeal and notification to the member within sixty (60) calendar days of receipt of the request. For Medicaid only, decisions for postservice appeals and notifications to members must be within 30 calendar days of receipt of the request. 8. ~~3.~~9. The decision for an expedited appeal and notification to the member within seventy-two (72) hours of receipt of the request ~~7.~~ Notification to the member about further appeal rights 10.	Members have the option to appeal directly to L.A. Care. Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs, including review, evaluation, and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care. ~~The~~ Delegate will supply L.A. with requested documentation for processing and investigating appeals and grievances filed by the member. Timeframes for supplying the requested information will be 7 calendar days for standard appeals or grievances and 24 hour or less for expedited appeal or grievances. Part B appeals 24 hours. The Delegate will assist L.A. Care in remaining in compliance with all regulatory guidelines and requests. The Delegate will supply L.A. Care with any requested documentation required to conduct research for any Regulatory inquires made by our Regulators within 24 hours or less contingent upon the turnaround times established by the Regulator.

Standard	Delegated Activities	Retained by L.A. Care
	4.11. Referencing the benefit provision guideline, protocol or other similar criterion on which the appeal decision is based 8. Giving members reasonable access to and copies of all documents relevant to the appeal, free of charge, upon request 12. 5. Including a list of titles and qualifications, including specialties, of individuals participating in the appeal review 13. 6. Allowing an authorized representative to act on behalf of the member 14. 7. Providing notices of the appeals process to members in a culturally and linguistically appropriate manner 15. 8.16. Continued coverage pending the outcome of an appeal	
Appropriate Handling of Appeals (NCQA 2020 UM 9)	**Preservice and Postservice Appeals** An NCQA review of the organization's appeal files indicates that they contain the following information: 1. Documentation of the substance of appeals 2. Investigation of appeals 3. Appropriate response to the substance of the appeal. **Timeliness of the Appeal Process** Timeliness of the organization's preservice, postservice, and expedited appeal process is within the specified time frames: a.1. The organization resolves preservice appeals within thirty (30) calendar days of receipt of the request b.2. The organization resolves postservice appeals within thirty (30) calendar days of receipt of the request c.3. The organization resolves expedited appeals within seventy-two (72) hours of receipt of the request **Appeal Reviewers** The organization provides non-subordinate reviewers who were not involved in the previous determination and same or similar specialist review, as appropriate. **Notification of Appeal Decision/Rights**	Members have the option to appeal directly to L.A. Care. Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs, including review, evaluation, and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	An NCQA review of the organization's internal appeal files indicates notification to members of the following: A. 1. Specific reasons for the appeal decision, in easily understandable language A. 2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based B. Notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based, upon request 3. 1. 4. Notification that the member is entitled to receive reasonable access to, and copies of all documents relevant to their appeal, free of charge, upon request A. A list of titles and qualifications, including specialties, of individuals participating in the appeal review 5. 2. 6. A description of the next level of appeal, either within the organization or to an independent external organization, as applicable, along with any relevant written procedures. **Final Internal and External Appeal Files** N/A **Appeals Overturned by the IRO** N/A	
Evaluation of New Technology (NCQA 2020 UM 10)		**Written Process** Evaluates the inclusion of new technology and the new application of existing technology in the benefits plan, including medical and behavioral health procedures, pharmaceuticals, and devices. This element is Not Applicable for Medicaid product lines if the state mandates all benefits and new technology determinations. L.A. Care will provide the state's language. **Description of the Evaluation Process** This element is Not Applicable for Medicaid product lines if the state

Standard	Delegated Activities	Retained by L.A. Care
		mandates all benefits and new technology determinations. L.A. Care will produce documentation that demonstrates this.
Procedures ~~Procedures for Pharmaceutical Management (NCQA 2020 UM 11)~~	~~**Pharmaceutical Management Procedures**~~ ~~The organization's policies and procedures for pharmaceutical management include the following:~~ ~~a) The criteria used to adopt pharmaceutical management procedures~~ ~~b) A process that uses clinical evidence from appropriate external organizations~~ ~~c) A process to include pharmacists and appropriate practitioners in the development of procedures~~ ~~9. A process to provide procedures to practitioners annually and when it makes changes.~~ ~~**Pharmaceutical Restrictions/Preferences**~~ ~~Annually, and after updates, the organization communicates to members and prescribing practitioners:~~ ~~a) A list of pharmaceuticals including restrictions and preferences to post on its Internet website on a monthly basis. (SB1052)~~ ~~b) How to use the pharmaceutical management procedures~~ ~~c) An explanation of limits or quotas~~ ~~1. How prescribing practitioners must provide information to support an exception request~~ ~~d) The organization's process for generic substitution, therapeutic interchange, and step-therapy protocols.~~ ~~**Pharmaceutical Patient Safety Issues**~~ ~~The organization's pharmaceutical procedures include:~~ ~~a. Identifying and notifying members and prescribing practitioners affected by Class II recalls or voluntary drug withdrawals from the market for safety reasons within thirty (30) calendar days of the FDA notification~~ ~~b. An expedited process for prompt identification and notification of members~~	

Standard	Delegated Activities	Retained by L.A. Care
	~~and prescribing practitioners affected by a Class I recall.~~ ~~**Reviewing and Updating Procedures**~~ ~~With the participation of physicians and pharmacists, the organization annually:~~ ~~1. Reviews the procedures~~ ~~2. Reviews the list of pharmaceuticals~~ ~~3. Updates the procedures as appropriate~~ ~~5. Updates the list of pharmaceuticals as appropriate~~ ~~4. Posts the list with changes on its Internet website on a monthly basis. (SB1052)~~ ~~**Considering Exceptions**~~ ~~The organization has exceptions policies and procedures that describe the process for:~~ ~~2. Making an exception request based on medical necessity~~ ~~3. Obtaining medical necessity information from prescribing practitioners~~ ~~4. Using appropriate pharmacists and practitioners to consider exception requests~~ ~~1. Timely handling of exception requests~~ 5. ~~Communicating the reason for a denial and an explanation of the appeal process when it does not approve an exception request~~.	
UM System Controls (NCQA 2020 UM 12)	**UM Denial System Controls** The organization has policies and procedures describing its system controls specific to UM denial notification dates that: 1. Define the date of receipt consistent with NCQA requirements. 2. Define the date of written notification consistent with NCQA requirements. 3. Describe the process for recording dates in systems. 4. Specify staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate. 5. Specify how the system tracks modified dates. 6. Describe system security controls in place to protect data from unauthorized modification. 7. Describe how the organization audits the processes and procedures in factors 1-6. **UM Appeal System Controls**	

Standard	Delegated Activities	Retained by L.A. Care
	The organization has policies and procedures describing its system controls specific to UM appeal dates that: 1. Define the date of receipt consistent with NCQA requirements. 2. Define the date of written notification consistent with NCQA requirements. 3. Describe the process for recording dates in systems. 4. Specify staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate. 5. Specify how the system tracks modified dates. 6. Describe system security controls in place to protect data from unauthorized modification. 7. Describe how the organization audits the processes and procedures in factors 1-6.	
Sub-Delegation of UM (NCQA 2020 UM 13)	**Sub-Delegation Agreement** A written sub-delegation agreement: ~~d)~~a. Is mutually agreed upon ~~e)~~b. Describes the sub-delegated activities and responsibilities of Delegate and Sub-delegated entity ~~f)~~c. Requires at least semiannual reporting from Sub-delegate to Delegate ~~g)~~d. Describes the process by which Delegate evaluates Sub-delegate's performance ~~h)~~e. Describes the process for providing member experience and clinical performance data to its delegates when requested ~~i)~~f. Describes the remedies available to the organization if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **Pre-delegation Evaluation** For new delegation agreements initiated in the look-back period, the delegate evaluated sub-delegate capacity to meet NCQA requirements before delegation began. **Review of the UM Program** For arrangements in effect for 12 months or longer, the organization: 1. Annually reviews its Sub-delegate's UM program 2. Annually audits UM denials and appeals files against NCQA standards for each year that delegation has been in effect 3. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities	

Standard	Delegated Activities	Retained by L.A. Care
	4. Semiannually evaluates regular reports as specified in the sub-delegation agreement 5. Annually monitors the delegate's UM denial and appeal system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures at least annually. 6. Annually acts on all findings from factor 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters. ~~4.~~ **Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identified and followed-up on opportunities for improvement, if applicable.	
	CREDENTIALING	
Credentialing Policies (NCQA ~~2020~~ 2022 CR 1) DMHC, DHCS, CMS	The Delegate has a well-defined credentialing and recredentialing process for evaluating licensed independent practitioners to provide care to its members. The organization specifies: 1. The types of practitioners to credential and re-credential, to also include all administrative physician reviewers responsible for making medical decisions. 2. The verification sources used. 3. The criteria for credentialing and re-credentialing. 4. The policies must explicitly define the process and criteria used for making credentialing and re-credentialing decisions. 5. The process for managing credentialing files that meet Delegate's established criteria. Policies must describe the process it uses to determine and approve clean files or the Delegate may present all files to the Credentialing Committee, including clean files, or it may designate approval	L.A. Care retains the right, based on quality issues, to approve, suspend, and terminate individual practitioners, providers, and sites at all times. Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs, including review, evaluation, and approval of its Delegates' credentialing activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	authority to the medical director or to an equally qualified practitioner. 6. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. Policies must specify that the organization does not base credentialing and recredentialing decisions on an applicant's race, ethnic/national identity, gender, age, sexual orientation or patient type in which the practitioner specializes. Has a process for preventing and monitoring discriminatory practices and monitors the credentialing and recredentialing processes for discriminatory practices, at least annually. 7. The process for notifying practitioners about any information obtained during the credentialing process that varies substantially from the information provided to Delegate by the practitioner. 8. The process for notifying practitioners of the credentialing and recredentialing decisions within sixty (60) calendar days of the committee's decision 9. The medical director or other designated physician's direct responsibility for, and participation in, the credentialing program 10. The process for securing the confidentiality of all information obtained in the credentialing process, except as otherwise provided by law 11. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, board certification, and specialty. ~~**Medi-Cal FFS Enrollment**~~ ~~Developing and implementing policies and procedures for Medi-Cal enrollment. Policy must clearly specify enrollment process including, but not limited to:~~ ~~1. All practitioners that have a FFS enrollment pathway must enroll in the Medi-Cal program.~~ ~~2. The process for ensuring and verifying Medi-Cal enrollment.~~ ~~3. The process for practitioners whose enrollment application is in process.~~ ~~4. The process for monitoring between recredentialing cycles to validate continued enrollment.~~	

Standard	Delegated Activities	Retained by L.A. Care
	5. Process for practitioners not currently enrolled in the Medi-Cal program. 6. Process for practitioners deactivated or suspended from the Medi-Cal program. The organization notifies practitioners about: their right to: 4. The right of practitioners to review information submitted to support their credentialing application 5.a. The right of practitioners to correct erroneous information: i. The timeframe for making corrections. ii. The format for submitting corrections. iii. The person to whom the corrections must be submitted. 6.b. The right of practitioners to be informed of the status of their credentialing or re-credentialing application, upon request. The Delegate must have policies and procedures for its CR system security controls. If the Organization outsources storage of credentialing information to an external entity, the contract between the Delegate and the external entity will be part of the oversight review. The organization's credentialing process describes: 1. How primary source verification information is received, dated and stored. 1.2. How modified information is tracked and dated from its initial verification. 2. Titles or roles of sStaff who are authorized to review, modify and delete information, and circumstances when modification or deletion is appropriate. 3. 2.4. The security controls in place to protect the information from unauthorized modification 1.5. How the organization monitors its compliance with audits the processes and procedures in factors 1–4.at least annually and takes appropriate action when applicable. At least annually, the organization demonstrates that it monitors compliance with its CR controls by: 1. Identifying all modifications to credentialing and recredentialing	

Standard	Delegated Activities	Retained by L.A. Care
(DHCS APL 19-004)	information that did not meet the organization's policies and procedures for modifications. 2. Analyzing all instances of modifications that did not meet the organization's policies and procedures for modifications. 3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement from one finding over three consecutive quarters. ~~During the annual oversight review, the Delegate is subject to a CAP (Corrective Action Plan) if their process does not match their policies. In addition, if the Delegate demonstrates reoccurring deficiencies that were identified in previous audits, the Delegate is subject to additional point deductions.~~ **Medi-Cal FFS Enrollment** Developing and implementing policies and procedures for Medi-Cal enrollment. Policy must clearly specify enrollment process including, but not limited to: All practitioners that have a FFS enrollment pathway must enroll in the Medi-Cal program. 1. ~~The~~ process for ensuring and verifying Medi-Cal enrollment. The process for practitioners whose enrollment application is in process. 2. ~~The~~ process for monitoring between recredentialing cycles to validate continued enrollment. 3. Process for practitioners not currently enrolled in the Medi-Cal program. 4. Process for practitioners deactivated or suspended from the Medi-Cal program. During the annual oversight review, the Delegate is subject to a CAP (Corrective Action Plan) if their process does not match their policies. In addition, if the Delegate demonstrates reoccurring deficiencies that were identified in previous audits, the Delegate is subject to additional point deductions.	

Standard	Delegated Activities	Retained by L.A. Care
Credentialing Committee (NCQA ~~2020~~ 2022 CR 2) DMHC, DHCS, CMS	Designating a credentialing committee that uses a peer review process to make recommendations regarding credentialing and re-credentialing decisions such that the organization's Credentialing Committee: 1. Includes representation from a range of participating practitioners, and provides advice and expertise for credentialing decisions 2. Has the opportunity to review the credentials of all practitioners being credentialed or recredentialed who do not meet Delegate's established criteria and to offer advice, which Delegate considers appropriate under the circumstances. 3. The Medical Director, designated physician or ~~equally qualified individual~~ credentialing committee reviews and approves files that meet the Delegate's established criteria.	
Credentialing Verification (NCQA ~~2020~~ 2022 CR 3) DMHC, DHCS, CMS	Primary source verification and credentialing and recredentialing decision-making, which includes verification of information to ensure that practitioners have the legal authority and relevant training and experience to provide quality care, within the NCQA prescribed time limits, through primary or other NCQA-approved sources, prior to credentialing and recredentialing The organization verifies that the following are within the prescribed time limits: 1. Current, valid license to practice (Develop a process to ensure providers' licenses are kept current at all times). 2. A valid DEA or CDS, with schedules 2 thru 5, if applicable; or the Delegate has a documented process for practitioners: ~~a.~~ • Allowing a practitioner with a valid DEA certificate to write all prescriptions for a practitioner with a pending DEA certificate ~~b.~~ • Requiring an explanation from a qualified practitioner who does not prescribe medications and provides arrangements for the practitioner's patients who need prescriptions for medications. 3. Verification of the highest of the following three levels of education and training obtained by the practitioner as appropriate: • Board certified if practitioner stated on the application that he/she is board certified, as well as expiration date of certification.	

Standard	Delegated Activities	Retained by L.A. Care
	• Completion of a residency program. • Graduation from medical or professional school. 4. Work history. 5. Current malpractice insurance coverage ($1 million/$3 million). 6. A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner. 7. Clinical Privileges in good standing at a Plan contracted facility designated by the physician as the primary admitting facility. 8. Current, valid FSR/MRR of primary care physician offices within 3 years prior to credentialing decision. 9. CLIA Certifications, if applicable. 10. NPI number. 11. Medi-Cal FFS enrollment All certifications and expiration dates must be made part of the practitioner's file and kept current. The Delegate must notify L.A. Care immediately when a practitioner's license has expired for removal from the network.	
CR Sanction Information (NCQA 20202022 CR 3) DMHC, DHCS, CMS	The organization verifies the following sanction information for credentialing: 1. State sanctions, restrictions on licensure, or limitations on scope of practice. 2. Medicare and Medicaid sanctions. 3. *Medicare Opt-out. 2.3. SAM. 4. CMS Preclusion The Delegate must notify L.A. Care immediately when practitioners are identified on any sanctions or reports for removal from the network.	
CR Application and Attestation (NCQA 20202022 CR 3) DMHC, DHCS, CMS	Applications for credentialing and recredentialing include the following: 1. Reasons for inability to perform the essential functions of the position, with or without accommodation 2. Lack of present illegal drug use 3. History of loss of license and felony convictions 3.	

Standard	Delegated Activities	Retained by L.A. Care
	1.4. History of loss or limitation of privileges or disciplinary action 4. Current malpractice insurance coverage 5. 2.6. Current and signed attestation confirming the correctness and completeness of the application.	
Re-credentialing Cycle Length (NCQA 20202022 CR 4) DMHC, DHCS, CMS	The length of the recredentialing cycle is within the required 36-month time frame. For PCPs only, must confirm provider has a valid FSR at least every 36 months as part of the recredentialing process.	
CR Ongoing Monitoring and Interventions (NCQA 20202022 CR 5) DMHC, DHCS, CMS	Developing and implements policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues and takes appropriate action against practitioners when it identifies occurrences of poor quality between recredentialing cycles by: • 1. Collecting and reviewing Medicare and Medicaid sanctions. • 2. Collecting and reviewing sanctions or limitations on licensure. • 3. Collecting and reviewing complaints. 1. • Collecting and reviewing information from identified adverse events. • 4. Implementing appropriate interventions when Delegate identifies instances of poor quality. a. 5. The Delegate's Credentialing committee may vote to flag a practitioner for ongoing monitoring 1. a. The Delegate must make clear the types of monitoring it imposes, the timeframe used, the intervention, and the outcome, which must be fully demonstrated in the Delegate's credentialing committee minutes 2. b. The Delegate's credentialing committee can: • 1. 6. Request a practitioner be placed on a watch list. Any list must be clearly defined and monitored. 1. Request that the practitioner demonstrate compliance with probation that has been imposed by the State and monitor completion	Upon notification of any Adverse Event, L.A. Care will notify the Delegate of their responsibility with respect to delegation of credentialing/re-credentialing activity. The notification will clearly delineate what is expected from the Adverse Event that has been identified. The notice will include, but is not limited to: a. Requesting what actions will be taken by the Delegate b. What type of monitoring is being performed c. What interventions are being implemented, including closing panel, moving members, or removal of practitioner from the network d. The notification will include a timeframe for responding to Plan to ensure Plan's members receive the highest level of quality care.

Standard	Delegated Activities	Retained by L.A. Care
	7. Impose upon the practitioner to demonstrate steps they have taken to improve processes and/or chart review, if applicable. ~~3.~~ 8. Delegated entities who fail to comply with the requested information within the specified timeframe are subject to sanctions as described in Plan's policies and procedures ~~b.~~ 9. The Plan will clearly delineate what is expected from the Delegate regarding the Adverse Event that has been identified. The notification may include performing the following: 1. Requesting what action will be taken by the Delegate. 2. What type of monitoring is being performed. 3. What interventions are being implemented, including closing panel, moving members, or removal of practitioner from the network. 4. The notification will include a timeframe for responding to L.A. Care to ensure L.A. Care members receive the highest level of quality care. ~~f.~~a. In the event that the Delegate fails to respond as required, the Plan will perform the oversight functions of the Adverse Event and the Delegate will be subject to Plan's credentialing committee's outcome of the adverse events. ~~g.~~b. The Delegate must notify L.A. Care immediately when practitioners are identified on any sanctions or reports for removal from the network ~~h.~~c. The above are samples, but not limited to, the steps the Delegate can take.	
Credentialing: Notification to Authorities and Practitioner Appeal Rights (NCQA ~~2020~~2022 CR 6) DMHC, DHCS, CMS	The Delegate uses objective evidence and patient care consideration when deciding on a course of action for dealing with a practitioner who does not meet its quality standards. The organization has policies and procedures specify for: ~~a.~~1. The range of actions available to Delegate ~~b.~~2. That the Delegate reviews participation of practitioners whose conduct could adversely affect members' health or welfare. ~~c.~~3. The range of actions that may be taken to improve practitioner performance before termination. ~~1.~~a. That the Delegate reports its actions to the appropriate authorities.	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation, routine monitoring and annual oversight review ~~and~~ or more frequently, as required, per changes in contract, Federal and State regulatory guidelines, and accreditation standards.

Standard	Delegated Activities	Retained by L.A. Care
	d.4. Making the appeal process known to practitioners. Within 14 days from criminal action taken against any contracted practitioner, Delegate shall notify L.A. Care in writing.	
CR Assessment of Organizational Providers (NCQA 20202022 CR 7) DMHC, DHCS, CMS	The delegate's organization's policy for assessing a health care delivery provider specifies that before it contracts with a provider, and for at least every 36 months thereafter, it: 1. Confirms that the provider organization is in good standing with state and federal regulatory bodies. 2. Confirms that the provider organization has been reviewed and approved by an accrediting body acceptable to Delegate, including which accrediting bodies are acceptable. 3. Conducts an onsite quality assessment is conducted if the provider organization is not accredited by an accrediting body acceptable to Delegate, including which accredited bodies are acceptable. 4. At least every three years that the provider organization continues to be in good standing with state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body acceptable to Delegate. Maintaining a tracking log that includes names of the organization, type of organization, a prior validation date, a current validation date for licensure, accreditation status (if applicable), CMS or state reviews conducted within 3 years at time of verification (if applicable), CLIA certificate (if applicable), NPI number for each organizational provider. The organization includes at least the following medical providers in its assessment: c.1. Hospitals. d.2. Home health agencies. e. Skilled nursing facilities. 3. 5.4. Freestanding surgical centers. f. *Hospices. 5. 6. *Clinical Laboratories (A CMS issued CLIA certificate or a hospital based exemption from CLIA).	

Standard	Delegated Activities	Retained by L.A. Care
	g.7. *Comprehensive Rehabilitation Facilities (CORFs). h. *Outpatient Physical Therapy and Speech Pathology Providers. 8. 7.9. *Providers of end-stage renal disease services. i. *Providers of outpatient diabetes self-management training. 10. 8.11. *Portable X-Ray Suppliers. j. *Rural Health Clinic (RHCs). 12. 9.13. Federally Qualified Health Center (FQHCs). The organization includes behavioral healthcare facilities providing mental health or substance abuse services in the following settings: 1. Inpatient. 2. Residential. 3. Ambulatory. The delegate assesses contracted medical health care providers. The delegate assesses contracted behavioral healthcare providers.	
Sub-Delegation of CR (NCQA 20202022 CR 8) DMHC, DHCS, CMS	If Delegate sub-delegates any NCQA required credentialing activities, there must be evidence of oversight of the delegated activities, including the written sub-delegation agreement that: 1. Is mutually agreed upon. 2. Describes the sub-delegated activities and the responsibilities of the organization and the delegated entity. 3. Requires at least quarterly reporting to Delegate. 3. 4. Describes the process by which Delegate evaluates Sub-delegated entity's performance. 4. Specifies that the delegate retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making. 5. 5.6. Describes the remedies available to Delegate if Sub-delegate does not fulfill its	L.A. Care retains the right to perform a pre-delegation audit of any entity to which the Plan sub-delegates delegated credentialing activities and approve any such sub-delegation audit of any sub-delegate. Prior to entering into an agreement to sub-delegate delegated credentialing activities, Delegated Plan shall provide L.A. Care with reasonable prior notice of Plan's intent to sub-delegate.

Standard	Delegated Activities	Retained by L.A. Care
	obligations including revocation of the sub-delegation agreement. Retention of the right by Delegate and L.A. Care, based on quality issues, to approve, suspend, and terminate individual practitioners, providers, and sites. For new sub-delegation agreements initiated in the look-back period, the delegate evaluated sub-delegate capacity to meet NCQA requirements before sub-delegation begins. For sub-delegation arrangements in effect for 12 months or longer, the Delegate: 1. Annually reviews its sub-delegate's credentialing policies and procedures. 1. 2. Annually audits credentialing and recredentialing files against NCQA standards for each year that sub-delegation has been in effect. 2. 3. Annually evaluates the sub-delegate's performance against relevant regulatory requirements, NCQA standards, and Delegate's expectations annually. 4. Evaluates regular reports from sub-delegate at least quarterly or more frequently based on the reporting schedule described in the sub-delegation document. 5. Annually monitors the delegate's credentialing system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures at least annually. 6. Annually acts on all findings from factor 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters.	

Standard	Delegated Activities	Retained by L.A. Care
	For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identifies and follows up on opportunities for improvement, if applicable If a Delegate fails to complete the corrective action plan and has gone through the exigent process which results in de-delegation, the Delegate cannot appeal and must wait one year to reapply for a pre-delegation audit. If the pre-delegation audit reveals deficiencies identified are the same as those from previous audits, delegation will be at the sole discretion of the Credentialing Committee regardless of score.	
MEMBER EXPERIENCE		
Statement of Members' Rights and Responsibilities (NCQA 2020 ME 1)	**Distribution of Rights Statement** The organization distributes its member rights and responsibilities statement to the following groups: 1. New members, upon enrollment. 2. Existing members, if requested. 3. New practitioners, when they join the network. 4. Existing practitioners, if requested.	**Rights and Responsibilities Statement** The organization's member rights and responsibilities statement specifies that members have: 1. A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities ~~1.~~2. A right to be treated with respect and recognition of their dignity and right to privacy ~~2.~~ 3. A right to participate with practitioners in making decisions about their health care ~~1.~~ 4. A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage ~~3.~~ 5. A right to voice complaints or appeals about the organization or the care it provides ~~2.~~ 6. A right to make recommendations regarding the organization's member rights and responsibilities policy ~~4.~~ 7. A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care ~~5.~~ 8. A responsibility to follow plans and instructions for care that they have agreed to with their practitioners ~~3.~~ 9. A responsibility to understand their health problems and

Standard	Delegated Activities	Retained by L.A. Care
		participate in developing mutually agreed-upon treatment goal, to the degree possible L.A. Care adheres to the most current NCQA standards to comply with these requirements.
Subscriber Information (NCQA 2020 ME 2)		**Subscriber Information:** L.A. Care informs its subscribers upon enrollment and annually thereafter about benefits and access to medical services. **Interpreter Services** L.A. Care provides interpreter or bilingual services in its Member Services Department and telephone functions based on linguistic needs of its subscribers. L.A. Care adheres to the most current NCQA standards to comply with these requirements.
Marketing Information (NCQA 2020 ME 3)		**Materials and Presentations** L.A. Care's prospective members receive an accurate description of the organization's benefits and operating procedures. L.A. Care adheres to the most current NCQA standards to comply with these requirements. **Communicating with Prospective Members** The organization uses easy-to-understand language in communications to prospective members about its policies and practices regarding collection, use and disclosure of PHI: ~~1.~~ 1. In routine notification of privacy practices ~~2.~~ 2. The right to approve the release of information (use of authorizations) ~~3.~~ 3. Access to Medical Records ~~1.~~ 4. Protection of oral, written, and electronic information across the organization ~~4.~~ 5. Information for employers **Assessing Member Understanding** ~~1.~~ 1. Assesses how well new members understand policies and procedures. The right to

Standard	Delegated Activities	Retained by L.A. Care
		approve the release of information (use of authorizations) ~~2.~~ 2. Implements procedures to maintain accuracy of marketing communication. Protection of oral, written, and electronic information across the organization ~~3.~~ 3. Information for employers
Functionality of Claims Processing (NCQA 2020 ME 4)	**Functionality-Website** Members can track the status of their claims in the claims process and obtain the following information on the organization's website in one attempt or contact: 1. The stage in the process. ~~1.~~2. The amount approved. ~~2.~~ The amount paid. 3. 4. Member cost. ~~1.~~5. The date paid **Functionality-Telephone Requests** Members can track the status of their claims in the claims process and obtain the following information over the telephone in one attempt or contact: 1. The stage in the process. ~~1.~~2. The amount approved. ~~2.~~ The amount paid. 3. 4. Member cost. ~~1.~~5. The date paid	
Pharmacy Benefit Information (NCQA 2020 ME 5)	**Pharmacy Benefit Information-Website** Members can complete the following actions on the website in one attempt or contact: ~~a.~~ Determine their financial responsibility for a drug, based on the pharmacy benefit. 1. ~~b.~~ Initiate the exceptions process 2. ~~c.~~3. Order a refill for an existing, unexpired mail-order prescription. ~~1.~~ Find the location of an in-network pharmacy. 4. ~~d.~~5. Conduct a pharmacy proximity search based on zip code. ~~2.~~a. Determine the availability of generic substitutes.	

Standard	Delegated Activities	Retained by L.A. Care
	*According to SB1052 Kaiser shall post the formulary on its internet website and update that posting on a monthly basis. **<u>Pharmacy Benefit Information Telephone</u>** Members can complete the following actions via telephone in one attempt or contact: 1. Determine their financial responsibility for a drug, based on the pharmacy benefit. ~~1.~~2. Initiate the exceptions process. ~~2.~~ Order a refill for an existing, unexpired, mail-order prescription. 3. ~~1.~~4. Find the location of an in-network pharmacy. ~~1.~~ Conduct a proximity search based on zip code. 5. ~~2.~~6. Determine the availability of generic substitutes. **<u>QI Process on Accuracy of Information</u>** The organization's quality improvement process for pharmacy benefit information: 1. Collects data on quality and accuracy of pharmacy benefit information. ~~1.~~2. Analyze data results. ~~1.~~3. Act to improve identified deficiencies. **<u>Pharmacy Benefit Updates</u>** The organization updates member pharmacy benefit information on its website and in materials used by telephone staff, as of the effective date of a formulary change and as new drugs are made available or are recalled.	
Personalized Information on Health Plan Services (NCQA 2020 ME 6)	**<u>Personalized Information on Health Plan Services</u>** Members can complete each of the following activities on the organization's website in one attempt or contact: 1. Change a primary care practitioner, as applicable. ~~1.~~2. Determine how and when to obtain referrals and authorizations for specific services, as applicable ~~1.~~3. N/A **<u>Functionality Telephone</u>**	

Standard	Delegated Activities	Retained by L.A. Care
	To support financial decision making, members can complete each of the following activities over the telephone within one business day: 1. Determine how and when to obtain referrals and authorizations for specific services, as applicable. ~~1.~~2. Determine benefit and financial responsibility for a specific service or treatment from a specified provider or institution. **Quality and Accuracy of Information** At least annually, the organization must evaluate the quality and accuracy of the information provided to members via the website and telephone must be evaluated by: 1. Collecting data on quality and accuracy of information provided. ~~1.~~2. Analyzing data against standards or goals. ~~2.~~ Determining causes of deficiencies, as applicable. 3. ~~2.~~4. Acting to improve identified deficiencies, as applicable. **E-mail Response Evaluation** The organization: 1. Has a process for responding to member e-mail inquiries within one business day of submission. ~~1.~~2. Has a process for annually evaluating the quality of e-mail responses. ~~2.~~ Annually collects data on email turnaround time. 3. ~~2.~~4. Annually collects data on the quality of email responses. ~~1.~~ Annually analyzes data. 5. ~~3.~~6. Annually act to improve identified deficiencies.	
Member Experience (NCQA 2021~~0~~-2022~~2020~~ ME 7)	**Policies and Procedures for Complaints** The organization has policies and procedures for registering and responding to oral and written complaints that include: ~~a)~~1. Documenting the substance of complaints and actions taken. ~~a)~~2. Investigating of the substance of complaints and actions taken. ~~a)~~3. Notification to members of the disposition of complaints, including any aspect of clinical care involved.	Members have the option to complain and appeal directly to L.A. Care. L.A. Care retains the right to perform a pre-delegation audit of any entity to which the Plan sub-delegates delegated activities and approve any such sub-delegation audit of any sub-delegate. Prior to entering into an agreement to sub-delegate Delegated Activities, Plan shall provide L.A. Care with reasonable

Standard	Delegated Activities	Retained by L.A. Care
	~~1.~~ a) Standards for timeliness including standards for clinically urgent situations. ~~a)~~4. Provision of language services for the complaint process. **Policies and Procedures for Appeals** The organization has policies and procedures for registering and responding to oral and written appeals which include: ~~a)~~1. Documentation of the substance of the appeals and actions taken. ~~a)~~2. Investigation of the substance of the appeals, including any aspects of clinical care involved ~~a)~~3. Notification to members of the disposition of appeals and the right to further appeal, as appropriate ~~1.~~ a) Standards for timeliness including standards for clinically urgent situations. ~~a)~~4. Provision of language services for the appeal process. **Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals** Using valid methodology, the organization annually analyzes nonbehavioral complaints and appeals for each of the five required categories. **Annual Assessment of Behavioral Healthcare and Services** Using valid methodology, the organization annually: 1. Evaluates behavioral healthcare member complaints and appeals for each of the five required categories. 2. Conducts a member experience survey. **Behavioral Healthcare Opportunities for Improvement** The organization works to improve members' experience with behavioral healthcare and service by annually: 1. Assessing data from complaints and appeals or from member experience surveys. 2. Identifying opportunities for improvement. 3. Implementing interventions, if applicable. 4. Measuring effectiveness of interventions, if applicable.	prior notice of Plan's intent to sub-delegate. **Nonbehavioral Opportunities for Improvement** The organization annually identifies opportunities for improvement, sets priorities and decides which opportunities to pursue based on analysis of the following information: 1. Member complaint and appeal data from the Member Experience standard for Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals. 2. CAHPS survey results and/or QHP Enrollee Experience Survey results.

Standard	Delegated Activities	Retained by L.A. Care
Sub-Delegation of RRME (NCQA RR 52020 ME 8	**Element A: Sub-Delegation Agreement** The written sub-delegation agreement: 1. Is mutually agreed upon 2. Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity ~~3.~~ Requires at least semiannual reporting by the sub-delegated entity to the delegate 3. 4. Describes the process by which the delegate evaluates the sub-delegated entity's performance ~~4.~~5. Describes the process for providing member experience and clinical performance data to its delegates when requested ~~5.~~ 6. Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **Element B: Predelegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the delegated entity evaluates sub-delegate capacity to meet NCQA requirements before sub-delegation begins. **Element C: Review of Performance** For sub-delegation arrangements in effect for 12 months or longer, the delegate: ~~1.~~ 1. Semiannually evaluates regular reports, as specified in the sub-delegation agreement ~~2.~~ 2. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities **Element D: Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	
Nurse Advice Line (Title 28 California Code of Regulations Section 1300.67.2.2; California Health and Safety Code Section 1348.8)	A Nurse Advice Line is offered to members to assist members with wellness and prevention **A. Access to Nurse Advice Line** A Nurse Advice Line that is staffed by licensed nurses or clinicians and meets the following factors: 1. Is available 24 hours a day, 7 days a week by telephone. 2. Provides secure transmission of electronic communication, with safeguards, and a 24-hour turnaround time.	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation and annual oversight review and more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards.

Standard	Delegated Activities	Retained by L.A. Care
	3. Provides interpretation services for members by telephone. ~~1.~~4. Provide telephone triage or screening services in a timely manner appropriate to the enrollee's condition. The triage and screening wait time shall not exceed 30 minutes. **B. Nurse Advice Line Capabilities** The nurse advice line gives staff the ability to: 1. Follow up on specified cases and contact members. 2. Link member contacts to a contact history. **C. Monitoring the Nurse Advice Line** The following shall be conducted: ~~2.~~1. Track telephone and website statistics at least quarterly. ~~3.~~2. Track member use of the nurse advice line at least quarterly. ~~4.~~ Evaluate member satisfaction with the nurse advice line at least annually. 3. ~~1.~~4. Monitors call periodically. 5. Analyze data at least annually and, if applicable, identify opportunities and establish priorities for improvement. D. **Policies and Procedures** ~~1.~~ 1. Establish and maintain an operational policy for operating and maintaining a Telephone Nurse Advice Service. E. **Promotion** 1. Promote the availability of Nurse Advice Line services in materials that are approved in accordance with the Plan Partner Services Agreement and L.A. Care policies and procedures. ~~1.~~2. In the form of, but not limited to: ~~a)~~ Flyers a. ~~c.~~b. Informational mailers ~~a)~~ ID Cards c. d. Evidence of Coverage (EOC)	
Potential Quality of Care Issue Review (Title 28 California Code of Regulations Section 1300.70)	The Quality Improvement program must document that the quality of care is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation and annual oversight review and more frequently, as required, per changes in contract,

Standard	Delegated Activities	Retained by L.A. Care
	The Quality Improvement program must include continuous review of the quality of care provided; quality of care problems are identified and corrected for all provider entities.	Federal and State regulatory guidelines and accreditation standards.
HEDIS Performance Benchmark APL 19-017	1. Annually measures performance and meets the NCQA 50th percentile benchmark for the Medi-Cal Managed Care Accountability Set established by DHCS and NCQA required Medi-Cal accreditation measures. 2. Opportunity for Improvement When the 50th percentile is not met the plan will identify and follow up on opportunities for improvement.	L.A. Care will still retain the PIP and PDSA reporting process with DHCS for the Medi-Cal line of business.
Blood Lead Screening of Young Children APL 20-016	1. Ensure network providers follow the blood lead anticipatory guidance and screening requirements in accordance with APL 20-016 2. Identify, on at least a quarterly basis (i.e. January – March, April – June, July – September, October – December), all child members under the age of six years (i.e. 72 months) who have no record of receiving a blood lead screening test as required ~~1.~~	Annual Submission to DHCS data for all child members under the age of six years (i.e. 72 months) who have no record of receiving a blood lead screening
	CLAIMS PROCESSING REQUIRMENTS	
Claims Processing (Title 28 California Code of Regulations Section 1300.71)~~Blood Lead Screening of Young Children~~ ~~APL 20-016~~	**Timely Claims Processing** 1. Process at a minimum ninety percent (90%) of claims within 30 calendar days of the claim receipt date, 2. Process at a minimum ninety-five percent (95%) of claims within 45 working days of the claim receipt date, **and** 3. Process at a minimum ninety-nine percent (99%) of claims within 90 calendar days of the claim receipt date. **Accurate Claims Payments** 1. Pay claims at the Medi-Cal rates or contracted rates at a minimum of 95% of the time. 2. All modified claims are reviewed and approved by a physician and medical records are reviewed. 3. Calculate and pay interest automatically for claims paid beyond 45 workings days from date of receipt at a minimum 95% of the time. a. **Emergency services claims:** Late payment on a complete claim which is not contested or denied will automatically include the greater of $15 or 15% rate per annum applied to the payment amount for the time period the payment is late.	~~Annual Submission to DHCS data for all child members under the age of six years (i.e. 72 months) who have no record of receiving a blood lead screening~~

Standard	Delegated Activities	Retained by L.A. Care
	b. **All other service claims:** Late payments on a complete claim will automatically include interest at a 15% rate per annum applied to the payment amount for the time period payment is late. c. **Penalty:** Failure to automatically include the interest due on the late claims regardless of service is $10 per late claim in addition to the interest amount. **Forwarding of Misdirected Claims** Forward misdirected claims within 10 working days of the claim receipt date at a minimum of 95% of the time. **Acknowledgement of Claims** Acknowledge the receipt of electronic claims within 2 working days and paper claims within 15 working days at a minimum of 95% of the time. **Dispute Resolution Mechanism** Provide written notice of a dispute resolution mechanism for all denied and modified claims at a minimum 95% of the time. **Accurate and Clear Written Explanation** Provide written notice of a dispute resolution mechanism for all denied and modified claims at a minimum 95% of the time. **Deadline for Claims Submission** Shall not impose a claims filing deadline less than 90 days after the date of service for contracted providers and less than 180 days after the date of service for non-contracted providers on three or more occasions. **Request for Reimbursement of Overpayment** Reimbursement for overpayment request shall be in writing and clearly identifying the claim and reason why the claim is believed to be overpaid within 365 days from the payment date, for at least 95% of the time. **Rescind or Modify an Authorization** An authorization shall not be rescinded or modified for health care services after the provider renders the service in good faith and pursuant to the authorization on three (3) or more occasions over the course of any three-month period. **Request for Medical Records**	

Standard	Delegated Activities	Retained by L.A. Care
	1. **Emergency services claims:** Medical records shall not be requested more frequently than twenty percent (20%) of the claims submitted by all providers for emergency services over any 12-month period. 2. **All other claims:** Medical records shall not be requested more frequently than three percent (3%) of the claims submitted by all providers, excluding claims involving unauthorized services over any 12-month period. **Exception:** The thresholds and limitations on requests for medical records as stated above should not apply to claims where reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices are being demonstrated. ~~Ensure network providers follow the blood lead anticipatory guidance and screening requirements in accordance with APL 20-016~~ ~~Identify, on at least a quarterly basis (i.e. January – March, April – June, July – September, October – December), all child members under the age of six years (i.e. 72 months) who have no record of receiving a blood lead screening test as required~~ 3.	
Provider Dispute Resolution (PDR) Processing and Payments requirement. (Title 28 California Code of Regulations Section 1300.71.38)	**Acknowledgement of Provider Disputes** Acknowledgement of received disputes is performed in a timely manner at a minimum of 95% of the time. a. 15 working days for paper disputes. b. 2 working days for electronic disputes. **Timely Dispute Determinations** Dispute determinations are made in a timely manner, at a minimum of 95% of the time. a. 45 working days from receipt of the dispute. b. 45 working days from receipt of additional information. **Clear Explanation of NOA Letter** Rationale for decision is clear, accurate and specific in NOA Letter, at a minimum of 95% of the time. a. Written determination stating the pertinent facts and explaining the reasons for the determination	

Standard	Delegated Activities	Retained by L.A. Care
	Accurate Provider Dispute Payments 1. Appropriately paying any outstanding monies determined to be due if the dispute is determined in whole or in part in favor of the provider. 2. Interest payments are paid correctly when dispute determination is in favor of provider, at a minimum of 95% of the time. Accrual of interest of payment on resolved provider disputes begin on the day after the expiration of forty-five (45) working days from the original claim receipt date. **Acceptance of Late Claims** The organization must accept and adjudicate disputes that were originally filed beyond the claim filing deadline and the provider was able to demonstrate good cause for the delay, at a minimum of 95% of the time.	

Exhibit 8
NCQA Delegation Agreement
[Attachment B]

Plan's Reporting Requirements

Report	Due Date	Submit To	Required Format
PHARMACY			
Pharmacy* Reporting requirements for additional delegated activities 2. Pharmacy Utilization Reports a. Top fifty drugs by number of Prescriptions b. Top fifty Drugs by Aggregate Cost c. Non-Formulary Medication **d.** Summary Report of L.A. Care member Prescription Utilization	1. Quarterly 1st Qtr May 30 2nd Qtr Aug 30 3rd Qtr Nov 30 4th Qtr Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-er/infile/Pharmacy/	Pharmacy* 1. Policy and Procedure PHRM-041: Plan Partner Pharmacy Reporting Requirements
NCQA ME Pharmacy reporting requirements 1. **ME:** Quality and accuracy (QI process) of pharmacy benefit information provided on website and telephone a. Collects data on quality and accuracy of pharmacy benefit information b. Analyzes data results c. Acts to improve identified deficiencies 2. **ME:** Pharmacy benefit updates for: a. Member information on its website and in materials used by telephone staff, as the effective date of a formulary change and as new drugs are made available.	1 2: Quarterly 1st Qtr May 30 2nd Qtr Aug 30 3rd Qtr Nov 30 4th Qtr Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-er/infile/Pharmacy/	1 2. Compliant with NCQA in accordance to Plan's accreditation submission
APPEALS & GRIEVANCES **Appeal & Grievance Logs to include raw data on all A&G cases received (example: case type category, case sub-classification, alleged provider information, provider information, MD reviewer information, dates/times received, resolution date/times, resolution decision, AOR information, withdrawal information, dismissal information, effectuation date/times, etc.) This data should be provided in the requested format defined by LA Care on a monthly basis. Delegate must do root cause analysis and remediation for all missed regulatory metrics. Delegate will provide data as requested for all regulatory inquiries.**			
MEMBER SERVICES			
Member Services Member complaints and Appeals Log	Monthly 12th Calendar Day of Each Month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-er/infile/Member Services/	Format as defined in the L.A. Care Technical Bulletin MS 005
QUALITY IMPROVEMENT			

NET 1A **Cultural Needs and Preferences Assessment** **NET 1B** Practitioners Providing Primary Care **NET 1C** Practitioners Providing Specialty Care **NET 1D** Practitioners Providing Behavioral Healthcare ~~1. Assess the cultural, ethnic, racial and linguistic needs of its members~~ ~~2. Adjust the availability of practitioners within its network, if necessary~~	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
~~NET 1B~~ ~~**Availability of Practitioners, if delegated:**~~ ~~Formal assessment of primary care, behavioral healthcare, and specialty care practitioners' (SCP) availability to include:~~ ~~1. Adjustment of practitioners' availability within its network to meet the cultural, ethnic, racial, and linguistic needs of its members~~ ~~2. Quantifiable and Measurable Standards for the number of each type of practitioner providing primary care.~~ ~~3. Quantifiable and Measurable Standards for Geographic Distribution of each type of practitioner providing primary care.~~ ~~4. Analysis of Performance against Standards~~	~~Annually during PP audit~~	~~L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/~~	~~Compliant with NCQA in accordance to Plan's accreditation submission~~
~~NET 1C~~ ~~**Formal assessment of Practitioners Providing Specialty Care, if delegated, to include:**~~ ~~1. Identification of High Volume Specialty Providers, one of which must be OB/GYN; and Identification of High Impact Specialty Providers, one of which must be Oncology.~~ ~~2. Quantifiable and Measurable Standards for the number of each type of high-volume specialist.~~ ~~3. Quantifiable and Measurable Standards and Distribution by Geographic Distribution of High Volume SCPs and High Impact SCPs; and~~ ~~4. Analysis of Performance against Standards~~	~~Annually during PP audit~~	~~L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/~~	~~Compliant with NCQA in accordance to Plan's accreditation submission~~

~~**NET 1D**~~ ~~**Assessment of Practitioners Providing Behavioral Healthcare, if delegated, to include:**~~ ~~1. Identification of High-Volume behavioral healthcare practitioners~~ ~~2. Quantifiable and Measurable Standards for the number of each type of High-Volume behavioral healthcare practitioner.~~ ~~3. Quantifiable and Measurable Standards for the geographic distribution of each type of High-Volume behavioral healthcare practitioner.~~ ~~4. Analysis of Performance against Standards~~	~~Annually during PP audit~~	~~L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/~~	~~Compliant with NCQA in accordance to Plan's accreditation submission~~
NET 2A **Access to Primary Care** **NET 2B** Access to Behavioral Healthcare **NET 2C** Access to Specialty Care , ~~**if delegated:**~~ ~~AnalysisAnalysis~~A analysis~~Analysis of data that measures:~~ ~~1. Regular and Routine Care Appointments~~ ~~2. Urgent Care Appointments~~ ~~3. After-Hours Care~~	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
~~**NET 2B**~~ ~~**Access to Behavioral Healthcare, if delegated:**~~ ~~AnalysisAnalysis~~A analysis~~Analysis of data that evaluate access to appointments for behavioral healthcare for:~~ ~~1. Care for a non-life-threatening emergency within 6 hours~~ ~~2. Urgent Care within 48 hours~~ ~~3. Initial visit for routine care within 10 business days~~ ~~4.~~1. ~~Follow-up routine care within a time frame defined by the organization~~	~~Annually during PP audit~~	~~L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/~~	~~Compliant with NCQA in accordance to Plan's accreditation submission~~
~~**NET 2C**~~ ~~**Access to Specialty Care, if delegated:**~~ ~~AnalysisAnalysis~~Aanalysis~~Analysis of data that evaluate access to appointments for:~~ ~~3. High-Volume specialty care.~~ ~~4. High-Impact specialty care.~~	~~Annually during PP audit~~	~~L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/~~	~~Compliant with NCQA in accordance to Plan's accreditation submission~~

NET 3A Assessment of Member Experience Accessing the Network NET 3B Opportunities to Improve Access to Nonbehavioral Healthcare Services NET 3C Opportunities to Improve Access to Behavioral Healthcare Services ~~3~~ ~~Assessment of Network Adequacy~~ ~~3. Assessment of Member Experience Accessing the Network by:~~ ~~a. Analyzing data from complaints and appeals about network adequacy for non-behavioral and behavioral healthcare services~~ ~~b. Using aspects of analysis from (b) to determine if there are issues specific to particular geographic areas or types of practitioners or providers~~ ~~4.~~ AnalyzeAnalyzeAnalyzieAnalyze ~~opportunities to improve access to non-behavioral healthcare services by:~~ ~~a. Prioritizing opportunities for improvement from analysis of availability, accessibility and CAHPS survey results and member complaints and appeals~~ ~~a. Implement interventions on at least one opportunity, if applicable~~ ~~b. Measure the effectiveness of interventions, if applicable~~ ~~5. Analyze opportunities to improve access to behavioral healthcare services by:~~ ~~b. Prioritizing improvement opportunities identified from analyses of availability, accessibility, complaints and appeals, or member experience~~ ~~a. Implementing interventions on at least on opportunity, if applicable~~ ~~b. Measures the effectiveness of the interventions, if applicable~~	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
-ME 7C Element C: Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP)	Compliant with NCQA in accordance to Plan's accreditation submission

ME 7E Element E: Annual Assessment of Behavioral Healthcare and Services **ME 7F** Element F: Behavioral Healthcare Opportunities for Improvement **7 A, B, C, E, F** **Analysis of Member Experience, if delegated, to include:** 1. Policies and Procedures for Complaints 2. Policies and Procedures for Appeals 3. Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals for each of 5 categories along with opportunities for improvement: a. Quality of Care b. Access c. Attitude and Service d. Billing and Financial Issues e. Quality of Practitioner Office Site 4. Annual Assessment of Behavioral Healthcare Complaints and Appeals and Services for each of 5 categories along with opportunities for improvement: a. Quality of Care b. Access c. Attitude and Service d. Billing and Financial Issues e. Quality of Practitioner Office Site		home/ukais-cr/infile/Member Services/	
QI 2A Practitioner Contracts	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission

QI 3 A Identifying Opportunities **QI 3B** Acting on Opportunities **QI 3C** Measuring Effectiveness ~~**-C & 4 A-C**~~ ~~**Annual Assessment and Improvement Actions taken for Continuity and Coordination of Care across the health care network**~~ ~~1. Continuity and Coordination of Medical Care analysis~~ ~~2. Continuity and Coordination Between Medical Care and Behavioral HealthCare analysis.~~ **1.**	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	Annual data collection analysis that identifies and acts on opportunities for improvement for Continuity of Care as outlined by NCQA guidelines for Continuity Coordination of Care of Medical Care and Continuity and Coordination Between Medical Care and Behavioral HealthCare
QI 4A Data Collection **QI 4B** Collaborative Activities **QI 4C** Measuring Effectiveness	Annually during PP audit	~~L.A. Care's Secure File Transfer Protocol (SFTP)~~ home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
QI 5A **Sub-Delegation Agreement** **QI 5B** Sub- Delegation Predelegation Evaluation **QI 5C** Sub-Delegation Review of QI Program **QI 5D** **Sub-Delegation** Opportunities for Improvement	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
Quality Improvement Quarterly reporting requirements 1. **QI Workplan Update(s))** 2. **Clinical Strategic Goals (CSG)** with MCAS Measures: 3. **Potential Quality of Care Issues (PQIs)** a. Number of PQIs b. Number of closed PQIs c. Number of closed PQIs within 6 months	1. Annually during PP audit 2. Quarterly Clinical Strategic goals 3. Quarterly PQI Report 1st Qtr – May 25 2nd Qtr – Aug 25 3rd Qtr – Nov 25	2-3. L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	2-3. Acceptable formats: • Clinical Strategic Goals (CSG) Report with L.A. Care member rates included.

~~Quality Improvement Quarterly reporting requirements~~ ~~1. QI Workplan Update(s)~~ ~~1. Asthma Report~~ ~~2. Diabetes Report~~ ~~3. Clinical Strategic Goals (CSG)~~ ~~2. Potential Quality of Care Issues (PQIs)~~ ~~a. Number of PQIs~~ ~~b. Number of closed PQIs~~ ~~c. Number of closed PQIs within 6 months~~ ~~d. PQI Detail Report with final PQI severity level~~	4th Qtr – Feb 25 ~~1 2. Quarterly~~ ~~1st Qtr – May 25~~ ~~April 25~~ ~~2nd Qtr – Aug 25~~ ~~July 25~~ ~~3rd Qtr – Nov 25~~ ~~Oct 25~~ ~~4th Qtr – Feb 25~~ ~~Jan 25~~	~~1 2. L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/~~	• Potential Quality of Care Issues (PQIs) ~~1 2. Acceptable formats:~~ ~~QI Workplan Update(s)~~ ~~1. Clinical Strategic Goals (CSG) Report~~ ~~Potential Quality of Care Issues (PQIs)~~ ~~2. Quarterly Workplan Updates~~
Quality Improvement Annual reporting requirements 1. **QI 1A:** QM Program Description 2. **QI 1C:** QM Program Evaluation 3. QI Workplan 4. PHM Work plan (if the activities are not included in the annual QI Workplan)	~~1 4.~~ Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	Acceptable formats: • Quarterly
ME 1B: Distribution of Member Rights & Responsibilities Statement 1. KP will randomly select 20 providers for each Reporting period and will complete the New Provider Training Tracking Sheet for the selected physicians each Reporting period.	Semi-Annually: **Jan 15th (Reporting period Q3 & Q4)** **July 15th (Reporting period Q1 & Q2)** KP to submit the New Provider Training Tracking Sheet to LA Care	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	New Provider Training Tracking Sheet (KP document) ME 1B_Distribution of Rights Statement
PHM 1A Strategy Description **PHM 1B** Informing Members ~~**PHM 1:** PHM Strategy~~ ~~Strategy Description~~	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission

PHM 2A Data Integration **PHM 2B** Population Assessment **PHM 2C** Activities and Resources **PHM 2D** Segmentation ~~**PHM 2:** Population Identification~~ ~~1. Population Assessment~~ ~~Segmentation.~~	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 3 A Practitioner or Provider Support	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 6A Measuring Effectiveness **PHM 6B** Improvement and Action ~~**6:** Population Health Management Impact~~ ~~1. Measuring Effectiveness~~ ~~Improvement and Action~~	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 7A Sub-Delegation Agreement **PHM 7B** Sub-Delegate Pre-Delegation Agreement **PHM 7C** Sub-Delegate Review of PHM Program **PHM 7D** Opportunities for Improvement	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
Title 28 California Code of Regulations Section 1300.67.2.2 **California Health and Safety Code Section 1348.8** **Assessment of Nurse Advice Line** ~~3.~~1. Nurse Advice Line monitoring for:	1. Quarterly 1st Qtr – April 25 2nd Qtr – July 25 3rd Qtr – Oct 25 4th Qtr – Jan 25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Health Education/	Mutually agreed upon format

a. Telephone statistics at least quarterly ~~1.~~• Average abandonment rate within 5 percent ~~(goal)~~ ~~2.~~• Average speed of answer within 30 seconds ~~(goal)~~ ~~4.~~2. Annual analysis of Nurse Advice Line statistics (website, telephone, use, and calls), identify opportunities and establish priorities for improvement.	2. Annually during PP Audit	Plan will also have the option to submit via email to remain compliant with due date.	
HEDIS Performance Benchmark A PDSA tool will be required when the plan does not meet the 50th percentile for the Managed Care Accountability Set and the 50th percentile for the Medicaid NCQA Accreditation Measures as established by both regulatory entities.	Annually during PP Audit. The PDSA tool is due 90 calendar days after final validated HEDIS results are available.	L.A. Care's Secure File Transfer Protocol (SFTP)/ home/ukais-cr/infile/Quality Improvement/ Plan will also have the option to submit via email to remain compliant	The PDSA tool provided by DHCS or L.A. Care
Blood Lead Screening of Young Children APL 20-016	1. Quarterly 1st Qtr – April 13 2nd Qtr – July 13 3rd Qtr – Oct 13 4th Qtr – Jan 13	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	Data template provided by QI
UTILIZATION MANAGEMENT			
Service Authorizations and Utilization Review			
UM 1 1. UM Program Description 2. UM Program Evaluation 3. UM Program Work Plan	1.Delegation Oversight to review Annually during PP audit 2-3. Due to Clinical Assurance on May 31st via the SFTP Site	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Clinical_Assurance/	1. Narrative 2. ICE Quarterly Reporting format 3. ICE Quarterly Format
Quarterly UM Activity Report **All elements outlined within L.A. Care Quarterly UM Activity (ICE) report including but not limited to:** ~~2.~~ 1. UM Summary – Inpatient Activity ~~1.~~a. Average monthly membership	Quarterly 1st Qtr –May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Clinical_Assurance/	ICE Quarterly Reporting Format

~~2.~~b. Acute Admissions/K ~~3.~~c. Acute Bed days/K ~~a.~~d. Acute LOS ~~4.~~e. Acute Readmits/K ~~5.~~f. SNF Admissions/K ~~6.~~g. SNF Bed days/K ~~b.~~ 2. SNF LOS ~~7.~~ a) SNF Readmits/K ~~3.~~ 3. UM Activities Summary ~~1.~~a) Referral Management Tracking of the number of Approvals/Modifications/Denials/ Deferrals (Routine/Urgent) ~~2.~~b) Referral Denial Rate ~~3.~~c) Appeals/K ~~4.~~d) Overturn Rate ~~4.~~2. **PHM 5:** CCM Complex Case Management CM Reports and Statistics	4th Qtr – Feb 28		
NET 4B: Continued Access to Care 1. Continued Access to Practitioners If a practitioner's contract is discontinued, the organization allows affected members continued access to the practitioner, as follows: ~~3.~~b. Continuation of treatment through the current period of active treatment for members undergoing active treatment for a chronic or acute medical condition ~~4.~~c. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy	Quarterly 1st Qtr – May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Clinical_Assurance/	L.A. Care Quarterly Reporting Format
PHM 5: CCM Log of Case Management Cases CCM for members who have been in CCM for at least 60 days to include both open and closed cases.	Quarterly 1st Qtr – May 25 2nd Qtr – Aug 25 3rd Qtr – Nov 25 4th Qtr – Feb 25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Clinical_Assurance/	Acceptable formats: L.A. Care Format
Medi-Cal Provider Preventable Reportable Conditions	Monthly 15th of Each Month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Clinical_Assurance/	Acceptable formats: DHCS Required Reporting Format
QI 3D: Transition to Other Care**--**member transition to other care, ~~a.~~ a. When their benefits end.	Quarterly 1st Qtr – May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Clinical_Assurance/	L.A. Care TOC Reporting Format
CREDENTIALING			

3.1. Initial Credentialed practitioner list containing Credentialing Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. 4.2. Re-credentialed practitioner list containing Re-credentialing Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. 5.3. Voluntary Practitioner Termination list containing Termination Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. 6.4. Involuntary Practitioner Termination list containing Termination Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name	Quarterly 1st Qtr – May 15 2nd Qtr – Aug 15 3rd Qtr – Nov 15 4th Qtr – Feb 15	~~L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Credentialing/~~ credinfo@lacare.org	Current L.A. Care Health Plan Delegated Credentialing Quarterly Credentialing Submission Form (ICE Format)
COMPLIANCE			
1. 274 EDI File Mandated by APL 16-019	Monthly – Due to L.A. Care by the 4th of each month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	DHCS required formatting.
2. Data Certification Statements Mandated by APL 17-005	Monthly – Due to L.A. Care 3 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	Word Document, Non-specific template. Utilize own template; however, all state reports submitted to L.A. Care within the month MUST be listed and CEO MUST sign off attesting to ALL data submissions.
3. Non-Medical Transportation & Non-Emergency Medical Transportation (NMT-NEMT) Report Mandated by APL 17-010	Monthly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	DHCS approved template
4. . AB1455 Claims Timeliness Reports a) AB1455 PDR Timeliness Reports ~~4.~~ b) ~~AB1455 Pharmacy Claims Timeliness Reports~~ ~~5.~~ c) Disclosure of Emerging Claims Payment Deficiencies	Quarterly – Due to L.A. Care within specified deadline set by L.A. Care	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	DMHC approved templates

~~6.~~5. Call Center Report	Quarterly- – Due to L.A. care 30 days after the end of each quarter of the calendar year. When due date falls on the weekend (Sunday or Saturday, data must be submitted by COB on the Friday before the due date. • Q1 – January, February, and March • Q2 – April, May, and June • Q3 – July, August, and September Q4 – October, November, and December~~Quarterly~~	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	Format as specified by L.A. Care
~~7.~~6. Community Based Adult Services (CBAS) Report	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	DHCS approved templates
~~8.~~7. Dental General Anesthesia Report Mandated by APL 15-012	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	DHCS approved templates
~~9.~~8. Coordinated Care Initiative – Long- Term Services & Supports (CCI – LTSS)	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	DHCS approved templates
~~10. Encounter Data Letters – CAP response~~	~~Quarterly - Due to L.A. Care 30 business days after receipt of CAP~~	~~L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/~~	~~Word Document, Non-Specific template~~
~~11. Grievance Report Mandated by APL 14-013~~	~~Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS~~	~~L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/~~	~~DHCS approved templates~~

~~12.~~9. Medi-Cal Managed Long-Term Services & Supports (MLTSS) Report Mandated by APL 14-010	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	DHCS approved templates
~~13. Out-of-Network (OON) Report~~	~~Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS~~	~~L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/~~	~~DHCS approved templates~~
~~14.~~10. Medi-Cal Managed Care Survey – Disproportionate State Hospitals (MMCS-DSH) Survey	Annually - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	DHCS approved templates
~~15. Pharmacy Formulary Changes Reports~~	~~Annually - Due to L.A. Care 7 business days prior to submission to DHCS~~	~~L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/~~	~~DHCS approved templates~~
~~16. Health Homes Program DHCS Required Reporting~~	~~Quarterly, Bi-Annually, & Annually, according to schedule in DHCS template -Due to L.A. Care 7 business days prior to submission to DHCS~~	~~L.A. Care Regulatory / Secure File Transfer Protocol (SFTP)~~ ~~home/ukais-cr/infile/Regulatory Reports/~~	~~DHCS approved template, plus attestation of data and brief written summary of oversight and monitoring activity for the reporting period~~
11. Enhanced Care Management DHCS Required Reporting	Quarterly~~, Bi-Annually, & Annually~~, according to schedule in DHCS template -Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/~~uefst~~ukais-cr/infile/Regulatory Reports	DHCS approved template, plus attestation of data and brief written summary of oversight and monitoring activity for the reporting period
12. Community Supports DHCS Required Reporting	Quarterly~~, Bi-Annually, & Annually~~, according to schedule in DHCS template -Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/~~uefst~~ukais-cr/infile/Regulatory Reports	DHCS approved template, plus attestation of data and brief written summary of oversight and monitoring activity for the reporting period
~~17.~~13. CBAS Monthly Wavier Report	Monthly -Due to L.A. Care on the specified dates stated below:	L.A. Care Regulatory	DHCS approved template

	January 5 February 3 March 2 April 2 May 3 June 2 July 2 August 3 September 2 October 4 November 2 December 2	/ Secure File Transfer Protocol (SFTP) home/ ukais-cr /infile/Regulatory Reports	
~~18.~~14. Prop 56 Directed Payment for Physician Services (APL 19-015)	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	DHCS approved template
~~19.~~15. Prop 56 Hyde Reimbursement Requirements for specific Services (APL 19-013)	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ ukais-cr /infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements
~~20.~~16. Prop 56 Directed Payments for Developmental Screening Services (APL 19-016)	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ ukais-cr infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements
~~21. Prop 56 Directed Payments for Valued Base Payment Program (APL 20-014014)~~	~~Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS~~	~~LA Care Regulatory/Secure File Transfer Protocol (sFTP)~~ ~~home/ ukais-cr /infile/Regulatory~~	~~Regulatory Reports provided Template based on APL reporting requirements~~
~~22.~~17. Prop 56 Directed Payments for Family Planning (APL 20-013)	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ ukais-cr /infile/Regulatory	Regulatory Reports provided Template based on APL reporting requirements
~~23.~~18. Prop 56 Directed Payment for Adverse Childhood Experiences Screening Services (AP-19-018)	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP)	Regulatory Reports provided Template based on APL reporting requirements

		home/ ukais-cr /infile/Regulatory	
~~24. MER Exemption Review Report (MMDR)~~	~~Monthly - Due to L.A. Care 7 business days prior to submission to DHCS~~	~~L.A. Care's Secure File Transfer Protocol (SFTP) home/ ukais-cr /infile/Regulatory Reports/~~	~~DHCS Reporting template~~
~~25.~~19. Third Party Liability (TPL)	15 days from the date LA Care submits case file.	L.A. Care via its Secure File Transfer ProtocoalProtocal (SFTP) – home/ ukais-cr /infile/Regulatory Reports/	DHCS approved templates
~~26.~~20. MCPD and PCPA Managed Care Program Date (MCPD) and Primary Care Provider Alignment (PCPA) The Managed Care Program Data (MCPD) report is a consolidated reporting requirement which DHCS introduced through APL 20-017. The MCPD file replaces the following reporting requirements, as this data is now incorporated into the MCPD file in .json format: • Grievances and appeals data in an Excel template, as specified in APL 14-013 ***(previously submitted by your plan as the Grievance Report Mandated by APL 14-013)*** • Monthly MERs and other continuity of care records data in an Excel template, as specified in Attachment B of APL 17-007 ***(previously submitted by your plan as the MMDR Report)*** • Other types of continuity of care data in ad-hoc Excel templates • Out-of-Network request data in a variety of ad-hoc Excel templates ***(previously submitted by your plan as the OON Report)***	Monthly - Due to L.A. Care every 4th day of the month ~~Monthly - Due per timeline mutually agreed upon by KP and LA Care~~ ~~FEB~~ ~~MCPD: February 15~~ ~~MAR~~ ~~PCPA: March 5~~ ~~MCPD: March 8~~ ~~APR~~ ~~PCPA: April 6~~ ~~MCPD: April 7~~ ~~MAY~~ ~~PCPA: May 6~~ ~~MCPD: May 6~~ ~~JUN~~ ~~PCPA: June 4~~ ~~MCPD: June 7~~ ~~JUL~~ ~~PCPA: July 6~~ ~~MCPD: July 7~~ ~~AUG~~ ~~PCPA: Aug 6~~ ~~MCPD: Aug 6~~ ~~SEPT~~ ~~PCPA: September 3~~ ~~MCPD: September 8~~ ~~OCT~~	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	Regulatory Reports provided Template based on APL reporting requirements

	~~PCPA: Oct 6~~ ~~MCPD: Oct 6~~ ~~NOV~~ ~~PCPA: Nov 5~~ ~~MCPD: Nov 5~~ ~~DEC~~ ~~PCPA: Dec 6~~ ~~MCPD: Dec 7~~		
~~27.~~21. New and or revised reports as released by DHCS	Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Regulatory Reports/	DMHC approved templates
22. APL 20-021 Acute Care at Home Hospital Report	Monthly – Due to LA Care the last day of every month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	DHCS Reporting Template
23. APL 20-016 Blood Lead Screening~~Screening~~	Monthly – Due to LA Care the first Friday of every month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	Regulatory Reports provided Template based on APL reporting requirements
24. Disaster and Recovery Plan Disaster Recovery Test Results L.A. Care will request all elements outlined below including but not limited to: 1. LA Care may require additional information on Business Continuity efforts based off current event. In the event there are any additional requests from regulators for individual instances, such as, an emergency declared by the governor; L.A. Care will send out an ad hoc written request asking to respond with the requested information should it be an element outside of what is already being requested and another mobile contact mechanism when outside of regular business hours.	Annually during PP audit and ad-hoc; Ad-Hoc	L.A. Care's Secure File Transfer Protocol (SFTP) EnterpriseRiskManagement@lacare.org home/ukais-cr/infile/Regulatory Reports/ EnterpriseRiskManagement@lacare.org ; RegulatoryReports@lacare.org	Word Document, Non-Specific template Template may change upon regulators request.

DELEGATION OVERSIGHT			
~~1.~~ New Member Welcome Kit Mailing Reports	Quarterly Jan 15 April 15 July 15 October 15	L.A. Care's Secure File Transfer Protocol (SFTP) home/ukais-cr/infile/Delegation Oversight	Format as specified by L.A. Care
CULTURAL AND LINGUISTC SERVICES			
C&L Program Description and Work Plan	Annually – due to L.A. Care January 31st of each year	L.A. Care's Secure File Transfer Protocol (SFTP) *OR* Via email to CL_Reports_Mailbox@lacare.org	Plan Partner can submit their own format of C&L PD and work Plan. Requirement is in reference to Policy and Procedure CL-008 and C&L Program Description delegated Subcontractor

All other non-conflicting rights and duties, obligations and liabilities of the parties to the Agreement shall remain unchanged.

~~[Signature block is on the following page]~~

IN WITNESS WHEREOF, the parties have entered into this Amendment as of the date set forth below.

Local Initiative Health Authority for Los Angeles County d.b.a. L.A. Care Health Plan (L.A. Care)
A local government agency

By: ___________________________
John Baackes
Chief Executive Officer

Date: _________________________, 20221

Kaiser Foundation Health Plan
A California health care services plan

By: ______________________________
Marcus J. Hoffman
Senior Vice President, Chief Financial Officer, Southern California and Hawai'i Market~~Region (Interim)~~

Date: ___________________________, 20221

By: ________________________

Hector De La Torre
Chairperson,
L.A. Care Board of Governors

Date: ____________________, 202~~1~~2

Amendment No. 48
to
Services Agreement
between
Local Initiative Health Authority for Los Angeles County
and
Blue Shield of California Promise Health Plan

This Amendment No. 48 is effective as of July 1, 2021, as indicated herein by and between the Local Initiative Health Authority for Los Angeles County, a local public agency operating as L.A. Care Health Plan ("Local Initiative") and ***Blue Shield of California Promise Health Plan***, a California health care service plan ("Plan").

RECITALS

WHEREAS, the State of California ("State") has, through statute, regulation, and policies, adopted a plan ("State Plan") for certain categories of Medi-Cal recipients to be enrolled in managed care plans for the provision of specified Medi-Cal benefits. Pursuant to this State Plan, the State has contracted with two health care service plans in Los Angeles County. One of these two health care service plans with which the State has a contract ("Medi-Cal Agreement") is a health care service plan locally created and designated by the County's Board of Supervisors for, among other purposes, the preservation of traditional and safety net providers in the Medi-Cal managed care environment ("Local Initiative"). The other health care service plan is an existing HMO which is selected by the State (the "Commercial Plan");

WHEREAS, the Local Initiative is licensed by the Department of Managed Health Care as a health care service plan under the California Knox-Keene Act (Health and Safety Code Sections 1340 *et seq*.) (the "Knox-Keene Act");

WHEREAS, Plan is duly licensed as a prepaid full service health care service plan under the Knox-Keene Act and is qualified and experienced in providing and arranging for health care services for Medi-Cal beneficiaries; and

WHEREAS, Local Initiative and Plan have entered into a prior agreement dated October 1, 2009, as amended ("Agreement"), for Plan to provide and arrange for the provision of health care services for Local Initiative enrollees as part of a coordinated, culturally and linguistically sensitive health care delivery program in accordance with the Medi-Cal Agreement and all applicable federal and state laws.

NOW, THEREFORE, in consideration of the foregoing and the terms and conditions set forth herein, the parties agree to amend the Agreement as follows:

I. Exhibit 8 – Delegation Agreement, shall be revised as is set forth in Exhibit 8, below.

IN WITNESS WHEREOF, the parties have entered into this Amendment No. 48 as of the date set forth below.

Local Initiative Health Authority for Los Angeles County operating as L.A. Care Health Plan (Local Initiative)
A local public agency

DocuSigned by:
By: John Baackes
70A86CF78A8E458...
John Baackes
Chief Executive Officer

Date: ____________________, 2023

By: 4/3/2023 | 5:42 PM PDT
Alvaro Ballesteros
Chairperson
L.A. Care Board of Governors

Date: ____________________, 2023

Blue Shield of California Promise Health Plan,
A California health care services plan

DocuSigned by:
By: Kristen Cerf
9AE0D7770A434C7...
Kristen Cerf
President and Chief Executive Officer

Date: 3/31/2023 | 11:06 AM PDT, 2023

II. Exhibit 8 – Delegation Agreement, shall be revised as follows:

Exhibit 8
Delegation Agreement
[Attachment A]

Delegated Activities Effective July 1, 2021-June 30, 2022
Responsibilities of Plan and Local Initiative

The purpose of the following grid is to specify the activities delegated by Local Initiative ("L.A. Care") to Blue Shield of California Promise Health Plan (individually and collectively "Plan" and/or "Delegate") under the Delegation Agreement with respect to: (i) quality management and improvement, (ii) population health management (iii) network management, (iv) utilization management, (v) credentialing and re-credentialing, (vi) member experience, (vii) claims recovery., and (viii) claims processing. All Delegated Activities are to be performed in accordance with currently applicable NCQA accreditation standards and State and Federal regulatory requirements, as modified from time to time. Blue Shield of California Promise Health Plan agrees to be accountable for all responsibilities delegated by L.A. Care and will not further delegate (sub-delegate) any such responsibilities without prior written approval by L.A. Care, except as outlined in the Delegation Agreement. Blue Shield of California Promise Health Plan is responsible for sub-delegation oversight of any sub-delegated activities. Blue Shield of California Promise Plan will provide periodic reports to L.A. Care as described elsewhere in the Delegation Agreement. L.A. Care will oversee the delegation to Blue Shield of California Promise Health Plan as described elsewhere in the Services Agreement. In the event deficiencies are identified through this oversight, Blue Shield of California Promise Health Plan will provide a specific corrective action plan acceptable to L.A. Care. If Blue Shield of California Promise Health Plan does not comply with the corrective action plan within the specified time frame, L.A. Care may revoke the delegation to Blue Shield of California Promise Health Plan, in whole or in part, in accordance with Exhibit 5, herein. Due to the Medi-Cal Rx Transition where the pharmacy benefit will be managed by DHCS starting January 1, 2022, standard and reporting requirements as related to Pharmacy items will no longer be required for data period beginning the transition date identified by DHCS. This would apply to all standard requirements and reports listed under "Pharmacy". The final monitoring and quarterly reporting requirement would be up to the data period until the transition date. However, while the monitoring and quarterly reporting will discontinue after the transition date, any reports required for regulatory or NCQA purposes mainly as it relates to any data up to the actual transition date would be still required upon request. *L.A. Care will provide* ***delegate with Member Experience data: complaints, CAHPS, survey results or other data collected on members' experience with the delegate's services. In addition, will also provide Clinical performance data: HEDIS measures, claims and other clinical data collected by the organization. L.A. Care may provide data feeds for relevant claims data or clinical performance measure results*** *when requested and as applicable. Request shall be sent to the L.A. Care business unit which maintains the data and/or L.A. Care's delegate Business Unit. The request must be precise and contain sufficient details so it is clear what minimum data needs to be provided to fulfill the request. The L.A. Care business unit responsible for the requested data shall respond timely and ensure that data is sent in compliance with L.A. Care's Policies and Procedures securing PHI through applicable protections, e.g., encryption.*

Standard	Delegated Activities	Retained by L.A. Care
	QUALITY MANAGEMENT AND IMPROVEMENT	
Program Structure and Operations: Applicable L.A. Care Policies: QI-003, QI-005, QI-006, QI-007, QI-0026	**QI Program Structure** The organization's QI program description specifies: 1. The QI Program Structure 2. The behavioral healthcare aspects of the program. 3. Involvement of a designated physician in the QI program	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs, including review, evaluation, and approval of its Delegates'

Standard	Delegated Activities	Retained by L.A. Care
(NCQA QI 1)	4. Involvement of a behavioral healthcare practitioner in the behavioral aspects of the program 5. Oversight of QI functions of the organization by the QI Committee 6. Objectives for serving a culturally and linguistically diverse membership **Annual Work Plan** The organization documents and executes a QI annual work plan that reflects ongoing activities throughout the year and addresses: 1. Yearly planned QI activities and objectives. 2. Time frame for each activity's completion. 3. Staff members responsible for each activity. 4. Monitoring of previously identified issues. 5. Evaluation of the QI program. **Annual Evaluation** The organization conducts an annual written evaluation of the QI program that includes the following information: 1. A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of service 2. Trending of measures of performance in the quality and safety of clinical care and quality of service 3. evaluation of the overall effectiveness of the QI program and of its progress toward influencing network-wide safe clinical practices **QI Committee Responsibilities** The organization's QI Committee: 1. Recommends policy decisions. 2. Analyzes and evaluates the results of QI activities. 3. Ensures practitioner participation in the QI program through planning, design, implementation or review. 4. Identifies needed actions. 5. Ensures follow-up, as appropriate. **Promoting Organizational Diversity, Equity and Inclusion** The organization: 1. Promotes diversity in recruiting and hiring. 2. Offers training to employees on cultural competency, bias or inclusion.	activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.
Health Services Contracting : Applicable L.A. Care Policy: QI-007 (NCQA QI 2)	**Practitioner Contracts** Contracts with practitioners specifically require that: 1. Practitioners cooperate with QI activities 2. Practitioners allow the organization to use their performance data.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and

Standard	Delegated Activities	Retained by L.A. Care
	Provider Contracts This standard is required for the first survey under NCQA guidelines. Plans are still required to maintain compliance with this standard. NCQA only removed this requirement to submit documentation for renewal surveys. Contracts with practitioners specifically require that: 1. Practitioners cooperate with QI activities. 2. Practitioners allow the organization to use their performance data.	approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.
Continuity and Coordination of Medical Care: Applicable L.A. Care Policy: QI-0026 (NCQA QI 3)	**Identifying Opportunities** The organization annually identifies opportunities to improve continuity and coordination of medical care across the network by: 1. Collecting data on member movement between practitioners. 2. Collecting data on member movement across settings. 3. Conducting quantitative and analysis of data to identify improvement opportunities. 4. Identifying and selecting one opportunity for improvement. 5. Identifying and selecting a second opportunity for improvement. 6. Identifying and selecting a third opportunity for improvement. 7. Identifying and selecting a fourth opportunity for improvement. **Acting on Opportunities** The organization annually acts to improve coordination of medical care by: 1. Acting on the first opportunity identified in Element A, factor 4-7 2. Acting on the second opportunity identified in Element A, factor 4-7 3. Acting on the third opportunity identified in Element A, factor 4-7. **Measuring Effectiveness** The organization annually measures the effectiveness of improvement actions taken for: 1. The first opportunity identified in Element B. 2. The second opportunity identified in Element B. 3. The third opportunity identified in Element B. **Transition to Other Care** Refer to Utilization Management Delegated Activities Section	

Standard	Delegated Activities	Retained by L.A. Care
Continuity and Coordination Between Medical Care and Behavioral Healthcare: Applicable L.A. Care Policy: QI-0026 (NCQA QI 4)	**<u>Data Collection</u>** The organization annually collects data about opportunities for collaboration between medical care and behavioral healthcare in the following areas: 1. Exchange of information. 2. Appropriate diagnosis, treatment and referral of behavioral healthcare disorders commonly seen in primary care. 3. Appropriate use of psychotropic medications. 4. Management of treatment access and follow-up for members with coexisting medical and behavioral disorders. 5. Primary or secondary preventive behavioral healthcare program implementation. 6. Special needs of members with severe and persistent mental illness. **<u>Collaborative Activities</u>** The organization annually conducts activities to improve the coordination of behavioral healthcare and general medical care including: 1. Collaborating with behavioral healthcare practitioners. 2. Quantitative and causal analysis of data to identify improvement opportunities 3. Identifying and selecting one opportunity for improvement from Element A. 4. Identifying and selecting a second opportunity for Improvement from Element A. 5. Taking collaborative action to address one identified opportunity for improvement from Element A. 6. Taking collaborative action to address a second identified opportunity for improvement from Element A **<u>Measuring Effectiveness</u>** The organization annually measures the effectiveness of improvement actions taken for: 1. The first opportunity in Element B. 2. The second opportunity in Element B.	

Standard	Delegated Activities	Retained by L.A. Care
Standards for Medical Record Documentation (DHCS)	Establishing medical record standards which require medical records to be maintained in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review, including: 1. Developing and distributing to practice sites: a. Policies and procedures for the confidentiality of medical records; b. Medical record documentation standards; c. Requirements for an organized medical record keeping system; d. Standards for the availability of medical records	

Standard	Delegated Activities	Retained by L.A. Care
Sub-Delegation of QI: Applicable L.A. Care Policy: QI-007 (NCQA QI 5)	**Sub-Delegation Agreement** **(LAC will ask Delegate of its sub-delegate during the annual audit)** The written sub-delegation agreement: 1. Is mutually agreed upon. 2. Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity. 3. Requires at least semiannual reporting by the sub-delegated entity to the delegate. 4. Describes the process by which the delegate evaluates the sub-delegated entity's performance. 5. Describes the process for providing member experience and clinical performance data to its delegates when requested. 6. Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **Predelegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the delegated entity evaluates sub-delegate capacity to meet NCQA requirements before sub-delegation begins. **Review of QI Program** For arrangements in effect for 12 months or longer, the delegate: 1. Annually reviews its sub-delegate's QI program. 2. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities. 3. Semiannually evaluates regular reports, as specified in the sub-delegation agreement **Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	
	POPULATION HEALTH MANAGEMENT	
PHM Strategy (NCQA PHM 1)	**Strategy Description** The strategy describes: 1. Goals and populations targeted for each of the four areas of focus. 2. Programs or Services offered to members. 3. Activities that are not direct member interventions,	

Standard	Delegated Activities	Retained by L.A. Care
	4. How member programs are coordinated. 5. How members are informed about available PHM programs. 6. How the organization promotes health equity. **Informing Members** The organization informs members eligible for programs that include interactive contact: 1. How members become eligible to participate 2. How to use program services. 3. How to opt in or opt out of the program	
Population Identification (NCQA PHM 2)	**Data Integration** The organization integrates the following data to use for population health management functions: 1. Medical and Behavioral claims or encounters 2. Pharmacy claim (Jul 1, 2021-Dec 31,2021) 3. Physician Administered Drugs (PAD) claim 4. Laboratory results 5. Health appraisal results 6. Electronic health records 7. Health Services programs within the organization 8. Advanced data sources **Population Assessment** The organization annually: 1. Assesses the characteristics and needs, including social determinants of health, of its member population. 2. Assesses the needs of child and adolescent members. 3. Assesses the needs of members with disabilities. 4. Assesses the needs of members with serious and persistent mental illness (SPMI). 5. Assesses the needs of members of racial or ethnic groups. 6. Assesses the needs of members with limited English proficiency. 7. Identifies and assesses the needs of relevant member subpopulations. **Activities and Resources** The organization annually uses the population assessment to: 1. Review and update its PHM activities to address member needs 2. Review and update its PHM resources to address member need 3. Review and update activities or resources to address health care disparities for at least one identified population. 4. Review community resources for integration into program offerings to address member needs.	

Standard	Delegated Activities	Retained by L.A. Care
	<u>Segmentation</u> 1. segments or stratifies its entire population into subset for targeted intervention. 2. Assesses for racial bias in its segmentation or stratification methodology.	
Delivery System Supports (NCQA PHM 3)	**<u>Practitioner or Provider Support</u>** The organization supports practitioners or providers in its network to achieve population health management goals by: 1. Sharing data 2. Offering certified shared-decision making aids 3. Providing practice transformation support to primary care practitioners 4. Providing comparative quality information on selected specialties 5. Providing comparative pricing information for selected services 6. One additional activity to support practitioners or providers in achieving PHM goals	**Value-Based Payment Arrangements** The organization demonstrates that it has a value-based payment (VBP) arrangement(s) and reports the percentages of total payments tied to VBP.
Wellness and Prevention (NCQA PHM 4)	**<u>Frequency of Health Appraisal Completion</u>** This standard is required for the first survey under NCQA guidelines. Plans are still required to maintain compliance with this standard. NCQA only removed this requirement to submit documentation for renewal surveys. The organization has the capability to administer a health appraisal (HA) annually. **<u>Topics of Self-Management Tools</u>** The organization offers self-management tools derived from available evidence, that provide members with information on at least the following wellness and health promotion areas: 1. Healthy weight (BMI) maintenance. 2. Smoking and tobacco cessation. 3. Encouraging physical activity. 4. Healthy eating. 5. Managing stress. 6. Avoiding at-risk drinking. 7. Identifying depressive symptoms.	
Complex Case Management (NCQA PHM 5)	**<u>Access to Case Management</u>** The organization has multiple avenues for members to be considered for complex case management services, including: 1. Medical management program referral 2. Discharge planner referral 3. Member or caregiver referral 4. Practitioner referral. **<u>Case Management Systems</u>**	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	The organization uses case management systems that support: 1. Evidence-based clinical guidelines or algorithms to conduct assessment and management; 2. Automatic documentation of the individual ID and date and time of action on the case when interaction with the member occurred; and 3. Automated prompts for follow-up as required by the case management plan. **Case Management Process** This standard is required for the first survey under NCQA guidelines. Plans are still required to maintain compliance with this standard. NCQA only removed this requirement to submit documentation for renewal surveys. The organization's complex case management procedures address the following: 1. Initial assessment of member health status, including condition-specific issues 2. Documentation of clinical history, including medications 3. Initial assessment of activities of daily living 4. Initial assessment of behavioral health status, including cognitive functions 5. Initial assessment of social determinants of health 6. Initial assessment of life planning activities 7. Evaluation of cultural and linguistic needs, preferences or limitations 8. Evaluation of visual and hearing needs, preferences or limitations 9. Evaluation of caregiver resources and involvement 10. Evaluation of available benefits 11. Evaluation of community resources 12. Development of an individualized case management plan, including prioritized goals and considers member and caregiver goals, preferences and desired level of involvement in the case management plan 13. Identification of barriers to the member meeting goals or complying with the case management plan 14. Facilitation of member referrals to resources and follow-up process to determine whether members act on referral 15. Development of a schedule for follow-up and communication with the member 16. Development and communication of self-management plans.	

Standard	Delegated Activities	Retained by L.A. Care
	17. A process to assess members' progress against case management plans for members. **<u>Initial Assessment</u>** An NCQA review of a sample of the organization's complex case management files demonstrates that the organization follows its documented processes for: 1. Initial assessment of members' health status, including condition-specific issues 2. Documentation of clinical history, including medications 3. Initial assessment of activities of daily living (ADL) 4. Initial assessment of behavioral health status, including cognitive functions 5. Initial assessment of social determinants of health 6. Evaluation of cultural and linguistic needs, preferences or limitations 7. Evaluation of visual and hearing needs, preferences or limitations 8. Evaluation of caregiver resources and involvement 9. Evaluation of available benefits 10. Evaluation of available community resources 11. Assessment of life planning activities. 12. Beginning the assessment for at least one factor within 30 calendar days of identifying a member for complex case management. **<u>Case Management Ongoing Management</u>** The NCQA review of a sample of the organization's case management files that demonstrates the Plan Partner follows its documented processes for: 1. Development of case management plans, including prioritized goals, that take into account member and caregiver goals, preferences and desired level of involvement in the complex case management program 2. Identification of barriers to meeting goals and complying with the plan 3. Development of a schedule for follow-up and communication with members. 4. Development and communication of member self-management plans. 5. Assessment of progress against case management plans and goals and modification as needed.	

Standard	Delegated Activities	Retained by L.A. Care
Population Health Management Impact (NCQA PHM 6)	**<u>Measuring Effectiveness</u>** At least annually, the organization conducts a comprehensive analysis of the impact of its PHM strategy that includes the following: 1. Quantitative results for relevant clinical, cost/utilization and experience measures. 2. Comparison of results with a benchmark or goal. 3. Interpretation of results. **<u>Improvement and Action</u>** The organization uses results from the PHM impact analysis to annually: 1. Identify opportunities for improvement. 2. Act on one opportunity for improvement.	
Sub-Delegation of PHM (NCQA PHM 7)	**<u>Sub-Delegation Agreement</u>** **(LAC will ask Delegate of its sub-delegate during the annual audit)** The written sub-delegation agreement: 1. Is mutually agreed upon 2. Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity 3. Requires at least semiannual reporting by the sub-delegated entity to the delegate 4. Describes the process by which the delegate evaluates the sub-delegated entity's performance 5. Describes the process for providing member experience and clinical performance data to its delegates when requested. 6. Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **<u>Predelegation Evaluation</u>** For new sub-delegation agreements initiated in the look-back period, the delegated entity evaluates sub-delegate capacity to meet NCQA requirements before sub-delegation begins. **<u>Review of PHM Program</u>** For arrangements in effect for 12 months or longer, the delegate: 1. Annually reviews its sub-delegate's PHM program 2. Annually audits complex case management files against NCQA standards for each year that sub-delegation has been in effect, if applicable 3. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities	

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	4. Semiannually evaluates regular reports, as specified in the sub-delegation agreement **<u>Opportunities for Improvement</u>** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	
	NETWORK MANAGEMENT	
Availability of Practitioners (NCQA NET 1)	**<u>Cultural Needs and Preferences</u>** The organization: 1. Assessing the cultural, ethnic, racial, and linguistic needs of members 2. Adjusts the availability of practitioners within its network if necessary. **<u>Practitioners Providing Primary Care</u>** To evaluate the availability of practitioners who provide primary care services, including general medicine or family practice, internal medicine and pediatrics, the organization: 1. Establishes measurable standards for the number of each type of practitioners providing primary care 2. Establishes measurable standards for the geographic distribution of each type of practitioner providing primary care. 3. Annually analyzes performance against the standards for the number of each type of practitioner providing primary care 4. Annually analyzes performance against the standards for the geographic distribution of each type of practitioner providing primary care. **<u>Practitioners Providing Specialty Care</u>** To evaluate the availability of specialists in its delivery system, the organization: 1. Defines the types of high-volume and high-impact specialists 2. Establishes measurable standards for the number of each type of high volume specialists. 3. Establishes measurable standards for the geographic distribution of each type of high-volume specialists. 4. Establishes measureable standards for the geographic distribution of each type of high-impact specialist. 5. Analyzes its performance against the established standards at least annually.	

Standard	Delegated Activities	Retained by L.A. Care
	<u>Practitioners Providing Behavioral Healthcare</u> To evaluate the availability of high-volume behavioral healthcare practitioners in its delivery system, the organization: 1. Defines the types of high-volume behavioral healthcare practitioners 2. Establishes measureable standards for the number of each type of high-volume behavioral healthcare practitioner 3. Establishes measureable standards for the geographic distribution of each type of high-volume behavioral healthcare practitioner 4. Analyzes performance against standards annually	
Accessibility of Services (NCQA NET 2)	**<u>Access to Primary Care</u>** Using valid methodology, the organization collects and performs an annual analysis of data to measure its performance against its standards for access to: 1. Regular and routine care appointments; 2. Urgent care appointments; 3. After-hours care **<u>Access to Behavioral Healthcare</u>** Using valid methodology, the organization annually collects and analyzes data to evaluate access to appointments for behavioral healthcare for: 1. Care for a non-life-threatening emergency within 6 hours 2. Urgent care within 48 hours 3. Initial visit for routine care within 10 business days 4. Follow-up routine care. **<u>Access to Specialty Care</u>** Using valid methodology, the organization annually collects and analyzes data to evaluate access to appointments for: 1. High-volume specialty care 2. High-impact specialty care	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
Assessment of Network Adequacy (NCQA NET 3)	<u>**Assessment of Member Experience Accessing the Network**</u> The organization annually identifies gaps in networks specific to geographic areas or types of practitioners or providers by: 1. Using analysis results related to member experience with network adequacy for nonbehavioral healthcare services from ME 7, Element C and Element D. 2. Using analysis results related to member experience with network adequacy for behavioral healthcare services from ME 7, Element C and Element E. 3. Compiling and analyzing non-behavioral requests for and utilization of out-of-network services 4. Compiling and analyzing behavioral healthcare requests for and utilization of out-of-network services. <u>**Opportunities to Improve Access to Nonbehavioral Healthcare Services**</u> The organization annually: 1. Prioritizes opportunities for improvement from analyses of availability (NET 1, Elements A, B and C), accessibility (NET 2, Elements A and C) and member experience accessing the network (NET 3, Element A, factors 1 and 3). 2. Implements interventions on at least one opportunity, if applicable. 3. Measures the effectiveness of interventions, if applicable. <u>**Opportunities to Improve Access Behavioral Healthcare Services**</u> The organization annually: 1. Prioritizes opportunities for improvement identified from analyses of availability (NET 1, Elements A and D), accessibility (NET 2, Element B) and member experience accessing the network (NET 3, Element A, factors 2 and 4). 2. Implements interventions on at least one opportunity, if applicable. 3. Measures the effectiveness of the interventions, if applicable.	

Standard	Delegated Activities	Retained by L.A. Care
Continued Access to Care (NCQA NET 4)	**Notification of Termination** Refer to Utilization Management Delegated Activities Section **Continued Access to Practitioners** Refer to Utilization Management Delegated Activities Section Note: Review process is managed by L.A. Care Utilization Management team.	
Physician and Hospital Directories (NCQA NET 5)	**<u>Physician Directory Data</u>** The organization has a web-based physician directory that includes the following physician information: 1. Name 2. Gender 3. Specialty 4. Hospital affiliations 5. Medical group affiliations 6. Board certification 7. Accepting new patients 8. Language spoken by the physician or clinical staff 9. Office locations and phone numbers **<u>Physician Directory Updates</u>** The organization updates its web-based physician directory within 30 calendar days of receiving new information from the network physician. **<u>Assessment of Physician Directory Accuracy</u>** Using valid methodology, the organization performs an annual evaluation of its physician directories for: 1. Accuracy of office locations and phone numbers 2. Accuracy of hospital affiliations 3. Accuracy of accepting new patients 4. Awareness of physician office staff of physician's participation in the organization's networks. **<u>Identifying and Acting on Opportunities</u>** Based on results of the analysis performed in Element C, at least annually the organization: 1. Identifies opportunities to improve the accuracy of the information in its physician directories. 2. Takes action to improve the accuracy of the information in its physician directory.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	Searchable Physician Web Based Directory The organization's web-based physician directory includes search functions with instructions for finding the following physician information: 1. Name 2. Gender 3. Specialty 4. Hospital affiliations 5. Medical group affiliations 6. Accepting new patients 7. Languages spoken by the physician or clinical staff 8. Office locations **Hospital Directory Data** The organization has a web-based hospital directory that includes the following: 1. Hospital name 2. Hospital location and phone number 3. Hospital accreditation status 4. Hospital quality data from recognized sources **Hospital Directory Updates** The organization updates its web-based hospital directory information within 30 calendar days of receiving new information from the network hospital. **Searchable Hospital Web-Based Directory** The organization's web-based directory includes search functions for specific data types and instructions for searching for the following information: 1. Hospital name 2. Hospital location **Usability Testing** The organization evaluates its web-based physician and hospital directories for understandability and usefulness to members and prospective members at least every three years, and considers the following: 1. Reading level 2. Intuitive content organization 3. Ease of navigation 4. Directories in additional languages, if applicable to the membership	

Standard	Delegated Activities	Retained by L.A. Care
	Availability of Directories The organization makes web-based physician and hospital directory information available to members and prospective members through alternative media, including: 1. Print 2. Telephone	
Sub-Delegation of NET (NCQA NET 6)	**Sub-Delegation Agreement** The written sub-delegation agreement: 1. Is mutually agreed upon 2. Describes the sub-delegated activities and the responsibilities of the delegate and the sub-delegated entity 3. Requires at least semiannual reporting by the sub-delegated entity to the delegate 4. Describes the process by which the delegate evaluates the sub-delegated entity's performance 5. Describes the process for providing member experience and clinical performance data to its delegates when requested. 6. Describes the remedies available to the delegate if the sub-delegated entity does not fulfill its obligations, including revocation of the sub-delegation agreement **Predelegation Evaluation** For new sub-delegation agreements initiated in the look-back period, the organization evaluated sub-delegate capacity to meet NCQA requirements before sub-delegation begins. **Review of Sub-Delegated Activities** For arrangements in effect for 12 months or longer, the delegate: 1. Annually reviews its sub-delegate's network management procedures 2. Annually evaluates sub-delegate performance against NCQA standards for sub-delegated activities 3. Semiannually evaluates regular reports, as specified in the sub-delegation agreement **Opportunities for Improvement** For sub-delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that sub-delegation has been in effect, the delegate identified and followed up on opportunities for improvement, if applicable.	

Standard	Delegated Activities	Retained by L.A. Care
	UTILIZATION MANAGEMENT	
Continued Access to Care and Continuity and Coordination of Medical Care (NCQA NET 4 and QI 3)	**<u>Notification of Termination (NET4)</u>** The organization notifies members affected by the termination of a practitioner or practice group in general, family or internal medicine or pediatrics, at least thirty (30) calendar days prior to the effective termination date and helps them select a new practitioner. **<u>Continued Access to Practitioners</u>** If a practitioner's contract is discontinued the organization allows affected members continued access to practitioner, as follows: 1. Continuation of treatment through the current period of active treatment or for up to ninety (90) calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition. 2. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy. **<u>Transition to Other Care</u>** The organization helps with members' transition to other care when their benefits end, if necessary.	
Program Structure (NCQA UM 1)	**<u>Written Program Description</u>** The organization's UM program description includes the following: 1. A written description of the program structure 2. The behavioral healthcare aspects of the program 3. Involvement of a designated senior physician in UM program implementation 4. Involvement of a designated behavioral healthcare practitioner in the implementation of the behavioral healthcare aspects of the UM program. 5. The program scope and processes used to make determinations of benefit coverage and medical necessity. 6. Information sources used to determine benefit coverage and medical necessity. **<u>Annual Evaluation</u>** The organization annually evaluates and updates the UM program, as necessary.	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.
Clinical Criteria for UM Decisions (NCQA UM 2)	**<u>UM Criteria</u>** The organization: 1. Has written UM decision-making criteria that are objective and based on medical evidence 2. Has written policies for applying the criteria based on individual needs	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates'

Standard	Delegated Activities	Retained by L.A. Care
	3. Has written policies for applying the criteria based on an assessment of the local delivery system 4. Involves appropriate practitioners in developing, adopting and reviewing criteria. 5. Annually reviews UM criteria and the procedures for applying them based on individual needs and assessment of the local delivery system, and updating as necessary. **Availability of Criteria** The organization: 1. States in writing how practitioners can obtain the UM criteria 2. Makes the criteria available to practitioners upon request. **Consistency in Applying Criteria** At least annually, the organization: 1. Evaluates the consistency with which health care professionals involved in UM apply criteria in decision making 2. Acts on opportunities to improve consistency, if applicable.	activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.
Communication Services (NCQA UM 3)	**Access to Staff** The organization provides the following communication services for members and practitioners: 1. Staff are available at least eight (8) hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues 2. Staff can receive inbound communication regarding UM issues after normal business hours 3. Staff are identified by name, title, and organization name when initiating or returning calls regarding UM issues 4. TDD/TTY services for members who need them 5. Language assistance for members to discuss UM issues.	
Appropriate Professionals (NCQA UM 4)	**Licensed health Professionals** The organization has written procedures: 1. Requiring appropriately licensed professionals to supervise all medical necessity decisions 2. Specifying the type of personnel responsible for each level of UM decision-making. **Use of Practitioners for UM Decisions** The organization has a written job description with qualifications for practitioners who review denials of care based on medical necessity. Practitioners are required to have: 1. Education, training and professional experience in medical or clinical practice	Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

Standard	Delegated Activities	Retained by L.A. Care
	2. A current license to practice or an administrative license to review UM cases without restriction. **<u>Practitioner Review of Nonbehavioral healthcare Denials</u>** The organization uses a physician, or other healthcare professional as appropriate, reviews any non-behavioral healthcare denial of coverage based on medical necessity. **<u>Practitioner Review of Behavioral Healthcare Denials</u>** The organization uses that a physician or appropriate behavioral healthcare practitioner, to review any behavioral healthcare denial of care based on medical necessity. **<u>Practitioner Review of Pharmacy Denials</u>** The organization uses a physician or a pharmacist reviews pharmacy denials based on medical necessity. Note: This only applies to pharmaceuticals (Physician Administered Drugs) covered under the medical benefit. **<u>Use of Board Certified Consultants</u>** The organization: 1. Has written procedures for using board certified consultants to assist in making medical necessity determinations 2. Provides evidence that it uses board-certified consultants for medical necessity determinations	
Timeliness of UM Decisions (NCQA UM 5)	**<u>Notification of Nonbehavioral Decisions</u>** The organization adheres to the following time frames for notification of non-behavioral healthcare UM Decisions: 1. N/A Marketplace 2. For Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request. 3. For Medicaid urgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request. 4. For Medicaid nonurgent preservice decisions the organization gives electronic or written notification of the decision to members and practitioners within 14 calendar days of the request.	

Standard	Delegated Activities	Retained by L.A. Care
	5. For Medicaid postservice decisions the organization gives electronic or written notification of the decision to members and practitioners within 30 calendar days of the request. 6. For postservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 30 calendar days of the request. **<u>Notification of Behavioral Healthcare Decisions</u>** The organization adheres to the following time frames for notification of behavioral healthcare UM decisions: 1. N/A (Marketplace) 2. For Medicaid urgent concurrent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 72 hours of the request. 3. For Medicaidurgent preservice decisions, the organization gives electronic or written notification of the decision to members and practitioners within 15 calendar days of the request. 4. For Medicaid nonurgent preservice decisions the organization gives electronic or written notification of the decision to members and practitioners within 14 calendar days of the request. 5. For Medicaid post service decisions, the organization gives electronic or written notification of the decision to practitioners and members within 30 calendar days of the request. **<u>Notification of Pharmacy Decisions</u>** The organization adheres to the following time frames for notifying members and practitioners of pharmacy UM decisions: 1. For Medicaid urgent concurrent decisions electronic or written notification of the decision to members and practitioners within 24 hours of the request. 2. For Medicaid urgent preservice decisions electronic or written notification of the decision to members and practitioners within 72 hours of the request. 3. For Medicaid nonurgent preservice decisions electronic or written notification of the decision to members and practitioners within 15 calendar days of the request.	

Standard	Delegated Activities	Retained by L.A. Care
	4. For Medicaid postservice decisions electronic or written notification of the decision to members and practitioners within 30 calendar days of the request. 5. N/A (Medicare and Marketplace) **<u>Timeliness Report</u>** The organization monitors and submits a report for timeliness of: 1. 1. Non-behavioral UM decision making 2. 2. Notification of non-behavioral UM decisions 3. 3.Behavioral UM decision making 4. 4.Notification of behavioral UM decisions 5. Pharmacy UM decision making 6. Notification of pharmacy UM decisions Note: This only applies to pharmaceuticals (Physician Administered Drugs) covered under the medical benefit. ***Note: L.A. Care and Plan must adhere to the applicable standards identified in the California Health and Safety Code and DHCS Contract, all current regulatory notifications (such as APLs), as well as the most recent NCQA HP Standards***	

Clinical Information (NCQA UM 6)	**<u>Relevant Information for Nonbehavioral Healthcare Decisions</u>** There is documentation that the organization gathers relevant clinical information consistently to support nonbehavioral healthcare UM decision making. **<u>Relevant Information for Behavioral Healthcare Decisions</u>** There is documentation that the organization gathers relevant clinical information consistently to support behavioral healthcare UM decision making. **<u>Relevant Information for Pharmacy Decisions</u>** The organization documents that it consistently gathers relevant information to support pharmacy UM decision making. Note: This only applies to pharmaceuticals (Physician Administered Drugs) covered under the medical benefit.	
Denial Notices (NCQA UM 7)	**<u>Discussing a Denial With a Reviewer</u>** The organization gives practitioners the opportunity to discuss nonbehavioral healthcare UM denial	

	decisions with a physician or other appropriate reviewer. **<u>Written Notification of Nonbehavioral healthcare Denials</u>** The organization's written notification of each non-behavioral denials, provided to members and their treating practitioners contains the following information: 1. The specific reason for denial, in easily understandable language 2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based 3. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision is based, upon request. **<u>Written Notification of Nonbehavioral Healthcare Notice of Appeal Rights/Process</u>** The organization's written non-behavioral denial notification to members and their treating practitioners contains the following information: 1. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal 2. An explanation of the appeal process, including the members' rights to representation and appeal time frames 3. A description of the expedited appeal process for urgent pre-service or urgent concurrent denials 4. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care. **<u>Discussing a Behavioral Healthcare Denial With a Reviewer</u>** The organization provides practitioners with the opportunity to discuss any behavioral healthcare UM denial decisions with a physician appropriate behavioral healthcare reviewer or pharmacist reviewer. **<u>Written Notification of Behavioral Healthcare Denials</u>** The organization's written notification of behavioral healthcare denials that it provided to members and their treating practitioners contains: 1. The specific reasons for the denial, in easily understandable language.	

	2. A reference to the benefit provision, guideline, protocol or similar criterion on which the denial decision is based 3. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or similar criterion on which the denial decision was based, upon request **<u>Written Notification of Behavioral Healthcare Notice of Appeal Rights/Process</u>** The organization's written notification of behavioral healthcare denials which it provides to members and their treating practitioners contains the following information: 1. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal 2. An explanation of the appeal process, including members' right to representation and appeal time frames 3. A description of the expedited appeal process for urgent pre-service or urgent concurrent denials 4. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care. **<u>Discussing a Pharmacy Denial with a Reviewer</u>** The organization gives practitioners the opportunity to discuss pharmacy UM denial decisions with a physician or pharmacist **<u>Written Notifications of Pharmacy Denials</u>** The organization's written notification of pharmacy denials to members and their treating practitioners contains the following information: 1. The specific reasons for the denial in language that is easy to understand. 2. A reference to the benefit provision guidelines protocol or similar criterion on which the denial decision is based. 3. A statement that members can obtain a copy of the actual benefit provision guideline protocol or similar criterion on which the denial decision was based, upon request. **<u>Pharmacy Notice of Appeals Rights/Process</u>** The organization's written notification of pharmacy denials to members and their treating practitioners contains the following information: 1. A description of appeal rights including the member's right to submit written comments documents or other information relevant to the appeal.	

	2. An explanation of the appeal process including the member's right to representation and the appeal time frames. 3. A description of the expedited appeal process for urgent preservice or urgent concurrent denials. 4. Notification that expedited external review can occur concurrently with the internal appeal process for urgent care Note: This only applies to pharmaceuticals (Physician Administered Drugs) covered under the medical benefit.	
Policies for Appeals (NCQA UM 8)	**<u>Internal Appeals</u>** The organization's written policies and procedures for registering and responding to written internal appeals include the following: 1. Allowing at least sixty (60) calendar days after notification of the denial for the member to file the appeal. 2. Documenting the substance of the appeal and any actions taken 3. Full investigation of the substance of the appeal, including any aspects of clinical care involved 4. The opportunity for the member to submit written comments, documents or other information relating to the appeal 5. Appointment of a new person to review an appeal, who was not involved in the initial determination and who is not the subordinate of any person involved in the initial determination 6. Appointment of at least one person to review an appeal who is a practitioner in the same or similar specialty The decision for a pre-service appeal and notification to the member within 30 calendar days of receipt of the request. 7. The decision for a post-service appeal and notification to the member within 60 calendar days of receipt of the request. For Medicaid only, decisions for postservice appeals and notifications to members must be within 30 calendar days of receipt of the request. 8. The decision for an expedited appeal and notification to the member within 72 hours of receipt of the request. 9. Notification to the member about further appeal rights. 10. Referencing the benefit provision, guideline, protocol or other similar criterion on which the appeal decision is based 11. Giving members reasonable access to and copies of all documents relevant to the appeal, free of charge, upon request.	Members have the option to appeal directly to L.A. Care. Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

	12. Including a list of titles and qualifications, including specialties, of individuals participating in the appeal review 13. Allowing an authorized representative to act on behalf of the member 14. Providing notices of the appeals process to members in a culturally and linguistically appropriate manner. 15. Continued coverage pending the outcome of an appeal.	
Appropriate Handling of Appeals (NCQA UM 9)	**Preservice and Postservice Appeals** An NCQA review of the organization's appeal files indicates that they contain the following information: 1. Documenting the substance of appeals 2. Investigating appeals 3. Appropriate response to the substance of the appeal. **Timeliness of the Appeal Process** Timeliness of the organization's preservice, postservice and expedited appeal processes is within the specified time frames: 1. For preservice appeals, the organization gives electronic or written notification within thirty (30) calendar days of receipt of the request 2. For Medicaid postservice appeals, the organization gives electronic or written notification within thirty (30) calendar days of receipt of the request 3. For expedited appeals, the organization gives electronic or written notification within seventy-two (72) hours of receipt of the request. **Appeal Reviewers** The organization provides non-subordinate reviewers who were not involved in the previous determination and same or similar specialist review, as appropriate. **Notification of Appeal Decision/Rights** An NCQA review of the organization's internal appeal files indicates notification to members of the following: 1. Specific reasons for the appeal decision in easily understandable language 2. A reference to the benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based 3. Notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based, upon request.	Members have the option to appeal directly to L.A. Care. Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

	4. Notification that the member is entitled to receive reasonable access to and copies of all documents free of charge upon request. 5. The list of titles and qualifications, including specialties, of individuals participating in the appeal review 6. A description of the next level of appeal, either within the organization or to an independent external organization, as applicable, along with relevant written procedures. **Final Internal and External Appeal Files** N/A **Appeals Overturned by the IRO** N/A	
Evaluation of New Technology (NCQA UM 10)		**Written Process** Evaluates the inclusion of new technology and the new application of existing technology in the benefits plan, including medical and behavioral health procedures, physician administered drugs effective January 2022 and devices. This element is Not Applicable for Medicaid product lines if the state mandates all benefits and new technology determinations. L.A. Care will provide the state's language. **Description of the Evaluation Process** This element is Not Applicable for Medicaid product lines if the state mandates all benefits and new technology determinations. L.A. Care will produce documentation that demonstrates this.
Procedures for Pharmaceutical Management (NCQA UM 11)	**Pharmaceutical Management Procedures** The organization's policies and procedures for pharmaceutical management include the following: 1. The criteria used to adopt pharmaceutical management procedures 2. A process that uses clinical evidence from appropriate external organizations 3. A process to include pharmacists and appropriate practitioners in the development of procedures	

	4. A process to provide procedures to practitioners annually and when it makes changes. **Pharmaceutical Restrictions/Preferences** Annually and after updates, the organization communicate to members and prescribing practitioners: 1. A list of pharmaceuticals including restrictions, updates and preferences to post on its Internet website and update that posting with changes on a monthly basis (SB1052) 2. How to use the pharmaceutical management procedures 3. An explanation of limits or quotas 4. How prescribing practitioners must provide information to support an exception request 5. The process for generic substitution, therapeutic interchange and step-therapy protocols. **Pharmaceutical Patient Safety Issues** The organization's pharmaceutical procedures include: 1. Identifying and notifying members and prescribing practitioners affected by Class II recalls or voluntary drug withdrawals from the market for safety reasons within thirty (30) calendar days of the FDA notification 2. An expedited process for prompt identification and notification of members and prescribing practitioners affected by a Class I recall. **Reviewing and Updating Procedures** With the participation of physicians and pharmacists the organization annually: 1. Reviews the procedures 2. Reviews the list of pharmaceuticals 3. Updates the procedures as appropriate 4. Updates the list of pharmaceuticals, as appropriate, and 5. Post the list with changes on its Internet website on a monthly basis. (SB1052) **Considering Exceptions** The organization has exceptions policies and procedures that describe the process for: 1. Making exception requests based on medical necessity 2. Obtaining medical necessity information from prescribing practitioners 3. Using appropriate pharmacists and practitioners to consider exception requests 4. Timely handling of request	

	5. Communicating the reason for denial and explanation of the appeal process when it does not approve an exception request. Note: This only applies to pharmaceuticals (Physician Administered Drugs) covered under the medical benefit.	
UM System Controls (NCQA UM 12)	**UM Denial System Controls** The organization has policies and procedures describing its system controls specific to UM denial notification dates that: 1. Define the date of receipt consistent with NCQA requirements. 2. Define the date of written notification consistent with NCQA requirements. 3. Describe the process for recording dates in systems. 4. Specify titles or roles of staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate. 5. Specify how the system tracks modified dates. 6. Describe system security controls in place to protect data from unauthorized modification. 7. Describe how the organization monitors its compliance with the policies and procedures in factors 1–6 at least annually and takes appropriate action, when applicable. **UM Denial System Controls Oversight** **At least annually, the organization demonstrates that it monitors compliance with its UM denial controls, as described in Element A, factor 7, by:** **1. Identifying all modifications to receipt and decision notification dates that did not meet the organization's policies and procedures for date modifications.** **2. Analyzing all instances of date modifications that did not meet the organization's policies and procedures for date modifications.** **3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters.**	
Sub-Delegation of UM (NCQA UM 13)	**Sub-Delegation Agreement** The written delegation agreement: 1. Is mutually agreed upon 2. Describes the delegated activities and the responsibilities of the organization and the delegated entity.	

	3. Requires at least semiannual reporting by the delegated entity to the organization. 4. Describes the process by which the organization evaluates the delegated entity's performance. 5. Describes the process for providing member experience and clinical performance data to its delegates when request. 6. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations including revocation of the delegation agreement. **Predelegation Evaluation** For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began. **Review of the UM Program** For arrangements in effect for 12 months or longer, the organization: 1. Annually reviews its delegate's UM program. 2. Annually audits UM denials and appeals files against NCQA standards for each year that delegation has been in effect. 3. Annually evaluates delegate performance against NCQA standards for delegated activities. 4. Semiannually evaluates regular reports, as specified in Element A. 5. Annually monitors the delegate's UM denial and appeal system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures at least annually. 6. Annually acts on all findings from factor 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters. **Opportunities for Improvement** For delegation arrangements that have been in effect for more than 12 months at least once in each of the past 2 years the organization identified and followed up on opportunities for improvement if applicable.	
	CREDENTIALING	

Credentialing Policies (NCQA CR 1) DMHC, DHCS, CMS	The Delegate has a well-defined credentialing and recredentialing process for evaluating licensed independent practitioners to provide care to its members by developing and implementing credentialing policies and procedures which specify: 1. The types of practitioners to credential and re-credential, to also include all administrative physician reviewers responsible for making medical decisions. 2. The verification sources used. 3. The criteria for credentialing and re-credentialing. 4. The policies must explicitly define the process and criteria used for making credentialing and re-credentialing decisions. 5. The process for managing credentialing files that meet Delegate's established criteria. Policies must describe the process it uses to determine and approve clean files or the Delegate may present all files to the Credentialing Committee, including clean files, or it may designate approval authority to the medical director or to an equally qualified practitioner. 6. The process for requiring that credentialing and recredentialing are conducted in a nondiscriminatory manner. Policies must specify that the Delegate does not base credentialing decisions on an applicant's race, ethnic/national identity, gender, age, sexual orientation or patient type in which the practitioner specializes. Has a process for preventing and monitoring discriminatory practices and monitors the credentialing and recredentialing processes for discriminatory practices, at least annually and maintain a heterogeneous credentialing committee to sign a statement affirming that they do not discriminate when they make decisions. 7. The process for notifying practitioners about any information obtained during the credentialing process that varies substantially from the information provided to Delegate by the practitioner. 8. The process to ensure that practitioners are notified of initial and recredentialing decisions within sixty (60) calendar days of the committee's decision. 9. The medical director or other designated physician's direct responsibility for, and participation in, the credentialing program.	L.A. Care retains the right based on quality issues to approve, suspend and terminate individual practitioners, providers and sites at all times. Although L.A. Care delegates the noted activities, it remains responsible for the procedural components of its Programs; including review, evaluation and approval of its Delegates' credentialing activities. L.A. Care must also provide evidence that its Delegates adhere to the standards delegated by L.A. Care.

	10. The process for securing the confidentiality of all information obtained in the credentialing process except as otherwise provided by law. 11. The process for confirming that listings in practitioner directories and other materials for members are consistent with credentialing data including education training board certification and specialty. The organization notifies practitioners about: 1. The right of practitioners to review information submitted to support their credentialing or recredentialing application 2. The right of practitioners to correct erroneous information and: • The timeframe for making corrections. • The format for submitting corrections. • The person to whom the corrections must be submitted. 3. The right of practitioners to be informed of the status of their credentialing or re-credentialing application, upon request. The Delegate must have policies and procedures for its CR system security controls. If the Organization outsources storage of credentialing information to an external entity, the contract between the Delegate and the external entity will be part of the oversight review. The organization's credentialing process describes: 1. How primary source verification information is received, dated and stored. 2. How modified information is tracked and dated from its initial verification. 4. Titles or roles of staff who are authorized to review, modify and delete information, and circumstances when modification or deletion is appropriate. 5. The security controls in place to protect the information from unauthorized modification. 6. How the organization monitors its compliance with the processes and procedures in factors 1–4 at least annually and takes appropriate action when applicable.	
(DHCS APL 19-004)	**Medi-Cal FFS Enrollment** Developing and implementing policies and procedures for Medi-Cal enrollment. Policy must clearly specify enrollment process including, but not limited to:	

	1. All practitioners that have a FFS enrollment pathway must enroll in the Medi-Cal program.process for ensuring and verifying Medi-Cal enrollment prior to contracting. 2. The process for practitioners whose enrollment application is in process. 3. The process for monitoring between recredentialing cycles to validate continued enrollment. 4. Process for practitioners not currently enrolled in the Medi-Cal program. 5. Process for practitioners deactivated, suspended or denied from the Medi-Cal program. During the annual oversight review, the Delegate is subject to a CAP (Corrective Action Plan) if their documented process does not align with policies. In addition, if the Delegate demonstrates reoccurring deficiencies that were identified in previous audits, the Delegate is subject to additional point deductions.	
Credentialing Committee (NCQA CR 2) DHCS, DMHC, CMS	Designating a credentialing committee that uses a peer review process to make recommendations regarding credentialing and recredentialing decisions such that: The committee: a. Includes representation from a range of participating practitioners to provide advice and expertise for credentialing decisions. b. Has the opportunity to review the credentials of all practitioners being credentialed or re-credentialed who do not meet Delegate's established criteria and to offer advice, which Delegate considers appropriate under the circumstances. c. The Medical Director, designated physician or credentialing committee reviews and approves files that meet the Delegate's established criteria.	
Credentialing Verification (NCQA CR 3) DHCS, DMHC, CMS	Primary source verification and credentialing and recredentialing decision-making, which includes verification of information to ensure that practitioners have the legal authority and relevant training and experience to provide quality care, within the NCQA prescribed time limits, through primary or other NCQA-approved sources prior to credentialing and recredentialing by: Verifying that the following are within the prescribed time limits: 1. Current, valid license to practice (develop a process to ensure providers licenses are kept current at all times).	

	2. A valid DEA or CDS, with schedules 2 thru 5, if applicable; or the Delegate has a documented process for practitioners: • Allowing a practitioner with a valid DEA certificate to write all prescriptions for a practitioner with a pending DEA certificate. • Require an explanation from a qualified practitioner who does not prescribe medications and provide arrangements for the practitioner's patients who need prescriptions for medications. 3. Verification of the highest of the following three levels of education and training obtained by the practitioners as appropriate: • Board certification if practitioner stated on the application that he/she is board certified, as well as expiration date of certification. • Completion of a residency program. • Graduation from medical or professional school. 4. Work history. 5. Current malpractice insurance coverage ($1 million/$3 million). 6. A history of professional liability claims that resulted in settlements or judgments paid on behalf of the practitioner. 7. Clinical Privileges in good standing at a Plan contracted facility designated by the physician as the primary admitting facility. 8. Current, valid FSR/MRR of primary care physician (PCP) offices within 3 years prior to credentialing decision. 9. CLIA Certifications, if applicable. 10. NPI number. 11. Medi-Cal FFS enrollment. All certifications and expiration dates must be made part of the practitioner's file and kept current. The Delegate must notify L.A. Care immediately when a practitioner's license has expired for removal from the network.	
CR Sanction Information (NCQA CR 3) DHCS, DMHC, CMS	Primary source verification and credentialing and recredentialing decision-making, which includes verifying, within the NCQA prescribed time limits, through primary or other NCQA-approved sources, the following prior to credentialing and recredentialing.	

	a. State sanctions, restrictions on licensure, or limitations on scope of practice. b. Medicare and Medicaid sanctions. c. *Medicare Opt-out. d. SAM. e. CMS Preclusion. The Delegate must notify L.A. Care immediately when practitioners are identified on any sanctions or reports for removal from the network.	
CR Application and Attestation (NCQA CR 3) DHCS, DMHC, CMS	Applications for credentialing and recredentialing include the following: a. Reasons for inability to perform the essential functions of the position, with or without accommodation. b. Lack of present illegal drug use. c. History of loss of license and felony convictions. d. History of loss or limitation of privileges or disciplinary action. e. Current malpractice insurance coverage. f. Current and signed attestation confirming the correctness and completeness of the application.	
Re-credentialing Cycle Length (NCQA CR 4) DHCS, DMHC, CMS	Recredentialing all practitioners at least every 36 months. For PCPs only, must confirm provider has a valid FSR at least every 36 months as part of the recredentialing process.	
CR Ongoing Monitoring and Interventions (NCQA CR 5) DHCS, DMHC, CMS	Developing and implementing policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues and takes appropriate action against practitioners when it identifies occurrences of poor quality between recredentialing cycles by: 1. Collecting and reviewing Medicare and Medicaid sanctions. 2. Collecting and reviewing sanctions or limitations on licensure. 3. Collecting and reviewing complaints. 4. Collecting and reviewing information from identified adverse events. 5. Implementing appropriate interventions when delegate identifies instances of poor quality. a. The Delegate's Credentialing committee may vote to flag a practitioner for ongoing monitoring. b. The Delegate must make clear the types of monitoring it imposes, the timeframe used, the intervention, and the outcome, which must be fully demonstrated in the Delegate's credentialing committee minutes.	Upon notification of any Adverse Event, L.A. Care will notify the Delegate of their responsibility with respect to delegation of credentialing/re-credentialing activity. The notification will clearly delineate what is expected from the Adverse Event that has been identified. The notice will include, but is not limited to: a. Requesting what actions will be taken by the Delegate. b. What type of monitoring is being performed. c. What interventions are being implemented including closing panel, moving members, or removal of practitioner from the network. d. The notification will include a timeframe for responding to L.A. Care to ensure L.A. Care's members receive the highest level of quality care.

	c. The Delegate's credentialing committee can: • Request a practitioner be placed on a watch list. Any list must be clearly defined and monitored. • Request that the practitioner demonstrate compliance with probation that has been imposed by the State and monitor completion. • Impose upon the practitioner to demonstrate steps they have taken to improve processes and/or chart review, if applicable. d. Delegated entities who fail to comply with the requested information within the specified timeframe are subject to sanctions as described in L.A. Care's policies and procedures. e. The Plan will clearly delineate what is expected from the Delegate regarding the Adverse Event that has been identified. The notification may include performing the following: • Requesting what action will be taken by the Delegate. • What type of monitoring is being performed. • What interventions are being implemented, including closing panel, moving members, or removal of practitioner from the network. • The notification will include a timeframe for responding to L.A. Care to ensure L.A. Care members receive the highest level of quality care. 6. In the event that the Delegate fails to respond as required, L.A. Care will perform the oversight functions of the Adverse Event and the Delegate will be subject to L.A. Care's credentialing committee's outcome of the adverse events. 7. The Delegate must notify L.A. Care immediately when practitioners are identified on any sanctions or reports for removal from the network. 8. The above are samples, but not limited to, the steps the Delegate can take.	
Notification to Authorities and Practitioner Appeal Rights (NCQA CR 6) DHCS, DMHC, CMS	The Delegate uses objective evidence and patient care considerations when deciding on a course of action for dealing with a practitioner who does not meet its quality standards, including: 1. Developing and implementing policies and procedures that specify:	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation, routine monitoring and annual oversight review or more frequently, as required, per

	a. The range of actions available to Delegate. b. That the Delegate reviews participation of practitioners whose conduct could adversely affect members' health or welfare. c. The range of actions that may be taken to improve practitioner performance before termination. d. That the Delegate reports its actions to the appropriate authorities. e. Making the appeal process known to practitioners. 2. Within 14 days from criminal action taken against any contracted practitioner, Delegate shall notify L.A. Care in writing.	changes in contract, Federal and State regulatory guidelines and accreditation standards.
CR Assessment of Organizational Providers (NCQA CR 7) DHCS, DMHC, CMS	The Delegate's policy for assessing a health care delivery provider specifies that before it contracts with a provider, and for at least every 36 months thereafter it: 1. Confirms that the provider is in good standing with state and federal regulatory bodies. 2. Confirms that the provider has been reviewed and approved by an accrediting body acceptable to Delegate, including which accrediting bodies are acceptable. 3. Conducts an onsite quality assessment if the provider is not accredited. 4. At least every three years that the provider continues to be in good standing with state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body acceptable to Delegate. Maintaining a tracking log that includes names of the organization, type of organization, a prior validation date, a current validation date for licensure, accreditation status (if applicable), CMS or state reviews conducted within 3 years at time of verification (if applicable), CLIA certificate (if applicable), NPI number for each organizational provider. The Delegate includes at least the following medical providers in its assessment: a. Hospitals. b. Home health agencies. c. Skilled nursing facilities. d. Freestanding surgical centers. e. Federally Qualified Health Center (FQHCs).	

	The Delegate includes behavioral healthcare facilities providing mental health or substance abuse services in the following setting: a. Inpatient. b. Residential. c. Ambulatory. The Delegate assesses contracted medical health care providers. The Delegate assesses contracted behavioral healthcare providers.	
Sub-Delegation of CR (NCQA CR 8) DHCS, DMHC, CMS	If Delegate sub-delegates any NCQA required credentialing activities, there must be evidence of oversight of the delegated activities, including a written sub-delegation agreement that: a. Is mutually agreed upon. b. Describes the sub-delegated activities and the responsibilities of the organization and the delegated entity. c. Requires at least quarterly reporting to Delegate. d. Describes the process by which Delegate evaluates sub-delegate's performance. e. Specifies that the delegate retains the right to approve, suspend and terminate individual practitioners, providers and sites, even if the organization delegates decision making. f. Describes the remedies available to Delegate if sub-delegate does not fulfill its obligations, including revocation of the delegation agreement. Retention of the right by Delegate and LA Care, based on quality issues, to approve, suspend, and terminate individual practitioners, providers, and sites. For new sub-delegation agreements initiated in the look-back period, the Delegate evaluated sub-delegate capacity to meet NCQA requirements before sub-delegation begins For sub-delegation arrangements in effect for 12 months or longer, the Delegate: a. Annually reviews its sub-delegate's credentialing policies and procedures. b. Annually audits credentialing and recredentialing files against NCQA standards for each year that sub-delegation has been in effect. c. Annually evaluates the sub-delegate's performance against relevant regulatory	L.A. Care retains the right to perform a pre-delegation audit of any entity to which the Plan sub-delegates delegated credentialing activities and approve any such sub-delegation audit of any sub-delegate. Prior to entering into an agreement to sub-delegate delegated credentialing activities, Delegated Plan shall provide L.A. Care with reasonable prior notice of Plan's intent to sub-delegate.

	requirements; NCQA standards and Delegate's expectations annually d. Evaluates regular reports from sub-delegate at least quarterly or more frequently based on the reporting schedule described in the sub-delegation document. e. Annually monitors the delegate's credentialing system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policies and procedures at least annually. f. Annually acts on all findings from factor 5 for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters. For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years, the organization identifies and follows up on opportunities for improvement, if applicable. If a Delegate fails to complete the corrective action plan and has gone through the exigent process which results in de-delegation, the Delegate cannot appeal and must wait one year to reapply for a pre-delegation audit. If the pre-delegation audit reveals deficiencies identified are the same as those from previous audits, delegation will be at the sole discretion of the Credentialing Committee regardless of score.	
MEMBER EXPERIENCE		
Statement of Members' Rights and Responsibilities (NCQA ME 1)	**<u>Distribution of Rights Statement</u>** The organization distributes its member rights and responsibilities statement to the following groups: 1. New members, upon enrollment. 2. Existing members, if requested. 3. New practitioners, when they join the network. 4. Existing practitioners, if requested.	**<u>Rights and Responsibilities Statement</u>** The organization's member rights and responsibilities statement specifies that members have: 1. A right to receive information about the organization its services its practitioners and providers and member rights and responsibilities. 2. A right to be treated with respect and recognition of their dignity and their right to privacy. 3. A right to participate with practitioners in making decisions about their health care. 4. A right to a candid discussion of appropriate or medically

		necessary treatment options for their conditions regardless of cost or benefit coverage. 5. A right to voice complaints or appeals about the organization or the care it provides. 6. A right to make recommendations regarding the organization's member rights and responsibilities policy. 7. A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care. 8. A responsibility to follow plans and instructions for care that they have agreed to with their practitioners. 9. A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible. L.A. Care adheres to the most current NCQA standards to comply with these requirements.
Subscriber Information (NCQA ME 2)		**<u>Subscriber Information</u>** L.A. Care informs its subscribers upon enrollment and annually thereafter about benefits and access to medical services. **<u>Interpreter Services</u>** L.A. Care provides interpreter or bilingual services in its Member Services Department and telephone functions based on linguistic needs of its subscribers. L.A. Care adheres to the most current NCQA standards to comply with these requirements.
Marketing Information (NCQA ME 3)		**<u>Materials and Presentations</u>** L.A. Care's prospective members receive an accurate description of the organization's benefits and operating procedures.

		L.A. Care adheres to the most current NCQA standards to comply with these requirements. **<u>Communicating with Prospective Members</u>** The organization uses easy-to-understand language in communications to prospective members about its policies and practices regarding collection, use and disclosure of PHI: 1. In routine notification of privacy practices 2. The right to approve the release of information (use of authorizations) 3. Access to Medical Records 4. Protection of oral, written, and electronic information across the organization 5. Information for employers **<u>Assessing Member Understanding</u>** 1. Assesses how well new members understand policies and procedures. The right to approve the release of information (use of authorizations) 2. Implements procedures to maintain accuracy of marketing communication. Protection of oral, written, and electronic information across the organization 3. Acts on opportunities for improvement, if applicable.
Functionality of Claims Processing (NCQA ME 4)	**<u>Functionality-Website</u>** Members can track the status of their claims in the claims process and obtain the following information on the organization's website in one attempt or contact: 1. The stage in the process. 2. The amount approved. 3. The amount paid. 4. Member cost. 5. The date paid **<u>Functionality-Telephone Requests</u>** Members can track the status of their claims in the claims process and obtain the following information over the telephone in one attempt or contact:	

	1. The stage in the process. 2. The amount approved. 3. The amount paid. 4. Member cost. 5. The date paid	
Pharmacy Benefit Information (NCQA ME 5)	**<u>Pharmacy Benefit Information-Website</u>** Members can complete the following actions on the website in one attempt or contact: 1. Determine their financial responsibility for a drug, based on the pharmacy benefit. 2. Initiate the exceptions process 3. Order a refill for an existing, unexpired mail-order prescription. 4. Find the location of an in-network pharmacy. 5. Conduct a pharmacy proximity search based on zip code. 6. Determine the availability of generic substitutes. *According to SB1052 Blue Shield shall post the formulary on its internet website and update that posting on a monthly basis. **<u>Pharmacy Benefit Information Telephone</u>** Members can complete the following actions via telephone in one attempt or contact: 1. Determine their financial responsibility for a drug, based on the pharmacy benefit. 2. Initiate the exceptions process. 3. Order a refill for an existing, unexpired, mail-order prescription. 4. Find the location of an in-network pharmacy. 5. Conduct a proximity search based on zip code. 6. Determine the availability of generic substitutes. **<u>QI Process on Accuracy of Information</u>** The organization's quality improvement process for pharmacy benefit information: 1. Collects data on quality and accuracy of pharmacy benefit information. 2. Analyze data results. 3. Act to improve identified deficiencies. **<u>Pharmacy Benefit Updates</u>** The organization updates member pharmacy benefit information on its website and in materials used by telephone staff, as of the effective date of a formulary change and as new drugs are made available or are recalled.	

Personalized Information on Health Plan Services (NCQA ME 6)	**<u>Functionality-Website</u>** Members can complete each of the following activities on the organization's website in one attempt or contact: 1. Change a primary care practitioner, as applicable. 2. Determine how and when to obtain referrals and authorizations for specific services, as applicable 3. Determine benefit and financial responsibility for a specific service or treatment from a specified provider or institution, if applicable. **<u>Functionality Telephone</u>** To support financial decision making, members can complete each of the following activities over the telephone within one business day: 1. Determine how and when to obtain referrals and authorizations for specific services, as applicable. 2. Determine benefit and financial responsibility for a specific service or treatment from a specified provider or institution. **<u>Quality and Accuracy of Information</u>** At least annually, the organization must evaluate the quality and accuracy of the information provided to members via the website and telephone must be evaluated by: 1. Collecting data on quality and accuracy of information provided. 2. Analyzing data against standards or goals. 3. Determining causes of deficiencies, as applicable. 4. Acting to improve identified deficiencies, as applicable. **<u>E-mail Response Evaluation</u>** The organization: 1. Has a process for responding to member e-mail inquiries within one business day of submission. 2. Has a process for annually evaluating the quality of e-mail responses. 3. Annually collects data on email turnaround time. 4. Annually collects data on the quality of email responses. 5. Annually analyzes data. 6. Annually act to improve identified deficiencies.	
Member Experience Applicable L.A. Care Policy: QI-031 (NCQA ME 7)	**<u>Policies and Procedures for Complaints</u>** The organization has policies and procedures for registering and responding to oral and written complaints that include: 1. Documenting the substance of complaints and actions taken.	Members have the option to complain and appeal directly to L.A. Care. L.A. Care retains the right to perform a pre-delegation audit of any entity to which the Plan sub-

	2. Investigating of the substance of complaints and actions taken. 3. Notification to members of the resolution of complaints and, if there is an adverse decision, the right to appeal. . 4. Standards for timeliness including standards for urgent situations. 5. Provision of language services for the complaint process. **<u>Policies and Procedures for Appeals</u>** The organization has policies and procedures for registering and responding to oral and written appeals which include: 1. Documentation of the substance of the appeals and actions taken. 2. Investigation of the substance of the appeals 3. Notification to members of the disposition of appeals and the right to further appeal, as appropriate 4. Standards for timeliness including standards for urgent situations. 5. Provision of language services for the appeal process. **<u>Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals</u>** Using valid methodology, the organization annually analyzes nonbehavioral complaints and appeals for each of the five required categories. **<u>Annual Assessment of Behavioral Healthcare and Services</u>** Using valid methodology, the organization annually: 1. Evaluates behavioral healthcare member complaints and appeals for each of the five required categories. 2. Conducts a member experience survey. **<u>Behavioral Healthcare Opportunities for Improvement</u>** The organization works to improve members' experience with behavioral healthcare and service by annually: 1. Assessing data from complaints and appeals or from member experience surveys. 2. Identifying opportunities for improvement. 3. Implementing interventions, if applicable. 4. Measuring effectiveness of interventions, if applicable.	delegates delegated activities and approve any such sub-delegation audit of any sub-delegate. Prior to entering into an agreement to sub-delegate Delegated Activities, Plan shall provide L.A. Care with reasonable prior notice of Plan's intent to sub-delegate. **<u>Nonbehavioral Opportunities for Improvement</u>** The organization annually identifies opportunities for improvement, sets priorities and decides which opportunities to pursue based on analysis of the following information: 1. Member complaint and appeal data from Member Experience standard for Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals. 2. CAHPS survey results and/or QHP Enrollee Experience Survey results.

Sub-Delegation of ME (NCQA ME 8)	**<u>Sub-Delegation Agreement</u>** The written sub-delegation agreement: 1. Is mutually agreed upon 2. Describes the delegated activities and the responsibilities of the organization and the delegated entity and the delegated activities. 3. Requires at least semiannual reporting by the delegated entity to the organization. 4. Describes the process by which the organization evaluates the delegated entity's performance. 5. Describes the process for providing member experience and clinical performance data to its delegates when requested. 6. Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement. **<u>Predelegation Evaluation</u>** For new delegation agreements initiated in the look-back period, the organization evaluates delegate capacity to meet NCQA requirements before delegation began. **<u>Review of Performance</u>** For delegation arrangements in effect for 12 months or longer, the organization: 1. Semiannually evaluates regular reports as specified in the sub-delegation agreement. 2. Annually evaluates delegate performance against NCQA standards for delegated activities. **<u>Opportunities for Improvement</u>** For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years the organization identified and followed up on opportunities for improvement, if applicable.	
Nurse Advice Line (Title 28 California Code of Regulations Section 1300.67.2.2)	A Nurse Advice Line is offered to members to assist members with wellness and prevention **A. Access to Nurse Advice Line** A Nurse Advice Line that is staffed by licensed nurses or clinicians and meets the following factors: 1. Is available 24 hours a day, 7 days a week, by telephone. 2. Provides secure transmission of electronic communication, with safeguards, and a 24-hour turnaround time. 3. Provides interpretation services for members by telephone. 4. Provide telephone triage or screening services in a timely manner appropriate to the enrollee's	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation and annual oversight review and more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards.

	condition. The triage and screening wait time shall not exceed 30 minutes. **B. Nurse Advice Line Capabilities** The nurse advice line gives staff the ability to: 1. Follow up on specified cases and contact members. 2. Link member contacts to a contact history. **C. Monitoring the Nurse Advice Line** The following shall be conducted: 1. Track telephone statistics at least quarterly 2. Track member use of the nurse advice line at least quarterly. 3. Evaluate member satisfaction with the nurse advice line at least annually. 4. Monitors call periodically. 5. Analyze data at least annually and, if applicable, identify opportunities and establish priorities for improvement. **D. Policies and Procedures** 1. Establish and maintain an operational policy for operating and maintaining a Telephone Nurse Advice Service. **E. Promotion** 1. Promote the availability of Nurse Advice Line services in materials that are approved in accordance with the Plan Partner Services Agreement and L.A. Care policies and procedures. 2. In the form of, but not limited to: a. Flyers b. Informational mailers c. ID Cards d. Evidence of Coverage (EOC)	
Potential Quality of Care Issue Review (Title 28 California Code of Regulations Section 1300.70)	The Quality Improvement program must document that the quality of care is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated. The Quality Improvement program must include continuous review of the quality of care provided; quality of care problems are identified and corrected for all provider entities.	L.A. Care retains accountability for procedural components and will oversee Delegate's adherence to these standards through pre-delegation and annual oversight review and more frequently, as required, per changes in contract, Federal and State regulatory guidelines and accreditation standards.
Quality Improvement Performance: Applicable L.A. Care Policy: QI-0008 APL 19-017	1. Annually measures performance and meets the NCQA 50th percentile benchmark for the Medi-Cal Managed Care Accountability Set established by DHCS and NCQA required Medi-Cal accreditation measures. 2. Opportunity for Improvement	L.A. Care will still retain the PIP and PDSA reporting process with DHCS for the Medi-Cal line of business.

	When the 50th percentile is not met the plan will identify and follow up on opportunities for improvement.	
Blood Lead Screening of Young Children Applicable L.A. Care Policy: QI-048 APL 20-016	1. Ensure network providers follow the blood lead anticipatory guidance and screening requirements in accordance with APL 20-016 2. Identify, on at least a quarterly basis (i.e. January – March, April – June, July – September, October – December), all child members under the age of six years (i.e. 72 months) who have any record of receiving a blood lead screening test as required Note: L.A. Care will send delegate CLPPB data when they receive from DHCS on a quarterly basis.	Annual Submission to DHCS data for all child members under the age of six years (i.e. 72 months) who have no record of receiving a blood lead screening
HEALTH EDUCATION		
DHCS Policy Letter 02-004 DHCS Policy Letter 16-014 DHCS Policy Letter 18-018 DHCS Policy Letter 13-001 DHCS Policy Letter 10-012 DHCS Policy Letter 16-005	1. Maintenance of a health education program description and work plan 2. Availability and promotion of member health education services in DHCS language and topic requirements including implementation of a closed-loop referral process. 3. Implementation of comprehensive tobacco cessation/prevention services including: a. individual, group, and telephone counseling b. Provider tobacco cessation trainings c. Tobacco user identification system d. Tracking individual utilization data of tobacco cessation interventions 4. Availability of a diabetes prevention program (DPP) that complies with CDC DPP guidelines and is delivered by a CDC recognized provider 5. Availability of written member health education materials in English and Spanish in DHCS required health topics including: a. a system for providers to order materials and informing providers how to do so b. Adherence to all regulatory requirements as dictated per the Readability & Suitability Checklist 6. Implementation of an Individual Health Education Behavioral Assessment (IHEBA), preferably the Staying Healthy Assessment (SHA) including a method of making the assessments available to providers and provider education 7. Employment of a full-time Health Education Director, or the equivalent, with a Master's Degree in Public Health (MPH) responsible for	L.A. Care retains responsibility for providing written health education materials in DHCS required health topics for non-English/Spanish threshold languages. L.A. Care retains responsibility for conducting the Health Education, Cultural & Linguistics Population Needs Assessment (PNA) annually but retains the right to request Plan Partner assistance as needed.

	the direction, management and supervision of the health education system. 8. Integration between health education activities and QI activities 9. Provision of provider education on health education requirements and resources 10. Adherence to all requirements regarding Non-Monetary Member Incentives including submission of Request for Approval and Annual Update/End of Program Evaluation forms to L.A. Care's Compliance Unit on an on-going basis.\ 11. Should Plan Partner delegate any or all health education requirements to a sub-delegate, Plan Partner must monitor sub-delegate's performance and ensure continued compliance.	
	CULTURAL & LINGUISTIC REQUIREMENTS	
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 28, §1300.67.04(c) CCR, Title 22, §53876 DHCS Agreement Exhibit A Attachment 9, (12)& (13)(A) Federal Guidelines: OMH CLAS Standards, Standards 1-4 & 9	**Cultural & Linguistic Program Description and Staffing** 1. Plan maintains an approved written program description of its C&L services program that complies with all applicable regulations, includes, at minimum, the following elements (or its equivalent): a. Organizational commitment to deliver culturally and linguistically appropriate health care services. b. Goals and objectives with timetable for implementation. c. Standards and performance requirements for the delivery of culturally and linguistically appropriate health care services. 2Plan centralizes coordination and monitoring of C&L services. The department and/or staff responsible for such services are documented in an organizational chart. 3. Plan has written description(s) of position(s) and qualifications of the staff involved in the C&L services program.	
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 22, §53876 CCR, Title 28, §1300.67.04, (c)(2)(G) & (H) Code of Federal Regulations (CFR), Title28, §35.160-25.164 CFR, Title 45 §92.4 & §92.201 DHCS Agreement Exhibit A, Attachment 9(12) & (14) DHCS All Plan Letter 21-004 Federal Guidelines:	**Access to Interpreting Services** 1. Plan has approved policies and procedures which include, at minimum, the following items: a. Provision of timely 24-hour, 7 days a week interpreting services from a qualified interpreter at all key points of contact, in any language requested, including American Sign Language, at no cost to members. b. Discouraging use of friends, family, and particularly minors as interpreters, unless specifically requested by the member after she/he was being informed of the right and availability of no-cost interpreting services.	

OMH CLAS Standards, Standard 5-7	c. Availability of auxiliary aids and services, such as TTY, video relay services, remote interpreting services, etc., to ensure effective communication with individuals with disabilities. Plan has a sound method to ensure qualifications of interpreters and quality of interpreting services. Qualified interpreter must have demonstrated: 2. a. Proficiency in speaking and understanding both spoken English and at least one other spoken language; and b. Ability to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using necessary specialized vocabulary and a fundamental knowledge in both languages of health care terminology and phraseology concepts relevant to health care delivery systems. c. Adherence to generally accepted interpreter ethics principles, including client confidentiality (such as the standards promulgated by the California Healthcare Interpreters Association and the National Council on Interpreting in Healthcare) 3. Plan makes available translated signage (tagline) on availability of no-cost language assistance services and how to access such services to providers. Tagline must be in English and all 18 non-English languages specified by DHCS 4. Plan posts non-discrimination notice and translated taglines in English and 18 non-English languages specified by DHCS at physical location where the plan interacts with the public and on plan's website. 5. Plan maintains utilization reports for face-to-face and telephonic interpreting services.	
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 28, §1300.67.04(c)(2)(H) Code of Federal Regulations (CFR), Title 45 §92.4 & §92.201(e)(4) DHCS Agreement Exhibit A, Attachment 9(13)(B) & (F) DHCS All Plan Letter 22-04	**Assessment of Linguistic Capabilities of Bilingual** 1. Plan has approved policies and procedures related to identifying, assessing, and tracking oral and/or written language proficiency of clinical and non-clinical bilingual employees who communicate directly with members in a language other than English. 2. Plan has a sound method to assess bilingual employees' oral and/or written language proficiency, including appropriate criteria for	

Federal Guidelines: OMH CLAS Standards, Standards - 7	ensuring the proficiency. Qualified bilingual staff must have demonstrated: a. Proficiency in speaking and understanding both spoken English and at least one other spoken language, including any necessary specialized vocabulary, terminology, and phraseology. b. Ability to effectively, accurately, and impartially communicate directly with Limited English Proficiency Members in their preferred language. 3. Plan maintains a current list of assessed and qualified bilingual employees, who communicate directly with members, including the following information at minimum, name, position, department, language, level of proficiency.	
Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 28, §1300.67.04(d)(9) DHCS Agreement Exhibit A, Attachment 6(11)(B)(2) & Attachment 18 (6)(K) DHCS Policy Letter 98-12 Federal Guidelines: OMH CLAS Standards, Standard 7	**Linguistic Capabilities of Provider Network** 1. Plan has approved policies and procedures related to identifying and monitoring language capabilities of providers and provider staff ensuring provider network is reflective of membership demographics. 2. Plan lists language spoken by providers and provider staff in the provider directory. 3. Plan updates language spoken by providers and provider staff in the provider directory. 4. Plan annually assesses the provider network language capabilities meet the members' needs.	
California Health and Safety Code, §1367.04(b)(1)(A)-(C) Civil Rights Act of 1964, Title VI Code of California Regulations (CCR), Title 22, §53876 (a)(2)&(3) CCR, Title 28, §1300.67.04, (b)(7), (c)(2)(F) & (e)(2)(i)-(ii) Code of Federal Regulations (CFR), Title28, §35.160-25.164 CFR, Title 45 §92.4 & §92.8 DHCS Agreement, Exhibit A, Attachment 9(14)(B)(2), (14)(C), Attachment 13(4)(C) DHCS All Plan Letter 21-011 DHCS All Plan Letter 21-004 DHCS All Plan Letter 22-002 Federal Guidelines: OMH CLAS Standards, Standard 5-	**Access to Written Member Informing Materials in Threshold Languages & Alternative Formats** 1. Plan has approved policies and procedures documenting the process to: a. Translate Written Member Informing Materials, including the non-template individualized verbiage in Notice of Action (NOA) letters, accurately using a qualified translator in all Los Angeles County threshold languages and alternative formats (large print 20pt, audio, Braille, accessible data) according to the required timelines. b. Track member's standing requests for Written Member Informing Materials in their preferred threshold language and alternative format. c. Submit newly captured members' alternative format selection data directly to the DHCS Alternate Format website d. Distribute fully translated Written Member Informing Materials in their identified Los	L.A. Care provides Plan with: 1. Any changes to threshold and tagline languages. 2. Weekly DHCS alternative format selection data

	Angeles County threshold language and alternative format to members on a routine basis based on the standing requests and DHCS alternative format selection (AFS) data. e. Attach the appropriate non-discrimination notice and translated tagline (a written language assistance notice) in English and required all 18 non-English required by DHCS to Member Informing Materials publications). Threshold Languages for Los Angeles County: English, Spanish, Arabic, Armenian, Chinese, Farsi, Khmer, Korean, Russian, Tagalog, and Vietnamese. Taglines (Language assistance notice) Languages: English, Spanish, Arabic, Armenian, Chinese, Farsi, Khmer, Korean, Russian, Tagalog, Vietnamese, Hindi, Hmong, Japanese, Lao, Mien, Punjabi, Thai and Ukrainian. 2. Plan has a sound method to ensure qualifications of translators and quality of translated Written Member Informing Materials. Qualified translators must have demonstrated: a. Adherence to generally accepted translator ethics principles, including client confidentiality to protect the privacy and independence of LEP Members. b. Proficiency reading, writing, and understanding both English and the other non-English target language. c. Ability to translate effectively, accurately, and impartially to and such language(s) and English, using necessary specialized vocabulary, terminology and phraseology. Plan maintains: a. Translated Written Member Informing materials on file along with attestations which affirm qualifications of the translators and translated document is an accurate rendition of the English version. b. Evidence of the distribution of Written Member Informing Materials to members in their identified Los Angeles County threshold language and alternative format on a routine basis.	

	c. Evidence of reporting newly captured AFS data to DHCS	
Code of California Regulations (CCR), Title 28, §1300.67.04(c)(2)(C) DHCS Agreement, Exhibit A, Attachment 13(1)(A) DHCS All Plan 21-004 Federal Guidelines: OMH CLAS Standards, Standard 6	**Member Education** 1. Plan informs members annually of their right to no-cost interpreting services 24-hour, 7 days a week, including American Sign Language and axillary aids/services and how to access these services. 2. Plan informs members annually about the importance of not using friends, family members and particularly minors, as interpreters. 3. Plan informs members annually of their right to receive Written Member Informing Materials in their preferred language and alternative format at no cost and how to access these services. 4. Plan informs members annually of their right to file complaints and grievances if their cultural or linguistic needs are not met and how to file them. 5. Plan informs members annually that Plan does not discriminate on the basis of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability or identification with any other persons or group identified in Penal Code 422.56 in its health programs and activities.	
Code of California Regulations (CCR), Title 28, §1300.67.04(c)(2)(E) & (3) DHCS Agreement Exhibit A, Attachment 7(5)(B), Attachment 9 (13)(E), Attachment 18(7)(F) & (9)(M) DHCS All Plan Letter 99-005 Federal Guidelines: OMH CLAS Standards, Standard 4	**Provider Education & Training** 1. Plan has approved policies and procedures related to education/training on C&L requirements, cultural competency, sensitivity or diversity training for providers. 2. Plan provides initial and annual education/training on cultural and linguistic requirements to providers, which includes the following items: a. Availability of no-cost language assistance services, including: i) 24-hour, 7 days a week interpreting services, including American Sign Language\ ii) Written Member Informing Materials in their identified Los Angeles threshold language and preferred alternative format iii) Auxiliary aids and services, such as TTY, video relay services, remote interpreting services, etc.	

	b. How to access language assistance services. c. Discouraging the use of friends, family, and particularly minors as interpreters. d. Not relying on staff other than qualified bilingual staff to communicate directly in a non-English language with members. e. Documenting the member's language and the request/refusal of interpreting services in the medical record. f. Posting translated taglines in English and 18 non-English languages required by DHCS at key points of contact with members. g. Working effectively with members using in-person or telephonic interpreters and using other media such as TTY and remote interpreting services. h. Referring members to culturally and linguistically appropriate community services. 3. Plan provides initial and annual cultural competency, sensitivity or diversity training to providers, which includes topics that are relevant to the cultural groups in Los Angeles County, such as: a. Promote access and the delivery of services in a culturally competent manner to all Members, regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental, disability, or identification with any other persons or groups defined in Penal Code 422. 4. a. Awareness that culture and cultural beliefs may influence health and health care delivery. b. Knowledge about diverse attitudes, beliefs, behaviors, practices, and methods regarding preventive health, illnesses, diseases, traditional home remedies, and interaction with providers and health care systems. c. Skills to communicate effectively with diverse populations d. Language and literacy needs.	
Code of California Regulations (CCR), Title 28, §1300.67.04(c)(3) DHCS Agreement Exhibit A,	**Plan Employee Education & Training** 1. Plan has approved policies and procedures related to education/training on C&L	

Attachment 9(13)(E) DHCS All Plan Letter 99-005 Federal Guidelines: OMH CLAS Standards, Standard 4	requirements, cultural competency sensitivity or diversity training for Plan employees. 2. Plan provides initial and annual education/training on cultural and linguistic requirements and language assistance services to plan staff, which includes the following items: a. The availability of Plan's no-cost language assistance services to members, including: i. 24-hour, 7 days a week interpreting services, including American Sign Language. ii. Written Member Informing Materials in their identified Los Angeles threshold language and preferred alternative format. iii. Auxiliary aids and services, such as TTY, video relay services, remote interpreting services, etc. b. How to access these language assistance services. c. Discouraging the use of friends, family, and particularly minors, as interpreters. d. Not relying on staff other than qualified bilingual staff to communicate directly in a non-English language with members. e. Working effectively with members using in-person or telephonic interpreters and using other media such as TTY and remote interpreting services f. Referring members to culturally and linguistically appropriate community services. 3. Plan has cultural competency, sensitivity or diversity training material(s) for Plan employees, which includes topics that are relevant to the cultural groups in Los Angeles County, such as: a. Promote access and the delivery of services in a culturally competent manner to all Members, regardless of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental, disability, or identification with any other per-sons or groups defined in Penal Code 422. b. c. Knowledge about diverse attitudes, beliefs, behaviors, practices, and methods regarding preventive health, illnesses, diseases, traditional home remedies, and interaction with providers and health care system.	

	d. Skills to communicate effectively with diverse populations. e. Language and literacy needs	
DHCS Agreement Exhibit A, Attachment 9(13)(F) DHCS All Plan Letter 99-005 Federal Guidelines: OMH CLAS Standards, Standard 10	**C&L and Quality Improvement** 1. Plan has approved policies and procedures related to C&L program evaluation, at minimum, including: a. Review and monitoring of C&L program that has a direct link to Plan's quality improvement processes. b. Procedures for continuous evaluation. 2. Plan analyzes C&L services performance and evaluates the overall effectiveness of the C&L program to identify barriers and deficiencies. For example: a. Grievances and complaints regarding C&L issues b. Trending of interpreting and translation utilization c. Member satisfaction with the quality and availability of language assistance services and culturally competent care d. Plan staff and providers' feedback on C&L services 3. Plan takes actions to correct identified barriers and deficiencies related to C&L services.	
Authority: Code of California Regulations (CCR), Title 28, §1300.67.04 (c)(4) DHCS Agreement, Exhibit A, Attachment 4(6)(A), (B) & Attachment 6(14)(B) DHCS All Plan Letter 99-005 DHCS All Plan Letter 17-004DHCS All Plan Letter 21-004	**Oversight of Subcontractors for Cultural & Linguistic Services and Requirements** 1. Plan has a contract and/or other written agreement with its network providers and subcontractor(s) regarding: a. C&L requirements (e.g., documentation of preferred language and refusal/request for interpreting services in the medical record, posting of translated tagline in English and 18 non-English languages) b. Delegated C&L services (e.g., language assistance services) 2. Plan has approved policies and procedures related to oversight and monitoring of its network providers and subcontractors to ensure compliance with the contract/agreement terms and applicable federal and state laws and regulations that are related to C&L requirements and/or delegated C&L services. 3. Plan has a mechanism to monitor network providers and subcontractors to ensure compliance with the contract terms and applicable federal and state laws and regulations	

	that are related to C&L requirements and/or delegated C&L services. 4. Plan monitors network providers and subcontractors with regular frequency to ensure compliance with the contract terms and applicable federal and state laws and regulations that are related to C&L requirements and/or delegated C&L services.	
Code of California Regulations (CCR), Title 22, §53876 DHCS Agreement Exhibit A, Attachment 9(5) & (14)(B)(3)	**Cultural & Linguistic Service Referral*** 1. Plan has approved policies and procedures related to referring members to culturally and linguistically appropriate community services and providers who can meet the members' religious and ethical needs. 2. Plan has a process and/or mechanism to refer members to culturally and linguistically appropriate community services. 3. Plan informs providers of the availability of culturally and linguistically appropriate community service programs for members and how to access them.	
	CLAIMS PROCESSING REQUIREMENTS	
Claims Processing (Title 28 California Code of Regulations Section 1300.71) Blood Lead Screening of Young Children APL 20-016	**Timely Claims Processing** 1. Process at a minimum ninety percent (90%) of claims within 30 calendar days of the claim receipt date, 2. Process at a minimum ninety-five percent (95%) of claims within 45 working days of the claim receipt date, **and** 3. Process at a minimum ninety-nine percent (99%) of claims within 90 calendar days of the claim receipt date. **Accurate Claims Payments** 1. Pay claims at the Medi-Cal rates or contracted rates at a minimum of 95% of the time. 2. All modified claims are reviewed and approved by a physician and medical records are reviewed. 3. Calculate and pay interest automatically for claims paid beyond 45 workings days from date of receipt at a minimum 95% of the time. a. **Emergency services claims:** Late payment on a complete claim which is not contested or denied will automatically include the greater of $15 or 15% rate per annum applied to the payment amount for the time period the payment is late. b. **All other service claims**: Late payments on a complete claim will automatically include	

	interest at a 15% rate per annum applied to the payment amount for the time period payment is late. **Penalty:** Failure to automatically include the interest due on the late claims regardless of service is $10 per late claim in addition to the interest amount. **Forwarding of Misdirected Claims** Forward misdirected claims within 10 working days of the claim receipt date at a minimum of 95% of the time. **Acknowledgement of Claims** Acknowledge the receipt of electronic claims within 2 working days and paper claims within 15 working days at a minimum of 95% of the time. **Dispute Resolution Mechanism** Provide written notice of a dispute resolution mechanism for all denied and modified claims at a minimum 95% of the time. **Accurate and Clear Written Explanation** Provide written notice of a dispute resolution mechanism for all denied and modified claims at a minimum 95% of the time. **Deadline for Claims Submission** Shall not impose a claims filing deadline less than 90 days after the date of service for contracted providers and less than 180 days after the date of service for non-contracted providers on three or more occasions. **Request for Reimbursement of Overpayment** Reimbursement for overpayment request shall be in writing and clearly identifying the claim and reason why the claim is believed to be overpaid within 365 days from the payment date, for at least 95% of the time. **Rescind or Modify an Authorization** An authorization shall not be rescinded or modified for health care services after the provider renders the service in good faith and pursuant to the authorization on three (3) or more occasions over the course of any three-month period. **Request for Medical Records** 1. **Emergency services claims:** Medical records shall not be requested more frequently than twenty percent (20%) of the claims submitted by	

	all providers for emergency services over any 12-month period. 2. **All other claims:** Medical records shall not be requested more frequently than three percent (3%) of the claims submitted by all providers, excluding claims involving unauthorized services over any 12-month period. **Exception:** The thresholds and limitations on requests for medical records as stated above should not apply to claims where reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices are being demonstrated.	
Provider Dispute Resolution (PDR) Processing and Payments requirement. (Title 28 California Code of Regulations Section 1300.71.38)	**Acknowledgement of Provider Disputes** Acknowledgement of received disputes is performed in a timely manner at a minimum of 95% of the time. a. 15 working days for paper disputes. b. 2 working days for electronic disputes. **Timely Dispute Determinations** Dispute determinations are made in a timely manner, at a minimum of 95% of the time. a. 45 working days from receipt of the dispute. b. 45 working days from receipt of additional information. **Clear Explanation of NOA Letter** Rationale for decision is clear, accurate and specific in NOA Letter, at a minimum of 95% of the time. a. Written determination stating the pertinent facts and explaining the reasons for the determination **Accurate Provider Dispute Payments** 1. Appropriately paying any outstanding monies determined to be due if the dispute is determined in whole or in part in favor of the provider. 2. Interest payments are paid correctly when dispute determination is in favor of provider, at a minimum of 95% of the time. Accrual of interest of payment on resolved provider disputes begin on the day after the expiration of forty-five (45) working days from the original claim receipt date. **Acceptance of Late Claims** The organization must accept and adjudicate disputes that were originally filed beyond the claim filing	

	deadline and the provider was able to demonstrate good cause for the delay, at a minimum of 95% of the time.	

Exhibit 8
Delegation Agreement
[Attachment B]

Plan's Reporting Requirements
(Pharmacy reporting requirements are only applicable from July 1, 2021 to December 31, 2021)

Report	Due Date	Submit To	Required Format
PHARMACY			
Pharmacy Reporting requirements for additional delegated activities 1. NCQA UM related a. **UM 4E:** Practitioner Review of Pharmacy Denials b. **UM 5:** Timeliness of Pharmacy UM Decision Making**UM 5C:** Notification of Pharmacy Decisions c. **UM 5D (factors 5&6):** UM Timeliness Report (Pharmacy) d. **UM 6C:** Relevant Information for Pharmacy Decisions e. **UM 7G:** Discussing a Pharmacy Denial with a Reviewer f. **UM 7H:** Written Notification of Pharmacy Denials g. **UM 7I:** Pharmacy Notice of Appeals Rights/Process h. **UM 9A** Preservice and Postservice Pharmacy Appeals i. **UM 9B:** Timeliness of the Pharmacy Appeal Process j. **UM 9C**: Pharmacy Appeal Reviewers k. **UM 9D**: Notification of Appeal Decision/Rights for Pharmacy l. **UM 12A:**UM Denial System Controls **2. DHCS Related** a. Decision timeliness rate for all PA requests according DHCS contractual agreement = PA	1-4. Quarterly 1st Qtr – May 30 2nd Qtr – Aug 30 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Pharmacy/	1-3. L.A. Care Reporting Format with data elements as defined in the Blue Shield Pharmacy Report Templates workbook, and 4. Policy and Procedure PHRM-041: Plan Partner Pharmacy Reporting Requirements

decisions within 24 hours of receipt/Total PAs. - includes approval and denials, <u>excludes all early close and administrative denials</u> b. Notification timeliness rate for all PA requests according DHCS contractual agreement = PA notifications within 24 hours of receipt/Total PAs. - includes approval and denials, <u>excludes all early close and administrative denials</u> 3. Pharmacy Activities Summary Reports a. Denial per 1000 = (Pharmacy Denials/1000 members) - all early close and administrative denials should be excluded. b. Appeal per 1000 = (Pharmacy Appeals/ 1000 members) - withdrawn appeals should be excluded c. Overturn Rate = (Pharmacy Overturned Appeals/ Total Pharmacy Appeals) - withdrawn appeals should be excluded. 4. Pharmacy Utilization Reports a. Top fifty drugs by number of Prescriptions b. Top fifty Drugs by Aggregate Cost c. Non-Formulary Medication d. Prior Authorization Report e. Summary Report of L.A. Care member Prescription Utilization			
<u>NCQA ME Pharmacy related reporting requirements</u> 1. **ME :** Quality and accuracy (QI process) of pharmacy benefit information provided on website and telephone a. Collects data on quality and accuracy of pharmacy benefit information b. Analyzes data results c. Acts to improve identified deficiencies 2. **ME :** Pharmacy benefit updates for: a. Member information on its website and in materials used by telephone staff, as the effective date of a formulary change and as new drugs are made available.	1 – 2. Quarterly 1st Qtr – May 30 2nd Qtr – Aug 30 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Pharmacy/	1 – 2. Compliant with NCQA in accordance to Plan's accreditation submission

QUALITY IMPROVEMENT			
NET 1A **Cultural Needs and Preferences Assessment** **NET 1B** Practitioners Providing Primary Care **NET 1C** Practitioners Providing Specialty Care **NET 1D** Practitioners Providing Behavioral Healthcare	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
NET 2A **Access to Primary Care** **NET 2B** Access to Behavioral Healthcare **NET 2C** Access to Specialty Care	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
NET 3A Assessment of Member Experience Accessing the Network **NET 3B** Opportunities to Improve Access to Nonbehavioral Healthcare Services **NET 3C** Opportunities to Improve Access to Behavioral Healthcare Services	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
QI 2A Practitioner Contracts	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
QI 3A Identifying Opportunities **QI 3B** Acting on Opportunities **QI 3C** Measuring Effectiveness	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Annual data collection analysis that identify and acts on opportunities for improvement for Continuity of Care as outlined by NCQA guidelines for Continuity Coordination of Care of Medical Care and Continuity and Coordination Between Medical Care and Behavioral HealthCare

QI 4A Data Collection **QI 4B** Collaborative Activities **QI 4C** Measuring Effectiveness	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
QI 5A **Sub-Delegation Agreement** **QI 5B** Sub- Delegation Predelegation Evaluation **QI 5C** Sub-Delegation Review of QI Program **QI 5D** **Sub-Delegation** Opportunities for Improvement	Annually during PP audit	home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
<u>Quality Improvement Quarterly reporting requirements</u> 1. **QI Workplan Update** **2. Potential Quality of Care Issues (PQIs)** a. Number of PQIs b. Number of closed PQIs c. Number of closed PQIs within 6 months d. PQI Detail Report with final PQI severity level	QI Workplan Quarterly 1st Qtr – Jun 30 2nd Qtr – Sep 30 3rd Qtr – Dec 30 4th Qtr – Mar 30 2. Quarterly PQI Report 1st Qtr – April 25 2nd Qtr – July 25 3rd Qtr – Oct 25 4th Qtr – Jan 25	1-3. L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	1 – 3. Acceptable formats: • Quarterly Workplan Updates • ICE Reporting Format
<u>Quality Improvement Annual reporting requirements</u> 1. **QI 1A:** QM Program Description 2. **QI 1C:** QM Program Evaluation 3. QI Workplan	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Acceptable formats: • Quarterly • ICE Reporting Format

4. PHM Work plan (if the activities are not included in the QI Workplan)			
ME 1B: Distribution of Member Rights & Responsibilities Statement	Semi-Annually: Jan 15th (Reporting period Q3 & Q4) July 15th (Reporting period Q1 &Q2)	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Mutually agreed upon format ME 1B_Distribution of Rights Statement
ME 7C Element C: Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals **ME 7E** Element E: Annual Assessment of Behavioral Healthcare and Services **ME 7F** Element F: Behavioral Healthcare Opportunities	Annually during PP audit	home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 1A Strategy Description **PHM 1B** Informing Members	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 2A Data Integration **PHM 2B** Population Assessment **PHM 2C** Activities and Resources **PHM 2D** Segmentation	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 3 A Practitioner or Provider Support	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 6A Measuring Effectiveness **PHM 6B** Improvement and Action	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission
PHM 7A Sub-Delegation Agreement **PHM 7B** Sub-Delegate Pre-Delegation Agreement **PHM 7C**	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Quality Improvement/	Compliant with NCQA in accordance to Plan's accreditation submission

Sub-Delegate Review of PHM Program **PHM 7D** Opportunities for Improvement			
Title 28 California Code of Regulations Section 1300.67.2.2 **California Health and Safety Code Section 1348.8** **Assessment of Nurse Advice Line** 1. Nurse Advice Line monitoring for: a. Telephone statistics at least quarterly • Average abandonment rate within 5 percent • Average speed of answer within 30 seconds 2. Annual analysis of Nurse Advice Line statistics (telephone, use, and calls), identify opportunities and establish priorities for improvement.	1. Quarterly 1st Qtr – May 18 2nd Qtr – August 18 3rd Qtr – November 18 4th Qtr – February 18 2. Annually during PP Audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Health Education/ Plan will also have the option to submit via email to remain compliant with due date.	Mutually agreed upon format
Quality Improvement Performance A PDSA tool will be required when the plan does not meet the 50th percentile for the Managed Care Accountability Set and the 50th percentile for the Medicaid NCQA Accreditation Measures as established by both regulatory entities.	Annually during PP Audit. The PDSA tool is due 90 calendar days after findings are received.	L.A. Care's Secure File Transfer Protocol (SFTP)/ home/ucfst/infile/Quality Improvement/ Plan will also have the option to submit via email to remain compliant	The PDSA tool provided by DHCS or L.A. Care
UTILIZATION MANAGEMENT			
APPEALS & GRIEVANCES Member complaints and Appeals Log	Monthly 15th Calendar Day of Each Month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/grievance/	Format as defined in the L.A. Care Technical Bulletin MS 005
ME 7 A, B, C, E, F **Analysis of Member Experience, if delegated, to include:** 1. Policies and Procedures for Complaints 2. Policies and Procedures for Appeals 3. Annual Assessment of Nonbehavioral Healthcare Complaints and Appeals for each of 5 categories: a. Quality of Care b. Access c. Attitude and Service	Annually during PP audit	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/greivance/	Compliant with NCQA in accordance to Plan's accreditation submission

d. Billing and Financial Issues e. Quality of Practitioner Office Site 4. Annual Assessment of Behavioral Healthcare Complaints and Appeals and Services for each of 5 categories along with opportunities for improvement: a. Quality of Care b. Access c. Attitude and Service d. Billing and Financial Issue e. Quality of Practitioner Office Site			
Service Authorizations and Utilization Review			
UM 1 1. UM Program Description 2. UM Program Evaluation 3. UM Program Work Plan	1. Delegation Oversight to review. Annually during PP audit 2-3. Due to Clinical Assurance on May 31st via the SFTP Site	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	1. Narrative 2. ICE Quarterly Reporting format 3. ICE Quarterly Format
Quarterly UM Activity Report **All elements outlined within L.A. Care Quarterly UM Activity (ICE) report including but not limited to:** 1. UM Summary – Inpatient Activity a. Average monthly membership b. Acute Admissions/K c. Acute Bed days/K d. Acute LOS e. Acute Readmits/K f. SNF Admissions/K g. SNF Bed days/K h. SNF LOS i. SNF Readmits/K 2. UM Activities Summary a. Referral Management Tracking of the number of Approvals/Modifications/Denials/ Deferrals (Routine/Urgent) b. Referral Denial Rate c. Appeals/K d. Overturn Rate 3. **PHM 5:** CCM Complex Case Management CM Reports and Statistics	Quarterly 1st Qtr –May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	ICE Quarterly Reporting Format

NET 4B: Continued Access to Care 1. Continued Access to Practitioners If a practitioner's contract is discontinued, the organization allows affected members continued access to the practitioner, as follows: a. Continuation of treatment through the current period of active treatment for members undergoing active treatment for a chronic or acute medical condition b. Continuation of care through the postpartum period for members in their second or third trimester of pregnancy	Quarterly 1st Qtr – May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	L.A. Care Quarterly Reporting Format
PHM 5: CCM Log of Case Management Cases (CCM) for members who have been in CCM for at least 60 days to include both open and closed cases.	Quarterly 1st Qtr – May 25 2nd Qtr – Aug 25 3rd Qtr – Nov 25 4th Qtr – Feb 25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	Acceptable formats: L.A. Care Format
Medi-Cal Provider Preventable Reportable Conditions	Quarterly 1st Qtr – May 25 2nd Qtr – Aug 25 3rd Qtr – Nov 25 4th Qtr – Feb 25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	Acceptable formats: DHCS Required Reporting Format
QI 3D: Transition to Other Care**--**member transition to other care, **a.** When their benefits end, if necessary **b.** During transition from pediatric care to adult care.	Quarterly 1st Qtr – May 31 2nd Qtr – Aug 31 3rd Qtr – Nov 30 4th Qtr – Feb 28	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Clinical Assurance_CFST/	L.A. Care TOC Reporting Format
CREDENTIALING			
1. Initial Credentialed practitioner list containing Credentialing Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. 2. Re-credentialed practitioner list containing Re-credentialing Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. 3. Voluntary Practitioner Termination list containing Termination Date, Last Name, First Name, MI, Title, Address, City, State, Zip, Group Name. 4. Involuntary Practitioner Termination list containing Termination Date, Last Name,	Quarterly 1st Qtr – May15 2nd Qtr – Aug 15 3rd Qtr – Nov 15 4th Qtr – Feb 15	credinfo@lacare.org	Current L.A. Care Health Plan Delegated Credentialing Quarterly Credentialing Submission Form (ICE Format)

First Name, MI, Title, Address, City, State, Zip, Group Name			
DMHC SURVEYS			
1. DMHC Timely Access and Network Reporting (TAR) a. Exhibit A-1 Timely Access Time-Elapsed Standards b. Exhibit A-2 Alternative Access Timely Access Time-Elapsed Standards (if applicable) c. Exhibit A-3 Timely Access Monitoring Policies and Procedures related to subdivision (c)(5) d. Exhibit A-4 Timely Access Monitoring policies and Procedures related to all other standards e. Exhibit C-1 Methodology f. Exhibit C-2 Incidents of Non-Compliance with Rule 1300.67.2.2 g. Exhibit C-3 Patterns of Non-Compliance with rule 1300.67.2.2 h. Exhibit D-1 Methodology for Verification of Advanced Access Program (if applicable) i. Exhibit D-2 List of Advanced Access Providers (if applicable) j. Exhibit E-1 Triage k. Exhibit E-2 Telemedicine l. Exhibit E-3 Health I.T. m. Exhibit F-1 Provider Satisfaction Survey Methodology (a) Policy & Procedures n. Exhibit F-1 Provider Satisfaction Survey Methodology (b) Survey Tool o. Exhibit F-1 Provider Satisfaction Survey Methodology (c) Detailed Explanation p. Exhibit F-2 Provider Satisfaction Survey Results	Annually - March	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	

q. Exhibit F3- Enrollee Satisfaction Survey Methodology (a) Policy and Procedures r. Exhibit F3- Enrollee Satisfaction Survey Methodology (b) Survey Tool s. Exhibit F3- Enrollee Satisfaction Survey Methodology (c) Detailed Explanation t. Exhibit F4- Enrollee Satisfaction Survey Results u. Quality Assurance Report v. Annual Provider Network Report Forms i. PCP ii. Specialists iii. Other Contracted iv. Hospitals and Clinics v. Telehealth vi. Service and Enrollment vii. Mental Health viii. Grievances			
2. DMHC Provider Appointment Availability Survey (PAAS) a. Provider Contact Lists i. PCP ii. Specialists iii. Psychiatry iv. Non-Physician Mental Health v. Ancillary	Annually - July	L.A. Care's Secure File Transfer Protocol (SFTP)/ home/ucfst/infile/Quality Improvement/	
COMPLIANCE			
1. 274 EDI File Mandated by APL 16-019	Monthly – Due to L.A. Care by the 4th of each month	L.A. Care's Secure File Transfer Protocol (SFTP) /home/ucfst/infile/274	DHCS required formatting.
2. Data Certification Statements Mandated by APL 17-005	Monthly – Due to L.A. Care 3 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	Word Document, Non-specific template. Utilize own template; however, all state reports submitted to L.A. Care within the month MUST be listed and CEO MUST sign off attesting to ALL data submissions.
3. Non-Medical Transportation & Non-Emergency Medical Transportation (NMT-NEMT) Report Mandated by APL 17-010	Monthly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template

4. **Health Industry Collaboration Effort** AB1455 Quarterly Reports M/Q Medi-Cal Claims Timeliness Report AB1455 Pharmacy Claims Timeliness Reports Quarterly Provider Dispute Resolution (PDR) Report Disclosure of Emerging Claims Payment Deficiencies	Quarterly – Due to L.A. Care within specified deadline set by L.A. Care	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	HICE Approved Documents
5. Call Center Report	Quarterly – Due to L.A. care 30 days after the end of each quarter of the calendar year. When due date falls on the weekend (Sunday or Saturday, data must be submitted by COB on the Friday before the due date. • Q1 – January, February, and March • Q2 – April, May, and June • Q3 – July, August, and September • Q4 – October, November, and December	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	Format as specified by L.A. Care
6. Community Based Adult Services (CBAS) Report	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved templates
7. Dental General Anesthesia Report Mandated by APL 15-012	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved templates
8. Coordinated Care Initiative – Long- Term Services & Supports (CCI – LTSS)	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved templates
9. Medi-Cal Managed Long-Term Services & Supports (MLTSS) Report Mandated by APL 17-012	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved templates
10. Medi-Cal Managed Care Survey – Disproportionate State Hospitals (MMCS-DSH) Survey	Annually - Due to L.A. Care 7 business days prior to submission to DHCS	BSCPHP has the option to submit report directly to DHCS Or	DHCS approved templates

		Via L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	
11. Health Homes Program DHCS Required Reporting (Sunset CY 2022)	Quarterly, Bi-Annually, & Annually, according to schedule in DHCS template -Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template, plus attestation of data and brief written summary of oversight and monitoring activity for the reporting period
12. Enhanced Care Management DHCS Required Reporting	Quarterly, Bi-Annually, & Annually, according to schedule in DHCS template -Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template, plus attestation of data and brief written summary of oversight and monitoring activity for the reporting period
13. Community Supports DHCS Required Reporting	Quarterly, Bi-Annually, & Annually, according to schedule in DHCS template -Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template, plus attestation of data and brief written summary of oversight and monitoring activity for the reporting period
14. CBAS Monthly Wavier Report	Monthly - Due to L.A. Care every 4th day of the month	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template
15. MOT Post Transitional Monitoring	Quarterly -Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved template
16. Prop 56 Directed Payment for Physician Services Mandated by APL 19-015	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care Regulatory / Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	Financial Compliance provided Template based on APL reporting requirements

17. Prop 56 Hyde Reimbursement Requirements for specific Services Mandated by APL 19-013	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ucfst/infile/Regulat ory	Regulatory Reports provided Template based on APL reporting requirements
18. Prop 56 Directed Payments for Developmental Screening Services Mandated by APL 19-016	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ucfst/infile/Regulat ory	Regulatory Reports provided Template based on APL reporting requirements
Prop 56 Directed Payments for Valued Base Payment Program Mandated by APL 20-014	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ucfst/infile/Regulat ory	Regulatory Reports provided Template based on APL reporting requirements
19. Prop 56 Directed Payments for Family Planning Mandated by APL 20-013	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ucfst/infile/Regulat ory	Regulatory Reports provided Template based on APL reporting requirements
20. Prop 56 Directed Payment for Adverse Childhood Experiences Screening Services Mandated by AP-19-018	Quarterly-Due to L.A. Care 7 business days prior to submission to DHCS	LA Care Regulatory/Secure File Transfer Protocol (sFTP) home/ucfst/infile/Regulat ory	Regulatory Reports provided Template based on APL reporting requirements
21. MCPD and PCPA Managed Care Program Date (MCPD) and Primary Care Provider Alignment (PCPA) Mandated by APL 20-017 The Managed Care Program Data (MCPD) report is a consolidated reporting requirement which DHCS introduced through APL 20-017. The MCPD file replaces the following reporting requirements, as this data is now incorporated into the MCPD file in .json format: • Grievances and appeals data in an Excel template, as specified in APL 14-013 ***(previously submitted by your plan as the Grievance Report Mandated by APL 14-013)***	Monthly - Due to L.A. Care every 4th day of the month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulat ory Reports/	Regulatory Reports provided Template based on APL reporting requirements

• Monthly MERs and other continuity of care records data in an Excel template, as specified in Attachment B of APL 17-007 ***(previously submitted by your plan as the MMDR Report)*** • Other types of continuity of care data in ad-hoc Excel templates • Out-of-Network request data in a variety of ad-hoc Excel templates ***(previously submitted by your plan as the OON Report)***			
22. Acute Care at Home Hospital Report Mandated by APL 20-021	Monthly – Due to LA Care the last day of every month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	**DHCS Reporting Template**
23. Blood Lead Screening Mandated by APL 20-016	Quarterly - Due to L.A. Care 45 days after the quarter ends	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	**Regulatory Reports provided Template based on APL reporting requirements**
24. Cost Avoidance & Post Payment (CAPP) Recovery Mandated by APL 21-002	Monthly – Due to L.A. Care 6th business day of every month	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	DHCS Approved Template
25. Provider Network Termination Mandated by APL 21-003	Quarterly - Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports/	DHCS Approved Template
26. Third Party Liability	15 days from the date LA Care submits case file.	L.A. Care via its Secure File Transfer Protocol (SFTP) – home/ucfst/infile/Regulatory Reports/	DHCS approved templates
27. New and or revised reports as released by DHCS	Due to L.A. Care 7 business days prior to submission to DHCS	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Regulatory Reports	DHCS approved templates
28. Disaster and Recovery Plan Disaster Recovery Test Results L.A. Care will request all elements outlined below including but not limited to:	Annually during PP audit and ad-hoc;	L.A. Care's Secure File Transfer Protocol (SFTP) EnterpriseRiskManagement@lacare.org	Word Document, Non-Specific template

LA Care may require additional information on Business Continuity efforts based off current event. In the event there are any additional requests from regulators for individual instances, such as, an emergency declared by the governor; 29. L.A. Care will send out an ad hoc written request asking to respond with the requested information should it be an element outside of what is already being requested and another mobile contact mechanism when outside of regular business hours.	Ad-Hoc	home/PPName/infile/Regulatory Reports/ EnterpriseRiskManagement@lacare.org ; RegulatoryReports@lacare.org	Template may change upon regulators request.
DELEGATED FINANCIAL AND DELEGATED CLAIMS COMPLIANCE			
1. a) Oversight Summary on Financial Solvency Monitoring of Delegates' Quarterly Unaudited Financial Statements b) Data elements that are from Claims Delegates' Quarterly Timeliness Reporting will be included in 1(a) above – Oversight Report on Financial Solvency Monitoring of Delegates' Quarterly Unaudited Financial Statements) Note: Delegates consist of PPGs and capitated hospitals.		L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Financial_Compliance/ Plan will also have the option to submit via email to remain compliant	Excel/PDF
2. Oversight Summary on Financial Solvency Monitoring of Delegates' Annual Independent Audited Financial Statements ***Note: 2) does not apply to Oversight reporting of claims processing audits of delegates*** Note: Delegates consist of PPGs and capitated hospitals.	Annually – Due to L.A. Care 180 calendar days after delegates' fiscal year end	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Financial_Compliance Plan will also have the option to submit via email to remain compliant	Excel/PDF
3. a) Oversight Summary on Annual Financial Solvency Audits of Delegates. b) Oversight Summary on Annual & Follow-Up Claims Processing Audit of Delegates	Quarterly – Due to L.A. Care 60 calendar days after each calendar quarter end for the delegate audits conducted[1] in the reporting quarter [1]the date of delegate audit is based on the first date of	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Financial_Compliance	Excel/PDF

Note: Delegates consist of PPGs and capitated hospitals.	fieldwork conducted by BSC PHP.	Plan will also have the option to submit via email to remain compliant	
4. Policy 2305 Medi-Cal Allocation	Annually – Due to L.A. Care 120 calendar year end (April 30)	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Financial_Compliance Plan will also have the option to submit via email to remain compliant	
DELEGATION OVERSIGHT			
New Member Welcome Kit Mailing Reports	Quarterly – Due to L.A. Care the 15th day of each quarter end	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Delegation Oversight	Format as specified by L.A. Care
HEALTH EDUCATION			
1. Health Education Referral Report	Quarterly – Due to L.A. Care the 25th day of the month following the end of the quarter: • Q1 due 4/25 • Q2 due 7/25 • Q3 due 10/25 • Q4 due 1/25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Health Education/	Format as specified by LA. Care or mutually agreed upon per Plan Partner process.
2. Health Education Material Distribution Report	Quarterly – Due to L.A. Care the 25th day of the month following the end of the quarter: • Q1 due 4/25 • Q2 due 7/25 • Q3 due 10/25 • Q4 due 1/25	L.A. Care's Secure File Transfer Protocol (SFTP) home/ucfst/infile/Health Education/	Format as specified by LA. Care or mutually agreed upon per Plan Partner process.
3. Health Education Program Description and Work Plan	Annually – due to L.A. Care January 31st of each year	Via email to designated Health Education contact	As appropriate per Plan Partner model.
CULTURAL AND LINGUISTC SERVICES			
1. C&L Program Description and Work Plan	Annually – due to L.A. Care January 31st of each year	L.A. Care's Secure File Transfer Protocol (SFTP) *OR* Via email to CL_Reports_Mailbox@lacare.org	Plan Partner can submit their own format of C&L PD and work Plan. Requirement is in reference to Policy and Procedure CL-008 and C&L Program Description delegated

			Subcontractor**.**
2. C&L Referral Report	Quarterly – Due to L.A. Care the 25th day of the month following the end of the quarter: • Q1 due 4/25 • Q2 due 7/25 • Q3 due 10/25 • Q4 due 1/25	L.A. Care's Secure File Transfer Protocol (SFTP) *OR* Via email to CL_Reports_Mailbox@lacare.org	Format as specified by LA. Care or mutually agreed upon per Plan Partner process.

All other non-conflicting rights and duties, obligations and liabilities of the parties to the Agreement shall remain unchanged.

IN WITNESS WHEREOF, the parties have entered into this Amendment as of the date set forth below.

Local Initiative Health Authority for Los Angeles County d.b.a. L.A. Care Health Plan (L.A. Care)
A local government agency

DocuSigned by:
By: John Baackes
70A86CF78A8F458...
John Baackes
Chief Executive Officer

Date: 4/3/2023 | 5:42 PM PDT, 2023

DocuSigned by:
By: [signature]
F6C72AC0AC4149C...
Alvaro Ballesteros
Chairperson,
L.A. Care Board of Governors

Date: 4/4/2023 | 7:36 AM PDT, 2023

Blue Shield of California Promise Health Plan
A California health care services plan

DocuSigned by:
By: Kristen Cerf
9AE0D7770A434C7...
Kristen Cerf
President and Chief Executive Officer

Date: 4/3/2023 | 4:28 PM PDT, 2023

Board of Governors
MOTION SUMMARY

Date: May 4, 2023 **Motion No**. **FIN 100.0523**

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

Issue: Accept the Investment Report for the quarter ended March 31, 2023

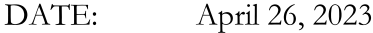
☐ **New Contract** ☐ **Amendment** ☐ **Sole Source** ☐ **RFP/RFQ was conducted**

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 March 31, 2023, as submitted.**



DATE: April 26, 2023

TO: Finance & Budget Committee

FROM: Afzal Shah, *Chief Financial Officer*

SUBJECT: Quarterly Investment Report – March 2023

As of March 31, 2023, L.A. Care's combined investments value was approximately $3.4 billion. Interest income, amortization, realized gains and losses was approximately $23.7 million for the quarter. Unrealized gain due to market price fluctuations was $5.8 million for the quarter. The rate of return for the quarter was 1.10%. Based upon an independent compliance review performed as of March 31, 2023, LA Care is in compliance with its investment policy guidelines pursuant to the California Government Code and the California Insurance Code.

At quarter end $2.9 billion (or approx. 84% of total investments) and $0.3 billion (or approx. 10% 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	4%	0%	4%
U.S. Treasury Securities	38%	0%	34%
U.S. Agency & Municipal Securities	50%	4%	45%
Corporate bonds	0%	96%	10%
Asset Backed and Mortgage Backed Securities	4%	0%	4%
Negotiable CDs	2%	0%	2%
Other	2%	0%	1%
	100%	100%	100%
Average credit quality:	AAA	A1	
Average duration:	0.16 years	2.59 years	
Average yield to maturity:	4.55%	4.74%	

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 $2,781 million invested as of March 31, 2023, and returned 1.10% for the quarter. The comparative benchmark returned 1.07% for the quarter. The extended term portfolio had approximately $91 million invested March 31, 2023, and returned 1.74% for the quarter. The comparative benchmark had a return of 1.86%.

Performance	1st Quarter	Trailing 1 Year	Trailing 3 Year
LA Care - Short-Term Portfolio	**1.10**	**2.57**	**0.96**
Benchmark*	[illegible]	2.50	0.80
LA Care - Extended-Term Portfolio	**1.74**	**0.32**	**-0.50**
Benchmark**	[illegible]	[illegible]	[illegible]
LA Care - Combined Portfolio	**[illegible]**	**2.10**	**0.87**

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

The $327 million portfolio managed by New England Asset Management, Inc (NEAM), focused on corporate fixed income bonds returned 1.68% for the quarter. The comparative benchmark returned 1.75% for the quarter.

LA 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 March 31, 2023 were $74 million in LAIF and $158 million in LACPIF.

The Local Agency Investment Fund (LAIF) yielded approximately 0.66% for the quarter. The fund's total portfolio market value as of February 28, 2023, was $201 billion, with a weighted average maturity of 275 days. LAIF is administered and overseen by the State Treasurer's office. The fund's investment holdings as of February 28, 2023 were as follows:

U.S. Treasury Securities	65%
Agencies	22%
CD's and bank notes	6%
Commercial paper	4%
Time deposits	3%
	100%

The Los Angeles County Pooled Investment Fund (LACPIF) yielded approximately 0.83% for the quarter. The fund's total market value as of February 28, 2023, was $47 billion, with a weighted average maturity of 815 days. LACPIF is administered and overseen by the Los Angeles County Treasurer. The fund's most recent published investment holdings (as of February 28, 2023) were as follows:

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

LA Care Securities Holdings
as of March 31, 2023

Porfolio	CUSIP/Identifier	Security	Type	Par	Maturity date
Payden	USD	DREYFUS TREASURY & AGENCY CASH	Cash/Money Market Funds	120,700,767	NA
NEAM	USD	NORTHERN INST GOVT MONEY MKT	Cash/Money Market Funds	871,164	NA
Payden	912796Z93	U.S. TREASURY BILL	U.S. Treasury Security	390,000,000	4/4/2023
Payden	912796YN3	U.S. TREASURY BILL	U.S. Treasury Security	54,000,000	4/6/2023
Payden	912796YU7	U.S. TREASURY BILL	U.S. Treasury Security	50,000,000	4/13/2023
Payden	912797LM7	CASH MGMT BILL	U.S. Treasury Security	51,000,000	4/17/2023
Payden	912796V48	U.S. TREASURY BILL	U.S. Treasury Security	50,000,000	4/20/2023
Payden	912796ZE2	U.S. TREASURY BILL	U.S. Treasury Security	50,000,000	5/11/2023
Payden	912796W47	U.S. TREASURY BILL	U.S. Treasury Security	50,000,000	5/18/2023
Payden	912796ZF9	U.S. TREASURY BILL	U.S. Treasury Security	31,000,000	5/25/2023
Payden	912796ZG7	U.S. TREASURY BILL	U.S. Treasury Security	17,000,000	6/1/2023
Payden	912796ZP7	U.S. TREASURY BILL	U.S. Treasury Security	50,000,000	6/8/2023
Payden	912797FP7	U.S. TREASURY BILL	U.S. Treasury Security	15,000,000	6/20/2023
Payden	912796ZZ5	U.S. TREASURY BILL	U.S. Treasury Security	25,000,000	7/20/2023
Payden	912796Y37	U.S. TREASURY BILL	U.S. Treasury Security	85,000,000	8/3/2023
Payden	912796XY0	U.S. TREASURY BILL	U.S. Treasury Security	50,000,000	8/10/2023
Payden	912796Z36	U.S. TREASURY BILL	U.S. Treasury Security	35,000,000	8/17/2023
Payden	912796ZY8	U.S. TREASURY BILL	U.S. Treasury Security	50,000,000	1/25/2024
Payden	91282CBA8	U.S. TREASURY NOTE	U.S. Treasury Security	12,000,000	12/15/2023
Payden	91282CBE0	U.S. TREASURY NOTE	U.S. Treasury Security	210,000	1/15/2024
Payden	91282CEA5	U.S. TREASURY NOTE	U.S. Treasury Security	495,000	2/29/2024
Payden	91282CBR1	U.S. TREASURY NOTE	U.S. Treasury Security	845,000	3/15/2024
Payden	912828XT2	U.S. TREASURY NOTE	U.S. Treasury Security	4,010,000	5/31/2024
Payden	9128286Z8	U.S. TREASURY NOTE	U.S. Treasury Security	885,000	6/30/2024
Payden	91282CCL3	U.S. TREASURY NOTE	U.S. Treasury Security	1,700,000	7/15/2024
Payden	912828YH7	U.S. TREASURY NOTE	U.S. Treasury Security	890,000	9/30/2024
Payden	912828YM6	U.S. TREASURY NOTE	U.S. Treasury Security	40,000	10/31/2024
Payden	912828YV6	U.S. TREASURY NOTE	U.S. Treasury Security	305,000	11/30/2024
Payden	91282CDZ1	U.S. TREASURY NOTE	U.S. Treasury Security	320,000	2/15/2025
Payden	912828ZC7	U.S. TREASURY NOTE	U.S. Treasury Security	455,000	2/28/2025
Payden	912828ZF0	U.S. TREASURY NOTE	U.S. Treasury Security	1,686,000	3/31/2025
Payden	912828ZL7	U.S. TREASURY NOTE	U.S. Treasury Security	935,000	4/30/2025
Payden	912828ZT0	U.S. TREASURY NOTE	U.S. Treasury Security	365,000	5/31/2025
Payden	91282CAJ0	U.S. TREASURY NOTE	U.S. Treasury Security	2,250,000	8/31/2025
Payden	91282CAM3	U.S. TREASURY NOTE	U.S. Treasury Security	500,000	9/30/2025
Payden	91282CAZ4	U.S. TREASURY NOTE	U.S. Treasury Security	4,365,000	11/30/2025
Payden	91282CBC4	U.S. TREASURY NOTE	U.S. Treasury Security	2,051,000	12/31/2025
Payden	91282CBH3	U.S. TREASURY NOTE	U.S. Treasury Security	1,410,000	1/31/2026
Payden	91282CGL9	U.S. TREASURY NOTE	U.S. Treasury Security	540,000	2/15/2026
Payden	91282CBT7	U.S. TREASURY NOTE	U.S. Treasury Security	2,315,000	3/31/2026
Payden	91282CBW0	U.S. TREASURY NOTE	U.S. Treasury Security	1,595,000	4/30/2026
Payden	91282CCF6	U.S. TREASURY NOTE	U.S. Treasury Security	470,000	5/31/2026
Payden	91282CCJ8	U.S. TREASURY NOTE	U.S. Treasury Security	470,000	6/30/2026
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	91282CEF4	U.S. TREASURY NOTE	U.S. Treasury Security	1,350,000	3/31/2027
Payden	91282CEN7	U.S. TREASURY NOTE	U.S. Treasury Security	900,000	4/30/2027
Payden	91282CET4	U.S. TREASURY NOTE	U.S. Treasury Security	730,000	5/31/2027
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	91282CFU0	U.S. TREASURY NOTE	U.S. Treasury Security	130,000	10/31/2027
Payden	91282CFZ9	U.S. TREASURY NOTE	U.S. Treasury Security	2,230,000	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	313396DX8	FHLMC DISCOUNT NOTE	U.S. Agency Security	110,000,000	4/4/2023
Payden	313384DY2	FHLB DISCOUNT NOTE	U.S. Agency Security	500,000,000	4/5/2023
Payden	313396DY6	FHLMC DISCOUNT NOTE	U.S. Agency Security	300,000,000	4/5/2023
Payden	313396ED1	FHLMC DISCOUNT NOTE	U.S. Agency Security	50,000,000	4/10/2023
Payden	313588ED3	FNMA DISCOUNT NOTE	U.S. Agency Security	15,000,000	4/10/2023
Payden	313396EG4	FHLMC DISCOUNT NOTE	U.S. Agency Security	80,000,000	4/13/2023
Payden	313384EX3	FHLB DISCOUNT NOTE	U.S. Agency Security	70,000,000	4/28/2023
Payden	313396FA6	FHLMC DISCOUNT NOTE	U.S. Agency Security	60,000,000	5/1/2023
Payden	313384FB0	FHLB DISCOUNT NOTE	U.S. Agency Security	31,000,000	5/2/2023
Payden	313384FH7	FHLB DISCOUNT NOTE	U.S. Agency Security	50,000,000	5/8/2023

LA Care Securities Holdings
as of March 31, 2023

Porfolio	CUSIP/Identifier	Security	Type	Par	Maturity date
Payden	313384FU8	FHLB DISCOUNT NOTE	U.S. Agency Security	43,000,000	5/19/2023
Payden	3130AUGN8	FHLB C 7/10/23 Q	U.S. Agency Security	7,500,000	1/10/2024
Payden	3135GADV0	FNMA C 7/25/23 1X	U.S. Agency Security	7,500,000	1/25/2024
Payden	3130AVGN6	FHLB C 4/27/23 M	U.S. Agency Security	8,500,000	3/27/2024
Payden	3134GYFM9	FHLMC C 8/1/23 Q	U.S. Agency Security	5,000,000	8/1/2024
Payden	911759MW5	HOUSING URBAN DEVELOPMENT	U.S. Agency Security	140,000	8/1/2023
Payden	3130ASME6	FHLB	U.S. Agency Security	1,200,000	7/8/2024
Payden	3130ATT31	FHLB	U.S. Agency Security	1,320,000	10/3/2024
Payden	3134GXDZ4	FHLMC C 11/25/22 Q	U.S. Agency Security	510,000	11/25/2024
Payden	3135G0X24	FNMA	U.S. Agency Security	940,000	1/7/2025
Payden	3134GXS88	FHLMC C 02/28/23 Q	U.S. Agency Security	570,000	2/28/2025
Payden	3135G03U5	FNMA	U.S. Agency Security	960,000	4/22/2025
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	45950KCW8	INTL FINANCE CORP FRN SOFRRATE	Non U.S. Government Bond	10,000,000	6/30/2023
Payden	45950VQM1	INTL FINANCE CORP FRN SOFRRATE	Non U.S. Government Bond	8,430,000	4/3/2024
Payden	459058KK8	INTL BK RECON & DEVELOP FRN SOFRINDX	Non U.S. Government Bond	5,720,000	9/23/2026
Payden	459058JV6	INTL BANK RECON & DEVELOP	Non U.S. Government Bond	340,000	4/20/2023
Payden	4581X0DM7	INTER-AMERICAN DEVELOPMENT BANK	Non U.S. Government Bond	300,000	5/24/2023
Payden	4581X0DP0	INTER-AMERICAN DEVELOPMENT BANK	Non U.S. Government Bond	560,000	11/15/2023
Payden	459058JM6	INTL BANK RECON & DEVELOP	Non U.S. Government Bond	580,000	11/24/2023
Payden	83050PP60	SKANDINAV ENSKILDA BK YCD FRN SOFRATE	Negotiable CD	7,500,000	4/12/2023
Payden	53947BJ43	LLOYDS BANK YCD FRN SOFRRATE	Negotiable CD	7,500,000	4/19/2023
Payden	65558UXX5	NORDEA BANK NY YCD FRN	Negotiable CD	7,500,000	4/20/2023
Payden	86959RM31	SVENSKA HANDELSBANKEN NY YCD FRN	Negotiable CD	7,500,000	4/21/2023
Payden	17330QAG2	CITIBANK CD FRN SOFRRATE	Negotiable CD	7,500,000	5/25/2023
Payden	23344NN85	DNB NOR BANK YCD	Negotiable CD	7,500,000	11/2/2023
Payden	06742T4S2	BARCLAYS YCD	Negotiable CD	7,500,000	11/10/2023
Payden	06417MT96	BANK OF NOVA SCOTIA FRN YCD SOFRRATE	Negotiable CD	7,500,000	11/20/2023
Payden	96130ASQ2	WESTPAC BANK YCD	Negotiable CD	7,500,000	11/27/2023
Payden	15654WAH9	CENTURY HOUSING CORP CP TXB	Municipal Securities	2,500,000	4/11/2023
Payden	45130HFC9	ID HSG AGY CP TXB	Municipal Securities	7,500,000	4/13/2023
Payden	79815WDJ4	CA SAN JOSE FIN AUTH LEASE REV CP TXB	Municipal Securities	4,097,000	4/18/2023
Payden	13068PEV4	CA STATE GO/ULT CP TXB	Municipal Securities	7,500,000	4/19/2023
Payden	757696AP4	CA REDONDO BEACH FIN AUTH LEASE REV TXB	Municipal Securities	1,155,000	5/1/2023
Payden	91411US22	CA UNIVERSITY OF CALIFORNIA CP TXB	Municipal Securities	7,500,000	5/2/2023
Payden	83708BBP0	SC SANTEE COOPER CP TXB	Municipal Securities	8,500,000	5/9/2023
Payden	79770TRD2	CA SAN FRAN PUB CP TXB	Municipal Securities	7,500,000	6/6/2023
Payden	576004GV1	MA ST SPL OBLG REV-SOCIAL TXB	Municipal Securities	3,560,000	7/15/2023
Payden	544445BC2	CA LOS ANGELES DEPT AIRPORTS LAX-TXBL	Municipal Securities	865,000	5/15/2023
Payden	13017HAM8	CA ST EARTHQUAKE AUTH TXB	Municipal Securities	440,000	7/1/2023
Payden	84247PHY0	CA SOUTHERN CA PUBLIC POWER TXB	Municipal Securities	750,000	7/1/2023
Payden	79770GGQ3	CA SAN FRANCISCO REDEV AGY TXB	Municipal Securities	500,000	8/1/2023
Payden	835569GQ1	CA SONOMA CNTY CLG DIST TXB	Municipal Securities	350,000	8/1/2023
Payden	42806KAS2	CA HESPERIA REDEV AGY SUCCESSOR TXB	Municipal Securities	790,000	9/1/2023
Payden	79730WAZ3	CA SAN DIEGO REDEV AGY TAB TXB	Municipal Securities	450,000	9/1/2023
Payden	798189RE8	CA SAN JOSE-EVERGREEN CCD TXB	Municipal Securities	390,000	9/1/2023
Payden	801096AR9	CA SANTA ANA CMNTY REDEV AGY TXB	Municipal Securities	450,000	9/1/2023
Payden	56453RAX2	CA MANTECA REDEV AGY TAB TXB	Municipal Securities	500,000	10/1/2023
Payden	54473ERV8	CA LOS ANGELESX CNTY PUB WORKS TXB	Municipal Securities	425,000	12/1/2023
Payden	072024WP3	CA BAY AREA TOLL AUTH TOLL BRDG REV TXB	Municipal Securities	1,220,000	4/1/2024
Payden	13032UVB1	CA HEALTH FACS-NO PLACE LIKE HOME-TXB	Municipal Securities	380,000	6/1/2024
Payden	769036BL7	CA CITY OF RIVERSIDE POB TXB	Municipal Securities	320,000	6/1/2024
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
Payden	365298Y51	CA GARDEN GROVE USD GO/ULT TXB	Municipal Securities	395,000	8/1/2024
Payden	796720MG2	CA SAN BERNARDINO CCD TXB	Municipal Securities	570,000	8/1/2024
Payden	796720NQ9	CA SAN BERNARDINO CCD TXB	Municipal Securities	200,000	8/1/2024
Payden	378460YD5	CA GLENDALE USD GO/ULT TXB	Municipal Securities	250,000	9/1/2024

LA Care Securities Holdings
as of March 31, 2023

Porfolio	CUSIP/Identifier	Security	Type	Par	Maturity date
Payden	798736AW4	CA SAN LUIS WESTLANDS WTR DIST TXB	Municipal Securities	410,000	9/1/2024
Payden	544290JH3	CA LOS ALTOS SCH DIST GO BANS TXB	Municipal Securities	800,000	10/1/2024
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	977100HT6	WI STATE GEN FUND APPROP REV TXB	Municipal Securities	230,000	5/1/2026
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	68609TN61	OREGON ST	Municipal Securities	1,000,000	5/1/2024
NEAM	54438CYJ5	LOS ANGELES CA CMNTY CLG DIST	Municipal Securities	3,350,000	8/1/2024
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	3137FNAV2	FHMS KI04 A 1MOFRN CMBS	Mortgage-Backed Security	85,560	7/25/2024
Payden	3137FBAR7	FHMS KF36 A	Mortgage-Backed Security	7,981	8/25/2024
Payden	3137FYUR5	FHMS Q015 A 1MOFRN CMBS	Mortgage-Backed Security	860,610	8/25/2024
Payden	3137FBUC8	FHMS KF38 A	Mortgage-Backed Security	276,099	9/25/2024
Payden	3137FVNA6	FHMS KI06 A 1MOFRN CMBS	Mortgage-Backed Security	544,852	3/25/2025
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	3,331,353	10/25/2026
Payden	3137B3NX2	FHMS K031 A2	Mortgage-Backed Security	405,700	4/25/2023
Payden	3137B4WB8	FHMS K033 A2	Mortgage-Backed Security	735,237	7/25/2023
Payden	3137B5JM6	FHMS K034 A2	Mortgage-Backed Security	432,128	7/25/2023
Payden	3137BWWE0	FHMS K725 AM CMBS	Mortgage-Backed Security	810,000	2/25/2024
Payden	3137BYPR5	FHMS K726 AM CMBS	Mortgage-Backed Security	570,000	4/25/2024
Payden	3137FUZN7	FHMS KJ30 A1 CMBS	Mortgage-Backed Security	33,643	1/25/2025
Payden	3137FREB3	FHMS KJ28 A1	Mortgage-Backed Security	5,113	2/25/2025
NEAM	459200HU8	IBM CORP	Corporate Security	2,000,000	2/12/2024
NEAM	38141GXE9	GOLDMAN SACHS GROUP INC	Corporate Security	9,000,000	2/20/2024
NEAM	375558AW3	GILEAD SCIENCES INC	Corporate Security	6,000,000	4/1/2024
NEAM	05565EBH7	BMW US CAPITAL LLC	Corporate Security	6,000,000	4/18/2024
NEAM	904764AX5	UNILEVER CAPITAL CORP	Corporate Security	1,250,000	5/5/2024
NEAM	66989HAG3	NOVARTIS CAPITAL CORP	Corporate Security	5,000,000	5/6/2024
NEAM	46625HJX9	JPMORGAN CHASE & CO	Corporate Security	1,000,000	5/13/2024
NEAM	06406HCV9	BANK OF NEW YORK MELLON	Corporate Security	3,750,000	5/15/2024
NEAM	459200JY8	IBM CORP	Corporate Security	3,000,000	5/15/2024
NEAM	14913Q2V0	CATERPILLAR FINL SERVICE	Corporate Security	2,500,000	5/17/2024
NEAM	747525AT0	QUALCOMM INC	Corporate Security	5,000,000	5/20/2024
NEAM	24422ESP5	JOHN DEERE CAPITAL CORP	Corporate Security	2,000,000	6/12/2024
NEAM	02665WCZ2	AMERICAN HONDA FINANCE	Corporate Security	2,250,000	6/27/2024
NEAM	05531FBH5	TRUIST FINANCIAL CORP	Corporate Security	5,000,000	8/1/2024
NEAM	828807DG9	SIMON PROPERTY GROUP LP	Corporate Security	5,000,000	9/13/2024
NEAM	828807CS4	SIMON PROPERTY GROUP LP	Corporate Security	2,500,000	10/1/2024
NEAM	61761JVL0	MORGAN STANLEY	Corporate Security	3,000,000	10/23/2024
NEAM	05348EAU3	AVALONBAY COMMUNITIES	Corporate Security	5,000,000	11/15/2024
NEAM	46647PAY2	JPMORGAN CHASE & CO	Corporate Security	4,000,000	12/5/2024
NEAM	07330NAT2	TRUIST BANK	Corporate Security	4,750,000	12/6/2024
NEAM	976656CL0	WISCONSIN ELECTRIC POWER	Corporate Security	1,500,000	12/15/2024
NEAM	57629WCG3	MASSMUTUAL GLOBAL FUNDIN	Corporate Security	2,500,000	1/11/2025
NEAM	89236TGT6	TOYOTA MOTOR CREDIT CORP	Corporate Security	3,000,000	2/13/2025
NEAM	384802AE4	WW GRAINGER INC	Corporate Security	1,000,000	2/15/2025
NEAM	69353REK0	PNC BANK NA	Corporate Security	2,000,000	2/23/2025
NEAM	57636QAN4	MASTERCARD INC	Corporate Security	3,000,000	3/3/2025
NEAM	30231GBH4	EXXON MOBIL CORPORATION	Corporate Security	2,000,000	3/19/2025
NEAM	254687FN1	WALT DISNEY COMPANY/THE	Corporate Security	3,000,000	3/24/2025
NEAM	458140BP4	INTEL CORP	Corporate Security	2,500,000	3/25/2025
NEAM	341081FZ5	FLORIDA POWER & LIGHT CO	Corporate Security	7,500,000	4/1/2025
NEAM	369550BK3	GENERAL DYNAMICS CORP	Corporate Security	5,000,000	4/1/2025

LA Care Securities Holdings
as of March 31, 2023

Porfolio	CUSIP/Identifier	Security	Type	Par	Maturity date
NEAM	911312BX3	UNITED PARCEL SERVICE	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	4,305,000	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	10,000,000	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
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	9,000,000	3/15/2026
NEAM	90320WAF0	UPMC	Corporate Security	1,000,000	4/15/2026
NEAM	95000U2N2	WELLS FARGO & COMPANY	Corporate Security	10,000,000	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	7,500,000	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	4,750,000	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	3,500,000	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
NEAM	756109BG8	REALTY INCOME CORP	Corporate Security	5,000,000	8/15/2027
NEAM	010392FY9	ALABAMA POWER CO	Corporate Security	7,000,000	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	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	04636NAF0	ASTRAZENECA FINANCE LLC	Corporate Security	5,000,000	3/3/2028
Payden	09659CXS2	BNP PARIBAS NY CP	Commercial Paper	7,500,000	10/26/2023
Payden	4497W1Y34	ING (US) FUNDING CP	Commercial Paper	7,500,000	11/3/2023
Payden	22533UYA5	CREDIT AGRICOLE CP	Commercial Paper	7,500,000	11/10/2023
Payden	29374FAA1	EFF 2022-3 A1 FLEET 144A	Asset-Backed Security	1,874,616	8/20/2023
Payden	36265QAA4	GMCAR 2022-4 A1 CAR	Asset-Backed Security	1,134,924	10/16/2023
Payden	39154TBU1	GALC 2022-1 A1 EQP 144A	Asset-Backed Security	2,256,008	10/16/2023
Payden	65480JAA8	NAROT 2022-B A1 CAR	Asset-Backed Security	1,651,693	10/16/2023
Payden	403951AA4	HPEFS 2022-3A A1 EQP 144A	Asset-Backed Security	557,350	10/20/2023
Payden	29374GAA9	EFF 2022-4 A1 FLEET 144A	Asset-Backed Security	3,385,363	11/20/2023
Payden	606940AA2	MMAF 2022-B A1 EQP 144A	Asset-Backed Security	2,534,772	12/1/2023
Payden	891940AA6	TAOT 2023-A A1 CAR	Asset-Backed Security	2,104,811	1/15/2024
Payden	38013JAA1	GMCAR 2023-1 A1 CAR	Asset-Backed Security	4,416,642	1/16/2024
Payden	44891TAC0	HALST 2021-A A3 LEASE 144A	Asset-Backed Security	591,782	1/16/2024
Payden	44933MAB7	HALST 2021-C A2 CAR LEASE 144A	Asset-Backed Security	224,828	1/16/2024
Payden	14318DAA7	CARMX 2023-1 A1 CAR	Asset-Backed Security	2,833,027	2/15/2024
Payden	345287AA4	FORDL 2023-A A1 LEASE	Asset-Backed Security	1,222,793	2/15/2024
Payden	65480VAA1	NALT 2023-A A1 LEASE	Asset-Backed Security	3,102,918	2/15/2024

LA Care Securities Holdings
as of March 31, 2023

Porfolio	CUSIP/Identifier	Security	Type	Par	Maturity date
Payden	233258AA0	DLLAD 2023-1A A1 EQP 144A	Asset-Backed Security	1,383,827	2/20/2024
Payden	36261RAC2	GMALT 2021-1 A3 LEASE	Asset-Backed Security	998,676	2/20/2024
Payden	43815EAB0	HONDA 2021-3 A2 CAR	Asset-Backed Security	58,589	2/20/2024
Payden	14688EAA7	CRVNA 2023-P1 A1 CAR 144A	Asset-Backed Security	4,815,865	3/11/2024
Payden	50117WAC8	KUBOTA 2020-1A A3 EQP 144A	Asset-Backed Security	604,185	3/15/2024
Payden	80286TAC7	SRT 2021-A A3 LEASE 144A	Asset-Backed Security	2,936,200	7/22/2024
Payden	05591RAD6	BMW 2021-1 A4 LEASE	Asset-Backed Security	2,550,000	7/25/2024
Payden	14315PAD7	CARMAX 2019-3 A3 CAR	Asset-Backed Security	411,203	8/15/2024
Payden	43815BAB6	HAROT 2022-1 A2 CAR	Asset-Backed Security	2,971,599	10/15/2024
Payden	98163NAB2	WOLS 2022-A A2 LEASE	Asset-Backed Security	1,031,219	10/15/2024
Payden	89239CAC3	TLOT 2021-B A3 LEASE 144A	Asset-Backed Security	5,967,934	10/21/2024
Payden	92868KAB9	VALET 2021-1 A2 CAR	Asset-Backed Security	1,370,133	10/21/2024
Payden	14317JAB3	CARMX 2021-4 A2A CAR	Asset-Backed Security	406,320	11/15/2024
Payden	47787NAC3	JOHN DEERE 2020-B A3 EQP	Asset-Backed Security	1,997,429	11/15/2024

L.A. Care Health Plan
Quarterly Investment Compliance Report
January 1, 2023 through March 31, 2023

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 January 1, 2023 through March 31, 2023.

PORTFOLIO SUMMARY

As of March 31, 2023, the market values of the portfolios managed by Payden & Rygel and New England Asset Management are as follows:

Portfolios	Payden & Rygel
Cash Portfolio #2365	*$2,781,405,279.19*
Low Duration Portfolio #2367	*$90,716,649.13*
Total Combined Portfolio	**$2,872,121,928.32**

Portfolios	NEAM
Government and Corporate Debt	**$326,969,735.22**

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 April 4, 2023, the March 31, 2023 balance is reported as $73,696,547.62 with accrued interest of $488,519. In the LACPIF statement dated April 6, 2023, the March 31, 2023 balance is reported as $156,101,106.13. The LACPIF account balance does not reflect accrued interest.

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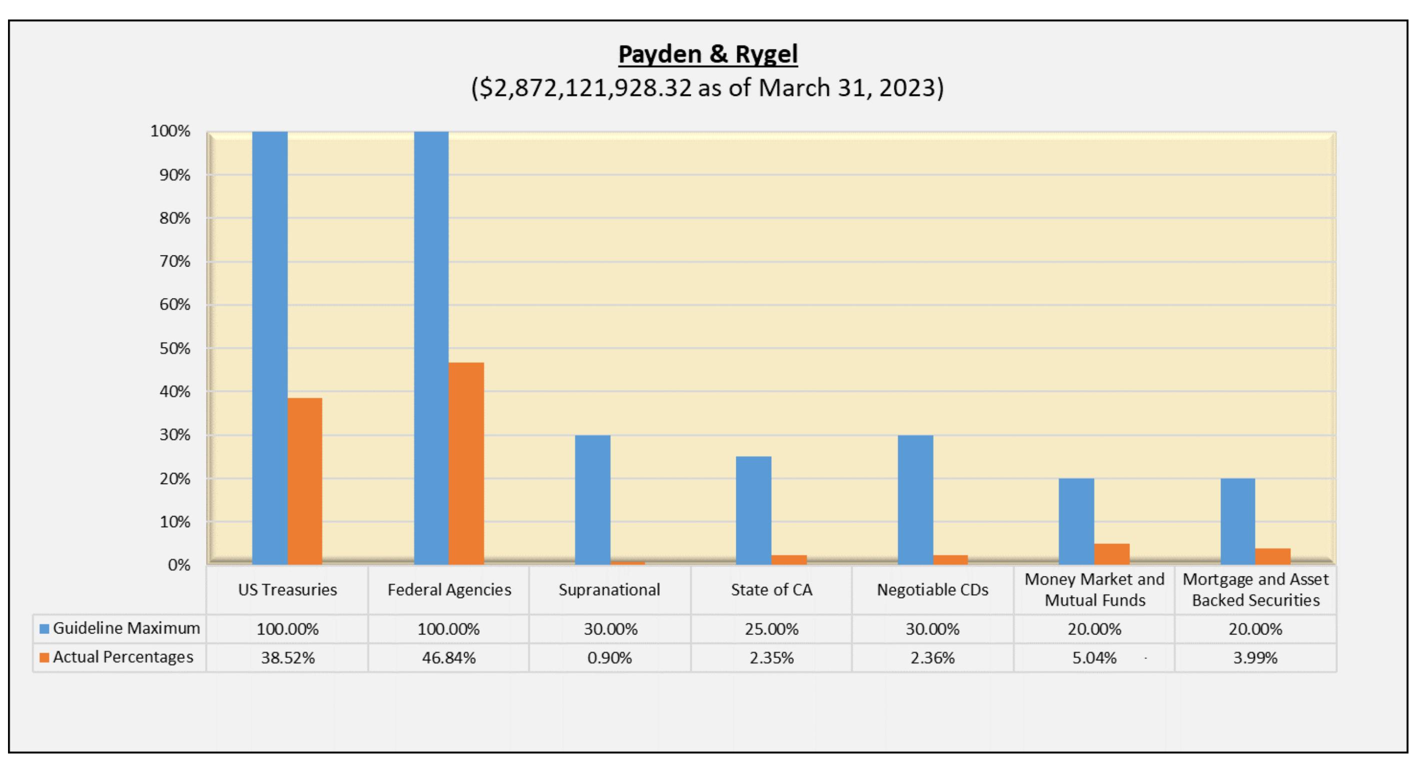
Payden & Rygel Compliance Verification

California Government Code Compliance Verification Detail as of March 31, 2023



	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	0.82 Years	4.92 Years	YES
Federal Agencies	5 Years	5 Years	1.34 Years	2.87 Years	YES
Supranational	5 Years	5 Years	3.48 Years	1.01 Years	YES
State of CA	5 Years	5 Years	0.29 Years	4.29 Years	YES
Negotiable CDs	270 Days	270 Days	241 days	-	YES
Money Market and Mutual Funds	NA	NA	1 Day	1 Day	YES
Mortgage and Asset Backed Securities	5 Years	5 Years	3.57 Years	3.21 Years	YES

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Payden & Rygel Compliance Verification

Combined #2365 and #2367 Portfolios as of March 31, 2023

	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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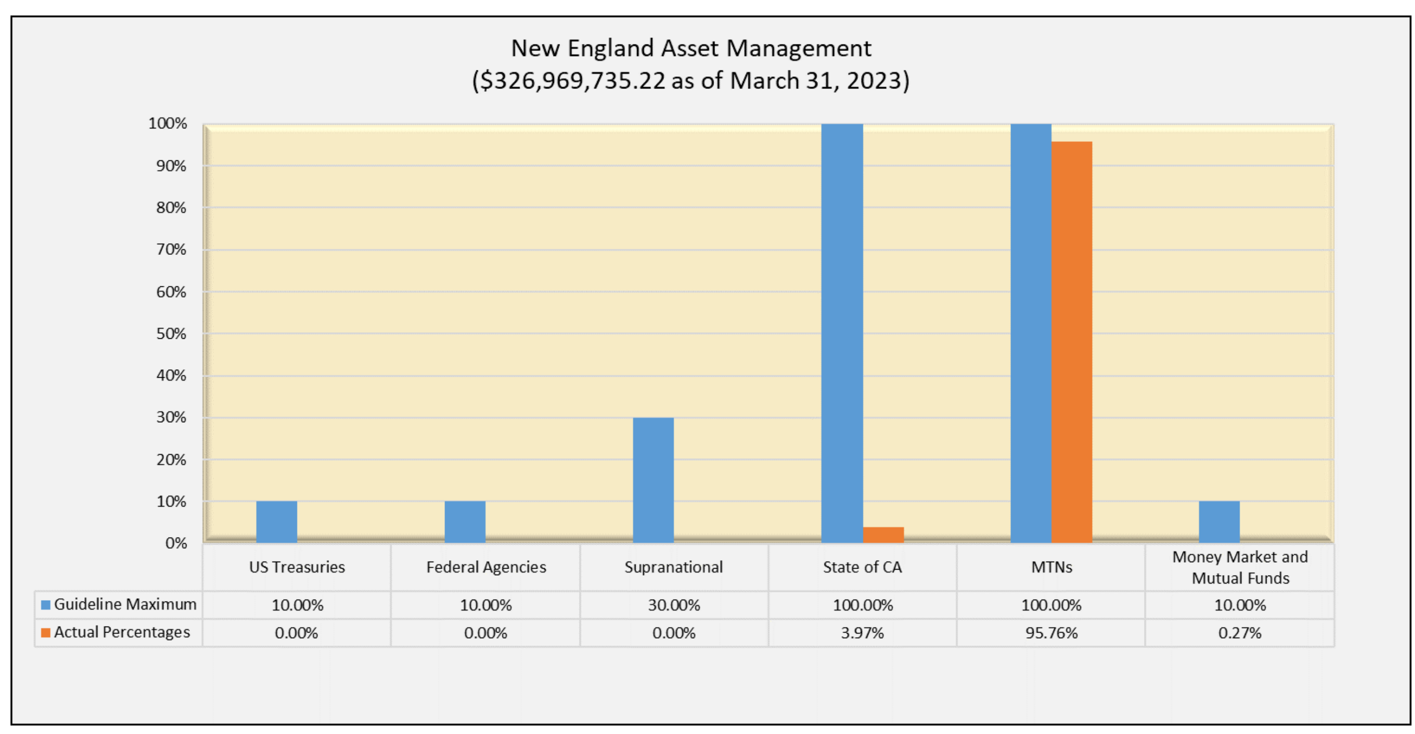
New England Asset Management Compliance Verification

California Government Code Compliance Verification Detail as of March 31, 2023



	Maximum Permitted Maturity	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	3.50 Years	**YES**
MTNs	5 Years	4.93 Years	**YES**
Money Market and Mutual Funds	NA	1 Day	**YES**

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New England Asset Management Compliance Verification

As of March 31, 2023

	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 was positive during the fourth quarter, expanding an annualized 2.6%. Growth for all of 2022 was modest at 0.9% after a rebound year in 2021, when the economy grew by 5.7%. Consumer, business and government spending all contributed to growth during the fourth quarter. The Atlanta Fed's GDPNow forecast for the first quarter of 2023 currently stands at 2.5%.
  Source: Bureau of Economic Analysis

- **Interest Rates**: The Treasury curve fell for maturities one year and higher during the first quarter and rose modestly in the shorter end of the curve. The 10-year Treasury closed at 3.47%, down 41 basis points. The 10-year real yield (i.e., net of inflation) fell 43 basis points to 1.15%. The Federal Open Market Committee increased their overnight rate by 0.50%, targeting a range of 4.75% to 5.00%. The committee's current median outlook is for a rate of approximately 5.1% by the end of 2023.
  Source: U.S. Treasury

- **Inflation**: Consumer price changes have moderated as the Consumer Price Index rose 1.0% for the three months ending February. For the one-year period, the CPI was up 6.0%. The 10-year break-even inflation rate was little changed at 2.32% in March versus 2.30% in December.
  Source: Dept. of Labor (BLS), U.S. Treasury

- **Employment**: Jobs growth remains solid, with an average of 351k jobs/month added during the three months ending in February. The unemployment rate was unchanged at 3.6%, as it was in November. Wage growth has slowed this year, up 0.2% in February, a likely welcome sign for the Federal Reserve.
  Source: Dept. of Labor (BLS)

U.S. Fixed Income Markets

The U.S. Treasury yield curve was up in the short-end (below 1-year) by approximately 50 basis points but fell across the remainder of the curve. The 10-year Treasury yield ended the quarter at 3.47%, down 41 basis points from December. Credit spreads were little changed during the quarter with investment grade up 8 basis points and high yield bonds down 14 basis points. The Federal Open Market Committee met twice during the quarter, as scheduled, and increased the overnight rate by 0.25% in both January and March, targeting a range of 4.75% to 5.00%. The Fed's "dot plot" is messaging that the current expectation is for another 25 basis point increase before the end of 2023 while markets are pricing a year-end rate that would be approximately 50 basis points lower than the current rate. Following the March meeting, Fed Chair Jerome Powell tried to ensure market participants that banking issues were isolated to a few banks and that the broader system was "sound and resilient."

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Payden&Rygel
Quarterly Portfolio Review

1st Quarter 2023

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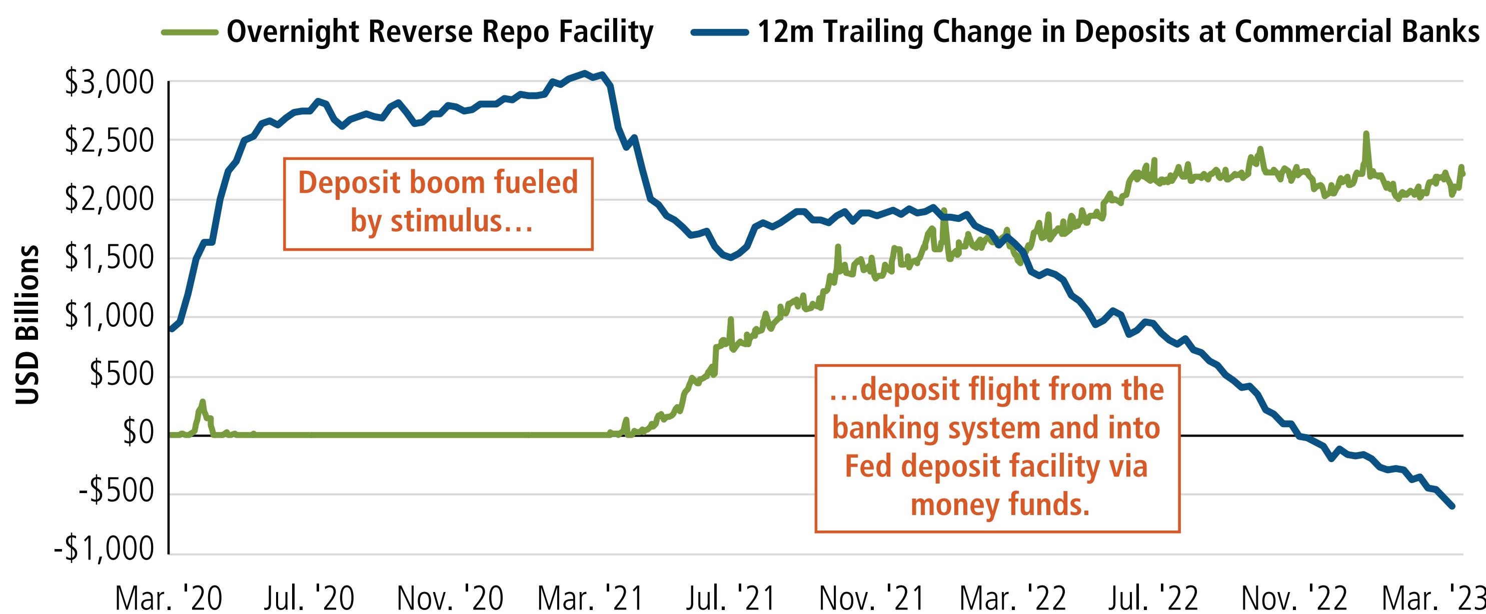
From the desk of Joan Payden:

- 2023 started on a positive note, as stocks and bonds recovered, inspired by China re-opening its economy after Covid and a resilient U.S. economy led by the stellar labor market data.
- As a consequence, the U.S. central bank and its global peers continued to tighten monetary policy due to elevated inflation and a tight labor market during the first quarter.
- However, a banking crisis—partly due to tighter financial conditions engendered by central banks—erupted during the quarter and upstaged many positive macro developments.
- Unfortunately, despite the good news to start the year, banking crises typically have preceded slowdowns in economic growth, raising the probability of a recession. It is too soon to fully gauge the economic fallout from the bank failures seen in Q1, but small and medium-sized banks play a critical role in credit creation for the U.S. economy. As a result, we maintain a cautious stance with our client portfolios, focusing on higher quality holdings to help cushion against a potential recession in the next 12 months.

DEPOSIT BOOM TURNED INTO A FLIGHT; THE DEPOSIT DRAWDOWN WILL CONTINUE TO STRESS BANKS



*Source: Federal Reserve *reports loans that were extended to depository institutions established by the Federal Deposit Insurance Corporation (FDIC)*

MARKET THEMES FOR Q1

- Interest rates fell, and the U.S. dollar weakened in the first quarter as investors interpreted the banking issues as signs that the Fed would soon pause its rate hikes and maybe even reverse course. Given how far inflation hovers above the central bank's target, we remain skeptical about rate cuts, though we acknowledge the end of hiking is approaching.
- Risk markets, including equities, emerging markets debt, and high yield, were among the best-performing sectors for the quarter.

OUTLOOK

- We will remain cautious in Q2 as elevated inflation will keep monetary policy restrictive while the knock-on effects of the banking crisis have yet to be felt.
- Since banking contractions usually precede recessions, recession risks will keep us neutral on duration and focused on portfolio quality.

L.A. CARE HEALTH PLAN COMBINED PORTFOLIO

Portfolio Review and Market Update – 1st Quarter 2023

PORTFOLIO CHARACTERISTICS (As of 3/31/2023)

Market Value	2,872,121,928
Avg Credit Quality	AAA
Avg Duration	0.16
Avg Yield to Maturity	4.55%

SECTOR ALLOCATION

Sector	Market Value	% of Port
Cash	120,700,767	4.20%
Money Market	89,546,476	3.12%
Treasury	1,106,211,012	38.52%
Agency	1,344,992,497	46.83%
Government Related	25,999,014	0.91%
Credit	-	0.00%
ABS/MBS	114,640,097	3.99%
Municipal	70,032,065	2.44%
Total	2,872,121,928	100.0%

MATURITY DISTRIBUTION

Sector	Market Value	% of Port
<90 day	2,405,559,316	83.8%
90 days - 1 Year	385,970,783	13.4%
1 - 2 Years	33,130,913	1.2%
2 - 5 years	47,460,916	1.7%
Total	2,872,121,928	100%

PORTFOLIO RETURNS

Periods over one year annualized

Periods ended 3/31/2023

Performance	1st Quarter	Trailing 1 Year	Trailing 3 Year
LA Care - Short-Term Portfolio	**1.10**	**2.57**	**0.96**
Benchmark*	1.07	2.50	0.89
LA Care - Extended-Term Portfolio	**1.74**	**0.32**	**-0.58**
Benchmark**	1.86	-0.35	-1.46
LA Care - Combined Portfolio	**1.11**	**2.39**	**0.87**

* 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 – 1st Quarter 2023

PORTFOLIO CHARACTERISTICS (As of 3/31/2023)

Market Value	2,781,405,279
Avg Credit Quality	AAA
Avg Duration	0.10
Avg Yield to Maturity	4.56%

SECTOR ALLOCATION

Sector	Market Value	% of Port
Cash	120,423,793	4.33%
Money Market	89,546,476	3.22%
Treasury	1,057,668,977	38.03%
Agency	1,335,987,619	48.03%
Government Related	23,312,060	0.84%
Corporate Credit	-	0.00%
ABS/MBS	104,469,147	3.76%
Municipal	49,997,207	1.80%
Total	2,781,405,279	100.0%

MATURITY DISTRIBUTION

Sector	Market Value	% of Port
<90 day	2,400,902,022	86.3%
90 days - 1 Year	369,950,975	13.3%
1 - 2 Years	10,552,282	0.4%
2 - 5 years	-	0.0%
Total	2,781,405,279	100.0%

PORTFOLIO RETURNS

Periods over one year annualized

Periods ended 3/31/2023

Performance	1st Quarter	Trailing 1 Year	Trailing 3 Year
L.A. Care - Short-Term Portfolio	**1.10**	**2.57**	**0.96**
Benchmark*	1.07	2.50	0.89

* ICE BofA 91 Day Treasury Index

L.A. CARE HEALTH PLAN EXTENDED TERM PORTFOLIO

Portfolio Review and Market Update – 1st Quarter 2023

PORTFOLIO CHARACTERISTICS (As of 3/31/2023)

Market Value	90,716,649
Avg Credit Quality	AA+
Avg Duration	2.06
Avg Yield to Maturity	4.40%

SECTOR ALLOCATION

Sector	Market Value	% of Port
Cash	276,974	0.31%
Money Market	-	0.00%
Treasury	48,542,035	53.51%
Agency	9,004,878	9.93%
Government Related	2,686,954	2.96%
Credit	-	0.00%
ABS/MBS	10,170,951	11.21%
Municipal	20,034,858	22.09%
Total	90,716,649	100.0%

MATURITY DISTRIBUTION

Sector	Market Value	% of Port
<90 day	4,657,294	5.1%
90 days - 1 Year	16,019,808	17.7%
1 - 2 Years	22,578,631	24.9%
2 - 5 years	47,460,916	52.3%
Total	90,716,649	100%

PORTFOLIO RETURNS

Periods over one year annualized

Periods ended 3/31/2023

Performance	1st Quarter	Trailing 1 Year	Trailing 3 Year
LA Care - Extended-Term Portfolio	**1.74**	**0.32**	**-0.58**
Benchmark**	1.86	-0.35	-1.46

** Bloomberg US Govt 1-5 Yr Bond Index

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Multi-Sector

Short Maturity Bonds

U.S. Core Bond

Absolute Return Fixed Income

Strategic Income

Global Fixed Income

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Sector-Specific

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Government/Sovereign

High Yield Bonds & Loans

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MILAN
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+39 02 76067111

L.A. Care Health Plan

NEAM's L.A. Care Board Report

Data as of March 31, 2023

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

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Portfolio Summary

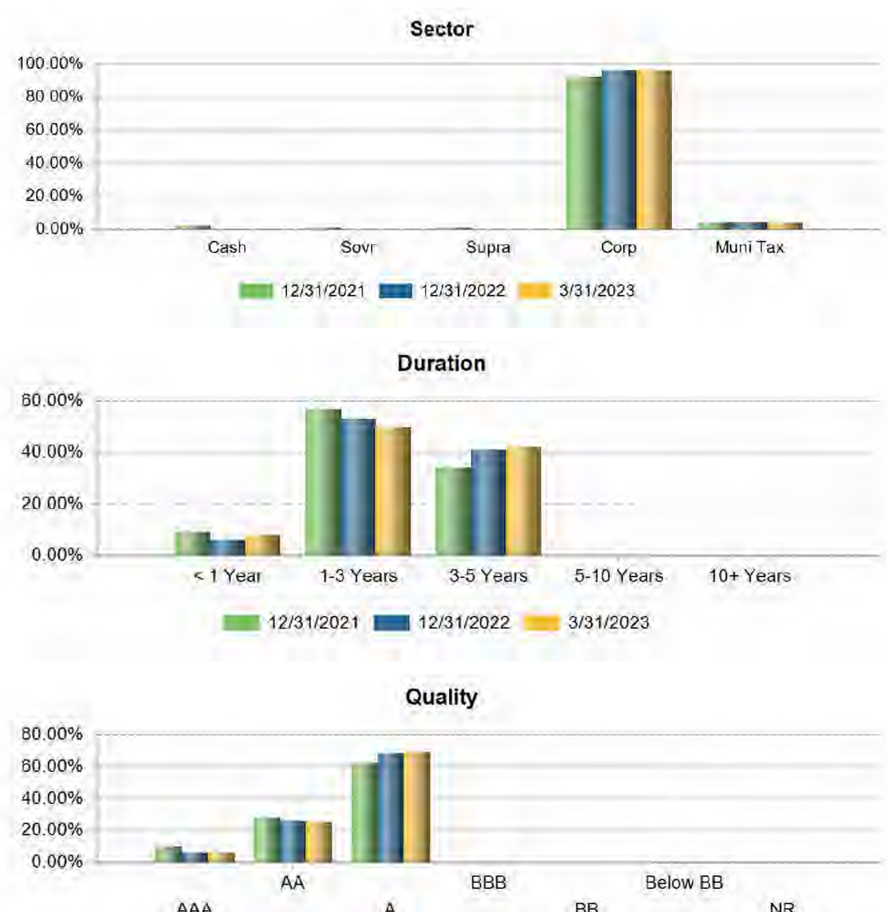
L.A. Care Health Plan - Comparative Overview

	12/31/2021	12/31/2022	3/31/2023	Change since 12/31/2022
Portfolio Overview (000's Omitted)				
Book Value	330,684	336,962	338,645	1,682
Market Value	334,273	319,103	324,381	5,278
Total Unrealized Gain/Loss	3,589	(17,859)	(14,263)	3,596
Net Gains	5,519	764	1,355	591
Net Losses	(1,929)	(18,622)	(15,618)	3,005
Realized Gain / Loss	1,024	(744)	(321)	
Annualized Book Income	6,490	8,399	8,769	369
After Tax Book Income	5,127	6,635	6,927	292
Asset Types				
Cash / Cash Equivalents	1.7%	0.2%	0.3%	0.1%
Taxable Fixed Income	98.3%	99.8%	99.7%	(0.1%)
Portfolio Yields				
Book Yield (Before Tax)	1.96%	2.49%	2.59%	0.10%
Book Yield (After Tax)	1.55%	1.97%	2.05%	0.08%
Market Yield	1.14%	4.88%	4.74%	(0.14%)
Fixed Income Analytics				
Average OAD	2.42	2.60	2.59	(0.01)
Average Life	2.62	2.86	2.87	0.01
Average OAC	6.66	8.71	8.42	(0.29)
Average Quality	A+	A+	A+	
144A %	12.43%	11.35%	11.33%	(0.02%)
Average Purchase Yield	1.06%	4.09%	4.77%	0.69%
Average Spread Over Tsy	38	84	66	(18)
5 Year US Govt On The Run	1.26%	3.96%	3.63%	(0.33%)

	12/31/21	12/31/22	03/31/23	Change since 12/31/2022
MV Excl. Acc. Int. Inc.	334,273,290	319,103,446	324,381,481	5,278,035
Acc. Int. Inc.	2,394,948	2,456,342	2,588,254	131,913
MV Inc. Acc. Int. Inc.	336,668,238	321,559,788	326,969,735	5,409,947

L.A. Care Health Plan - Fixed Income Summary

	12/31/2021	12/31/2022	3/31/2023	Change since 12/31/2022
Sector				
Cash & Cash Equivalents	2%	< 1%	< 1%	< 1%
Sovereigns	1%	-	-	-
Supranationals	1%	-	-	-
Corporates	92%	96%	96%	-
Municipals - Taxable	4%	4%	4%	-
Fixed Income	100%	100%	100%	
Duration				
< 1 Year	9%	6%	8%	2%
1-3 Years	57%	53%	50%	(3%)
3-5 Years	34%	41%	42%	1%
Average Duration	2.42	2.60	2.59	(0.01)
Quality				
AAA	10%	6%	6%	-
AA	28%	26%	25%	(1%)
A	62%	68%	69%	1%
Average Quality	A+	A+	A+	



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	20,167	95.1	68	4.80	A	4.30
Municipals - Taxables	1,046	4.9	24	4.32	AA	3.23
Total Purchases	21,213	100.0	66	4.77	A+	4.25

Sales	Market Value	%	Realized G/L	Trade / Book Yld	High	Duration
Corporates	19,250	100.0	(321)	5.31 / 3.40	A+	0.90
Total Sales	19,250	100.0	(321)	5.31 / 3.40	A+	0.90

Tax Equivalent Spread for Municipal bonds calculated at time of purchase, excluding floating rate securities.

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Performance Report

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

	Mar 2023 Market*	Mar 2023	Feb 2023	Jan 2023	Q1	Annualized 12 Month	Annualized 3 Year	Annualized 5 Year	Annualized Inception	Inc Date
LA Care HealthPlan	326,970	1.60	(1.07)	1.16	1.68	0.25	0.61	1.88	1.64	Jan 2018
Barclay Bloomberg U.S. Credit: 1-5 Yr A- or better (Highest)		1.56	(1.19)	1.40	1.75	(0.36)	(0.10)	1.63	1.41	Jan 2018
Difference		0.04	0.12	(0.24)	(0.07)	0.61	0.71	0.25	0.23	

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

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

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	871,164	871,164	871,164	-	4.61	4.76	0.08	0.05	0.08	0.27
Corporates	285,657,000	284,652,751	273,844,285	(10,808,466)	2.73	4.77	2.59	8.33	2.90	84.42
144A	39,500,000	39,245,079	36,767,640	(2,477,439)	2.13	4.56	2.83	10.36	2.99	11.33
Municipals - Taxable	13,800,000	13,875,749	12,898,391	(977,358)	0.90	4.69	2.03	5.50	2.10	3.98
Total Portfolio	**339,828,164**	**338,644,743**	**324,381,481**	**(14,263,262)**	**2.59**	**4.74**	**2.59**	**8.42**	**2.87**	**100.00**

Rating Analysis - Highest

	% of Portfolio
AAA	6.21
AA	24.57
A	69.23
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	0.22	0.16	0.08	0.04	(0.04)	(0.08)	(0.16)	(0.24)
Corporates	8.13	5.35	2.64	1.31	(1.29)	(2.55)	(5.02)	(7.40)
144A	8.97	5.87	2.89	1.43	(1.40)	(2.78)	(5.46)	(8.05)
Municipals - Taxable	6.33	4.16	2.05	1.02	(1.01)	(2.00)	(3.94)	(5.84)
Total Portfolio	**8.13**	**5.35**	**2.63**	**1.31**	**(1.29)**	**(2.55)**	**(5.01)**	**(7.39)**

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	871,164	0.08	-	-	-	-	-	-	-	-
Corporates	273,844,285	0.25	0.49	1.01	0.85	< 0.00	-	-	-	-
144A	36,767,640	0.19	0.25	1.63	0.76	-	-	-	-	-
Municipals - Taxable	12,898,391	0.29	1.00	0.67	0.06	-	-	-	-	-
Total Portfolio	**324,381,481**	**0.24**	**0.48**	**1.07**	**0.80**	**< 0.00**	**-**	**-**	**-**	**-**

Disclaimers

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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.

Clients will experience different results from any projected returns shown. There is a potential for loss, as well as gain, that is not reflected in the projected information portrayed. The projected performance results shown are for illustrative purposes only and do not represent the results of actual trading using client assets but were achieved by means of the prospective application of certain assumptions. No representations or warranties are made as to the reasonableness of the assumptions. Results shown are not a guarantee of performance returns. Please carefully review the additional information presented by NEAM.

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Board of Governors
MOTION SUMMARY

Date: May 4, 2023 **Motion No.** **FIN 101.0523**

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

Issue: Amend the existing contract with Health Dialog to continue providing access to Nurse Advice Line (NAL) and online Health and Wellness Platform (HWP) to meet regulatory requirement and add funds in the amount of $8,720,000.

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

Background: L.A. Care staff requests approval to amend the existing contract with Health Dialog to extend the NAL term by three additional years through August 2026 and HWP term until December 2023 and add funds in the amount of $8,720,000 (NAL: $8,400,000; HWP: $320,000). Health Dialog provides NAL and HWP services under two separate scopes of work.

Health Dialog provides access to Nurse Advice Line (NAL) services 24 hours per day, 7 days per week (24/7) to L.A. Care's direct line of business members in their preferred language. The NAL supports L.A. Care's compliance with timely access to telephonic medical advice by a licensed professional. NAL provides members with timely access to licensed Registered Nurses to assist them in making informed decisions regarding care, promote appropriate triaging, and redirection that may subsequently reduce emergency department utilization. The NAL contract amendment will extend the duration to August 31, 2026.

Health Dialog also provides an online Health & Wellness Portal (HWP) through a subcontract with Cerner Corporation. The HWP offers health appraisal and self-management tools, such as health education materials and videos that meet the National Commission on Quality Assurance (NCQA) Population Health Management (PHM 4) Standard for which L.A. Care receives NCQA auto credit. Through Health Dialog's delegated relationship with Cerner, administrative processes are streamlined such as contract execution, vendor management and relations, performance oversight and compliance. The HWP amendment will extend the contract to December 31, 2023, as the Cerner HWP services will be sun setting at the end of year.

Health Dialog was selected as the result of a competitive Request for Proposal (RFP) process for both NAL and HWP services in February 2019, based on their performance metrics, larger NAL staffing pool, NCQA certification for HWP, proven ability to meet and exceed L.A. Care's key performance indicators (KPIs), and pricing. The Health Education staff will continue assuring vendor's performance through regular monitoring of their services and KPI's.

The contract extension and additional funds will ensure compliance with the regulatory requirement and provision of uninterrupted NAL and HWP services to L.A. Care DLOB members. The additional funds were estimated based on the monthly average expenditure for the last year based on eligible membership, PMPM cost and includes an additional 5% to accommodate anticipated utilization increase due to membership growth. In 2019, the total L.A. Care Health Plan membership eligible for these services was at 1.2 million members, whereas the current eligible membership for both NAL and HWP is at 1.6

million members. The growth in membership has resulted in an increase in the annual utilization and PMPM based on eligible population necessitating an increase in funds requested for both services. The rates for NAL and HWP will stay the same as negotiated in 2019.

In 2019, the Board of Governors approved $7,000,000 for NAL and $2,000,000 for HWP contracts (FIN BOG 107.1119). With the three year contract extension for NAL and 4 month contract extension for HWP, the additional funds requested are as follows:

Health Dialog (Service Type)	Current Contract Total	Amendment Term	Funds requested for additional term	Revised Contract Total
Nurse Advice Line	$7,000,000	9/1/2023 to 8/31/2026	$8,400,000	$15,400,000
Health & Wellness Platform	$2,000,000	9/1/2023 to 12/31/2023	$320,000	$2,320,000
Total			**$8,720,000**	$17,720,000

<u>Member Impact</u>: L.A. Care members will continue to benefit from access to an advice/triage line available 365/24/7 that better informs members regarding their healthcare options, along with the convenience of online health and wellness tools and information. Since the NAL recommends the most clinically appropriate setting for treatment of a symptom, over a rolling 12-month period, approximately 75% of symptom check calls for emergency room were able to be directed to a less acute setting based on NAL Coach's recommendation. Continuation of these services will promote timely medical advice, member satisfaction and ensure L.A. Care's compliance with regulatory and accreditation requirements.

<u>Budget Impact</u>: Sufficient funds for Health and Wellness Platform are budgeted for FY 2022-2023. Funds for NAL are budgeted in the current fiscal year and will be requested for subsequent fiscal years.

<u>Motion</u>: **To extend contract term with Health Dialog to provide Nurse Advice Line for three additional years (September 2023 to August 2026) and Health & Wellness Platform services for additional four months (September 2023 to December 2023) in the amount of $8,720,000 for a new aggregate contract total of $17,720,000.**

Board of Governors

MOTION SUMMARY

Date: May 4, 2023 **Motion No. FIN 102.0523**

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

Issue: Amend Statement of Work No. 1 (SOW 1) with Integrated Healthcare Association (IHA) to provide Symphony Utility provider directory services.

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

Background: L.A. Care staff requests approval to execute an amendment to SOW 1 with IHA that extends the term by 3 years, from June 1, 2023 to May 31, 2026, and increases the maximum compensation by $1,207,658, from $1,000,000 to $2,207,658.

Currently, L.A. Care is engaged in a 3-year agreement with IHA from June 1, 2020 to May 31, 2023, under which IHA provides L.A. Care with access to a web application called, the Symphony Utility. The Symphony Utility is a platform that ingests, validates, and maintains accurate and detailed demographic, services, products, and network information for health care providers contracted with IHA. L.A. Care utilizes the Symphony Utility to validate provider information submitted by Participating Provider Groups (PPGs) and remediate data discrepancies within L.A. Care's provider data domains that feed downstream functions including utilization management and generation of the provider directory. The current Covered California agreement requires L.A. Care to use the Symphony Utility to populate and continuously maintain the Covered California Provider Directory.

L.A. Care has used IHA's Symphony Utility as required since June 1, 2020 and is satisfied with the progress IHA has made in implementing and enhancing the Symphony Utility.

No request for proposal was conducted for this vendor since it is the only authorized vendor specified in the Covered California agreement with L.A. Care.

Member Impact: L.A. Care members will benefit from this motion through the enhanced accuracy of provider demographic information in the online provider directory. The increased accuracy will reduce the occurrence of incorrect and/or erroneous provider information displayed in the directory. It also gives members up-to-date information about providers and contributes to appropriate decision making about their health care.

Budget Impact: The cost was anticipated and included in the approved budget for Provider Data Management for the current fiscal year and the balance will be budgeted in future fiscal years.

Motion: **To authorize staff to amend SOW 1 with the Integrated Healthcare Association to extend the term for 3 years through May 31, 2026, and increase the total compensation by $1,207,658, from $1,000,000 to $2,207,658.**

Board of Governors
MOTION SUMMARY

Date: May 4, 2023 **Motion No. FIN 103.0523**

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

Issue: Amend a contract with O'Neil Digital Solutions, LLC to continue to provide L.A. Care with EOB (Explanation of Benefits) and Threshold Certificate printing and mailing services to our members for our L.A. Care Covered (LACC), Direct (LACCD) and PASC-SEIU members. As well as, providing L.A. Care members with the ability to access EOB & Threshold Certificate documents electronically and to update their preference on whether to receive electronic document and/or hardcopy mailing of EOB (Explanation of Benefits) and Threshold Certificate, via an SSO (Single Sign On) connection between Member Portal (HealthX) and O'Neil's Platform. Our internal staff will continue to have access to the vendor-hosted portal for document access. Also, to expand the Threshold Certificates fulfillment to include D-SNP LOB.

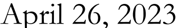
☐ **New Contract** ☒ **Amendment** ☐ **Sole Source** ☐ **RFQ was conducted**

Background: L.A. Care staff requests approval to amend a contract with O'Neil Digital Solutions, LLC in the amount of $1,000,000 through June 30, 2024. The original approved amount was $2,000,000. The vendor will provide us with a solution and implementation services for L.A. Care Covered (LACC) and PASC members to have the ability to access their EOB & TC documents electronically as well as update their EOB and Threshold Certificate documents delivery preference via an SSO (Single Sign On). In addition, the vendor will continue to provide L.A. Care LACC, LACCD and PASC members with EOB and Threshold Certificate electronic delivery and/or printing and mailing services as well as Threshold Certificates for D-SNP members.

Member Impact: L.A. Care Members will benefit from this motion through being able to receive their EOB and TCs via mail, as well as access their documents electronically and set their delivery preference.

Budget Impact: Sufficient funds are accounted for in the Marketing Department budget for FY 2022-23. Budget will be appropriated in FY 2023-24.

Motion: **To authorize staff to amend a contract with O'Neil Digital Solutions, LLC in the amount of $1,000,000 (total amount not to exceed $3,000,000), through June 30, 2024 for electronic and/or printing and mailing services.**



April 26, 2023

TO: Board of Governors

FROM: John Baackes, *Chief Executive Officer*

SUBJECT: CEO Report – May 2023

Two publications were released in late April which highlighted the power of L.A. Care as a public option in L.A. County. The Journal of the American Medical Association JAMA Health Forum released an Original Investigation which concluded that L.A. Care's presence in the Covered California marketplace as resulted in a decline in premium growth in the L.A. market by 4.8%. T he resulting savings from 2019-2022 was $345 million. A second article from the Commonwealth Fund cited this data and proposed a statewide public option for all of California. The importance of these two publications underscores the position L.A. Care has claimed as the only functioning public option health plan in the United States. Our model is a catalyst and a best practice.

This past month we've been busy implementing our redeterminations strategy for our Medi-Cal members. L.A. Care completed a redetermination robocall campaign that launched in mid-March. We are also launching L.A. Care's first redetermination text message campaign in May, which will last two months. In addition, we are providing outreach to include Covered California information to support continuous coverage for individuals who are potentially no longer eligible for Medi-Cal. Other member outreach strategies include social media postings and stories, an upcoming social media live collaboration with providers, and the redeterminations marketing campaign consisting of social media ads, bus shelter ads, and radio segments. On May 10, L.A. Care will be conducting a redeterminations webinar for the provider network, in collaboration with our Plan Partners, Anthem Blue Cross and Blue Shield Promise. Every effort is being made to ensure that members retain continuity of coverage as redeterminations resume.

Following is a snapshot of our progress on some of our community- and provider-focused work.

	Since Last CEO Report (3/27/23)	As of 4/26/23
Provider Recruitment Program Physicians hired under PRP[1]	—	152
Provider Loan Repayment Program Active grants for medical school loan repayment[2]	—	138
Medical School Scholarships Grants for medical school scholarships[3]	—	40
Elevating Community Health Home care worker graduates from CCA's IHSS training program	—	5,601

Notes:
1. The number of physicians fluctuates as physicians are hired and/or leave clinics.
2. The number of active grants for loan repayment may decrease due to physicians completing their service commitment, paying off debt, or leaving prior to completing their service commitment.
3. The count includes scholarships that have been awarded and announced, not prospective scholar seats.

Below please find organizational updates for April:

L.A. Care Awards $2 Million in Medical School Loan Repayment Grants
In an effort to boost the number of physicians working in the safety-net, L.A. Care Health Plan is proud to announce a new investment of $2 million in Provider Loan Repayment Program (PLRP) grants that will help reduce the burden of loan debt for 11 physicians working in under-resourced communities. This is the second round of PLRP grants in 2023; L.A. Care has now invested $4 million to award a total of 25 physicians this year.

L.A. Care Announces Top Health Care Providers for 2022
This is the fifth year that L.A. Care is recognizing the top practitioners, clinics, and medical groups or independent physician associations serving L.A. Care's Medi-Cal members. The commitment these top providers have shown through some very challenging times during the COVID-19 emergency is exceptional. The awardees are chosen based on an internal performance rating system used by L.A. Care to determine quality of care being provided. This is the second year that L.A. Care is also announcing a health equity award. All awardees will be honored at a dinner in late April and with a congratulatory billboard near their workplaces.

L.A. Care Hosts IHSS Training Graduation
In April, L.A. Care hosted another graduation for the In Home Supportive Services caregiver training program, in partnership with the Center for Caregiver Advancement. The trainings provide caregivers with essential skills to help them care for their client and also maintain their own self-care – an essential facet to preventing caregiver burnout. After the training, there is a material decline in the use of emergency rooms and hospital readmissions, resulting in a modest cost savings. To date, we have over 5,600 graduates of the program.

Speaking Engagements

- April 25 – 28. Global Health Care, LLC: Virtual Fourth National Medicare Advantage Summit, *MA Health Plan Case Study: A Fireside Chat with John Baackes, Chief Executive Officer, LA Care Health Plan.*

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 shared with the Board of Governors at the beginning of the Fiscal Year, and is available upon request thereafter.

Progress Reports

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

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

Quarterly Progress Report
FISCAL YEAR QUARTER 2
January – March 2023

Operational Excellence

Achieve operational excellence by improving health plan functionality.

Goals	Q2: January – March 2023 Highlights
Build out information technology systems that support improved health plan functionality.	• Documentation of prior authorizations in the Intelligent Desktop deployed, allowing the Provider Service Unit to document calls within the system. • New Community Supports services functions went live and operational enhancements were completed. • Brought expert staff onboard to begin the implementation of our Data Governance model. • Deployed a set of Application Program Interfaces, which provides a data connection for members to access their health information maintained by L.A. Care.
Support and sustain a diverse and skilled workforce and plan for future needs.	• Launched a Strategic Leadership Program targeted toward senior level leadership and three Leadership Development Programs tailored to the needs of leaders at various levels of the organization.
Ensure long-term financial sustainability.	• Our Q2 administrative expenses are on track as compared to the 3+9 forecast; will continue to monitor spending activities for the remaining months.
Mature L.A. Care's family of product lines, taking an "all products" approach whenever possible.	• Successfully transitioned Cal MediConnect membership to our Medicare Plus (D-SNP) plan, reaching 17,700 members by the end of January. • Continued to develop Sales and Marketing strategies around SB 260. • Began to develop enhancements to L.A. Care's internal network rosters and provider directory.

High Quality Network

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

Goals	Q2: January – March 2023 Highlights
Mature and grow our Direct Network.	• Direct Network providers were notified of upcoming monitoring of Initial Health Assessments through random sample selection. • Completed development of a dashboard to compare month-over-month performance of the Direct Network to delegated provider groups contracted in L.A. Care's MCLA line of business.
Improve our quality across products and providers.	• As part of the Direct Network VIIP + P4P Action Plan, the Transform L.A. team conducted outreach to improve Member Satisfaction (Adult) and CIS-10 (Childhood Immunizations) domains. • Transform L.A. completed enrollment of seven Direct Network providers for the Physician Advisory Collaborative. • Completed projects to include Sexual Orientation and Gender Identity (SOGI) in our data model. Completed the data model design and are in the vendor selection phase for the Clinical Data Repository.
Invest in providers and practices serving our members and the L.A. County safety net.	• The number of Direct Network practices enrolled in Transform L.A. to receive practice transformation support increased to 21 with 107 providers and 35% of Direct Network members. • Help Me Grow L.A. practices increased the number of screenings conducted by 12% over baseline to 26% of patients seen. The second of three CME events was held with 151 attendees at the Children's Healthcare Conference. • We continue to grow the Provider Recruitment Program, with 152 active providers totaling slightly more than $20.2 million in investment. There are currently 21 vacancies. • L.A. Care committed an additional $2 million to award 11 new primary care physicians in exchange for a three-year service commitment in the safety net. This brings our total to 138 active provider loan repayment awards. • Community Benefits awarded 15 non-profit community dental clinics Oral Health Initiative (OHI) grants totaling $1.5 million.

Member Centric Care

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

Goals	Q2: January – March 2023 Highlights
Operate all components of California Advancing and Innovating Medi-Cal (CalAIM) as they are launched.	• L.A. Care finalized review of Community Supports (CS) and Enhanced Care Management (ECM) letters of interest, and provider certification applications for prospective providers who will join the CS and ECM networks effective July 2023. • Approximately 62K members transitioned from Fee-for-Service to L.A. Care for the Mandatory Managed Care Enrollment initiative. Enrollment was slightly lower than projected due to a decrease in L.A. Care's auto assignment rate.
Establish and implement a strategy for a high-touch care management approach.	• Warm transfers of Direct Network members already under care management were completed to ensure continuity of support. • Outreach and engagement for new Direct Network referrals increased to continue the expansion of care manager use. • Care management community health workers completed 60% more field visits during this quarter compared to the previous quarter.
Ensure that the services we provide to members promote equity and are free of implicit and explicit bias.	• The first eight Generating African American Infant and Nurturers' Survival (GAIINS) initiative grantees completed more than 45% of the cumulative goals in the first six months of the grant initiative. • L.A. Care launched a Medically Tailored Meal pilot for a cohort of Black/African American L.A. Care Covered members with diabetes. • The perinatal text messaging campaigns for MCLA members continued. Twenty-six percent of members enrolled confirmed completing their postpartum visit, while 32% of Black/African American members enrolled in the prenatal campaign completed the full 6-week program.

Health Leader

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

Goals	Q2: January – March 2023 Highlights
Drive improvements to the Affordable Care Act by serving as a model of a successful public option.	• The California Safety Net Coalition continued to explore options for increased funding for Medi-Cal, possibly through a ballot measure. • L.A. Care continued to share its experience with other public plans considering entering the Covered California market.
Optimize members' use of Community Resource Centers and expand our member and community offerings.	• Construction continued on CRC locations in South L.A., Lincoln Heights and Panorama City. Public grand opening for the Norwalk CRC held. • Focused on partnering with community based organizations to provide onsite, in-person Medi-Cal redetermination assistance at CRCs.
Drive change to advance health and social services for our members and the community.	• Dr. Alex Li named new Chief Health Equity Officer. • Member Equity Council goals for FY 2022-23 finalized in January and are in progress. • As of March, L.A. Care served over 11,000 Homeless and Housing Support Services (HHSS) members (not including Plan Partners) through Community Supports and Enhanced Care Management. • Worked with L.A. County Department of Health Services, IT, and vendor UpHealth to reauthorize 5,696 former Whole Person Care individuals for six additional months of HHSS, for a total authorization of 18 months.

APPENDIX

Detailed Vision 2024 Progress Report

Fiscal Year Quarter 2

January – March 2023

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.	• The Courtesy Callback feature, which was deployed in December 2022 for the MCLA line of business, allows customers to hang up without losing their place in line by receiving a call back as soon as a representative is available. Planning for Courtesy Callback for additional lines of business and for the Health Risk Assessment (HRA) calls began and deployment is anticipated by June. • Documentation of prior authorizations in the Intelligent Desktop deployed in March, allowing the Provider Service Unit to document calls within the system and eliminating a system to be used by the agent. • Due to some resource constraints, planning for the post-call survey and other self-service tools was delayed; kick-off meetings for these tools will be scheduled next quarter. • Discovery sessions for additional enhancements to the Intelligent Desktop are underway.
Improve efficiency and effectiveness of financial management functions with the implementation of the additional phases of the SAP Enterprise Resource Planning (ERP).	SAP Analytics Cloud for Planning and Reporting is in progress and will be used for the budgeting process starting in FY 23-24. The completion of this phase will also enhance our financial reporting, which includes a dashboard with KPIs for senior management, administrative spending comparison between actual and budget/forecast, and other analytical reports. The reporting aspect of this phase will also go live starting in FY 23-24.
Complete the implementation of SyntraNet to support new and updated regulatory requirements, in addition to operational improvements across the enterprise.	**CalAIM**: New Community Supports services functions went live in January. Other operational enhancements including bulk data loading, code stabilization, data fixes, and oversight reporting were done in February and March. **Utilization Management**: D-SNP core configuration went live in January, with additional member notice templates added in February and March. Final sprints were completed for the automated process to send denial notice content to the translation vendor, with user testing to begin next quarter. Business units and IT developed a list of items that need to be completed and that is being negotiated with the vendor.

Build out information technology systems that support improved health plan functionality.	
Tactics	**Update**
	Appeals, Grievances and Potential Quality Review: Project currently on hold. L.A. Care teams continue to document system-agnostic business requirements.
Modernize provider data management by defining and creating a roadmap for achieving our target state for our provider data ecosystem.	L.A. Care continued its efforts towards achieving target state by: • Finalizing a roadmap document that outlines and sequences the steps to integrate multiple data sources, develop a single domain database, and implement a new provider data management platform; • Developing an initial data model that will be used to configure and array data within a single domain database; • Compiling sample data sets to demonstrate the data model, workflow, and integration capabilities of each provider data management platform being evaluated; and • Finalizing the process to measure each platform's ability to meet L.A. Care's functional and nonfunctional capabilities and select a single provider data management application for implementation.
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.	Brought expert staff onboard to begin the implementation of our Data Governance model, which will ensure we have uniformity of definition across the enterprise as we roll out our new programs to enhance the member experience.
Develop real-time interoperability capabilities to share data with providers and members.	In accordance with a CMS mandate, L.A. Care deployed a set of Application Program Interfaces, which provides a data connection for members to access their health information maintained by L.A. Care. The data connection interfaces enable members to use third party applications (typically on smart phones) to access their data, but only with member consent, and only after the third party app has registered with L.A. Care. L.A. Care activated the data connection interfaces in March. More information including member advisories regarding protecting their health information will be available next month. At this point, OneRecord is the only third party that has approached L.A. Care with a desire to connect.

Support and sustain a diverse and skilled workforce and plan for future needs.	
Tactics	**Update**
Conduct succession planning, particularly at the leadership level.	Launched a Strategic Leadership Program targeted toward senior level leadership in March. Session topics include Decision Making, Presentation Skills, Difficult Interactions, Strategy Planning and Execution, and Resilient Leadership. Additionally, the Succession Plan Framework is set to launch and the department for the pilot program is currently being assessed.
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 36.4% Hispanic or Latino, 22.3% Asian, 14.8% Black or African American, 9.7% White, 5.9% Native Hawaiian or other Pacific Islander, 2.9% two or more races, 7.8% non-applicable. Additionally, our employees are 69.5% Female and 30.5% Male.
Improve managed care and Management Services Organization (MSO) acumen among staff.	We have had initial discussions with Local Health Plans of California (LHPC) regarding the possibility of having them provide Medi-Cal Managed Care 101 to L.A. Care employees.
Promote retention of staff in an evolving work environment.	L.A. Care has launched the Management Certification Program which, once completed, allows non-management employees to apply for entry level management positions. Currently, 28 employees are going through the first cohort of the program. In March we launched three Leadership Development Programs tailored to the needs of leaders at various levels of the organization—one for newly promoted first time managers, one for leaders who only manage individual contributors, and one for leaders who have direct reports. A fourth program, tailored to more senior level leadership was also launched. These programs are designed with the objective of supporting our leaders in developing and growing their leadership knowledge and skills.

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.	Based on actual administrative spending for Q1 FY 22-23, we have increased funding in the 3+9 forecast in order to support the company's business needs. Our Q2 administrative expenses are on track as compared to the 3+9 forecast and we will continue to monitor the spending activities for the remaining months.

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.	L.A. Care successfully transitioned Cal MediConnect membership to our Medicare Plus (D-SNP) plan this quarter, reaching 17,700 members by the end of January 2023. The D-SNP command center met daily to resolve any concerns or issues that arose after the go-live date. Work continued to develop L.A. Care's 2024 CMS bid submission, which is due June 2023.
Increase membership across all products by implementing member recruitment and retention strategies.	**Sales** • L.A. Care Covered gained the #1 market share position in Los Angeles (Covered California regions 15 and 16) for Open Enrollment 2023, with membership exceeding forecasted levels. Sales campaign analysis suggests both price position and broker distribution drove membership gains. • Continued to develop sales strategy around SB 260, which authorizes Covered California to automatically enroll consumers in the lowest cost silver plan available to them when they lose Medi-Cal coverage and gain eligibility for advanced premium tax credits, for implementation next quarter. • D-SNP membership continues to grow above forecasted levels and work continued to analyze Q2 disenrollment potentially related to network disruptions. **Marketing** • Finalized MCLA campaign development and prepared to begin initial campaign tactics. The campaign will center on messaging around Medi-Cal redetermination and segments will align with concurrent SB 260 efforts.

Mature L.A. Care's family of product lines, taking an "all products" approach whenever possible.	
Tactics	**Update**
	• D-SNP campaign concluded with some remaining presence via digital ads and outcome reporting began. Work continued to develop a strategic playbook focused on annual D-SNP marketing tactics to support growth and retention efforts. • L.A. Care Covered 2023 Open Enrollment Period campaign concluded in March with some digital presence remaining as the Special Enrollment Period (SEP) begins. Preparations made to provide creative support for SB 260 efforts. • Continued work to plan a marketing campaign focused on L.A. Care's Community Resource Centers and the programming and resources they offer.
Engage in a provider network strategy that meets distinct business and competitive needs of all products and ensures that members receive high-value care.	L.A. Care began to develop enhancements to its internal network rosters and provider directory. Enhancements include specifying multiple provider subspecialties, which will enable referring providers to make more appropriate referrals, ensuring member access to optimal care.

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.	L.A. Care has been conducting oversight of the Direct Network to ensure that regulatory requirements for Utilization Management (UM) decision-making and member/provider notification timeliness are being met. Monthly scorecards are issued to the UM team, and where a deficiency is detected, remediation efforts are in place. In March, Direct Network providers were notified of upcoming monitoring of Initial Health Assessments (IHA) through random sample selection. The first review cycle will include a

Mature and grow our Direct Network.	
Tactics	**Update**
	random sample of IHAs in 2022 and will serve as a baseline assessment for succeeding quarterly reviews.
Improve the operations of all L.A. Care functions necessary to support and scale up the Direct Network.	Development of a dashboard has been completed to compare month-over-month performance of the Direct Network to delegated provider groups contracted in L.A. Care's MCLA line of business. This dashboard includes a variety of quality, utilization, and member experience measures that will be used to evaluate network performance, inform contracting decisions, and optimize internal operations. An interdepartmental team is being formed to work with directly contracted primary care physicians to assess and mitigate service delivery gaps measured and revealed by enhanced provider opportunity reports.
Strategically address gaps in the Direct Network to meet all member needs countywide.	L.A. Care continued to monitor Direct Network membership and network adequacy to ensure members enrolled in the Direct Network have access to professional, facility, and ancillary providers within time and distance standards. Refined enrollment projections were developed to identify enrollment trends in order to forecast utilization and focus contracting efforts to meet the needs of our growing network.
Increase access to virtual care by implementing L.A. Care's Virtual Specialty Care Program (V-SCP).	Entering 2023, recruiting and training more high volume Direct Network practices and adding more adult and pediatric specialists were our main priorities. However, in the past quarter, we continued to experience both progress and growing pains with this pilot. The number of eConsult cases and telehealth requests continued to slow as some of our participating primary care practices continued to feel that "traditional" referrals (send the patient for an in-person visit) are easier than an actual dialog with a specialist or encouraging a member to use telehealth. We plan to continue to focus our efforts on reinforcing our engagement and training efforts and consider some changes to the workflow and platform. As of March 2023, the Virtual Care project team has signed up seven high volume Direct Network practices, including Catalina Island Medical Center. Plans are also in place to expand V-SCP to our contracted street medicine providers.

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 worked with Quality Performance Management and the Direct Network Advisory council on creating Provider Opportunity Reports at the contracted practice level. This would constitute a change from the existing process of sending out license-level reports, which contain a provider's full Medi-Cal panel. The Initiatives team is developing the QI *Resources for Quality Care* flyer for Direct Network providers to be included in the monthly Provider Opportunity Report distributions. The measures and domains for the MY2023 Pay-for-Performance (P4P) program were finalized. As part of the Direct Network VIIP + P4P Action Plan, the Transform L.A. team conducted outreach to improve two domains: Member Satisfaction (Adult) and CIS-10 (Childhood Immunizations). Transform L.A. completed 100% of outreach for Member Satisfaction and 70% for CIS-10, and they completed enrollment of seven Direct Network providers for the Physician Advisory Collaborative, part of the Provider Engagement & Outreach workgroup. The kickoff meeting is planned for next quarter.
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.	• Members received reminder calls for cervical cancer testing, along with social media. • Asthma Medication Mailer sent to the MCLA membership. The mailer contains educational material and a magnet to remind members to take their medicines. • Letters and faxes went out to providers and hospitals with best practices for improving postpartum care. • Mobile (at-home) DEXA Scans are now offered to eligible members to improve osteoporosis care.
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.	We completed the projects to include Sexual Orientation and Gender Identity (SOGI) in our data model. Our planning and design continue for the remaining data elements of Race, Ethnicity, and Language. We have completed the data model design and are in the vendor selection phase for the Clinical Data Repository.
Improve clinical performance for children's care.	• Actions for the DHCS mandated SWOT (Strengths, Weaknesses, Opportunities, Threats) for underperforming on Childhood Immunization Status and Well-Child Visits are underway.

Improve our quality across products and providers.	
Tactics	**Update**
	Actions include revising member touchpoints, adding staff, working with provider offices, and data comparison and analysis with Anthem Blue Cross and Blue Shield Promise. • Social Media to promote preteen health launched in late February. • Well-Child Visit reminder calls for children 0-2 years old started in late March and calls for children ages 3-21 years old will begin next quarter.

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.**: Practices are reporting ten clinical quality measures from their electronic health record system. Nine practices are continuing to regularly receive Admit, Discharge or Transfer reports electronically. **Help Me Grow L.A.**: Practices are continuing to incorporate validated developmental screening tools and referrals processes into their electronic medical record software programs to streamline workflows and increase overall screenings and referrals.
Provide practice coaching to support patient-centered care.	**Transform L.A.**: The number of Direct Network practices enrolled in Transform L.A. to receive practice transformation support increased to 21 with 107 providers and 35% of Direct Network members. Three practices are reporting a 3% improvement from baseline in Diabetes A1c Poor Control (>9%). Four practices are reporting a 6% improvement from baseline in Controlling Blood Pressure. Transform L.A. has added CIS-10 (Childhood Immunizations) as the newest required measure. **Help Me Grow L.A.**: Cohort 1 practices have increased the number of screenings conducted by 12% over baseline to 26% of patients seen. Five practices are enrolled in Cohort 2 for a total of seven practices in the pilot. Data collection and practice transformation work is continuing. Fifteen of the 20 planned early childhood development classes have been provided to the community and L.A. Care members. The second of three CME events was held in March with 151 attendees at the Children's Healthcare Conference.

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 152 active providers totaling slightly more than $20.2 million in investment. There are currently 21 vacancies. **Provider Loan Repayment Program:** L.A. Care committed an additional $2 million to award 11 new primary care physicians in exchange for a three-year service commitment in the safety net. This brings our total to 138 active loan repayment awards. **Medical School Scholarship Program:** CDU and UCLA actively reviewed qualified student applicants who could be eligible for a full-tuition scholarship from L.A. Care in 2023. **In-Home Supportive Services Training Program (IHSS) Center for Caregiver Advancement (CCA):** We currently have 5,601 providers who have successfully completed the L.A. Care training course through CCA. Trimester 18 will wrap up next quarter with a new group of graduates.
Utilize the Community Health Investment Fund (CHIF) to leverage opportunities for providers to increase quality and access to care.	In February 2023, Community Benefits awarded 15 non-profit community dental clinics Oral Health Initiative (OHI) grants totaling $1.5 million to provide integrated dental, medical, and/or behavioral health care or improve rates of kindergarten entry oral health screenings. OHI aims to prevent missed school/work and better manage chronic disease for up to 10,500 new and existing patients through diverse interventions including clinical and support staff hires, coordinated visits, extended hours, IT/EHR enhancements, and/or patient education and referral.

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.	**Community Supports:** L.A. Care finalized review of Community Supports letters of interest and provider certification applications for prospective providers who will join the Community Supports network effective July 2023. **Enhanced Care Management:** L.A. Care finalized review of Enhanced Care Management letters of interest and provider certification applications for prospective providers who will join the Enhanced Care Management network effective July 2023. Our Populations of Focus will expand to include Children and Youth which will be implemented effective July 2023.
Ensure CalAIM Population Health Management (PHM) requirements are met.	• CalAIM PHM requirements are now included in the Universal Provider Manual • CalAIM Transitional Care Services: o Expanding the admission/discharge/transfer data feed from all hospitals to all providers o Optimizing the Optum Ipro risk stratification process o Identifying staffing needs for Care Management and delegation oversight for PPGs using the DHCS definition of "high risk" o Developing all business unit processes on Transitional Care Services o Developing Key Performance Indicators Dashboard for DHCS July deadline o Developing 2023 Program Strategy to meet NCQA and CalAIM requirements (due to DHCS October 2023)
Monitor and establish infrastructure for longer-term CalAIM initiatives.	This quarter, business units continued to prepare for the Long-Term Care Intermediate Care Facility/Developmentally Disabled carve-in planned for January 1, 2024. Approximately 62K members transitioned from Fee-for-Service to L.A. Care in January and February for the Mandatory Managed Care Enrollment initiative. Enrollment was slightly lower than projected due to a decrease in L.A. Care's auto assignment rate.

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.	Warm transfers of Direct Network members already under care management were completed to ensure continuity of support. This quarter, outreach and engagement for new Direct Network referrals, those identified manually as well as those through data-driven modeling, increased to continue the expansion of care manager use. Care management community health workers completed 60% more field visits during this quarter compared to FY Q1, as members and staff both continue to adjust to field visit expectations post-public health emergency as well as the return from the holiday season.
Expand upon our progress with palliative care and add other end-of-life services.	Palliative care remains an important benefit to members with serious illness. Through the CalAIM program there is an expanded focus to bring these services to eligible members. New populations such as transplant recipients will be eligible and are encouraged to be offered this service. Additionally, those members who are under our D-SNP line of business will be offered services by their providers. Through our data analytics, we have found that there are many more members who would benefit from palliative care services and we are providing direct education and the opportunity to receive the services by contacting eligible members.

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.	The first eight Generating African American Infant and Nurturers' Survival (GAIINS) initiative grantees completed more than 45% of the cumulative goals in the first six months of the grant initiative. A committee of health equity, Black culture, and infant and maternal mortality experts reviewed the second cohort of GAAINS applications. Final awards will be announced next quarter to augment culturally congruent strategies to reduce, and eventually eradicate, the racial disparity in infant and maternal mortality rates.

Ensure that the services we provide to members promote equity and are free of implicit and explicit bias.	
Tactics	**Update**
Identify and reduce health disparities among our members by implementing targeted quality improvement programs.	L.A. Care continues to focus on disparities in prenatal and postpartum care, diabetes, and hypertension. • L.A. Care launched a Medically Tailored Meal pilot for a cohort of Black/African American L.A. Care Covered members with diabetes. • The perinatal text messaging campaigns for MCLA members continued this quarter. Twenty-six percent of members enrolled confirmed completing their postpartum visit, while 32% of Black/African American members enrolled in the prenatal campaign completed the full 6-week program. • The L.A. Care Maternal Health webpage refresh is currently underway. The new webpage will include updated multicultural photos, doula benefit information, pregnancy resources, and trimester educational content. • The DHCS Doula benefit launched in January. The doula provider recommendation form, doula member flyer, and provider trainings are currently under review by the Doula workgroup. • Health Education is exploring digital maternal health platforms that support pregnant members who need additional support.
Implement initiatives to promote diversity among providers, vendors, and purchased services.	This quarter we began to assess the feasibility of incorporating diversity in the RFP (Request For Proposal) process. A draft Diversity section has been created to potentially add to the RFP Project Charter. This section is intended to encourage business units to find diverse vendors for consideration when they are preparing for a potential RFP.
Offer providers Diversity, Equity, and Inclusion resources to promote bias-free care.	Planning continued for L.A. Care's Gun Safety Webinar Series by working to find speakers for future webinars. The first webinar in the series, which will feature Dr. Amy Barnhorst of the Bullet Points Project, is planned for next quarter and will be a free CME certified webinar worth 1.00 CME/CE credit. We also continued planning for social determinants/drivers of health (SDOH) provider training that L.A. Care will be offering next quarter. The purpose of the training is to provide an overview of SDOH Z-codes and reasons for collecting this information including improvements in member data capture.

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.	The California Safety Net Coalition continued to explore options for increased funding for Medi-Cal, possibly through a ballot measure.
Provide expertise and assistance to other public plans interested in participating in state exchanges.	L.A. Care continued to share its experience with other public plans considering entering the Covered California market.

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 60,000 by Q4 2023.	Construction continued on CRC locations in South L.A., Lincoln Heights and Panorama City. Public grand opening for the Norwalk CRC held in March.
Partner with community-based organizations to offer a range of services onsite.	Focused this quarter on partnering with community based organizations to provide onsite, in-person Medi-Cal redetermination assistance at CRCs. Procurement of services from 13 different partners in progress.

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.	• Dr. Alex Li named new Chief Health Equity Officer. • Provider equity awardees finalized and will be announced at Provider Recognition Ceremony next quarter. • Member Equity Council goals for FY 2022-23 were finalized in January and are in progress. Goals include receiving member feedback from Consumer Health Equity Council, improving provider utilization of SDOH Z-codes, gun violence prevention activities, Sexual Orientation and Gender Identity (SOGI) member data collection, and improvement in disparities for Prenatal Care, Diabetes, and Cardiovascular Disease.
Support regional Health Information Exchanges (HIE).	L.A. Care is committed to promoting regional Health Information Exchanges (HIEs) by utilizing federal and state interoperability regulations to encourage contracted hospitals' participation in the HIE and incentivize IPAs for meaningful utilization of HIEs. Additionally, L.A. Care continues to actively engage the L.A. County IT/Data Advisory Group and provide funding opportunities for community organizations through the Incentive Payment Program (IPP) to enhance their technical infrastructure and foster interoperability. Moreover, we have introduced initiatives that enable near real-time access to member visits at over 80% of the contracted Skilled Nursing Facilities (SNF) in L.A. County, fulfilling various programmatic requirements to ensure effective transitions of care.
Create a deliberate and tailored strategy to address homelessness among our members.	As of March, L.A. Care served over 11,000 Homeless and Housing Support Services (HHSS) members (not including Plan Partners) through Community Supports and Enhanced Care Management. L.A. Care is focused on network expansion and engagement of providers to better serve our members. Staff worked with L.A. County Department of Health Services, IT, and vendor UpHealth to reauthorize 5,696 former Whole Person Care individuals for six additional months of HHSS, for a total authorization of 18 months. Also, staff has been working internally with IT and UpHealth to build out a bulk upload process to receive outstanding Housing Assessments and Individualized Housing Support Plans.

LEGAL SERVICES

April 19, 2023

TO: L.A. Care Board of Governors

FROM: Augustavia Haydel, General Counsel
Nadia Grochowski, Associate Counsel III

SUBJECT: ***DMHC Enforcement Matter Report***

INTRODUCTION:

This report is provided for the Board's information. The Board has delegated authority to the CEO up to $250,000 under L.A. Care's policy LS-010 to settle threatened litigation matters, including DMHC Enforcement Matters, without Board approval. The policy does require the CEO to report the settlement to the Executive Committee and/or to the Board, but it could be either before or after the settlement. The settlement amounts listed below are within the CEO's delegated authority.

DMHC Enforcement Matter 21-434 (received 1/25/23)

- Allegation: Plan's delegate failed to properly process claims for service, and the Plan failed to timely resolve the enrollee's grievance.
- Violations: The Plan, through its capitated provider, improperly processed claims for service in connection with the enrollee's care. (Cal. Code Regs., tit. 28, § 1300.71, subd. (d)(1).) The Plan failed to timely resolve the enrollee's grievance. (Cal. Code Regs., tit. 28, § 1300.68, subd. (d)(3).)
- Settlement Offer: $19,500 (Corrective Action Plan required); Letter of Agreement has been fully executed.

DMHC Enforcement Matter 19-1185 (received 1/30/23)

- Allegation: On November 8, 2019, the Plan notified the Department that the Plan had identified an error related to provider remittance advice (RA) issued to non-contracting providers. Specifically, some RAs issued between January 1, 2019, and September 30, 2019, erroneously assigned member liability to claim amounts for which the enrollees were not responsible.
- Violations: DMHC found that the Plan improperly processed non-contracted provider claims in violation of California Code of Regulations, title 28, section 1300.71, subdivision (d)(1). A health care service plan or its capitated provider shall not improperly deny, adjust or contest a claim. (Health & Saf. Code, § 1300.71, subd. (d)(1).)
- Settlement Offer: $125,000 (Corrective Action Plan required); Letter of Agreement has been partially executed.

March 2023 Grants & Sponsorships Report May 2023 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	**Care Harbor**	Healthcare for the Unhoused	3/1/2023	Sponsorship	$ -	25,000	$ 25,000
2	**Christopher Street West Association, Inc. dba LA Pride**	LA PRIDE	3/22/2023	Sponsorship	$ -	50,000	$ 50,000
3	**Justice In Aging**	Celebrate Justice in Aging	3/1/2023	Sponsorship	$ -	2,500	$ 2,500
4	**LA Family Housing**	LA Family Housing Awards 2023	3/1/2023	Sponsorship	$ -	10,000	$ 10,000
	Total of grants and sponsorships approved in March 2023				**$ -**	**$ 87,500**	**$ 87,500**

* No grants were approved in March

Board of Governors
Executive Community Advisory Committee
Meeting Minutes – February 8, 2023

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

ECAC Members	RCAC Members/Public	L.A. Care Board of Governors/Senior Staff
Russell Mahler, *RCAC 1 Chair* ***	Mary Hernandez-Castellanos, *Interpreter* ***	Hilda Pérez, *Member, Board of Governors* ***
Estela Lara, *RCAC 2 Chair* ***	Isaac Ibarlucea, *Interpreter* ***	Layla Gonzalez, *Advocate, Board of Governors* ***
Cynthia Conteas-Wood, *RCAC 3 Chair, ECAC Vice-Chair* ***	Eduardo Kogan, *Interpreter* ***	John Baackes, *Chief Executive Office, L.A. Care* ***
Silvia Poz, *RCAC 4 Chair* ***	Alex Mendez, *Interpreter* ***	Sameer Amin, *MD, Chief Medical Officer, L.A. Care* ***
Maria Sanchez, *RCAC 5 Chair* ***	Estefanie Mendez, *Interpreter* ***	Thomas Mapp, *Chief Compliance Officer, Compliance* ***
Andria McFerson, *RCAC 6 Chair* ***	Katelynn Mory, *Closed Captioner* ***	Miriam Admasu, *Department Assistant, CO&E* ***
Fátima Vázquez, *RCAC 7 Chair, ECAC Chair* ***	Ruth Nuno, *Interpreter* ***	Phinney Ahn, *Executive Director, Medi-Cal, Medic-Cal Product Management* ***
Ana Romo, *RCAC 8 Chair* ***		Tyonna Baker, *Community Outreach Field Specialist, CO&E* ***
Tonya Byrd, *RCAC 9 Chair* ***	Gladis Alvarez, Public ***	Malou Balones, *Board Specialist, Board Services* ***
Damares O Hernández de Cordero, *RCAC 10 Chair* ***	Carrie Brodus, *Public* ***	Kristina Chung, *Community Outreach Field Specialist, CO&E* ***
Maria Angel Refugio, *RCAC 11 Chair* ***	Joann Cannon, *Public* ***	Idalia De La Torre, *Field Specialist Supervisor, CO&E* ***
Lluvia Salazar, *At-Large Member* ***	Nereyda Ibarra, *Public****	Auleria Eakins, *Manager, CO&E* ***
Deaka McClain, *At Large Member* ***		Hilda Herrera, *Community Outreach Field Specialist, CO&E* ***
		Brandi Gatling-Swann, *Quality Improvement Specialist, Quality Improvement Department* ***
		Karla Lee-Romero, *Director, Medi-Cal Product Management* ***
		Joshua Mendoza, *Community Outreach Field Specialist, CO&E* ***
		Linda Merkens, *Senior Manager, Board Services* ***
** Excused Absent ** Absent*		Frank Meza, *Community Outreach Field Specialist, CO&E* ***
**** Via teleconference*		Nicole Moussa, *Manager, Technical Information, Pharmacy & Formulary* ***
***** Via teleconference (with technical issues)*		Cindy Pozos, *Community Outreach Field Specialist, CO&E* ***
		Victor Rodriquez, *Board Specialist, Board Services* ***
		Prity Thanki, *Local Government Advisor, Government Affairs* ***
		Martin Vicente, *Community Outreach Field Specialist, CO&E* ***

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Chairperson Vazquez called the meeting to order at 10:00 a.m. Chairperson Fatima Vazquez advised the public to recheck the directions for updates prior to the start of the meeting. She announced that this meeting would be conducted in accordance with the provisions of the Ralph M. Brown Act, allowing members of the Executive Community Advisory Committee, members of the public and staff to participate via teleconference, because State and Local officials are recommending measures to promote social distancing. Accordingly, members of the public should join this meeting via teleconference as follows: https://us06web.zoom.us/j/89647094878 Teleconference Call –In information/Site Call-in number: 1-415-655-0002 Participants Access Code: **2491 286 4772** (English) Call-in number: 1-415-655-0002 Participants Access Code: **2494 522 5454** (Spanish) Members of the Executive Community Advisory Committee or staff may also participate in this meeting via teleconference. The public is encouraged to submit public comments or comments on Agenda items in writing by email to COEpubliccomments@lacare.org or by sending a text or voicemail to (888) 522-2732. Attendees who log on using the URL above will be able to use "chat" during the meeting for public comment. Attendees 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 the 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 the public comment in the box. 6. After hitting the enter key, the message is sent and everyone can see it. 7. The chat message, text, voicemail, or email must indicate if the submitter wishes to be identified or remain anonymous, and must also include the name of the item to which the 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 text, voicemail, or email. If we receive your comments by 10:00 a.m. on February 8, 2023, it will be provided to the members of the Executive Community Advisory Committee at the beginning of the meeting. 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. If you do not indicate an Agenda item for your comment, your comment(s) will be read for up to 3 minutes at item VIII Public Comments on the Agenda. 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 comments for up to three minutes. Chat messages submitted during the public comment period for each agenda item will be read for up to three 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 3 minutes at item VIII Public Comments on the agenda. These are extraordinary circumstances, and the process for public comment is evolving and may change at future meetings. We thank you for your patience. Please note that there may be delay in the digital transmittal of emails, texts and voicemail. The Chair will announce when 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 Executive Community Advisory Committee appreciates hearing the input as it considers the business on the Agenda. 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 text (888) 522-2732 or by email to COEpubliccomments@lacare.org. Goals for today's meeting: 1. Receive an update from L.A. Care's Chief Medical Officer. 2. Receive an update from L.A. Care's Chief Executive Officer. 3. Receive an update from Government Affairs Department. 4. Receive recommendations from the ECAC ad-hoc committee – Disability Awareness Month. 5. Receive recommendations from the ECAC ad-hoc committee – African American Health Disparities.	

	6. Receive a presentation on the County of Los Angeles Delete the Divide. Idalia De La Torre, *Field Specialist Supervisor, CO&E*, confirmed attendance by roll call. Chairperson Vazquez read the ECAC Meeting Ground Rules and Meeting Guidelines. Meeting Ground Rules • We treat each other with respect • We raise our virtual hand icon and wait to be called on • We lower our virtual hand icon when done speaking • Only one member speaks at a time • We speak up when something is wrong or not working: we confront issues not people • We do not personally attack each other Meeting Guidelines • ECAC Members will have three (3) minutes to speak on each agenda item • The ECAC Chair can reduce the time to two (2) minutes if time is limited • The three (3) or two (2) minutes allotment will be consecutive and may include questions, comments, and/or anecdotes as long as they fall within the time limit • If time is limited and ECAC members are unable to make a comment or ask a question, the member/s will be asked to forward their comment or question to CO&E staff for follow-up • The response will be recorded in the ECAC meeting minutes for that meeting • The L.A. Care staff schedule to provide an update or present during the ECAC meeting will be timed to ensure they stay within their allotted time. Andria McFerson, *RCAC 6 Chair*, asked if these are new provisions that are being dictated to the committee. She asked if the committee approved the meeting guidelines. Chairperson Vazquez responded that as a reminder these guidelines that are reviewed are the guidelines that they review every month before the meeting and they were approved in March. These were the guidelines that were reviewed in the beginning of the public health emergency.	
APPROVE MEETING AGENDA		**Approved by roll call. 12 AYES (Byrd, Conteas-Wood, Hernandez de Cordero, Lara, McClain, Mahler,**

	The Agenda for today's meeting was approved.	**Poz, Romo, Salazar, Sanchez, Refugio, Vazquez)** **1 NAY McFerson**
APPROVE MEETING MINUTES	Lluvia Salazar, *At-Large Member*, said that she does not see Ms. Gonzalez's name listed under Board Members and Senior Staff. Ms. De La Torre said that Ms. Gonzalez was not present at the January 2023 ECAC meeting. Member McFerson said that she did not receive the meeting minutes in a feasible amount of time. She wants to make sure they are accessible to everyone. **The January 11, 2023 meeting minutes were approved as submitted.**	**Approved by roll call. 11 AYES (Byrd, Conteas-Wood, Hernandez de Cordero, Lara, McClain, Poz, Romo, Salazar, Sanchez, Refugio, Vazquez)** **2 ABSTENTIONS (Mahler, McFerson)**
STANDING ITEMS		

CHIEF EXECUTIVE OFFICER UPDATE
• **Medi-Cal Redetermination**
	John C. Baackes, *Chief Executive Officer*, introduced Phinney Ahn, *Executive Director, Medi-Cal, Medi-Cal Product Management*. Ms. Ahn reviewed L.A. Care's preparation for Medi-Cal Redeterminations *(a copy of the full report can be obtained from CO&E)*.
	Ms. Ahn thanked the chair and the committee for inviting her to speak on the Medi-Cal redeterminations.
	• During the COVID-19 public health emergency (PHE), coverage was contined for Medicaid beneficiaries regardless of changes in circumstances, so that the beneficiaries would have access to health care during the pandemic.
	• The 2023 Consolidated Appropriations Act decoupled the continuous coverage requirement from the PHE end date, effective 3/31/23.
	  - Sets the stage for the resumption of Medi-Cal redeterminations
	  - Continuous coverage unwinding period is projected to begin 4/1/23.
	• Normal renewal processing will resume in April 2023 for individuals with a June 2023 renewal month *(see DHCS timeline)*.
	• Disenrollment will not start immediately after the continuous coverage requirement ends.
	  - The first and second months will focus on renewal activities including automatic renewal and renewal document packets (April and May 2023)	

- The third month is when the first eligibility redeterminations will be processed (in June 2023)
- The fourth month is when the first disenrollment will occur (July 2023)

- DHCS has projected that 2-3million current Medi-Cal beneficiaries statewide could lose their Medi-Cal coverage once redeterminations resume
  - This is an estimated decrease of 13-20% of beneficiaries statewide
  - L.A. Care is projecting a 13% annualized disenrollment rate, or about 330K members
- Guidance from DHCS and CMS provides a great opportunity for collaboration between states, counties, and managed care plans
  - Consistent, key messages
    - Keep your contact information up to date
    - Quickly complete and submit any paperwork received from DPSS
  - Promote continuity of coverage for individuals no longer eligible for Medi-Cal but potentially eligible through Covered CA
- L.A. Care is actively working to mitigate the negative impact to Medi-Cal beneficiaries through:
  - Member and provider outreach activities
  - Strengthen our partnership with the Los Angeles County Department of Public Social Services (DPSS)

PUBLIC COMMENT
Submitted by Elizabeth Cooper, *RCAC 2 Member*, via phone call:
Good morning Mr. Baackes. This is Elizabeth Cooper and Jonathon Cooper. I am concerned how this will affect dual eligibles and want more information to be informed.

Ms. Ahn responded that she would follow up and provide more information to members.

Member McFerson asked if L.A. Care has direct caseworkers that can make phone calls. That is the most feasible way to contact members, because that is how it used to be. During the pandemic, people used to stand outside for hours. Once people got in they would have to wait another hour to speak to someone randomly that they had never spoken to before, and that's basically how it's set up now. People may now be reluctant to do so, especially people that are homeless. The world is closing in on them. She asked if there is any way that shelters, caseworkers, primary care providers, can have a script from L.A. Care to call their members or their patients. Ms. Ahn responded that L.A. Care is encouraging its providers to do as much as they can, because they are on the front line. L.A. Care does

	understand the long wait times that can happen with the DPSS, and is working with providers to do as much outreach has they can, because they are in the community. Mr. Baackes stated that he thinks all the committee members should be aware that the providers are as equally as motivated as L.A. Care because they want to keep their patients., The issue that will happen is that somebody fails to respond to the redetermination paperwork and coverage is dropped. Members probably will not realize it until they show up for an appointment or go to get a prescription filled. L.A. Care is reaching out to the providers with information so they can remind the patients when they see them either virtually, in the exam room or as part of a street medicine program. Ms. Perez thanked Ms. Ahn for attending ECAC and for all the effort L.A. Care is doing with DPSS, so that all members get proper information about redetermination. She thanked her for her empathy. That is something that everyone needs to pay attention to. She noted that members had the pleasure of being invited to participate in many of the events at the community resource centers. She noted that people in the community expressed a lack of access to computers; some have to use their smartphones to access certain information. She noted that there is a representative from DPSS that visits the centers on certain days to provide information to people. Ms. Ahn thanked Ms. Perez for her comments. Estela Lara, *RCAC 2 Chair*, thanked Ms. Ahn for her thorough presentation. She asked if flyers are also being distributed to the dental offices, because they also see patients that are covered by Medi-Cal. She suggested having posters placed in public places such as train and bus stops. Ms. Ahn thanked Member Lara for her comments and said that she likes the way she is thinking broadly across the network. She noted that L.A. Care can connect with the dental association to distribute information about the Medi-Cal redetermination. Chairperson Vazquez stated that some RCAC 7 members have received these packages. Some members have asked if they will receive a letter letting them know if they still have Medi-Cal or not. She suggested handing ECAC members flyers so they can be distributed in their communities. Ms. Ahn responded that knowing the person's renewal month is a very common question. The easiest way to find out is by calling DPSS. People usually receive their paperwork three months before the renewal date. Mr. Baackes thanked the committee for their interest in this subject and for helping L.A. Care share this information with their community. Staff will be providing udpates to ECAC at future meetings.	
UPDATE FROM CHIEF MEDICAL OFFICER	Sameer Amin, *MD, Chief Medical Officer*, gave a Chief Medical Officer update. Dr. Amin said that he is happy to be joining ECAC again, it is a wonderful group of engaged individuals.	

	COVID-19 Update The federal government announced that on May 11, 2023, the federal public health emergency (PHE) will end, , the state's public health emergency is scheduled to end on May 20., The end of the PHE will impact Medi-Cal redetermination and potentially other issues like the cost share for individuals for in-home COVID-19 testing. As time goes on L.A. Care will know more. L.A. Care is bracing itself on the health service side to help members navigate through this, because it will be complicated, particularly as members and providers adjust to the impact and confusion associated with conclusion of the PHE. This is going to be a significant change to process. L.A. Care has bolstered its staff teams to deal with the confusion and answer member questions. The county and statewide COVID-19 dashboards reveal the continual decline in the number of people hospitalized or whose death was associated with COVID-19. The downward trend began in the second week of January 2023 and it continues going down. This a relief, but there are still people who are affected by COVID-19. If one person passes away or is hospitalized by COVID-19, it is on person too many. He has also spoken with local public health colleagues who have also expressed this sense of relief as the COVID-19 pandemic wanes. He has been gathering input as to what they are seeing with other health plans and with other areas of the healthcare system. It seems like everybody is seeing some degree of relief. They do not currently see any immediate threat from the new variants. Dr. Amin said that regulatory bodies are making a push toward quality preventive services, which L.A. Care fully endorses. Medi-Cal quality measures are increasing this year from 15 to 20 measures. He said that L.A. Care should probably be keeping a smaller set of metrics that we can show continuous improvement on to really move forward on improvements in a few key elements of healthcare. It is an expansion of the number of metrics that L.A. Care can be measured against, and now there are penalties associated with those measures as well. He reported that L.A. Care is in the midst of preparing for the review by the National Committee for Quality Assurance , which is our national accreditation body. L.A. Care is also preparing for the annual Department of Health Care Services audit. L.A. Care teams are hard at work preparing for both audits. Dr. Amin said that he is now in his second month at L.A. Care and is excited to continue in his role. He sees great energy from his team and is building on the wonderful culture that exists here at L.A. Care. In the setting of that, he is redesigning some elements of the team around two major organizational principles. One is the collaboration of operational clinical leadership with leaders of these disciplines working in concert to move our departments forward. And the other is redesigning the departments with clear charters, roles and responsibilities, and some of that work is ongoing. **PUBLIC COMMENT**	

	Submitted by Elizabeth Cooper, *RCAC 2 Member*, via phone call: *Do we have to wear masks? What is the protocol for RCACs?* Dr. Amin responded that he can't specifically speak about the RCAC meeting protocol, and RCAC members should reach out to CO&E staff. He recommended that people who have high risk should wear masks. Layla Gonzalez, *Member Advocate, Board of Governors*, asked if people that need to be tested for COVID-19 for work, will be covered by their health plans. Dr. Amin responded that the answer to that question is complicated. It very much depends on the benefits in each line of business, Covered California product or Medi-Cal, for example. It also depends on whether they are talking about the vaccine. There are many elements to that. He could provide more details offline if necessary. Member McFerson thanked Dr. Amin for his report, noting that this information can save lives and she will pass it on. She questioned statistical data that is used in research to make things more feasible. She noted that some facilities on any relative parties that may receive the information may not have more along the lines of true information just due to no peer on peer contact because some people, if they can't see the person directly eye to eye, they're reluctant to give personal information. There needs to be a peer to peer survey. She asked if there is data that can be compared to other situations with the different communities, such as the Black community, the white community, and the Latino community. She said that the RCACs and Health Promoters can go out to the community and hand out surveys to get this information. Dr. Amin responded that he appreciates her comments and agrees that information can be difficult to come by. He noted that Information Technology teams sometimes don't communicate well within the health plan or delegated provider groups. Getting information from providers can also be difficult. There are multiple steps along the way where information drops out or where we don't get a clean connection, and it harms L.A. Care's ability to know what's going on in real time. The Quality Improvement team is working hard to get information out to the rest of the organization. They run a series of different surveys and accreditation that they have to do, in which they need clinical information and they are getting it from the providers and so there are always things that he would love to add to their plate and will continue to evaluate that as time goes on. One of the considerations that he has is making sure that the sample is appropriate and is giving L.A. Care the right information. L.A. Care needs to be cautious about the surveys it puts out into the community. Deaka McClain, *Member At-Large*, noted that some patients are rushed by their doctors and noted that patients with disabilities may need more time to be properly evaluated by their doctors. This can sometimes cause anxiety in some members. Dr. Amin responded that is	

	a responsibility for him as a leader at L.A. Care, to make sure that L.A. Care's providers are behaving correctly and if they are providing the care that they should be providing to its membership. L.A. Care addresses patient quality issues as they come up through its Provider Quality Issues team. L.A. Care has its Performance Optimization department that makes sure providers are behaving properly.	
GOVERNMENT AFFAIRS DEPARTMENT UPDATE	Prity Thanki, *Local Government Affairs, Government Affairs Department,* reported on Government Affairs *(a copy of the full report can be obtained from CO&E).* **PUBLIC COMMENT** Submitted by Elizabeth Cooper, *RCAC 2 Member*, via phone call: *I am concerned about issues affecting Medicare consumers and would like an update from L.A. Care.* Ms. Thanki responded that L.A. Care is monitoring legislative items to make sure that people are aware of what services they receive in Medi-Cal. Government Affairs is working closely with the legislators to make sure that beneficiaries get the services that they need and are constantly advocating for the members. Member McClain asked for clarification on the Social Security segment of her report. She asked if the increase will be applied to state level portion. Ms. Thanki responded that this is a proposed increase. She will address it at the next meeting when she has more details. Member McFerson noted that Black people are being abused by the police. She that she communicates with Black men and women daily and a lot of people, they say this abuse makes them afraid to go outside for fear of being harassed and driving behind the wheel without being brutally beaten or killed. This abuse causes mental disparities like post-traumatic stress disorder. She noted that it is as posted in the National Institute of Mental Health website, that's the government website, and it's after substantial research from this government website, what a lot of people don't know is that bad mental health causes conditions. This stress can cause increased risk of cardiovascular disease, diabetes, stroke, pain, and headaches. She said this is an issue that needs to be underlined and addressed by L.A. Care. Ms. Thanki agreed with her comments and said that this is a discussion that needs to be had by CO&E and the Behavioral Health Department.	
BOARD MEMBERS REPORT	Ms. Gonzalez and Ms. Perez gave a Board Member report *(A copy of the full report can be obtained from CO&E.).* **PUBLIC COMMENT** Submitted by Elizabeth Cooper, *RCAC 2 Member*, via phone call: *Thank you Layla for your communication with the members. It is important that members have access to their representative.*	

	Member McFerson thanked Ms. Gonzalez and Ms. Perez for their updates. She asked about the provisions they read before the meeting. She said that she has asked Ms. Merkens about managing of time during ECAC and Ms. Merkens responded that the chair manages the time and runs the meeting. Member McFerson said that some people are reluctant to make comments because of their disabilities. Some people may have speech impediments or other disability that may require that they be allotted more than three minutes to make a comment. She said that it may be embarrassing for someone to say "I have a disability and I need extra time to make my comment." She asked that they let the Board know, because ECAC really wants people's input. Dr. Eakins responded that she will reach out to the Board for an appropriate response. Ms. Perez said that she doesn't know if this pertains to the Board or if it is a question for staff, but they can have a discussion if necessary.	
COMMUNICATIONS AND COMMUNITY RELATIONS DEPARTMENT UPDATE	Auleria Eakins, *Ed.D, MPA*, *CO&E*, gave a CO&E Update *(a copy of the full report can be obtained from CO&E.).* **PUBLIC COMMENT** Submitted by Elizabeth Cooper, *RCAC 2 Member*, via phone call: *Welcome Dr. Eakins. Regarding the RCACS, when is it open publicly? I appreciate African Awareness Month. Disability Awareness Month - Why aren't members who have a family member with a disability part of this? I am concerned about no participants being invited.* Member McFerson thanked Dr. Eakins for her update and she appreciates the information. She said that due to the findings of the data given to members about the highest mortality rate being the African American community, she routinely asks that L.A. Care please participate in a Black history month event. She understands the virtual events and other organizations giving Black history events. She said they need to make sure that they give out information such as the information given today about the redetermination process, but they need to do their own outreach. She has brought up this request several times. Ms. Perez asked Dr. Eakins if someone can attend ECAC to provide an update on the Family Resource Centers and Community Resource Centers. Dr. Eakins stated that RCAC meetings would begin to have official meetings in February and the meetings are open to the public. RCAC members with disabilities will be participating in the disability awareness program. CO&E will be working with key staff and noted that an ad-hoc met in June of last year on this topic. She advised members that if they have future events that they would like for CO&E or the RCACs to participate in to please send them to their field specialist. They have the ability to look at those events and ensure that they align and to follow the processes for participation. She asked that they	

	please keep in mind that L.A. Care has internal controls. Dr. Eakins stated that she will reach out to Francisco Oaxaca, *Chief, Communications and Community Relations*, to assign a staff member to provide an update on the resource centers. She noted that he will be sharing information at a future meeting about the changes coming from the state that will affect the RCACs and ECAC.	
MEMBER ISSUES	Ms. Gonzalez stated that on her version of the agenda it does not mention when people with disabilities can speak about members issues. She said that it is very important that people get an opportunity to discuss anything that may be happening to them or to people that they know so that we are aware, especially due to the fact that we are no longer having public meetings. Member McFerson thanked Ms. Gonzalez for showing some sort of love to the disabled community and those who may have difficulty communicating. She said that her heart goes out to the family of Tyree Nichols and the residents of Memphis, Tennessee. She said it is scary, because her brother lives out there. Overall, her heart goes out to Black and Brown people all over the nation. And that recently released video, of course, of that particular incident, it's like a catalyst to our efforts to seek a more just and safe nation. They need to be able to work together being that this plan, L.A. Care does support mental health as well. We need to work with our RCACs and talk about different issues having to do with our communities. And what we can do as a community to actually work on these things and discuss that. Possibly to give information to the Board in order to make decisions to help them in their communities.	
	OLD BUSINESS	
2023 BOARD OF GOVERNORS ELECTION PROCESS	Linda Merkens, *Senior Manager, Board Services*, presented the 2023 Board of Governors Election Process *(A copy of the written report can be obtained from Board Services.)*. **PUBLIC COMMENT** Submitted by Elizabeth Cooper, *RCAC 2 Member*, via phone call: *Linda thank you for your presentation in advance. I am concerned about the motion and what it entails. It is very important RCAC members are aware. Members of the ECAC and public, thank you African American History Month for highlighting the accomplishments and all cultures. I am proud of the African American culture and I reach out to all cultures. Thank you to the media and committee. Please listen to the concern of the African American community - not just history but present today. The President focuses on police reform, seniors and healthcare. Have a great day Madam Chair. Thank you from Elizabeth Cooper and Jonathan Cooper.*	

	Member McFerson said that she needs information from other ECAC members. She said this needs to be discussed with the RCACs first. They need to have this discussion along with Ms. Merkens so that members know what they have in front of them. She said that they can still participate in a sense where they have a doctor's notice or religious type of thing. They have not heard how they will participate in the meeting either. She noted that they have their first RCAC meetings this month and they should be talking about the election process. ECAC can vote on the motion in April. Member McClain added that Member McFerson does have a point. They should have their February and March meetings and then vote on the motion, after the RCACs have discussed the election. She would prefer to do that if possible. Dr. Eakins responded that nothing has changed. There were minor changes made to the document and those were highlighted by Ms. Merkens. The election rules were approved before. Ms. De La Torre stated that this document was presented at the RCAC check ins in December and January. Ms. Merkens stated that this document was brought to ECAC in November and staff pointed out that the rules are the same as in the previous elections. Whoever is elected will be completing the current term. Member McClain asked for clarification on Ms. Merkens comment about finishing the current term. Ms. Merkens responded that this election would be to complete the terms from whenever the election is held and the nominees are appointed by the Board of Supervisors, until October 31, 2024. That is a little over a one year term. In 2024, another election would be conducted for the next 4-year term. She noted that this election is in response to members requesting that an election be held as soon as possible. ***Motion: To approve the new proposed timeline and attached rules for the election of nominees to the two consumer Board Seats.***	**Approved by roll call. 12 AYES (Byrd, Conteas-Wood, Hernandez de Cordero, Lara, McClain, Mahler, Poz, Romo, Salazar, Sanchez, Refugio, Vazquez)** **1 NAY McFerson**
FUTURE AGENDA ITEMS		
	Member McFerson said that they need to have more time on the agenda for discussion and communication among members. She said they need specific times after presenters to not only make a two-minute comment but also to either rebuttal or have a discussion with another chair about this information. They need to have a democratic process and not be spoken at and then speak to each other. She said that members need to be able to vote on different things having to do with the agenda Chairperson Vazquez said that she would like to add an agenda item to discuss durable medical equipment and billing issues. She knows of people that have had issues obtaining necessary medical equipment and have been billed, because their insurance information was not updated.	

PUBLIC COMMENTS		
	PUBLIC COMMENT Submitted by Jonathan Cooper and Elizabeth Cooper, *RCAC 2 Member*, via phone call: *From Jonathan Cooper. For Black History Month, thank you L.A. Care, John Baackes, Board of Governors. Thank you to all those looking out for justice and advocating for African Americans. Inform the public - thank you. For tenant's rights - please members of ECAC, get to know your rights and ECAC, take notice of this and members know your rights and responsibilities. TY LA County, City of LA, state of California. Disability Awareness Month - please remember those that are disabled and who would like to participate. Thank you member of the public for highlighting issues - they protect our rights. Thank you ECAC and L.A. Care.* *Good morning members of the ECAC. This is from Elizabeth Cooper and Jonathan Cooper. Since RCACs have not met, it's important that ECAC address members and communicate with the RCACs. I feel like ECAC is a source for RCAC roles identified and ECAC, it's important to address issues to the members.*	
ADJOURNMENT	Chairperson Vazquez thanked the interpreters, L.A. Care staff, and the public for attending. The meeting was adjourned at 1:10 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

Fatima Vasquez, *ECAC Chair* ________________________________
Date ________________________________

Legislative Matrix for Board of Governors Meeting

Last Updated: April 17, 2023

Bills by Issue

2023 Legislation (206)

Bill Number	Status	Position
AB 4	In Assembly	Support

Title
Covered California: expansion.

Description
AB 4, as amended, Arambula. Covered California: expansion. Existing federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. Existing state law creates the California Health Benefit Exchange, also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Existing law requires the Exchange to apply to the United States Department of Health and Human Services for a waiver to allow individuals who are not eligible to obtain health coverage through the Exchange because of their immigration status to obtain coverage from the Exchange, by waiving the requirement that the Exchange offer only qualified health plans solely for the purpose of offering coverage to persons otherwise not able to obtain coverage by reason of immigration status. Existing law limits the waiver of that requirement to requiring the Exchange to offer only "California qualified health plans," as specified, to those individuals. Existing law requires an issuer that offers a qualified health plan in the individual market through the Exchange to concurrently offer a California qualified health plan that meets prescribed criteria.This bill would revise those provisions by deleting the requirement that limits coverage for the described individuals to the California qualified health plans. Contingent upon federal approval of the waiver, specified requirements for applicants eligible for the coverage described in the bill would become operative on January 1, 2025, for coverage effective for qualified health plans beginning January 1, 2026.

Primary Sponsors
Joaquin Arambula, Sabrina Cervantes, Maria Durazo

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 6:21 PM
L.A. Care: Support

Bill Number
AB 40

Status
In Assembly

Position
Monitor

Title
Emergency medical services.

Description
AB 40, as amended, Rodriguez. Emergency medical services. Existing law, the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, creates the Emergency Medical Services Authority, which is responsible for the coordination of various state activities concerning emergency medical services. Among other duties, existing law requires the authority to develop planning and implementation guidelines for EMS systems, provide technical assistance to existing agencies, counties, and cities for the purpose of developing the components of EMS systems, and receive plans for the implementation of EMS and trauma care systems from local EMS agencies. Existing law makes a violation of the act or regulations adopted pursuant to the act punishable as a misdemeanor.This bill would require the authority to develop an electronic signature for use between the emergency department medical personnel at a receiving facility and the transporting emergency medical personnel that captures the points in time when the hospital receives notification of ambulance arrival and when transfer of care is executed for documentation of ambulance patient offload time, as defined. The bill would require the authority to develop a statewide standard of 20 minutes, 90% of the time, for ambulance patient offload time. The bill would also require the authority to develop an audit tool to improve data accuracy regarding transfer of care, as specified, and to provide technical assistance and funding as needed, subject to an appropriation, for small rural hospitals and volunteer EMS providers to implement these provisions. The bill would require the authority to adopt emergency regulations to implement these provisions on or before March 1, 2024. The bill would require a general acute care hospital with an emergency department to develop, in consultation with its emergency department staff, an ambulance patient offload time reduction protocol by June 1, 2024, that addresses specified factors, including, among other things, mechanisms to improve hospital operations to reduce ambulance patient offload time. The bill would require the hospital to file its protocol with the authority and to report annually any revisions to its protocol. The bill would require the authority, on or after March 1, 2024, to monitor monthly ambulance patient offload time data for each facility. The bill would require the authority to, among other things, report ambulance patient offload time exceedance to the relevant local EMS agency and the Commission on Emergency Medical Services if, on or after July 1, 2024, the general acute care hospital with an emergency department has an ambulance patient offload time that exceeds the statewide standard of 20 min... (click bill link to see more).

Primary Sponsors
Freddie Rodriguez

Bill Number	Status	Position
AB 47	**In Assembly**	**Monitor**

Title
Pelvic floor physical therapy coverage.

Description
AB 47, as introduced, Boerner Horvath. Pelvic floor physical therapy coverage. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan contract or health insurance policy to provide maternity coverage, and prohibits the restriction, reduction, or denial of specified maternity benefits. This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2024, to provide coverage for pelvic floor physical therapy after pregnancy. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.The California 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
Tasha Boerner Horvath

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 5:50 PM
California Association of Health Plans: Oppose

Bill Number	Status	Position
AB 48	**In Assembly**	**Monitor**

Title
Nursing Facility Resident Informed Consent Protection Act of 2023.

Description
AB 48, as amended, Aguiar-Curry. Nursing Facility Resident Informed Consent Protection Act of 2023. Existing law provides for the licensure and regulation of health facilities, including skilled nursing facilities and intermediate care facilities, by the State Department of Public Health. Existing law requires skilled nursing facilities and intermediate care facilities to have written policies regarding the rights of patients.This bill would add to these rights the right of every resident to receive the information that is material to an individual's informed consent decision concerning whether to accept or refuse the administration of psychotherapeutic drugs, as specified. This bill would also add the right to be free from psychotherapeutic drugs used for the purpose of resident discipline, convenience, or chemical restraint, except in an emergency that threatens to cause immediate injury to the resident or others. This bill would make the prescriber responsible for disclosing the material information relating to psychotherapeutic drugs to the resident and obtaining their informed consent, as defined. The bill would require facility staff to verify that a resident's health record contains a signed, written consent form before initiating treatment with psychotherapeutic drugs. The bill would require the facility, within 6 months after the consent form is signed, and every 6 months thereafter, to provide a written notice to the resident and their representative of any recommended dosage adjustments and the resident's right to revoke consent, as specified. The bill would permit the use of remote technology, including telehealth, to allow a prescriber to examine and obtain informed written consent. The bill would declare the willful or repeated violation of these provisions to be punishable as a misdemeanor. By establishing a new crime, the bill would create a state-mandated local program.The bill would require the State Department of Public Health, in consultation with interested stakeholders, to develop a standardized informed consent form. The bill would require the informed consent form to be available to skilled nursing facilities and intermediate care facilities by December 31, 2024, and would exempt the skilled nursing facilities from this requirement until the informed consent form is available.This bill would also require the State Department of Public Health to inspect for compliance with the informed consent requirements described above during prescribed inspections.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 reimbu... (click bill link to see more).

Primary Sponsors
Cecilia Aguiar-Curry

Bill Number	Status	Position
AB 55	In Assembly	Monitor

Title
Medi-Cal: workforce adjustment for ground ambulance transports.

Description
AB 55, as amended, Rodriguez. Medi-Cal: workforce adjustment for ground ambulance transports. 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 emergency or nonemergency medical transportation services, as specified. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Existing law requires, with exceptions, that Medi-Cal reimbursement to providers of emergency medical transports be increased by application of an add-on to the associated Medi-Cal fee-for-service payment schedule. Under existing law, those increased payments are funded solely from a quality assurance fee (QAF), which emergency medical transport providers are required to pay based on a specified formula, and from federal reimbursement and any other related federal funds. Existing law sets forth separate provisions for increased Medi-Cal reimbursement to providers of ground emergency medical transportation services that are owned or operated by certain types of public entities.This bill would establish, for dates of service on or after July 1, 2024, a workforce adjustment, serving as an additional payment, for each ground ambulance transport performed by a provider of medical transportation services, excluding the above-described public entity providers. The bill would vary the rate of adjustment depending on federal maximum allowances based on the point of pickup and whether the service was for an emergency or nonemergency.The bill would require that the workforce adjustment meet a certain workforce standard, as determined by the department, which would apply to specified classes of employees, including emergency medical dispatchers, emergency medical technicians, paramedics, and registered nurses. The bill would set forth criteria for a provider to meet the workforce standard, with formulas taking into account the fiscal year and base hourly wage rates within a class of employees, and whether the provider is a new provider of ground ambulance services.The bill would require the department to direct each Medi-Cal managed care plan to implement a value-based purchasing model that provides for reimbursement to a network provider that meets the workforce standard requirement and that furnishes ambulance transport services, as specified.The bill would require the department to establish the manner and format for participating providers to report the required data, as specified. The bill would require a provider that has received the workforce adjustment to certify under penalty of perjury that it met the workforce standard, as specified. By expanding the scope... (click bill link to see more).

Primary Sponsors
Freddie Rodriguez

Bill Number	Status	Position
AB 85	In Assembly	Monitor

Title
Social determinants of health: screening and outreach.

Description
AB 85, as introduced, Weber. Social determinants of health: screening and outreach. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plans and health insurers to include coverage for screening for various conditions and circumstances, including adverse childhood experiences. Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2024, to include coverage for screenings for social determinants of health, as defined. The bill would require a health care service plan or health insurer to provide primary care providers with adequate access to community health workers in counties where the health care service plan or health insurer has enrollees or insureds, as specified. The bill would authorize the respective departments to adopt guidance to implement its provisions. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program. The 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 to provide reimbursement for those screenings.Existing law establishes the Department of Health Care Access and Information, under the control of the Director of the Department of Health Care Access and Information, to administer programs relating to areas including health policy and planning.This bill would require the department to convene a working group, with specified membership, to create a standardized model and procedures for connecting patients with community resources, to assess the need for a centralized list of accredited community providers, and to determine gaps in research and data to inform policies on system changes to address social determinants of health. The bill would require the working group, by January 1, 2025, to submit a report to the Legislature with recommendations on the topics addressed by the working group.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory pr... (click bill link to see more).

Primary Sponsors
Akilah Weber

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 5:51 PM
California Association of Health Plans: Oppose

Bill Number
AB 90

Status
In Assembly

Position
Monitor

Title
Family PACT Program: contraceptive device coverage.

Description
AB 90, as introduced, Petrie-Norris. Family PACT Program: contraceptive device coverage. Existing law establishes the Family Planning, Access, Care, and Treatment (Family PACT) Program, administered by the Office of Family Planning within the State Department of Health Care Services, under which 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 is eligible to receive these services. Under existing law, those comprehensive clinical family planning services include coverage for contraceptive devices approved by the federal Food and Drug Administration.This bill would clarify that Family PACT comprehensive clinical family planning services include inpatient services relating to the placement or insertion of a contraceptive device.

Primary Sponsors
Cottie Petrie-Norris

Organizational Notes

Last edited by Joanne Campbell at Apr 17, 2023, 4:04 PM
California Association of Health Plans: Oppose

Bill Number
AB 221

Status
In Assembly

Position
Monitor

Title
Budget Act of 2023.

Description
AB 221, as introduced, Ting. Budget Act of 2023. This bill would make appropriations for the support of state government for the 2023–24 fiscal year.This bill would declare that it is to take effect immediately as a Budget Bill.

Primary Sponsors
Phil Ting

Bill Number
AB 236

Status
In Assembly

Position
Monitor

Title
Health care coverage: provider directories.

Description
AB 236, as amended, Holden. Health care coverage: provider directories. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan and a health insurer that contracts with providers for alternative rates of payment to publish and maintain a provider directory or directories with information on contracting providers that deliver health care services enrollees or insureds, and requires a health care service plan and health insurer to regularly update its printed and online provider directory or directories, as specified.This bill would require a plan or insurer to annually audit and delete inaccurate listings from its provider directories, and would require a provider directory to be 60% accurate on January 1, 2024, with increasing required percentage accuracy benchmarks to be met each year until the directories are 95% accurate on or before January 1, 2027. The bill would subject a plan or insurer to administrative penalties for failure to meet the prescribed benchmarks and for each inaccurate listing in its directories. If a plan or insurer has not financially compensated a provider in the prior year, the bill would require the plan or insurer to delete the provider from its directory beginning July 1, 2024, unless specified criteria applies. The bill would require a plan or insurer to provide information about in-network providers to enrollees and insureds upon request, and would limit the cost-sharing amounts an enrollee or insured is required to pay for services from those providers under specified circumstances. 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
Chris Holden

Organizational Notes

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

Bill Number	Status	Position
AB 248	**In Senate**	**Monitor**

Title
Individuals with intellectual or developmental disabilities: The Dignity for All Act.

Description
AB 248, as amended, Mathis. Individuals with intellectual or developmental disabilities: The Dignity for All Act. Existing law includes the terms “mentally retarded persons,” “mentally retarded children,” and “retardation.”This bill, The Dignity for All Act, would make nonsubstantive changes to those provisions to eliminate this obsolete terminology. The bill would repeal obsolete provisions of law.

Primary Sponsors
Devon Mathis, Isaac Bryan, Tim Grayson, Akilah Weber, Buffy Wicks

Bill Number
AB 254

Status
In Assembly

Position
Monitor

Title
Confidentiality of Medical Information Act: reproductive or sexual health application information.

Description
AB 254, as introduced, Bauer-Kahan. Confidentiality of Medical Information Act: reproductive or sexual health application information. The Confidentiality of Medical Information Act (CMIA) prohibits a provider of health care, a health care service plan, a contractor, or a corporation and its subsidiaries and affiliates from intentionally sharing, selling, using for marketing, or otherwise using any medical information, as defined, for any purpose not necessary to provide health care services to a patient, except as provided. The CMIA makes a business that offers software or hardware to consumers, including a mobile application or other related device that is designed to maintain medical information in order to make the information available to an individual or a provider of health care at the request of the individual or a provider of health care for purposes of allowing the individual to manage the individual's information or for the diagnosis, treatment, or management of a medical condition of the individual, a provider of health care subject to the requirements of the CMIA. Existing law makes a violation of these provisions that results in economic loss or personal injury to a patient punishable as a misdemeanor.This bill would revise the definition of "medical information" to include reproductive or sexual health application information, which the bill would define to mean information related to a consumer's reproductive or sexual health collected by a reproductive or sexual health digital service. The bill would make a business that offers a reproductive or sexual health digital service to a consumer for the purpose of allowing the individual to manage the individual's information, or for the diagnosis, treatment, or management of a medical condition of the individual, a provider of health care subject to the requirements of the CMIA. Because the bill would expand the scope of a crime, it 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

Bill Number
AB 269

Status
Enacted

Position
Monitor

Title
Public health: COVID-19 testing and dispensing sites.

Description
AB 269, Berman. Public health: COVID-19 testing and dispensing sites. Existing law, the California Emergency Services Act, authorizes the Governor to declare a state of emergency during conditions of disaster or extreme peril to persons or property, including epidemics. Pursuant to this authority, on March 4, 2020, the Governor declared a state of emergency relating to the novel coronavirus 2019 (COVID-19) pandemic, and ordered, among other things, that the certification and licensure requirements as specified in statute and regulation be suspended to all persons who meet the requirements under the Clinical Laboratory Improvement Amendments (CLIA) for high complexity testing and who are performing analysis of samples to test for SARS-CoV-2, the virus that causes COVID-19, in any certified public health laboratory or licensed clinical laboratory, and that the California Health and Human Services Agency is required to identify and make available medical facilities and other facilities that are suitable for use as medical facilities as necessary for treating individuals who test positive for COVID-19. This bill would authorize a person to perform an analysis of samples to test for SARS-CoV-2 in a clinical laboratory or a city, county, or city and county public health laboratory if they meet the requirements under CLIA for high complexity testing. The bill would, until January 1, 2024, authorize an entity contracted with and approved by the State Department of Public Health to operate a designated COVID-19 testing and dispensing site to acquire, dispense, and store COVID-19 oral therapeutics, as defined, at or from a designated site.This bill would declare that it is to take effect immediately as an urgency statute.

Primary Sponsors
Marc Berman

Bill Number
AB 289

Status
In Senate

Position
Monitor

Title
Mental health services: representation.

Description
AB 289, as amended, Holden. Mental health services: representation. Existing law, the Bronzan-McCorquodale Act, contains provisions governing the operation and financing of community mental health services in every county through locally administered and locally controlled community mental health programs. Existing law, the Mental Health Services Act, an initiative measure enacted by the voters as Proposition 63 in the November 2, 2004, statewide general election, establishes the Mental Health Services Fund to fund various county mental health programs. The act may be amended by the Legislature only by a 2/3 vote of both houses and only so long as the amendment is consistent with and furthers the intent of the act. The Legislature may clarify procedures and terms of the act by majority vote.Existing law establishes the Mental Health Services Oversight and Accountability Commission and requires counties to prepare and submit a 3-year program and expenditure plan, and annual updates, as specified, to the commission and the State Department of Health Care Services. Existing law requires the plan to be developed with specified local stakeholders, along with other important interests.This bill would require stakeholders to include sufficient participation of individuals representing diverse viewpoints, including representatives from youth from historically marginalized communities, representatives from organizations specializing in working with underserved racially and ethnically diverse communities, and representatives from LGBTQ+ communities. By requiring counties to consult with additional stakeholders, 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
Chris Holden

Bill Number
AB 311

Status
In Assembly

Position
Support

Title
California Food Assistance Program: eligibility and benefits.

Description
AB 311, as introduced, Santiago. California Food Assistance Program: eligibility and benefits. Existing federal law provides for the Supplemental Nutrition Assistance Program (SNAP), known in California as CalFresh, under which supplemental nutrition assistance benefits allocated to the state by the federal government are distributed to eligible individuals by each county.Existing law requires the State Department of Social Services to establish a food assistance program, known as the California Food Assistance Program (CFAP), to provide assistance to a noncitizen of the United States if the person's immigration status meets the eligibility criteria of SNAP in effect on August 21, 1996, but the person is not eligible for SNAP benefits solely due to their immigration status, as specified. Existing law also makes eligible for the program an applicant who is otherwise eligible for the program, but who entered the United States on or after August 22, 1996, if the applicant is sponsored and the applicant meets one of a list of criteria, including that the applicant, after entry into the United States, is a victim of the sponsor or the spouse of the sponsor if the spouse is living with the sponsor.Existing law, to become operative on the date that the department notifies the Legislature that the Statewide Automated Welfare System (SAWS) has been updated to perform the necessary automation, and subject to an appropriation in the annual Budget Act, makes an individual 55 years of age or older eligible for the program if the individual's immigration status is the sole basis for their ineligibility for CalFresh benefits.This bill would remove that age limitation and make any individual eligible for the program if the individual's immigration status is the sole basis for their ineligibility for CalFresh benefits. By extending eligibility for CFAP, which is administered by the counties, 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
Miguel Santiago, Melissa Hurtado

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 6:22 PM
L.A. Care: Support

Bill Number
AB 317

Status
In Assembly

Position
Monitor

Title
Pharmacist service coverage.

Description
AB 317, as introduced, Weber. Pharmacist service 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 under authority of the Director of the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law authorizes health care service plans and certain disability insurers, that offer coverage for a service that is within the scope of practice of a duly licensed pharmacist, to pay or reimburse the cost of the service performed by a pharmacist for the plan or insurer if the pharmacist otherwise provides services for the plan or insurer.This bill would instead require a health care service plan and certain disability insurers that offer coverage for a service that is within the scope of practice of a duly licensed pharmacist to pay or reimburse the cost of services performed by a pharmacist at an in-network pharmacy or by a pharmacist at an out-of-network pharmacy if the health care service plan or insurer has an out-of-network pharmacy benefit. Because a willful violation of the bill’s requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.The California 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

Bill Number
AB 352

Status
In Assembly

Position
Monitor

Title
Health information.

Description
AB 352, as amended, Bauer-Kahan. Health information. Existing law, the Reproductive Privacy Act, provides that every individual possesses a fundamental right of privacy with respect to their personal reproductive decisions. Existing law prohibits the state from denying or interfering with a person's right to choose or obtain an abortion prior to viability of the fetus, or when the abortion is necessary to protect the life or health of the person.Existing law, the Confidentiality of Medical Information Act (CMIA), generally prohibits a provider of health care, a health care service plan, or a contractor from disclosing medical information regarding a patient, enrollee, or subscriber without first obtaining an authorization, unless a specified exception applies. The CMIA requires every provider of health care, health care service plan, pharmaceutical company, or contractor who, among other things, maintains or stores medical information to do so in a manner that preserves the confidentiality of the information contained therein. The CMIA also prohibits a provider of health care, a health care service plan, a contractor, or an employer from releasing medical information that would identify an individual or related to an individual seeking or obtaining an abortion in response to a subpoena or a request or to law enforcement if that subpoena, request, or the purpose of law enforcement for the medical information is based on, or for the purpose of enforcement of, either another state's laws that interfere with a person's rights to choose or obtain an abortion or a foreign penal civil action. Existing law makes a violation of the CMIA that results in economic loss or personal injury to a patient punishable as a misdemeanor.This bill would require specified businesses that electronically store or maintain medical information on the provision of sensitive services on behalf of a provider of health care, health care service plan, pharmaceutical company, contractor, or employer to develop capabilities, policies, and procedures, on or before July 1, 2024, to enable certain security features, including limiting user access privileges and segregating medical information related to sensitive services, as specified. The bill would additionally prohibit a provider of health care, health care service plan, contractor, or employer from cooperating with any inquiry or investigation by, or from providing medical information to, an individual, agency, or department from another state or, to the extent permitted by federal law, to a federal law enforcement agency that would identify an individual or that is related to an individual seeking or obtaining an abortion or abortion-related services that are lawful under the laws of this state, u... (click bill link to see more).

Primary Sponsors
Rebecca Bauer-Kahan

Bill Number	Status	Position
AB 365	**In Assembly**	**Monitor**

Title

Medi-Cal: diabetes management.

Description

AB 365, as amended, Aguiar-Curry. Medi-Cal: diabetes management. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law sets forth a schedule of benefits under the Medi-Cal program. This bill would add continuous glucose monitors and related supplies required for use with those monitors as a covered benefit under the Medi-Cal program, subject to utilization controls. The bill would require the department, by July 1, 2024, to review and update, as appropriate, coverage policies for continuous glucose monitors, as specified. The bill would authorize the department to require a manufacturer of a continuous glucose monitor to enter into a rebate agreement with the department. The bill would limit its implementation to the extent that any necessary federal approvals are obtained and federal financial participation is not otherwise jeopardized. The bill would make related findings and declarations.

Primary Sponsors

Cecilia Aguiar-Curry

Bill Number	Status	Position
AB 366	**In Assembly**	**Monitor**

Title

County human services agencies: workforce development.

Description

AB 366, as amended, Petrie-Norris. County human services agencies: workforce development. Existing law generally provides for various human services programs, including, but not limited to, child welfare services. Existing law requires the state, through the department and county welfare departments, to establish and support a public system of statewide child welfare services to be available in each county of the state, and requires all counties to establish and maintain specialized organizational entities within the county welfare department, which have sole responsibility for the operation of the child welfare services program.This bill would require the State Department of Social Services to establish a $5,000,000 stipend program, subject to an appropriation by the Legislature, for the purpose of providing grants in the form of educational stipends to community college students who have an interest in public child welfare work. The bill would require the department to administer the program through existing mechanisms applicable to other postsecondary education stipend programs administered by the department for which the state receives matching funds pursuant to specified federal law. The bill would require the program to provide stipends to students enrolled in a community college in counties with a population of 500,000 or less, and who are in a relevant program of coursework, as specified.The bill also would provide for competitive grants, subject to an appropriation for that purpose, to be made to eligible entities for the purpose of establishing career-track programs within the county human services departments. The bill would define eligible entities for this purpose to include county human services agencies, public education agencies, and nonprofit organizations, as specified. The bill would require grant awards to be prioritized based on geographic diversity, with priority to rural and central valley counties, and other factors, including, but not limited to, the applicant's ability to establish, in collaboration with local public colleges and universities, dedicated county internship programs that provide educational training and credit towards related human service degree programs. The bill would authorize the department to implement, interpret, or make specific the competitive grant provisions through all-county letters or similar instructions.Existing law vests the Department of Human Resources with the jurisdiction and responsibility of establishing and maintaining personnel standards on a merit basis, and administering merit systems for local government agencies where those merit systems of employment are required by statute or regulation as a condition of a state-funded program or a federal grant-... (click bill link to see more).

Primary Sponsors

Cottie Petrie-Norris

Bill Number	Status	Position
AB 379	In Assembly	Monitor

Title
Emergency medical services.

Description
AB 379, as amended, Rodriguez. Emergency medical services. Existing law, the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, governs local emergency medical services (EMS) systems. The existing act establishes the Emergency Medical Services Authority (authority), which is responsible for the coordination and integration of all emergency medical services. Existing law authorizes each county to develop an emergency medical services program and requires a county that does so to designate a local EMS agency (LEMSA).Existing law authorizes a LEMSA to adopt policies and procedures for calculating and reporting ambulance patient offload times. Existing law authorizes a LEMSA to develop and submit an emergency medical services system plan to the authority and requires the LEMSA to annually submit its emergency medical services plan for the EMS area to the authority.This bill would make these authorizations mandatory. The bill would also require LEMSAs and the authority to make the plans accessible on the LEMSA's and the authority's internet websites within 30 days of approval by the authority.

Primary Sponsors
Freddie Rodriguez

Bill Number
AB 392

Status
In Assembly

Position
Monitor

Title
Multicultural health.

Description
AB 392, as amended, Blanca Rubio. Multicultural health. Existing law, the Information Practices Act of 1977, prohibits an agency, as defined, from disclosing personal information in a manner that would link the information to the individual to whom it pertains unless a specified exemption applies, including that the information is disclosed to a governmental entity if required by state or federal law.This bill would permit an agency to disclose personal information to the California Tribal Epidemiology Center (CTEC) for a specific purpose.Existing law establishes the Department of Health Care Access and Information in the California Health and Human Services Agency. Existing law requires an organization that operates, conducts, owns, or maintains a health facility, each hospital, and each general acute care hospital and freestanding ambulatory surgery clinic to make and file with the office certain information regarding patients that is recorded on a Hospital Discharge Abstract Data Record, an Emergency Care Data Record, and an Ambulatory Surgery Data Record, respectively, as described. The information includes, among other things, the date of birth, race, date of services, and principal diagnosis of the patient. Existing law requires the department to disclose this information to certain entities, including, among others, any California hospital and tribal epidemiology centers, except as specified. Existing law prohibits those entities from disclosing that information except in response to a court order, search warrant, or subpoena, or as otherwise required or permitted by specified federal law.Existing law requires the State Department of Public Health to establish a list of reportable communicable and noncommunicable diseases and conditions and specify the timeliness requirements related to the reporting of each disease and condition. Existing law also requires the State Department of Public Health to collect data on coccidioidomycosis cases from the California Reportable Disease Information Exchange (CalREDIE) system and any other electronic data system used by a local health department.This bill would require the State Department of Public Health to enter into a data sharing agreement with the CTEC for access to and use of the CalREDIE and the California Immunization Registry systems no later than January 1, 2024, and would prohibit the CTEC from disclosing the information, as described above.

Primary Sponsors
Blanca Rubio

Bill Number	Status	Position
AB 403	**In Assembly**	**Monitor**

Title
Health systems: community benefits plan.

Description
AB 403, as amended, Arambula. Health systems: community benefits plan. Existing law establishes the Department of Health Care Access and Information to oversee various aspects of the health care market, including oversight of hospital facilities and community benefits plans. Existing law requires a private, not-for-profit hospital to adopt and update a community benefits plan that describes the activities the hospital has undertaken to address identified community needs within its mission and financial capacity, including health care services rendered to vulnerable populations. Existing law defines “community benefit” to include the unreimbursed cost of services, as specified, among other things. Existing law requires a hospital to conduct a community needs assessment to evaluate the health needs of the community and to update that assessment at least once every 3 years. Existing law requires a hospital to annually submit a community benefits plan to the department not later than 150 days after the hospital’s fiscal year ends. Existing law authorizes the department to impose a fine not to exceed $5,000 against a hospital that fails to adopt, update, or submit a community benefits plan, and requires the department to annually report on its internet website the amount of community benefit spending and list those that failed to report community benefit spending, among other things.This bill would redefine the term “community benefit” to include the unreimbursed cost of services as reported in a specified federal tax filing, would require a hospital to annually submit a copy of that completed tax filing, and would require a community benefits plan to include community benefits reported by category consistent with that filing. The bill would increase the maximum fine for failure to adopt, update, or submit, a community benefits plan to $25,000 and would specify that the community benefits plan should address the community needs identified by the community needs assessment.

Primary Sponsors
Joaquin Arambula

Bill Number
AB 412

Status
In Assembly

Position
Monitor

Title
Distressed Hospital Loan Program.

Description
AB 412, as amended, Soria. Distressed Hospital Loan Program. The California Health Facilities Financing Authority Act authorizes the California Health Facilities Financing Authority to, among other things, make loans from the continuously appropriated California Health Facilities Financing Authority Fund to participating health institutions, as defined, for financing or refinancing the acquisition, construction, or remodeling of health facilities.This bill would create the Distressed Hospital Loan Program, until January 1, 2032, for the purpose of providing loans to not-for-profit hospitals and public hospitals, as defined, in significant financial distress or to governmental entities representing a closed hospital to prevent the closure or facilitate the reopening of a closed hospital. The bill would require, subject to an appropriation by the Legislature, the Department of Health Care Access and Information to administer the program and would require the department to enter into an interagency agreement with the authority to implement this program. The bill would require the department, in collaboration with the State Department of Health Care Services, the Department of Managed Health Care, and the State Department of Public Health, to develop a methodology to evaluate an at-risk hospital's potential eligibility for state assistance from the program, as specified. The bill would require a hospital or a closed hospital to provide the authority and the department with financial information, in a format determined by the authority, demonstrating the hospital's need for assistance due to financial hardship. The bill would additionally require that the department, in consultation with the authority, develop a loan forgiveness application and approval process, as specified. The bill would specify that the authority and the department may implement these provisions by information notices or other similar instructions, without taking any further regulatory action.This bill would create the Distressed Hospital Loan Program Fund, a continuously appropriated fund, for use by the department and the authority to administer the loan program, as specified. The bill would authorize both the authority and the department to recover administrative costs from the fund, as specified. By creating a continuously appropriated fund, the bill would make an appropriation.Existing law generally requires a health care facility to report specified data to the department, including total inpatient and outpatient revenues by payer, including Medicare and Medi-Cal. Existing law requires the department to adopt regulations regarding the identification and reporting of charity care services, and specifies various obligations to provide hard copies of h... (click bill link to see more).

Primary Sponsors
Esmeralda Soria, Jim Wood, Anna Caballero

Bill Number	Status	Position
AB 425	**In Assembly**	**Monitor**

Title
Medi-Cal: pharmacogenomic testing.

Description
AB 425, as amended, Alvarez. Medi-Cal: pharmacogenomic testing. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law sets forth a schedule of covered benefits under the Medi-Cal program.This bill would add pharmacogenomic testing as a covered benefit under Medi-Cal, as specified. The bill would define pharmacogenomic testing as laboratory genetic testing that includes, but is not limited to, a panel test, to identify how a person’s genetics may impact the efficacy, toxicity, and safety of medications, including medications prescribed for behavioral or mental health, oncology, hematology, pain management, infectious disease, urology, reproductive or sexual health, neurology, gastroenterology, or cardiovascular diseases.The bill would also make related legislative findings.

Primary Sponsors
David Alvarez

Bill Number	Status	Position
AB 435	**In Assembly**	**Monitor**

Title
Public social services: automated application process.

Description
AB 435, as amended, Cervantes. Public social services: automated application process. Existing law requires the Office of Systems Integration within the California Health and Human Services Agency to implement a statewide automated welfare system, known as the California Statewide Automated Welfare System (CalSAWS), for various public assistance programs, including the CalWORKs program, CalFresh, and the Medi-Cal program. Under existing law, among other duties, the state is consolidating existing consortia systems into the single CalSAWS.Existing law requires the State Department of Social Services to establish and supervise the Cash Assistance Program for Aged, Blind, and Disabled Legal Immigrants (CAPI), which provides cash assistance to aged, blind, and disabled legal immigrants who are not citizens of the United States, as specified. Existing law establishes the state-funded Trafficking and Crime Victim Assistance Program (TCVAP), which provides critical benefits and services to noncitizen victims of human trafficking, domestic violence, and other serious crimes. Existing law also requires the department, after setting aside state administrative funds, to allocate social services funds derived from appropriated federal funds and federally targeted assistance to eligible counties. Existing law requires these funds, known as Refugee Cash Assistance (RCA), to be used by the county, pursuant to a plan developed by the county, to provide services to refugees that lead to successful self-sufficiency and social integration for the refugees.This bill would require CalSAWS to accept and process applications for CAPI, TCVAP, and RCA. The bill would require a county social services department to post on its internet website general information identifying available immigrant benefit services, including, but not limited to, those programs. By increasing the duties of county human services departments, the bill would impose a state-mandated local program. The bill would require the State Department of Social Services, with 60 days of the effective date of the bill, to report to the budget committees and relevant policy committees of the Legislature the department's plan to ensure that potential beneficiaries are able to apply online for those programs by December 1, 2024, or when the department notifies the Legislature that CalSAWS can perform the necessary automation to implement it, as specified. The bill would require the department to implement the bill's requirements by all-county letters or similar instructions, beginning no later than March 1, 2024, or when the department notifies the Legislature that CalSAWS can perform the necessary automation to implement it, until regulations are adopted. The bill also would ma... (click bill link to see more).

Primary Sponsors
Sabrina Cervantes

Bill Number
AB 448

Status
In Assembly

Position
Monitor

Title
Juveniles: relative placement: family finding.

Description
AB 448, as amended, Juan Carrillo. Juveniles: relative placement: family finding. (1) Existing law requires a county social worker to investigate the circumstances of each child taken into temporary custody by a peace officer under specified circumstances. Existing law requires the social worker to conduct an investigation, within 30 days of the child's removal, to identify and locate adult relatives of the child, as specified, and to provide them with a notification that the child has been removed from the custody of the child's parents, guardians, or Indian custodian, and an explanation of the various options to participate in the care and placement of the child. This bill would require the social worker to conduct the investigation to identify and locate adult relatives, immediately, and no later than 30 days, after the child has been taken into temporary custody.(2) Existing law establishes procedures for an initial petition hearing by the juvenile court if a child is being taken into temporary custody. Existing law requires a social worker to report to the court the reasons the child was removed from the parent's, guardian's, or Indian custodian's physical custody and the need, if any, for continued detention, available services, and if there are any relatives who are willing and able to take temporary physical custody of the child.This bill would additionally require the social worker to report to the court what efforts, and in the case of an Indian child, the active efforts, as defined, and findings the social worker has made to locate any relatives who are able and willing to take temporary physical custody of the child, and the names of any relatives who are able and willing to take temporary physical custody of the child.(3) Existing law provides that a child may be adjudged to be a dependent of the juvenile court because of abuse or neglect, and that after this determination, the court is required to hear evidence on the question of the proper disposition to be made of the child. Existing law requires that before determining the appropriate disposition, the court receive in evidence, among other things, the social study of the child made by the social worker and evaluation made by a child advocate appointed by the court. Existing law further prescribes the information that is required to be included in that social study or evaluation, including the appropriateness of any relative placement. Existing law requires the court to review the status of every dependent child in foster care no less frequently than once every 6 months and requires a supplemental report to be filed as part of that review.This bill would additionally require the social study, and any supplemental report, to include the efforts, and in... (click bill link to see more).

Primary Sponsors
Juan Carrillo

Bill Number
AB 459

Status
In Assembly

Position
Monitor

Title
California Behavioral Health Outcomes and Accountability Review.

Description
AB 459, as amended, Haney. California Behavioral Health Outcomes and Accountability Review. Existing law, the Bronzan-McCorquodale Act, contains provisions governing the operation and financing of community mental health services for persons with mental disorders in every county through locally administered and locally controlled community mental health programs.Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 in the November 2, 2004, statewide general election, establishes the continuously appropriated Mental Health Services Fund to fund various county mental health programs, including prevention and early intervention programs.This bill would require the California Health and Human Services Agency, by July 1, 2026, to establish the California Behavioral Health Outcomes and Accountability Review (CBH-OAR), consisting of performance indicators, county self-assessments, and county and health plan improvement plans, to facilitate an accountability system that fosters continuous quality improvement in county and commercial behavioral health services and in the collection and dissemination of best practices in service delivery by the agency. The bill would require the agency to convene a workgroup, as specified, to establish a workplan by which the CBH-OAR shall be conducted. The bill would require the agency to establish specific process measures and uniform elements for the county and health plan improvement plan updates. The bill would require the agency to report to the Legislature, as specified. By imposing new requirements on counties, this bill would impose a state-mandated local program.This bill would require the agency to request the University of California to enter into a contract with the state to provide specific services, including preparing an analysis of how data pertaining to the provision of behavioral health services and client outcomes collected by the counties and health plans may be used to demonstrate the impact of services on life outcomes. The bill would require the analysis to be delivered to the agency, the Legislature, and the workgroup on or before July 1, 2026.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
Matt Haney

Bill Number
AB 469

Status
In Assembly

Position
Monitor

Title
California Public Records Act Ombudsperson.

Description
AB 469, as introduced, Vince Fong. California Public Records Act Ombudsperson. The California Public Records Act requires state and local agencies to make their records available for public inspection, unless an exemption from disclosure applies. The act declares that access to information concerning the conduct of the people's business is a fundamental and necessary right of every person in this state.Existing law creates the California State Auditor's Office, which is independent of the executive branch and legislative control, to examine and report annually upon the financial statements prepared by the executive branch. Existing law establishes, within the State Treasury, the State Audit Fund, which is a continuously appropriated fund, for the expenses of the California State Auditor.This bill would establish, within the California State Auditor's Office, the California Public Records Act Ombudsperson. The bill would require the California State Auditor to appoint the ombudsperson subject to certain requirements. The bill would require the ombudsperson to receive and investigate requests for review, as defined, determine whether the denials of original requests, as defined, complied with the California Public Records Act, and issue written opinions of its determination, as provided. The bill would require the ombudsperson to create a process to that effect, and would authorize a member of the public to submit a request for review to the ombudsperson consistent with that process. The bill would require the ombudsperson, within 30 days from receipt of a request for review, to make a determination, as provided, and would require the state agency to provide the public record if the ombudsperson determines that it was improperly denied. The bill would, if requested by the ombudsperson, require any state agency determined to have improperly denied a request to reimburse the ombudsperson for its costs to investigate the request for review. The bill would require the ombudsperson to create a process through which a person whose information is contained in a record being reviewed may intervene to assert their privacy and confidentiality rights, and would otherwise require the ombudsperson to maintain the privacy and confidentiality of records, as provided. The bill would require the ombudsperson to report to the Legislature, on or before January 1, 2025, and annually thereafter, on, among other things, the number of requests for review the ombudsperson has received in the prior year.By expanding the duties of the California State Auditor's Office, this bill would create an appropriation.

Primary Sponsors
Vince Fong

Bill Number
AB 481

Status
In Assembly

Position
Monitor

Title
Dentistry: dental assistants.

Description
AB 481, as amended, Wendy Carrillo. Dentistry: dental assistants. (1) Existing law, the Dental Practice Act, establishes the Dental Board of California for the licensure and regulation of dentists and dental assistants. Existing law creates the Dental Assisting Council of the Dental Board of California, which is required to consider all matters relating to dental assistants in the state and make appropriate recommendations to the Dental Board of California, as specified.Existing law requires the board to include 5 registered dental assistants. Existing law requires 2 members to be employed for at least the prior 5 years as faculty members of a registered dental assisting educational program approved by the board and 3 members, including one registered dental assistant in extended functions, to be employed clinically in a private dental practice, public safety net, or dental health care clinic. Existing law establishes procedures for submission and consideration of the council's recommendations by the board.This bill would revise the member requirements, including, among other things, requiring one member to be employed as a faculty member of a registered dental assisting educational program approved by the board and one member to be a registered dental assistant in extended functions employed clinically in a private dental practice, public safety net, or dental health care clinic. The bill would revise procedures for submission and consideration of recommendations by the council.(2) Existing law sets forth requirements for licensure as a registered dental assistant and as a registered dental assistant in extended functions, and sets forth duties and functions that a registered dental assistant or a registered dental assistant in extended function is authorized to perform.This bill would revise and recast those provisions.(3) Existing law specifies a dental assistant is an individual who, without a license, may perform basic supportive dental procedures, as specified, and sets forth the responsibilities of a supervising licensed dentist, including ensuring that a dental assistant has completed specified courses. Existing law sets forth the duties and functions a dental assistant is authorized to perform.This bill would revise the responsibilities of a dentist-employer relating to an unlicensed dental assistant, and the functions and duties that an unlicensed dental assistant is authorized to perform. The bill would revise the course requirements for an unlicensed dental assistant and the preceptorship in dental assisting requirements, as defined. The bill would require an unlicensed dental assistant to obtain a certificate of completion of radiation safety to perform radiographic procedures.(4) Existing law establishe... (click bill link to see more).

Primary Sponsors
Wendy Carrillo

Bill Number
AB 482

Status
In Assembly

Position
Monitor

Title
Air ambulance services.

Description
AB 482, as amended, Wilson. Air ambulance services. Existing law, the Emergency Medical Air Transportation Act, imposed a penalty of $4 until December 31, 2022, upon every conviction for a violation of the Vehicle Code or a local ordinance adopted pursuant to the Vehicle Code, other than a parking offense. The act requires the county or court that imposed the fine to transfer the revenues collected to the Treasurer for deposit into the Emergency Medical Air Transportation and Children’s Coverage Fund. Existing law requires the assessed penalty to continue to be collected, administered, and distributed until exhausted or until December 31, 2023, whichever occurs first.Existing law establishes the Aeronautics Account in the State Transportation Fund, and continuously appropriates the moneys in the account for expenditure for airport purposes by the Division of Aeronautics within the Department of Transportation and the California Transportation Commission.This bill would annually transfer $8,000,000 from the Aeronautics Account to the Emergency Medical Air Transportation and Children’s Coverage Fund and continuously appropriate those moneys to augment Medi-Cal reimbursement for emergency medical air transportation and related costs.

Primary Sponsors
Lori Wilson

Bill Number
AB 483

Status
In Assembly

Position
Monitor

Title
Local educational agency: Medi-Cal billing option.

Description
AB 483, as introduced, Muratsuchi. Local educational agency: Medi-Cal billing option. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed by, and funded pursuant to, federal Medicaid program provisions. Existing law establishes the Administrative Claiming process under which the department is authorized to contract with local governmental agencies and local educational consortia for the purpose of obtaining federal matching funds to assist with the performance of administrative activities relating to the Medi-Cal program that are provided by a local governmental agency or local educational agency (LEA).Existing law requires the department to engage in specified activities relating to the LEA Medi-Cal Billing Option, including amending the Medicaid state plan to ensure that schools are reimbursed for all eligible services, consulting with specified entities in formulating state plan amendments, examining methodologies for increasing school participation in the LEA Medi-Cal Billing Option, and conducting an audit of a Medi-Cal Billing Option claim consistent with prescribed requirements, such as generally accepted accounting principles. Existing law requires the department to file an annual report with the Legislature that includes, among other things, a summary of department activities.This bill would require the department to revise the state plan to establish a revised audit process for Medi-Cal Billing Option claims submitted for dates of service on or after January 1, 2025, pursuant to specified requirements and limitations. The bill would require the department to report to the relevant policy committees and post on its internet website any changes made to the state plan pursuant to the requirement to revise the state plan. The bill would require the department to provide technical assistance to the LEA or to complete appeals by the LEA within 180 days if an audit requires a specified percentage of an LEA's total value of claims to be paid back. The bill would prohibit an auditor from determining that an LEA is required to pay back reimbursement for certain claims, except as specified. The bill would require the department's summary of activities in the above-described report to also include training for LEAs and a summary of the number of audits conducted of Medi-Cal Billing Option claims, as specified. The bill would require the department to ensure, for those claims, that "medical necessity" for a beneficiary under 21 years of age has a specified meaning. The bill would make other technical, nonsubstantive changes to these provision... (click bill link to see more).

Primary Sponsors
Al Muratsuchi, Jim Wood, Dave Cortese

Bill Number
AB 486

Status
In Assembly

Position
Monitor

Title
Long-term health facilities: citation appeals.

Description
AB 486, as amended, Kalra. Long-term health facilities: citation appeals. The Long-Term Care, Health, Safety, and Security Act of 1973 generally requires the State Department of Public Health to license and regulate long-term health care facilities and to establish an inspection and reporting system to ensure that long-term health care facilities are in compliance with state statutes and regulations. The act divides violations into classes AA, A, and B, depending on the severity and probability of the harm resulting or that could result from the violation.Under existing law, if a licensee decides to contest a class “AA” or “A” citation, the licensee is required, within 15 business days of the service of the citation, to inform the director of the licensee’s intent to adjudicate the validity of the violation in the superior court, and to file that action within 90 days, as specified. Existing law requires a licensee who desires to contest a class “B” citation to, within 15 working days after service of the citation, notify the director or the director’s designee that the licensee wishes to appeal the citation through specified department administrative adjudicatory procedures, or elects to submit the matter to binding arbitration through the American Arbitration Association. Existing law authorizes a licensee that disagrees with the determination of an administrative law judge to seek judicial review.This bill would delete the civil action provisions for contesting a class “AA” or “A” citation under these provisions, and would make those citation classifications subject to the administrative proceedings applicable for contesting a class “B” citation. The bill would authorize an administrative law judge to affirm, modify, or dismiss a citation, the class of a citation, or the proposed penalty. The bill would authorize a licensee to seek judicial review of an administrative law judge’s decision in the context of a class “AA” or “A” citation and would authorize a licensee to elect to submit the decision of an administrative law judge to arbitration for a class “B” citation. The bill would make related conforming changes and various technical, nonsubstantive changes.

Primary Sponsors
Ash Kalra

Bill Number
AB 488

Status
In Assembly

Position
Monitor

Title
Medi-Cal: skilled nursing facilities: vision loss.

Description
AB 488, as introduced, Stephanie Nguyen. Medi-Cal: skilled nursing facilities: vision loss. 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, subject to any necessary federal approvals, for managed care rating periods that begin between January 1, 2023, and December 31, 2026, inclusive, to establish and implement the Workforce and Quality Incentive Program under which a network provider furnishing skilled nursing facility services to a Medi-Cal managed care enrollee may earn performance-based directed payments from the Medi-Cal managed care plan with which they contract, as specified. Existing law, subject to an appropriation, requires the department to set the amounts of those directed payments under a specified formula.Existing law requires the department to establish the methodology or methodologies, parameters, and eligibility criteria for the directed payments, including the milestones and metrics that network providers of skilled nursing facility services must meet in order to receive a directed payment from a Medi-Cal managed care plan, with at least 2 of these milestones and metrics tied to workforce measures.This bill would require that the measures and milestones include program access, staff training, and capital improvement measures aimed at addressing the needs of skilled nursing facility residents with vision loss. The bill would make related legislative findings.

Primary Sponsors
Stephanie Nguyen

Bill Number
AB 503

Status
In Assembly

Position
Monitor

Title
Health care: organ donation enrollment.

Description
AB 503, as amended, Juan Carrillo. Health care: organ donation enrollment. Existing law, the Uniform Anatomical Gift Act, authorizes the creation of a not-for-profit entity to be designated as the California Organ and Tissue Donor Registrar and requires that entity to establish and maintain the Donate Life California Organ and Tissue Donor Registry for persons who have identified themselves as organ and tissue donors upon their death.Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law requires the department, in consultation with the board governing the California Health Benefit Exchange, to develop a single paper, electronic, and telephone application for insurance affordability programs, including Medi-Cal.This bill would require the department to modify the electronic application for insurance affordability programs to add an option for individuals to enroll in the Donate Life California Organ and Tissue Donor Registry. The bill would require the option to include specified check boxes for an applicant to indicate whether to add the applicant’s name to the registry. The bill would require the option to be voluntary to complete and to not be a required part of the application. The bill would also require a specified disclosure related to organ and tissue donations to be included with the check boxes described above. The bill would require the department to electronically transmit specified information related to enrollment in the registry on a weekly basis to the Donate Life California nonprofit organization.

Primary Sponsors
Juan Carrillo, Mike Gipson

Bill Number
AB 512

Status
In Assembly

Position
Monitor

Title
Mental health and substance use disorders: database of facilities.

Description
AB 512, as amended, Waldron. Mental health and substance use disorders: database of facilities. Existing law establishes a system of mental health programs, largely administered through the counties, to provide mental health and substance use disorder services in the state. Existing law regulates the facilities that provide these services, including acute psychiatric hospitals, residential substance abuse treatment facilities, and outpatient programs.This bill would require that, by July 1, 2024, the California Health and Human Services Agency, either on its own or through the Behavioral Health Task Force established by the Governor, create an ad hoc committee to study how to develop a real-time, internet-based system, usable by hospitals, clinics, law enforcement, paramedics and emergency medical technicians (EMTs), and other health care providers as deemed appropriate, to display information about available beds in inpatient psychiatric facilities, crisis stabilization units, residential community mental health facilities, and residential alcoholism or substance abuse treatment facilities in order to facilitate the identification and designation of available facilities for the transfer to, and temporary treatment of, individuals in mental health or substance use disorder crisis. The ad hoc committee shall submit a report of its findings to the Legislature no later than July 1, 2025.

Primary Sponsors
Marie Waldron

Bill Number
AB 517

Status
In Assembly

Position
Monitor

Title
Health Professions Career Opportunity Program.

Description
AB 517, as amended, Soria. Health Professions Career Opportunity Program. Existing law establishes the Department of Health Care Access and Information and requires the department to maintain a Health Professions Career Opportunity Program to, among other things, implement programs at colleges and universities selected by the department and include in those programs pipeline programs that provide comprehensive academic enrichment, career development, mentorship, and advising in order to support students from underrepresented regions and backgrounds to pursue health careers.This bill would require the department to provide to the Legislature a spending report of the Health Professions Career Opportunity Program for the 2021–22 and 2022–23 fiscal years.

Primary Sponsors
Esmeralda Soria

Bill Number
AB 532

Status
In Assembly

Position
Monitor

Title
Emergency medical services.

Description
AB 532, as introduced, Lackey. Emergency medical services. Existing law, the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, establishes the Emergency Medical Services Authority. Under existing law, the authority is responsible for the coordination and integration of all state activities concerning emergency medical services.This bill would make technical, nonsubstantive changes to those provisions.

Primary Sponsors
Tom Lackey

Bill Number	Status	Position
AB 551	**In Assembly**	**Monitor**

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

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

Primary Sponsors
Steve Bennett

Bill Number	Status	Position
AB 557	**In Assembly**	**Monitor**

Title
Open meetings: local agencies: teleconferences.

Description
AB 557, as introduced, Hart. Open meetings: local agencies: teleconferences. (1) Existing law, the Ralph M. Brown Act, requires, with specified exceptions, that all meetings of a legislative body of a local agency, as those terms are defined, be open and public and that all persons be permitted to attend and participate. The act contains specified provisions regarding providing for the ability of the public to observe and provide comment. The act allows for meetings to occur via teleconferencing subject to certain requirements, particularly that the legislative body notice each teleconference location of each member that will be participating in the public meeting, that each teleconference location be accessible to the public, that members of the public be allowed to address the legislative body at each teleconference location, that the legislative body post an agenda at each teleconference location, and that at least a quorum of the legislative body participate from locations within the boundaries of the local agency's jurisdiction. The act provides an exemption to the jurisdictional requirement for health authorities, as defined.Existing law, until January 1, 2024, authorizes a local agency to use teleconferencing without complying with those specified teleconferencing requirements in specified circumstances when a declared state of emergency is in effect, or in other situations related to public health, as specified. If there is a continuing state of emergency, or if state or local officials have imposed or recommended measures to promote social distancing, existing law requires a legislative body to make specified findings not later than 30 days after the first teleconferenced meeting, and to make those findings every 30 days thereafter, in order to continue to meet under these abbreviated teleconferencing procedures.Existing law requires a legislative body that holds a teleconferenced meeting under these abbreviated teleconferencing procedures to give notice of the meeting and post agendas, as described, to allow members of the public to access the meeting and address the legislative body, to give notice of the means by which members of the public may access the meeting and offer public comment, including an opportunity for all persons to attend via a call-in option or an internet-based service option. Existing law prohibits a legislative body that holds a teleconferenced meeting under these abbreviated teleconferencing procedures from requiring public comments to be submitted in advance of the meeting and would specify that the legislative body must provide an opportunity for the public to address the legislative body and offer comment in real time.This bill would extend the above-described abbreviated teleconferen... (click bill link to see more).

Primary Sponsors
Gregg Hart

Bill Number	Status	Position
AB 564	**In Assembly**	**Monitor**

Title

Medi-Cal: claim or remittance forms: signature.

Description

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

Primary Sponsors

Carlos Villapudua

Bill Number	Status	Position
AB 571	**In Assembly**	**Monitor**

Title
Medical malpractice insurance.

Description
AB 571, as amended, Petrie-Norris. Medical malpractice insurance. Existing law generally regulates classes of insurance, including liability insurance. Existing law defines “liability insurance” to include, among other things, insurance coverage against the legal liability of the insured, and against loss, damage, or expense incident to a claim arising out of the death or injury of any person as the result of negligence or malpractice in rendering professional services by any person who holds a certificate or license issued pursuant to the Medical Practice Act or the Osteopathic Initiative Act, or a license as a community clinic or health facility, as specified. This bill would prohibit an insurer from refusing to issue or renew or terminating professional liability insurance for health care providers and from imposing a surcharge or increasing the premium or deductible solely based on any prohibited bases for discrimination, including a health care provider offering or performing abortion, contraception, gender-affirming health care, or care related to those health care services that are lawful in this state but unlawful in another state.The bill would prohibit an insurer from denying coverage for liability for damages arising from offering, performing, or rendering abortion, contraception, gender-affirming health care, or care related to those health care services, if those services are within the scope of the insured’s license and the policy would otherwise cover liability for damages arising from performing or rendering other professional services within the insured’s scope of license.

Primary Sponsors
Cottie Petrie-Norris, Buffy Wicks

Bill Number	Status	Position
AB 576	**In Assembly**	**Monitor**

Title
Medi-Cal: reimbursement for abortion.

Description
AB 576, as amended, Weber. Medi-Cal: reimbursement for abortion. 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 provides that abortion is a covered benefit under Medi-Cal. Existing regulation authorizes reimbursement for specified medications used to terminate a pregnancy through the 70th day from the first day of the recipient's last menstrual period.This bill would require the department, by March 1, 2024, to review and update Medi-Cal coverage policies for medication abortion to align with current evidence-based clinical guidelines. After the initial review, the bill would require the department to update its Medi-Cal coverage policies for medication abortion as needed to align with evidence-based clinical guidelines.The bill would require the department to allow flexibility for providers to exercise their clinical judgment when services are performed in a manner that aligns with one or more evidence-based clinical guidelines.

Primary Sponsors
Akilah Weber

Bill Number
AB 586

Status
In Assembly

Position
Monitor

Title
Medi-Cal: community supports: climate change or environmental remediation devices.

Description
AB 586, as amended, Calderon. Medi-Cal: community supports: climate change or environmental remediation devices. 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, 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, housing deposits, environmental accessibility adaptations or home modifications, and asthma remediation.This bill would add climate change or environmental remediation devices to the above-described list of community supports. For purposes of these provisions, the bill would define “climate change or environmental remediation devices” as coverage of devices and installation of those devices, as necessary, to address health-related complications, barriers, or other factors linked to extreme weather, poor air quality, or climate events, including air conditioners, electric heaters, air filters, or backup power sources, among other specified devices for certain purposes.

Primary Sponsors
Lisa Calderon

Bill Number
AB 607

Status
In Assembly

Position
Monitor

Title
Public postsecondary education: course materials.

Description
AB 607, as introduced, Kalra. Public postsecondary education: course materials. Existing law requires each campus of the California Community Colleges and the California State University, and requests each campus of the University of California, to clearly highlight the courses that exclusively use digital course materials, as specified, and clearly communicate to students that the course materials for these courses are free of charge and therefore not required to be purchased. This bill would require each campus of the California Community Colleges and the California State University, and request each campus of the University of California, to prominently display the estimated costs for each course of all required course materials and fees directly related to those materials, for no less than 75% of the total number of courses on the online campus course schedule. The bill would define, for purposes of this requirement, “course materials” to include digital or physical textbooks, devices such as calculators and remote attendance platforms, and software subscriptions. By imposing new duties on community college district, 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
Ash Kalra

Bill Number
AB 608

Status
In Assembly

Position
Monitor

Title
Medi-Cal: comprehensive perinatal services.

Description
AB 608, as introduced, Schiavo. Medi-Cal: comprehensive perinatal 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, including comprehensive perinatal services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, a pregnant individual or targeted low-income child who is eligible for, and is receiving, health care coverage under any of specified Medi-Cal programs is eligible for full-scope Medi-Cal benefits for the duration of the pregnancy and for a period of one year following the last day of the individual’s pregnancy.This bill, during the one-year postpregnancy eligibility period, and as part of comprehensive perinatal services under Medi-Cal, would require the department to cover additional comprehensive perinatal assessments and individualized care plans and to provide additional visits and units of services in an amount, duration, and scope that are at least proportional to those available on July 27, 2021, during pregnancy and the initial 60-day postpregnancy period in effect on that date. The bill would require the department to collaborate with the State Department of Public Health and a broad stakeholder group to determine the specific number of additional comprehensive perinatal assessments, individualized care plans, visits, and units of services to be covered.The bill would require the department to seek any necessary federal approvals to cover preventive services that are recommended by a physician or other licensed practitioner and that are rendered by a nonlicensed perinatal health worker in a beneficiary’s home or other community setting away from a medical site, as specified. The bill would also require the department to seek any necessary federal approvals to allow a nonlicensed perinatal health worker rendering those preventive services to be supervised by (1) an enrolled Medi-Cal provider that is a clinic, hospital, community-based organization (CBO), or licensed practitioner, or (2) a CBO that is not an enrolled Medi-Cal provider, so long as an enrolled Medi-Cal provider is available for Medi-Cal billing purposes.The bill would condition implementation of the provisions above on an appropriation by the Legislature and on receipt of any necessary federal approvals and the availability of federal financial participation.

Primary Sponsors
Pilar Schiavo, Joaquin Arambula

Bill Number
AB 614

Status
In Assembly

Position
Monitor

Title

Medi-Cal.

Description

AB 614, as introduced, Wood. Medi-Cal. 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.This bill would make a change to an obsolete reference to the former Healthy Families Program, whose health services for children have been transitioned to the Medi-Cal program. The bill would make a change to an obsolete reference to the former Access for Infants and Mothers Program and would revise a related provision to instead refer to the successor Medi-Cal Access Program. The bill would delete, within certain Medi-Cal provisions, obsolete references to a repealed provision relating to nonprofit hospital service plans.Existing law establishes, under Medi-Cal, the County Health Initiative Matching Fund, a program administered by the department, through which an applicant county, county agency, local initiative, or county organized health system that provides an intergovernmental transfer, as specified, is authorized to submit a proposal to the department for funding for the purpose of providing comprehensive health insurance coverage to certain children. The program is sometimes known as the County Children’s Health Initiative Program (CCHIP).This bill would revise certain provisions to rename that program as CCHIP.Existing law requires the Director of Health Care Services to enter into contracts with managed care plans under Medi-Cal and related provisions, including health maintenance organizations, prepaid health plans, or other specified entities, for the provision of medical benefits to all persons who are eligible to receive medical benefits under publicly supported programs.This bill would delete that list of entities and would instead specify that the director would be required to enter into contracts with managed care plans licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975, except as otherwise authorized under the Medi-Cal program.The bill would also make technical changes to some of the provisions described above.

Primary Sponsors

Jim Wood

Bill Number
AB 616

Status
In Assembly

Position
Monitor

Title
Medical Group Financial Transparency Act.

Description
AB 616, as amended, Rodriguez. Medical Group Financial Transparency Act. Existing law establishes the Office of Health Care Affordability within the Department of Health Care Access and Information to analyze the health care market for cost trends and drivers of spending, develop data-informed policies for lowering health care costs for consumers and purchasers, and create a state strategy for controlling the cost of health care. Existing law requires the office to collect data and other information it deems necessary from health care entities to carry out the functions of the office, and requires the office to require providers and physician organizations to submit audited financial reports or comprehensive financial statements, as specified. Existing law requires those reports and statements to be kept confidential, and specifies that they are not required to be disclosed under the California Public Records Act.Existing law requires the office to obtain information about health care service plans from the Department of Managed Health Care. Existing law requires a contract between a health care service plan and a risk-bearing organization to include provisions concerning the risk-bearing organization's administrative and financial capacity. Existing law requires the director of the Department of Managed Health Care to adopt regulations regarding, among other things, periodic reports from a health care service plan that include information concerning the risk-bearing organizations and the type and amount of financial risk they have assumed.Existing law establishes, within the office, the Health Care Affordability Board, composed of 8 members, appointed as prescribed. This bill, the Medical Group Financial Transparency Act, would authorize the disclosure of audited financial reports and comprehensive financial statements of providers and physician organizations collected by the Office of Health Care Affordability and financial and other records of risk-bearing organizations made available to the Department of Managed Health Care. This bill would authorize the board, members of the board, the office, the department, and the employees, contractors, and advisors of the office and the department to use confidential audited financial reports and comprehensive financial statements only as necessary to carry out functions of the office. The bill would also require certain physician organizations, as specified, to produce or disclose audited financial reports and comprehensive financial statements to the office, subject to these provisions. The bill would require the audited financial reports and comprehensive financial statements produced or disclosed to the office to be made available to the public, by the office, as specif... (click bill link to see more).

Primary Sponsors
Freddie Rodriguez

Bill Number
AB 620

Status
In Assembly

Position
Monitor

Title
Health care coverage for metabolic disorders.

Description
AB 620, as introduced, Connolly. Health care coverage for metabolic disorders. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of disability insurers, including health insurers, by the Department of Insurance. Existing law requires a health care service plan contract and disability insurance policy that provides coverage for hospital, medical, or surgical expenses and is issued, amended, delivered, or renewed on and after July 1, 2000, to provide coverage for the testing and treatment of phenylketonuria, including coverage for the formulas and special food products that are part of a prescribed diet, as specified.This bill would require a health care service plan contract and disability insurance policy that provides coverage for hospital, medical, or surgical expenses and is issued, amended, delivered, or renewed on and after January 1, 2024, to provide coverage for the testing and treatment of other digestive and inherited metabolic disorders. Because a violation of the bill’s requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Damon Connolly

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 5:51 PM
California Association of Health Plans: Oppose

Bill Number
AB 632

Status
In Assembly

Position
Monitor

Title
Health care coverage: prostate cancer screening.

Description
AB 632, as introduced, Gipson. Health care coverage: prostate 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, 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 an individual and group health care service plan contract or health insurance policy to provide coverage for the screening and diagnosis of prostate cancer when medically necessary and consistent with good professional practice. Under existing law, the application of a deductible or copayment for those services is not prohibited.This bill would prohibit a health care service plan or a health insurance policy issued, amended, renewed, or delivered on or after January 1, 2024, from applying a deductible, copayment, or coinsurance to coverage for prostate cancer screening services for an enrollee or insured who is 55 years of age or older or who is 40 years of age or older and is high risk, as determined by the attending or treating health care 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
Mike Gipson

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 5:52 PM
California Association of Health Plans: Oppose

Bill Number
AB 659

Status
In Assembly

Position
Monitor

Title
Cancer Prevention Act.

Description
AB 659, as amended, Aguiar-Curry. Cancer Prevention Act. Existing law prohibits the governing authority of a school or other institution from unconditionally admitting any person as a pupil of any private or public elementary or secondary school, childcare center, day nursery, nursery school, family daycare home, or development center, unless prior to their admission to that institution they have been fully immunized. Existing law requires the documentation of immunizations for certain diseases, including, among others, measles, mumps, pertussis, and any other disease deemed appropriate by the State Department of Public Health, as specified. Existing law authorizes certain exemptions from these provisions subject to specified conditions.This bill, the Cancer Prevention Act, would declare the public policy of the state that pupils are expected to be fully immunized against human papillomavirus (HPV) before admission or advancement to the 8th grade level of any private or public elementary or secondary school. The bill would, upon a pupil's admission or advancement to the 6th grade level, require the governing authority to submit to the pupil and their parent or guardian a notification containing a statement about that public policy and advising that the pupil be fully immunized against HPV before admission or advancement to the 8th grade level. By creating new notification duties for school districts, the bill would impose a state-mandated local program.Existing law requires the Trustees of the California State University and, subject to a resolution, the Regents of the University of California to require the first-time enrollees at those institutions who are 18 years of age or younger to provide proof of full immunization against the hepatitis B virus prior to enrollment, with certain exemptions.This bill would declare the public policy of the state that students who are 26 years of age or younger are expected to be fully immunized against HPV before first-time enrollment at an institution of the California State University, the University of California, or the California Community Colleges. The bill would make a conforming change to a consultation-related provision.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 issued, amended, or renewed on or after January 1, 2002, as specified, to provide coverage for an annual cervical cancer screening test, including an HPV ... (click bill link to see more).

Primary Sponsors
Cecilia Aguiar-Curry

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 5:52 PM
California Association of Health Plans: Oppose

Bill Number
AB 663

Status
In Assembly

Position
Monitor

Title
Pharmacy: mobile units.

Description
AB 663, as amended, Haney. Pharmacy: mobile units. Existing law, the Pharmacy Law, requires the California State Board of Pharmacy within the Department of Consumer Affairs to license and regulate the practice of pharmacy, including pharmacists, pharmacy technicians, and pharmacies. Existing law authorizes a county, city and county, or special hospital authority, as defined, to operate a mobile unit as an extension of a pharmacy license held by the county, city and county, or special hospital authority to provide prescription medication within its jurisdiction to specified individuals, including those individuals without fixed addresses. Existing law authorizes a mobile unit to dispense prescription medication pursuant to a valid prescription if the county, city and county, or special hospital authority meets prescribed requirements for licensure, staffing, and operations, including a prohibition on carrying or dispensing controlled substances.Existing law, the California Uniform Controlled Substances Act, classifies certain controlled substances into Schedules I to V, inclusive.This bill would exempt from that prohibition on carrying or dispensing controlled substances Schedule III, Schedule IV, or Schedule V controlled substances approved by the United States Food and Drug Administration for the treatment of opioid use disorder. The bill would require any controlled substance for the treatment of opioid use disorder carried or dispensed in accordance with that exemption to be carried in reasonable quantities based on prescription volume and stored securely in the mobile pharmacy unit. The bill would also authorize a mobile unit to provide prescription medication within its jurisdiction to city-and-county-operated housing facilities.

Primary Sponsors
Matt Haney

Bill Number	Status	Position
AB 665	**In Senate**	**Monitor**

Title

Minors: consent to mental health services.

Description

AB 665, as introduced, Wendy Carrillo. Minors: consent to mental health services. Existing law, for some purposes, authorizes a minor who is 12 years of age or older to consent to mental health treatment or counseling on an outpatient basis, or to residential shelter services, if the minor is mature enough to participate intelligently in the outpatient services or residential shelter services, as specified, and either the minor would present a danger of serious physical or mental harm to themselves or to others or if the minor is the alleged victim of incest or child abuse. For other purposes, existing law authorizes a minor who is 12 years of age or older to consent to mental health treatment or counseling services if the minor is mature enough to participate intelligently in the outpatient services or counseling services. This bill would align the existing laws by removing the additional requirement that, in order to consent to mental health treatment or counseling on an outpatient basis, or to residential shelter services, the minor must present a danger of serious physical or mental harm to themselves or to others, or be the alleged victim of incest or child abuse.Existing law, for some purposes, requires that the mental health treatment or counseling include involvement of the minor’s parent or guardian unless the professional person treating or counseling the minor determines that the involvement would be inappropriate. For other purposes, existing law requires the involvement of the parent or guardian unless the professional person who is treating or counseling the minor, after consulting with the minor, determines that the involvement would be inappropriate. This bill would also align the existing laws by requiring the professional person treating or counseling the minor to consult with the minor before determining whether involvement of the minor’s parent or guardian would be inappropriate.

Primary Sponsors

Wendy Carrillo, Scott Wiener

Bill Number
AB 666

Status
In Assembly

Position
Monitor

Title
Health systems: community benefits plans.

Description
AB 666, as amended, Arambula. Health systems: community benefits plans. Existing law establishes the Department of Health Care Access and Information to oversee various aspects of the health care market, including oversight of hospital facilities and community benefits plans. Existing law requires a private, not-for-profit hospital to adopt and update a community benefits plan that describes the activities the hospital has undertaken to address identified community needs within its mission and financial capacity, including health care services rendered to vulnerable populations. Existing law defines the term “community” as the service areas or patient populations for which the hospital provides health care services, defines “vulnerable populations” for these purposes to include a population that is exposed to medical or financial risk by virtue of being uninsured, underinsured, or eligible for Medi-Cal, Medicare, California Children’s Services Program, or county indigent programs, and defines “community benefit” to mean the hospital’s activities that are intended to address community needs, such as support to local health departments, among other things. Existing law requires a hospital to conduct a community needs assessment to evaluate the health needs of the community and to update that assessment at least once every 3 years. Existing law requires a hospital to annually submit a community benefits plan to the department not later than 150 days after the hospital’s fiscal year ends. Existing law authorizes the department to impose a fine not to exceed $5,000 against a hospital that fails to adopt, update, or submit a community benefits plan, and requires the department to annually report on its internet website the amount of community benefit spending and list those that failed to report community benefit spending, among other things.This bill would require the department to define the term “community” by regulation within certain parameters, would redefine the term “community benefit” to mean services rendered to those eligible for, but not enrolled in the above-described programs, the unreimbursed costs as reported in specified tax filings, and the support to local health departments as documented by those local health departments, among other things, and would redefine the term “vulnerable populations” to include those eligible for, but not enrolled in the above-described programs, those below median income experiencing economic disparities, and certain socially disadvantaged groups, such as those who are incarcerated. The bill would require that a community needs assessment include the needs of the vulnerable populations and include a description of which vulnerable populations are low or moderate income, coord... (click bill link to see more).

Primary Sponsors
Joaquin Arambula

Bill Number	Status	Position
AB 677	**In Assembly**	**Monitor**

Title
Confidentiality of Medical Information Act.

Description
AB 677, as introduced, Addis. Confidentiality of Medical Information Act. The Confidentiality of Medical Information Act, among other things, prohibits a health care provider, a contractor, or a health care service plan from disclosing medical information, as defined, regarding a patient of the provider or an enrollee or subscriber of the health care service plan without first obtaining an authorization, except as specified. This bill would make nonsubstantive changes to the title provision of the act.

Primary Sponsors
Dawn Addis

Bill Number	Status	Position
AB 710	**In Assembly**	**Monitor**

Title
State Department of Public Health: pregnancy care and abortion services awareness campaign.

Description
AB 710, as amended, Schiavo. State Department of Public Health: pregnancy care and abortion services awareness campaign. Existing law provides for the licensure and regulation of clinics and health facilities, including, but not limited to, primary care and specialty clinics, by the State Department of Public Health. Under existing law, the department is also responsible for the statewide administration of various programs and policies relating to personal health, including maternal, child, and adolescent health. Existing law requires the department to develop a coordinated state strategy for addressing the health-related needs of women, including implementation of goals and objectives for women’s health, as specified.This bill would require the department to conduct an awareness campaign to communicate with local health departments, health care providers, and the public regarding facilities that provide health care services, including, but not limited to, primary care and specialty clinics. The bill would require the awareness campaign to include information about the services the facilities offer, and the activities of the department, relating to pregnancy care and abortion. The bill would require the campaign to provide outreach to, among others, health care professional associations and societies and health care employers. The bill would authorize the department to award grants or enter into contracts to perform the functions required to conduct the awareness campaign, as specified. The bill would repeal these provisions on January 1, 2025.

Primary Sponsors
Pilar Schiavo

Bill Number	Status	Position
AB 712	In Assembly	Monitor

Title
CalFresh: hot and prepared foods.

Description
AB 712, as amended, Wendy Carrillo. CalFresh: hot and prepared foods. Existing law establishes various public social services programs, including, among others, the California Work Opportunity and Responsibility to Kids (CalWORKs) program, CalFresh, and the Medi-Cal program. Existing federal law provides for the federal Supplemental Nutrition Assistance Program (SNAP), known in California as CalFresh, under which supplemental nutrition assistance benefits allocated to the state by the federal government are distributed to eligible individuals by each county.This bill would require the State Department of Social Services to seek all available federal waivers and approvals to maximize food choices for CalFresh recipients, including hot and prepared foods ready for immediate consumption.

Primary Sponsors
Wendy Carrillo

Bill Number
AB 716

Status
In Assembly

Position
Monitor

Title
Emergency ground medical transportation.

Description
AB 716, as introduced, Boerner Horvath. Emergency ground medical transportation. Existing law creates the Emergency Medical Services Authority to coordinate various state activities concerning emergency medical services. Existing law requires the authority to report specified information, including reporting ambulance patient offload time twice per year to the Commission on Emergency Medical Services.This bill would require the authority to annually report the allowable maximum rates for ground ambulance transportation services in each county, including trending the rates by county, as specified.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 that health care service plan contracts and health insurance policies provide coverage for certain services and treatments, including emergency medical transportation services, and requires a policy or contract to provide for the direct reimbursement of a covered medical transportation services provider if the provider has not received payment from another source.This bill would delete that direct reimbursement requirement and would require a health care service plan contract or a health insurance policy issued, amended, or renewed on or after January 1, 2024, to require an enrollee or insured who receives covered services from a noncontracting ground ambulance provider to pay no more than the same cost-sharing amount that the enrollee or insured would pay for the same covered services received from a contracting ground ambulance provider. The bill would prohibit a noncontracting ground ambulance provider from billing or sending to collections a higher amount, and would prohibit a ground ambulance provider from billing an uninsured or self-pay patient more than the established payment by Medi-Cal or Medicare fee-for-service amount, whichever is greater. The bill would require a plan or insurer to reimburse for ground ambulance services at the authorized rate for the specific exclusive operating area, unless it reaches another agreement with the noncontracting ground ambulance provider. Because a willful violation of the bill’s requirements relative to 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 reim... (click bill link to see more).

Primary Sponsors
Tasha Boerner Horvath

Bill Number
AB 719

Status
In Assembly

Position
Monitor

Title
Medi-Cal benefits.

Description
AB 719, as introduced, Boerner Horvath. Medi-Cal benefits. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes a schedule of benefits under the Medi-Cal program, including nonmedical transportation for a beneficiary to obtain covered Medi-Cal services. Existing law requires nonmedical transportation to be provided by the beneficiary's managed care plan or by the department for a Medi-Cal fee-for-service beneficiary.This bill would require the department to require managed care plans to contract with public transit operators for the purpose of establishing reimbursement rates for nonmedical and nonemergency medical transportation trips provided by a public transit operator. The bill would require the rates reimbursed by the managed care plan to the public transit operator to be based on the department's fee-for-service rates for nonmedical and nonemergency medical transportation service.

Primary Sponsors
Tasha Boerner Horvath

Organizational Notes

Last edited by Joanne Campbell at Apr 17, 2023, 4:40 PM
California Association of Health Plans: Oppose

Bill Number
AB 745

Status
In Assembly

Position
Monitor

Title
Reentry Housing and Workforce Development Program.

Description
AB 745, as amended, Bryan. Reentry Housing and Workforce Development Program. Existing law establishes the Department of Housing and Community Development in the Business, Consumer Services, and Housing Agency and makes the department responsible for administering various housing programs throughout the state, including, among others, the Multifamily Housing Program, the Housing for a Healthy California Program, and the California Emergency Solutions Grants Program. Upon appropriation by the Legislature for this express purpose, this bill would require the department to create the Reentry Housing and Workforce Development Program, and would require the department to take specified actions to provide grants to applicants, as defined, for innovative or evidence-based housing, housing-based services, family reunification services, women services, and employment interventions to allow people with recent histories of incarceration to exit homelessness and remain stably housed. The bill would require the department to establish a process, in collaboration with the Department of Corrections and Rehabilitation and with counties in which recipients are operating, for referral of participants, in accordance with certain guidelines and procedures.The bill would require the department to score applicants to the program competitively according to specified criteria. The bill would require recipients of funds from the program to use those funds for, among other things, long-term rental assistance in permanent housing, incentives to landlords, and innovative or evidence-based services to assist participants in accessing permanent supportive housing. The bill would require the department to distribute funds allocated by executing contracts with awarded entities for a term of 5 years, subject to automatic renewal.The bill would require a recipient of the program to submit an annual report to the department. The bill would require the department to hire an independent evaluator to assess outcomes from the program and would require the department to submit the analysis of that assessment to specified committees of the Legislature.

Primary Sponsors
Isaac Bryan, Mia Bonta

Bill Number	Status	Position
AB 813	**In Assembly**	**Monitor**

Title
Emergency services: blood donations.

Description
AB 813, as introduced, Rodriguez. Emergency services: blood donations. Existing law establishes the Office of Emergency Services within the office of the Governor, which is responsible for, among other things, the state's emergency and disaster response services for specified disasters and emergencies.This bill would authorize the Office of Emergency Services to enter into partnerships with private sector entities to encourage the private sector to provide meaningful incentives for individuals to make donations of human whole blood or human blood components.

Primary Sponsors
Freddie Rodriguez

Bill Number	Status	Position
AB 815	**In Assembly**	**Monitor**

Title
Health care coverage: provider credentials.

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

Primary Sponsors
Jim Wood

Bill Number	Status	Position
AB 816	In Assembly	Monitor

Title
Minors: consent to medical care.

Description
AB 816, as introduced, Haney. Minors: consent to medical care. Existing law authorizes a minor who is 12 years of age or older to consent to medical care and counseling relating to the diagnosis and treatment of a drug- or alcohol-related problem. Existing law exempts replacement narcotic abuse treatment, as specified, from these provisions.This bill would authorize a minor who is 16 years of age or older to consent to replacement narcotic abuse treatment that uses buprenorphine.

Primary Sponsors
Matt Haney

Bill Number
AB 817

Status
In Assembly

Position
Monitor

Title
Open meetings: teleconferencing: subsidiary body.

Description
AB 817, as amended, Pacheco. Open meetings: teleconferencing: subsidiary body. Existing law, the Ralph M. Brown Act, requires, with specified exceptions, each legislative body of a local agency to provide notice of the time and place for its regular meetings and an agenda containing a brief general description of each item of business to be transacted. The act also requires that all meetings of a legislative body be open and public, and that all persons be permitted to attend unless a closed session is authorized. The act generally requires for teleconferencing that the legislative body of a local agency that elects to use teleconferencing post agendas at all teleconference locations, identify each teleconference location in the notice and agenda of the meeting or proceeding, and have each teleconference location be accessible to the public. Existing law also requires that, during the teleconference, at least a quorum of the members of the legislative body participate from locations within the boundaries of the territory over which the local agency exercises jurisdiction.Existing law, until January 1, 2024, authorizes the legislative body of a local agency to use alternate teleconferencing provisions during a proclaimed state of emergency or in other situations related to public health that exempt a legislative body from the general requirements (emergency provisions) and impose different requirements for notice, agenda, and public participation, as prescribed. The emergency provisions specify that they do not require a legislative body to provide a physical location from which the public may attend or comment.Existing law, until January 1, 2026, authorizes the legislative body of a local agency to use alternative teleconferencing in certain circumstances related to the particular member if at least a quorum of its members participate from a singular physical location that is open to the public and situated within the agency's jurisdiction and other requirements are met, including restrictions on remote participation by a member of the legislative body.This bill would authorize a subsidiary body, as defined, to use alternative teleconferencing provisions similar to the emergency provisions indefinitely and without regard to a state of emergency. In order to use teleconferencing pursuant to this act, the bill would require the legislative body that established the subsidiary body by charter, ordinance, resolution, or other formal action to make specified findings by majority vote, before the subsidiary body uses teleconferencing for the first time and every 12 months thereafter.Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings... (click bill link to see more).

Primary Sponsors
Blanca Pacheco

Bill Number	Status	Position
AB 834	**In Assembly**	**Monitor**

Title
Physicians and surgeons and doctors of podiatric medicine: professional partnerships.

Description
AB 834, as amended, Irwin. Physicians and surgeons and doctors of podiatric medicine: professional partnerships. Existing law, the Medical Practice Act, establishes the Medical Board of California for the licensing, regulation, and discipline of physicians and surgeons. Existing law establishes the California Board of Podiatric Medicine within the Medical Board of California for the licensing, regulation, and discipline of podiatrists. 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 and requires the Osteopathic Medical Board of California to enforce the Medical Practice Act with respect to its licensees. Existing law makes a violation of specified provisions of the Medical Practice Act a crime.The Medical Practice Act authorizes physicians and surgeons and doctors of podiatric medicine to establish a professional partnership or group that includes both physicians and surgeons and doctors of podiatric medicine if a majority of the partners and partnership interests in the professional partnership are physicians and surgeons or osteopathic physicians and surgeons. Existing law prohibits a partner who is not a physician and surgeon from practicing in the partnership or voting on partnership matters related to the practice of medicine that are outside the partner’s scope of practice.This bill would revise the above-described provisions to allow a majority of the partners and partnership interests to be physicians and surgeons, osteopathic physicians and surgeons, or doctors of podiatric medicine. The bill would additionally prohibit a partner who is not a doctor of podiatric medicine from practicing in the partnership or voting on partnership matters related to the practice of podiatric medicine that are outside the partner’s scope of practice. By imposing a new requirement under the Medical Practice Act, the violation of which is a crime, the bill would impose a state-mandated local program. The bill would correct an erroneous cross-reference and make other nonsubstantive changes.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
Jacqui Irwin

Bill Number
AB 845

Status
In Assembly

Position
Monitor

Title
Behavioral health: older adults.

Description
AB 845, as amended, Alvarez. Behavioral health: older adults. Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the continuously appropriated Mental Health Services Fund to fund various county mental health programs, including the Adult and Older Adult Mental Health System of Care Act. Existing law authorizes the MHSA to be amended by a 2/3 vote of the Legislature if the amendments are consistent with and further the intent of the MHSA.This bill would establish within the State Department of Health Care Services an Older Adult Behavioral Health Services Administrator to oversee behavioral health services for older adults. The bill would require that position to be funded with administrative funds from the Mental Health Services Fund. The bill would prescribe the functions of the administrator and their responsibilities, including, but not limited to, developing outcome and related indicators for older adults for the purpose of assessing the status of behavioral health services for older adults, monitoring the quality of programs for those adults, and guiding decisionmaking on how to improve those services. The bill would require the administrator to receive data from other state agencies and departments to implement these provisions, subject to existing state or federal confidentiality requirements. The bill would require the administrator to report to the entities that administer the MHSA on those outcome and related indicators by July 1, 2024, and would require the report to be posted on the department's internet website. The bill would also require the administrator to develop a strategy and standardized training for all county behavioral health personnel in order for the counties to assist the administrator in obtaining the data necessary to develop the outcome and related indicators. By expanding the purposes for which funds from a continuously appropriated fund may be spent, this bill would make an appropriation.This bill would declare that it is consistent with and furthers the intent of the MHSA.

Primary Sponsors
David Alvarez

Bill Number
AB 847

Status
In Assembly

Position
Monitor

Title
Medi-Cal: pediatric palliative care services.

Description
AB 847, as amended, Luz Rivas. Medi-Cal: pediatric palliative care 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 develop a pediatric palliative care benefit as a pilot program to Medi-Cal beneficiaries under 21 years of age, to be implemented only to the extent that any necessary federal approvals are obtained and federal financial participation is available. Existing law requires that program to include, among other things, hospice services to individuals whose conditions may result in death, regardless of the estimated length of the individual's remaining period of life.Pursuant to the above-described provisions, the department established the Pediatric Palliative Care (PPC) Waiver in 2009, upon receiving federal approval in December 2008. After the waiver ended on December 31, 2018, the department implemented a plan in 2019 to transition some pediatric palliative care services to the Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) benefit, which is available to Medi-Cal beneficiaries under 21 years of age, as specified.Existing federal law makes individuals less than 21 years of age eligible for both hospice care and treatment for their underlying illness for which a physician has made a terminal diagnosis.This bill would extend eligibility for pediatric palliative care services and concurrent treatment for an underlying illness for those individuals who have been determined eligible for those services prior to 21 years of age, after 21 years of age. To the extent that these provisions would alter the eligibility of individuals for these services, the bill would create a state-mandated local program. The bill would require a managed care plan to be liable for payment of these services received in a county different from the individual's county of residence if they are not available in that county. The bill would implement these provisions only to the extent that necessary federal approvals are obtained and federal financial participation is not otherwise jeopardized.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
Luz Rivas

Bill Number
AB 864

Status
In Assembly

Position
Monitor

Title
Substance use disorder: telephone system.

Description
AB 864, as amended, Haney. Substance use disorder: telephone system. Existing law requires the State Department of Health Care Services to license and regulate alcoholism or drug abuse recovery or treatment facilities serving adults. Existing law authorizes the department to certify qualified alcoholism or drug abuse recovery or treatment programs, as prescribed. Under existing law, the department regulates the quality of these programs, taking into consideration the significance of community-based programs to alcohol and other drug abuse recovery and the need to encourage opportunities for low-income and special needs populations to receive alcohol and other drug abuse recovery or treatment services.This bill would require the department to establish and maintain a 3-digit, statewide, nonemergency telephone system for substance use disorder treatment referrals.

Primary Sponsors
Matt Haney

Bill Number
AB 869

Status
In Assembly

Position
Monitor

Title
Hospitals: seismic safety compliance.

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

Primary Sponsors
Jim Wood, Eduardo Garcia

Bill Number
AB 874

Status
In Assembly

Position
Monitor

Title
Health care coverage: out-of-pocket expenses.

Description
AB 874, as introduced, Weber. Health care coverage: out-of-pocket expenses. Existing law generally prohibits a person who manufactures a prescription drug from offering in California any discount, repayment, product voucher, or other reduction in an individual's out-of-pocket expenses associated with the individual's health insurance, health care service plan, or other health coverage, including, but not limited to, a copayment, coinsurance, or deductible, for any prescription drug if a lower cost generic drug is covered under the individual's health insurance, health care service plan, or other health coverage on a lower cost-sharing tier that is designated as therapeutically equivalent to the prescription drug manufactured by that person or if the active ingredients of the drug are contained in products regulated by the federal Food and Drug Administration, are available without prescription at a lower cost, and are not otherwise contraindicated for the condition for which the prescription drug is approved.Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance.This bill would require a health care service plan, health insurance policy, other health coverage carrier, or pharmacy benefit manager that administers pharmacy benefits to apply any amounts paid by the enrollee, insured, or another source pursuant to a discount, repayment, product voucher, or other reduction to the enrollee's or insured's out-of-pocket expenses toward the enrollee's or insured's overall contribution to any out-of-pocket maximum, deductible, copayment, coinsurance, or applicable cost-sharing requirement under the enrollee's or insured's health care service plan, health insurance policy, or other health care coverage. The bill would make a willful violation of that requirement by a health care service plan a crime. The bill would limit the application of the section to health care service plans and health insurance policies issued, amended, delivered, or renewed on or after January 1, 2024. Because a willful violation of these requirements by a health care service plan would be a crime, this bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Akilah Weber

Bill Number	Status	Position
AB 904	In Assembly	Monitor

Title
Health care coverage: doulas.

Description
AB 904, as amended, Calderon. Health care coverage: doulas. 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 a health care service plan or health insurer to develop a maternal mental health program designed to promote quality and cost-effective outcomes. Existing law encourages a plan or insurer to include coverage for doulas.This bill would require a health care service plan or health insurer, on or before January 1, 2025, to develop a maternal and infant health equity program that addresses racial health disparities in maternal and infant health outcomes through the use of doulas. The bill would authorize the departments to jointly convene a workgroup to examine the implementation of these programs. The bill would specify workgroup membership and duties. The bill would require the Department of Managed Health Care, in consultation with the Department of insurance, to collect data and submit a report on doula coverage and the above-described programs to the Legislature by January 1, 2027. Because a willful violation of the provisions relative to health care service plans 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
Lisa Calderon, Sabrina Cervantes

Bill Number	Status	Position
AB 907	**In Assembly**	**Monitor**

Title
Coverage for PANDAS and PANS.

Description
AB 907, 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, 2024, 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 a provider. The bill would prohibit coverage for PANDAS and PANS from being subject to a copayment, coinsurance, deductible, or other cost sharing that is greater than that applied to other benefits. The bill would prohibit a plan or insurer from denying or delaying coverage for PANDAS or PANS therapies because the enrollee or insured previously received treatment for PANDAS or PANS or was diagnosed with or received treatment for the condition under a different diagnostic name. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Josh Lowenthal

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 5:54 PM
California Association of Health Plans: Oppose

Bill Number
AB 911

Status
In Assembly

Position
Monitor

Title
Unlawfully restrictive covenants: affordable housing.

Description
AB 911, as amended, Schiavo. Unlawfully restrictive covenants: affordable housing. Existing law permits a person who holds or is acquiring an ownership interest of record in property that the person believes is the subject of an unlawfully restrictive covenant based on, among other things, the number of persons or families who may reside on the property, to record a restrictive covenant modification. Existing law entitles the owner of an affordable housing development to establish that an existing restrictive covenant is unenforceable by submitting a restrictive covenant modification document that modifies or removes any existing restrictive covenant language. Before recording the modification document, existing law requires the owner to submit to the county recorder a copy of the original restrictive covenant and any documents the owner believes necessary to establish that the property qualifies as an affordable housing development for purposes of these provisions. As part of this process, existing law requires the county counsel to determine, among other things, if the property qualifies as an affordable housing development and if a modification document may be recorded. If the county counsel has authorized the county recorder to record the modification document, that authorization is required to be noted on the face of the modification or on a cover sheet affixed to it. This bill would require the county recorder to notify the owner of the county counsel's determination within 5 business days so that notice may be given by the owner regarding the authorization to record the modification document. The bill would permit the owner, upon receipt of that notification, to mail copies of the modification documents and related materials by certified mail to anyone who the owner knows has an interest in the property or the restrictive covenant. The bill would also establish a process by which notice by the owner to the intended recipient would be deemed given. The bill would provide that notice by the owner is optional and failure to provide it does not invalidate a recorded restrictive covenant modification document.Existing law prohibits the county recorder from recording the modification document if the county counsel finds that the original restrictive covenant document does not contain a restriction prohibited by this provision or if the county counsel finds that the property does not qualify as an affordable housing development.This bill would prohibit the county recorder from recording the modification document if the owner of the property is not yet its record title owner but is instead a beneficial owner, as specified, until the owner closes escrow on the property and becomes its record title owner. For purposes o... (click bill link to see more).

Primary Sponsors
Pilar Schiavo

Bill Number	Status	Position
AB 921	**In Assembly**	**Monitor**

Title

Mental health: workforce.

Description

AB 921, as amended, Bonta. Mental health: workforce. Existing law regulates the provision of programs and services relating to mental health and requires the creation of community programs to increase access to, and quality of, community-based mental health services. Existing law requires any program permitting mental health professions to respond to emergency mental health crisis calls in collaboration with law enforcement to ensure the program is supervised by a licensed mental health professional, including, among others, a licensed clinical social worker, except as specified.This bill would require the Department of Health Care Access and Information to establish a mentorship program that will connect students enrolled in behavioral health programs with community-based organizations, as specified. The bill would require the department to coordinate a cost-of-living stipend that a student mentee may use for specific expenses. The bill would authorize a community-based organization to apply for the stipend and would require the community-based organization to distribute the stipend to its student mentees distinct from wages earned for work performed. This bill would require the department to offer an increased stipend to encourage bilingual students to participate in the program.This bill would require an eligible student to enter into an agreement with a community-based organization to complete the mentorship program concurrent with their education and to work for the community-based organization after graduation, as specified. The bill would require a community-based organization to, among other things, formally mentor each student mentee and offer each student mentee permanent employment upon successful completion of their educational program.

Primary Sponsors

Mia Bonta

Bill Number
AB 931

Status
In Assembly

Position
Monitor

Title
Prior authorization: physical therapy.

Description
AB 931, as introduced, Irwin. Prior authorization: physical therapy. 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 prior authorization limitations for health care service plans and health insurers.This bill would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, that provides coverage for physical therapy from imposing prior authorization for the initial 12 treatment visits for a new episode of care for physical therapy. 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
Jacqui Irwin

Organizational Notes

Last edited by Joanne Campbell at Apr 17, 2023, 4:41 PM
California Association of Health Plans: Oppose

Bill Number
AB 940

Status
In Assembly

Position
Monitor

Title
Health care: eating disorders.

Description
AB 940, as amended, Villapudua. Health care: eating disorders. Existing law establishes the licensure and regulation of health facilities by the State Department of Public Health. Existing law requires that inpatient treatment of eating disorders must be provided only in state licensed hospitals, which may be general acute care hospitals, acute psychiatric hospitals, or any other licensed health facility designed by the State Department of Public Health.This bill would expand the approved facilities for inpatient treatment of eating disorders to include psychiatric health facilities.

Primary Sponsors
Carlos Villapudua

Bill Number	Status	Position
AB 948	**In Assembly**	**Monitor**

Title
Prescription drugs.

Description
AB 948, as introduced, Berman. Prescription drugs. 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, until January 1, 2024, prohibits the copayment, coinsurance, or any other form of cost sharing for a covered outpatient prescription drug for an individual prescription from exceeding $250 for a supply of up to 30 days, except as specified. Existing law, until January 1, 2024, requires a nongrandfathered individual or small group plan contract or policy to use specified definitions for each tier of a drug formulary.This bill would delete the January 1, 2024, repeal date of those provisions, thus making them operative indefinitely. Because extension of the bill's requirements relative to health care service plans would extend the existence of a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Marc Berman, Scott Wiener

Bill Number	Status	Position
AB 952	**In Assembly**	**Monitor**

Title
Dental coverage disclosures.

Description
AB 952, as introduced, Wood. Dental coverage disclosures. 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 or health insurer that issues, sells, renews, or offers a contract covering dental services, or a specialized health care service plan or specialized health insurer covering dental services, to disclose whether or not an enrollee's or insured's dental coverage is subject to regulation by the appropriate department at the time a treatment plan is communicated to the plan or insurer. The bill would also require that plan or insurer to include whether or not an enrollee's or insured's dental coverage is subject to regulation by the appropriate department on an identification card, membership card, coverage card, or other documentation of coverage. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Jim Wood

Bill Number
AB 988

Status
In Assembly

Position
Monitor

Title

Miles Hall Lifeline and Suicide Prevention Act: veteran and military data reporting.

Description

AB 988, as amended, Mathis. Miles Hall Lifeline and Suicide Prevention Act: veteran and military data reporting. Existing federal law, the National Suicide Hotline Designation Act of 2020, designates the 3-digit telephone number “988” as the universal number within the United States for the purpose of the national suicide prevention and mental health crisis hotline system operating through the 988 Suicide and Crisis Lifeline, maintained by the Assistant Secretary for Mental Health and Substance Use, and the Veterans Crisis Line, which is maintained by the Secretary of Veterans Affairs.Existing law creates a separate surcharge, beginning January 1, 2023, on each access line for each month, or part thereof, for which a service user subscribes with a service supplier. Existing law sets the 988 surcharge for the 2023 and 2024 calendar years at $0.08 per access line per month and beginning January 1, 2025, at an amount based on a specified formula not to exceed $0.30 per access line per month. Existing law authorizes the 911 and 988 surcharges to be combined into a single-line item, as described. Existing law provides for specified costs to be paid by the fees prior to distribution to the Office of Emergency Services.Existing law, the Miles Hall Lifeline and Suicide Prevention Act, creates the 988 State Suicide and Behavioral Health Crisis Services Fund and requires the fees to be deposited along with other specified moneys into the fund. Existing law provides that, upon appropriation by the Legislature, the funds be used for specified purposes and in accordance with specified priorities. Existing law requires the Office of Emergency Services to require an entity seeking moneys available through the fund to annually file an expenditure and outcomes report containing specified information, including, among other things, the number of individuals served and the outcomes for individuals served, if known.This bill would require an entity seeking moneys from the fund to also include the number of individuals who used the service and self-identified as veterans or active military personnel in its annual expenditure and outcomes report.

Primary Sponsors

Devon Mathis, Buffy Wicks

Bill Number
AB 991

Status
In Assembly

Position
Monitor

Title
Public social services: reporting and verification.

Description
AB 991, as introduced, Alvarez. Public social services: reporting and verification. Existing law provides for various public social services programs administered by the State Department of Social Services, State Department of Health Care Services, and counties, including, among others, the California Work Opportunity and Responsibility to Kids (CalWORKs) program, under which each county provides cash assistance and other benefits to qualified low-income families and individuals, CalFresh, under which supplemental nutrition assistance benefits allocated to the state by the federal government are distributed to eligible individuals by each county, and the Medi-Cal program, under which qualified low-income individuals receive health care service. Existing law imposes various reporting and verification requirements on applicants and recipients of these public social services programs relating to identity, income, and assets, among other things.This bill would, to the extent permitted under federal law, require state and county agencies to accept the reporting by an applicant or recipient of public social services of any lawfully required information, changes, and verification required by law that affect eligibility and benefit amounts, by any means available to the applicant or recipient, including, but not limited to, in person, by telephone, through facsimile, by email, or by any other electronic means. The bill would require the State Department of Social Services and the State Department of Health Care Services to implement this provision through all-county letters, provider bulletins or notices, policy letters, or similar instructions from the director of each department issued no later than July 1, 2024. To the extent this bill expands eligibility for county administered programs and by imposing additional duties on counties, this bill would impose a state-mandated local program.Existing law continuously appropriates moneys from the General Fund to defray a portion of county costs under the CalWORKs program.This bill would instead provide that the continuous appropriation would not be made for purposes of implementing the bill.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that with regard to certain mandates no reimbursement is required by this act for a specified reason.With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Primary Sponsors
David Alvarez

Bill Number
AB 1001

Status
In Assembly

Position
Monitor

Title
Health facilities: behavioral health response.

Description
AB 1001, as amended, Haney. Health facilities: behavioral health response. Existing law provides for the licensing, regulation, and inspection of various types of health facilities by the State Department of Public Health, including general acute care hospitals. Existing law requires certain building standards and regulations to prescribe standards of adequacy, safety, and sanitation of the physical plant, of staffing with duly qualified licensed personnel, and of services, based on the type of health facility and the needs of the persons served. Existing law requires specified financial and utilization data to be reported to the department by a hospital at the end of a calendar quarter.Existing law generally makes a violation of the licensure provisions for health facilities a misdemeanor.This bill would require a general acute care hospital to adopt policies for behavioral health personnel to respond to patients with a mental health or substance use crisis. The bill would require that these protocols meet standards established by the department and consist of various parameters such as minimum staffing requirements for behavioral health responses, procedures for response by behavioral health personnel in a timely manner, and annual training, as specified. The bill would require the department to adopt regulations on standards for general acute care hospitals related to behavioral health response. The bill would require all general acute care hospitals to maintain records on each patient who receives care from behavioral health response personnel and the number of hours of services provided for a period of 3 years. The bill would require hospitals to include related data in their quarterly summary utilization data reported to the department. Existing law establishes the Department of Health Care Access and Information, which is responsible for administering various programs with respect to health care professions and establishes various programs to facilitate the expansion of the health care workforce.Existing law authorizes the board of supervisors in each county to establish and maintain a county hospital to provide public health care services within the county. Existing law authorizes the board to prescribe rules for the hospital’s government and management, and to appoint a county physician and other necessary officers and employees of the hospital, as specified.This bill would establish the Behavioral Health Response and Training Fund to provide grants to qualifying applicants for the purpose of funding a new program or supporting an existing program that increases the staffing in general acute care hospitals of direct care personnel who are trained in behavioral health care and behavioral health response o... (click bill link to see more).

Primary Sponsors
Matt Haney

Bill Number	Status	Position
AB 1005	**In Assembly**	**Monitor**

Title

In-home supportive services: terminal illness diagnosis.

Description

AB 1005, as amended, Alvarez. In-home supportive services: terminal illness diagnosis. Existing law establishes the In-Home Supportive Services (IHSS) program, administered by the State Department of Social Services and counties, under which qualified aged, blind, or disabled persons are provided with supportive services in order to permit them to remain in their own homes.As a condition of receiving services under the IHSS program, existing law requires an applicant or recipient to obtain a certification from a licensed health care professional declaring that the applicant or recipient is unable to perform some activities of daily living independently, and that without services to assist the applicant or recipient with activities of daily living, the applicant or recipient is at risk of placement in out-of-home care. Existing law requires that the certification be received prior to service authorization, except under certain circumstances. Existing law requires the department to develop a standard certification form, as specified, and to identify alternative documentation, including, but not limited to, hospital or nursing facility discharge plans, containing the required information.Existing law sets forth various provisions relating to end-of-life care. When a health care provider makes a diagnosis that a patient has a terminal illness, existing law generally requires the health care provider, upon request, to provide the patient or another person authorized to make health care decisions with comprehensive information and counseling regarding legal end-of-life care options.This bill would, before the discharge of a patient diagnosed with a terminal illness, require the diagnosing health care provider to disclose to the patient or authorized person information about the IHSS program and about the option for a family member to provide care as an IHSS provider subject to the IHSS provider enrollment conditions.The bill would require the health care provider to provide a physical IHSS application and to inform the patient or authorized person of the option for sending a digital copy if a family member is identified for purposes of an IHSS provider. If the patient seeks to apply for services under the IHSS program, the bill would require the health care provider to provide a copy of the health care certification form and to complete the applicable portion before the patient’s discharge.Existing law sets forth various conditions on the number of hours of service authorized for an IHSS provider, with a modified number based on exemptions for a provider who is related to the recipients whom the provider serves, as specified.Existing law requires the county welfare department to assess each IHSS recipient’s continuing monthly ... (click bill link to see more).

Primary Sponsors

David Alvarez

Bill Number	Status	Position
AB 1022	**In Assembly**	**Monitor**

Title
Medi-Cal: Program of All-Inclusive Care for the Elderly.

Description
AB 1022, as introduced, Mathis. Medi-Cal: Program of All-Inclusive Care for the Elderly. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Existing federal law establishes the Program of All-Inclusive Care for the Elderly (PACE), which provides specified services for older individuals at a PACE center so that they may continue living in the community. Federal law authorizes states to implement PACE as a Medicaid state option. Existing state law establishes the California Program of All-Inclusive Care for the Elderly (PACE program) to provide community-based, risk-based, and capitated long-term care services as optional services under the state's Medi-Cal state plan. Existing law requires the department to develop and pay capitation rates to entities contracted through the PACE program using actuarial methods and that reflect the level of care associated with the specific populations served pursuant to the contract. Existing law authorizes a PACE organization approved by the department to use video telehealth to conduct initial assessments and annual reassessments for eligibility for enrollment in the PACE program.This bill, among other things relating to the PACE program, would require those capitation rates to also reflect the frailty level and risk associated with those populations. The bill would also expand an approved PACE organization's authority to use video telehealth to conduct all assessments, as specified.

Primary Sponsors
Devon Mathis

Bill Number
AB 1036

Status
In Assembly

Position
Monitor

Title
Health care coverage: emergency medical transport.

Description
AB 1036, as introduced, Bryan. Health care coverage: emergency medical transport. 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 requires a health care service plan contract or large group health insurance policy to provide an enrollee or insured with basic health care services, which include emergency health care services. Existing law prohibits a health care service plan that provides basic health care services from requiring prior authorization or refusing to pay for an ambulance or ambulance transport services if the request was made for an emergency medical condition and the services were required or if an enrollee reasonably believed the medical condition was an emergency that required ambulance transport services. Existing law requires a policy of disability insurance issued, amended, delivered, or renewed in this state on or after January 1, 1999, that provides hospital, medical, or surgical coverage with coverage for emergency health care services to include coverage for emergency medical transportation services without regard to whether or not the emergency provider contracts with the insurer or to prior authorization.Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes a schedule of benefits under the Medi-Cal program, including various emergency medical services. This bill would require a physician, upon an individual's arrival to an emergency department of a hospital, to certify in the treatment record whether an emergency medical condition existed, or was reasonably believed to have existed, and required emergency medical transportation services, as specified. This bill would, if a physician has certified that emergency medical transportation services according to these provisions, require a health care service plan, disability insurance policy, and Medi-Cal managed care plan, to provide coverage for emergency medical transport, consistent with an individual's plan or policy. The bill would specify that the indication by a physician pursuant to these provisions is limited to an assessment of the medical necessity of the emergency medical transport services, and does not apply or otherwise impact provisions regarding coverage for care provided following comple... (click bill link to see more).

Primary Sponsors
Isaac Bryan

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 5:54 PM
California Association of Health Plans: Oppose

Bill Number
AB 1048

Status
In Assembly

Position
Monitor

Title
Dental benefits and rate review.

Description
AB 1048, as amended, Wicks. Dental benefits and rate 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'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, on and after January 1, 2024, would prohibit a health care service plan or health insurer that covers dental services, including a specialized health care service plan or health insurer that covers dental services, from issuing, amending, renewing, or offering a plan contract or policy that imposes a dental waiting period provision or preexisting condition provision, as defined, upon an enrollee or insured. Because a violation of these requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.Existing law establishes a process for the Department of Managed Health Care and the Department of Insurance to review proposed rate increases by health care service plans and health insurers in the individual or group market in California. Existing law excludes specialized health care service plan contracts and specialized health insurance policies, among others, from those provisions.This bill would include health care service plan contracts and health insurance policies covering dental services, including specialized health care service plan contracts and specialized health insurance policies covering dental services, within those provisions. The bill would retain the exclusion with respect to specialized health care service plan contracts and specialized health insurance policies that do not provide dental services. The bill would require the Department of Managed Health Care and the Department of Insurance to establish the appropriate methodology, factors, and assumptions to determine whether a rate change for a plan contract or policy of health insurance covering dental services, including a specialized health care service plan contract or specialized health insurance policy covering dental services that is issued, sold, renewed, or offered by a health care service plan or health insurer is unreasonable, or not justified, under the applicable requirements of the rate review provisions. By making plan contracts covering dental services, including specialized health care service plan contracts that provide dental services subject to these rate review provisions, the bill would e... (click bill link to see more).

Primary Sponsors
Buffy Wicks

Bill Number
AB 1055

Status
In Assembly

Position
Monitor

Title
Alcohol drug counselors.

Description
AB 1055, as amended, Bains. Alcohol drug counselors. Existing law requires the State Department of Health Care Services to license and regulate adult alcoholism or drug abuse recovery or treatment facilities. Existing law also requires the department to require that an individual providing counseling services within a program be certified by a certifying organization approved by the department.This bill would create, upon appropriation by the Legislature, the Allied Behavioral Health Board within the Department of Consumer Affairs. The bill would require the board to establish regulations and standards for the licensure of alcohol drug counselors, as specified. The bill would authorize the board to collaborate with the Department of Health Care Access and Information regarding behavioral health professions, review sunrise review applications for emerging behavioral health license and certification programs, and refer complaints regarding behavioral health workers to appropriate agencies, as specified. The bill would require an applicant to satisfy certain requirements, including, among other things, possession of a master's degree in alcohol and drug counseling or a related counseling master's degree, as specified. The bill would, commencing 18 months after the board commences approving licenses, impose additional requirements on an applicant, including completion of a supervised practicum from an approved educational institution, and documentation that either the applicant is certified by a certifying organization or the applicant has completed 2,000 hours of postgraduate supervised work experience. The bill would impose requirements related to continuing education and discipline of licensees. The bill would prohibit a person from using the title of "Licensed Alcohol Drug Counselor" unless the person has applied for and obtained a license from the board, and would make a violation of that provision punishable by an administrative penalty not to exceed $10,000.The bill would specify that it does not require a person employed or volunteering at an outpatient treatment program or residential treatment facility certified or licensed by the State Department of Health Care Services to be licensed by the board. The bill would require the board to establish fees for licensure, as specified.

Primary Sponsors
Jasmeet Bains

Bill Number
AB 1060

Status
In Assembly

Position
Monitor

Title
Health care coverage: naloxone hydrochloride.

Description
AB 1060, as amended, Ortega. Health care coverage: naloxone hydrochloride. Existing law sets forth various programs relating to opioid overdose prevention and treatment, including, among others, standing orders for the distribution of an opioid antagonist, a naloxone grant program, and a grant program to reduce fentanyl overdoses and use 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. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, the pharmacist service of furnishing naloxone hydrochloride is a covered Medi-Cal benefit. The Medi-Cal program also covers certain medications to treat opioid use disorders as part of narcotic treatment program services, or as part of medication-assisted treatment services within the Drug Medi-Cal Treatment Program, as specified.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 make legislative findings relating to developments within the United States Food and Drug Administration (FDA) on potentially approving a certain naloxone hydrochloride nasal spray for nonprescription use.Under the bill, prescription or nonprescription naloxone hydrochloride would be a covered benefit under the Medi-Cal program, if that medication is approved, for prescription or nonprescription use, respectively, by the FDA for treatment of an opioid overdose. The bill would require a health care service plan contract or health insurance policy, as specified, to include coverage for that same medication under the same conditions. The bill would prohibit a health care service plan contract or health insurance policy from imposing any cost-sharing requirements for that coverage, would prohibit the department from subjecting that coverage to any share-of-cost requirements under the Medi-Cal program, and would require that coverage to include the total cost of that medication.Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified... (click bill link to see more).

Primary Sponsors
Liz Ortega

Organizational Notes

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

Bill Number
AB 1085

Status
In Assembly

Position
Monitor

Title
Medi-Cal: housing support services.

Description
AB 1085, as amended, Maienschein. Medi-Cal: housing support 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, 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, housing transition navigation services, housing deposits, and housing tenancy and sustaining services.Existing law, subject to an appropriation, requires the department to complete an independent analysis to determine whether network adequacy exists to obtain federal approval for a covered Medi-Cal benefit that provides housing support services. Existing law requires that the analysis take into consideration specified information, including the number of providers in relation to each region’s or county’s number of people experiencing homelessness. Existing law requires the department to report the outcomes of the analysis to the Legislature by January 1, 2024.This bill would require the department to seek any necessary federal approvals for a Medi-Cal benefit to cover housing support services within 6 months of the completion of the above-described analysis. Under the bill, subject to receipt of those federal approvals, a Medi-Cal beneficiary would be eligible for those services if they either experience homelessness or are at risk of homelessness, as specified. Under the bill, the services would include housing transition and navigation services, housing deposits, and housing tenancy and sustaining services, as defined.If the evaluation finds that the state has insufficient network capacity to meet state and federal guidelines to create a new housing support services benefit, the bill would require the department to provide recommendations for building capacity and a timeline for implementation consistent with the analysis findings.

Primary Sponsors
Brian Maienschein

Organizational Notes

Last edited by Joanne Campbell at Mar 29, 2023, 4:35 PM
Local Health Plans of California: Support

Bill Number
AB 1091

Status
In Assembly

Position
Monitor

Title
Health Care Consolidation and Contracting Fairness Act of 2023.

Description
AB 1091, as introduced, Wood. Health Care Consolidation and Contracting Fairness Act of 2023. 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 regulates contracts between health care service plans or health insurers and health care providers or health facilities, including requirements for reimbursement and the cost-sharing amount collected from an enrollee or insured.This bill, the Health Care Consolidation and Contracting Fairness Act of 2023, would prohibit a contract issued, amended, or renewed on or after January 1, 2024, between a health care service plan or health insurer and a health care provider or health facility from containing terms that, among other things, restrict the plan or insurer from steering an enrollee or insured to another provider or facility or require the plan or insurer to contract with other affiliated providers or facilities. The bill would authorize the appropriate regulating department to refer a plan's or insurer's contract to the Attorney General, and would authorize the Attorney General or state entity charged with reviewing health care market competition to review a health care practitioner's or health facility's entrance into a contract that contains specified terms. 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.Existing law requires a nonprofit corporation that operates or controls a health facility to provide written notice to, and obtain the written consent from, the Attorney General before entering an agreement to dispose of its assets or transfer control of a material amount of its assets. Existing law requires the Attorney General, within 90 days of receiving the written notice, to notify the corporation of the Attorney General's decision to consent to, give conditional consent to, or not consent to the agreement. Existing law authorizes that period to be extended by 45 days if specified conditions are met.This bill would require a medical group, hospital or hospital system, specified health facility, health care service plan, health insurer, or pharmacy benefit manager to provide written notice to the Attorney General at the same time as another state or federal agency is notified or otherwise at least 90 days before entering an agreement or transaction to make a specified material change with a value of $15,000,000 or more. The bill would authorize the Attorney General to consent to, give condit... (click bill link to see more).

Primary Sponsors
Jim Wood

Bill Number
AB 1092

Status
In Assembly

Position
Monitor

Title
Health care service plans: consolidation.

Description
AB 1092, as amended, Wood. Health care service plans: consolidation. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law requires a health care service plan that intends to merge with, consolidate with, or enter into an agreement resulting in its purchase, acquisition, or control by, an entity, to give notice to, and secure prior approval from, the Director of the Department of Managed Health Care. Existing law authorizes the director to disapprove the transaction or agreement if the director finds it would substantially lessen competition in health care service plan products or create a monopoly in this state. Existing law authorizes the director to conditionally approve the transaction or agreement, contingent upon the health care service plan's agreement to fulfill one or more conditions to benefit subscribers and enrollees of the health care service plan, provide for a stable health care delivery system, and impose other conditions specific to the transaction or agreement, as specified.This bill would additionally require a health care service plan that intends to acquire or obtain control of an entity, as specified, to give notice to, and secure prior approval from, the director. Because a willful violation of this provision would be a crime, the bill would impose a state-mandated local program. The bill would also authorize the director to disapprove a transaction or agreement if it would substantially lessen competition in the health system or among a particular category of health care providers, and would require the director to provide information related to competition to the Attorney General. The bill would revise the director's authority to conditionally approve a transaction or agreement, including authorizing the director to review information from federal agencies and other state agencies, including agencies in other states, that is relevant to any of the parties to the transaction, as specified. The bill would prohibit the director from waiving, or delaying implementation of, certain requirements imposed under existing law and the bill, notwithstanding a specified provision.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Jim Wood

Organizational Notes

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

Bill Number
AB 1110

Status
In Assembly

Position
Monitor

Title
Public health: adverse childhood experiences.

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

Primary Sponsors
Joaquin Arambula

Bill Number
AB 1122

Status
In Assembly

Position
Monitor

Title
Medi-Cal provider applications.

Description
AB 1122, as amended, Bains. Medi-Cal provider applications. 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 generally requires an applicant that currently is not enrolled in the Medi-Cal program, a provider applying for continued enrollment, or a provider not currently enrolled at a location where the provider intends to provide services, goods, supplies, or merchandise to a Medi-Cal beneficiary, to submit a complete application package for enrollment, continuing enrollment, or enrollment at a new location or a change in location, as specified.Existing law requires an applicant or provider, for new or continued enrollment in the Medi-Cal program, to disclose all information as required in federal Medicaid regulations and any other information required by the department, as specified.This bill would authorize an applicant or provider to submit any primary authoritative source documentation as proof of the above-described information, and would require the Director of Health Care Services to reasonably accept alternative formats and sources of that documentation so long as it is verified as authentic and comes from a primary source.Existing law authorizes the department to make unannounced visits to an applicant or provider for the purpose of determining whether enrollment, continued enrollment, or certification is warranted, or as necessary for the administration of the Medi-Cal program. Existing law requires, at the time of the visit, the applicant or provider to demonstrate an established place of business appropriate and adequate for the services billed or claimed to the Medi-Cal program, as specified.This bill would authorize the applicant or provider to submit its application for enrollment up to 30 days before having an established place of business and have its application considered by the department.If the department exercises its authority to conduct background checks, preenrollment inspections, or unannounced visits, existing law requires that the applicant or provider receive notice, from the department, after the conclusion of the background check, preenrollment inspection, or unannounced visit of either (1) the applicant or provider being granted provisional provider status for a period of 12 months, or (2) discrepancies or failure to meet program requirements having been found to exist during the preenrollment period.Existing law requires that the notice identify the discrepancies or failures, and whether remediation can be made or not, and if so, the ti... (click bill link to see more).

Primary Sponsors
Jasmeet Bains

Bill Number	Status	Position
AB 1130	**In Assembly**	**Monitor**

Title

Substance use disorder.

Description

AB 1130, as introduced, Berman. Substance use disorder. Existing law, the California Uniform Controlled Substances Act, regulates the distribution and use of controlled substances, as defined. Under the act, the State Department of Health Care Services is responsible for the administration of prevention, treatment, and recovery services for alcohol and drug abuse. Existing law, the Medical Practice Act, provides for the licensing and regulation of physicians and surgeons by the Medical Board of California. Existing law authorizes a physician and surgeon to prescribe, dispense, or administer prescription drugs, including prescription controlled substances, to an addict under their treatment for a purpose other than maintenance on, or detoxification from, prescription drugs or controlled substances and under specified conditions to an addict for purposes of maintenance on, or detoxification from, prescription drugs or controlled substances.This bill would revise and recast these provisions, among others, to delete the reference to an "addict" and instead replace it with the term "a person with substance use disorder," among other technical nonsubstantive changes.

Primary Sponsors

Marc Berman

Bill Number	Status	Position
AB 1131	**In Assembly**	**Monitor**

Title

Health care: Hospitals First Revolving Fund.

Description

AB 1131, as amended, Garcia. Health care: Hospitals First Revolving Fund. Existing law establishes the Department of Health Care Access and Information, which administers, among other programs, the Rural Hospital Grant Program, which provides grants to alternative rural hospitals and rural hospitals that are sole community providers to encourage the development and transition to an alternative rural hospital model, and to provide essential access to services not available at the alternative rural hospital level, and the Small and Rural Hospital Relief Program for the purpose of funding seismic safety compliance with respect to small hospitals, rural hospitals, and critical access hospitals in the state.This bill would establish the Hospitals First Revolving Fund, administered by the department, to offer grants and low-cost loans to hospitals in rural and medically underserved communities to prevent the closure of a hospital or facilitate the reopening of a closed hospital.

Primary Sponsors

Eduardo Garcia

Bill Number	Status	Position
AB 1157	**In Assembly**	**Monitor**

Title

Rehabilitative and habilitative services: durable medical equipment and services.

Description

AB 1157, as introduced, Ortega. Rehabilitative and habilitative services: durable medical equipment and services. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, requires the Department of Managed Health Care to license and regulate health care service plans and makes a willful violation of the act a crime. Other existing law requires the Department of Insurance to regulate health insurers. Existing law requires an individual or small group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2017, to include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act. Under existing law, essential health benefits includes, among other things, rehabilitative and habilitative services. Existing law requires habilitative services and devices to be covered under the same terms and conditions applied to rehabilitative services and devices under the plan contract or policy, and defines habilitative services to mean health care services and devices that help a person keep, learn, or improve skills and functioning for daily living.This bill would specify that coverage of rehabilitative and habilitative services and devices under a health care service plan or health insurance policy includes durable medical equipment, services, and repairs, if the equipment, services, or repairs are prescribed or ordered by a physician, surgeon, or other health professional acting within the scope of their license. The bill would define “durable medical equipment” to mean devices, including replacement devices, that are designed for repeated use, and that are used for the treatment or monitoring of a medical condition or injury in order to help a person to partially or fully acquire, improve, keep, or learn, or minimize the loss of, skills and functioning of daily living. The bill would prohibit coverage of durable medical equipment and services from being subject to financial or treatment limitations, as specified. Because a violation of the bill’s provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors

Liz Ortega, Lori Wilson

Organizational Notes

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

Bill Number	Status	Position
AB 1180	**In Assembly**	**Monitor**

Title
Emergency medical services.

Description
AB 1180, as amended, Rodriguez. Emergency medical services. Existing law establishes the Emergency Medical Services Authority, and requires the authority to be headed by a director who is a licensed physician and surgeon with substantial experience in the practice of emergency medicine.This bill would remove the requirement that the director be a licensed physician and surgeon with substantial experience in the practice of emergency medicine and would instead require the director to have substantial experience in emergency medicine, emergency medical services, emergency management, or other related background. The bill would require the authority to have a chief medical officer who is appointed by the Governor upon nomination by the Secretary of California Health and Human Services. The bill would require the chief medical officer to be a physician and surgeon who has substantial experience in the practice of emergency medicine.

Primary Sponsors
Freddie Rodriguez

Bill Number
AB 1202

Status
In Assembly

Position
Monitor

Title
Medi-Cal: time or distance standards: children's health care services.

Description
AB 1202, as amended, Lackey. Medi-Cal: time or distance standards: children's health care 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 through various health care delivery systems, including managed care pursuant to Medi-Cal managed care plan contracts. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Existing law establishes, until January 1, 2026, certain time or distance and appointment time standards for specified Medi-Cal managed care covered services, consistent with federal regulations relating to network adequacy standards, to ensure that those services are available and accessible to enrollees of Medi-Cal managed care plans in a timely manner, as specified. Existing law sets forth various limits on the number of miles or minutes from the enrollee's place of residence, depending on the type of service or specialty and, in some cases, on the county.Existing law authorizes a Medi-Cal managed care plan to use clinically appropriate video synchronous interaction as a means of demonstrating compliance with those standards. Existing law authorizes the department, upon request of a Medi-Cal managed care plan, to authorize alternative access standards for those standards under certain conditions, with the request being approved or denied on ZIP Code and provider type basis, as specified.This bill would, no later than January 1, 2025, require each Medi-Cal managed care plan to conduct, and report to the department the results of, an analysis to identify the number and, as appropriate, the geographic distribution of Medi-Cal providers needed to ensure the Medi-Cal managed care plan's compliance with the above-described time or distance and appointment time standards for pediatric primary care, across all service areas of the plan. The bill would, no later than January 1, 2026, require the department to prepare and submit a report to the Legislature that includes certain information, including a summary of the results reported by Medi-Cal managed care plans, specific steps for Medi-Cal managed care plan accountability, evidence of progress and compliance, and level of accuracy of provider directories, as specified.The bill would, no later than July 1, 2024, require the department to submit a report to the Legislature, and to make it publicly available, with certain information for the 2019, 2020, 2021, and 2022 calendar years, including (1) the number of children 0 to 5 years of age, inclusive, and the number of children 6 to 18 years of age, inclusive, who are Medi-Cal beneficiaries receiving any of specified early chi... (click bill link to see more).

Primary Sponsors
Tom Lackey

Bill Number
AB 1208

Status
In Assembly

Position
Support

Title
California Health Benefit Exchange: Health Care Affordability Reserve Fund.

Description
AB 1208, as amended, Schiavo. California Health Benefit Exchange: Health Care Affordability Reserve Fund. Existing federal law, the Patient Protection and Affordable Care Act (PPACA), requires each state to establish an American Health Benefit Exchange to facilitate the purchase of qualified health benefit plans by qualified individuals and qualified small employers. Existing state law creates the California Health Benefit Exchange, also known as Covered California, to facilitate the enrollment of qualified individuals and qualified small employers in qualified health plans as required under PPACA. Existing law requires the Exchange to administer a program of financial assistance to help low- and middle-income Californians, by providing financial assistance to residents with household incomes at or below 600% of the federal poverty level, including appropriate subsidies designed to make health care coverage more accessible and affordable for individuals and households. Existing law requires a premium assistance subsidy provided by the program to be able to be advanced to a program participant and remitted by the Exchange to a qualified health plan issuer, based on specified factors.Existing law establishes the Health Care Affordability Reserve Fund, and authorizes the Controller to use funds in the Health Care Affordability Reserve Fund for cashflow loans to the General Fund. Existing law requires the fund to be used, upon appropriation by the Legislature, for the purpose of health care affordability programs operated by the Exchange. Existing law requires the Exchange to consult with the Legislature and stakeholders to develop options to reduce cost sharing for low- and middle-income Californians, as specified.This bill would require the Exchange to annually update the proposed program design for cost-sharing reduction, as specified, and would require the Exchange, in developing benefit designs, to maximize the number of low- and middle-income Californians with zero deductibles. The bill would provide that the premium assistance subsidy program would not be operative in any year in which federal premium subsidies are equal to or greater than those provided for the 2023 program year, and would require the program to include subsidies for cost sharing and maximum out-of-pocket limits until January 1, 2029, if federal premium subsidies continue at the level for the 2023 coverage year. The bill would make related conforming changes and delete obsolete provisions.

Primary Sponsors
Pilar Schiavo

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 6:22 PM
California Association of Health Plans: Support L.A. Care: Support

Bill Number
AB 1223

Status
In Assembly

Position
Monitor

Title
Medi-Cal: audit of PACE organizations.

Description
AB 1223, as amended, Hoover. Medi-Cal: audit of PACE organizations. Existing federal law establishes the Program of All-Inclusive Care for the Elderly (PACE), which provides specified services for older individuals at a PACE center so that they may continue living in the community. Federal law authorizes states to implement PACE as a Medicaid state option. Existing state law establishes the California Program of All-Inclusive Care for the Elderly (PACE program) to provide community-based, risk-based, and capitated long-term care services as optional services under the state's Medi-Cal state plan. Existing law authorizes the State Department of Health Care Services to enter into contracts with public or private organizations for implementation of the PACE program and sets out mandatory requirements of the PACE model, as provided under federal law.This bill would require the department to perform program audits of PACE organizations and to develop and maintain standards, rules, and auditing protocols. The bill would require the protocol to include data collection procedures and formal decision rules and procedures for enforcement consequences when the requirements of law are not met.

Primary Sponsors
Joshua Hoover

Bill Number	Status	Position
AB 1230	**In Assembly**	**Oppose**

Title

Medi-Cal and Medicare: dual eligible beneficiaries: special needs plans.

Description

AB 1230, as introduced, Valencia. Medi-Cal and Medicare: dual eligible beneficiaries: special needs plans. 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 federal law establishes the Medicare Program, which is a public health insurance program for persons who are 65 years of age or older and specified persons with disabilities who are under 65 years of age.Existing law sets forth various provisions, including within the Coordinated Care Initiative (CCI) and the California Advancing and Innovating Medi-Cal (CalAIM) initiative, relating to beneficiaries who are dually eligible for the Medicare Program and the Medi-Cal program, for purposes of promoting more integrated care through those beneficiaries' aligned enrollment in a Medicare Advantage Dual Eligible Special Needs Plan (D-SNP), as defined.This bill would require the department, commencing no later than January 1, 2025, to offer contracts to health care service plans for Highly Integrated Dual Eligible Special Needs Plans (HIDE-SNPs) and Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs), as defined, to provide care to dual eligible beneficiaries.The bill would require that a HIDE-SNP or FIDE-SNP contract authorize a beneficiary to select from a number of available options and to maintain their established or selected health care providers. The bill would also require a contracting plan to perform all applicable required care coordination and data-sharing functions, and to provide documentation demonstrating the care integration that dual eligible beneficiaries receive through a HIDE-SNP or FIDE-SNP contract.

Primary Sponsors

Avelino Valencia

Organizational Notes

Last edited by Joanne Campbell at Apr 17, 2023, 5:45 PM
L.A. Care, Local Health Plans of California: Oppose

Bill Number
AB 1233

Status
In Assembly

Position
Monitor

Title

Substance abuse: Naloxone Distribution Project: tribal governments.

Description

AB 1233, as amended, Waldron. Substance abuse: Naloxone Distribution Project: tribal governments. Existing law establishes the State Department of Health Care Services within the California Health and Human Services Agency. The Naloxone Distribution Project (NDP) is administratively created by the department to reduce opioid-related overdose deaths by providing free naloxone hydrochloride to eligible entities.This bill would require the department to conduct outreach to each of the tribal governments in California for the purpose of advising them of the availability of naloxone hydrochloride or another opioid antagonist through the NDP. The bill would require the department to provide technical assistance to the tribal entities applying for naloxone kits through the NDP if requested to do so by the tribal government. The bill would require the department to report to the Legislature and to the Assembly and Senate Health Committees, the results of the outreach program, as specified, annually on or before March 31 of each year, beginning on March 31, 2025. The bill would repeal these provisions on March 31, 2027.

Primary Sponsors

Marie Waldron

Bill Number	Status	Position
AB 1241	**In Assembly**	**Monitor**

Title

Medi-Cal: telehealth.

Description

AB 1241, as amended, Weber. Medi-Cal: telehealth. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Under existing law, in-person, face-to-face contact is not required when covered health care services are provided by video synchronous interaction, audio-only synchronous interaction, remote patient monitoring, or other permissible virtual communication modalities, when those services and settings meet certain criteria.Existing law requires a provider furnishing services through video synchronous interaction or audio-only synchronous interaction, by a date set by the department, no sooner than January 1, 2024, to also either offer those services via in-person contact or arrange for a referral to, and a facilitation of, in-person care, as specified.This bill would instead require, under the above-described circumstance, a provider to maintain the ability to either offer those services via in-person contact or arrange for a referral to, and a facilitation of, in-person care. The bill would specify that the referral and facilitation arrangement would not require a provider to schedule an appointment with a different provider on behalf of a patient.

Primary Sponsors

Akilah Weber

Bill Number
AB 1282

Status
In Assembly

Position
Monitor

Title
Mental health: impacts of social media.

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

Primary Sponsors
Josh Lowenthal

Bill Number
AB 1283

Status
In Assembly

Position
Monitor

Title
Pupil health: emergency stock albuterol inhalers.

Description
AB 1283, as amended, Chen. Pupil health: emergency stock albuterol inhalers. Existing law requires the governing board of any school district to give diligent care to the health and physical development of pupils and authorizes the governing board of a school district to employ properly certified persons for the work. Existing law requires school districts, county offices of education, and charter schools to provide emergency epinephrine auto-injectors to school nurses or trained personnel who have volunteered, and authorizes school nurses or trained personnel to use emergency epinephrine auto-injectors to provide emergency medical aid to persons suffering, or reasonably believed to be suffering, from an anaphylactic reaction, as provided.This bill would authorize a school district, county office of education, or charter school to provide emergency stock albuterol inhalers, including, if necessary, single-use disposable holding chambers, as specified, to school nurses or trained personnel who have volunteered, and would authorize school nurses or trained personnel to use an emergency stock albuterol inhaler to provide emergency medical aid to persons suffering, or reasonably believed to be suffering, from respiratory distress, as provided. The bill would require the Superintendent of Public Instruction to establish minimum standards of training for the administration of stock albuterol inhalers, as provided, and every 5 years or sooner, as provided, review those standards. The bill would define the terms, including, among others, “stock albuterol inhaler” and “respiratory distress” for purposes of these provisions.

Primary Sponsors
Phillip Chen

Bill Number
AB 1286

Status
In Assembly

Position
Monitor

Title
Pharmacy.

Description
AB 1286, as introduced, Haney. Pharmacy. Existing law, the Pharmacy Law, provides for the licensure and regulation of pharmacists, pharmacy technicians, and pharmacies by the California State Board of Pharmacy, which is within the Department of Consumer Affairs. A violation of existing law is a crime.(1) Existing law requires every pharmacy to designate a pharmacist-in-charge who is responsible for a pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy. This bill would authorize a pharmacist-in-charge to make staffing decisions to ensure sufficient personnel are present in the pharmacy to prevent fatigue, distraction, or other conditions that may interfere with a pharmacist's ability to practice competently and safely. The bill would authorize a pharmacist on duty, if the pharmacist-in-charge is not available, to adjust staffing according to workload if needed. The bill would authorize a pharmacist-in-charge, or, if not available, the pharmacist on duty, to close a pharmacy if workplace hazards, as specified, may create an unsafe environment for personnel or pharmacy staff.(2) Existing law, with specified exceptions, prohibits a community pharmacy from requiring a pharmacist employee to engage in the practice of pharmacy at any time the pharmacy is open to the public, unless either another employee of the pharmacy or, if the pharmacy is located within another establishment, an employee of the establishment within which the pharmacy is located, is made available to assist the pharmacist at all times.This bill would authorize the pharmacist on duty to close a community pharmacy if, in their opinion, the staffing at the pharmacy is inadequate to safely fill or dispense prescriptions or provide other patient care services in a safe manner without fear of retaliation. The bill would require a community pharmacy to be staffed at all times with at least one clerk or pharmacy technician fully dedicated to performing pharmacy-related services. The bill would require, if staffing of pharmacist hours does not overlap sufficiently, that scheduled closures for lunch time for all pharmacy staff be established and publicly posted and included on the outgoing telephone message. The bill would define "community pharmacy" for these purposes.The bill would require a licensed community pharmacy, as defined, to report all medication errors to an entity approved by the board and to maintain records, as prescribed. The bill would deem these reports confidential and not subject to discovery, subpoena, or disclosure pursuant to the California Public Records Act. Under the bill, a report alone would not be subject to enforcement unless the board receives other information regarding the med... (click bill link to see more).

Primary Sponsors
Matt Haney

Bill Number
AB 1288

Status
In Assembly

Position
Monitor

Title
Health care coverage: Medication-assisted treatment.

Description
AB 1288, as introduced, Reyes. Health care coverage: Medication-assisted treatment. Existing law, the Knox–Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law authorizes health care service plans and health insurers that cover prescription drugs to utilize reasonable medical management practices, including prior authorization and step therapy, consistent with applicable law. This bill would prohibit a medical service plan and a health insurer from subjecting a buprenorphine product, methadone, or long-acting injectable naltrexone for detoxification or maintenance treatment of a substance use disorder that is prescribed according to generally accepted national professional guidelines for the treatment of a substance use disorder to prior authorization. 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 27, 2023, 5:56 PM
California Association of Health Plans: Oppose

Bill Number
AB 1300

Status
In Assembly

Position
Monitor

Title
Health care service plans.

Description
AB 1300, as introduced, Flora. Health care service plans. 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 charges the department with the execution of the laws of this state relating to health care service plans to ensure that health care service plans provide enrollees with access to quality health care services.This bill would make technical, nonsubstantive changes to those provisions.

Primary Sponsors
Heath Flora

Bill Number	Status	Position
AB 1316	**In Assembly**	**Monitor**

Title

Emergency services: psychiatric emergency medical conditions.

Description

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

Primary Sponsors

Jacqui Irwin, Chris Ward

Bill Number	Status	Position
AB 1325	**In Assembly**	**Monitor**

Title

Microenterprise home kitchen operations.

Description

AB 1325, as amended, Waldron. Microenterprise home kitchen operations. The California Retail Food Code (code) authorizes the governing body of a city, county, or city and county, by ordinance or resolution, to permit microenterprise home kitchen operations (MHKO) if certain conditions are met. Existing law requires an MHKO, as a restricted food service facility, to meet specified food safety standards, including, among others things, that the food is prepared, cooked, and served on the same day. Under existing law, the food preparation is limited to no more than 30 individual meals per day, or the approximate equivalent of meal components when sold separately, and no more than 60 individual meals, or the approximate equivalent of meal components when sold separately, per week. Existing law also requires an MHKO to have no more than $50,000 in verifiable gross annual sales, as adjusted annually for inflation. A violation of the code is a misdemeanor.This bill would require the food preparation to be limited to no more than 90 individual meals, or the approximate equivalent of meal components when sold separately, per week. The bill would also allow an MHKO to have no more than $100,000 in verifiable gross annual sales, adjusted for inflation.

Primary Sponsors

Marie Waldron, Eduardo Garcia

Bill Number	Status	Position
AB 1331	**In Assembly**	**Monitor**

Title
California Health and Human Services Data Exchange Framework.

Description
AB 1331, as amended, Wood. California Health and Human Services Data Exchange Framework. Existing law establishes the Center for Data Insights and Innovation within the California Health and Human Services Agency to ensure the enforcement of state law mandating the confidentiality of medical information. Existing law, subject to an appropriation in the annual Budget Act, requires the California Health and Human Services Agency to establish the California Health and Human Services Data Exchange Framework on or before July 1, 2022, to govern and require the exchange of health information among health care entities and government agencies.This bill would require the Center for Data Insights and Innovation to take over establishment, implementation, and all the functions related to the California Health and Human Services Data Exchange Framework on or before July 1, 2023, subject to an appropriation in the annual Budget Act. The bill would require the center to establish the CalHHS Data Exchange Board, with specified membership, to develop recommendations and to approve any modifications to the Data Exchange Framework data sharing agreement, among other things.

Primary Sponsors
Jim Wood

Bill Number	Status	Position
AB 1338	**In Assembly**	**Monitor**

Title
Medi-Cal: community supports.

Description
AB 1338, as introduced, Petrie-Norris. Medi-Cal: community supports. 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, 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, housing transition navigation services, recuperative care, respite, day habilitation programs, and medically supportive food and nutrition services.This bill would add fitness, physical activity, recreational sports, and mental wellness memberships to the above-described list of community supports.

Primary Sponsors
Cottie Petrie-Norris

Bill Number
AB 1341

Status
In Assembly

Position
Monitor

Title
Public health: COVID-19: testing and dispensing sites: oral therapeutics.

Description
AB 1341, as amended, Berman. Public health: COVID-19: testing and dispensing sites: oral therapeutics. Existing law authorizes a person to perform an analysis of samples to test for SARS-CoV-2 in a clinical laboratory or a city, county, or city and county public health laboratory if they meet the requirements under specified federal regulations for high complexity testing.This bill would repeal these provisions as of July 1, 2028.Existing law, the Pharmacy Law, establishes the California State Board of Pharmacy to license and regulate pharmacists. A violation of these requirements is a crime. Existing law authorizes a pharmacist, among other things, to administer drugs and biological products that have been ordered by a prescriber. This bill, until January 1, 2025, would authorize a pharmacist to furnish COVID-19 oral therapeutics, as defined, following a positive test for SARS-CoV-2, the virus that causes COVID-19, as specified. Among other things, the bill would require a pharmacist to document, to the extent possible, the kind and amounts of COVID-19 oral therapeutics furnished pursuant to these provisions, as well as information regarding any testing services provided, in the record system maintained by the pharmacy and to maintain those records for 3 years. Because a violation of these requirements would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.This bill would declare that it is to take effect immediately as an urgency statute.

Primary Sponsors
Marc Berman

Bill Number
AB 1348

Status
In Assembly

Position
Monitor

Title
State government: Controller: claims audits.

Description
AB 1348, as amended, Grayson. State government: Controller: claims audits. Existing law, the Government Claims Act, generally requires the presentation of all claims for money or damages against local public entities and the state. Existing law provides for the presentation of a claim for which appropriations have been made, or for which state funds are available, under that act to the Controller, in the form and manner prescribed by the general rules and regulations adopted by the Department of General Services. Existing law, with specified exceptions, prohibits the Controller from drawing a warrant for any claim until it has been audited in conformity with law and the general rules and regulations adopted by the Department of General Services governing the presentation and audit of claims.This bill would require the Controller to conduct, unless prohibited by the provisions of a state ballot proposition passed by the electorate, financial and compliance audits as the Controller's office deems as necessary for purposes of ensuring that any expenditures, regardless of the source or fund from which the warrants for claims are drawn, are expended in a manner consistent with the law and the voters' intent. The bill would also require the Controller to conduct any audits necessary to carry out their constitutional and statutory duties and responsibilities under the law. The bill would, among other things, authorize the Controller to recover their costs in conducting these and the above-described audits from amounts appropriated for purposes of carrying out these audits, except as described. The bill would require the Controller to provide a report with specified information from these audits to the Legislature by June 30 of each year and would require the Controller to allow all auditees in the report a reasonable period of time to review and comment on the section of the report relating to the auditee, as described. The bill would make related legislative findings and declarations.

Primary Sponsors
Tim Grayson

Bill Number
AB 1359

Status
In Assembly

Position
Monitor

Title
Paid sick days: health care employees.

Description
AB 1359, as amended, Schiavo. Paid sick days: health care employees. Existing law, the Healthy Workplaces, Healthy Families Act of 2014, entitles employees who satisfy specified requirements to sick leave. The act generally entitles an employee who, on or after July 1, 2015, works in California for the same employer for 30 or more days within a year to paid sick leave, subject to various use and accrual limits. The act also authorizes an employer to limit an employee's use of accrued paid sick days to 24 hours or 3 days in each year of employment, calendar year, or 12-month period.This bill would establish new procedures governing the accrual and use of paid sick leave days for employees of a covered health care facility, as defined. The bill would permit accrued paid sick days to carry over to the following year of employment for those employees, subject to certain conditions, and would prohibit a covered health care facility from limiting an employee's use of accrued paid sick days. The bill would exempt those employees from certain existing limits on the use of accrued paid sick days. The bill would authorize an employee of a covered health care facility to bring a civil action against an employer that violates this provision and would entitle the employee to collect specified legal and equitable relief to remedy a violation. The bill's provisions would not apply to employees of a covered health care facility who are subject to an existing collective bargaining agreement.

Primary Sponsors
Pilar Schiavo

Bill Number
AB 1360

Status
In Assembly

Position
Monitor

Title
Hope California: Secured Residential Treatment Pilot Program.

Description
AB 1360, as amended, McCarty. Hope California: Secured Residential Treatment Pilot Program. Existing law authorizes a court to grant pretrial diversion to a defendant in specified cases, including when the defendant is suffering from a mental disorder, specified controlled substances crimes, and when the defendant was, or currently is, a member of the United States military.This bill would, until January 1, 2026, authorize the Counties of Sacramento and Yolo to offer secured residential treatment pilot programs, known as Hope California, for individuals suffering from substance use disorders (SUDs) who have been convicted of qualifying drug-motivated felony crimes, as specified. The bill would require the program to meet certain conditions relating to, among other things, a risk, needs, and psychological assessment, a comprehensive curriculum, a determination by a judge of the length of treatment, data collection, licensing and monitoring of the facility by the State Department of Health Care Services, and reporting to the department and the Legislature.The bill would require the judge to offer the defendant voluntary participation in the pilot programs, as an alternative to a jail or prison sentence otherwise imposed, if the defendant's crime was caused, in whole or in part, by the defendant's SUD, the crime was not a sex crime, serious or violent felony, or nonviolent drug possession, and the judge makes their determination based on the recommendations of the treatment providers, on a finding by the county health and human services agency that the defendant's participation would be appropriate, and on a specified report prepared with input from interested parties. Under the bill, the defendant would be eligible to receive credits for participation in the program, as specified.The bill would set forth a procedure for the transfer of a participant out of the secured residential treatment program based on the recommendations of the treatment providers or program administrators or based on the participant's request, as specified.If the participant successfully completes the court-ordered drug treatment, as determined by treatment providers pursuant to the pilot program, the bill would require the court to expunge and seal the conviction from the participant's record and would authorize the court to expunge the conviction of any previous drug possession or drug use crimes on the participant's record.Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services, including mental health and substance use disorder services, pursuant to a schedule of benefits. The Medi-Cal program is, in part... (click bill link to see more).

Primary Sponsors
Kevin McCarty

Bill Number
AB 1369

Status
In Assembly

Position
Monitor

Title
Out-of-state physicians and surgeons: telehealth: license exemption.

Description
AB 1369, as amended, Bauer-Kahan. Out-of-state physicians and surgeons: telehealth: license exemption. Existing law, the Medical Practice Act, establishes the Medical Board of California within the Department of Consumer Affairs and sets forth its powers and duties relating to the licensure and regulation of the practice of medicine by physicians and surgeons. Existing law generally prohibits the practice of medicine without a physician’s and surgeon’s certificate issued by the board.Existing law authorizes a health care provider to deliver health care via telehealth to a patient pursuant to specified protocols and conditions. Existing law defines “telehealth ” as the delivery of health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care, and that telehealth includes synchronous interactions and asynchronous store and forward transfers.Under this bill, a person licensed as a physician and surgeon in another state, as specified, who does not possess a certificate issued by the board would be authorized to deliver health care via telehealth to a patient who, among other requirements, has a disease or condition that is immediately life-threatening.

Primary Sponsors
Rebecca Bauer-Kahan

Bill Number
AB 1376

Status
In Assembly

Position
Monitor

Title
Emergency medical services: liability limitation.

Description
AB 1376, as amended, Juan Carrillo. Emergency medical services: liability limitation. Existing law provides specified liability limitations to, among others, physicians, nurses, and other authorized individuals who provide assistance in emergency situations.This bill would provide that a private provider of ambulance services, and employees of that provider, when operating in accordance with the standards, regulations, policies, and protocols of local emergency medical services agencies, shall not be criminally or civilly liable for the continued detainment of a person when that detainment is requested by a peace officer, facility staff, or other professionals authorized to detain persons in specified circumstances involving the transport and continued containment of a person who requires mental health evaluation and treatment, as specified. The bill would also require a private provider of ambulance services subject to these provisions to provide care according to the policies and procedures established by the local emergency medical services agency, as specified, and the policies of the California Emergency Medical Services Authority.

Primary Sponsors
Juan Carrillo

Bill Number
AB 1377

Status
In Assembly

Position
Monitor

Title
Homeless Housing, Assistance, and Prevention Program: Round 3.

Description
AB 1377, as amended, Friedman. Homeless Housing, Assistance, and Prevention Program: Round 3. Existing law establishes, among various other programs intended to address homelessness in this state, the Homeless Housing, Assistance, and Prevention program for the purpose of providing jurisdictions with one-time grant funds to support regional coordination and expand or develop local capacity to address their immediate homelessness challenges informed by a best-practices framework focused on moving homeless individuals and families into permanent housing and supporting the efforts of those individuals and families to maintain their permanent housing. Existing law provides for the allocation of funding under the program among continuums of care, cities, counties, and tribes in 4 rounds, which are to be administered by the Interagency Council on Homelessness.Existing law, beginning with round 3 of the program, requires applicants to provide specified information for all rounds of program allocations through a data collection, reporting, performance monitoring, and accountability framework, as established by the council. This includes data on the applicant's progress towards meeting their outcome goals, to be submitted annually, for each year of the program, and other information if the applicant has not made significant progress towards those goals.This bill would also require data and a narrative summary of specific and quantifiable steps that the applicant has taken to improve the delivery of housing and services to people experiencing homelessness or at risk of homelessness, on transit facilities owned and operated by a transit district, as defined, in their jurisdiction.

Primary Sponsors
Laura Friedman

Bill Number
AB 1387

Status
In Assembly

Position
Support

Title
In-Home Supportive Services Program: provider shortage: grant-based outreach program.

Description
AB 1387, as introduced, Ting. In-Home Supportive Services Program: provider shortage: grant-based outreach program. Existing law provides for the county-administered In-Home Supportive Services (IHSS) program, under which qualified aged, blind, and disabled persons are provided with services in order to permit them to remain in their own homes and avoid institutionalization. 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. Existing law authorizes certain Medi-Cal recipients to receive waiver personal care services (WPCS) in order to permit them to remain in their own homes. Existing law permits services to be provided under the IHSS program either through the

employment of individual providers, a contract between the county and an entity for the provision of services, the creation by the county of a public authority, or a contract between the county and a nonprofit consortium.This bill would require the department, by March 1, 2024, to issue a request for proposals for a 3-year, grant-based program to support outreach and education to encourage immigrants to become in-home supportive services (IHSS) providers, contingent upon an appropriation by the Legislature for that purpose. The bill would require eligible grantees for the program to include nonprofit, community-based agencies that engage with immigrant populations, counties administering the IHSS program, and county public authorities. The bill would set forth eligible outreach activities, including developing educational and outreach materials, and providing community outreach workers. The bill would require grantees to report to the department, at least semiannually, on the outcomes achieved by the outreach campaign, including, but not limited to, activities and methods utilized to reach and recruit providers. If the grantee reporting requirements result in additional workload for counties, those provisions would be implemented only if funding for that purpose is provided in the State Budget. The bill would require the department to report to the Legislature, within 6 months after the conclusion of the program, on the effectiveness of the program, including the extent to which the outreach campaign resulted in an increase in the IHSS provider workforce. The provisions of the bill would be repealed on January 1, 2028.The bill would make related findings and declarations relating to the existence of a shortage in the IHSS program workforce. The bill also would declare the intent of the Legislature to enact subsequent legislation that permits undocumented in-home supportive services recipients to select a relative as their pr... (click bill link to see more).

Primary Sponsors
Phil Ting

Organizational Notes

Last edited by Joanne Campbell at Apr 5, 2023, 8:04 PM
L.A. Care: Support

Bill Number
AB 1392

Status
In Assembly

Position
Monitor

Title
Hospitals: procurement contracts.

Description
AB 1392, as amended, Rodriguez. Hospitals: procurement contracts. Existing law requires a licensed hospital with operating expenses of $50,000,000 or more, and a licensed hospital with operating expenses of $25,000,000 or more that is part of a hospital system, to submit an annual report to the Department of Health Care Access and Information, formerly structured as the Office of Statewide Health Planning and Development, on the hospital's minority, women, LGBT, and disabled veteran business enterprise procurement efforts, as specified. Existing law imposes certain civil penalties for failure to file a report.This bill would require the department to require those hospitals to annually submit a detailed and verifiable plan, instead of the above-described report, for increasing procurement from minority, women, LGBT, and disabled veteran business enterprises. In addition to the existing required contents within the report, the bill would require the plan to include short- and long-term goals and timetables, but not quotas, for increasing procurement from those business enterprises, the methods in which the hospital resolves any issues that may limit or impede an enterprise from becoming a supplier, and planned and past implementation of relevant recommendations made by the hospital diversity commission described below, among other changes.The bill would authorize the department to audit the plans for compliance and accuracy. The bill would require the department to establish guidelines for hospitals to voluntarily utilize when pursuing procurement efforts, activities, or programs in accordance with these provisions. Existing law requires the department to maintain a link on its internet website that provides public access to the contents of those reports, as specified.This bill would also require the department to establish a supplier diversity web page on the department's internet website to inform diverse suppliers on the hospital's procurement process, as specified.The bill would make legislative findings that each licensed hospital and hospital that is part of a hospital system that is not required to submit a plan is encouraged to voluntarily adopt one for increasing procurement from the above-described business enterprises.Existing law requires the department to convene a hospital diversity commission comprised of the public and health care, diversity, and procurement stakeholders, and sets forth the composition of the commission, including, among others, representatives of minority, women, LGBT, and disabled veteran business enterprises. Existing law prohibits the commissioners from receiving compensation for their services, but authorizes the department to reimburse them for their actual and necessary expenses... (click bill link to see more).

Primary Sponsors
Freddie Rodriguez

Bill Number	Status	Position
AB 1402	In Assembly	Monitor

Title
Medical evidentiary examinations: reimbursement.

Description
AB 1402, as amended, Megan Dahle. Medical evidentiary examinations: reimbursement. Existing law requires the Office of Emergency Services to establish medical forensic forms, instructions, and examination protocols for victims of child physical abuse or neglect based on the guidelines for those forms as they relate to sexual assault. Existing law requires the forms to have a place for notation of specified information, including, among other things, the performance of a physical examination for evidence of child physical abuse or neglect.This bill would require victims of child physical abuse or neglect to have access to medical evidentiary examinations, free of charge, by Local Sexual Assault Response Teams (SART), Sexual Assault Forensic Examiner (SAFE) teams, or other qualified medical evidentiary examiners. The bill would require each county’s board of supervisors to authorize a designee to approve the SART, SAFE teams, or other qualified medical evidentiary examiners to receive reimbursement through the Office of Emergency Services for the performance of medical evidentiary examinations for victims of child physical abuse or neglect and to notify the office of this designation. The bill would require that the costs associated with these medical evidentiary exams be funded by the state, subject to appropriation by the Legislature, and would require the Office of Emergency Services to establish a 60-day reimbursement process within one year upon initial appropriation.

Primary Sponsors
Megan Dahle

Bill Number	Status	Position
AB 1417	**In Assembly**	**Monitor**

Title
Elder and dependent adult abuse: mandated reporting.

Description
AB 1417, as amended, Wood. Elder and dependent adult abuse: mandated reporting. Existing law, the Elder Abuse and Dependent Adult Civil Protection Act, sets forth various provisions for the reporting, investigation, and prosecution of elder and dependent adult abuse. Existing law requires specified people, known as mandated reporters, to report cases of elder or dependent adult abuse. Under existing law, failure to report the abuse is a misdemeanor.Existing law establishes certain procedures for mandated reporters to report known or suspected instances of abuse by telephone followed by a written report, or through a confidential internet reporting tool, as specified. If the abuse is physical abuse, and the abuse occurred in a long-term care facility, with exceptions, existing law sets forth the reporting conditions, including those relating to the format, timelines, and recipients of the reporting. Under existing law, the reporting conditions are based on whether or not the suspected abuse results in serious bodily injury, or whether the suspected abuse is allegedly caused by a resident with a physician's diagnosis of dementia and there is no serious bodily injury, as specified. If the abuse is not physical abuse, and the abuse occurred in a long-term care facility, with exceptions, existing law requires a telephone report and a written report to be made to the local ombudsman or the local law enforcement agency.This bill would delete and reorganize some of those reporting provisions. Under the bill, if the abuse that occurred in a long-term facility was allegedly caused by another resident of the facility with dementia diagnosed by a licensed physician and there was no serious bodily injury, the reporter would be required to submit a written report within 24 hours to the long-term care ombudsman, the local law enforcement agency, and the corresponding state agency. Under the bill, in all other instances, immediately or as soon as practically possible, but no longer than 2 hours, the reporter would be required to submit a verbal report to the local law enforcement agency, and to submit a written report within 24 hours to the aforementioned recipients. The bill would make conforming changes to related provisions.By expanding the scope of the mandated reporting crime, and to the extent the bill would change the duties of local entities receiving the reports, 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 with regard to certain mandates no reimbursement is required by this act for... (click bill link to see more).

Primary Sponsors
Jim Wood

Bill Number
AB 1419

Status
In Assembly

Position
Monitor

Title
Insulin.

Description
AB 1419, as introduced, Grayson. Insulin. Existing law requires a health care service plan contract or disability insurance policy issued, amended, delivered, or renewed on or after January 1, 2000, that covers prescription benefits to include coverage for insulin if it is determined to be medically necessary.This bill would state the intent of the Legislature to enact legislation to lower the cost of insulin for Californians.

Primary Sponsors
Tim Grayson

Bill Number
AB 1425

Status
In Assembly

Position
Monitor

Title
Health care: employers.

Description
AB 1425, as introduced, Chen. Health care: employers. Existing law requires employers to provide specified information to health care providers or health insurers regarding employees who were terminated on or after March 2, 2010, and who were enrolled in an employer-offered health care service plan or health insurance policy on or after September 1, 2008, as specified.This bill would make technical, nonsubstantive changes to that requirement.

Primary Sponsors
Phillip Chen

Bill Number
AB 1432

Status
In Assembly

Position
Monitor

Title
Health care coverage.

Description
AB 1432, as amended, Wendy Carrillo. 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 and makes a willful violation of its provisions 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 and a health insurance policy to provide group coverage to the registered domestic partner of an employee, subscriber, insured, or policyholder that is equal to the coverage it provides to the spouse of those persons. Existing law provides that every group health care service plan contract and every policy or certificate of health insurance that is marketed, issued, or delivered to a California resident, regardless of the situs of the contract, subscriber, or master group policyholder, is subject to the requirements to provide equal coverage to domestic partners as is provided to spouses, notwithstanding any other provision of law.This bill additionally would subject a group health care service plan contract, policy, or certificate of group health insurance that is marketed, issued, or delivered to a California resident to all provisions of the Health and Safety Code and Insurance Code requiring coverage of abortion, abortion-related services, and gender-affirming care, regardless of the situs of the contract, subscriber, or master group policyholder. 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
Wendy Carrillo

Bill Number	Status	Position
AB 1437	**In Assembly**	**Monitor**

Title
Medi-Cal: serious mental illness.

Description
AB 1437, as amended, Irwin. Medi-Cal: serious mental illness. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Existing law sets forth a schedule of benefits under the Medi-Cal program, including specialty and nonspecialty mental health services through different delivery systems, in certain cases subject to utilization controls, such as prior authorization. Under existing law, prior authorization is approval of a specified service in advance of the rendering of that service based upon a determination of medical necessity. Existing law sets forth various provisions relating to processing, or appealing the decision of, treatment authorization requests, and provisions relating to certain services requiring or not requiring a treatment authorization request.After a determination of cost benefit, existing law requires the Director of Health Care Services to modify or eliminate the requirement of prior authorization as a control for treatment, supplies, or equipment that costs less than $100, except for prescribed drugs, as specified.Under this bill, a prescription refill for a drug for serious mental illness would automatically be approved for a period of 365 days after the initial prescription is dispensed.The bill would condition the above-described provisions on the prescription being for a person 18 years of age or over, and on the person not being within the transition jurisdiction of the juvenile court, as specified.

Primary Sponsors
Jacqui Irwin, Sharon Quirk-Silva

Bill Number	Status	Position
AB 1438	**In Assembly**	**Monitor**

Title

Los Angeles County Affordable Housing Solutions Agency.

Description

AB 1438, as introduced, Juan Carrillo. Los Angeles County Affordable Housing Solutions Agency. Existing law, the Los Angeles County Regional Housing Finance Act, establishes the Los Angeles County Affordable Housing Solutions Agency. Under existing law, the purpose of the Los Angeles County Affordable Housing Solutions Agency is to increase the supply of affordable housing in Los Angeles County by providing for significantly enhanced funding and technical assistance at a regional level for renter protections, affordable housing preservation, and new affordable housing production, as specified. Existing law makes legislative findings and declarations as to the necessity of a countywide agency to address the housing crisis in Los Angeles County.This bill would make nonsubstantive changes to the above-described legislative findings and declarations provisions.

Primary Sponsors

Juan Carrillo

Bill Number
AB 1450

Status
In Assembly

Position
Monitor

Title
Pupil health: universal screenings: adverse childhood experiences and dyslexia.

Description
AB 1450, as introduced, Jackson. Pupil health: universal screenings: adverse childhood experiences and dyslexia. Existing law requires the governing board of any school district to give diligent care to the health and physical development of pupils and authorizes the governing board of a school district to employ properly certified persons for the work. Existing law authorizes the governing board of a school district to provide a comprehensive educational counseling program for all pupils enrolled in the school district.Existing law prohibits specified medical professionals, including psychiatrists, not employed in that capacity by the State Department of Health Care Services from being employed or permitted to supervise the health and physical development of pupils unless that person holds a services credential with a specialization in health or a valid credential, as provided.Existing law prohibits any person who is an employee of a school district from administering psychological tests or engaging in other psychological activities involving the application of psychological principles, methods, or procedures unless (1) the person holds a valid and current credential as a school psychologist issued by the Commission on Teacher Credentialing that permits the holder to administer psychological testing to, or engage in psychological activities with, pupils, or (2) psychological assistants or school psychology interns perform the testing or activities under the supervision of a person described in (1).Under existing law, parents and guardians of pupils enrolled in public schools have the right and should have the opportunity, as mutually supportive and respectful partners in the education of their children within the public schools, to be informed by the school, and to participate in the education of their children, including, among others, the right to receive information about any psychological testing the school does involving their child and to deny permission to give the test.This bill would require a school district, county office of education, or charter school to employ or contract with at least one mental health clinician, as defined, and at least one case manager, as defined, for each schoolsite of the local educational agency, and to conduct universal screenings for adverse childhood experiences, as defined, and dyslexia, pursuant to a graduated schedule by grade span, as specified. The bill would require a mental health clinician who conducts a screening to develop, and provide to the pupil and their parent or guardian, an action plan based upon findings from the screening, as appropriate, and would require case managers to help implement approved action plans. By imposing additional requirements on local educat... (click bill link to see more).

Primary Sponsors
Corey Jackson

Bill Number	Status	Position
AB 1451	**In Assembly**	**Monitor**

Title

Behavioral health crisis treatment.

Description

AB 1451, as introduced, Jackson. Behavioral health crisis 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 health insurers by the Department of Insurance. Existing law requires a health care service plan or health insurer that provides hospital, medical, or surgical coverage shall provide coverage for medically necessary treatment of mental health and substance use disorders, under the same terms and conditions applied to other medical conditions, as specified. Existing law also includes requirements for timely access to care, including mental health services, including a requirement that a health care service plan or health insurer provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's or insured's condition consistent with good professional practice.This bill would require a health care service plan contract or health insurance policy issued, amended, renewed, or delivered on or after January 1, 2024, to provide coverage for treatment of a behavioral health crisis that is identified during an appointment at a contracted facility where an enrollee or insured is receiving treatment from a contracted provider for a medical condition, as specified. The bill would authorize treatment for the behavioral health crisis to be provided at the contracted facility, if the facility has the appropriate staff to provide that care. The bill would require the treatment to be provided without preauthorization, and would authorize the provider or facility to use same-day billing to obtain reimbursement for both the medical and behavioral health services provided to the enrollee or insured. 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

Corey Jackson

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 5:56 PM
California Association of Health Plans: Oppose

Bill Number	Status	Position
AB 1457	**In Assembly**	**Monitor**

Title

Public social services: merit or civil service employee.

Description

AB 1457, as introduced, Ortega. Public social services: merit or civil service employee. Existing law requires that any decisions governing eligibility for the Medi-Cal program, the California Work Opportunity and Responsibility to Kids (CalWORKs) program, or the CalFresh program that, in the state, are made by a county pursuant to provisions relating to public social services be made exclusively by a merit or civil service employee of the county.Existing law generally requires the federal and state laws and regulations governing the federal Supplemental Nutrition Assistance Program (or CalFresh in the state) to also govern the California Food Assistance Program (CFAP). Existing law requires the delivery of nutrition benefits under CFAP to be identical to the delivery of CalFresh benefits, to the extent permissible under federal law.Existing law generally requires the federal and state laws and regulations governing the Supplemental Security Income/State Supplementary Program for the Aged, Blind, and Disabled (SSI/SSP) program to also govern the Cash Assistance Program for Immigrants (CAPI).Existing law sets forth various provisions relating to the implementation of the In-Home Supportive Services (IHSS) program as a covered Medi-Cal benefit.Existing law requires that the investigation of allegations of elder and dependent adult abuse under provisions relating to Adult Protective Services (APS), and the case management of elder and dependent adult abuse cases, be performed by county merit systems civil service employees.This bill would add CFAP, CAPI, IHSS, and APS to the above-described list of programs for which any decisions governing eligibility that are made by a county would be made exclusively by a merit or civil service employee of the county.

Primary Sponsors

Liz Ortega

Bill Number
AB 1470

Status
In Assembly

Position
Monitor

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

Description
AB 1470, as amended, Quirk-Silva. Medi-Cal: behavioral health services: documentation standards. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including behavioral health services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes the California Advancing and Innovating Medi-Cal (CalAIM) initiative, subject to receipt of any necessary federal approvals and the availability of federal financial participation, in order to, among other things, improve quality outcomes and reduce health disparities.Existing law, as part of CalAIM, requires the department to develop documentation standards and changes to the department's clinical auditing standards, and authorizes the department to require the use of those documentation standards by Medi-Cal behavioral health delivery systems, as specified.This bill would instead require the department to require Medi-Cal behavioral health delivery systems to use those documentation standards.The bill, as part of CalAIM, and with respect to behavioral health services provided under the Medi-Cal program, would require the department to develop standard forms, including intake and assessment forms, relating to medical necessity criteria, mandatory screening and transition of care tools, and documentation requirements 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 authorize the department to develop and maintain a list of department-approved nonstandard forms.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, exclusively using the standard forms, unless it uses department-approved nonstandard forms. The bill would require providers of applicable entities to use those 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 w... (click bill link to see more).

Primary Sponsors
Sharon Quirk-Silva

Bill Number	Status	Position
AB 1477	**In Assembly**	**Monitor**

Title

Alcohol and drug treatment programs: licensing and certification fee.

Description

AB 1477, as amended, Quirk-Silva. Alcohol and drug treatment programs: licensing and certification fee. Existing law makes the State Department of Health Care Services responsible for administering prevention, treatment, and recovery programs for adult alcoholism and drug abuse. Existing law requires the department to charge a fee to all programs for licensure or certification by the department and to submit any proposed new fees or fee changes to the Legislature for approval, as specified. Existing law prohibits new fees or fee changes from being implemented without legislative approval.This bill would require all fees for licensing of residential treatment facilities and certification of treatment programs that provide addiction treatment services to be at the rate last published in 2022. The bill would leave that rate in effect until January 1, 2031, or until deaths related to opioid overdose reported by the California Overdose Surveillance Dashboard have declined by 50%, whichever is first. The bill would then require that fee increases continue until licensing and certification programs are self-sufficient, but would prohibit the increase from exceeding 15% in a single year.

Primary Sponsors

Sharon Quirk-Silva, Marie Waldron

Bill Number	Status	Position
AB 1481	**In Assembly**	**Monitor**

Title
Medi-Cal: presumptive eligibility.

Description
AB 1481, as amended, Boerner Horvath. Medi-Cal: presumptive eligibility. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing federal law, as a condition of receiving federal Medicaid funds, requires states to provide health care services to specified individuals. Existing federal law authorizes states to provide presumptive eligibility to pregnant women or children, and existing state law requires the department to provide presumptive eligibility to pregnant women and children, as specified.Under existing law, a minor may consent to pregnancy prevention or treatment services without parental consent. Under existing law, an individual under 21 years of age who qualifies for presumptive eligibility is required to go to a county welfare department office to obtain approval for presumptive eligibility.This bill would expand the presumptive eligibility for pregnant women to all pregnant people, renaming the program “Presumptive Eligibility for Pregnant People” (PE4PP). The bill would make a presumptively eligible pregnant person eligible for coverage of all medical care, services, prescriptions, and supplies available under the Medi-Cal program, except for inpatient services and institutional long-term care. The bill would also require the department to ensure that a pregnant person receiving coverage under PE4PP who applies for full-scope Medi-Cal benefits within 60 days receives coverage under PE4PP until their full-scope Medi-Cal application is approved or denied, as specified.The bill would allow a pregnant individual under 26 years of age who can consent to services without parental approval to receive presumptive eligibility by a qualified hospital. The bill would also make conforming changes. Because counties are required to make eligibility determinations, and this bill would expand Medicaid eligibility, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Primary Sponsors
Tasha Boerner Horvath, Rebecca Bauer-Kahan

Bill Number
AB 1502

Status
In Assembly

Position
Monitor

Title
Health care coverage: discrimination.

Description
AB 1502, as introduced, Schiavo. Health care coverage: discrimination. 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 prohibits a health care service plan or health insurer from employing marketing practices or benefit designs that discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions. Existing law requires a plan or insurer to notify enrollees and insureds that it does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.This bill would prohibit a health care service plan or health insurer from discriminating on the basis of race, color, national origin, sex, age, or disability through the use of clinical algorithms in its decisionmaking. 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
Pilar Schiavo

Bill Number
AB 1537

Status
In Assembly

Position
Monitor

Title
Skilled nursing facilities: direct care spending requirement.

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

Primary Sponsors
Jim Wood

Bill Number
AB 1549

Status
In Assembly

Position
Monitor

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

Description
AB 1549, as amended, Wendy Carrillo. Medi-Cal: federally qualified health centers and rural health clinics. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services, including federally qualified health center services and rural health clinic services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.Under existing law, to the extent that federal financial participation is available, FQHC and RHC services are reimbursed on a per-visit basis, as specified.This bill would, among other things, require that per-visit rate to account for the costs of the FQHC or RHC that are reasonable and related to the provision of covered services, including the specific methods and processes used by the FQHC and RHC to deliver those services. The bill would also require the rate for any newly qualified health center to include the cost of care coordination services provided by the health center, as specified.

Primary Sponsors
Wendy Carrillo

Bill Number
AB 1592

Status
In Assembly

Position
Monitor

Title
Interagency Council on Homelessness.

Description
AB 1592, as introduced, Dixon. Interagency Council on Homelessness. Existing law requires the Governor to establish the Interagency Council on Homelessness, and requires the council to have specified goals, including, to identify mainstream resources, benefits, and services that can be accessed to prevent and end homelessness in California, and to report to the Governor, federal Cabinet members, and the Legislature on homelessness and work to reduce homelessness.This bill would require the council to report annually to the Governor, federal Cabinet members, and the Legislature, commencing June 30, 2026, on homelessness and work to reduce homelessness, and would require the report to include the cost per person and distribution of funding within United States Department of Housing and Urban Development’s Continuum of Care program by city and census-designated area.

Primary Sponsors
Diane Dixon

Bill Number
AB 1608

Status
In Assembly

Position
Monitor

Title
Medi-Cal: managed care plans.

Description
AB 1608, as amended, Joe Patterson. Medi-Cal: managed care plans. The Lanterman Developmental Disabilities Services Act makes the State Department of Developmental Services responsible for providing various services and supports to individuals with developmental disabilities, and for ensuring the appropriateness and quality of those services and supports. Pursuant to that law, the department contracts with regional centers to provide services and supports to persons with developmental disabilities. The act requires regional centers to pursue all possible sources of funding for consumers receiving regional center services, including, among others, Medi-Cal.Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes the California Advancing and Innovating Medi-Cal (CalAIM) initiative, subject to receipt of any necessary federal approvals and the availability of federal financial participation, in order to, among other things, improve quality outcomes, reduce health disparities, and increase flexibility.Existing law authorizes the department to standardize those populations that are subject to mandatory enrollment in a Medi-Cal managed care plan across all aid code groups and Medi-Cal managed care models statewide, subject to a Medi-Cal managed care plan readiness, continuity of care transition plan, and disenrollment process developed in consultation with stakeholders, in accordance with specified requirements and the CalAIM Terms and Conditions. Existing law, if the department standardizes those populations subject to mandatory enrollment, exempts certain dual and non-dual beneficiary groups, as defined, from that mandatory enrollment.This bill would additionally exempt dual and non-dual-eligible beneficiaries who receive services from a regional center and use a Medi-Cal fee-for-service delivery system as a secondary form of health coverage.

Primary Sponsors
Joe Patterson

Bill Number	Status	Position
AB 1624	In Assembly	Monitor

Title
Mental health: patients' rights programs.

Description
AB 1624, as introduced, Addis. Mental health: patients' rights programs. Existing law requires the State Department of State Hospitals and the State Department of Health Care Services to contract with a single nonprofit entity to provide for protection and advocacy services to persons with mental disabilities, as specified.This bill would make a technical, nonsubstantive change to that provision.

Primary Sponsors
Dawn Addis

Bill Number	Status	Position
AB 1636	In Assembly	Monitor

Title
Mental health services.

Description
AB 1636, as amended, Santiago. Mental health services. Existing law, the Mental Health Services Act (MHSA), an initiative measure enacted by the voters as Proposition 63 at the November 2, 2004, statewide general election, establishes the continuously appropriated Mental Health Services Fund to fund various county mental health programs. The MHSA also established the Mental Health Services Oversight and Accountability Commission to oversee the administration of various parts of the act. This bill would require the commission to develop, implement, and oversee a public and comprehensive framework for tracking and reporting spending on mental health programs and services from all major fund sources and of program- and service-level and statewide outcome data, as specified. The bill would require counties to report to the commission their expenses in specific categories, including, but not limited to, inpatient care or intensive outpatient services, as well as their unspent funding from all major funding sources. By imposing new reporting requirements on counties, 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
Miguel Santiago

Bill Number	Status	Position
AB 1644	In Assembly	Monitor

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

Description
AB 1644, as amended, Bonta. Medi-Cal: medically supportive food and nutrition 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 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 intervention plans, as defined, a covered benefit under the Medi-Cal program, upon issuance of final guidance by the department. The bill would require medically supportive food and nutrition intervention plans be covered when determined to be medically necessary by a health care provider or health care plan. In order to qualify for coverage under the Medi-Cal program, the bill would require medically supportive food and nutrition intervention plans include at least 3 of 6 specified medically supportive food and nutrition interventions. The bill would only provide coverage for nutrition support interventions when combined with the minimum 3 interventions. The bill would require health care providers or health care plans to match the acuity of a patient's condition to the intensity and duration of the medically supportive food and nutrition intervention plan and include culturally appropriate foods whenever possible.The bill would establish the Medically Supportive Food and Nutrition Benefit Committee to assist the department in developing final guidance related to eligible populations, the duration and dosage of medically supportive food and nutrition intervention plans, the ratesetting process, determination of permitted providers, and continuing education for health ca... (click bill link to see more).

Primary Sponsors
Mia Bonta, Buffy Wicks

Organizational Notes

Last edited by Joanne Campbell at Mar 29, 2023, 4:36 PM
Local Health Plans of California: Support

Bill Number
AB 1645

Status
In Assembly

Position
Monitor

Title
Health care coverage: cost sharing.

Description
AB 1645, 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, 2024, from imposing a cost-sharing requirement for office visits for the above-described preventive care services and screenings and for items or services that are integral to their provision. The bill would prohibit nongrandfathered and grandfathered contracts and policies from imposing a cost-sharing requirement, utilization review, or other specified limits on a recommended sexually transmitted infections screening, and from imposing a cost-sharing requirement for any items and services integral to a sexually transmitted infections screening, as specified. The bill would require a plan or insurer to directly reimburse a nonparticipating provider or facility of sexually transmitted infections screening that meets specified criteria its median contracted rate in the general geographic region for screening tests and integral items and services rendered, and would prohibit a nonparticipating provider from billing or collecting a cost-sharing amount for a sexually transmitted infections screening from an enrollee or insured. 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
Rick Zbur

Organizational Notes

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

Bill Number	Status	Position
AB 1671	**In Assembly**	**Monitor**

Title
Pupil mental health: services.

Description
AB 1671, as introduced, Muratsuchi. Pupil mental health: services. Existing law requires a school of a school district or county office of education and a charter school to notify pupils and parents or guardians of pupils no less than twice during the school year on how to initiate access to available pupil mental health services on campus or in the community, or both, using at least 2 of specified methods, as provided.This bill would make nonsubstantive changes to those provisions.

Primary Sponsors
Al Muratsuchi

Bill Number
AB 1672

Status
In Assembly

Position
Monitor

Title
In-Home Supportive Services Employer-Employee Relations Act.

Description
AB 1672, as introduced, Haney. In-Home Supportive Services Employer-Employee Relations Act. (1) Existing law establishes the In-Home Supportive Services (IHSS) program, which is administered by the State Department of Social Services, counties, and other entities, under which qualified aged, blind, or disabled persons are provided with supportive services in order to permit them to remain in their own homes. Existing law authorizes a county board of supervisors to elect to contract with a nonprofit consortium to provide for the delivery of in-home supportive services or to establish, by ordinance, a public authority to provide for the delivery of those services, in accordance with certain procedures. Existing law deems a public authority created under these provisions to be the employer of in-home supportive services personnel under the Meyers-Milias-Brown Act, which governs labor relations between local public employers and employees. Existing law also deems a nonprofit consortium contracting with a county to be the employer of in-home supportive services personnel for purposes of collective bargaining over wages, hours, and other terms and conditions of employment. Existing law grants recipients of in-home supportive services the right to hire, fire, and supervise the work of any in-home supportive services personnel providing services for them. Existing law prohibits the state and specified local public employers from deterring or discouraging public employees from becoming or remaining members of an employee organization. Existing law also requires specified public employers to provide exclusive employee representatives access to new employee orientations. Existing law generally grants the Public Employment Relations Board jurisdiction over violations of these provisions. Existing law defines “public employers” who are subject to these provisions as including, among others, public agencies, cities, counties, and districts. This bill would expand the definition of “public employer,” for purposes of those provisions, to include an employer who is subject to the In-Home Supportive Services Employer-Employee Relations Act, which the bill would create. The bill would establish a method for resolving disputes regarding wages, benefits, and other terms and conditions of employment between the state and recognized employee organizations representing independent providers. The bill would provide for the right of employees, also known as individual providers under the act, to form, join, and participate in activities of employee organizations for the purposes of representation on all matters within the scope of employee organizations. The bill would define “employee” or “individual provider” for these purposes to mean a person... (click bill link to see more).

Primary Sponsors
Matt Haney, Wendy Carrillo, Miguel Santiago, Henry Stern

Bill Number	Status	Position
AB 1676	In Assembly	Monitor

Title
Mental health: patients’ rights programs.

Description
AB 1676, as introduced, Quirk-Silva. Mental health: patients’ rights programs. Existing law requires the State Department of State Hospitals and the State Department of Health Care Services to contract with a single nonprofit entity to provide for protection and advocacy services to persons with mental disabilities, as specified.This bill would make a technical, nonsubstantive change to that provision.

Primary Sponsors
Sharon Quirk-Silva

Bill Number	Status	Position
AB 1690	In Assembly	Monitor

Title
Universal health care coverage.

Description
AB 1690, as introduced, Kalra. Universal health care coverage. Existing law provides for the creation of various programs to provide health care services to persons who have limited incomes and meet various eligibility requirements, including the Medi-Cal program administered by the State Department of Health Care Services. Existing law provides for the regulation of health care service plans by the Department of Managed Health Care and health insurers by the Department of Insurance. Existing law establishes the California Health Benefit Exchange to facilitate the purchase of qualified health plans through the Exchange by qualified individuals and small employers.This bill would state the intent of the Legislature to guarantee accessible, affordable, equitable, and high-quality health care for all Californians through a comprehensive universal single-payer health care program that benefits every resident of the state.

Primary Sponsors
Ash Kalra

Bill Number	Status	Position
AB 1698	**In Assembly**	**Monitor**

Title
Medi-Cal.

Description
AB 1698, as introduced, Wood. Medi-Cal. 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.This bill would make specified findings and would express the intent of the Legislature to enact future legislation relating to Medi-Cal.

Primary Sponsors
Jim Wood

Bill Number	Status	Position
AB 1707	**In Assembly**	**Monitor**

Title

Health professionals and facilities: adverse actions based on another state's law.

Description

AB 1707, as amended, Pacheco. Health professionals and facilities: adverse actions based on another state's law. Existing law establishes various boards within the Department of Consumer Affairs to license and regulate various health professionals. Existing law prohibits the Medical Board of California, the Osteopathic Medical Board of California, the Board of Registered Nursing, and the Physician Assistant Board from denying an application for licensure or suspending, revoking, or otherwise imposing discipline upon a licensee because the person was disciplined in another state in which they are licensed solely for performing an abortion in that state or because the person was convicted in another state for an offense related solely to performing an abortion in that state.Existing law provides for the licensure of clinics and health facilities by the Licensing and Certification Division of the State Department of Public Health. Existing law makes a violation of these provisions punishable as a misdemeanor, except as specified.This bill would prohibit a healing arts board under the Department of Consumer Affairs from denying an application for a license or imposing discipline upon a licensee on the basis of a civil judgment, criminal conviction, or disciplinary action in another state that is based on the application of another state's law that interferes with a person's right to receive sensitive services, as defined, that would be lawful in this state. The bill would similarly prohibit a health facility from denying staff privileges to, removing from medical staff, or restricting the staff privileges of a licensed health professional on the basis of such a civil judgment, criminal conviction, or disciplinary action imposed by another state. The bill also would also prohibit the denial, suspension, revocation, or limitation of a clinic or health facility license on the basis of those types of civil judgments, criminal convictions, or disciplinary actions imposed by another state. The bill would exempt from the above-specified provisions a civil judgment, criminal conviction, or disciplinary action imposed by another state for which a similar claim, charge, or action would exist against the applicant or licensee under the laws of this state. By imposing new prohibitions under the provisions related to clinics and health facilities, the violation of which is 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

Blanca Pacheco

Bill Number	Status	Position
ACR 10	Enacted	Monitor

Title
Children’s Dental Health Month.

Description
ACR 10, Weber. Children’s Dental Health Month. This measure would recognize and declare the month of February 2023 as Children’s Dental Health Month.

Primary Sponsors
Akilah Weber

Bill Number	Status	Position
SB 11	In Senate	Monitor

Title
California State University: mental health counseling.

Description
SB 11, as amended, Menjivar. California State University: mental health counseling. Existing law establishes the California State University, under the administration of the Trustees of the California State University, as one of the segments of public postsecondary education in the state. The California State University comprises 23 institutions of higher education located throughout the state.This bill would require the trustees to comply with various requirements on mental health counseling at CSU, including having one full-time equivalent California-licensed mental health counselor per 1,500 students enrolled at each CSU campus. The bill, contingent upon appropriation by the Legislature, would establish the CSU Mental Health Professionals Act to provide incentives for CSU students to become mental health counselors in the state. The bill would define “mental health counselor” for purposes of these provisions.

Primary Sponsors
Caroline Menjivar, Pilar Schiavo

Bill Number
SB 43

Status
In Senate

Position
Monitor

Title
Behavioral health.

Description
SB 43, as amended, Eggman. Behavioral health. 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. Existing law, for purposes of involuntary commitment, defines “gravely disabled” as either a condition in which a person, as a result of a mental health disorder, is unable to provide for their basic personal needs for food, clothing, or shelter or has been found mentally incompetent, as specified.This bill expands the definition of “gravely disabled” to also include a condition that will result in substantial risk of serious harm to the physical or mental health of a person due to a mental health disorder or a substance use disorder or both. The bill defines “serious harm” for purposes of these provisions to mean significant deterioration, debilitation, or illness due to a person’s failure to meet certain conditions, including, among other things, attend to needed personal or medical care and attend to self-protection or personal safety. The bill specifies circumstances under which substantial risk of serious harm may be evidenced, as specified. The bill would make conforming changes. To the extent that this change increases the level of service required of county mental health departments, the bill would impose a state-mandated local program.Existing law also authorizes the appointment of a conservator, in the County of Los Angeles, the County of San Diego, or the City and County of San Francisco, for a person who is incapable of caring for the person’s own health and well-being due to a serious mental illness and substance use disorder. Existing law establishes the hearsay rule, under which evidence of a statement is generally inadmissible if it was made other than by a witness while testifying at a hearing and is offered to prove the truth of the matter stated. Existing law sets forth exceptions to the hearsay rule to permit the admission of specified kinds of evidence.Under this bill, for purposes of an expert witness in any proceeding relating to the appointment or reappointment of a conservator pursuant to the above-described provisions, the statements of specified health practitioners or a licensed clinical social worker included in the medical record would not be hearsay. The bill would authorize the court to grant a reasonable continuance if an expert witness in a proceeding relied on the medical record and the medical record has not been provided to the parties or their counsel.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 reimburseme... (click bill link to see more).

Primary Sponsors
Susan Eggman, Roger Niello, Miguel Santiago, Scott Wiener

Bill Number	Status	Position
SB 59	In Senate	Monitor

Title
Menstrual Product Accessibility Act.

Description
SB 59, as amended, Skinner. Menstrual Product Accessibility Act. Existing law requires certain public schools, as specified, to stock the school's restrooms with an adequate supply of free menstrual products, as defined, available and accessible, free of cost, in all women's restrooms and all-gender restrooms, and in at least one men's restroom, at all times. Existing law also requires the California State University and each community college district to stock an adequate supply of menstrual products, available and accessible, free of cost, at no fewer than one designated and accessible central location on each campus. This bill would enact the Menstrual Product Accessibility Act, which would require all women's restrooms, all all-gender restrooms, and at least one men's restroom in a building owned by the state or in the portion of a building where the state rents or leases office space, a building owned by a local government where a specified state-funded safety net program is administered, or in a hospital that receives state funds, as specified, to be stocked with menstrual products, as defined, available and accessible to employees and the public, free of cost, at all times. By imposing additional requirements on local agencies, this bill would create a state-mandated local program. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Primary Sponsors
Nancy Skinner, Cecilia Aguiar-Curry

Bill Number
SB 70

Status
In Senate

Position
Monitor

Title
Prescription drug coverage.

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

Primary Sponsors
Scott Wiener

Organizational Notes

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

Bill Number
SB 72

Status
In Senate

Position
Monitor

Title
Budget Act of 2023.

Description
SB 72, as introduced, Skinner. Budget Act of 2023. This bill would make appropriations for the support of state government for the 2023–24 fiscal year.This bill would declare that it is to take effect immediately as a Budget Bill.

Primary Sponsors
Nancy Skinner

Bill Number
SB 87

Status
In Senate

Position
Monitor

Title
Mental health: involuntary commitment.

Description
SB 87, as amended, Nguyen. Mental health: involuntary commitment. Existing law, the Lanterman-Petris-Short Act, provides for the involuntary commitment and treatment of persons with specified mental disorders for the protection of the persons committed. Under the act, when a person, as a result of a mental health disorder, is a danger to others, or to themselves, or gravely disabled, the person may, upon probable cause, be taken into custody and placed in a facility designated by the county and approved by the State Department of Health Care Services. Existing law provides that a conservator of the person, of the estate, or of the person and the estate may be appointed for a person who is gravely disabled due to a mental health disorder or impairment by chronic alcoholism. Existing law authorizes that a person for whom conservatorship is sought has a right to demand a court or jury trial on the issue of whether the individual is gravely disabled. Existing law requires that such a demand must be made within 5 days following the hearing on the conservatorship petition. Existing law requires that the court or jury trial must commence within 10 days of the date of the demand, except the court may continue the trial date for a period not to exceed 15 days upon request of counsel for the proposed conservatee.This bill would extend the period for which a court or jury trial may be continued at the request of counsel for the proposed conservatee from 15 days to 20 days.

Primary Sponsors
Janet Nguyen

Bill Number	Status	Position
SB 90	**In Senate**	**Monitor**

Title
Health care coverage: insulin affordability.

Description
SB 90, as amended, Wiener. Health care coverage: insulin affordability. 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 a health care service plan contract or disability insurance policy issued, amended, delivered, or renewed on or after January 1, 2000, that covers prescription benefits to include coverage for insulin if it is determined to be medically necessary.This bill would prohibit a health care service plan contract or a disability insurance policy, as specified, issued, amended, delivered, or renewed on or after January 1, 2024, from imposing a copayment of more than $35 for a 30-day supply of an insulin prescription drug or imposing a deductible, coinsurance, or other cost sharing on an insulin prescription drug, and would prohibit a high deductible health plan from imposing a deductible, coinsurance, or other cost sharing on an insulin prescription drug, as specified. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Scott Wiener

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 5:58 PM
California Association of Health Plans: Oppose

Bill Number
SB 232

Status
In Senate

Position
Monitor

Title
Mental health services: gravely disabled.

Description
SB 232, as introduced, Niello. Mental health services: gravely disabled. 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. The act also provides for a conservator of the person or estate to be appointed for a person who is gravely disabled. Other existing law exempts specified licensed general acute care hospitals, licensed acute psychiatric hospitals, licensed professional staff of those hospitals, or a physician and surgeon, providing emergency medical services in any department of those hospitals, from civil or criminal liability for detaining a person if certain conditions exist, including that the person cannot be safely released from the hospital because the person, as a result of a mental health disorder, presents a danger to themselves or others or is gravely disabled.Existing law, for the purposes of these provisions, defines "gravely disabled," among other things, as a condition in which a person, as a result of a mental health disorder, is unable to provide for the basic personal needs of food, clothing, or shelter.This bill would change the definition of "gravely disabled" for these purposes to read, in part, a condition in which a person, as a result of a mental health disorder, is incapable of making informed decisions about, or providing for, their own basic personal needs for food, clothing, shelter, or medical care without significant supervision and assistance from another person and, as a result of being incapable of making these informed decisions, the person is at risk of substantial bodily harm, dangerous worsening of a concomitant serious physical illness, significant psychiatric deterioration, or mismanagement of essential needs that could result in bodily harm. The bill would also define "gravely disabled" for purposes of the act to mean a condition in which a person has an incapacity to provide informed consent to treatment due to anosognosia. By increasing the level of service required of county mental health departments, 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
Roger Niello

Bill Number	Status	Position
SB 238	In Senate	Monitor

Title
Health care coverage: independent medical review.

Description
SB 238, as amended, Wiener. Health care coverage: independent medical review. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of disability insurers by the Department of Insurance. Existing law establishes the Independent Medical Review System within each department, under which an enrollee or insured may seek review if a health care service has been denied, modified, or delayed by a health care service plan or disability insurer and the enrollee or insured has previously filed a grievance that remains unresolved after 30 days.This bill would require a health care service plan or a disability insurer that modifies, delays, or denies a health care service that is a covered benefit based in whole or in part on medical necessity, to automatically submit a decision regarding a disputed health care service to the Independent Medical Review System, without requiring an enrollee or insured to submit a grievance, if the decision is to deny, modify, or delay specified services relating to mental health or substance use disorder conditions for an enrollee or insured up to 26 years of age. The bill would require a health care service plan or disability insurer, within 24 hours after submitting its decision to the Independent Medical Review System to provide notice to the appropriate department, the enrollee or insured or their representative, if any, and the enrollee's or insured's provider. The bill would require the notice to include notification to the enrollee or insured that they or their representative may cancel the independent medical review within 5 days, as specified.The bill would apply specified existing provisions relating to mental health and substance use disorders for purposes of its provisions, and would be subject to relevant provisions relating to the Independent Medical Review System that do not otherwise conflict with the express requirements of the bill. With respect to health care service plans, the bill would specify that its provisions do not apply to Medi-Cal managed care plan contracts. The bill would authorize the Insurance Commissioner to promulgate regulations subject to the Administrative Procedure Act to implement and enforce the bill. 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 reimbu... (click bill link to see more).

Primary Sponsors
Scott Wiener

Organizational Notes

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

Bill Number	Status	Position
SB 242	**In Senate**	**Monitor**

Title

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

Description

SB 242, as introduced, Skinner. California Hope, Opportunity, Perseverance, and Empowerment (HOPE) for Children Trust Account Program. Existing law establishes the California Hope, Opportunity, Perseverance, and Empowerment (HOPE) for Children Trust Account Program to provide a trust fund account to an eligible child, defined to include minor California residents who are specified dependents or wards under the jurisdiction of juvenile court in foster care with reunification services terminated by court order, or who have a parent, Indian custodian, or legal guardian who died due to COVID-19 during the federally declared COVID-19 public health emergency and meet the specified family household income limit. Under the program, all assets of the fund and moneys allocated to individual HOPE trust accounts shall be considered to be owned by the state until an eligible youth withdraws or transfers money from their HOPE trust account.Existing law establishes various means-tested public social services programs administered by counties to provide eligible recipients with certain benefits, including, but not limited to, cash assistance under the California Work Opportunity and Responsibility to Kids (CalWORKs) program, nutrition assistance under the CalFresh program, and health care services under the Medi-Cal program.This bill would, to the extent permitted by federal law, prohibit funds deposited and investment returns accrued in a HOPE trust fund account from being considered as income or assets when determining eligibility and benefit amount for any means-tested program until an eligible youth withdraws or transfers the funds from the HOPE trust fund account, as specified. To the extent this bill would expand county duties, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Primary Sponsors

Nancy Skinner

Bill Number	Status	Position
SB 246	In Senate	Monitor

Title
California Interagency Council on Homelessness.

Description
SB 246, as introduced, Ochoa Bogh. California Interagency Council on Homelessness. Existing law requires the Governor to establish the California Interagency Council on Homelessness, and requires the council to, among other things, identify mainstream resources, benefits, and services that can be accessed to prevent and end homelessness in California, and promote systems integration to increase efficiency and effectiveness while focusing on designing systems to address the needs of people experiencing homelessness. Existing law sets forth the composition of the council, which includes, among others, the Secretary of Business, Consumer Services, and Housing and the Secretary of California Health and Human Services, who serve as cochairs of the council.This bill would add a representative from the State Council on Developmental Disabilities to the council described above.

Primary Sponsors
Rosilicie Ochoa Bogh

Bill Number	Status	Position
SB 257	**In Senate**	**Monitor**

Title
Health care coverage: diagnostic imaging.

Description
SB 257, as introduced, Portantino. Health care coverage: diagnostic imaging. 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 issued, amended, delivered, or renewed on or after January 1, 2000, or an individual or group policy of disability insurance or self-insured employee welfare benefit plan to provide coverage for mammography for screening or diagnostic purposes upon referral by specified professionals. Under existing law, mammography performed pursuant to those requirements or that meets the current recommendations of the United States Preventive Services Task Force is provided to an enrollee or an insured without cost sharing.This bill would require a health care service plan contract, a policy of disability insurance that provides hospital, medical, or surgical coverage, or a self-insured employee welfare benefit plan issued, amended, or renewed on or after January 1, 2025, to provide coverage without imposing cost sharing for, among other things, screening mammography and medically necessary diagnostic breast imaging, including diagnostic breast imaging following an abnormal mammography result and for an enrollee or insured indicated to have a risk factor associated with breast cancer, except as specified.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Anthony Portantino

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 5:58 PM
California Association of Health Plans: Oppose

Bill Number	Status	Position
SB 282	**In Senate**	**Support**

Title

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

Description

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

Primary Sponsors

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

Organizational Notes

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

Bill Number	Status	Position
SB 299	In Senate	Monitor

Title
Medi-Cal eligibility: redetermination.

Description
SB 299, as amended, Eggman. Medi-Cal eligibility: redetermination. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law generally requires a county to redetermine a Medi-Cal beneficiary's eligibility to receive Medi-Cal benefits every 12 months and whenever the county receives information about changes in a beneficiary's circumstances that may affect their eligibility for Medi-Cal benefits. In response to a change in circumstances, if a county cannot obtain sufficient information to redetermine eligibility, existing law requires the county to send to the beneficiary a form that is prepopulated with the information that the county has obtained and that states the information needed to renew eligibility. Under existing law, if the purpose for a redetermination is loss of contact with the beneficiary, as evidenced by the return of mail, as specified, a return of the prepopulated form requires the county to immediately send a notice of action terminating Medi-Cal eligibility.This bill would remove loss of contact with a beneficiary, as evidenced by the return of mail, as a circumstance requiring prompt redetermination and would delete the above-described requirement for a county to send a notice of action terminating eligibility if the prepopulated form is returned and the purpose for the redetermination is loss of contact with the beneficiary. To the extent that the bill would modify county duties relating to the redetermination of Medi-Cal eligibility, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Primary Sponsors
Susan Eggman

Bill Number	Status	Position
SB 302	**In Senate**	**Monitor**

Title
Compassionate Access to Medical Cannabis Act.

Description
SB 302, as amended, Stern. Compassionate Access to Medical Cannabis Act. Existing law, the Compassionate Access to Medical Cannabis Act or Ryan's Law, requires specified types of health care facilities to allow a terminally ill patient's use of medicinal cannabis within the health care facility, subject to certain restrictions. Existing law requires that health care facilities permitting patient use of medical cannabis comply with other drug and medication requirements, as specified, and makes those facilities subject to enforcement actions by the State Department of Public Health.This bill would expand those provisions to a patient who is over 65 years of age with a chronic disease, as defined.

Primary Sponsors
Henry Stern

Bill Number
SB 311

Status
In Senate

Position
Support

Title
Medi-Cal: Part A buy-in.

Description
SB 311, as introduced, Eggman. Medi-Cal: Part A buy-in. 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 State Department of Health Care Services, to the extent required by federal law, for Medi–Cal recipients who are qualified Medicare beneficiaries, to pay the Medicare premiums, deductibles, and coinsurance for certain elderly and disabled persons. Existing federal law authorizes states to pay for Medicare benefits for specified enrollees pursuant to either a buy-in agreement to directly enroll and pay premiums or a group payer arrangement to pay premiums.This bill would require the department to submit a state plan amendment no later than January 1, 2024, to enter into a Medicare Part A buy-in agreement with the federal Centers for Medicare and Medicaid Services. To the extent that the bill would increase duties for a county, the bill would create 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
Susan Eggman

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 6:24 PM
Local Health Plans of California: Support L.A. Care: Support

Bill Number	Status	Position
SB 324	**In Senate**	**Monitor**

Title

Health care coverage: endometriosis.

Description

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

Primary Sponsors

Monique Limon

Organizational Notes

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

Bill Number	Status	Position
SB 326	**In Senate**	**Monitor**

Title

Mental Health Services Act.

Description

SB 326, as amended, Eggman. Mental Health Services Act. 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, funds a system of county mental health plans for the provision of mental health services, as specified. The act establishes the Mental Health Services Fund, which is continuously appropriated to, and administered by, the State Department of Health Care Services to fund specified county mental health programs. The act may be amended by the Legislature only by a 2/3 vote of both houses and only so long as the amendment is consistent with and furthers the intent of the act. The Legislature may clarify procedures and terms of the act by majority vote.This bill would require a county, for a behavioral health service eligible for reimbursement pursuant to the federal Social Security Act, to submit the claims for reimbursement to the State Department of Health Care Services under specific circumstances. By imposing a new duty on local officials, this bill would create a state-mandated local program.The bill would make findings that it clarifies procedures and terms of the Mental Health Services Act.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

Susan Eggman

Bill Number	Status	Position
SB 333	In Senate	Monitor

Title
Homeless pupils: California Success, Opportunity, and Academic Resilience (SOAR) Guaranteed Income Program.

Description
SB 333, as amended, Cortese. Homeless pupils: California Success, Opportunity, and Academic Resilience (SOAR) Guaranteed Income Program. (1) Existing law establishes various programs to provide assistance to homeless youth, including, among others, homeless youth emergency service pilot projects and the Runaway Youth and Families in Crisis Projects.This bill, subject to an appropriation by the Legislature for this purpose, would require the State Department of Social Services to establish the California Success, Opportunity, and Academic Resilience (SOAR) Guaranteed Income Program. The program would award public school pupils who are in grade 12 and are homeless children or youths, as defined, a guaranteed income of $1,000 each month for 5 months from April 1, 2025, to August 1, 2025, inclusive, as provided. The bill would establish the California SOAR Guaranteed Income Fund as the initial depository of all moneys appropriated, donated, or otherwise received for the program, and upon appropriation by the Legislature, would provide moneys in the fund to eligible participants.(2) Existing federal law, the McKinney-Vento Homeless Assistance Act, provides grants to states to carry out activities relating to the education of homeless children and youths, as defined, including, among others, providing services and activities to improve the identification of homeless children and youths and to enable them to enroll in and succeed in school. Existing law requires local educational agency liaisons, as defined, to ensure that homeless children and youths are identified by school personnel through outreach and coordination activities, as specified.This bill would require local educational agency liaisons to identify eligible participants for purposes of assisting the State Department of Social Services in distributing entitled awards under the California SOAR Guaranteed Income Program. By imposing additional duties on local educational agency liaisons, the bill would impose a state-mandated local program.(3) Existing law, beginning on or after January 1, 2015, in modified conformity with federal income tax law, allows an earned income tax credit, the California Earned Income Tax Credit, against personal income tax. The Personal Income Tax Law also allows, for each taxable year beginning on or after January 1, 2019, a young child tax credit against the taxes imposed under that law.This bill, for the taxable year beginning on January 1, 2025, would exclude from gross income, for purposes of the personal income tax, any amount received as an award pursuant to the California SOAR Guaranteed Income Program. The bill, for the taxable year beginning on January 1, 2025, would additionally provide that the amount awarded is not earn... (click bill link to see more).

Primary Sponsors
Dave Cortese

Bill Number	Status	Position
SB 339	In Senate	Monitor

Title
HIV preexposure prophylaxis and postexposure prophylaxis.

Description
SB 339, as amended, 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 July 1, 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.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 costs for the pharmacist’s services and related testing ordered by the pharmacist, and reimburse pharmacist services at 100% of the fee schedule for physician services. 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 local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutor... (click bill link to see more).

Primary Sponsors
Scott Wiener

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 5:59 PM
California Association of Health Plans: Oppose

Bill Number
SB 340

Status
In Senate

Position
Monitor

Title
Medi-Cal: eyeglasses: Prison Industry Authority.

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

Primary Sponsors
Susan Eggman, Scott Wilk

Bill Number
SB 345

Status
In Senate

Position
Monitor

Title
Health care services: legally protected health care activities.

Description
SB 345, as amended, Skinner. Health care services: legally protected health care activities. (1) Existing law provides for the licensure and regulation of various categories of medical professionals by boards within the Department of Consumer Affairs, including, among others, the Medical Board of California and the Dental Board of California. Existing law makes specified actions by licensed health care providers unprofessional conduct and, in certain cases, a criminal offense.This bill would prohibit a board from suspending or revoking the license of a person regulated under the above healing arts provisions solely because the person provided a legally protected health care activity. In this connection, the bill would define a "legally protected health care activity" to mean specified acts, including exercising rights related to reproductive health care services or gender-affirming health care services secured by the Constitution or the provision of insurance coverage for those services.The bill would also prohibit a board from denying an application for licensure or suspending, revoking, or otherwise imposing discipline on a licensed person because they were disciplined or convicted of an offense in another state, if that disciplinary action was for providing a legally protected health care activity. The bill would further provide that the performance, recommendation, or provision of a legally protected health care activity by a health care practitioner acting within their scope of practice for a patient who resides in a state in which the performance, recommendation, or provision of that legally protected health care activity is illegal, does not, by itself, constitute professional misconduct, upon which discipline or other penalty may be taken.(2) Existing law, the Confidentiality of Medical Information Act, generally prohibits a health care provider, health care service plan, contractor, or corporation from sharing, selling, using for marketing, or otherwise using medical information for a purpose not necessary to provide health care services to the patient.Existing law, as amended by the California Privacy Rights Act of 2020 (CPRA), an initiative approved by the voters at the November 3, 2020, statewide general election, imposes various obligations on businesses with respect to protecting consumer privacy and information, including requiring certain disclosures to consumers regarding a consumer's rights under the act. The CPRA authorizes the Legislature to amend the act to further the purposes and intent of the act by a majority vote of both houses of the Legislature, as specified.This bill would prohibit a business that tracks, uses, collects, or stores geographic location data from tracking, using, storing... (click bill link to see more).

Primary Sponsors
Nancy Skinner

Bill Number
SB 348

Status
In Senate

Position
Support

Title
Pupil meals.

Description
SB 348, as amended, Skinner. Pupil meals. (1) Existing law establishes a system of public elementary and secondary schools in this state. This system comprises local educational agencies throughout the state that provide instruction to pupils in kindergarten and grades 1 to 12, inclusive, at schoolsites operated by these agencies. Existing law, commencing with the 2022–23 school year, requires each school district and county superintendent of schools maintaining kindergarten or any of grades 1 to 12, inclusive, and each charter school to provide 2 nutritiously adequate school meals free of charge during each schoolday, regardless of the length of the schoolday, to any pupil who requests a meal without consideration of the pupil's eligibility for a federally funded free or reduced-price meal, as specified, with a maximum of one free meal for each meal service period. Existing law requires the department to develop and maintain nutrition guidelines for school lunches and breakfasts, and for all food and beverages sold on public school campuses.This bill would require local educational agencies to provide breakfast and would authorize those local educational agencies to provide lunch on each 4-hour schoolday unless the State Department of Education receives an approval for a waiver from the United States Department of Agriculture to allow for lunch on a 4-hour schoolday to be served in a noncongregate manner, in which case, both meals are required to be served. The bill would require those local educational agencies to provide pupils with adequate time to eat, as determined by the State Department of Education. The bill would require the State Department of Education, in partnership with specified entities to determine the maximum amount of added sugar to be allowed in a nutritionally adequate breakfast or lunch, as provided. The bill also would make conforming changes to related provisions of law. By imposing additional duties on local educational agencies, the bill would impose a state-mandated local program.(2) Existing law requires a school district, county superintendent of schools, or charter school to provide each needy pupil with one nutritionally adequate free or reduced-price meal during each schoolday, except as provided.This bill would revise and recast provisions regarding school meals for needy pupils by, among other things, instead requiring school districts and county superintendents of schools, and, commencing with the 2024–25 school year, requiring a charter school to provide 2 school meals free of charge during each schoolday to any pupil who requests a meal without consideration of the pupil's eligibility for a federally funded free or reduced-price meal, as provided. By imposing additional d... (click bill link to see more).

Primary Sponsors
Nancy Skinner

Organizational Notes

Last edited by Joanne Campbell at Apr 17, 2023, 3:56 PM
L.A. Care, Local Health Plans of California: Support

Bill Number
SB 363

Status
In Senate

Position
Monitor

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

Description
SB 363, as introduced, Eggman. Facilities for inpatient and residential mental health and substance use disorder: database. Existing law generally requires the State Department of Public Health to license, inspect, and regulate health facilities, defined to include, among other types of health facilities, an acute psychiatric hospital. Existing law generally requires the State Department of Social Services to license, inspect, and regulate various types of care facilities, including, among others, a community crisis home. Existing law requires the State Department of Health Care Services to license and regulate facilities that provide residential nonmedical services to adults who are recovering from problems related to alcohol, drug, or alcohol and drug misuse or abuse, and who need alcohol, drug, or alcohol and drug recovery treatment or detoxification services.This bill would require, by January 1, 2025, the State Department of Health Care Services, in consultation with the State Department of Public Health and the State Department of Social Services, and by conferring with specified stakeholders, to develop a real-time, internet-based database to collect, aggregate, and display information about beds in specified types of facilities, such as chemical dependency recovery hospitals, acute psychiatric hospitals, and mental health rehabilitation centers, among others, to identify the availability of inpatient and residential mental health or substance use disorder treatment. The bill would require the database to include a minimum of specific information, including the contact information for a facility's designated employee, the types of diagnoses or treatments for which the bed is appropriate, and the target populations served at the facility, and have the capacity to, among other things, enable searches to identify beds that are appropriate for individuals in need of inpatient or residential mental health or substance use disorder treatment.This bill would authorize the department to impose a plan of correction or assess penalties against a facility that fails to submit data accurately, timely, or as otherwise required and would establish a process for facilities to appeal these penalties. The bill would create the Available Care for Inpatient and Residential Mental Health or Substance Use Disorder Treatment Database Maintenance and Oversight Fund for the receipt of any penalties. Because the bill would continuously appropriate moneys in the fund for administrative costs of implementing the database, it would create an appropriation.

Primary Sponsors
Susan Eggman

Bill Number	Status	Position
SB 385	**In Senate**	**Monitor**

Title
Physician Assistant Practice Act: abortion by aspiration: training.

Description
SB 385, as introduced, Atkins. Physician Assistant Practice Act: abortion by aspiration: training. The Physician Assistant Practice Act establishes the Physician Assistant Board to license and regulate physician assistants. Existing law makes it a crime to perform an abortion without holding a license to practice as a physician and surgeon or holding a specified license or certificate under the Physician Assistant Practice Act that authorizes the holder to perform specified functions necessary for an abortion. The act requires a physician assistant to complete training and comply with certain protocols, as specified, to receive authority from the physician assistant’s supervising physician and surgeon to perform an abortion by aspiration techniques.This bill would revise the training requirements to instead require a physician assistant to achieve clinical competency by successfully completing requisite training, as described, in performing an abortion by aspiration techniques. The bill would set forth what types of training qualify. The bill would remove the requirement that a physician assistant follow certain protocols to receive authority from the physician assistant’s supervising physician and surgeon to perform an abortion by aspiration techniques.This bill would authorize a physician assistant who has completed the training and achieved clinical competency, as described, to perform abortions by aspirations techniques without the personal presence of a supervising physician and surgeon, except as provided. The bill would require a physician assistant to practice abortion by aspiration techniques consistent with applicable standards of care, within the scope of their clinical and professional education and training, and pursuant to their practice agreement. The bill would provide that specified persons authorized to perform abortion by aspiration techniques shall not be punished, held liable for damages in a civil action, or denied any right or privilege for any action relating to the evaluation of clinical competency of a physician assistant, as described. The bill would make other technical changes.

Primary Sponsors
Toni Atkins

Bill Number
SB 411

Status
In Senate

Position
Monitor

Title
Open meetings: teleconferences: bodies with appointed membership.

Description
SB 411, as introduced, Portantino. Open meetings: teleconferences: bodies with appointed membership. Existing law, the Ralph M. Brown Act, requires, with specified exceptions, that all meetings of a legislative body, as defined, of a local agency be open and public and that all persons be permitted to attend and participate. The act generally requires for teleconferencing that the legislative body of a local agency that elects to use teleconferencing post agendas at all teleconference locations, identify each teleconference location in the notice and agenda of the meeting or proceeding, and have each teleconference location be accessible to the public. Existing law also requires that, during the teleconference, at least a quorum of the members of the legislative body participate from locations within the boundaries of the territory over which the local agency exercises jurisdiction. The act provides an exemption to the jurisdictional requirement for health authorities, as defined.Existing law, until January 1, 2024, authorizes the legislative body of a local agency to use alternate teleconferencing provisions during a proclaimed state of emergency or in other situations related to public health that exempt a legislative body from the general requirements (emergency provisions) and impose different requirements for notice, agenda, and public participation, as prescribed. The emergency provisions specify that they do not require a legislative body to provide a physical location from which the public may attend or comment.Existing law, until January 1, 2026, authorizes the legislative body of a local agency to use alternative teleconferencing in certain circumstances related to the particular member if at least a quorum of its members participate from a singular physical location that is open to the public and situated within the agency's jurisdiction and other requirements are met, including restrictions on remote participation by a member of the legislative body.This bill would authorize a legislative body to use alternate teleconferencing provisions similar to the emergency provisions indefinitely and without regard to a state of emergency. The bill would alternatively define "legislative body" for this purpose to mean a board, commission, or advisory body of a local agency, the membership of which board, commission, or advisory body is appointed and which board, commission, or advisory body is otherwise subject to the act.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 w... (click bill link to see more).

Primary Sponsors
Anthony Portantino

Bill Number
SB 424

Status
In Senate

Position
Monitor

Title
California Children’s Services Program.

Description
SB 424, as amended, Durazo. California Children’s Services Program. (1) Existing law establishes the California Children’s Services (CCS) Program, administered by the State Department of Health Care Services and a designated agency of each county, to provide medically necessary services for persons under 21 years of age who have any of specified medical conditions and who meet certain financial eligibility requirements.Under existing law, CCS-eligible medical conditions include, among others, cystic fibrosis and hemophilia, and other conditions set forth by the Director of Health Care Services.This bill would statutorily expand the list of CCS-eligible medical conditions to include those conditions that are specified in existing CCS-related regulations. The bill would, commencing no later than January 1, 2026, and every 5 years thereafter, require the department to consult with, at a minimum, CCS medical directors and experts from the department’s CCS technical advisory committees, to consider the addition of other medical conditions to the list, by regulation. The bill would make conforming changes to related provisions.(2) This bill would, commencing on January 1, 2025, and subject to an appropriation, for a child who has an eligible medical condition, but who is not financially eligible for the CCS Program, require the department to provide financial assistance for out-of-pocket costs not covered by the child’s health care coverage, as specified, if those costs are for medically necessary services to treat a CCS-eligible medical condition. The bill would require the department to establish a procedure for providing that financial assistance.(3) This bill would require the department, on or before December 31 of each year, commencing on December 31, 2025, to provide an annual sustainability and access grant, under a certain formula, to each CCS-approved hospital that operates one or more CCS special care centers, as specified.For medically necessary treatments provided during the 2025 calendar year, the bill would require the department to adjust CCS payment rates for physician services, reflecting the cumulative effect of inflation, as specified. Under the bill, commencing on January 1, 2026, those payments would be updated annually to reflect the effect of inflation. Under the bill, the adjustments and updates would apply to both CCS payments made under the Medi-Cal program and CCS payments that are not made under the Medi-Cal program, as specified.For lifesaving specialty drugs, as defined, that are provided by a hospital on an inpatient basis, the bill would require the department to reimburse the hospital for the cost incurred by the hospital to acquire and administer the drug. Under the bill, the reimbursement wo... (click bill link to see more).

Primary Sponsors
Maria Durazo

Organizational Notes

Last edited by Joanne Campbell at Mar 29, 2023, 4:34 PM
Local Health Plans of California: Oppose Unless Amended

Bill Number
SB 427

Status
In Senate

Position
Monitor

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

Description
SB 427, as amended, Portantino. Health care coverage: antiretroviral drugs, devices, and 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 or health insurer from subjecting antiretroviral drugs that are medically necessary for the prevention of AIDS/HIV, 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 or health insurer from subjecting antiretroviral drugs, devices, or 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 AIDS/HIV 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 insurer provides coverage for a noncovered therapeutic equivalent antiretroviral drug, device, or product without cost sharing pursuant to an exception request. The bill 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 antiretroviral drugs, devices, or products that are either approved by the FDA or recommended by the CDC for the prevention of AIDS/HIV. The bill would require a grandfathered health care service plan contract or health insurance policy to provide coverage for those drugs, devices, or products, and would require a plan or insurer to provide coverage under the outpatient prescription drug benefit for those drugs, devices, or products, including by supplying participating providers directly with a drug, device, or product, 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 ... (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
SB 457

Status
In Senate

Position
Monitor

Title
Vision care: consent by a minor.

Description
SB 457, as amended, Menjivar. Vision care: consent by a minor. Existing law authorizes a minor 15 years of age or older to consent to the minor's medical care or dental care, if the minor is living separate and apart from the minor's parents or guardian and the minor is managing their own financial affairs, as specified. Existing law authorizes a physician and surgeon or dentist, with or without the minor's consent, to advise the minor's parent or guardian of the treatment given or needed if the physician and surgeon has reason to know the parent's or guardian's whereabouts, based on information given by the minor. Under existing law, a parent or guardian is not liable for care provided according to these provisions.This bill additionally would authorize minors to consent to their own vision care, and would authorize an optometrist to advise a minor's parent or guardian of the care given or needed, under the same conditions applicable to the provision of medical care and dental care. The bill would define "vision care" as the diagnosis, prevention, treatment, and management of disorders, diseases, and dysfunctions of the visual system and the provision of habilitative or rehabilitative optometric services by a licensed optometrist, as specified.

Primary Sponsors
Caroline Menjivar, Angelique Ashby

Bill Number	Status	Position
SB 496	**In Senate**	**Monitor**

Title
Biomarker testing.

Description
SB 496, as introduced, Limón. Biomarker testing. (1) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plan contract or health insurance policy issued, amended, delivered, or renewed on or after July 1, 2000, to provide coverage for all generally medically accepted cancer screening tests, and prohibits that contract or policy issued, amended, delivered, or renewed on or after July 1, 2022, from requiring prior authorization for biomarker testing for certain enrollees or insureds. Existing law applies the provisions relating to biomarker testing to Medi-Cal managed care plans, as prescribed.This bill would require a health care service plan contract or health insurance policy issued, amended, or renewed on or after July 1, 2024, to provide coverage for biomarker testing, including whole genome sequencing, for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's or insured's disease or condition to guide treatment decisions if the test is supported by medical and scientific evidence, as prescribed. The bill would specify that it does not require a health care service plan or health insurer to cover biomarker testing for screening purposes unless otherwise required by law. The bill would subject restricted use of biomarker testing for the purpose of diagnosis, treatment, or ongoing monitoring of a medical condition to state and federal grievance and appeal processes. This bill would apply these provisions relating to biomarker testing to the Medi-Cal program, including Medi-Cal managed care plans, as specified. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.(2) Existing law 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 Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law includes Rapid Whole Genome Sequencing as a covered benefit for any Medi-Cal beneficiary who is one year of age or younger and is receiving inpatient hospital services in an intensive care unit.Subject to the extent that federal financial participation is available and not otherwise jeopardized, and any necessary federal approvals have been obtained, this bill, by July 1, 2024, would expand... (click bill link to see more).

Primary Sponsors
Monique Limon

Organizational Notes

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

Bill Number
SB 502

Status
In Senate

Position
Monitor

Title
Medi-Cal: children: mobile optometric office.

Description
SB 502, as amended, Allen. Medi-Cal: children: mobile optometric office. 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, with specified coverage for eligible children and pregnant persons funded by the federal Children's Health Insurance Program (CHIP). Existing federal law authorizes a state to provide services under CHIP through a Medicaid expansion program, a separate program, or a combination program.Pursuant to existing law, the department established a 3-year pilot program, from 2015 through 2017, in the County of Los Angeles that enabled school districts to allow students enrolled in Medi-Cal managed care plans to receive vision care services at the schoolsite through the use of a mobile vision service provider, limited to vision examinations and providing eyeglasses.Existing law authorizes an applicant or provider that meets the requirements to qualify as a mobile optometric office to be enrolled in the Medi-Cal program as either a mobile optometric office or within any other provider category for which the applicant or provider qualifies. Existing law defines "mobile optometric office" as a trailer, van, or other means of transportation in which the practice of optometry is performed and which is not affiliated with an approved optometry school in the state. Under existing law, the ownership and operation of a mobile optometric office is limited to a nonprofit or charitable organization, as specified, with the owner and operator registering with the State Board of Optometry.This bill would require the department, subject to an appropriation, to file all necessary state plan amendments to exercise the option made available under CHIP provisions to cover vision services provided to low-income children statewide through a mobile optometric office, as specified.The bill would condition implementation of these provisions on receipt of any necessary federal approvals and the availability of federal financial participation. The bill would require implementation of these provisions by January 1, 2025, or the date that any necessary federal approvals have been obtained, whichever date is later. The bill would state the intent of the Legislature that General Fund moneys not be used for any future appropriation for these provisions.Existing law prohibits the owner and operator of a mobile optometric office and the optometrist providing services from accepting payment for services other than those provided to Medi-Cal beneficiaries.This bill would authorize acceptance of payment... (click bill link to see more).

Primary Sponsors
Ben Allen

Bill Number
SB 525

Status
In Senate

Position
Monitor

Title
Minimum wage: health care workers.

Description
SB 525, as amended, Durazo. Minimum wage: health care workers. Existing law generally requires the minimum wage for all industries to not be less than specified amounts to be increased until it is $15 per hour commencing January 1, 2022, for employers employing 26 or more employees and commencing January 1, 2023, for employers employing 25 or fewer employees. Existing law makes a violation of minimum wage requirements a misdemeanor.This bill would require a health care worker minimum wage of $25 per hour for hours worked in covered health care employment, as defined, subject to adjustment, as prescribed. The bill would provide that the health care worker minimum wage constitutes the state minimum wage for covered health care employment for all purposes under the Labor Code and the Wage Orders of the Industrial Welfare Commission. The health care worker minimum wage would be enforceable by the Labor Commissioner or by a covered worker through a civil action, through the same means and with the same relief available for violation of any other state minimum wage requirement. By establishing a new minimum wage, the violation of which would be a crime, the bill would impose a state-mandated local program.This bill would require, for covered health care employment where the employee is paid on a salary basis, that the employee earn a monthly salary equivalent to no less than 2 times the health care worker minimum wage for full-time employment in order to qualify as exempt from the payment of minimum wage and overtime.This bill would make legislative findings and declarations as to the necessity of a special statute for health care workers.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
Maria Durazo

Bill Number
SB 535

Status
In Senate

Position
Monitor

Title
Knox-Keene Health Care Service Plan Act of 1975.

Description
SB 535, as introduced, Nguyen. Knox-Keene Health Care Service Plan Act of 1975. 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. Among other provisions, existing law requires a health care service plan to meet specified requirements, including, but not limited to, furnishing services in a manner providing continuity of care, ready referral of patients to other providers at appropriate times, and making services readily accessible to all enrollees, as specified.This bill would make technical, nonsubstantive changes to those provisions.

Primary Sponsors
Janet Nguyen

Bill Number	Status	Position
SB 537	**In Senate**	**Monitor**

Title

Open meetings: local agencies: teleconferences.

Description

SB 537, as amended, Becker. 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, 2024, authorizes the legislative body of a local agency to use alternate teleconferencing provisions during a proclaimed state of emergency or in other situations related to public health that exempt a legislative body from the general requirements (emergency provisions) and impose different requirements for notice, agenda, and public participation, as prescribed. The emergency provisions specify that they do not require a legislative body to provide a physical location from which the public may attend or comment.Existing law, until January 1, 2026, authorizes the legislative body of a local agency to use alternative teleconferencing in certain circumstances related to the particular member if at least a quorum of its members participate from a singular physical location that is open to the public and situated within the agency's jurisdiction and other requirements are met, including restrictions on remote participation by a member of the legislative body. These circumstances include if a member shows "just cause," including for a childcare or caregiving need of a relative that requires the member to participate remotely. This bill would authorize certain legislative bodies to use alternate teleconferencing provisions similar to the emergency provisions indefinitely and without regard to a state of emergency. The bill would also require a legislative body to provide a record of attendance on its internet website within 7 days after a teleconference meeting, as specified. The bill would define "legislative body" for this purpose to mean a board, commission, or advisory body of a multijurisdictional cross county agency, the membership of which board, commission, or advisory body is appointed and which board, commission, or advisory body ... (click bill link to see more).

Primary Sponsors

Josh Becker

Bill Number
SB 541

Status
In Senate

Position
Monitor

Title
Sexual health: contraceptives: immunization.

Description
SB 541, as amended, Menjivar. Sexual health: contraceptives: immunization. (1) Existing law, the California Healthy Youth Act, requires school districts, defined to include county boards of education, county superintendents of schools, the California School for the Deaf, the California School for the Blind, and charter schools, to ensure that all pupils in grades 7 to 12, inclusive, receive comprehensive sexual health education and human immunodeficiency virus (HIV) prevention education, as specified.This bill would, in order to prevent and reduce unintended pregnancies and sexually transmitted infections, on or before the start of the 2024–25 school year, require each public school, including schools operated by a school district or county office of education and charter schools, to make internal and external condoms available to all pupils in grades 9 to 12, inclusive, free of charge, as provided. The bill would require these public schools to, at the beginning of each school year, inform pupils through existing school communication channels that free condoms are available and where the condoms can be obtained on school grounds. The bill would require a public school to post at least one notice regarding these requirements, as specified. The bill would require this notice to include certain information, including, among other information, information about how to use condoms properly. The bill would require each public school serving any of grades 7 to 12, inclusive, to allow the distribution of condoms during the course of, or in connection with, educational or public health programs and initiatives, as provided. The bill would authorize a state agency, the State Department of Education, or a public school to accept gifts, grants, and donations from any source for the support of a public school carrying out these provisions, including, but not limited to, the acceptance of condoms from a manufacturer or wholesaler. By imposing additional duties on public schools, the bill would impose a state-mandated local program. The bill would additionally prohibit a public school, as defined, maintaining any combination of classrooms from grades 7 to 12, inclusive, from prohibiting a school-based health center, as defined, from making internal and external condoms available and easily accessible to pupils.(2) Under existing law, the Sherman Food, Drug, and Cosmetic Law, the State Department of Public Health generally regulates the packaging, labeling, advertising, and sale of food, drugs, devices, and cosmetics, in accordance with the Federal Food, Drug, and Cosmetic Act. A violation of those provisions is generally a crime. Existing law sets forth various other provisions relating to the furnishing and health care co... (click bill link to see more).

Primary Sponsors
Caroline Menjivar

Bill Number
SB 582

Status
In Senate

Position
Monitor

Title
Health records: EHR vendors.

Description
SB 582, as introduced, Becker. Health records: EHR vendors. Existing law establishes the California Health and Human Services Agency (CHHSA), which includes departments charged with administration of health, social, and human services. Existing law establishes the California Health and Human Services Data Exchange Framework that includes a single data sharing agreement and common set of policies and procedures that govern and require the exchange of health information among health care entities and government agencies in California. Existing law requires specified entities to execute the framework data sharing agreement on or before January 31, 2023. This bill would require EHR vendors, as defined, to execute the framework data sharing agreement on or before July 1, 2024. The bill would require any fees charged by an EHR vendor to enable compliance with the framework to comply with specified federal regulations and would require the agency to develop a process for signatories to report if the EHR vendor fees are not in compliance.

Primary Sponsors
Josh Becker

Bill Number
SB 595

Status
In Senate

Position
Monitor

Title

Covered California: data sharing.

Description

SB 595, as amended, Roth. Covered California: data sharing. 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 (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, beginning no later than September 1, 2023, and at least monthly thereafter, to request from the Employment Development Department (EDD) specified information of each new applicant for unemployment compensation, state disability, and paid family leave. Existing law requires the EDD to provide that information in a manner prescribed by the Exchange. Existing law requires the Exchange to market and publicize the availability of health care coverage through the Exchange, and engage in outreach activities, to the individuals whose contact information is received by the Exchange from the EDD, as specified. Existing law prohibits the Exchange from disclosing the personal information obtained from the EDD without the consent of the applicant.This bill would specifically apply that prohibition to the disclosure of personal information by the Exchange to a certified insurance agent or a certified employment counselor. The bill would require a person or entity that receives personal information from the Exchange pursuant to these provisions to at all times take reasonable measures to safeguard the confidentiality of any personal information obtained from the Exchange and would prohibit a person or entity from using or disclosing that information for any purpose other than to market and publicize the availability of health care coverage through the Exchange to individuals, as directed by the Exchange. The bill also would make a technical change to a related provision.

Primary Sponsors

Richard Roth

Bill Number	Status	Position
SB 598	In Senate	Monitor

Title
Health care coverage: prior authorization.

Description
SB 598, as amended, Skinner. Health care coverage: prior authorization. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law generally authorizes a health care service plan or health insurer to use prior authorization and other utilization review or utilization management functions, under which a licensed physician or a licensed health care professional who is competent to evaluate specific clinical issues may approve, modify, delay, or deny requests for health care services based on medical necessity. Existing law requires a health care service plan or health insurer, including those plans or insurers that delegate utilization review or utilization management functions to medical groups, independent practice associations, or to other contracting providers, to comply with specified requirements and limitations on their utilization review or utilization management functions. Existing law requires the criteria or guidelines used to determine whether or not to authorize, modify, or deny health care services to be developed with involvement from actively practicing health care providers.On or after January 1, 2025, this bill would prohibit a health care service plan or health insurer from requiring a contracted health professional to complete or obtain a prior authorization for any covered health care services if the plan or insurer approved or would have approved not less than 90% of the prior authorization requests they submitted in the most recent one-year contracted period. The bill would set standards for this exemption and its denial, rescission, and appeal. The bill would authorize a plan or insurer to evaluate the continuation of an exemption not more than once every 12 months, and would authorize a plan or insurer to rescind an exemption only at the end of the 12-month period and only if specified criteria are met. Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.The California 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
Nancy Skinner

Organizational Notes

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

Bill Number
SB 607

Status
In Senate

Position
Monitor

Title
Self-funded student health care coverage.

Description
SB 607, as introduced, Portantino. Self-funded student 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 provides for the regulation of health insurers by the Department of Insurance. Under existing law, specified persons are exempt from that regulation by the Department of Managed Health Care or the Department of Insurance.This bill would authorize a student health plan operated by a bona fide, private, nonprofit institution of higher learning to operate in California if the institution files a yearly report with the Director of the Department of Managed Health Care that certifies specified information under penalty of perjury. The bill would exempt a student health plan that complies with those requirements from other regulation by the Department of Managed Health Care or the Department of Insurance, except as specified. By expanding the crime of perjury, 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.This bill would declare that it is to take effect immediately as an urgency statute.

Primary Sponsors
Anthony Portantino

Bill Number
SB 621

Status
In Senate

Position
Monitor

Title
Health care coverage: biosimilar drugs.

Description
SB 621, as introduced, Caballero. Health care coverage: biosimilar drugs. 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 authorizes a health care service plan or health insurer that provides coverage for prescription drugs to require step therapy if there is more than one drug that is clinically appropriate for the treatment of a medical condition. Existing law does not prohibit a plan, insurer, or utilization review organization from requiring an enrollee or insured to try an AB-rated generic equivalent or interchangeable biological product before providing coverage for the equivalent branded prescription drug.This bill would specify that a plan, insurer, or utilization review organization is also not prohibited from requiring an enrollee or insured to try a biosimilar before providing coverage for the equivalent branded prescription drug.

Primary Sponsors
Anna Caballero

Bill Number
SB 667

Status
In Senate

Position
Monitor

Title
Healing arts: pregnancy and childbirth.

Description
SB 667, as amended, Dodd. Healing arts: pregnancy and childbirth. (1) Existing law, the Nursing Practice Act, establishes the Board of Registered Nursing within the Department of Consumer Affairs for the licensure and regulation of the practice of nursing. A violation of the act is a crime. Existing law requires the board to issue a certificate to practice nurse-midwifery to a person who meets specified qualifications. Existing law authorizes a certified nurse-midwife to attend cases of low-risk pregnancy and childbirth and to provide prenatal, intrapartum, and postpartum care, including interconception care, family planning care, and immediate care for the newborn, as specified. Existing law authorizes a certified nurse-midwife to practice with a physician and surgeon under mutually agreed-upon policies and protocols, as specified, to provide a patient with care outside of that scope of services or to provide intrapartum care to a patient who has had a prior cesarean section or surgery that interrupts the myometrium.This bill would revise and recast those provisions to, among other things, authorize a certified nurse-midwife, pursuant to policies and protocols that are mutually agreed upon with a physician and surgeon, as specified, to provide a patient with care outside of that scope of services or to provide intrapartum care to a patient who has had a prior cesarean section or surgery that interrupts the myometrium. The bill would include care for common gynecologic conditions, as specified, in the scope of services a certified nurse-midwife is authorized to perform without policies and protocols that are mutually agreed upon with a physician and surgeon. The bill would additionally authorize a hospital, as defined, to grant privileges to a certified nurse-midwife, allowing them to admit and discharge patients upon their own authority if in accordance with the bylaws of that facility and within the nurse-midwife’s scope of practice.Existing law generally authorizes a certified nurse-midwife to furnish drugs or devices incidentally to the provision of care and services described above that the certified nurse-midwife is authorized to perform and care rendered to persons within certain settings, subject to specified requirements and exceptions. Among those requirements is that a certified nurse-midwife follow standardized procedures or protocols if they furnish or order Schedule IV or V controlled substances or drugs or devices for services other than attending cases of low-risk pregnancy and childbirth or providing prenatal, intrapartum, and postpartum care, as specified. Existing law requires those standardized procedures or protocols to specify which nurse-midwife is authorized to furnish or order drugs or de... (click bill link to see more).

Primary Sponsors
Bill Dodd

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 5:48 PM
Local Health Plans of California: Support

Bill Number
SB 694

Status
In Senate

Position
Monitor

Title
Medi-Cal: self-measured blood pressure devices and services.

Description
SB 694, as introduced, Eggman. Medi-Cal: self-measured blood pressure devices and 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 sets forth a schedule of benefits under the Medi-Cal program, including pharmacy benefits (Medi-Cal Rx) and durable medical equipment. The department announced that, effective June 1, 2022, personal home blood pressure monitoring devices, and blood pressure cuffs for use with those devices, are a covered benefit under Medi-Cal Rx as a pharmacy-billed item.This bill would make self-measured blood pressure (SMBP) devices and SMBP services, as defined, covered benefits under the Medi-Cal program for the treatment of high blood pressure. The bill would state the intent of the Legislature that those covered devices and services be consistent in scope with devices and services that are recognized under specified existing billing codes or their successors. The bill would condition implementation of that coverage on receipt of any necessary federal approvals and the availability of federal financial participation.

Primary Sponsors
Susan Eggman

Bill Number	Status	Position
SB 717	In Senate	Monitor

Title

County mental health services.

Description

SB 717, as introduced, Stern. County mental health services. Existing law prohibits a person from being tried or adjudged to punishment while that person is mentally incompetent. If a defendant who has been charged with a misdemeanor has been determined to be mentally incompetent, existing law authorizes the court to either grant diversion for a period of one year, refer the defendant to treatment, or dismiss the charge.Existing law, the Bronzan-McCorquodale Act, governs the organization and financing of community mental health services for persons with mental disorders in every county through locally administered and locally controlled community mental health programs.This bill would require a county behavioral health department to maintain contact for 180 days with, and offer mental health services to, an individual charged with a misdemeanor who has been found incompetent to stand trial and who is not receiving court directed services. By creating new requirements for county behavioral health departments, 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

Henry Stern

Bill Number
SB 729

Status
In Senate

Position
Monitor

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

Description
SB 729, as introduced, 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 health insurers by the Department of Insurance. Existing law imposes various requirements and restrictions on health care service plans and health insurers, including, among other things, a requirement that every group health care service plan contract or health 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 a health care service plan contract or health insurance policy that is issued, amended, or renewed on or after January 1, 2024, to provide coverage for the diagnosis and treatment of infertility and fertility services. 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 health 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 health 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. With respect to a health care service plan, the bill would not apply to Medi-Cal managed care health care service plan contracts or any entity that enters into a contract with the State Department of Health Care Services for the delivery of health care services pursuant to specified provisions. 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 730	**In Senate**	**Monitor**

Title
Home care aides.

Description
SB 730, as amended, Ochoa Bogh. Home care aides. Existing law, the Home Care Services Consumer Protection Act, provides for the licensure and regulation of home care organizations by the State Department of Social Services and for the registration of home care aides. Existing law authorizes a registered home care aide to provide certain home care services and assistance to a client, including assisting with medication that the client self-administers.This bill would authorize a registered home care aide to read the client's blood pressure and body temperature, as specified. The bill would specify that authorized home care services include taking a reading of the client's digital blood pressure, body temperature, or oxygen level from a device provided by the client and reporting the reading to the client's nurse, doctor, or family representative and assisting the client with emptying their colostomy bag, catheter bag, or urostomy bag. The bill would clarify that a home care aide may assist with medication that the client self-administers by opening the container, filling the medication pill box organizer, ensuring that the client is aware of the written medication instructions, and assisting the client in the application of topical medication, as specified.

Primary Sponsors
Rosilicie Ochoa Bogh

Bill Number	Status	Position
SB 759	**In Senate**	**Monitor**

Title
Hospitals: seismic safety.

Description
SB 759, as amended, Grove. Hospitals: seismic safety. 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, a program of seismic safety building standards for certain hospitals constructed on and after March 7, 1973. Existing law requires, by January 1, 2030, owners of all acute care inpatient hospitals to either seismically retrofit all acute care inpatient hospitals, or demolish, replace, or change to nonacute care use all hospital buildings not in substantial compliance with regulations and standards developed by the department in accordance with the act, as specified.This bill would extend the deadline to January 1, 2040, and would make conforming changes related to the deadline extension.

Primary Sponsors
Shannon Grove

Bill Number	Status	Position
SB 765	In Senate	Monitor

Title
Teachers: retired teachers: teacher preparation: student financial aid.

Description
SB 765, as amended, Portantino. Teachers: retired teachers: teacher preparation: student financial aid. (1) Existing law, the Teachers' Retirement Law, establishes the State Teachers' Retirement System (STRS) and creates the Defined Benefit Program of the State Teachers' Retirement Plan, which provides a defined benefit to members of the program, based on final compensation, credited service, and age at retirement, subject to certain variations. Under existing law, STRS is governed by the Teachers' Retirement Board.Existing law permits members retired for service from STRS to perform retired member activities without reinstatement into the system if certain conditions are met. Existing law, however, requires payment for the performance of retired member activities to be $0 during the first 180 calendar days after the most recent retirement of a retired member, unless certain conditions are met.This bill would authorize a member retired from service to perform retired member activities, notwithstanding the above-mentioned 180 calendar days compensation limitation, if a request for exemption containing specified information is submitted to the system, as prescribed. This bill's authorization to perform retirement member activities does not apply if a member has not attained a normal retirement age, if the member's termination of employment is the basis for the need to acquire the services of the member, or if a member received additional service credit or any financial inducement to retire.Existing law limits the postretirement compensation of a member of the Defined Benefit Program of the Teachers' Retirement Plan to an amount calculated by STRS, as specified. If the member's postretirement compensation exceeds this amount, the law requires the member's retirement allowance to be reduced by the amount of excess compensation. Existing law, however, permits members retired for service from STRS to perform retired member activities, as defined, without being subject to the compensation limit under certain limited conditions and circumstances.This bill would, until June 30, 2026, exempt a retired member, who has returned to work after retirement to fulfill a critical need in a teaching position, as defined, from the postretirement compensation limitation, as specified. The bill would require an employer to submit specified documentation, certified under penalty of perjury, to substantiate a retired member's eligibility. By expanding the crime of perjury, the bill would impose a state-mandated local program.This bill would prohibit a retired member from performing retired member activities until after the employer has submitted the specified documentation to the system. The bill's exemption to existing law's postre... (click bill link to see more).

Primary Sponsors
Anthony Portantino

Bill Number
SB 770

Status
In Senate

Position
Monitor

Title
Health care: unified health care financing.

Description
SB 770, as amended, Wiener. Health care: unified health care financing. Prior state law established the Healthy California for All Commission for the purpose of developing a plan towards the goal of achieving a health care delivery system in California that provides coverage and access through a unified health care financing system for all Californians, including, among other options, a single-payer financing systemThis bill would direct the Secretary of the California Health and Human Services Agency to pursue waiver discussions with the federal government with the objective of a unified health care financing system that incorporates specified features and objectives, including, among others, a comprehensive package of medical, behavioral health, pharmaceutical, dental, and vision benefits, and the absence of cost sharing for essential services and treatments. The bill would further require the secretary to establish a Waiver Development Workgroup comprised of members appointed by the Governor, Speaker of the Assembly, and President Pro Tempore of the Senate, as specified. The bill would require the workgroup to include stakeholders representing various specified interests, including consumers, patients, health care professionals, labor unions, government agencies, and philanthropic organizations. The bill would require the secretary to provide quarterly reports to the chairs of the Assembly and Senate Health Committees on the status and outcomes of waiver discussions with the federal government and the progress of the workgroup. The bill would also require the secretary to submit a complete set of recommendations regarding the elements to be included in a formal waiver application, as specified, by no later than June 1, 2024. The bill would also include findings and declarations of the Legislature related to the implementation of a unified health care financing system.

Primary Sponsors
Scott Wiener, Mike McGuire

Organizational Notes

Last edited by Joanne Campbell at Mar 27, 2023, 6:17 PM
California Association of Health Plans: Oppose

Bill Number	Status	Position
SB 774	**In Senate**	**Monitor**

Title

Nonprofit health facilities: sale of assets: Attorney General approval: conditional consent.

Description

SB 774, as introduced, Jones. Nonprofit health facilities: sale of assets: Attorney General approval: conditional consent. Existing law requires a nonprofit corporation, as defined, that operates or controls a health facility, as defined, or operates or controls a facility that provides similar health care to provide written notice to, and obtain the written consent of, the Attorney General prior to selling or otherwise disposing of a material amount of its assets to a for-profit corporation or entity, to a mutual benefit corporation or entity, or to another nonprofit corporation or entity. Existing law provides that the Attorney General has discretion to give consent to, give conditional consent to, or to not consent to, the agreement or transaction and requires the Attorney General to consider any factors they deem relevant, including, but not limited to, whether the terms are fair and reasonable.This bill would prohibit the Attorney General from giving conditional consent to any above-described agreement or transaction upon any condition or conditions that, individually or in aggregate, would reasonably be expected to, among other things, impose conditions that are unique to the selling nonprofit corporation, and are distinct from conditions that similarly situated selling nonprofit corporations are required to maintain or perform.

Primary Sponsors

Brian Jones, Shannon Grove

Bill Number	Status	Position
SB 779	**In Senate**	**Monitor**

Title
Primary Care Clinic Data Modernization Act.

Description
SB 779, as amended, Stern. Primary Care Clinic Data Modernization Act. Existing law provides for the licensure and regulation of clinics, including primary care clinics, by the State Department of Public Health. A violation of these provisions is a crime. Existing law excludes certain facilities from those provisions, including a clinic that is operated by a primary care community or free clinic and that is operated on separate premises from the licensed clinic and is only open for limited services of no more than 40 hours a week, also referred to as an intermittent clinic.Existing law imposes various reporting requirements on clinics, including requiring a clinic to provide a verified report to the Department of Health Care Access and Information including information relating to the previous calendar year, such as the number of patients served and specified descriptive information, medical and other health services provided, total clinic operating expenses, and gross patient charges by payer category. Existing law specifies that the reporting requirements apply to all primary care clinics.This bill would revise those reporting requirements, including specifying the type of descriptive information required to be reported. The bill would extend application of the reporting requirements to intermittent clinics, as specified.Existing law requires the Department of Health Care Access and Information to be the single state agency designated to collect certain health facility or clinic data for use by all state agencies, as prescribed. The bill would require an organization that operates, conducts, owns, or maintains a primary care clinic or intermittent clinic, and its officers, to file specified reports with the Department of Health Care Access and Information for every primary care clinic and every intermittent clinic that it operates, conducts, owns, or maintains, on or before the 15th day of February each year, including, but not limited to, the percentage of all revenue spent on workforce expenditures, as specified, a report of all mergers and acquisitions, and a report of quality and equity measures. The bill would impose specified civil penalties on a primary care clinic or intermittent clinic that fails to file a required report pursuant to the bill's requirements. The bill would authorize a clinic affected by a determination made pursuant to the bill's requirements to petition the department for a review of the decision, and would further provide for judicial review of any final action by the department, as specified. The bill would authorize the department to adopt regulations necessary to implement these reporting requirements.Because a violation of certain provisions of the bill by a primary care clinic or in... (click bill link to see more).

Primary Sponsors
Henry Stern

Bill Number
SB 784

Status
In Senate

Position
Monitor

Title
Health care districts: employment.

Description
SB 784, as amended, Becker. Health care districts: employment. Existing law, the Medical Practice Act, restricts the employment of physicians and surgeons or doctors of podiatric medicine by a corporation or other artificial legal entity to entities that do not charge for professional services rendered to patients and are approved by the Medical Board of California, subject to specified exemptions. Existing law, the Local Health Care District Law, regulates the organization and management of health care districts.This bill would create an exemption to the general prohibition described above by authorizing health care districts and nonprofit corporations with a health care district as its sole corporate member that own or control a general acute care hospital to employ physicians and surgeons and charge for professional services. The bill would prohibit the health care district from interfering with, controling, or otherwise directing the professional judgment of a physician or surgeon as proscribed.

Primary Sponsors
Josh Becker

Bill Number
SB 786

Status
In Senate

Position
Monitor

Title
Prescription drug pricing.

Description
SB 786, as amended, Portantino. Prescription drug pricing. Existing federal law requires the United States Secretary of Health and Human Services to enter into an agreement with each manufacturer of covered outpatient drugs to ensure the amount a covered entity is required to pay for those drugs does not exceed the average manufacturer price of the drug under the federal Medicaid program. Existing state law requires a covered entity to dispense only drugs subject to these federal pricing requirements to Medi-Cal beneficiaries. Existing law defines a “covered entity” to include a federally qualified health center and entities receiving specified grants and federal funding.This bill would prohibit a pharmacy benefit manager from discriminating against a covered entity or its pharmacy in connection with dispensing a drug subject to federal pricing requirements or preventing a covered entity from retaining the benefit of discounted pricing for those drugs.

Primary Sponsors
Anthony Portantino

Bill Number	Status	Position
SB 805	**In Senate**	**Monitor**

Title
Health care coverage: pervasive developmental disorders or autism.

Description
SB 805, as amended, Portantino. Health care coverage: pervasive developmental disorders or autism. 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 contract or a health insurance policy to provide coverage for behavioral health treatment for pervasive developmental disorder or autism, and defines “behavioral health treatment” to mean specified services and treatment programs, including treatment provided pursuant to a treatment plan that is prescribed by a qualified autism service provider and administered either by a qualified autism service provider or by a qualified autism service professional or qualified autism service paraprofessional who is supervised as specified. Existing law defines a “qualified autism service professional” to refer to a person who meets specified educational, training, and other requirements and is supervised and employed by a qualified autism service provider. Existing law defines a “qualified autism service paraprofessional” to mean an unlicensed and uncertified individual who meets specified educational, training, and other criteria, is supervised by a qualified autism service provider or a qualified autism service professional, and is employed by the qualified autism service provider.This bill would expand the criteria for a qualified autism service professional to include a behavioral health professional and a registered, certified, or licensed health care associate or assistant, as specified. The bill would expand the criteria for a qualified autism service paraprofessional to include a behavioral health paraprofessional, as specified.Existing law, the Lanterman Developmental Disabilities Services Act, requires the State Department of Developmental Services to contract with regional centers to provide services and supports to individuals with developmental disabilities and their families. Existing law defines developmental disability for these purposes to include, among other things, autism. This bill would require the department to adopt emergency regulations to address the use of behavioral health professionals and behavioral health paraprofessionals in group practice provider behavioral intervention services. The bill would require the department to establish rates and the educational or experiential qualifications and professional supervision requirements necessary for these positions to provide behavioral intervention services, as specified. Because a wil... (click bill link to see more).

Primary Sponsors
Anthony Portantino

Bill Number
SB 819

Status
In Senate

Position
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
SB 839

Status
In Senate

Position
Monitor

Title
Obesity Treatment Parity Act.

Description
SB 839, as amended, Bradford. Obesity Treatment Parity Act. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of disability and health insurers by the Department of Insurance. Existing law sets forth specified coverage requirements for plan contracts and insurance policies, and limits the copayment, coinsurance, deductible, and other cost sharing that may be imposed for specified health care services.This bill would require an individual or group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to include comprehensive coverage for the treatment of obesity in the same manner as any other illness, condition, or disorder for purposes of determining deductibles, lifetime dollar limits, copayment and coinsurance factors, and benefit year maximums for deductibles and copayment and coinsurance factors.Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Steve Bradford

Organizational Notes

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

Bill Number
SB 842

Status
In Senate

Position
Monitor

Title
California Interagency Council on Homelessness.

Description
SB 842, as introduced, Jones. California Interagency Council on Homelessness. Existing law requires the Governor to establish the California Interagency Council on Homelessness, and requires the council to, among other things, identify mainstream resources, benefits, and services that can be accessed to prevent and end homelessness in California, and promote systems integration to increase efficiency and effectiveness while focusing on designing systems to address the needs of people experiencing homelessness. Existing law sets forth the composition of the council, which includes, among others, the Secretary of Business, Consumer Services, and Housing and the Secretary of California Health and Human Services, who serve as cochairs of the council.This bill would add the Director of Developmental Services to the council described above.This bill would declare that it is to take effect immediately as an urgency statute.

Primary Sponsors
Brian Jones

Bill Number
SB 870

Status
In Senate

Position
Monitor

Title
Medi-Cal: managed care organization provider tax.

Description
SB 870, as amended, Caballero. 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, inoperative on January 1, 2023, and to be repealed on January 1, 2024, imposed a managed care organization (MCO) provider tax, administered and assessed by the department, on licensed health care service plans and managed care plans contracted with the department to provide full-scope Medi-Cal services. Those provisions set forth taxing tiers and corresponding per enrollee tax amounts for the 2019–20, 2020–21, and 2021–22, fiscal years, and the first 6 months of the 2022–23 fiscal year. Under those provisions, all revenues, less refunds, derived from the tax were deposited into the State Treasury to the credit of the Health Care Services Special Fund, and continuously appropriated to the department for purposes of funding the nonfederal share of Medi-Cal managed care rates, as specified.Those inoperative provisions authorized the department, subject to certain conditions, to modify or make adjustments to any methodology, tax amount, taxing tier, or other provision relating to the MCO provider tax to the extent the department deemed necessary to meet federal requirements, to obtain or maintain federal approval, or to ensure federal financial participation was available or was not otherwise jeopardized. Those provisions required the department to request approval from the federal Centers for Medicare and Medicaid Services (CMS) as was necessary to implement those provisions. In April 2020, CMS approved a modified tax structure that the department had submitted as part of a waiver request, involving taxing tiers that were based on cumulative Medi-Cal or other member months for certain fiscal years.This bill would extend the above-described MCO provider tax to an unspecified date and would make conforming changes to the timeline of related provisions by incorporating other unspecified dates. The bill would reorganize the taxing tiers of the MCO provider tax, in a manner consistent with the above-described modified tax structure under the previous waiver, but with unspecified tax rate amounts. By extending the authority to fund the nonfederal share of Medi-Cal managed care rates from the continuously appropriated fund, the bill would make an appropriation.This bill would make these provisions inope... (click bill link to see more).

Primary Sponsors
Anna Caballero

Bill Number
SB 873

Status
In Senate

Position
Monitor

Title
Prescription drugs: cost sharing.

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

Primary Sponsors
Steve Bradford

Organizational Notes

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

Bill Number	Status	Position
SB 875	In Senate	Monitor

Title

Referral source for residential care facilities for the elderly: duties.

Description

SB 875, as amended, Glazer. Referral source for residential care facilities for the elderly: duties. The California Residential Care Facilities for the Elderly Act generally requires the State Department of Social Services to license, inspect, and regulate residential care facilities for the elderly and imposes criminal penalties on a person who violates the act or who willfully or repeatedly violates any rule or regulation adopted under the act. The act prohibits a placement agency, as defined, from placing an individual in a licensed residential care facility for the elderly if the individual, because of a health condition, cannot be cared for within the limits of the license or requires inpatient care in a health facility. The act requires an employee of a placement agency who knows, or reasonably suspects, that a facility is improperly operating without a license to report the facility to the department, and requires the department to investigate those reports. The act further requires a placement agency to notify the appropriate licensing agency of any known or suspected incidents that would jeopardize the health or safety of residents in a facility. The act specifically makes a violation of these requirements a crime.This bill additionally would impose requirements for referral sources, defined to mean any specified county department, stated-funded program, entity, or person that is engaged in identifying senior housing options at residential care facilities for the elderly. The bill would require a referral source, before sending a compensated referral, as defined, to a residential care facility for the elderly, to provide a person or their representative with specific written, electronic, or verbal disclosures that include, among others, the referral source's privacy policy. The bill would additionally require a compensated referral source to comply with additional requirements that include, among others, maintaining a minimum amount of liability insurance coverage. The bill would impose civil penalties for a violation of these provisions, as specified, in addition to any other remedy available by law.

Primary Sponsors

Steve Glazer

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Board of Governors
MOTION SUMMARY

Date: May 4, 2023 **Motion No. EXE 102.0523**

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

Issue: Establish the Provider Relations Advisory Committee

Background: At the April 6 Board Meeting, Board Member and Los Angeles County Supervisor Hilda Solis requested that the Board direct staff to review the process and requirements for the Board to establish the "Provider Relations Advisory Committee". She suggested that the Committee's purposes would include:

- identifying and informing the Board of the challenges affecting providers in Los Angeles County,
- considering opportunities to mitigate those challenges, and
- making recommendations to the Board.

Board Member Supervisor Solis requested that staff review and make recommendations concerning the potential appointment of Board Member George Greene as Chair of the Committee, and appointing other potential members to include other board members, Los Angeles County providers and other individuals, as appropriate. Staff recommendations should also include any other issues as designated in L.A. Care's bylaws and other applicable governing sources or law. Board Member Greene accepted the role of Chairperson of this Committee.

Suggestions at the meeting included:

- that this Committee would report to the Board on a regular basis in the same manner as other committees report at the Board meetings, and there will be a routine item on the Agenda,
- that the new Committee could provide specific suggestions on the dashboard metrics to align the measurements with the needs of providers, although some things may be considered proprietary and consideration will be made for L.A. Care's capacity to provide some metrics. The dashboards will be developed to recognize the nuances of the issues that individual providers and hospitals may have, keeping the beneficiaries at the center of discussions to determine opportunities for improvement in the delivery and quality of health care,
- that staff make a recommendation about the resources that may be needed to support the work of the Committee,
- that L.A. Care has a role in fostering collaboration across the spectrum of providers that serve L.A. Care's members, including Plan Partners.

Member Impact: The PRAC will advise the Board on potential actions that L.A. Care can take to improve services to members by developing deeper understanding and stronger relationships with all providers.

Budget Impact: No Budget impact.

Motion:

To establish a Provider Relations Advisory Committee ("Committee") to function as a committee of the Board of Governors ("Board") with its first regular meeting to be held in June 2023 or as soon thereafter as possible. The Committee will develop a Committee Charter that includes, but is not limited to:

- **identifying and informing the Board of challenges affecting providers in Los Angeles County**
- **recommending opportunities to mitigate those challenges,**
- **reporting to the Board regularly on progress made toward achieving its objectives,**
- **recommending to the Board the number and qualifications of Committee members, scope of matters on which Committee will review,**
- **recommending parameters for the conduct of proceedings, and**
- **Board Member George Greene shall serve as founding Chairperson.**

Founding Committee members may include Board members, Los Angeles County providers and others. Committee members will be recommended by John Baackes, *Chief Executive Officer,* and Committee Chairperson Greene, and shall be appointed by the Chairperson of the Board.

April 17, 2023

To: John Baackes, CEO

From: Augustavia Haydel, Esq., *General Counsel*
Linda Merkens, *Senior Manager, Board Services*

Subject: Establishing a Provider Relations Advisory Committee

Background
This memo is in response to a request from the Board on April 6, 2023 to:

- Review the process and requirements for the Board to establish the Provider Relations Advisory Committee (PRAC).
- Review and make recommendations concerning the potential appointment of George Greene as Chairperson of the Committee, and appointing other potential members to include other board members, Los Angeles County providers and other individuals, as appropriate, and
- Review and make recommendations concerning any other issues as designated in L.A. Care's bylaws and other applicable governing sources or law.

Below is a list of the categories of provider stakeholders in L.A. Care's enabling legislation to be included on the L.A. Care Board of Governors and other L.A. Care committees, to provide ideas for the stakeholders that might be included in the Committee.

Recommended Next Steps
Board Member Supervisor Solis made a motion at the April 6 L.A. Care Board of Governors' meeting. Below are recommended next steps to implement Board Supervisor Solis' proposed action, which was endorsed by Board Members:

1. Staff will place an item on the April 26 Executive Committee meeting Agenda.
2. The Executive Committee can discuss the proposal and approve a motion that will then be placed on the Agenda for the May Board of Governors meeting (a draft motion is attached).
3. Staff will prepare for the first meeting of the Committee to be held in June, once the Board action to create the Committee is completed.
4. Mr. Baackes and PRAC Chairperson Board Member Greene will solicit and recommend members of the Committee for appointment by the Chairperson of the Board of Governors. The PRAC member appointments will be made by the Chairperson, in accordance with the Bylaws. The appointment of individuals to the PRAC do not need any further action by the Board of Governors.
5. Meetings will be conducted in accordance with L.A. Care's Bylaws and applicable law. At its first meeting, the PRAC shall establish:
   a. Meeting schedule and location (schedule will then be approved by the Board),

   b. Draft purpose and goals to be achieved by the Committee in accordance with the board's direction in its motion to establish the Committee,
   c. Guidance for metrics to determine progress in the goals to be achieved.
6. Board Services will support the meetings of the PRAC in the same way as all Board committees are supported, which includes maintaining a schedule of meetings, planning the agenda, a roster of members, notice of the meetings to participants, agendas, meeting summaries, and logistics for the meetings.

Attached is a draft motion to establish a Provider Relations Advisory Committee for consideration by the Executive Committee on April 26: The draft motion includes the initial scope that was set out in the motion. Here is the motion recorded in the April 6 Board meeting minutes (there was no action on this proposed motion language):
Motion

> It is moved that the L.A. Care Board of Governors establish an advisory committee designated as the "Provider Relations Advisory Committee" for the purposes of identifying and informing the Board of the challenges affecting providers in Los Angeles County, considering opportunities to mitigate those challenges, and making recommendations to the Board. It is further moved that the initial Chair of the Committee shall be George Greene and that membership of the Committee shall consist of Board members, Los Angeles County providers and others, as deemed appropriate by this Board.

Provider stakeholders on L.A. Care Board and Committees
Board of Governors
One Los Angeles County Supervisor, three members with experience as a health care administrator or as a health care provider, a children's health care provider, health plan or health insurance expertise, community clinics and health centers, federally qualified health centers, private hospitals that have Medi-Cal disproportionate share (DSH) status, or if such status no longer exists, that serve an equivalent patient population, private hospitals (non-DSH), physician representative, a L.A. Care member, a L.A. Care member advocate.

Children's Health Consultant Advisory Committee
Children and family services, maternal and child health care, obstetrics, pediatrics, mental health, dental care, school-based care, health advocacy, community-based services, Los Angeles County/Department of Health Services (LAC/DHS) maternal and children's health programs and other experts and stakeholders in children's health care

Technical Advisory Committee
A medical school representative, an epidemiologist, a pharmacist, a nursing association representative, a home health care representative, a long-term care provider, a mental health care provider, a medical rehabilitation provider, an expert on health care quality, or, in the alternative, other persons with health care expertise.

Authority to form the committee and appoint members is in the L.A. Care Bylaws:
L.A. Care Bylaws
Section 6.4 Additional Advisory Groups or Committees
The Board may, as it deems necessary, establish additional advisory groups or committees, including, without limitation, one or more "peer review bodies" in accordance with W&I Code Section

14087.38(n). A resolution of the Board establishing any additional advisory group or committee may specify the number and qualifications of members, scope of matters on which such group or committee will provide review and recommendations, parameters for the conduct of proceedings, and conditions and procedures for dissolution of the advisory group or committee. The membership of the advisory groups or committees described in this Article VI, including, without limitation, the Technical Advisory Committee and the Community Advisory Committees specified in Sections 6.1 and 6.2 above, may include Board Members; provided that all of the members of such committees and subcommittees shall serve at the pleasure of the Board. The Board may adopt rules for the conduct of proceedings for any such advisory group or committee.

While there is no specific mention about forming committees in L.A. Care's enabling legislation, the following authority applies to the Committee's meetings:
California Code, Welfare and Institutions Code - WIC § 14087.963
(a) The governing body of the commission shall establish rules for its proceedings. There shall be at least six meetings per year.

BOARD OF GOVERNORS
Executive Committee
Meeting Minutes – March 22, 2023
1055 West 7th Street, 10th Floor, Los Angeles, CA 90017

Members
Al Ballesteros, *Chairperson*
Ilan Shapiro MD, MBA, FAAP, FACHE, *Vice Chairperson**
Stephanie Booth, MD, *Treasurer*
John G. Raffoul, *Secretary**
Hilda Perez**

* *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*
Linda Greenfeld, *Chief Products Officer*
Tom MacDougall, *Chief Technology & Information Officer*
Thomas Mapp, *Chief Compliance Officer*
Marie Montgomery, *Chief Financial Officer*
Noah Paley, *Chief of Staff*
Acacia Reed, *Chief Operating Officer*
Afzal Shah, *Deputy Chief Financial Officer*

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Alvaro Ballesteros, *Chairperson,* called to order the regular and special supplemental meetings of the L.A. Care Executive Committee and the L.A. Care Joint Powers Authority Executive Committee regular meeting at 2:02 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, L.A. Care is glad that they provided input today. The Committee will hear their comments and the Committee also needs to finish the business on the Agenda today. • For people who have access to the internet, the meeting materials are available at the lacare.org website. If anyone needs information about how to locate the meeting materials, they can reach out to L.A. Care staff. • Information for public comment is on the Agenda available on the web site. Staff will read the comment received from each person for up to three minutes. • Public comment will be heard before the Committee discusses an item. If the comment is not on a specific agenda item, it will be read at the general Public Comment.	

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	He provided information on how to submit a comment in-person, or using the "chat" feature.	
APPROVE MEETING AGENDA	The Agenda for today's meeting was approved.	**Approved unanimously by roll call. 3 AYES (Ballesteros, Booth and Perez)**
PUBLIC COMMENT	There were no public comments.	
APPROVE MEETING MINUTES	The minutes of the February 22, 2023 meeting were approved as submitted.	**Approved unanimously by roll call. 3 AYES (Ballesteros, Booth and Perez)**
CHAIRPERSON'S REPORT	Al Ballesteros, *Chairperson* commented on the recent announcement that former Los Angeles County Supervisor Gloria Molina has terminal cancer. She is a former member of the L.A. Care Board of Governors and served from 2011 to 2014. Mr. Ballesteros knows her from 1993 when she appointed him as a Commissioner on the Los Angeles County Commission on HIV. Ms. Molina is such an icon in the community and has done so much for Los Angeles. He remembers her for her support of the work on HIV in the early 1990s, when no politicians on the East Side of Los Angeles were standing up for people at risk of HIV or living with HIV. Ms. Molina helped with resources that were needed to educate a community that was hard to reach. Chairperson Ballesteros will always be thankful to her for that work and beyond that. Ms. Molina worked to support community health centers and programs to support the uninsured in Los Angeles County. Ms. Molina was steadfast in her support for people that had no insurance and needed health care. She fought for a new county hospital, organized many meetings and hearings on the size of the hospital and was steadfast in achieving what she thought was needed for Los Angeles. She worked for homeless individuals and foster care youth, and the list goes on with things this Supervisor did for Los Angeles County. Chairperson Ballesteros has so much respect for what she has done. She will always be in his thoughts as one of the greatest politicians that has worked in Los Angeles County. John Baackes, *Chief Executive Officer,* noted that it is remarkable that Ms. Molina and Yvonne Burke were the first women elected to the Los Angeles County Board of	

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Supervisors, and now all five Supervisors are women. She paved the way that has been a good reflection of the diversity in Los Angeles County.	
CHIEF EXECUTIVE OFFICER REPORT	Mr. Baackes reported that L.A. Care is in solid financial shape for 2023 with a more robust reimbursement compared to prior years. The reserves are intact. There was 1.5% in revenue that was taken by the California Department of Health Care Services at the beginning the pandemic over an 18-month period, because it was believed there would be a recession. The recession never materialized, but those funds were not returned to L.A. Care. In that year, L.A. Care incurred a loss of $138 million. The following year L.A. Care bounced back with a slightly more than 1.5% operating margin, and last year experienced a thin operating margin. Over the three years, L.A. Care took in over $25 billion in revenue and posted a net gain of $33 million. For 2023, the picture is much more robust. There are strong headwinds for 2024 and beyond. California will report in the May Budget Revise a deficit in excess of $33 billion and L.A. Care should be prepared that it will be among those affected by that. In 2024, the Medi-Cal enrollment will be buffeted by the eligibility redetermination for Medi-Cal for which L.A. Care has budgeted a loss of 13% of its members, and by the loss of Kaiser as a Plan Partner due to its direct contract with California for Medi-Cal that will start in 2024. It is not clear how the contract with Kaiser will affect the rates. New members are expected to enroll when undocumented residents ages 26-49 who qualify will be eligible for Medi-Cal in January 2024. L.A. Care has made sound and conservative financial forecasts and is working diligently on mitigation plans to limit the potential loss of members during the redetermination process. The California Safety Net Coalition began in June 2022. L.A. Care invited hospitals, clinics, independent physicians and competitor health plans to address the chronic underfunding of Medi-Cal, compared to Medicare and commercial insurance. The California Safety Net Coalition (CSNC) was formed as a 501(c)(4) corporation to focus on getting an initiative on the November 2024 ballot that will redirect the proceeds from a managed care organization (MCO) tax to supplement Medi-Cal funding. Because of the current budget deficit issue, the Governor is planning to reinstate the MCO tax, with proceeds going to the general fund in California. The MCO tax is levied on Medi-Cal managed care health plans. Before the MCO tax expired last year, L.A. Care was taxed $65 per member, while commercial health plans were taxed at the rate	

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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	of $1.20 per member. The funds collected were claimed as state-generated revenue and were matched by the federal government. L.A. Care received funding through the Medi-Cal rates and commercial plans did not receive funding. The ballot initiative will propose to voters that the MCO tax will be redirected to supplement Medi-Cal reimbursement. CSNC has hired Jim DeBoo to lead the campaign. Mr. DeBoo was Chief of Staff for Governor Newsom in his first administration. He will be a stellar champion, with contact in the current administration, to gain support for the ballot initiative. Mr. Baackes is a member of the CSNC Steering Committee, which is vitally important to the future of Medi-Cal, and to L.A. Care and its members. He will attend the meetings in person in Sacramento. CSNC work will not be a panacea; it puts a stake in the ground to do something serious about Medi-Cal, which has not had a base rate increase since the 1990s. He will provide additional information at the April 6 Board Meeting. Board Member Booth asked if there are other taxes collected in California that are matched by the federal government. Mr. Baackes does not think there are any others than those used by Medi-Cal. When adopted 58 years ago, the cost of the Medi-Cal program was to be shared between states and the federal government, and started at a simple 50-50 split. Strategies were developed by states over the years to increase the funding stream from the federal government. States began taxing providers to increase the tax funds, and then giving providers a supplemental payment from the federal share. In California, about 2/3rds of the costs of Medi-Cal. States pay 100% of the costs for undocumented Medi-Cal beneficiaries with no matching federal funds. Board Member Booth stated that if the taxes are collected to be matched by the federal government for Medi-Cal, then the funds should be spent on Medi-Cal.	
COMMITTEE ISSUES		
Government Affairs Update	Cherie Compartore, *Senior Director, Government Affairs,* reported: • At the last Board meeting, she reported that Assembly Member Kalra introduced AB 1690 for single payer health care. It is a two-year bill to be voted on in 2024. The California Nurses Association sponsors this bill. There is currently no funding stream for this AB 1690. • SB 770 was introduced by Senator Weiner, and is intended to work in conjunction with the Kalra bill. SB 770 specifies a timeline for the state to discuss a single payer	

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AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	program with the federal government by 2024. Government Affairs will continue to monitor both bills. • California's fiscal loss is now projected to be in excess of $30 billion. Last year, the budget included a $130 billion surplus. The Governor will release the May Budget Revise in mid-May. There will clearly be a lot of competition for state funding. • There have been quite a few meetings with legislators on hospital financing issues. AB 412 will create a hospital emergency loan program to be used to prevent hospital closures. The loan program would end in 2029. No hearings have been held yet, and more information will be reported at future meetings. • SB 870 was introduced by Senator Caballero to reinstitute the managed care organization (MCO) tax, which Mr. Baackes described in his CEO report above. The MCO tax expired last year and was not renewed. California legislature and administration are both seeking federal approval to reinstitute the tax. Currently, the bill does not include language about how the tax funds would be used. The preamble statement references the losses experienced by rural hospitals because of the pandemic and inadequate Medicaid funding. This preamble language indicates that the tax proceeds may be used to offset those losses. Mr. Baackes noted that in relation to the California Budget and some of the bills introduced, there is a high level of anxiety in the legislature about hospital finances. A small hospital closed in Madera on New Year's Eve, and it has drawn attention to the status of other hospitals in California. L.A. Care is concerned about hospitals in Los Angeles County, as there are some in financial difficulties. Hospitals that were not in good financial shape prior to the pandemic appear to be in worse shape. There have been spot bills introduced in the legislature to address this, which illustrates that legislators are concerned and will work to save the hospitals in their districts. Chairperson Ballesteros asked about the ballot initiative related to the MCO tax and how it relates to the work of the CSNC. Mr. Baackes responded that the CSNC initiative will be targeted for the ballot in November 2024. Governor Newsom will be reinstating the MCO tax in the May Budget Revise for California, with proceeds from the MCO to be placed in the general fund. CSNC would support the MCO tax for two years if there is support from the administration for the ballot initiative in November 2024. Support from the administration would be of immense value to the CSNC. The use of the tax would be different for the first two years, and after that, it would be a supplement to Medi-Cal rates.	

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
Approve Consent Agenda	Approve the list of items that will be considered on a Consent Agenda for the April 6, 2023 Board of Governors Meeting. • March 2, 2023 Board of Governors Meeting Minutes • Customer Motivators Contract Amendment • Center for Caregiver Advancement Contract Amendment	**Approved unanimously by roll call. 3 AYES (Ballesteros, Booth and Perez)**
PUBLIC COMMENTS	There were no public comments.	
ADJOURN TO CLOSED SESSION	The Joint Powers Authority Executive Committee meeting adjourned at 2:31 pm. Augustavia J. Haydel, Esq., *General Counsel* announced the items to be discussed in closed session. She announced there is no report anticipated from the closed session. The meeting adjourned to closed session at 2:32 pm. CONTRACT RATES Pursuant to Welfare and Institutions Code Section 14087.38(m) • Plan Partner Rates • Provider Rates • DHCS Rates 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: *March 2025* CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act USC Keck Hospital, et al. v. L.A. Care (AAA Case No. 01-21-0016-6078) 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—ANTICIPATED LITIGATION Significant exposure to litigation pursuant to Section 54956.9(d)(2) of Ralph M. Brown Act: Four Potential Cases	

APPROVED

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 • 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 meeting reconvened in open session at 3:33 pm. No reportable actions were taken during the closed session.	
ADJOURNMENT	The meeting adjourned at 3:34 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:

DocuSigned by:
AA470543B1BB4A1...
Al Ballesteros, *Chair*
Date: 4/27/2023 | 11:53 AM PDT

APPROVED

Financial Update

Board of Governors Meeting

May 4, 2023

Agenda

Financial Performance – March 2023 YTD

- Membership
- Consolidated Financial Performance
- Operating Margins by Segment
- Paid vs. Reported Claims trend
- Key Financial Ratios
- Tangible Net Equity & Days of Cash On-Hand Comparison

Financial Informational Updates

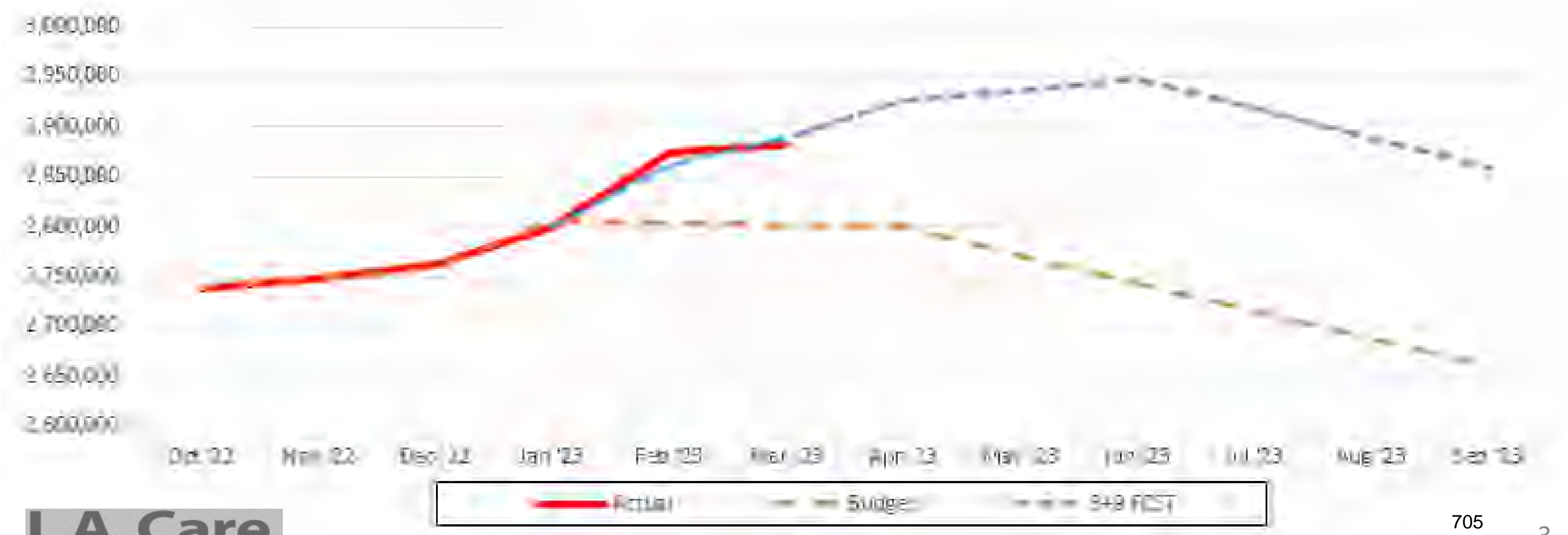
- Investment Transactions
- Quarterly Internal Policy Reports

Membership

for the 6 months ended March 2023

	March 2023			Year-to-Date		
Sub-Segment	**Actual**	**3+9 FCST**	**Variance**	**Actual**	**3+9 FCST**	**Variance**
Medi-Cal	2,705,454	2,714,588	(9,134)	15,741,737	15,742,072	(335)
CMC	(17)	-	(17)	51,322	51,081	241
D-SNP	17,674	17,707	(33)	53,177	53,092	85
Commercial	176,133	174,463	1,670	1,009,447	1,005,192	4,255
*Elimination	(17,674)	(17,707)	33	(53,177)	(53,092)	(85)
Consolidated	**2,881,570**	**2,889,051**	**(7,481)**	**16,802,506**	**16,798,344**	**4,162**

*D-SNP members included in MCLA membership under CCI beginning in January 2023



Consolidated Financial Performance
for the month of March 2023

($ in Thousands)	Actual	3+9 FCST	Variance
Member Months	2,881,570	2,889,051	(7,481)
Total Revenues	$977,584	$960,771	$16,813
Total Healthcare Expenses	$884,922	$882,496	($2,426)
Operating Margin	$92,662	$78,275	$14,387
Operating Margin (excl HHIP/IPP)	$92,662	$81,513	$11,149
Total Admin Expenses	$50,659	$46,043	($4,616)
Income/(Loss) from Operations	$42,003	$32,232	$9,771
Non-Operating Income (Expense)	$14,765	$932	$13,833
Net Surplus	**$56,768**	**$33,164**	**$23,604**
Net Surplus (excl HHIP/IPP)	***$56,810***	***$36,632***	***$20,178***

Consolidated Financial Performance

for the 6 months ended March 2023

($ in Thousands)	Actual	3+9 FCST	Variance
Member Months	16,802,506	16,798,344	4,162
Total Revenues	$5,385,582	$5,385,154	$428
Total Healthcare Expenses	$4,962,879	$5,040,336	$77,457
Operating Margin	$422,703	$344,817	$77,885
Operating Margin (excl HHIP/IPP)	*$393,076*	*$321,719*	*$71,357*
Total Admin Expenses	$255,745	$265,804	$10,059
Income/(Loss) from Operations	$166,957	$79,013	$87,944
Non-Operating Income (Expense)	$33,022	$15,094	$17,929
Net Surplus	**$199,980**	**$94,107**	**$105,873**
Net Surplus (excl HHIP/IPP)	***$170,554***	***$72,010***	***$98,545***

Operating Margin by Segment

for the 6 months ended March 2023

$ in Thousands

	Medi-Cal	CMC	D-SNP	Commercial	HHIP/IPP	Total	Total *(excl HHIP/IPP)*
Revenue	$4,900,088	$78,130	[illegible]	$302,882	$31,245	$5,385,582	$5,354,337
Healthcare Exp.	$4,541,098	$84,847	$62,253	$278,827	$1,618	$4,962,879	$4,961,261
Operating Margin	$358,991	($11,837)	$18,827	[illegible]	$29,627	$411,703	$383,075
MCR %	92.7%	108.0%	78.7%	92.4%	N/A	92.2%	92.7%
Forecast MCR%	94.2%	100.4%	80.2%	93.3%	N/A	93.6%	94.0%

Reported vs Paid Claims Trend
Paid Claims through March 2023

$350,000,000
$300,000,000
$250,000,000
$200,000,000
$150,000,000
$100,000,000
$50,000,000

Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23

Paid Reported

Key Financial Ratios

for the 6 months ended March 2023

(Excl. HHIP/IPP)	Actual		3+9 FCST	
MCR	92.7%	vs.	94.0%	✓
Admin Ratio	4.8%	vs.	5.0%	✓

	Actual		Benchmark	
Working Capital	1.19	vs.	1.00+	✓
Cash to Claims (w/hospital pass-through funds)	0.88	vs.	0.75+	✓
Cash to Claims (w/o hospital pass-through funds)	0.58	vs.	0.75+	✗
Tangible Net Equity	5.89	vs.	1.30+	✓

Tangible Net Equity & Days of Cash On-Hand

for the 6 months ended March 2023

	Kern	Santa Clara	Inland Empire	L.A. Care March 2023 (pass-through)	L.A. Care March 2023 (no pass-through)	Partnership	CCAH	San Mateo	San Francisco	CalOptima
Tangible Net Equity	479%	492%	548%	589%	589%	637%	889%	975%	1,087%	1,142%
Days of Cash On-Hand	131	145	70	101	63	173		254		

* As of December 2022 Quarterly filings, unless noted otherwise.

Questions & Consideration

Motion FIN 104

- To accept the Financial Reports for the six months ended March 31, 2023, as submitted.

Informational Items

Investment Transactions

- As of March 31, 2023, L.A. Care's total investment market value was $3.4B ($2.2B without hospital pass-through funds)
  - $3.2B managed by Payden & Rygel and New England Asset Management (NEAM)
    - $2.0B without hospital pass-through funds
  - $74M in Local Agency Investment Fund
  - $158M in Los Angeles County Pooled Investment Fund

Quarterly Internal Policy Reports

Board of Governors

MOTION SUMMARY

Date: May 4, 2023 **Motion No. FIN 104.0523**

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

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

Issue: Acceptance of the Financial Reports for February and March 2023.

Background: N/A

Member Impact: N/A

Budget Impact: N/A

Motion: To accept the Financial Reports for February and March 2023, as submitted.

Financial Performance
February 2023
(Unaudited)

Overall

The combined member months are 13.9 million year-to-date, which is 11,643 favorable to the 3+9 forecast. The performance is a surplus of $143.2 million or 3.2% of revenue and is $82.3 million favorable to the forecast. The favorability is driven by lower inpatient and outpatient claims, lower provider incentives expenses due to timing, and lower pharmacy costs. The unfavorable variance in revenue is offset by lower skilled nursing facility costs and capitation expenses due to lower than forecasted LTC member counts. Operating expenses are favorable to the forecast due to added funding to the forecast and timing in vendor spending. Higher interest income and timing in grant spending also contributed to higher surplus.

Medi-Cal

Medi-Cal consists of members through our contracted providers and our contracted health plans ("Plan Partners"). The member months are 13.0 million, which is 8,799 favorable to the forecast. The performance is a surplus of $136.0 million and is $75.3 million favorable to the forecast. The favorability in net surplus is driven by lower inpatient claims, outpatient claims and skilled nursing facility costs. Lower provider incentives due to timing also contributed to favorable variance in net surplus. The unfavorable variance in revenue is offset by lower skilled nursing facility costs and capitation expenses due to lower than forecasted LTC member counts. Also contributed to the favorable variance in surplus are lower operating and non-operating expenses as discussed in the Overall section above.

Cal MediConnect (CMC)

The member months are 51,339, which is 258 favorable to the forecast. The performance is a deficit of $4.9 million which is in line with the forecast. Effective January 1, 2023, members enrolled in CMC have been transitioned to our D-SNP plan. The net deficit of $4.9 million is primarily driven by operating expenses incurred through YTD December 2022 prior to the transition.

D-SNP

January 2023 is the first month of the D-SNP plan as the CMC members were transitioned into this product. For YTD February 2023, the member months are 35,503, which is 119 favorable to the forecast. The performance is a surplus of $8.8 million which is $9.9 million favorable to the forecast driven by better than forecasted capitation expenses and providers shared risk and incentives due to timing. Lower operating expenses also contributed to the favorable variance in net surplus.

Commercial

L.A. Care Commercial consists of LACC and PASC-SEIU. The member months are 833,314, which is 2,586 favorable to the forecast. The performance is a deficit of $13.2 million and is $8.9 million unfavorable to the forecast due to higher inpatient claims. Higher operating expenses also contributed to the unfavorable variance in net deficit.

Incentive Programs

L.A. Care Incentive Programs consist of CalAIM Incentive Payment Program (IPP) and Housing and Homelessness Incentive Program (HHIP). The YTD surplus of $29.5 million, which is $3.9 million favorable to the forecast, is driven by the recognition of revenue for the submission of our investment plan to DHCS. The expenditures related to this program will be expensed when incur in future periods. The $3.9 million favorable variance is driven by the timing in provider incentive spending for HHIP.

Consolidated Operations Income Statement ($ in thousands)

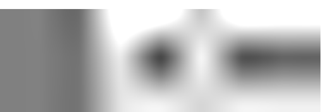
February 2023

	Current Actual $	Current Actual PMPM	Current Forecast $	Current Forecast PMPM	Fav(Unfav) Forecast $	Fav(Unfav) Forecast PMPM	YTD Actual $	YTD Actual PMPM	YTD Forecast $	YTD Forecast PMPM	Fav(Unfav) Forecast $	Fav(Unfav) Forecast PMPM
Membership												
Member Months	2,873,322		2,861,679		11,643		13,920,936		13,909,293		11,643	
Revenue												
Capitation	$ 974,577	$ 339.18	$ 951,790	$ 332.60	$ 22,787	$ 6.58	$ 4,407,997	$ 316.65	$ 4,424,383	$ 318.09	$ (16,385)	$ (1.44)
Total Revenues	**$ 974,577**	**$ 339.18**	**$ 951,790**	**$ 332.60**	**$ 22,787**	**$ 6.58**	**$ 4,407,997**	**$ 316.65**	**$ 4,424,383**	**$ 318.09**	**$ (16,385)**	**$ (1.44)**
Healthcare Expenses												
Capitation	$ 508,283	$ 176.90	$ 505,211	$ 176.54	$ (3,072)	$ (0.35)	$ 2,412,030	$ 173.27	$ 2,425,467	$ 174.38	$ 13,438	$ 1.11
Inpatient Claims	$ 120,116	$ 41.80	$ 124,834	$ 43.62	$ 4,717	$ 1.82	$ 598,858	$ 43.02	$ 604,619	$ 43.47	$ 5,761	$ 0.45
Outpatient Claims	$ 103,253	$ 35.94	$ 114,405	$ 39.98	$ 11,152	$ 4.04	$ 509,045	$ 36.57	$ 525,901	$ 37.81	$ 16,856	$ 1.24
Skilled Nursing Facility	$ 94,357	$ 32.84	$ 96,667	$ 33.78	$ 2,310	$ 0.94	$ 450,264	$ 32.34	$ 466,609	$ 33.55	$ 16,345	$ 1.20
Pharmacy	$ 10,402	$ 3.62	$ 11,856	$ 4.14	$ 1,454	$ 0.52	$ 50,020	$ 3.59	$ 55,191	$ 3.97	$ 5,171	$ 0.37
Provider Incentives and Shared Risk	$ 2,538	$ 0.88	$ 14,683	$ 5.13	$ 12,145	$ 4.25	$ 17,810	$ 1.28	$ 36,488	$ 2.62	$ 18,679	$ 1.34
Medical Administrative Expenses	$ 8,002	$ 2.79	$ 8,768	$ 3.06	$ 766	$ 0.28	$ 39,931	$ 2.87	$ 43,565	$ 3.13	$ 3,633	$ 0.26
Total Healthcare Expenses	**$ 846,952**	**$ 294.76**	**$ 876,425**	**$ 306.26**	**$ 29,473**	**$ 11.50**	**$ 4,077,957**	**$ 292.94**	**$ 4,157,840**	**$ 298.93**	**$ 79,884**	**$ 5.99**
MCR(%)	*86.9%*		*92.1%*		*5.2%*		*92.5%*		*94.0%*		*1.5%*	
Operating Margin	**$ 127,624**	**$ 44.42**	**$ 75,365**	**$ 26.34**	**$ 52,259**	**$ 18.08**	**$ 330,041**	**$ 23.71**	**$ 266,542**	**$ 19.16**	**$ 63,498**	**$ 4.55**
Total Operating Expenses	$ 39,203	$ 13.64	$ 46,384	$ 16.21	$ 7,182	$ 2.57	$ 205,086	$ 14.73	$ 219,761	$ 15.80	$ 14,675	$ 1.07
Admin Ratio(%)	*4.0%*		*4.9%*		*0.9%*		*4.7%*		*5.0%*		*0.3%*	
Income (Loss) from Operations	**$ 88,422**	**$ 30.77**	**$ 28,981**	**$ 10.13**	**$ 59,441**	**$ 20.65**	**$ 124,954**	**$ 8.98**	**$ 46,781**	**$ 3.36**	**$ 78,173**	**$ 5.61**
Other Income/(Expense), net	$ (3,735)	$ (1.30)	$ (3,557)	$ (1.24)	$ (178)	$ (0.06)	$ (10,597)	$ (0.76)	$ (13,807)	$ (0.99)	$ 3,210	$ 0.23
Interest Income, net	$ 6,140	$ 2.14	$ 5,084	$ 1.78	$ 1,056	$ 0.36	$ 25,488	$ 1.83	$ 23,761	$ 1.71	$ 1,727	$ 0.12
Realized Gain / Loss	$ (105)	$ (0.04)	$ -	$ -	$ (105)	$ (0.04)	$ (888)	$ (0.06)	$ (842)	$ (0.06)	$ (46)	$ (0.00)
Unrealized Gain / Loss	$ (4,832)	$ (1.68)	$ -	$ -	$ (4,832)	$ (1.68)	$ 4,254	$ 0.31	$ 5,050	$ 0.36	$ (795)	$ (0.06)
Total Non-Operating Income (Expense)	**$ (2,532)**	**$ (0.88)**	**$ 1,527**	**$ 0.53**	**$ (4,059)**	**$ (1.41)**	**$ 18,258**	**$ 1.31**	**$ 14,162**	**$ 1.02**	**$ 4,096**	**$ 0.29**
Net Surplus (Deficit)	**$ 85,890**	**$ 29.89**	**$ 30,508**	**$ 10.66**	**$ 55,382**	**$ 19.23**	**$ 143,212**	**$ 10.29**	**$ 60,943**	**$ 4.38**	**$ 82,269**	**$ 5.91**
Margin(%)	*8.8%*		*3.2%*		*5.6%*		*3.2%*		*1.4%*		*1.9%*	

Total Medi-Cal Income Statement ($ in thousands)

February 2023

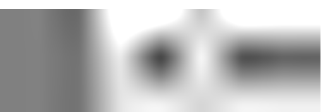
Current Actual $	Current Actual PMPM	Current Forecast $	Current Forecast PMPM	Fav(Unfav) Forecast $	Fav(Unfav) Forecast PMPM		YTD Actual $	YTD Actual PMPM	YTD Forecast $	YTD Forecast PMPM	Fav(Unfav) Forecast $	Fav(Unfav) Forecast PMPM
						Membership						
2,695,960		2,687,161		8,799		Member Months	13,036,283		13,027,484		8,799	
						Revenue						
$ 894,667	$ 331.85	$ 868,495	$ 323.20	$ 26,172	$ 8.65	Capitation	$ 4,002,709	$ 307.04	$ 4,012,120	$ 307.97	$ (9,411)	$ (0.93)
$ 894,667	**$ 331.85**	**$ 868,495**	**$ 323.20**	**$ 26,172**	**$ 8.65**	**Total Revenues**	**$ 4,002,709**	**$ 307.04**	**$ 4,012,120**	**$ 307.97**	**$ (9,411)**	**$ (0.93)**
						Healthcare Expenses						
$ 479,648	$ 177.91	$ 474,692	$ 176.65	$ (4,956)	$ (1.26)	Capitation	$ 2,271,015	$ 174.21	$ 2,283,429	$ 175.28	$ 12,414	$ 1.07
$ 99,035	$ 36.73	$ 109,720	$ 40.83	$ 10,684	$ 4.10	Inpatient Claims	$ 512,939	$ 39.35	$ 527,555	$ 40.50	$ 14,616	$ 1.15
$ 95,478	$ 35.42	$ 104,344	$ 38.83	$ 8,866	$ 3.42	Outpatient Claims	$ 458,513	$ 35.17	$ 472,976	$ 36.31	$ 14,462	$ 1.13
$ 94,392	$ 35.01	$ 96,667	$ 35.97	$ 2,274	$ 0.96	Skilled Nursing Facility	$ 442,013	$ 33.91	$ 459,061	$ 35.24	$ 17,049	$ 1.33
$ (13)	$ (0.00)	$ -	$ -	$ 13	$ 0.00	Pharmacy	$ 394	$ 0.03	$ (162)	$ (0.01)	$ (556)	$ (0.04)
$ 515	$ 0.19	$ 5,260	$ 1.96	$ 4,745	$ 1.77	Provider Incentives and Shared Risk	$ 10,133	$ 0.78	$ 18,902	$ 1.45	$ 8,769	$ 0.67
$ 7,605	$ 2.82	$ 8,031	$ 2.99	$ 425	$ 0.17	Medical Administrative Expenses	$ 37,810	$ 2.90	$ 40,777	$ 3.13	$ 2,967	$ 0.23
$ 776,661	**$ 288.08**	**$ 798,713**	**$ 297.23**	**$ 22,052**	**$ 9.15**	**Total Healthcare Expenses**	**$ 3,732,818**	**$ 286.34**	**$ 3,802,539**	**$ 291.89**	**$ 69,721**	**$ 5.55**
86.8%		*92.0%*		*5.2%*		*MCR(%)*	*93.3%*		*94.8%*		*1.5%*	
$ 118,006	**$ 43.77**	**$ 69,782**	**$ 25.97**	**$ 48,224**	**$ 17.80**	**Operating Margin**	**$ 269,891**	**$ 20.70**	**$ 209,581**	**$ 16.09**	**$ 60,310**	**$ 4.62**
$ 31,923	$ 11.84	$ 37,552	$ 13.97	$ 5,629	$ 2.13	**Total Operating Expenses**	$ 164,393	$ 12.61	$ 176,808	$ 13.57	$ 12,415	$ 0.96
3.6%		*4.3%*		*0.8%*		*Admin Ratio(%)*	*4.1%*		*4.4%*		*0.3%*	
$ 86,083	**$ 31.93**	**$ 32,230**	**$ 11.99**	**$ 53,853**	**$ 19.94**	**Income (Loss) from Operations**	**$ 105,498**	**$ 8.09**	**$ 32,773**	**$ 2.52**	**$ 72,725**	**$ 5.58**
$ 580	**$ 0.22**	**$ 4,606**	**$ 1.71**	**$ (4,026)**	**$ (1.50)**	**Total Non-Operating Income (Expense)**	**$ 30,495**	**$ 2.34**	**$ 27,872**	**$ 2.14**	**$ 2,624**	**$ 0.20**
$ 86,663	**$ 32.15**	**$ 36,836**	**$ 13.71**	**$ 49,827**	**$ 18.44**	**Net Surplus (Deficit)**	**$ 135,993**	**$ 10.43**	**$ 60,644**	**$ 4.66**	**$ 75,349**	**$ 5.78**
9.7%		*4.2%*		*5.4%*		*Margin(%)*	*3.4%*		*1.5%*		*1.9%*	



CMC Income Statement ($ in thousands)

February 2023

Current Actual $	Current Actual PMPM	Current Forecast $	Current Forecast PMPM	Fav(Unfav) Forecast $	Fav(Unfav) Forecast PMPM		YTD Actual $	YTD Actual PMPM	YTD Forecast $	YTD Forecast PMPM	Fav(Unfav) Forecast $	Fav(Unfav) Forecast PMPM
						Membership						
258				258		Member Months	51,339		51,081		258	
						Revenue						
$ (326)	N/A	$ -	$ -	$ (326)	N/A	Capitation	$ 74,127	$ 1,443.87	$ 75,769	$ 1,483.31	$ (1,642)	$ (39.44)
$ (326)	**$ -**	**$ -**	**$ -**	**$ (326)**	**$ -**	**Total Revenues**	**$ 74,127**	**$ 1,443.87**	**$ 75,769**	**$ 1,483.31**	**$ (1,642)**	**$ (39.44)**
						Healthcare Expenses						
$ (123)	N/A	$ -	$ -	$ 123	N/A	Capitation	$ 31,061	$ 605.01	$ 30,024	$ 587.77	$ (1,037)	$ (17.24)
$ 954	N/A	$ -	$ -	$ (954)	N/A	Inpatient Claims	$ 26,111	$ 508.59	$ 24,578	$ 481.16	$ (1,532)	$ (27.43)
$ (1,204)	N/A	$ -	$ -	$ 1,204	N/A	Outpatient Claims	$ 10,123	$ 197.18	$ 11,230	$ 219.85	$ 1,107	$ 22.67
$ (530)	N/A	$ -	$ -	$ 530	N/A	Skilled Nursing Facility	$ 7,206	$ 140.37	$ 7,194	$ 140.84	$ (12)	$ 0.47
$ (605)	N/A	$ -	$ -	$ 605	N/A	Pharmacy	$ (3,465)	$ (67.49)	$ 1,193	$ 23.35	$ 4,658	$ 90.84
$ 813	N/A	$ -	$ -	$ (813)	N/A	Provider Incentives and Shared Risk	$ 2,337	$ 45.52	$ 1,046	$ 20.48	$ (1,291)	$ (25.04)
$ 191	N/A	$ -	$ -	$ (191)	N/A	Medical Administrative Expenses	$ 1,281	$ 24.95	$ 842	$ 16.48	$ (439)	$ (8.47)
$ (504)	**$ -**	**$ -**	**$ -**	**$ 504**	**$ -**	**Total Healthcare Expenses**	**$ 74,654**	**$ 1,454.13**	**$ 76,107**	**$ 1,489.93**	**$ 1,453**	**$ 35.80**
154.8%		*0.0%*		*-154.8%*		*MCR(%)*	*100.7%*		*100.4%*		*-0.3%*	
$ 178	**$ -**	**$ -**	**$ -**	**$ 178**	**$ -**	**Operating Margin**	**$ (527)**	**$ (10.27)**	**$ (338)**	**$ (6.62)**	**$ (189)**	**$ (3.64)**
$ 237	$ -	$ -	$ -	$ (237)	$ -	**Total Operating Expenses**	$ 5,474	$ 106.63	$ 5,189	$ 101.58	$ (285)	$ (5.05)
-72.9%		*0.0%*		*72.9%*		*Admin Ratio(%)*	*7.4%*		*6.8%*		*-0.5%*	
$ (59)	**$ -**	**$ -**	**$ -**	**$ (59)**	**$ -**	**Income (Loss) from Operations**	**$ (6,001)**	**$ (116.89)**	**$ (5,527)**	**$ (108.20)**	**$ (474)**	**$ (8.69)**
$ 44	**N/A**	**$ -**	**$ -**	**$ 44**	**N/A**	**Total Non-Operating Income (Expense)**	**$ 1,070**	**$ 20.83**	**$ 670**	**$ 13.11**	**$ 400**	**$ 7.72**
$ (15)	**N/A**	**$ -**	**$ -**	**$ (15)**	**N/A**	**Net Surplus (Deficit)**	**$ (4,932)**	**$ (96.06)**	**$ (4,857)**	**$ (95.09)**	**$ (74)**	**$ (0.97)**
4.7%		*0.0%*		*4.7%*		*Margin(%)*	*-6.7%*		*-6.4%*		*-0.2%*	



D-SNP Income Statement ($ in thousands)

February 2023

Current Actual $	Current Actual PMPM	Current Forecast $	Current Forecast PMPM	Fav(Unfav) Forecast $	Fav(Unfav) Forecast PMPM		YTD Actual $	YTD Actual PMPM	YTD Forecast $	YTD Forecast PMPM	Fav(Unfav) Forecast $	Fav(Unfav) Forecast PMPM
						Membership						
17,814		17,695		119		Member Months	35,503		35,384		119	
						Revenue						
$ 26,675	$ 1,497.44	$ 24,531	$ 1,386.34	$ 2,144	$ 111.10	Capitation	$ 51,924	$ 1,462.52	$ 49,054	$ 1,386.34	$ 2,869	$ 76.18
$ 26,675	**$ 1,497.44**	**$ 24,531**	**$ 1,386.34**	**$ 2,144**	**$ 111.10**	**Total Revenues**	**$ 51,924**	**$ 1,462.52**	**$ 49,054**	**$ 1,386.34**	**$ 2,869**	**$ 76.18**
						Healthcare Expenses						
$ 9,834	$ 552.02	$ 10,705	$ 604.94	$ 871	$ 52.93	Capitation	$ 18,877	$ 531.71	$ 21,405	$ 604.94	$ 2,528	$ 73.23
$ 6,624	$ 371.86	$ 6,206	$ 350.72	$ (418)	$ (21.15)	Inpatient Claims	$ 13,036	$ 367.18	$ 12,410	$ 350.72	$ (626)	$ (16.47)
$ 2,253	$ 126.48	$ 2,673	$ 151.08	$ 420	$ 24.60	Outpatient Claims	$ 5,266	$ 148.32	$ 5,316	$ 150.23	$ 50	$ 1.91
$ 372	$ 20.87	$ -	$ -	$ (372)	$ (20.87)	Skilled Nursing Facility	$ 372	$ 10.48	$ -	$ -	$ (372)	$ (10.48)
$ 1,019	$ 57.18	$ 1,244	$ 70.27	$ 225	$ 13.09	Pharmacy	$ 2,762	$ 77.81	$ 2,487	$ 70.27	$ (276)	$ (7.53)
$ -	$ -	$ 910	$ 51.43	$ 910	$ 51.43	Provider Incentives and Shared Risk	$ -	$ -	$ 1,820	$ 51.43	$ 1,820	$ 51.43
$ 80	$ 4.48	$ 392	$ 22.13	$ 312	$ 17.65	Medical Administrative Expenses	$ 142	$ 4.00	$ 797	$ 22.51	$ 655	$ 18.52
$ 20,181	**$ 1,132.89**	**$ 22,129**	**$ 1,250.58**	**$ 1,948**	**$ 117.68**	**Total Healthcare Expenses**	**$ 40,455**	**$ 1,139.49**	**$ 44,234**	**$ 1,250.11**	**$ 3,779**	**$ 110.63**
75.7%		*90.2%*		*14.6%*		*MCR(%)*	*77.9%*		*90.2%*		*12.3%*	
$ 6,494	**$ 364.54**	**$ 2,402**	**$ 135.76**	**$ 4,092**	**$ 228.78**	**Operating Margin**	**$ 11,468**	**$ 323.03**	**$ 4,820**	**$ 136.22**	**$ 6,648**	**$ 186.81**
$ 589	$ 33.09	$ 1,293	$ 73.06	$ 703	$ 39.98	**Total Operating Expenses**	$ 2,635	$ 74.21	$ 6,216	$ 175.67	$ 3,581	$ 101.46
2.2%		*5.3%*		*3.1%*		*Admin Ratio(%)*	*5.1%*		*12.7%*		*7.6%*	
$ 5,905	**$ 331.46**	**$ 1,109**	**$ 62.70**	**$ 4,795**	**$ 268.76**	**Income (Loss) from Operations**	**$ 8,834**	**$ 248.82**	**$ (1,396)**	**$ (39.45)**	**$ 10,230**	**$ 288.26**
$ -	**$ -**	**$ 162**	**$ 9.17**	**$ (162)**	**$ (9.17)**	**Total Non-Operating Income (Expense)**	**$ -**	**$ -**	**$ 322**	**$ 9.10**	**$ (322)**	**$ (9.10)**
$ 5,905	**$ 331.46**	**$ 1,272**	**$ 71.86**	**$ 4,633**	**$ 259.60**	**Net Surplus (Deficit)**	**$ 8,834**	**$ 248.82**	**$ (1,074)**	**$ (30.34)**	**$ 9,907**	**$ 279.16**
22.1%		*5.2%*		*17.0%*		*Margin(%)*	*17.0%*		*-2.2%*		*19.2%*	

Commercial Income Statement ($ in thousands)

February 2023

Current Actual $	Current Actual PMPM	Current Forecast $	Current Forecast PMPM	Fav(Unfav) Forecast $	Fav(Unfav) Forecast PMPM		YTD Actual $	YTD Actual PMPM	YTD Forecast $	YTD Forecast PMPM	Fav(Unfav) Forecast $	Fav(Unfav) Forecast PMPM
						Membership						
177,104		174,518		2,586		Member Months	833,314		830,728		2,586	
						Revenue						
$ 53,560	$ 302.42	$ 53,820	$ 308.39	$ (260)	$ (5.97)	Capitation	$ 247,993	$ 297.60	$ 248,704	$ 299.38	$ (711)	$ (1.78)
$ 53,560	**$ 302.42**	**$ 53,820**	**$ 308.39**	**$ (260)**	**$ (5.97)**	**Total Revenues**	**$ 247,993**	**$ 297.60**	**$ 248,704**	**$ 299.38**	**$ (711)**	**$ (1.78)**
						Healthcare Expenses						
$ 18,924	$ 106.85	$ 18,967	$ 108.68	$ 43	$ 1.83	Capitation	$ 91,077	$ 109.29	$ 88,928	$ 107.05	$ (2,149)	$ (2.25)
$ 13,503	$ 76.24	$ 8,908	$ 51.04	$ (4,595)	$ (25.20)	Inpatient Claims	$ 46,772	$ 56.13	$ 40,075	$ 48.24	$ (6,696)	$ (7.89)
$ 6,726	$ 37.98	$ 7,389	$ 42.34	$ 662	$ 4.36	Outpatient Claims	$ 35,143	$ 42.17	$ 36,379	$ 43.79	$ 1,236	$ 1.62
$ 123	$ 0.69	$ -	$ -	$ (123)	$ (0.69)	Skilled Nursing Facility	$ 673	$ 0.81	$ 354	$ 0.43	$ (319)	$ (0.38)
$ 10,002	$ 56.47	$ 10,613	$ 60.81	$ 611	$ 4.34	Pharmacy	$ 50,324	$ 60.39	$ 51,670	$ 62.20	$ 1,345	$ 1.81
$ 1,210	$ 6.83	$ 1,205	$ 6.90	$ (5)	$ 0.07	Provider Incentives and Shared Risk	$ 3,721	$ 4.47	$ 4,180	$ 5.03	$ 458	$ 0.57
$ 126	$ 0.71	$ 259	$ 1.48	$ 133	$ 0.77	Medical Administrative Expenses	$ 661	$ 0.79	$ 935	$ 1.13	$ 274	$ 0.33
$ 50,614	**$ 285.79**	**$ 47,340**	**$ 271.26**	**$ (3,274)**	**$ (14.53)**	**Total Healthcare Expenses**	**$ 228,371**	**$ 274.05**	**$ 222,521**	**$ 267.86**	**$ (5,851)**	**$ (6.19)**
94.5%		*88.0%*		*-6.5%*		*MCR(%)*	*92.1%*		*89.5%*		*-2.6%*	
$ 2,946	**$ 16.64**	**$ 6,481**	**$ 37.13**	**$ (3,534)**	**$ (20.50)**	**Operating Margin**	**$ 19,621**	**$ 23.55**	**$ 26,183**	**$ 31.52**	**$ (6,562)**	**$ (7.97)**
$ 6,390	$ 36.08	$ 6,943	$ 39.78	$ 553	$ 3.70	**Total Operating Expenses**	$ 34,273	$ 41.13	$ 32,005	$ 38.53	$ (2,269)	$ (2.60)
11.9%		*12.9%*		*1.0%*		*Admin Ratio(%)*	*13.8%*		*12.9%*		*-1.0%*	
$ (3,443)	**$ (19.44)**	**$ (462)**	**$ (2.65)**	**$ (2,981)**	**$ (16.80)**	**Income (Loss) from Operations**	**$ (14,652)**	**$ (17.58)**	**$ (5,821)**	**$ (7.01)**	**$ (8,831)**	**$ (10.58)**
$ 0	**$ 0.00**	**$ 316**	**$ 1.81**	**$ (316)**	**$ (1.81)**	**Total Non-Operating Income (Expense)**	**$ 1,434**	**$ 1.72**	**$ 1,453**	**$ 1.75**	**$ (20)**	**$ (0.03)**
$ (3,443)	**$ (19.44)**	**$ (146)**	**$ (0.84)**	**$ (3,297)**	**$ (18.60)**	**Net Surplus (Deficit)**	**$ (13,218)**	**$ (15.86)**	**$ (4,368)**	**$ (5.26)**	**$ (8,850)**	**$ (10.60)**
-6.4%		*-0.3%*		*-6.2%*		*Margin(%)*	*-5.3%*		*-1.8%*		*-3.6%*	

Incentive Programs (IPP & HHIP) Income Statement ($ in thousands)

February 2023

Current Actual $	Current Actual PMPM	Current Forecast $	Current Forecast PMPM	Fav(Unfav) Forecast $	Fav(Unfav) Forecast PMPM		YTD Actual $	YTD Actual PMPM	YTD Forecast $	YTD Forecast PMPM	Fav(Unfav) Forecast $	Fav(Unfav) Forecast PMPM
						Membership						
				-		Member Months					-	
						Revenue						
$ -	$ -	$ 4,943	$ -	$ (4,943)	$ -	Capitation	$ 31,245	$ -	$ 38,735	$ -	$ (7,490)	$ -
$ -	**$ -**	**$ 4,943**	**$ -**	**$ (4,943)**	**$ -**	**Total Revenues**	**$ 31,245**	**$ -**	**$ 38,735**	**$ -**	**$ (7,490)**	**$ -**
						Healthcare Expenses						
$ -	$ -	$ 847	$ -	$ 847	$ -	Capitation	$ -	$ -	$ 1,681	$ -	$ 1,681	$ -
$ -	$ -	$ 7,308	$ -	$ 7,308	$ -	Provider Incentives and Shared Risk	$ 1,618	$ -	$ 10,541	$ -	$ 8,922	$ -
$ -	$ -	$ 87	$ -	$ 87	$ -	Medical Administrative Expenses	$ -	$ -	$ 177	$ -	$ 177	$ -
$ -	**$ -**	**$ 8,242**	**$ -**	**$ 8,242**	**$ -**	**Total Healthcare Expenses**	**$ 1,618**	**$ -**	**$ 12,399**	**$ -**	**$ 10,781**	**$ -**
0.0%		*166.7%*		*166.7%*		*MCR(%)*	*5.2%*		*32.0%*		*26.8%*	
$ -	**$ -**	**$ (3,299)**	**$ -**	**$ 3,299**	**$ -**	**Operating Margin**	**$ 29,627**	**$ -**	**$ 26,336**	**$ -**	**$ 3,290**	**$ -**
$ -	$ -	$ 339	$ -	$ 339	$ -	**Total Operating Expenses**	$ 158	$ -	$ 771	$ -	$ 612	$ -
0.0%		*6.9%*		*6.9%*		*Admin Ratio(%)*	*0.5%*		*2.0%*		*1.5%*	
$ -	**$ -**	**$ (3,638)**	**$ -**	**$ 3,638**	**$ -**	**Income (Loss) from Operations**	**$ 29,468**	**$ -**	**$ 25,566**	**$ -**	**$ 3,903**	**$ -**
$ -	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**Total Non-Operating Income (Expense)**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
$ -	**$ -**	**$ (3,638)**	**$ -**	**$ 3,638**	**$ -**	**Net Surplus (Deficit)**	**$ 29,468**	**$ -**	**$ 25,566**	**$ -**	**$ 3,903**	**$ -**
0.0%		*-73.6%*		*73.6%*		*Margin(%)*	*94.3%*		*66.0%*		*28.3%*	

Comparative Balance Sheet

(Dollars in thousands)	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23
ASSETS												
CURRENT ASSETS												
Total Current Assets	$5,474,251	$4,849,447	$4,871,908	$4,873,636	$4,936,270	$4,820,099	$5,663,469	$5,084,708	$5,172,416	$5,211,120	$5,469,816	$5,452,064
Capitalized Assets - net	$106,054	$106,171	$105,872	$105,275	$102,369	$104,591	$98,723	$98,849	$98,849	$92,230	$95,333	$96,465
NONCURRENT ASSETS	$2,878	$2,739	$2,635	$2,496	$2,363	$2,230	$2,129	$2,006	$1,946	$1,946	$1,531	$1,033
TOTAL ASSETS	**$5,583,182**	**$4,958,357**	**$4,980,415**	**$4,981,408**	**$5,046,815**	**$4,926,919**	**$5,833,900**	**$5,255,144**	**$5,342,529**	**$5,377,377**	**$5,635,100**	**$5,616,811**
LIABILITIES AND FUND EQUITY												
CURRENT LIABILITIES												
Total Current Liability	$4,494,782	$3,883,690	$3,872,966	$3,886,281	$3,964,303	$3,857,575	$4,746,546	$4,148,776	$4,249,831	$4,253,401	$4,493,204	$4,388,975
Long Term Liability	$3,058	$2,240	$2,362	$2,326	$2,429	$2,476	$0	($9)	$38	($2,775)	($2,781)	($2,731)
Total Liabilities	**$4,497,840**	**$3,885,929**	**$3,875,327**	**$3,888,607**	**$3,966,733**	**$3,860,051**	**$4,746,546**	**$4,148,767**	**$4,249,869**	**$4,250,626**	**$4,490,424**	**$4,386,245**
FUND EQUITY												
Invested in Capital Assets, net of related debt	$106,054	$106,171	$105,872	$105,275	$102,369	$104,591	$98,723	$98,849	$98,849	$92,230	$95,333	$96,465
Restricted Equity	$600	$600	$600	$600	$600	$600	$600	$600	$600	$600	$600	$600
Minimum Tangible Net Equity	$204,666	$205,980	$203,622	$203,266	$204,167	$204,247	$207,029	$206,981	$206,981	$208,364	$212,637	$214,911
Board Designated Funds	$125,441	$124,260	$113,244	$110,644	$108,737	$106,837	$104,822	$113,719	$107,669	$106,809	$103,706	$100,888
Unrestricted Net Assets	$648,581	$635,417	$681,750	$673,016	$664,209	$650,594	$676,180	$686,228	$678,561	$718,747	$732,399	$817,702
Total Fund Equity	**$1,085,342**	**$1,072,427**	**$1,105,088**	**$1,092,801**	**$1,080,082**	**$1,066,868**	**$1,087,354**	**$1,106,377**	**$1,092,660**	**$1,126,751**	**$1,144,676**	**$1,230,566**
TOTAL LIABILITIES AND FUND EQUITY	**$5,583,182**	**$4,958,357**	**$4,980,415**	**$4,981,408**	**$5,046,815**	**$4,926,919**	**$5,833,900**	**$5,255,144**	**$5,342,529**	**$5,377,377**	**$5,635,100**	**$5,616,811**
Solvency Ratios												
Working Capital Ratio	1.22	1.25	1.26	1.25	1.25	1.25	1.19	1.23	1.22	1.23	1.22	1.24
Cash to Claims Ratio	0.76	0.53	0.53	0.52	0.52	0.49	0.63	0.46	0.48	0.48	0.54	0.51
Tangible Net Equity Ratio	5.30	5.21	5.43	5.38	5.29	5.22	5.25	5.35	5.28	5.41	5.38	5.73

Cash Flows Statement ($ in thousands) February 2023

	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	YTD
Cash Flows from Operating Activities:						
Capitation Revenue	$ 763,710	$ 817,194	$ 840,632	$ 1,017,855	$ 803,604	$ 4,242,995
Other Income (Expense), net	$ 6,284	$ (1,516)	$ 6,286	$ 788	$ 3,433	$ 15,275
Healthcare Expenses	$ (737,336)	$ (716,891)	$ (781,483)	$ (839,834)	$ (651,002)	$ (3,726,546)
Operating Expenses	$ (29,792)	$ (36,802)	$ (54,221)	$ (29,955)	$ (37,060)	$ (187,830)
Net Cash Provided By Operating Activities	**$ 2,866**	**$ 61,985**	**$ 11,214**	**$ 148,854**	**$ 118,975**	**$ 343,894**
Cash Flows from Investing Activities						
Purchase of investments - Net	$ (65,406)	$ (114,037)	$ (94,704)	$ (57,274)	$ (57,555)	$ (388,976)
Purchase of Capital Assets	$ (2,036)	$ (1,650)	$ (1,538)	$ (2,652)	$ (3,361)	$ (11,237)
Net Cash Provided By Investing Activities	**$ (67,442)**	**$ (115,687)**	**$ (96,242)**	**$ (59,926)**	**$ (60,916)**	**$ (400,213)**
Cash Flows from Financing Activities:						
Lease Payment - Capital & ROU	$ -	$ -		$ (2,833)	$ (1,171)	$ (4,004)
Gross Premium Tax (MCO Sales Tax) - Net	$ (39,300)	$ 25,277	$ 16,069	$ (34,639)	$ 21,457	$ (11,136)
Pass through transactions (AB 85, IGT, etc.)	$ (575,356)	$ 12	$ (15,957)	$ 135,967	$ (131,768)	$ (587,102)
Net Cash Provided By Financing Activities	**$ (614,656)**	**$ 25,289**	**$ 112**	**$ 98,495**	**$ (111,482)**	**$ (602,242)**
Net Increase in Cash and Cash Equivalents	**$ (679,232)**	**$ (28,413)**	**$ (84,916)**	**$ 187,423**	**$ (53,423)**	**$ (658,561)**
Cash and Cash Equivalents, Beginning	$ 1,239,407	$ 560,175	$ 531,762	$ 446,846	$ 634,269	$ 1,239,407
Cash and Cash Equivalents, Ending	**$ 560,175**	**$ 531,762**	**$ 446,846**	**$ 634,269**	**$ 580,846**	**$ 580,846**

Reconciliation of Income from Operations to Net Cash Provided By (Used In) Operating Activities:

	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	YTD
Excess of Revenues over Expenses	**$ 19,023**	**$ (13,716)**	**$ 34,090**	**$ 17,925**	**$ 85,890**	**$ 143,212**
Adjustments to Excess of Revenues Over Expenses:						
Depreciation	$ 1,910	$ 1,912	$ 5,393	$ 3,211	$ 3,400	$ 15,826
Realized and Unrealized (Gain)/Loss on Investments	$ 2,065	$ (5,545)	$ (728)	$ (4,096)	$ 4,937	$ (3,367)
Deferred Rent	$ (9)	$ 47	$ (2,813)	$ (6)	$ 50	$ (2,731)
Gross Premium Tax provision	$ (708)	$ (778)	$ (862)	$ (2,376)	$ 580	$ (4,144)
Loss on Disposal of Capital Assets	$ -					$ -
Total Adjustments to Excess of Revenues over Expenses	**$ 3,258**	**$ (4,364)**	**$ 990**	**$ (3,267)**	**$ 8,967**	**$ 5,584**
Changes in Operating Assets and Liabilities:						
Capitation Receivable	$ (32,935)	$ (3,386)	$ (19,040)	$ 32,496	$ (95,242)	$ (118,107)
Interest and Non-Operating Receivables	$ 277	$ (941)	$ 3,653	$ (1,790)	$ (652)	$ 547
Prepaid and Other Current Assets	$ 5,448	$ (1,775)	$ (11,846)	$ 7,691	$ 2,710	$ 2,228
Accounts Payable and Accrued Liabilities	$ 2,713	$ 2,806	$ (6,256)	$ 4,546	$ (2,255)	$ 1,554
Subcapitation Payable	$ 28,522	$ 57,608	$ 11,307	$ 43,530	$ 151,132	$ 292,099
MediCal Adult Expansion Payable	$ 3	$ (649)	$ 1	$ -	$ 1	$ (644)
Deferred Capitation Revenue	$ (25,814)	$ (1,348)	$ 492	$ 55,505	$ (75,730)	$ (46,895)
Accrued Medical Expenses	$ (6,449)	$ 4,176	$ (2,080)	$ 4,932	$ 3,129	$ 3,708
Reserve for Claims	$ 7,512	$ 16,195	$ 22,490	$ 12,240	$ 40,128	$ 98,565
Reserve for Provider Incentives	$ 421	$ 5,561	$ (22,425)	$ (25,270)	$ (403)	$ (42,116)
Grants Payable	$ 887	$ 1,818	$ (162)	$ 316	$ 1,300	$ 4,159
Net Changes in Operating Assets and Liabilities	**$ (19,415)**	**$ 80,065**	**$ (23,866)**	**$ 134,196**	**$ 24,118**	**$ 195,098**
Net Cash Provided By Operating Activities	**$ 2,866**	**$ 61,985**	**$ 11,214**	**$ 148,854**	**$ 118,975**	**$ 343,894**

Financial Performance
March 2023
(Unaudited)

Financial Performance Results Highlights - Year-to-Date

March 2023

Overall

The combined member months are 16.8 million year-to-date, which is 4,162 favorable to the 3+9 forecast. The performance is a surplus of $200.0 million or 3.7% of revenue and is $105.9 million favorable to the forecast. The favorability is driven by lower outpatient claims, skilled nursing facility costs, pharmacy costs, and provider incentives expenses due to timing. Operating expenses are favorable to the forecast due to added funding to the forecast and timing in vendor spending. Higher interest income, higher unrealized investment gains and timing in grant spending also contributed to higher surplus.

Medi-Cal

Medi-Cal consists of members through our contracted providers and our contracted health plans ("Plan Partners"). The member months are 15.7 million, which is 335 unfavorable to the forecast. The performance is a surplus of $200.9 million and is $100.3 million favorable to the forecast. The favorability in net surplus is driven by lower inpatient claims, outpatient claims and skilled nursing facility costs. Also contributed to the favorable variance in surplus are lower provider incentives due to timing, lower operating and non-operating expenses as discussed in the Overall section above.

Cal MediConnect (CMC)

The member months are 51,322, which is 241 favorable to the forecast. The performance is a deficit of $16.4 million which is unfavorable to the forecast by $11.5 million driver by a provider shared risk adjustment. Effective January 1, 2023, members enrolled in CMC have been transitioned to our D-SNP plan. The net deficit of $16.4 million is primarily driven by the shared risk adjustment and operating expenses incurred through YTD December 2022 prior to the transition.

D-SNP

January 2023 is the first month of the D-SNP plan as the CMC members were transitioned into this product. For YTD March 2023, the member months are 53,177, which is 85 favorable to the forecast. The performance is a surplus of $13.8 million which is $13.7 million favorable to the forecast driven by higher revenue due to RAF and risk share adjustments, better than forecasted capitation expenses and timing in provider incentives and shared risk. Lower operating expenses also contributed to the favorable variance in net surplus.

Commercial

L.A. Care Commercial consists of LACC and PASC-SEIU. The member months are 1.0 million, which is 4,255 favorable to the forecast. The performance is a deficit of $12.2 million and is $7.7 million unfavorable to the forecast driven by higher inpatient claims but partially offset by lower provider incentives and shared risk due to timing. Higher operating expenses also contributed to the unfavorable variance in net deficit.

Incentive Programs

L.A. Care Incentive Programs consist of CalAIM Incentive Payment Program (IPP) and Housing and Homelessness Incentive Program (HHIP). The YTD surplus of $29.4 million, which is $7.3 million favorable to the forecast, is driven by the recognition of revenue for the submission of our investment plan to DHCS. The expenditures related to this program will be expensed when incur in future periods. The $7.3 million favorable variance is driven by the timing in provider incentive spending for HHIP.

Consolidated Operations Income Statement ($ in thousands)

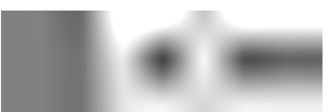
March 2023

Current Actual $	Current Actual PMPM	Current Forecast $	Current Forecast PMPM	Fav(Unfav) Forecast $	Fav(Unfav) Forecast PMPM		YTD Actual $	YTD Actual PMPM	YTD Forecast $	YTD Forecast PMPM	Fav(Unfav) Forecast $	Fav(Unfav) Forecast PMPM
						Membership						
2,881,570		2,889,051		(7,481)		Member Months	16,802,506		16,798,344		4,162	
						Revenue						
$ 977,584	$ 339.25	$ 960,771	$ 332.56	$ 16,813	$ 6.70	Capitation	$ 5,385,582	$ 320.52	$ 5,385,154	$ 320.58	$ 428	$ (0.05)
$ 977,584	**$ 339.25**	**$ 960,771**	**$ 332.56**	**$ 16,813**	**$ 6.70**	**Total Revenues**	**$ 5,385,582**	**$ 320.52**	**$ 5,385,154**	**$ 320.58**	**$ 428**	**$ (0.05)**
						Healthcare Expenses						
$ 517,527	$ 179.60	$ 506,838	$ 175.43	$ (10,689)	$ (4.16)	Capitation	$ 2,929,556	$ 174.35	$ 2,932,305	$ 174.56	$ 2,749	$ 0.21
$ 129,447	$ 44.92	$ 126,114	$ 43.65	$ (3,333)	$ (1.27)	Inpatient Claims	$ 728,304	$ 43.34	$ 730,733	$ 43.50	$ 2,429	$ 0.16
$ 105,860	$ 36.74	$ 115,684	$ 40.04	$ 9,824	$ 3.31	Outpatient Claims	$ 614,905	$ 36.60	$ 641,585	$ 38.19	$ 26,680	$ 1.60
$ 97,481	$ 33.83	$ 97,836	$ 33.86	$ 354	$ 0.03	Skilled Nursing Facility	$ 547,745	$ 32.60	$ 564,445	$ 33.60	$ 16,700	$ 1.00
$ 13,880	$ 4.82	$ 11,855	$ 4.10	$ (2,025)	$ (0.71)	Pharmacy	$ 63,900	$ 3.80	$ 67,046	$ 3.99	$ 3,146	$ 0.19
$ 11,086	$ 3.85	$ 14,937	$ 5.17	$ 3,850	$ 1.32	Provider Incentives and Shared Risk	$ 28,896	$ 1.72	$ 51,425	$ 3.06	$ 22,529	$ 1.34
$ 9,641	$ 3.35	$ 9,234	$ 3.20	$ (407)	$ (0.15)	Medical Administrative Expenses	$ 49,572	$ 2.95	$ 52,798	$ 3.14	$ 3,226	$ 0.19
$ 884,922	**$ 307.10**	**$ 882,496**	**$ 305.46**	**$ (2,426)**	**$ (1.63)**	**Total Healthcare Expenses**	**$ 4,962,879**	**$ 295.37**	**$ 5,040,336**	**$ 300.05**	**$ 77,457**	**$ 4.68**
90.5%		*91.9%*		*1.3%*		*MCR(%)*	*92.2%*		*93.6%*		*1.4%*	
$ 92,662	**$ 32.16**	**$ 78,275**	**$ 27.09**	**$ 14,387**	**$ 5.06**	**Operating Margin**	**$ 422,703**	**$ 25.16**	**$ 344,817**	**$ 20.53**	**$ 77,885**	**$ 4.63**
$ 50,659	$ 17.58	$ 46,043	$ 15.94	$ (4,616)	$ (1.64)	**Total Operating Expenses**	$ 255,745	$ 15.22	$ 265,804	$ 15.82	$ 10,059	$ 0.60
5.2%		*4.8%*		*-0.4%*		*Admin Ratio(%)*	*4.7%*		*4.9%*		*0.2%*	
$ 42,003	**$ 14.58**	**$ 32,232**	**$ 11.16**	**$ 9,771**	**$ 3.42**	**Income (Loss) from Operations**	**$ 166,957**	**$ 9.94**	**$ 79,013**	**$ 4.70**	**$ 87,944**	**$ 5.23**
$ (2,606)	$ (0.90)	$ (4,156)	$ (1.44)	$ 1,550	$ 0.53	Other Income/(Expense), net	$ (13,203)	$ (0.79)	$ (17,963)	$ (1.07)	$ 4,760	$ 0.28
$ 10,901	$ 3.78	$ 5,088	$ 1.76	$ 5,813	$ 2.02	Interest Income, net	$ 36,389	$ 2.17	$ 28,849	$ 1.72	$ 7,540	$ 0.45
$ (136)	$ (0.05)	$ -	$ -	$ (136)	$ (0.05)	Realized Gain / Loss	$ (1,024)	$ (0.06)	$ (842)	$ (0.05)	$ (182)	$ (0.01)
$ 6,606	$ 2.29	$ -	$ -	$ 6,606	$ 2.29	Unrealized Gain / Loss	$ 10,860	$ 0.65	$ 5,050	$ 0.30	$ 5,810	$ 0.35
$ 14,765	**$ 5.12**	**$ 932**	**$ 0.32**	**$ 13,833**	**$ 4.80**	**Total Non-Operating Income (Expense)**	**$ 33,022**	**$ 1.97**	**$ 15,094**	**$ 0.90**	**$ 17,929**	**$ 1.07**
$ 56,768	**$ 19.70**	**$ 33,164**	**$ 11.48**	**$ 23,604**	**$ 8.22**	**Net Surplus (Deficit)**	**$ 199,980**	**$ 11.90**	**$ 94,107**	**$ 5.60**	**$ 105,873**	**$ 6.30**
5.8%		*3.5%*		*2.4%*		*Margin(%)*	*3.7%*		*1.7%*		*2.0%*	

Total Medi-Cal Income Statement ($ in thousands)

March 2023

Current Actual $	Current Actual PMPM	Current Forecast $	Current Forecast PMPM	Fav(Unfav) Forecast $	Fav(Unfav) Forecast PMPM		YTD Actual $	YTD Actual PMPM	YTD Forecast $	YTD Forecast PMPM	Fav(Unfav) Forecast $	Fav(Unfav) Forecast PMPM
						Membership						
2,705,454		2,714,588		(9,134)		Member Months	15,741,737		15,742,072		(335)	
						Revenue						
$ 897,379	$ 331.69	$ 877,233	$ 323.16	$ 20,146	$ 8.54	Capitation	$ 4,900,088	$ 311.28	$ 4,889,353	$ 310.59	$ 10,736	$ 0.69
$ 897,379	**$ 331.69**	**$ 877,233**	**$ 323.16**	**$ 20,146**	**$ 8.54**	**Total Revenues**	**$ 4,900,088**	**$ 311.28**	**$ 4,889,353**	**$ 310.59**	**$ 10,736**	**$ 0.69**
						Healthcare Expenses						
$ 488,073	$ 180.40	$ 476,313	$ 175.46	$ (11,760)	$ (4.94)	Capitation	$ 2,759,088	$ 175.27	$ 2,759,743	$ 175.31	$ 654	$ 0.04
$ 113,003	$ 41.77	$ 110,997	$ 40.89	$ (2,006)	$ (0.88)	Inpatient Claims	$ 625,942	$ 39.76	$ 638,552	$ 40.56	$ 12,610	$ 0.80
$ 94,982	$ 35.11	$ 105,623	$ 38.91	$ 10,641	$ 3.80	Outpatient Claims	$ 553,496	$ 35.16	$ 578,599	$ 36.75	$ 25,103	$ 1.59
$ 96,869	$ 35.80	$ 97,836	$ 36.04	$ 967	$ 0.24	Skilled Nursing Facility	$ 538,881	$ 34.23	$ 556,897	$ 35.38	$ 18,015	$ 1.14
$ 11	$ 0.00	$ -	$ -	$ (11)	$ (0.00)	Pharmacy	$ 406	$ 0.03	$ (162)	$ (0.01)	$ (567)	$ (0.04)
$ 6,170	$ 2.28	$ 5,313	$ 1.96	$ (857)	$ (0.32)	Provider Incentives and Shared Risk	$ 16,303	$ 1.04	$ 24,215	$ 1.54	$ 7,912	$ 0.50
$ 9,171	$ 3.39	$ 8,517	$ 3.14	$ (654)	$ (0.25)	Medical Administrative Expenses	$ 46,981	$ 2.98	$ 49,294	$ 3.13	$ 2,313	$ 0.15
$ 808,279	**$ 298.76**	**$ 804,599**	**$ 296.40**	**$ (3,680)**	**$ (2.36)**	**Total Healthcare Expenses**	**$ 4,541,097**	**$ 288.47**	**$ 4,607,138**	**$ 292.66**	**$ 66,041**	**$ 4.19**
90.1%		*91.7%*		*1.6%*		*MCR(%)*	*92.7%*		*94.2%*		*1.6%*	
$ 89,100	**$ 32.93**	**$ 72,634**	**$ 26.76**	**$ 16,466**	**$ 6.18**	**Operating Margin**	**$ 358,991**	**$ 22.81**	**$ 282,215**	**$ 17.93**	**$ 76,776**	**$ 4.88**
$ 40,814	$ 15.09	$ 37,314	$ 13.75	$ (3,500)	$ (1.34)	**Total Operating Expenses**	$ 205,208	$ 13.04	$ 214,123	$ 13.60	$ 8,915	$ 0.57
4.5%		*4.3%*		*-0.3%*		*Admin Ratio(%)*	*4.2%*		*4.4%*		*0.2%*	
$ 48,285	**$ 17.85**	**$ 35,320**	**$ 13.01**	**$ 12,966**	**$ 4.84**	**Income (Loss) from Operations**	**$ 153,783**	**$ 9.77**	**$ 68,092**	**$ 4.33**	**$ 85,691**	**$ 5.44**
$ 16,594	**$ 6.13**	**$ 4,610**	**$ 1.70**	**$ 11,984**	**$ 4.44**	**Total Non-Operating Income (Expense)**	**$ 47,089**	**$ 2.99**	**$ 32,481**	**$ 2.06**	**$ 14,608**	**$ 0.93**
$ 64,879	**$ 23.98**	**$ 39,930**	**$ 14.71**	**$ 24,949**	**$ 9.27**	**Net Surplus (Deficit)**	**$ 200,872**	**$ 12.76**	**$ 100,574**	**$ 6.39**	**$ 100,299**	**$ 6.37**
7.2%		*4.6%*		*2.7%*		*Margin(%)*	*4.1%*		*2.1%*		*2.0%*	



CMC Income Statement ($ in thousands)

March 2023

Current Actual $	Current Actual PMPM	Current Forecast $	Current Forecast PMPM	Fav(Unfav) Forecast $	Fav(Unfav) Forecast PMPM		YTD Actual $	YTD Actual PMPM	YTD Forecast $	YTD Forecast PMPM	Fav(Unfav) Forecast $	Fav(Unfav) Forecast PMPM
						Membership						
(17)				(17)		Member Months	51,322		51,081		241	
						Revenue						
$ (977)	N/A	$ -	$ -	$ (977)	N/A	Capitation	$ 73,150	$ 1,425.32	$ 75,769	$ 1,483.31	$ (2,619)	$ (57.99)
$ (977)	**$ -**	**$ -**	**$ -**	**$ (977)**	**$ -**	**Total Revenues**	**$ 73,150**	**$ 1,425.32**	**$ 75,769**	**$ 1,483.31**	**$ (2,619)**	**$ (57.99)**
						Healthcare Expenses						
$ (69)	N/A	$ -	$ -	$ 69	N/A	Capitation	$ 30,991	$ 603.86	$ 30,024	$ 587.77	$ (968)	$ (16.10)
$ 827	N/A	$ -	$ -	$ (827)	N/A	Inpatient Claims	$ 26,938	$ 524.88	$ 24,578	$ 481.16	$ (2,359)	$ (43.71)
$ (301)	N/A	$ -	$ -	$ 301	N/A	Outpatient Claims	$ 9,822	$ 191.39	$ 11,230	$ 219.85	$ 1,408	$ 28.46
$ 42	N/A	$ -	$ -	$ (42)	N/A	Skilled Nursing Facility	$ 7,248	$ 141.23	$ 7,194	$ 140.84	$ (54)	$ (0.39)
$ 637	N/A	$ -	$ -	$ (637)	N/A	Pharmacy	$ (2,828)	$ (55.10)	$ 1,193	$ 23.35	$ 4,021	$ 78.45
$ 8,791	N/A	$ -	$ -	$ (8,791)	N/A	Provider Incentives and Shared Risk	$ 11,128	$ 216.83	$ 1,046	$ 20.48	$ (10,082)	$ (196.35)
$ 266	N/A	$ -	$ -	$ (266)	N/A	Medical Administrative Expenses	$ 1,547	$ 30.15	$ 842	$ 16.48	$ (705)	$ (13.66)
$ 10,193	**$ -**	**$ -**	**$ -**	**$ (10,193)**	**$ -**	**Total Healthcare Expenses**	**$ 84,847**	**$ 1,653.23**	**$ 76,107**	**$ 1,489.93**	**$ (8,740)**	**$ (163.30)**
-1043.8%		*0.0%*		*1043.8%*		*MCR(%)*	*116.0%*		*100.4%*		*-15.5%*	
$ (11,170)	**$ -**	**$ -**	**$ -**	**$ (11,170)**	**$ -**	**Operating Margin**	**$ (11,697)**	**$ (227.91)**	**$ (338)**	**$ (6.62)**	**$ (11,359)**	**$ (221.29)**
$ 890	$ -	$ -	$ -	$ (890)	$ -	**Total Operating Expenses**	$ 6,364	$ 124.01	$ 5,189	$ 101.58	$ (1,176)	$ (22.43)
-91.2%		*0.0%*		*91.2%*		*Admin Ratio(%)*	*8.7%*		*6.8%*		*-1.9%*	
$ (12,060)	**$ -**	**$ -**	**$ -**	**$ (12,060)**	**$ -**	**Income (Loss) from Operations**	**$ (18,061)**	**$ (351.92)**	**$ (5,527)**	**$ (108.20)**	**$ (12,534)**	**$ (243.72)**
$ 632	**N/A**	**$ -**	**$ -**	**$ 632**	**N/A**	**Total Non-Operating Income (Expense)**	**$ 1,702**	**$ 33.16**	**$ 670**	**$ 13.11**	**$ 1,032**	**$ 20.05**
$ (11,428)	**N/A**	**$ -**	**$ -**	**$ (11,428)**	**N/A**	**Net Surplus (Deficit)**	**$ (16,359)**	**$ (318.76)**	**$ (4,857)**	**$ (95.09)**	**$ (11,502)**	**$ (223.67)**
1170.2%		*0.0%*		*1170.2%*		*Margin(%)*	*-22.4%*		*-6.4%*		*-16.0%*	

D-SNP Income Statement ($ in thousands)

March 2023

Current Actual $	Current Actual PMPM	Current Forecast $	Current Forecast PMPM	Fav(Unfav) Forecast $	Fav(Unfav) Forecast PMPM		YTD Actual $	YTD Actual PMPM	YTD Forecast $	YTD Forecast PMPM	Fav(Unfav) Forecast $	Fav(Unfav) Forecast PMPM
						Membership						
17,674		17,707		(33)		Member Months	53,177		53,092		85	
						Revenue						
$ 27,173	$ 1,537.45	$ 24,548	$ 1,386.34	$ 2,624	$ 151.11	Capitation	$ 79,097	$ 1,487.42	$ 73,603	$ 1,386.34	$ 5,494	$ 101.09
$ 27,173	**$ 1,537.45**	**$ 24,548**	**$ 1,386.34**	**$ 2,624**	**$ 151.11**	**Total Revenues**	**$ 79,097**	**$ 1,487.42**	**$ 73,603**	**$ 1,386.34**	**$ 5,494**	**$ 101.09**
						Healthcare Expenses						
$ 9,998	$ 565.71	$ 10,712	$ 604.94	$ 714	$ 39.23	Capitation	$ 28,876	$ 543.01	$ 32,117	$ 604.94	$ 3,242	$ 61.93
$ 6,022	$ 340.75	$ 6,210	$ 350.72	$ 188	$ 9.97	Inpatient Claims	$ 19,059	$ 358.40	$ 18,620	$ 350.72	$ (438)	$ (7.68)
$ 2,765	$ 156.43	$ 2,674	$ 151.03	$ (90)	$ (5.41)	Outpatient Claims	$ 8,031	$ 151.01	$ 7,990	$ 150.50	$ (40)	$ (0.52)
$ 533	$ 30.14	$ -	$ -	$ (533)	$ (30.14)	Skilled Nursing Facility	$ 905	$ 17.01	$ -	$ -	$ (905)	$ (17.01)
$ 1,857	$ 105.05	$ 1,244	$ 70.27	$ (612)	$ (34.78)	Pharmacy	$ 4,619	$ 86.86	$ 3,731	$ 70.27	$ (888)	$ (16.59)
$ 564	$ 31.92	$ 911	$ 51.43	$ 347	$ 19.51	Provider Incentives and Shared Risk	$ 564	$ 10.61	$ 2,731	$ 51.43	$ 2,167	$ 40.82
$ 75	$ 4.23	$ 396	$ 22.39	$ 322	$ 18.16	Medical Administrative Expenses	$ 217	$ 4.07	$ 1,193	$ 22.47	$ 976	$ 18.40
$ 21,814	**$ 1,234.24**	**$ 22,148**	**$ 1,250.79**	**$ 334**	**$ 16.55**	**Total Healthcare Expenses**	**$ 62,269**	**$ 1,170.98**	**$ 66,382**	**$ 1,250.34**	**$ 4,113**	**$ 79.36**
80.3%		*90.2%*		*9.9%*		*MCR(%)*	*78.7%*		*90.2%*		*11.5%*	
$ 5,359	**$ 303.21**	**$ 2,400**	**$ 135.55**	**$ 2,959**	**$ 167.66**	**Operating Margin**	**$ 16,827**	**$ 316.44**	**$ 7,220**	**$ 136.00**	**$ 9,607**	**$ 180.45**
$ 403	$ 22.83	$ 1,381	$ 77.97	$ 977	$ 55.14	**Total Operating Expenses**	$ 3,038	$ 57.13	$ 7,597	$ 143.08	$ 4,558	$ 85.95
1.5%		*5.6%*		*4.1%*		*Admin Ratio(%)*	*3.8%*		*10.3%*		*6.5%*	
$ 4,956	**$ 280.38**	**$ 1,020**	**$ 57.58**	**$ 3,936**	**$ 222.80**	**Income (Loss) from Operations**	**$ 13,789**	**$ 259.31**	**$ (376)**	**$ (7.09)**	**$ 14,165**	**$ 266.39**
$ -	**$ -**	**$ 162**	**$ 9.17**	**$ (162)**	**$ (9.17)**	**Total Non-Operating Income (Expense)**	**$ -**	**$ -**	**$ 484**	**$ 9.12**	**$ (484)**	**$ (9.12)**
$ 4,956	**$ 280.38**	**$ 1,182**	**$ 66.75**	**$ 3,774**	**$ 213.64**	**Net Surplus (Deficit)**	**$ 13,789**	**$ 259.31**	**$ 108**	**$ 2.04**	**$ 13,681**	**$ 257.27**
18.2%		*4.8%*		*13.4%*		*Margin(%)*	*17.4%*		*0.1%*		*17.3%*	

Commercial Income Statement ($ in thousands)

March 2023

Current Actual $	Current Actual PMPM	Current Forecast $	Current Forecast PMPM	Fav(Unfav) Forecast $	Fav(Unfav) Forecast PMPM		YTD Actual $	YTD Actual PMPM	YTD Forecast $	YTD Forecast PMPM	Fav(Unfav) Forecast $	Fav(Unfav) Forecast PMPM
						Membership						
176,133		174,463		1,670		Member Months	1,009,447		1,005,192		4,255	
						Revenue						
$ 54,009	$ 306.64	$ 53,803	$ 308.39	$ 206	$ (1.75)	Capitation	$ 302,002	$ 299.18	$ 302,507	$ 300.94	$ (505)	$ (1.77)
$ 54,009	**$ 306.64**	**$ 53,803**	**$ 308.39**	**$ 206**	**$ (1.75)**	**Total Revenues**	**$ 302,002**	**$ 299.18**	**$ 302,507**	**$ 300.94**	**$ (505)**	**$ (1.77)**
						Healthcare Expenses						
$ 19,524	$ 110.85	$ 18,956	$ 108.65	$ (569)	$ (2.20)	Capitation	$ 110,601	$ 109.57	$ 107,884	$ 107.33	$ (2,717)	$ (2.24)
$ 9,594	$ 54.47	$ 8,906	$ 51.05	$ (688)	$ (3.42)	Inpatient Claims	$ 56,366	$ 55.84	$ 48,982	$ 48.73	$ (7,384)	$ (7.11)
$ 8,414	$ 47.77	$ 7,387	$ 42.34	$ (1,027)	$ (5.43)	Outpatient Claims	$ 43,557	$ 43.15	$ 43,766	$ 43.54	$ 209	$ 0.39
$ 38	$ 0.22	$ -	$ -	$ (38)	$ (0.22)	Skilled Nursing Facility	$ 711	$ 0.70	$ 354	$ 0.35	$ (357)	$ (0.35)
$ 11,375	$ 64.58	$ 10,610	$ 60.82	$ (765)	$ (3.76)	Pharmacy	$ 61,699	$ 61.12	$ 62,280	$ 61.96	$ 581	$ 0.84
$ (4,439)	$ (25.20)	$ 1,205	$ 6.91	$ 5,644	$ 32.11	Provider Incentives and Shared Risk	$ (718)	$ (0.71)	$ 5,384	$ 5.36	$ 6,102	$ 6.07
$ 129	$ 0.73	$ 260	$ 1.49	$ 131	$ 0.76	Medical Administrative Expenses	$ 791	$ 0.78	$ 1,195	$ 1.19	$ 404	$ 0.41
$ 44,636	**$ 253.42**	**$ 47,324**	**$ 271.25**	**$ 2,688**	**$ 17.83**	**Total Healthcare Expenses**	**$ 273,007**	**$ 270.45**	**$ 269,845**	**$ 268.45**	**$ (3,162)**	**$ (2.00)**
82.6%		*88.0%*		*5.3%*		*MCR(%)*	*90.4%*		*89.2%*		*-1.2%*	
$ 9,373	**$ 53.22**	**$ 6,479**	**$ 37.14**	**$ 2,894**	**$ 16.08**	**Operating Margin**	**$ 28,995**	**$ 28.72**	**$ 32,662**	**$ 32.49**	**$ (3,668)**	**$ (3.77)**
$ 8,337	$ 47.33	$ 6,865	$ 39.35	$ (1,472)	$ (7.98)	**Total Operating Expenses**	$ 42,610	$ 42.21	$ 38,870	$ 38.67	$ (3,741)	$ (3.54)
15.4%		*12.8%*		*-2.7%*		*Admin Ratio(%)*	*14.1%*		*12.8%*		*-1.3%*	
$ 1,036	**$ 5.88**	**$ (386)**	**$ (2.21)**	**$ 1,422**	**$ 8.10**	**Income (Loss) from Operations**	**$ (13,616)**	**$ (13.49)**	**$ (6,207)**	**$ (6.18)**	**$ (7,408)**	**$ (7.31)**
$ 0	**$ 0.00**	**$ 316**	**$ 1.81**	**$ (316)**	**$ (1.81)**	**Total Non-Operating Income (Expense)**	**$ 1,434**	**$ 1.42**	**$ 1,769**	**$ 1.76**	**$ (336)**	**$ (0.34)**
$ 1,036	**$ 5.88**	**$ (70)**	**$ (0.40)**	**$ 1,106**	**$ 6.29**	**Net Surplus (Deficit)**	**$ (12,182)**	**$ (12.07)**	**$ (4,438)**	**$ (4.42)**	**$ (7,744)**	**$ (7.65)**
1.9%		*-0.1%*		*2.0%*		*Margin(%)*	*-4.0%*		*-1.5%*		*-2.6%*	

Incentive Programs (IPP & HHIP) Income Statement ($ in thousands)

March 2023

Current Actual $	Current Actual PMPM	Current Forecast $	Current Forecast PMPM	Fav(Unfav) Forecast $	Fav(Unfav) Forecast PMPM		YTD Actual $	YTD Actual PMPM	YTD Forecast $	YTD Forecast PMPM	Fav(Unfav) Forecast $	Fav(Unfav) Forecast PMPM
						Membership						
				-		Member Months					-	
						Revenue						
$ -	$ -	$ 5,187	$ -	$ (5,187)	$ -	Capitation	$ 31,245	$ -	$ 43,922	$ -	$ (12,677)	$ -
$ -	**$ -**	**$ 5,187**	**$ -**	**$ (5,187)**	**$ -**	**Total Revenues**	**$ 31,245**	**$ -**	**$ 43,922**	**$ -**	**$ (12,677)**	**$ -**
	$ -					**Healthcare Expenses**						
$ -	$ -	$ 857	$ -	$ 857	$ -	Capitation	$ -	$ -	$ 2,538	$ -	$ 2,538	$ -
$ -	$ -	$ 7,508	$ -	$ 7,508	$ -	Provider Incentives and Shared Risk	$ 1,618	$ -	$ 18,049	$ -	$ 16,431	$ -
$ -	$ -	$ 60	$ -	$ 60	$ -	Medical Administrative Expenses	$ -	$ -	$ 237	$ -	$ 237	$ -
$ -	**$ -**	**$ 8,425**	**$ -**	**$ 8,425**	**$ -**	**Total Healthcare Expenses**	**$ 1,618**	**$ -**	**$ 20,824**	**$ -**	**$ 19,205**	**$ -**
0.0%		*162.4%*		*162.4%*		*MCR(%)*	*5.2%*		*47.4%*		*42.2%*	
$ -	**$ -**	**$ (3,238)**	**$ -**	**$ 3,238**	**$ -**	**Operating Margin**	**$ 29,627**	**$ -**	**$ 23,099**	**$ -**	**$ 6,528**	**$ -**
$ 43	$ -	$ 231	$ -	$ 188	$ -	**Total Operating Expenses**	$ 201	$ -	$ 1,001	$ -	$ 800	$ -
0.0%		*4.4%*		*4.4%*		*Admin Ratio(%)*	*0.6%*		*2.3%*		*1.6%*	
$ (43)	**$ -**	**$ (3,468)**	**$ -**	**$ 3,426**	**$ -**	**Income (Loss) from Operations**	**$ 29,426**	**$ -**	**$ 22,097**	**$ -**	**$ 7,328**	**$ -**
$ -	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**Total Non-Operating Income (Expense)**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
$ (43)	**$ -**	**$ (3,468)**	**$ -**	**$ 3,426**	**$ -**	**Net Surplus (Deficit)**	**$ 29,426**	**$ -**	**$ 22,097**	**$ -**	**$ 7,328**	**$ -**
0.0%		*-66.9%*		*66.9%*		*Margin(%)*	*94.2%*		*50.3%*		*43.9%*	

Comparative Balance Sheet

(Dollars in thousands)	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
ASSETS												
CURRENT ASSETS												
Total Current Assets	$4,849,447	$4,871,908	$4,873,636	$4,936,270	$4,820,099	$5,663,469	$5,084,708	$5,172,416	$5,211,120	$5,469,816	$5,452,064	$7,027,117
Capitalized Assets - net	$106,171	$105,872	$105,275	$102,369	$104,591	$98,723	$98,849	$98,849	$92,230	$95,333	$96,465	$99,515
NONCURRENT ASSETS	$2,739	$2,635	$2,496	$2,363	$2,230	$2,129	$2,006	$1,946	$1,946	$1,531	$1,033	$1,556
TOTAL ASSETS	**$4,958,357**	**$4,980,415**	**$4,981,408**	**$5,046,815**	**$4,926,919**	**$5,833,900**	**$5,255,144**	**$5,342,529**	**$5,377,377**	**$5,635,100**	**$5,616,811**	**$7,193,822**
LIABILITIES AND FUND EQUITY												
CURRENT LIABILITIES												
Total Current Liability	$3,883,690	$3,872,966	$3,886,281	$3,964,303	$3,857,575	$4,746,546	$4,148,776	$4,249,831	$4,253,401	$4,493,204	$4,388,975	$5,909,168
Long Term Liability	$2,240	$2,362	$2,326	$2,429	$2,476	$0	($9)	$38	($2,775)	($2,781)	($2,731)	($2,681)
Total Liabilities	**$3,885,929**	**$3,875,327**	**$3,888,607**	**$3,966,733**	**$3,860,051**	**$4,746,546**	**$4,148,767**	**$4,249,869**	**$4,250,626**	**$4,490,424**	**$4,386,245**	**$5,906,488**
FUND EQUITY												
Invested in Capital Assets, net of related debt	$106,171	$105,872	$105,275	$102,369	$104,591	$98,723	$98,849	$98,849	$92,230	$95,333	$96,465	$99,515
Restricted Equity	$600	$600	$600	$600	$600	$600	$600	$600	$600	$600	$600	$600
Minimum Tangible Net Equity	$205,980	$203,622	$203,266	$204,167	$204,247	$207,029	$206,981	$206,981	$208,364	$212,637	$214,911	$218,383
Board Designated Funds	$124,260	$113,244	$110,644	$108,737	$106,837	$104,822	$113,719	$107,669	$106,809	$103,706	$100,888	$98,646
Unrestricted Net Assets	$635,417	$681,750	$673,016	$664,209	$650,594	$676,180	$686,228	$678,561	$718,747	$732,399	$817,702	$870,190
Total Fund Equity	**$1,072,427**	**$1,105,088**	**$1,092,801**	**$1,080,082**	**$1,066,868**	**$1,087,354**	**$1,106,377**	**$1,092,660**	**$1,126,751**	**$1,144,676**	**$1,230,566**	**$1,287,334**
TOTAL LIABILITIES AND FUND EQUITY	**$4,958,357**	**$4,980,415**	**$4,981,408**	**$5,046,815**	**$4,926,919**	**$5,833,900**	**$5,255,144**	**$5,342,529**	**$5,377,377**	**$5,635,100**	**$5,616,811**	**$7,193,822**
Solvency Ratios												
Working Capital Ratio	1.25	1.26	1.25	1.25	1.25	1.19	1.23	1.22	1.23	1.22	1.24	1.19
Cash to Claims Ratio	0.53	0.53	0.52	0.52	0.49	0.63	0.46	0.48	0.48	0.54	0.51	0.88
Tangible Net Equity Ratio	5.21	5.43	5.38	5.29	5.22	5.25	5.35	5.28	5.41	5.38	5.73	5.89

Cash Flows Statement ($ in thousands) — March 2023

	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	YTD
Cash Flows from Operating Activities:							
Capitation Revenue	$ 763,710	$ 817,194	$ 840,632	$ 1,017,855	$ 803,604	$ 1,185,273	$ 5,428,268
Other Income (Expense), net	$ 6,284	$ (1,516)	$ 6,286	$ 788	$ 3,433	$ 2,910	$ 18,185
Healthcare Expenses	$ (737,336)	$ (716,891)	$ (781,483)	$ (839,834)	$ (651,002)	$ (878,499)	$ (4,605,045)
Operating Expenses	$ (29,792)	$ (36,802)	$ (54,221)	$ (29,955)	$ (37,060)	$ (48,926)	$ (236,756)
Net Cash Provided By Operating Activities	**$ 2,866**	**$ 61,985**	**$ 11,214**	**$ 148,854**	**$ 118,975**	**$ 260,758**	**$ 604,652**
Cash Flows from Investing Activities							
Purchase of investments - Net	$ (65,406)	$ (114,037)	$ (94,704)	$ (57,274)	$ (57,555)	$ 152,854	$ (236,122)
Purchase of Capital Assets	$ (2,036)	$ (1,650)	$ (1,538)	$ (2,652)	$ (3,361)	$ (4,585)	$ (15,822)
Net Cash Provided By Investing Activities	**$ (67,442)**	**$ (115,687)**	**$ (96,242)**	**$ (59,926)**	**$ (60,916)**	**$ 148,269**	**$ (251,944)**
Cash Flows from Financing Activities:							
Lease Payment - Capital & ROU	$ -	$ -		$ (2,833)	$ (1,171)	$ (1,713)	$ (5,717)
Gross Premium Tax (MCO Sales Tax) - Net	$ (39,300)	$ 25,277	$ 16,069	$ (34,639)	$ 21,457	$ (109)	$ (11,245)
Pass through transactions (AB 85, IGT, etc.)	$ (575,356)	$ 12	$ (15,957)	$ 135,967	$ (131,768)	$ 1,194,616	$ 607,514
Net Cash Provided By Financing Activities	**$ (614,656)**	**$ 25,289**	**$ 112**	**$ 98,495**	**$ (111,482)**	**$ 1,192,794**	**$ 590,552**
Net Increase in Cash and Cash Equivalents	**$ (679,232)**	**$ (28,413)**	**$ (84,916)**	**$ 187,423**	**$ (53,423)**	**$ 1,601,821**	**$ 943,260**
Cash and Cash Equivalents, Beginning	$ 1,239,407	$ 560,175	$ 531,762	$ 446,846	$ 634,269	$ 580,846	$ 1,239,407
Cash and Cash Equivalents, Ending	**$ 560,175**	**$ 531,762**	**$ 446,846**	**$ 634,269**	**$ 580,846**	**$ 2,182,667**	**$ 2,182,667**

Reconciliation of Income from Operations to Net Cash Provided By (Used In) Operating Activities:

	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	YTD
Excess of Revenues over Expenses	**$ 19,023**	**$ (13,716)**	**$ 34,090**	**$ 17,925**	**$ 85,890**	**$ 56,768**	**$ 199,980**
Adjustments to Excess of Revenues Over Expenses:							
Depreciation	$ 1,910	$ 1,912	$ 5,393	$ 3,211	$ 3,400	$ 3,151	$ 18,977
Realized and Unrealized (Gain)/Loss on Investments	$ 2,065	$ (5,545)	$ (728)	$ (4,096)	$ 4,937	$ (6,469)	$ (9,836)
Deferred Rent	$ (9)	$ 47	$ (2,813)	$ (6)	$ 50	$ 50	$ (2,681)
Gross Premium Tax provision	$ (708)	$ (778)	$ (862)	$ (2,376)	$ 580	$ 148	$ (3,996)
Loss on Disposal of Capital Assets	$ -					$ (3)	$ (3)
Total Adjustments to Excess of Revenues over Expenses	**$ 3,258**	**$ (4,364)**	**$ 990**	**$ (3,267)**	**$ 8,967**	**$ (3,123)**	**$ 2,461**
Changes in Operating Assets and Liabilities:							
Capitation Receivable	$ (32,935)	$ (3,386)	$ (19,040)	$ 32,496	$ (95,242)	$ (132,584)	$ (250,691)
Interest and Non-Operating Receivables	$ 277	$ (941)	$ 3,653	$ (1,790)	$ (652)	$ (3,553)	$ (3,006)
Prepaid and Other Current Assets	$ 5,448	$ (1,775)	$ (11,846)	$ 7,691	$ 2,710	$ (2,922)	$ (694)
Accounts Payable and Accrued Liabilities	$ 2,713	$ 2,806	$ (6,256)	$ 4,546	$ (2,255)	$ (3,903)	$ (2,349)
Subcapitation Payable	$ 28,522	$ 57,608	$ 11,307	$ 43,530	$ 151,132	$ (2,762)	$ 289,337
MediCal Adult Expansion Payable	$ 3	$ (649)	$ 1	$ -	$ 1	$ -	$ (644)
Deferred Capitation Revenue	$ (25,814)	$ (1,348)	$ 492	$ 55,505	$ (75,730)	$ 340,273	$ 293,378
Accrued Medical Expenses	$ (6,449)	$ 4,176	$ (2,080)	$ 4,932	$ 3,129	$ 10,758	$ 14,466
Reserve for Claims	$ 7,512	$ 16,195	$ 22,490	$ 12,240	$ 40,128	$ 5,392	$ 103,957
Reserve for Provider Incentives	$ 421	$ 5,561	$ (22,425)	$ (25,270)	$ (403)	$ (1,808)	$ (43,924)
Grants Payable	$ 887	$ 1,818	$ (162)	$ 316	$ 1,300	$ (1,778)	$ 2,381
Net Changes in Operating Assets and Liabilities	**$ (19,415)**	**$ 80,065**	**$ (23,866)**	**$ 134,196**	**$ 24,118**	**$ 207,113**	**$ 402,211**
Net Cash Provided By Operating Activities	**$ 2,866**	**$ 61,985**	**$ 11,214**	**$ 148,854**	**$ 118,975**	**$ 260,758**	**$ 604,652**

DATE: April 26, 2023

TO: Finance & Budget Committee

FROM: Marie Montgomery, *Chief Financial Officer*

SUBJECT: Monthly Investment Portfolio Securities Transaction Report for February, 2023

To keep the Committee apprised of L.A. Care's investment portfolios and to comply with California Government Code Section 53607, attached are the monthly investment transaction details from February 1 to February 28, 2023.

L.A. Care's investment market value as of February 28, 2023, was $2.0 billion. This includes our funds invested with the government pooled funds. L.A. Care has approximately $74 million invested with the statewide Local Agency Investment Fund (LAIF), and approximately $157 million invested with the Los Angeles County Pooled Investment Fund (LACPIF).

The remainder as of February 28, 2023, of $1.8 billion is managed by two independent asset managers, 1) Payden & Rygel and 2) New England Asset Management (NEAM) and is divided into three portfolios based on investment style,

1. Payden & Rygel - Short-term portfolio
2. Payden & Rygel - Extended term portfolio
3. New England Asset Management - Corporate notes extended term portfolio

The transactions within these three portfolios are included in the attached reports.

LA Care, as a California government entity, only makes investments in bonds/fixed income, as per the California Government Code. The entries on the Investment Securities Portfolio Transaction Report reflect transactions undertaken by financial management companies on L.A. Care's behalf. L.A. Care does not direct these individual transactions. The firms, managing investments on behalf of L.A. Care, conduct the transactions based on L.A. Care's investment guidelines.

Account Name: L.A. CARE HEALTH PLAN

02/01/2023 through 02/28/2023

Tr Date	St Date	Transaction Type	Units	Description		Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/06/23	02/07/23	Buy	30,000,000.000	U.S. TREASURY BILL MAT 02/09/23 Cpn	912796XZ7	(29,992,798.33)		0.00	0.00	(29,992,798.33)
02/06/23	02/07/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 02/09/23 Cpn	912796XZ7	(49,987,997.22)		0.00	0.00	(49,987,997.22)
02/06/23	02/07/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 02/09/23 Cpn	912796XZ7	(49,987,997.22)		0.00	0.00	(49,987,997.22)
02/06/23	02/07/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 02/09/23 Cpn	912796XZ7	(49,987,997.22)		0.00	0.00	(49,987,997.22)
02/06/23	02/07/23	Buy	3,000,000.000	U.S. TREASURY BILL MAT 02/09/23 Cpn	912796XZ7	(2,999,281.67)		0.00	0.00	(2,999,281.67)
02/06/23	02/07/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 02/09/23 Cpn	912796XZ7	(49,988,027.78)		0.00	0.00	(49,988,027.78)
02/06/23	02/07/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 02/09/23 Cpn	912796XZ7	(49,988,027.78)		0.00	0.00	(49,988,027.78)
02/06/23	02/07/23	Buy	7,500,000.000	DNB NOR BANK YCD MAT 11/02/23 Cpn 5.01	23344NN85	(7,498,196.85)	(5,218.75)	0.00	0.00	(7,503,415.60)
02/08/23	02/08/23	Buy	7,500,000.000	CA UNIVERSITY OF CALIFORNIA C MAT 02/28/23 Cpn	91411UPU3	(7,480,833.33)		0.00	0.00	(7,480,833.33)
02/08/23	02/09/23	Buy	5,000,000.000	FNMA DISCOUNT NOTE MAT 02/13/23 Cpn	313588BV6	(4,997,600.00)		0.00	0.00	(4,997,600.00)
02/08/23	02/09/23	Buy	50,000,000.000	FNMA DISCOUNT NOTE MAT 02/13/23 Cpn	313588BV6	(49,976,000.00)		0.00	0.00	(49,976,000.00)
02/08/23	02/09/23	Buy	50,000,000.000	FNMA DISCOUNT NOTE MAT 02/13/23 Cpn	313588BV6	(49,976,000.00)		0.00	0.00	(49,976,000.00)
02/08/23	02/09/23	Buy	7,500,000.000	ING (US) FUNDING CP MAT 11/03/23 Cpn	4497W1Y34	(7,221,875.00)		0.00	0.00	(7,221,875.00)

Account Name: L.A. CARE HEALTH PLAN

02/01/2023 through 02/28/2023

Tr Date	St Date	Transaction Type	Units	Description		Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/09/23	02/10/23	Buy	45,000,000.000	U.S. TREASURY BILL MAT 02/16/23 Cpn	912796YA1	(44,966,625.00)		0.00	0.00	(44,966,625.00)
02/09/23	02/10/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 02/16/23 Cpn	912796YA1	(49,962,916.67)		0.00	0.00	(49,962,916.67)
02/09/23	02/10/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 02/16/23 Cpn	912796YA1	(49,962,916.67)		0.00	0.00	(49,962,916.67)
02/09/23	02/10/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 02/16/23 Cpn	912796YA1	(49,962,916.67)		0.00	0.00	(49,962,916.67)
02/09/23	02/10/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 02/16/23 Cpn	912796YA1	(49,962,916.67)		0.00	0.00	(49,962,916.67)
02/10/23	02/10/23	Buy	40,000,000.000	U.S. TREASURY BILL MAT 02/16/23 Cpn	912796YA1	(39,970,383.33)		0.00	0.00	(39,970,383.33)
02/09/23	02/10/23	Buy	15,000,000.000	U.S. TREASURY BILL MAT 02/21/23 Cpn	912796Y60	(14,979,363.54)		0.00	0.00	(14,979,363.54)
02/09/23	02/10/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 02/21/23 Cpn	912796Y60	(49,931,211.81)		0.00	0.00	(49,931,211.81)
02/10/23	02/10/23	Buy	25,000,000.000	U.S. TREASURY BILL MAT 02/21/23 Cpn	912796Y60	(24,965,537.15)		0.00	0.00	(24,965,537.15)
02/10/23	02/10/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 02/21/23 Cpn	912796Y60	(49,931,074.31)		0.00	0.00	(49,931,074.31)
02/10/23	02/10/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 02/21/23 Cpn	912796Y60	(49,931,074.31)		0.00	0.00	(49,931,074.31)
02/10/23	02/10/23	Buy	30,000,000.000	U.S. TREASURY BILL MAT 02/28/23 Cpn	912796Y78	(29,931,952.50)		0.00	0.00	(29,931,952.50)
02/10/23	02/10/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 03/02/23 Cpn	912796YB9	(49,876,111.11)		0.00	0.00	(49,876,111.11)

Account Name: L.A. CARE HEALTH PLAN

02/01/2023 through 02/28/2023

Tr Date	St Date	Transaction Type	Units	Description		Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/10/23	02/10/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 03/07/23 Cpn	912796Y86	(49,843,557.29)		0.00	0.00	(49,843,557.29)
02/10/23	02/10/23	Buy	25,000,000.000	U.S. TREASURY BILL MAT 03/09/23 Cpn	912796YK9	(24,915,798.44)		0.00	0.00	(24,915,798.44)
02/10/23	02/10/23	Buy	14,000,000.000	U.S. TREASURY BILL MAT 03/16/23 Cpn	912796YL7	(13,940,901.96)		0.00	0.00	(13,940,901.96)
02/10/23	02/10/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 08/10/23 Cpn	912796XY0	(48,809,422.22)		0.00	0.00	(48,809,422.22)
02/10/23	02/10/23	Buy	40,000,000.000	U.S. TREASURY BILL MAT 02/23/23 Cpn	912796T33	(39,934,566.67)		0.00	0.00	(39,934,566.67)
02/10/23	02/10/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 05/11/23 Cpn	912796ZE2	(49,419,500.00)		0.00	0.00	(49,419,500.00)
02/10/23	02/13/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 02/14/23 Cpn	912796ZU6	(49,993,783.33)		0.00	0.00	(49,993,783.33)
02/10/23	02/13/23	Buy	25,000,000.000	U.S. TREASURY BILL MAT 07/20/23 Cpn	912796ZZ5	(24,491,930.56)		0.00	0.00	(24,491,930.56)
02/13/23	02/14/23	Buy	30,000,000.000	U.S. TREASURY BILL MAT 02/16/23 Cpn	912796YA1	(29,992,575.00)		0.00	0.00	(29,992,575.00)
02/13/23	02/14/23	Buy	50,000,000.000	FNMA DISCOUNT NOTE MAT 02/15/23 Cpn	313588BX2	(49,994,041.67)		0.00	0.00	(49,994,041.67)
02/13/23	02/14/23	Buy	50,000,000.000	FNMA DISCOUNT NOTE MAT 02/15/23 Cpn	313588BX2	(49,994,041.67)		0.00	0.00	(49,994,041.67)
02/15/23	02/15/23	Buy	5,000,000.000	FHLB DISCOOUNT NOTE MAT 02/17/23 Cpn	313384BZ1	(4,998,805.56)		0.00	0.00	(4,998,805.56)
02/07/23	02/15/23	Buy	5,500,000.000	WOART 2023-A A2A CAR MAT 07/15/26 Cpn 5.18	98164JAB0	(5,499,954.90)		0.00	0.00	(5,499,954.90)

Account Name: L.A. CARE HEALTH PLAN

02/01/2023 through 02/28/2023

Tr Date	St Date	Transaction Type	Units	Description		Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/13/23	02/16/23	Buy	30,000,000.000	U.S. TREASURY BILL MAT 08/17/23 Cpn	912796Z36	(29,267,298.33)		0.00	0.00	(29,267,298.33)
02/15/23	02/16/23	Buy	5,000,000.000	U.S. TREASURY BILL MAT 08/17/23 Cpn	912796Z36	(4,878,224.31)		0.00	0.00	(4,878,224.31)
02/15/23	02/16/23	Buy	7,500,000.000	BARCLAYS YCD MAT 11/10/23 Cpn 5.48	06742T4S2	(7,500,000.00)		0.00	0.00	(7,500,000.00)
02/15/23	02/16/23	Buy	35,000,000.000	FHLB DISCOOUNT NOTE MAT 02/17/23 Cpn	313384BZ1	(34,995,819.44)		0.00	0.00	(34,995,819.44)
02/08/23	02/16/23	Buy	2,700,000.000	GMALT 2023-1 A2A LEASE MAT 06/20/25 Cpn 5.27	362541AB0	(2,699,779.41)		0.00	0.00	(2,699,779.41)
02/16/23	02/17/23	Buy	7,500,000.000	CREDIT AGRICOLE CP MAT 11/10/23 Cpn	22533UYA5	(7,220,700.00)		0.00	0.00	(7,220,700.00)
02/17/23	02/21/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 02/28/23 Cpn	912796Y78	(49,955,885.42)		0.00	0.00	(49,955,885.42)
02/17/23	02/21/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 02/28/23 Cpn	912796Y78	(49,955,885.42)		0.00	0.00	(49,955,885.42)
02/17/23	02/21/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 02/28/23 Cpn	912796Y78	(49,955,885.42)		0.00	0.00	(49,955,885.42)
02/21/23	02/21/23	Buy	30,000,000.000	U.S. TREASURY BILL MAT 03/14/23 Cpn	912796Z69	(29,921,600.00)		0.00	0.00	(29,921,600.00)
02/17/23	02/21/23	Buy	15,000,000.000	U.S. TREASURY BILL MAT 06/20/23 Cpn	912797FP7	(14,763,140.42)		0.00	0.00	(14,763,140.42)
02/21/23	02/21/23	Buy	8,000,000.000	U.S. TREASURY BILL MAT 02/23/23 Cpn	912796T33	(7,998,086.78)		0.00	0.00	(7,998,086.78)
02/22/23	02/23/23	Buy	18,000,000.000	U.S. TREASURY BILL MAT 03/07/23 Cpn	912796Y86	(17,973,360.00)		0.00	0.00	(17,973,360.00)

Account Name: L.A. CARE HEALTH PLAN

02/01/2023 through 02/28/2023

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/22/23	02/23/23	Buy	7,500,000.000	BANK OF NOVA SCOTIA FRN YCD MAT 11/20/23 Cpn 4.84 06417MT96	(7,500,000.00)		0.00	0.00	(7,500,000.00)
02/17/23	02/23/23	Buy	6,550,000.000	CRVNA 2023-P1 A1 CAR 144A MAT 03/11/24 Cpn 5.28 14688EAA7	(6,550,000.00)		0.00	0.00	(6,550,000.00)
02/27/23	02/27/23	Buy	32,000,000.000	U.S. TREASURY BILL MAT 03/16/23 Cpn 912796YL7	(31,933,133.33)		0.00	0.00	(31,933,133.33)
02/27/23	02/28/23	Buy	2,000,000.000	U.S. TREASURY BILL MAT 03/07/23 Cpn 912796Y86	(1,998,269.44)		0.00	0.00	(1,998,269.44)
02/27/23	02/28/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 03/14/23 Cpn 912796Z69	(49,913,054.17)		0.00	0.00	(49,913,054.17)
02/27/23	02/28/23	Buy	4,000,000.000	U.S. TREASURY BILL MAT 03/16/23 Cpn 912796YL7	(3,992,067.56)		0.00	0.00	(3,992,067.56)
02/27/23	02/28/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 03/16/23 Cpn 912796YL7	(49,900,844.44)		0.00	0.00	(49,900,844.44)
02/27/23	02/28/23	Buy	31,000,000.000	U.S. TREASURY BILL MAT 05/25/23 Cpn 912796ZF9	(30,653,345.94)		0.00	0.00	(30,653,345.94)
02/28/23	02/28/23	Buy	7,500,000.000	CA UNIVERSITY OF CALIFORNIA C MAT 05/02/23 Cpn 91411US22	(7,436,606.25)		0.00	0.00	(7,436,606.25)
			1,909,250,000.000		(1,903,209,497.49)	(5,218.75)	0.00	0.00	(1,903,214,716.24)
02/09/23	02/09/23	Coupon		MMAF 2022-B A1 EQP 144A MAT 12/01/23 Cpn 4.92 606940AA2		14,695.45	0.00	0.00	14,695.45
02/10/23	02/10/23	Coupon		CRVNA 2021-P4 A2 CAR MAT 04/10/25 Cpn 0.82 14687KAB2		1,729.90	0.00	0.00	1,729.90
02/13/23	02/13/23	Coupon		MMAF 2022-A A1 EQP 144A MAT 05/03/23 Cpn 1.48 55317RAA0		838.73	0.00	0.00	838.73

Account Name: L.A. CARE HEALTH PLAN

02/01/2023 through 02/28/2023

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/13/23	02/13/23	Coupon		SKANDINAV ENSKILDA BK YCD FR MAT 04/12/23 Cpn 5.06 83050PP60		32,133.33	0.00	0.00	32,133.33
02/15/23	02/15/23	Coupon		ALLYA 2022-2 A2 CAR MAT 10/15/25 Cpn 4.62 02008MAB5		14,245.00	0.00	0.00	14,245.00
02/15/23	02/15/23	Coupon		ARIFL 2022-A A1 FLEET 144A MAT 04/17/23 Cpn 1.49 00217QAA9		5.53	0.00	0.00	5.53
02/15/23	02/15/23	Coupon		CARMAX 2019-3 A3 CAR MAT 08/15/24 Cpn 2.18 14315PAD7		1,586.74	0.00	0.00	1,586.74
02/15/23	02/15/23	Coupon		CARMX 2021-4 A2A CAR MAT 11/15/24 Cpn 0.24 14317JAB3		164.38	0.00	0.00	164.38
02/15/23	02/15/23	Coupon		CARMX 2023-1 A1 CAR MAT 02/15/24 Cpn 4.96 14318DAA7		11,872.23	0.00	0.00	11,872.23
02/15/23	02/15/23	Coupon		CNH 2021-C A2 EQP MAT 01/15/25 Cpn 0.33 12598LAB2		762.68	0.00	0.00	762.68
02/15/23	02/15/23	Coupon		COPAR 2022-2 A1 CAR MAT 08/15/23 Cpn 2.87 14043GAA2		1,095.78	0.00	0.00	1,095.78
02/15/23	02/15/23	Coupon		FORDL 2023-A A1 LEASE MAT 02/15/24 Cpn 4.96 345287AA4		5,702.85	0.00	0.00	5,702.85
02/15/23	02/15/23	Coupon		FORDO 2022-C A1 CAR MAT 10/15/23 Cpn 3.63 34535AAA8		7,640.67	0.00	0.00	7,640.67
02/15/23	02/15/23	Coupon		GALC 2022-1 A1 EQP 144A MAT 10/16/23 Cpn 4.34 39154TBU1		12,289.04	0.00	0.00	12,289.04
02/15/23	02/15/23	Coupon		HALST 2021-A A3 LEASE 144A MAT 01/16/24 Cpn 0.33 44891TAC0		408.59	0.00	0.00	408.59
02/15/23	02/15/23	Coupon		HALST 2021-A A3 LEASE 144A MAT 01/16/24 Cpn 0.33 44891TAC0		362.28	0.00	0.00	362.28

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/15/23	02/15/23	Coupon		HALST 2021-C A2 CAR LEASE 144A MAT 01/16/24 Cpn 0.24 44933MAB7		229.15	0.00	0.00	229.15
02/15/23	02/15/23	Coupon		HALST 2021-C A2 CAR LEASE 144A MAT 01/16/24 Cpn 0.24 44933MAB7		55.36	0.00	0.00	55.36
02/15/23	02/15/23	Coupon		HAROT 2022-1 A2 CAR MAT 10/15/24 Cpn 1.44 43815BAB6		4,485.02	0.00	0.00	4,485.02
02/15/23	02/15/23	Coupon		HART 2019-B A4 CAR MAT 04/15/25 Cpn 2.00 44891JAD0		7,794.95	0.00	0.00	7,794.95
02/15/23	02/15/23	Coupon		JOHN DEERE 2020-B A3 EQP MAT 11/15/24 Cpn 0.51 47787NAC3		1,250.40	0.00	0.00	1,250.40
02/15/23	02/15/23	Coupon		KUBOTA 2020-1A A3 EQP 144A MAT 03/15/24 Cpn 1.96 50117WAC8		1,550.78	0.00	0.00	1,550.78
02/15/23	02/15/23	Coupon		KUBOTA 2020-1A A3 EQP 144A MAT 03/15/24 Cpn 1.96 50117WAC8		372.05	0.00	0.00	372.05
02/15/23	02/15/23	Coupon		KCOT 2022-2A A1 EQP 144A MAT 07/17/23 Cpn 2.60 50117JAA1		1,871.18	0.00	0.00	1,871.18
02/15/23	02/15/23	Coupon		MERCEDES 2020-B A4 LEASE MAT 06/15/26 Cpn 0.50 58769EAD0		2,708.33	0.00	0.00	2,708.33
02/15/23	02/15/23	Coupon		MERCEDES 2021-B A2 LEASE MAT 01/16/24 Cpn 0.22 58769KAC8		65.36	0.00	0.00	65.36
02/15/23	02/15/23	Coupon		NALT 2023-A A1 LEASE MAT 02/15/24 Cpn 4.97 65480VAA1		12,026.70	0.00	0.00	12,026.70
02/15/23	02/15/23	Coupon		NAROT 2022-B A1 CAR MAT 10/16/23 Cpn 3.69 65480JAA8		10,785.86	0.00	0.00	10,785.86
02/15/23	02/15/23	Coupon		TAOT 2022-C A2A CAR MAT 08/15/25 Cpn 4.19 89231CAB3		18,156.67	0.00	0.00	18,156.67

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/15/23	02/15/23	Coupon		TAOT 2023-A A1 CAR MAT 01/15/24 Cpn 4.84 891940AA6		7,747.20	0.00	0.00	7,747.20
02/15/23	02/15/23	Coupon		WOART 2022-B A2A CAR MAT 10/15/25 Cpn 2.77 98163QAB5		9,356.08	0.00	0.00	9,356.08
02/15/23	02/15/23	Coupon		WOLS 2022-A A2 LEASE MAT 10/15/24 Cpn 2.63 98163NAB2		2,658.39	0.00	0.00	2,658.39
02/16/23	02/16/23	Coupon		GMCAR 2022-4 A1 CAR MAT 10/16/23 Cpn 3.62 36265QAA4		9,277.34	0.00	0.00	9,277.34
02/16/23	02/16/23	Coupon		GMCAR 2023-1 A1 CAR MAT 01/16/24 Cpn 4.89 38013JAA1		29,543.75	0.00	0.00	29,543.75
02/18/23	02/18/23	Coupon		HONDA 2021-3 A2 CAR MAT 02/20/24 Cpn 0.20 43815EAB0		72.75	0.00	0.00	72.75
02/20/23	02/20/23	Coupon		GMALT 2021-1 A3 LEASE MAT 02/20/24 Cpn 0.26 36261RAC2		681.36	0.00	0.00	681.36
02/20/23	02/20/23	Coupon		GMALT 2021-1 A3 LEASE MAT 02/20/24 Cpn 0.26 36261RAC2		23.10	0.00	0.00	23.10
02/20/23	02/20/23	Coupon		GMALT 2021-2 A LEASE MAT 05/20/25 Cpn 0.41 380144AD7		717.50	0.00	0.00	717.50
02/20/23	02/20/23	Coupon		SRT 2021-A A3 LEASE 144A MAT 07/22/24 Cpn 0.51 80286TAC7		1,508.70	0.00	0.00	1,508.70
02/20/23	02/20/23	Coupon		TESLA 2021-B A2 LEASE 144A MAT 09/22/25 Cpn 0.36 88161KAB1		505.66	0.00	0.00	505.66
02/20/23	02/20/23	Coupon		TLOT 2021-B A3 LEASE 144A MAT 10/21/24 Cpn 0.42 89239CAC3		875.00	0.00	0.00	875.00
02/20/23	02/20/23	Coupon		TLOT 2021-B A3 LEASE 144A MAT 10/21/24 Cpn 0.42 89239CAC3		1,281.00	0.00	0.00	1,281.00

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/20/23	02/20/23	Coupon		VALET 2021-1 A2 CAR MAT 10/21/24 Cpn 0.49 92868KAB9		934.66	0.00	0.00	934.66
02/20/23	02/20/23	Coupon		VERIZON 2019-C A1A PHONE MAT 04/22/24 Cpn 1.94 92348AAA3		4.31	0.00	0.00	4.31
02/20/23	02/20/23	Coupon		VERIZON 2019-C A1A PHONE MAT 04/22/24 Cpn 1.94 92348AAA3		2.11	0.00	0.00	2.11
02/21/23	02/21/23	Coupon		BANK OF NOVA SCOTIA YCD FRN MAT 02/21/23 Cpn 06417MH40		10,688.89	0.00	0.00	10,688.89
02/21/23	02/21/23	Coupon		CREDIT AGRICOLE NY YCD MAT 02/21/23 Cpn 4.60 22536A3S1		91,041.67	0.00	0.00	91,041.67
02/21/23	02/21/23	Coupon		DLLAD 2023-1A A1 EQP 144A MAT 02/20/24 Cpn 5.01 233258AA0		5,557.18	0.00	0.00	5,557.18
02/21/23	02/21/23	Coupon		EFF 2022-2 A1 FLEET 144A MAT 06/20/23 Cpn 2.76 29374JAA3		3,053.85	0.00	0.00	3,053.85
02/21/23	02/21/23	Coupon		EFF 2022-3 A1 FLEET 144A MAT 08/20/23 Cpn 3.61 29374FAA1		10,193.92	0.00	0.00	10,193.92
02/21/23	02/21/23	Coupon		EFF 2022-4 A1 FLEET 144A MAT 11/20/23 Cpn 5.15 29374GAA9		20,662.86	0.00	0.00	20,662.86
02/21/23	02/21/23	Coupon		HPEFS 2022-2A A1 EQP 144A MAT 05/22/23 Cpn 1.91 40441TAA7		559.25	0.00	0.00	559.25
02/21/23	02/21/23	Coupon		HPEFS 2022-3A A1 EQP 144A MAT 10/20/23 Cpn 4.33 403951AA4		4,615.31	0.00	0.00	4,615.31
02/21/23	02/21/23	Coupon		NORDEA BANK NY YCD FRN MAT 04/20/23 Cpn 5.16 65558UXX5		32,800.00	0.00	0.00	32,800.00
02/21/23	02/21/23	Coupon		SVENSKA HANDELSBANKEN NY Y MAT 04/21/23 Cpn 5.16 86959RM31		32,733.33	0.00	0.00	32,733.33

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02/21/23	02/21/23	Coupon		SUMITOMO MITSUI BANKING YCD MAT 03/20/23 Cpn 4.95 86565FTC6		31,400.00	0.00	0.00	31,400.00
02/22/23	02/22/23	Coupon		DEFT 2022-2 A1 EQP 144A MAT 07/24/23 Cpn 3.06 24702CAA2		3,488.32	0.00	0.00	3,488.32
02/25/23	02/25/23	Coupon		BMW 2021-1 A4 LEASE MAT 07/25/24 Cpn 0.37 05591RAD6		693.75	0.00	0.00	693.75
02/25/23	02/25/23	Coupon		CITIBANK CD FRN SOFRRATE MAT 05/25/23 Cpn 5.00 17330QAG2		30,677.08	0.00	0.00	30,677.08
02/25/23	02/25/23	Coupon		FHMS KF36 A MAT 08/25/24 Cpn 4.73 3137FBAR7		525.67	0.00	0.00	525.67
02/25/23	02/25/23	Coupon		FHMS KI04 A 1MOFRN CMBS MAT 07/25/24 Cpn 4.93 3137FNAV2		350.08	0.00	0.00	350.08
02/25/23	02/25/23	Coupon		FHMS KI06 A 1MOFRN CMBS MAT 03/25/25 Cpn 4.79 3137FVNA6		2,163.65	0.00	0.00	2,163.65
02/25/23	02/25/23	Coupon		FHMS KI07 A SOFRFRN MAT 09/25/26 Cpn 4.48 3137H3KA9		25,325.73	0.00	0.00	25,325.73
02/25/23	02/25/23	Coupon		FHMS KI08 A 1MOFRN CMBS MAT 10/25/26 Cpn 4.51 3137H4RC6		12,866.10	0.00	0.00	12,866.10
02/25/23	02/25/23	Coupon		FHMS Q015 A 1MOFRN CMBS MAT 08/25/24 Cpn 4.56 3137FYUR5		3,608.67	0.00	0.00	3,608.67
02/27/23	02/27/23	Coupon		FHMS KF38 A MAT 09/25/24 Cpn 4.90 3137FBUC8		1,196.56	0.00	0.00	1,196.56

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Fixed Income - cont.									
02/28/23	02/28/23	Coupon		TORONTO-DOMINION NY YCD MAT 02/28/23 Cpn 3.70 89115BNE6		140,291.67	0.00	0.00	140,291.67
						696,567.44	0.00	0.00	696,567.44
02/01/23	02/01/23	Income	148.330	STIF INT MAT Cpn USD		148.33	0.00	0.00	148.33
02/01/23	02/01/23	Income	18,713.830	ADJ NET INT MAT Cpn USD		18,713.83	0.00	0.00	18,713.83
02/01/23	02/01/23	Income	275,618.110	STIF INT MAT Cpn USD		275,618.11	0.00	0.00	275,618.11
			294,480.270			294,480.27	0.00	0.00	294,480.27
02/09/23	02/09/23	Contributn	310,000,000.000	NM MAT Cpn USD	310,000,000.00		0.00	0.00	310,000,000.00
02/10/23	02/10/23	Contributn	470,000,000.000	NM MAT Cpn USD	470,000,000.00		0.00	0.00	470,000,000.00
			780,000,000.000		780,000,000.00		0.00	0.00	780,000,000.00
02/01/23	02/02/23	Sell Long	30,000,000.000	U.S. TREASURY BILL MAT 02/07/23 Cpn 912796ZT9	29,914,260.41	68,333.34	(322.92)	0.00	29,982,593.75
02/01/23	02/02/23	Sell Long	15,000,000.000	U.S. TREASURY BILL MAT 02/07/23 Cpn 912796ZT9	14,957,130.21	34,166.67	(161.45)	0.00	14,991,296.88
02/03/23	02/06/23	Sell Long	2,000,000.000	U.S. TREASURY BILL MAT 02/07/23 Cpn 912796ZT9	1,994,305.14	5,466.67	(0.41)	0.00	1,999,771.81

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02/24/23	02/27/23	Sell Long	30,000,000.000	U.S. TREASURY BILL MAT 02/28/23 Cpn 912796Y78	29,931,962.09	64,267.08	9.59	0.00	29,996,229.17
			77,000,000.000		76,797,657.86	172,233.75	(475.19)	0.00	76,969,891.61
02/09/23	02/09/23	Pay Princpl	498,715.717	MMAF 2022-B A1 EQP 144A MAT 12/01/23 Cpn 4.92 606940AA2	498,715.72		0.00	0.00	498,715.72
02/10/23	02/10/23	Pay Princpl	415,778.563	CRVNA 2021-P4 A2 CAR MAT 04/10/25 Cpn 0.82 14687KAB2	415,778.56		0.00	17.53	415,778.56
02/13/23	02/13/23	Pay Princpl	657,101.407	MMAF 2022-A A1 EQP 144A MAT 05/03/23 Cpn 1.48 55317RAA0	657,101.41		0.00	0.00	657,101.41
02/15/23	02/15/23	Pay Princpl	4,595.028	ARIFL 2022-A A1 FLEET 144A MAT 04/17/23 Cpn 1.49 00217QAA9	4,595.03		0.00	0.00	4,595.03
02/15/23	02/15/23	Pay Princpl	235,092.504	CARMAX 2019-3 A3 CAR MAT 08/15/24 Cpn 2.18 14315PAD7	235,092.50		0.00	(583.41)	235,092.50
02/15/23	02/15/23	Pay Princpl	211,110.737	CARMX 2021-4 A2A CAR MAT 11/15/24 Cpn 0.24 14317JAB3	211,110.74		0.00	0.67	211,110.74
02/15/23	02/15/23	Pay Princpl	644,824.093	CARMX 2023-1 A1 CAR MAT 02/15/24 Cpn 4.96 14318DAA7	644,824.09		(0.00)	0.00	644,824.09
02/15/23	02/15/23	Pay Princpl	527,702.204	CNH 2021-C A2 EQP MAT 01/15/25 Cpn 0.33 12598LAB2	527,702.20		0.00	13.18	527,702.20
02/15/23	02/15/23	Pay Princpl	473,633.175	COPAR 2022-2 A1 CAR MAT 08/15/23 Cpn 2.87 14043GAA2	473,633.18		0.00	0.00	473,633.18
02/15/23	02/15/23	Pay Princpl	281,100.071	FORDL 2023-A A1 LEASE MAT 02/15/24 Cpn 4.96 345287AA4	281,100.07		(0.00)	0.00	281,100.07
02/15/23	02/15/23	Pay Princpl	1,436,878.364	FORDO 2022-C A1 CAR MAT 10/15/23 Cpn 3.63 34535AAA8	1,436,878.36		(0.00)	0.00	1,436,878.36

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02/15/23	02/15/23	Pay Princpl	639,699.840	GALC 2022-1 A1 EQP 144A MAT 10/16/23 Cpn 4.34 39154TBU1	639,699.84		(0.00)	0.00	639,699.84
02/15/23	02/15/23	Pay Princpl	601,240.304	HALST 2021-A A3 LEASE 144A MAT 01/16/24 Cpn 0.33 44891TAC0	601,240.30		2,132.78	0.00	601,240.30
02/15/23	02/15/23	Pay Princpl	533,099.737	HALST 2021-A A3 LEASE 144A MAT 01/16/24 Cpn 0.33 44891TAC0	533,099.74		2,715.43	0.00	533,099.74
02/15/23	02/15/23	Pay Princpl	490,528.590	HALST 2021-C A2 CAR LEASE 144A MAT 01/16/24 Cpn 0.24 44933MAB7	490,528.59		0.00	3.62	490,528.59
02/15/23	02/15/23	Pay Princpl	118,503.937	HALST 2021-C A2 CAR LEASE 144A MAT 01/16/24 Cpn 0.24 44933MAB7	118,503.94		372.66	0.00	118,503.94
02/15/23	02/15/23	Pay Princpl	391,103.072	HAROT 2022-1 A2 CAR MAT 10/15/24 Cpn 1.44 43815BAB6	391,103.07		15.81	0.00	391,103.07
02/15/23	02/15/23	Pay Princpl	710,669.999	HART 2019-B A4 CAR MAT 04/15/25 Cpn 2.00 44891JAD0	710,670.00		4,121.10	0.00	710,670.00
02/15/23	02/15/23	Pay Princpl	581,082.639	JOHN DEERE 2020-B A3 EQP MAT 11/15/24 Cpn 0.51 47787NAC3	581,082.64		7,713.30	0.00	581,082.64
02/15/23	02/15/23	Pay Princpl	238,852.000	KUBOTA 2020-1A A3 EQP 144A MAT 03/15/24 Cpn 1.96 50117WAC8	238,852.00		0.00	(1,497.44)	238,852.00
02/15/23	02/15/23	Pay Princpl	57,303.058	KUBOTA 2020-1A A3 EQP 144A MAT 03/15/24 Cpn 1.96 50117WAC8	57,303.06		0.00	(332.42)	57,303.06
02/15/23	02/15/23	Pay Princpl	475,146.850	KCOT 2022-2A A1 EQP 144A MAT 07/17/23 Cpn 2.60 50117JAA1	475,146.85		(0.00)	0.00	475,146.85
02/15/23	02/15/23	Pay Princpl	2,090,088.847	MERCEDES 2020-B A4 LEASE MAT 06/15/26 Cpn 0.50 58769EAD0	2,090,088.85		12,643.80	0.00	2,090,088.85
02/15/23	02/15/23	Pay Princpl	356,535.171	MERCEDES 2021-B A2 LEASE MAT 01/16/24 Cpn 0.22 58769KAC8	356,535.17		0.00	2.69	356,535.17

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02/15/23	02/15/23	Pay Princpl	504,936.345	NALT 2023-A A1 LEASE MAT 02/15/24 Cpn 4.97 65480VAA1	504,936.34		(0.00)	0.00	504,936.34
02/15/23	02/15/23	Pay Princpl	1,017,513.880	NAROT 2022-B A1 CAR MAT 10/16/23 Cpn 3.69 65480JAA8	1,017,513.88		0.00	0.00	1,017,513.88
02/15/23	02/15/23	Pay Princpl	1,051,737.681	TAOT 2023-A A1 CAR MAT 01/15/24 Cpn 4.84 891940AA6	1,051,737.68		(0.00)	0.00	1,051,737.68
02/15/23	02/15/23	Pay Princpl	319,118.682	WOART 2022-B A2A CAR MAT 10/15/25 Cpn 2.77 98163QAB5	319,118.68		19.21	0.00	319,118.68
02/15/23	02/15/23	Pay Princpl	92,491.701	WOLS 2022-A A2 LEASE MAT 10/15/24 Cpn 2.63 98163NAB2	92,491.70		1.42	0.00	92,491.70
02/16/23	02/16/23	Pay Princpl	972,769.286	GMCAR 2022-4 A1 CAR MAT 10/16/23 Cpn 3.62 36265QAA4	972,769.29		0.00	0.00	972,769.29
02/16/23	02/16/23	Pay Princpl	2,111,461.977	GMCAR 2023-1 A1 CAR MAT 01/16/24 Cpn 4.89 38013JAA1	2,111,461.98		0.00	0.00	2,111,461.98
02/18/23	02/18/23	Pay Princpl	192,102.050	HONDA 2021-3 A2 CAR MAT 02/20/24 Cpn 0.20 43815EAB0	192,102.05		0.00	3.47	192,102.05
02/20/23	02/20/23	Pay Princpl	1,085,472.982	GMALT 2021-1 A3 LEASE MAT 02/20/24 Cpn 0.26 36261RAC2	1,085,472.98		4,871.64	0.00	1,085,472.98
02/20/23	02/20/23	Pay Princpl	36,795.694	GMALT 2021-1 A3 LEASE MAT 02/20/24 Cpn 0.26 36261RAC2	36,795.69		165.14	0.00	36,795.69
02/20/23	02/20/23	Pay Princpl	415,929.240	HPEFS 2022-3A A1 EQP 144A MAT 10/20/23 Cpn 4.33 403951AA4	415,929.24		0.00	0.00	415,929.24
02/20/23	02/20/23	Pay Princpl	315,218.089	SRT 2021-A A3 LEASE 144A MAT 07/22/24 Cpn 0.51 80286TAC7	315,218.09		6,840.25	0.00	315,218.09
02/20/23	02/20/23	Pay Princpl	171,513.434	TESLA 2021-B A2 LEASE 144A MAT 09/22/25 Cpn 0.36 88161KAB1	171,513.43		0.00	6.98	171,513.43

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02/20/23	02/20/23	Pay Princpl	472,963.993	VALET 2021-1 A2 CAR MAT 10/21/24 Cpn 0.49 92868KAB9	472,963.99		0.00	11.35	472,963.99
02/20/23	02/20/23	Pay Princpl	2,663.163	VERIZON 2019-C A1A PHONE MAT 04/22/24 Cpn 1.94 92348AAA3	2,663.16		0.00	(0.00)	2,663.16
02/20/23	02/20/23	Pay Princpl	1,304.954	VERIZON 2019-C A1A PHONE MAT 04/22/24 Cpn 1.94 92348AAA3	1,304.95		0.00	(0.00)	1,304.95
02/21/23	02/21/23	Pay Princpl	516,492.128	DLLAD 2023-1A A1 EQP 144A MAT 02/20/24 Cpn 5.01 233258AA0	516,492.13		0.00	0.00	516,492.13
02/21/23	02/21/23	Pay Princpl	861,625.198	EFF 2022-2 A1 FLEET 144A MAT 06/20/23 Cpn 2.76 29374JAA3	861,625.20		0.00	0.00	861,625.20
02/21/23	02/21/23	Pay Princpl	623,479.739	EFF 2022-3 A1 FLEET 144A MAT 08/20/23 Cpn 3.61 29374FAA1	623,479.74		0.00	0.00	623,479.74
02/21/23	02/21/23	Pay Princpl	537,522.441	EFF 2022-4 A1 FLEET 144A MAT 11/20/23 Cpn 5.15 29374GAA9	537,522.44		(0.00)	0.00	537,522.44
02/21/23	02/21/23	Pay Princpl	340,917.740	HPEFS 2022-2A A1 EQP 144A MAT 05/22/23 Cpn 1.91 40441TAA7	340,917.74		0.00	0.00	340,917.74
02/22/23	02/22/23	Pay Princpl	753,443.958	DEFT 2022-2 A1 EQP 144A MAT 07/24/23 Cpn 3.06 24702CAA2	753,443.96		0.00	0.00	753,443.96
02/25/23	02/25/23	Pay Princpl	121,036.709	FHMS KF36 A MAT 08/25/24 Cpn 4.73 3137FBAR7	121,036.71		0.00	31.75	121,036.71
02/25/23	02/25/23	Pay Princpl	136.399	FHMS KF38 A MAT 09/25/24 Cpn 4.90 3137FBUC8	136.40		0.00	0.06	136.40
02/25/23	02/25/23	Pay Princpl	174,566.190	FHMS KI08 A 1MOFRN CMBS MAT 10/25/26 Cpn 4.51 3137H4RC6	174,566.19		0.00	0.00	174,566.19

Account Name: L.A. CARE HEALTH PLAN

02/01/2023 through 02/28/2023

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
Fixed Income - cont.									
02/25/23	02/25/23	Pay Princpl	96,891.444	FHMS Q015 A 1MOFRN CMBS MAT 08/25/24 Cpn 4.56 3137FYUR5	96,891.44		0.00	(0.00)	96,891.44
			25,460,491.005		25,460,490.99		41,612.53	(2,321.98)	25,460,490.99
02/01/23	02/01/23	Mature Long	7,500,000.000	TRAVELERS COMPANIES CP 144A MAT 02/01/23 Cpn 8941P3P15	7,493,772.92	6,227.08	0.00	0.00	7,500,000.00
02/02/23	02/02/23	Mature Long	17,000,000.000	U.S. TREASURY BILL MAT 02/02/23 Cpn 912796XT1	16,961,466.67	38,533.33	0.00	0.00	17,000,000.00
02/02/23	02/02/23	Mature Long	20,000,000.000	U.S. TREASURY BILL MAT 02/02/23 Cpn 912796XT1	19,967,912.78	32,087.22	0.00	0.00	20,000,000.00
02/03/23	02/03/23	Mature Long	7,500,000.000	JOHN DEERE CANADA CP 144A MAT 02/03/23 Cpn 24423JP35	7,431,341.67	68,658.33	0.00	0.00	7,500,000.00
02/07/23	02/07/23	Mature Long	33,000,000.000	U.S. TREASURY BILL MAT 02/07/23 Cpn 912796ZT9	32,906,041.67	93,958.33	0.00	0.00	33,000,000.00
02/07/23	02/07/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/07/23 Cpn 912796ZT9	49,857,638.89	142,361.11	0.00	0.00	50,000,000.00
02/07/23	02/07/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/07/23 Cpn 912796ZT9	49,857,638.89	142,361.11	0.00	0.00	50,000,000.00
02/07/23	02/07/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/07/23 Cpn 912796ZT9	49,857,638.89	142,361.11	0.00	0.00	50,000,000.00
02/07/23	02/07/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/07/23 Cpn 912796ZT9	49,857,638.89	142,361.11	0.00	0.00	50,000,000.00
02/07/23	02/07/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/07/23 Cpn 912796ZT9	49,857,638.89	142,361.11	0.00	0.00	50,000,000.00

Account Name: L.A. CARE HEALTH PLAN

02/01/2023 through 02/28/2023

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/07/23	02/07/23	Mature Long	7,500,000.000	TOTAL CAPITAL CP 144A MAT 02/07/23 Cpn 89152FP74	7,494,437.50	5,562.50	0.00	0.00	7,500,000.00
02/08/23	02/08/23	Mature Long	7,500,000.000	CA UNIVERSITY OF CALIFORNIA C MAT 02/08/23 Cpn 91411UP82	7,467,150.00	32,850.00	0.00	0.00	7,500,000.00
02/09/23	02/09/23	Mature Long	25,000,000.000	U.S. TREASURY BILL MAT 02/09/23 Cpn 912796XZ7	24,920,931.25	79,068.75	0.00	0.00	25,000,000.00
02/09/23	02/09/23	Mature Long	15,000,000.000	U.S. TREASURY BILL MAT 02/09/23 Cpn 912796XZ7	14,962,935.00	37,065.00	0.00	0.00	15,000,000.00
02/09/23	02/09/23	Mature Long	30,000,000.000	U.S. TREASURY BILL MAT 02/09/23 Cpn 912796XZ7	29,992,798.33	7,201.67	0.00	0.00	30,000,000.00
02/09/23	02/09/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/09/23 Cpn 912796XZ7	49,987,997.22	12,002.78	0.00	0.00	50,000,000.00
02/09/23	02/09/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/09/23 Cpn 912796XZ7	49,987,997.22	12,002.78	0.00	0.00	50,000,000.00
02/09/23	02/09/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/09/23 Cpn 912796XZ7	49,987,997.22	12,002.78	0.00	0.00	50,000,000.00
02/09/23	02/09/23	Mature Long	3,000,000.000	U.S. TREASURY BILL MAT 02/09/23 Cpn 912796XZ7	2,999,281.67	718.33	0.00	0.00	3,000,000.00
02/09/23	02/09/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/09/23 Cpn 912796XZ7	49,988,027.78	11,972.22	0.00	0.00	50,000,000.00
02/09/23	02/09/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/09/23 Cpn 912796XZ7	49,988,027.78	11,972.22	0.00	0.00	50,000,000.00
02/13/23	02/13/23	Mature Long	5,000,000.000	FNMA DISCOUNT NOTE MAT 02/13/23 Cpn 313588BV6	4,997,600.00	2,400.00	0.00	0.00	5,000,000.00
02/13/23	02/13/23	Mature Long	50,000,000.000	FNMA DISCOUNT NOTE MAT 02/13/23 Cpn 313588BV6	49,976,000.00	24,000.00	0.00	0.00	50,000,000.00

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02/01/2023 through 02/28/2023

Tr Date	St Date	Transaction Type	Units	Description		Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/13/23	02/13/23	Mature Long	50,000,000.000	FNMA DISCOUNT NOTE MAT 02/13/23 Cpn	313588BV6	49,976,000.00	24,000.00	0.00	0.00	50,000,000.00
02/14/23	02/14/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/14/23 Cpn	912796ZU6	49,340,347.22	659,652.78	0.00	0.00	50,000,000.00
02/14/23	02/14/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/14/23 Cpn	912796ZU6	49,993,783.33	6,216.67	0.00	0.00	50,000,000.00
02/15/23	02/15/23	Mature Long	50,000,000.000	FNMA DISCOUNT NOTE MAT 02/15/23 Cpn	313588BX2	49,994,041.67	5,958.33	0.00	0.00	50,000,000.00
02/15/23	02/15/23	Mature Long	50,000,000.000	FNMA DISCOUNT NOTE MAT 02/15/23 Cpn	313588BX2	49,994,041.67	5,958.33	0.00	0.00	50,000,000.00
02/16/23	02/16/23	Mature Long	35,000,000.000	U.S. TREASURY BILL MAT 02/16/23 Cpn	912796YA1	34,635,273.26	364,726.74	0.00	0.00	35,000,000.00
02/16/23	02/16/23	Mature Long	45,000,000.000	U.S. TREASURY BILL MAT 02/16/23 Cpn	912796YA1	44,966,625.00	33,375.00	0.00	0.00	45,000,000.00
02/16/23	02/16/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/16/23 Cpn	912796YA1	49,962,916.67	37,083.33	0.00	0.00	50,000,000.00
02/16/23	02/16/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/16/23 Cpn	912796YA1	49,962,916.67	37,083.33	0.00	0.00	50,000,000.00
02/16/23	02/16/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/16/23 Cpn	912796YA1	49,962,916.67	37,083.33	0.00	0.00	50,000,000.00
02/16/23	02/16/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/16/23 Cpn	912796YA1	49,962,916.67	37,083.33	0.00	0.00	50,000,000.00
02/16/23	02/16/23	Mature Long	40,000,000.000	U.S. TREASURY BILL MAT 02/16/23 Cpn	912796YA1	39,970,383.33	29,616.67	0.00	0.00	40,000,000.00
02/16/23	02/16/23	Mature Long	30,000,000.000	U.S. TREASURY BILL MAT 02/16/23 Cpn	912796YA1	29,992,575.00	7,425.00	0.00	0.00	30,000,000.00

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/17/23	02/17/23	Mature Long	20,000,000.000	FHLB DISCOOUNT NOTE MAT 02/17/23 Cpn 313384BZ1	19,875,200.00	124,800.00	0.00	0.00	20,000,000.00
02/17/23	02/17/23	Mature Long	35,000,000.000	FHLB DISCOOUNT NOTE MAT 02/17/23 Cpn 313384BZ1	34,995,819.44	4,180.56	0.00	0.00	35,000,000.00
02/17/23	02/17/23	Mature Long	5,000,000.000	FHLB DISCOOUNT NOTE MAT 02/17/23 Cpn 313384BZ1	4,998,805.56	1,194.44	0.00	0.00	5,000,000.00
02/21/23	02/21/23	Mature Long	15,000,000.000	U.S. TREASURY BILL MAT 02/21/23 Cpn 912796Y60	14,979,363.54	20,636.46	0.00	0.00	15,000,000.00
02/21/23	02/21/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/21/23 Cpn 912796Y60	49,931,211.81	68,788.19	0.00	0.00	50,000,000.00
02/21/23	02/21/23	Mature Long	25,000,000.000	U.S. TREASURY BILL MAT 02/21/23 Cpn 912796Y60	24,965,537.15	34,462.85	0.00	0.00	25,000,000.00
02/21/23	02/21/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/21/23 Cpn 912796Y60	49,931,074.31	68,925.69	0.00	0.00	50,000,000.00
02/21/23	02/21/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/21/23 Cpn 912796Y60	49,931,074.31	68,925.69	0.00	0.00	50,000,000.00
02/21/23	02/21/23	Mature Long	2,500,000.000	BANK OF NOVA SCOTIA YCD FRN MAT 02/21/23 Cpn 06417MH40	2,500,000.00		0.00	0.00	2,500,000.00
02/21/23	02/21/23	Mature Long	7,500,000.000	CREDIT AGRICOLE NY YCD MAT 02/21/23 Cpn 4.60 22536A3S1	7,500,000.00		0.00	0.00	7,500,000.00
02/23/23	02/23/23	Mature Long	40,000,000.000	U.S. TREASURY BILL MAT 02/23/23 Cpn 912796T33	39,934,566.67	65,433.33	0.00	0.00	40,000,000.00
02/23/23	02/23/23	Mature Long	8,000,000.000	U.S. TREASURY BILL MAT 02/23/23 Cpn 912796T33	7,998,086.78	1,913.22	0.00	0.00	8,000,000.00
02/28/23	02/28/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/28/23 Cpn 912796Y78	49,955,885.42	44,114.58	0.00	0.00	50,000,000.00

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/28/23	02/28/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/28/23 Cpn 912796Y78	49,955,885.42	44,114.58	0.00	0.00	50,000,000.00
02/28/23	02/28/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 02/28/23 Cpn 912796Y78	49,955,885.42	44,114.58	0.00	0.00	50,000,000.00
02/28/23	02/28/23	Mature Long	7,500,000.000	TORONTO-DOMINION NY YCD MAT 02/28/23 Cpn 3.70 89115BNE6	7,500,000.00		0.00	0.00	7,500,000.00
02/28/23	02/28/23	Mature Long	7,500,000.000	CA UNIVERSITY OF CALIFORNIA C MAT 02/28/23 Cpn 91411UPU3	7,480,833.33	19,166.67	0.00	0.00	7,500,000.00
			1,801,000,000.000		1,797,903,877.45	3,096,122.56	0.01	0.00	1,801,000,000.00
02/02/23	02/02/23	Withdrawal	(40,000,000.000)	WD MAT Cpn USD	(40,000,000.00)		(40,000,000.00)	0.00	(40,000,000.00)
02/06/23	02/06/23	Withdrawal	(50,000,000.000)	WD MAT Cpn USD	(50,000,000.00)		(50,000,000.00)	0.00	(50,000,000.00)
02/08/23	02/08/23	Withdrawal	(70,000,000.000)	WD MAT Cpn USD	(70,000,000.00)		(70,000,000.00)	0.00	(70,000,000.00)
02/09/23	02/09/23	Withdrawal	(140,000,000.000)	WD MAT Cpn USD	(140,000,000.00)		(140,000,000.00)	0.00	(140,000,000.00)
02/15/23	02/15/23	Withdrawal	(60,000,000.000)	WD MAT Cpn USD	(60,000,000.00)		(60,000,000.00)	0.00	(60,000,000.00)
02/16/23	02/16/23	Withdrawal	(280,000,000.000)	WD MAT Cpn USD	(280,000,000.00)		(280,000,000.00)	0.00	(280,000,000.00)
02/17/23	02/17/23	Withdrawal	(60,000,000.000)	WD MAT Cpn USD	(60,000,000.00)		(60,000,000.00)	0.00	(60,000,000.00)
02/23/23	02/23/23	Withdrawal	(45,000,000.000)	WD MAT Cpn USD	(45,000,000.00)		(45,000,000.00)	0.00	(45,000,000.00)

Account Name: L.A. CARE HEALTH PLAN

02/01/2023 through 02/28/2023

Tr Date	St Date	Transaction Type	Units	Description			Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/28/23	02/28/23	Withdrawal	(20,000,000.000)	WD MAT	Cpn	USD	(20,000,000.00)		(20,000,000.00)	0.00	(20,000,000.00)
			(765,000,000.000)				(765,000,000.00)		(765,000,000.00)	0.00	(765,000,000.00)

Account Name: L.A. CARE HEALTH PLAN-LOW DURATION PORT

02/01/2023 through 02/28/2023

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/09/23	02/15/23	Buy	256,000.000	U.S. TREASURY NOTE MAT 02/15/26 Cpn 4.00 91282CGL9	(254,960.00)		0.00	0.00	(254,960.00)
02/10/23	02/15/23	Buy	148,000.000	U.S. TREASURY NOTE MAT 02/15/26 Cpn 4.00 91282CGL9	(147,213.75)		0.00	0.00	(147,213.75)
02/10/23	02/15/23	Buy	136,000.000	U.S. TREASURY NOTE MAT 02/15/26 Cpn 4.00 91282CGL9	(135,277.50)		0.00	0.00	(135,277.50)
			540,000.000		(537,451.25)		0.00	0.00	(537,451.25)
02/01/23	02/01/23	Coupon		CA STWD CMTY DEV AUTH REV-CA MAT 02/01/25 Cpn 0.73 13080SZL1		2,745.00	0.00	0.00	2,745.00
02/01/23	02/01/23	Coupon		CA CONTRA COSTA CCD GO/ULT T MAT 08/01/24 Cpn 1.77 212204JE2		1,507.90	0.00	0.00	1,507.90
02/01/23	02/01/23	Coupon		CA COVINA-VALLEY USD GO/ULT T MAT 08/01/24 Cpn 2.03 223093VM4		2,533.75	0.00	0.00	2,533.75
02/01/23	02/01/23	Coupon		CA FRESNO USD GO/ULT TXB MAT 08/01/25 Cpn 0.87 3582326T8		2,607.00	0.00	0.00	2,607.00
02/01/23	02/01/23	Coupon		CA GARDEN GROVE USD GO/ULT T MAT 08/01/24 Cpn 1.97 365298Y51		3,882.85	0.00	0.00	3,882.85
02/01/23	02/01/23	Coupon		HOUSING URBAN DEVELOPMENT MAT 08/01/23 Cpn 2.62 911759MW5		1,832.60	0.00	0.00	1,832.60
02/01/23	02/01/23	Coupon		CA OAKLAND-ALAMEDA COLISEUM MAT 02/01/25 Cpn 3.64 672211BM0		16,848.88	0.00	0.00	16,848.88
02/01/23	02/01/23	Coupon		CA OAKLAND USD GO/ULT TXB MAT 08/01/25 Cpn 1.38 672325M95		2,900.10	0.00	0.00	2,900.10
02/01/23	02/01/23	Coupon		CA SAN BERNARDINO CCD TXB MAT 08/01/24 Cpn 0.94 796720NQ9		942.00	0.00	0.00	942.00

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/01/23	02/01/23	Coupon		CA SAN BERNARDINO CCD TXB MAT 08/01/24 Cpn 2.04 796720MG2		5,825.40	0.00	0.00	5,825.40
02/01/23	02/01/23	Coupon		CA SONOMA CNTY CLG DIST TXB MAT 08/01/23 Cpn 1.99 835569GQ1		3,484.25	0.00	0.00	3,484.25
02/01/23	02/01/23	Coupon		CA SAN FRANCISCO REDEV AGY T MAT 08/01/23 Cpn 2.50 79770GGQ3		6,250.00	0.00	0.00	6,250.00
02/12/23	02/12/23	Coupon		FHLB C 05/12/21 Q MAT 02/12/26 Cpn 0.60 3130AKXQ4		2,820.00	0.00	0.00	2,820.00
02/15/23	02/15/23	Coupon		CARMX 2020-1 A3 CAR MAT 12/16/24 Cpn 1.89 14315XAC2		231.61	0.00	0.00	231.61
02/15/23	02/15/23	Coupon		CARMX 2021-2 A3 AUTO MAT 02/17/26 Cpn 0.52 14314QAC8		374.27	0.00	0.00	374.27
02/15/23	02/15/23	Coupon		CARMX 2021-3 A3 CAR MAT 06/15/26 Cpn 0.55 14317DAC4		435.42	0.00	0.00	435.42
02/15/23	02/15/23	Coupon		CAPITAL ONE 2020-1 A3 CAR MAT 11/15/24 Cpn 1.60 14043MAC5		141.04	0.00	0.00	141.04
02/15/23	02/15/23	Coupon		FORDL 2021-B A3 LEASE MAT 10/15/24 Cpn 0.37 345329AC0		277.50	0.00	0.00	277.50
02/15/23	02/15/23	Coupon		JOHN DEERE 2020-A A3 EQP MAT 08/15/24 Cpn 1.10 47789KAC7		114.42	0.00	0.00	114.42
02/15/23	02/15/23	Coupon		JOHN DEERE 2021-A A3 EQP MAT 09/15/25 Cpn 0.36 47788UAC6		133.87	0.00	0.00	133.87
02/15/23	02/15/23	Coupon		KUBOTA 2021-2A A3 EQP 144A MAT 11/17/25 Cpn 0.56 50117XAE2		443.33	0.00	0.00	443.33
02/15/23	02/15/23	Coupon		MERCEDES 2021-B A3 LEASE MAT 11/15/24 Cpn 0.40 58769KAD6		200.00	0.00	0.00	200.00

Account Name: L.A. CARE HEALTH PLAN-LOW DURATION PORT

02/01/2023 through 02/28/2023

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/15/23	02/15/23	Coupon		CA RIVERSIDE CNTY PENSN OBLG MAT 02/15/23 Cpn 2.36 76913CAX7		3,308.20	0.00	0.00	3,308.20
02/15/23	02/15/23	Coupon		U.S. TREASURY NOTE MAT 02/15/25 Cpn 1.50 91282CDZ1		2,400.00	0.00	0.00	2,400.00
02/15/23	02/15/23	Coupon		WORLD OMNI 2021-A A3 LEASE MAT 08/15/24 Cpn 0.42 98163JAC9		245.00	0.00	0.00	245.00
02/16/23	02/16/23	Coupon		GMCAR 2021-2 A3 CAR MAT 04/16/26 Cpn 0.51 380149AC8		84.92	0.00	0.00	84.92
02/20/23	02/20/23	Coupon		GMALT 2021-2 A LEASE MAT 05/20/25 Cpn 0.41 380144AD7		256.25	0.00	0.00	256.25
02/20/23	02/20/23	Coupon		SRT 2021-C A3 LEASE 144A MAT 03/20/25 Cpn 0.50 80286CAC4		206.84	0.00	0.00	206.84
02/20/23	02/20/23	Coupon		TESLA 2021-B A2 LEASE 144A MAT 09/22/25 Cpn 0.36 88161KAB1		66.32	0.00	0.00	66.32
02/20/23	02/20/23	Coupon		VERIZON 2020-B A PHONE MAT 02/20/25 Cpn 0.47 92290BAA9		176.99	0.00	0.00	176.99
02/25/23	02/25/23	Coupon		BMW 2021-1 A4 LEASE MAT 07/25/24 Cpn 0.37 05591RAD6		92.50	0.00	0.00	92.50
02/01/23	02/25/23	Coupon		FHMS K029 A2 CMBS MAT 02/25/23 Cpn 3.32 3137B36J2		52.30	0.00	0.00	52.30
02/01/23	02/25/23	Coupon		FHMS K029 A2 CMBS MAT 02/25/23 Cpn 3.32 3137B36J2		82.80	0.00	0.00	82.80
02/01/23	02/25/23	Coupon		FHMS K029 A2 CMBS MAT 02/25/23 Cpn 3.32 3137B36J2		39.22	0.00	0.00	39.22
02/01/23	02/25/23	Coupon		FHMS K031 A2 MAT 04/25/23 Cpn 3.30 3137B3NX2		1,951.66	0.00	0.00	1,951.66

Account Name: L.A. CARE HEALTH PLAN-LOW DURATION PORT

02/01/2023 through 02/28/2023

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/01/23	02/25/23	Coupon		FHMS K033 A2 MAT 07/25/23 Cpn 3.06 3137B4WB8		2,091.00	0.00	0.00	2,091.00
02/01/23	02/25/23	Coupon		FHMS K034 A2 MAT 07/25/23 Cpn 3.53 3137B5JM6		1,402.78	0.00	0.00	1,402.78
02/01/23	02/25/23	Coupon		FHMS K725 AM CMBS MAT 02/25/24 Cpn 3.10 3137BWWE		2,095.20	0.00	0.00	2,095.20
02/01/23	02/25/23	Coupon		FHMS K726 AM CMBS MAT 04/25/24 Cpn 2.99 3137BYPR5		1,417.88	0.00	0.00	1,417.88
02/01/23	02/25/23	Coupon		FHMS KJ28 A1 MAT 02/25/25 Cpn 1.77 3137FREB3		10.92	0.00	0.00	10.92
02/01/23	02/25/23	Coupon		FHMS KJ30 A1 CMBS MAT 01/25/25 Cpn 0.53 3137FUZN7		15.60	0.00	0.00	15.60
02/28/23	02/28/23	Coupon		FHLMC C 02/28/23 Q MAT 02/28/25 Cpn 4.00 3134GXS88		11,400.00	0.00	0.00	11,400.00
02/28/23	02/28/23	Coupon		FHLMC C 11/28/22 Q MAT 08/28/25 Cpn 4.05 3134GXR63		11,606.63	0.00	0.00	11,606.63
02/28/23	02/28/23	Coupon		FHLMC C 11/28/2022 Q MAT 08/28/25 Cpn 4.20 3134GXS47		11,970.00	0.00	0.00	11,970.00
02/28/23	02/28/23	Coupon		U.S. TREASURY NOTE MAT 08/31/25 Cpn 0.25 91282CAJ0		587.50	0.00	0.00	587.50
02/28/23	02/28/23	Coupon		U.S. TREASURY NOTE MAT 08/31/25 Cpn 0.25 91282CAJ0		2,225.00	0.00	0.00	2,225.00
02/28/23	02/28/23	Coupon		U.S. TREASURY NOTE MAT 08/31/26 Cpn 0.75 91282CCW9		7,050.00	0.00	0.00	7,050.00
02/28/23	02/28/23	Coupon		U.S. TREASURY NOTE MAT 02/28/25 Cpn 1.13 912828ZC7		2,559.38	0.00	0.00	2,559.38

Account Name: L.A. CARE HEALTH PLAN-LOW DURATION PORT

02/01/2023 through 02/28/2023

Tr Date	St Date	Transaction Type	Units	Description		Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/28/23	02/28/23	Coupon		U.S. TREASURY NOTE MAT 02/29/24 Cpn 1.50	91282CEA5		3,712.50	0.00	0.00	3,712.50
02/28/23	02/28/23	Coupon		U.S. TREASURY NOTE MAT 08/31/27 Cpn 3.13	91282CFH9		13,984.38	0.00	0.00	13,984.38
02/28/23	02/28/23	Coupon		U.S. TREASURY NOTE MAT 08/31/27 Cpn 3.13	91282CFH9		6,718.75	0.00	0.00	6,718.75
							144,341.71	0.00	0.00	144,341.71
02/01/23	02/01/23	Income	1,166.690	ADJ NET INT MAT Cpn	USD		1,166.69	0.00	0.00	1,166.69
02/01/23	02/01/23	Income	32,342.540	STIF INT FROM BofA MAT Cpn	USD		32,342.54	0.00	0.00	32,342.54
			33,509.230				33,509.23	0.00	0.00	33,509.23
02/09/23	02/10/23	Sell Long	263,000.000	U.S. TREASURY NOTE MAT 01/15/26 Cpn 3.88	91282CGE5	261,007.10	731.97	(1,881.04)	0.00	261,739.07
02/10/23	02/13/23	Sell Long	140,000.000	U.S. TREASURY NOTE MAT 01/15/26 Cpn 3.88	91282CGE5	138,742.01	434.60	(1,198.61)	0.00	139,176.61
02/10/23	02/13/23	Sell Long	152,000.000	U.S. TREASURY NOTE MAT 01/15/26 Cpn 3.88	91282CGE5	150,633.96	471.85	(1,301.57)	0.00	151,105.81
			555,000.000			550,383.07	1,638.42	(4,381.22)	0.00	552,021.49

Account Name: L.A. CARE HEALTH PLAN-LOW DURATION PORT

02/01/2023 through 02/28/2023

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/15/23	02/15/23	Pay Princpl	18,562.897	CARMX 2020-1 A3 CAR MAT 12/16/24 Cpn 1.89 14315XAC2	18,562.90		0.00	(125.39)	18,562.90
02/15/23	02/15/23	Pay Princpl	48,047.540	CARMX 2021-2 A3 AUTO MAT 02/17/26 Cpn 0.52 14314QAC8	48,047.54		0.00	5.31	48,047.54
02/15/23	02/15/23	Pay Princpl	17,312.132	CAPITAL ONE 2020-1 A3 CAR MAT 11/15/24 Cpn 1.60 14043MAC5	17,312.13		0.00	0.73	17,312.13
02/15/23	02/15/23	Pay Princpl	29,811.202	JOHN DEERE 2020-A A3 EQP MAT 08/15/24 Cpn 1.10 47789KAC7	29,811.20		0.00	0.37	29,811.20
02/15/23	02/15/23	Pay Princpl	33,752.858	JOHN DEERE 2021-A A3 EQP MAT 09/15/25 Cpn 0.36 47788UAC6	33,752.86		0.00	3.23	33,752.86
02/15/23	02/15/23	Pay Princpl	12,767.948	MERCEDES 2021-B A3 LEASE MAT 11/15/24 Cpn 0.40 58769KAD6	12,767.95		0.00	0.40	12,767.95
02/15/23	02/15/23	Pay Princpl	22,887.526	WORLD OMNI 2021-A A3 LEASE MAT 08/15/24 Cpn 0.42 98163JAC9	22,887.53		0.00	1.06	22,887.53
02/16/23	02/16/23	Pay Princpl	10,611.217	GMCAR 2021-2 A3 CAR MAT 04/16/26 Cpn 0.51 380149AC8	10,611.22		0.00	0.48	10,611.22
02/20/23	02/20/23	Pay Princpl	48,640.672	SRT 2021-C A3 LEASE 144A MAT 03/20/25 Cpn 0.50 80286CAC4	48,640.67		0.00	1.04	48,640.67
02/20/23	02/20/23	Pay Princpl	22,493.565	TESLA 2021-B A2 LEASE 144A MAT 09/22/25 Cpn 0.36 88161KAB1	22,493.57		0.00	0.92	22,493.57
02/20/23	02/20/23	Pay Princpl	74,483.375	VERIZON 2020-B A PHONE MAT 02/20/25 Cpn 0.47 92290BAA9	74,483.38		0.00	(39.55)	74,483.38
02/01/23	02/25/23	Pay Princpl	40,534.020	FHMS K031 A2 MAT 04/25/23 Cpn 3.30 3137B3NX2	40,534.02		0.00	(192.81)	40,534.02
02/01/23	02/25/23	Pay Princpl	1,852.320	FHMS K033 A2 MAT 07/25/23 Cpn 3.06 3137B4WB8	1,852.32		0.00	(12.88)	1,852.32

Account Name: L.A. CARE HEALTH PLAN-LOW DURATION PORT

02/01/2023 through 02/28/2023

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
02/01/23	02/25/23	Pay Princpl	18,968.426	FHMS K034 A2 MAT 07/25/23 Cpn 3.53 3137B5JM6	18,968.43		0.00	(201.08)	18,968.43
02/01/23	02/25/23	Pay Princpl	998.244	FHMS KJ28 A1 MAT 02/25/25 Cpn 1.77 3137FREB3	998.24		0.00	(0.00)	998.24
02/01/23	02/25/23	Pay Princpl	837.670	FHMS KJ30 A1 CMBS MAT 01/25/25 Cpn 0.53 3137FUZN7	837.67		0.00	0.01	837.67
			402,561.611		402,561.63		0.00	(558.16)	402,561.63
02/15/23	02/15/23	Mature Long	280,000.000	CA RIVERSIDE CNTY PENSN OBLG MAT 02/15/23 Cpn 2.36 76913CAX7	280,000.00		0.00	0.00	280,000.00
02/01/23	02/25/23	Mature Long	18,902.640	FHMS K029 A2 CMBS MAT 02/25/23 Cpn 3.32 3137B36J2	18,902.64		0.00	0.00	18,902.64
02/01/23	02/25/23	Mature Long	29,929.180	FHMS K029 A2 CMBS MAT 02/25/23 Cpn 3.32 3137B36J2	29,929.18		0.00	0.00	29,929.18
02/01/23	02/25/23	Mature Long	14,176.980	FHMS K029 A2 CMBS MAT 02/25/23 Cpn 3.32 3137B36J2	14,176.98		0.00	0.00	14,176.98
			343,008.800		343,008.80		0.00	0.00	343,008.80

LA CARE

Cash Activity by Transaction Type GAAP Basis

Accounting Period From 02/01/2023 To 02/28/2023

Cash Date	Trade/Ex-Date	Settle/Pay Date	Custodian	Cusip	Description	Quantity	Income Amount	Principal Amount	Contributions/ Withdrawals	Total Amount
BUY										
02/13/23	02/09/23	02/13/23	TNT77	13063D3A4	CALIFORNIA ST	1,000,000.00	(13,616.66)	(1,045,810.00)	0.00	(1,059,426.66)
02/16/23	02/14/23	02/16/23	TNT77	278865BP4	ECOLAB INC	5,000,000.00	(64,895.83)	(5,114,600.00)	0.00	(5,179,495.83)
02/16/23	02/14/23	02/16/23	TNT77	882508BV5	TEXAS INSTRUMENTS INC	5,000,000.00	(638.89)	(5,012,150.00)	0.00	(5,012,788.89)
02/16/23	02/16/23	02/16/23	TNT77	665278404	NORTHERN INST GOVT MONEY MKT	784,277.22	0.00	(784,277.22)	0.00	(784,277.22)
TOTAL BUY						11,784,277.22	(79,151.38)	(11,956,837.22)	0.00	(12,035,988.60)
DIVIDEND										
02/01/23	02/01/23	02/01/23	TNT77	665278404	NORTHERN INST GOVT MONEY MKT	1,454,577.28	3,277.04	0.00	0.00	3,277.04
TOTAL DIVIDEND						1,454,577.28	3,277.04	0.00	0.00	3,277.04
INTEREST										
02/01/23	02/01/23	02/01/23	TNT77	05531FBH5	TRUIST FINANCIAL CORP	5,000,000.00	62,500.00	0.00	0.00	62,500.00
02/01/23	02/01/23	02/01/23	TNT77	31677QBR9	FIFTH THIRD BANK	5,000,000.00	56,250.00	0.00	0.00	56,250.00
02/01/23	02/01/23	02/01/23	TNT77	54438CYJ5	LOS ANGELES CA CMNTY CLG DIST	3,350,000.00	11,272.75	0.00	0.00	11,272.75
02/01/23	02/01/23	02/01/23	TNT77	54438CYK2	LOS ANGELES CA CMNTY CLG DIST	1,100,000.00	4,251.50	0.00	0.00	4,251.50
02/01/23	02/01/23	02/01/23	TNT77	969268DG3	WILLIAM S HART CA UNION HIGH S	2,350,000.00	8,894.75	0.00	0.00	8,894.75
02/05/23	02/05/23	02/05/23	TNT77	458140BY5	INTEL CORP	5,000,000.00	93,750.00	0.00	0.00	93,750.00
02/12/23	02/12/23	02/12/23	TNT77	14913R3A3	CATERPILLAR FINL SERVICE	2,500,000.00	45,000.00	0.00	0.00	45,000.00
02/12/23	02/12/23	02/12/23	TNT77	459200HU8	IBM CORP	2,000,000.00	36,250.00	0.00	0.00	36,250.00
02/13/23	02/13/23	02/13/23	TNT77	89236TGT6	TOYOTA MOTOR CREDIT CORP	3,000,000.00	27,000.00	0.00	0.00	27,000.00
02/15/23	02/15/23	02/15/23	TNT77	384802AE4	WW GRAINGER INC	1,000,000.00	9,250.00	0.00	0.00	9,250.00
02/15/23	02/15/23	02/15/23	TNT77	576000ZE6	MASSACHUSETTS ST SCH BLDG AUTH	5,000,000.00	22,125.00	0.00	0.00	22,125.00
02/15/23	02/15/23	02/15/23	TNT77	756109BG8	REALTY INCOME CORP	5,000,000.00	98,750.00	0.00	0.00	98,750.00
02/20/23	02/20/23	02/20/23	TNT77	38141GXE9	GOLDMAN SACHS GROUP INC	9,000,000.00	163,125.00	0.00	0.00	163,125.00
02/23/23	02/23/23	02/23/23	TNT77	037833BY5	APPLE INC	1,500,000.00	24,375.00	0.00	0.00	24,375.00
02/23/23	02/23/23	02/23/23	TNT77	69353REK0	PNC BANK NA	2,000,000.00	29,500.00	0.00	0.00	29,500.00
TOTAL INTEREST						52,800,000.00	692,294.00	0.00	0.00	692,294.00
SELL										
02/16/23	02/15/23	02/16/23	TNT77	17325FAS7	CITIBANK NA	5,000,000.00	11,659.72	4,933,300.00	0.00	4,944,959.72
02/16/23	02/15/23	02/16/23	TNT77	89236TFS9	TOYOTA MOTOR CREDIT CORP	5,000,000.00	17,680.56	4,923,200.00	0.00	4,940,880.56

LA CARE

Cash Activity by Transaction Type GAAP Basis

Accounting Period From 02/01/2023 To 02/28/2023

Cash Date	Trade/Ex-Date	Settle/Pay Date	Custodian	Cusip	Description	Quantity	Income Amount	Principal Amount	Contributions/ Withdrawals	Total Amount
02/16/23	02/16/23	02/16/23	TNT77	665278404	NORTHERN INST GOVT MONEY MKT	1,454,577.28	0.00	1,454,577.28	0.00	1,454,577.28
TOTAL SELL						11,454,577.28	29,340.28	11,311,077.28	0.00	11,340,417.56
GRAND TOTAL						77,493,431.78	645,759.94	(645,759.94)	0.00	0.00

Avg Date 16

DATE: April 26, 2023

TO: Finance & Budget Committee

FROM: Marie Montgomery, *Chief Financial Officer*

SUBJECT: Monthly Investment Portfolio Securities Transaction Report for March, 2023

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, 2023.

L.A. Care's investment market value as of March 31, 2023, was $3.4 billion. This includes our funds invested with the government pooled funds. L.A. Care has approximately $74 million invested with the statewide Local Agency Investment Fund (LAIF), and approximately $158 million invested with the Los Angeles County Pooled Investment Fund (LACPIF).

The remainder as of March 31, 2023, of $3.2 billion is managed by two independent asset managers, 1) Payden & Rygel and 2) New England Asset Management (NEAM) and is divided into three portfolios based on investment style,

1. Payden & Rygel - Short-term portfolio
2. Payden & Rygel - Extended term portfolio
3. New England Asset Management - Corporate notes extended term portfolio

The transactions within these three portfolios are included in the attached reports.

LA Care, as a California government entity, only makes investments in bonds/fixed income, as per the California Government Code. The entries on the Investment Securities Portfolio Transaction Report reflect transactions undertaken by financial management companies on L.A. Care's behalf. L.A. Care does not direct these individual transactions. The firms, managing investments on behalf of L.A. Care, conduct the transactions based on L.A. Care's investment guidelines.

Account Name: L.A. CARE HEALTH PLAN

03/01/2023 through 03/31/2023

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
03/01/23	03/02/23	Buy	7,500,000.000	WESTPAC BANK YCD MAT 11/27/23 Cpn 5.44 96130ASQ2	(7,500,000.00)		0.00	0.00	(7,500,000.00)
03/03/23	03/06/23	Buy	17,000,000.000	U.S. TREASURY BILL MAT 06/01/23 Cpn 912796ZG7	(16,805,716.92)		0.00	0.00	(16,805,716.92)
03/06/23	03/07/23	Buy	20,000,000.000	U.S. TREASURY BILL MAT 03/16/23 Cpn 912796YL7	(19,977,750.00)		0.00	0.00	(19,977,750.00)
03/06/23	03/08/23	Buy	6,950,000.000	SYNCT 2018-2 A CDT MAT 05/15/26 Cpn 3.47 87165LCC3	(6,930,181.64)	(15,407.76)	0.00	0.00	(6,945,589.40)
03/09/23	03/09/23	Buy	40,000,000.000	U.S. TREASURY BILL MAT 03/21/23 Cpn 912796Z77	(39,941,173.33)		0.00	0.00	(39,941,173.33)
03/09/23	03/09/23	Buy	8,500,000.000	SC SANTEE COOPER CP TXB MAT 05/09/23 Cpn 5.00 83708BBP0	(8,500,000.00)		0.00	0.00	(8,500,000.00)
03/09/23	03/10/23	Buy	10,000,000.000	U.S. TREASURY BILL MAT 03/14/23 Cpn 912796Z69	(9,994,994.44)		0.00	0.00	(9,994,994.44)
03/09/23	03/10/23	Buy	40,000,000.000	U.S. TREASURY BILL MAT 03/16/23 Cpn 912796YL7	(39,970,663.33)		0.00	0.00	(39,970,663.33)
03/09/23	03/10/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 03/16/23 Cpn 912796YL7	(49,963,329.17)		0.00	0.00	(49,963,329.17)
03/09/23	03/10/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 03/16/23 Cpn 912796YL7	(49,963,329.17)		0.00	0.00	(49,963,329.17)
03/09/23	03/10/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 03/16/23 Cpn 912796YL7	(49,963,329.17)		0.00	0.00	(49,963,329.17)
03/09/23	03/10/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 03/16/23 Cpn 912796YL7	(49,963,329.17)		0.00	0.00	(49,963,329.17)
03/09/23	03/10/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 03/16/23 Cpn 912796YL7	(49,963,329.17)		0.00	0.00	(49,963,329.17)

Account Name: L.A. CARE HEALTH PLAN

03/01/2023 through 03/31/2023

Tr Date	St Date	Transaction Type	Units	Description		Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
03/10/23	03/10/23	Buy	40,000,000.000	U.S. TREASURY BILL MAT 03/16/23 Cpn	912796YL7	(39,970,666.67)		0.00	0.00	(39,970,666.67)
03/09/23	03/10/23	Buy	10,000,000.000	U.S. TREASURY BILL MAT 03/21/23 Cpn	912796Z77	(9,986,387.50)		0.00	0.00	(9,986,387.50)
03/10/23	03/10/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 03/28/23 Cpn	912796Z85	(49,889,867.50)		0.00	0.00	(49,889,867.50)
03/10/23	03/10/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 03/28/23 Cpn	912796Z85	(49,889,867.50)		0.00	0.00	(49,889,867.50)
03/10/23	03/10/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 03/28/23 Cpn	912796Z85	(49,889,867.50)		0.00	0.00	(49,889,867.50)
03/10/23	03/10/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 03/28/23 Cpn	912796Z85	(49,889,867.50)		0.00	0.00	(49,889,867.50)
03/10/23	03/10/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 03/28/23 Cpn	912796Z85	(49,889,867.50)		0.00	0.00	(49,889,867.50)
03/10/23	03/10/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 03/28/23 Cpn	912796Z85	(49,889,867.50)		0.00	0.00	(49,889,867.50)
03/10/23	03/10/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 03/28/23 Cpn	912796Z85	(49,889,867.50)		0.00	0.00	(49,889,867.50)
03/10/23	03/10/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 03/28/23 Cpn	912796Z85	(49,889,867.50)		0.00	0.00	(49,889,867.50)
03/10/23	03/10/23	Buy	40,000,000.000	U.S. TREASURY BILL MAT 03/28/23 Cpn	912796Z85	(39,911,280.00)		0.00	0.00	(39,911,280.00)
03/09/23	03/10/23	Buy	30,000,000.000	U.S. TREASURY BILL MAT 03/23/23 Cpn	912796U31	(29,953,525.00)		0.00	0.00	(29,953,525.00)
03/09/23	03/10/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 03/23/23 Cpn	912796U31	(49,922,541.67)		0.00	0.00	(49,922,541.67)

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Tr Date	St Date	Transaction Type	Units	Description		Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
03/09/23	03/10/23	Buy	30,000,000.000	U.S. TREASURY BILL MAT 04/04/23 Cpn	912796Z93	(29,905,208.33)		0.00	0.00	(29,905,208.33)
03/10/23	03/10/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 04/04/23 Cpn	912796Z93	(49,844,536.46)		0.00	0.00	(49,844,536.46)
03/10/23	03/10/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 04/04/23 Cpn	912796Z93	(49,844,536.46)		0.00	0.00	(49,844,536.46)
03/10/23	03/10/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 04/04/23 Cpn	912796Z93	(49,844,536.46)		0.00	0.00	(49,844,536.46)
03/10/23	03/10/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 04/04/23 Cpn	912796Z93	(49,844,536.46)		0.00	0.00	(49,844,536.46)
03/10/23	03/10/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 04/04/23 Cpn	912796Z93	(49,844,536.46)		0.00	0.00	(49,844,536.46)
03/10/23	03/10/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 04/04/23 Cpn	912796Z93	(49,844,536.46)		0.00	0.00	(49,844,536.46)
03/10/23	03/10/23	Buy	40,000,000.000	FHLB DISCOUNT NOTE MAT 03/13/23 Cpn	313384CZ0	(39,985,333.33)		0.00	0.00	(39,985,333.33)
03/10/23	03/10/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 03/29/23 Cpn	313384DR7	(49,881,777.78)		0.00	0.00	(49,881,777.78)
03/10/23	03/10/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 03/29/23 Cpn	313384DR7	(49,881,777.78)		0.00	0.00	(49,881,777.78)
03/10/23	03/10/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 03/29/23 Cpn	313384DR7	(49,881,777.78)		0.00	0.00	(49,881,777.78)
03/10/23	03/10/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 03/29/23 Cpn	313384DR7	(49,881,777.78)		0.00	0.00	(49,881,777.78)
03/10/23	03/10/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 03/29/23 Cpn	313384DR7	(49,881,777.78)		0.00	0.00	(49,881,777.78)

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Tr Date	St Date	Transaction Type	Units	Description		Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
03/10/23	03/10/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 03/29/23 Cpn	313384DR7	(49,881,777.78)		0.00	0.00	(49,881,777.78)
03/10/23	03/10/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 03/29/23 Cpn	313384DR7	(49,881,777.78)		0.00	0.00	(49,881,777.78)
03/10/23	03/10/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 03/29/23 Cpn	313384DR7	(49,881,777.78)		0.00	0.00	(49,881,777.78)
03/10/23	03/10/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 04/05/23 Cpn	313384DY2	(49,833,527.78)		0.00	0.00	(49,833,527.78)
03/10/23	03/10/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 04/05/23 Cpn	313384DY2	(49,833,527.78)		0.00	0.00	(49,833,527.78)
03/10/23	03/10/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 04/05/23 Cpn	313384DY2	(49,833,527.78)		0.00	0.00	(49,833,527.78)
03/10/23	03/10/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 04/05/23 Cpn	313384DY2	(49,833,527.78)		0.00	0.00	(49,833,527.78)
03/10/23	03/10/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 04/05/23 Cpn	313384DY2	(49,833,527.78)		0.00	0.00	(49,833,527.78)
03/10/23	03/13/23	Buy	20,000,000.000	U.S. TREASURY BILL MAT 03/30/23 Cpn	912796YM5	(19,959,275.56)		0.00	0.00	(19,959,275.56)
03/10/23	03/13/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 03/30/23 Cpn	912796YM5	(49,898,188.89)		0.00	0.00	(49,898,188.89)
03/10/23	03/13/23	Buy	50,000,000.000	U.S. TREASURY BILL MAT 03/30/23 Cpn	912796YM5	(49,898,188.89)		0.00	0.00	(49,898,188.89)
03/10/23	03/13/23	Buy	5,000,000.000	U.S. TREASURY BILL MAT 04/06/23 Cpn	912796YN3	(4,984,983.33)		0.00	0.00	(4,984,983.33)
03/10/23	03/13/23	Buy	10,000,000.000	U.S. TREASURY BILL MAT 04/04/23 Cpn	912796Z93	(9,972,373.50)		0.00	0.00	(9,972,373.50)

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03/10/23	03/13/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 04/05/23 Cpn 313384DY2	(49,852,736.11)		0.00	0.00	(49,852,736.11)
03/10/23	03/13/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 04/05/23 Cpn 313384DY2	(49,852,736.11)		0.00	0.00	(49,852,736.11)
03/10/23	03/13/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 04/05/23 Cpn 313384DY2	(49,852,736.11)		0.00	0.00	(49,852,736.11)
03/10/23	03/13/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 04/05/23 Cpn 313384DY2	(49,852,736.11)		0.00	0.00	(49,852,736.11)
03/10/23	03/13/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 04/05/23 Cpn 313384DY2	(49,852,736.11)		0.00	0.00	(49,852,736.11)
03/13/23	03/14/23	Buy	23,000,000.000	U.S. TREASURY BILL MAT 04/06/23 Cpn 912796YN3	(22,935,197.50)		0.00	0.00	(22,935,197.50)
03/14/23	03/14/23	Buy	2,500,000.000	CENTURY HOUSING CORP CP TXB MAT 04/11/23 Cpn 5.19 15654WAH9	(2,500,000.00)		0.00	0.00	(2,500,000.00)
03/15/23	03/15/23	Buy	7,500,000.000	CA SAN FRAN PUB CP TXB MAT 06/06/23 Cpn 5.02 79770TRD2	(7,500,000.00)		0.00	0.00	(7,500,000.00)
03/16/23	03/16/23	Buy	11,000,000.000	U.S. TREASURY BILL MAT 04/06/23 Cpn 912796YN3	(10,974,378.25)		0.00	0.00	(10,974,378.25)
03/16/23	03/16/23	Buy	4,097,000.000	CA SAN JOSE FIN AUTH LEASE RE MAT 04/18/23 Cpn 5.15 79815WDJ4	(4,097,000.00)		0.00	0.00	(4,097,000.00)
03/17/23	03/20/23	Buy	10,000,000.000	U.S. TREASURY BILL MAT 04/06/23 Cpn 912796YN3	(9,981,628.19)		0.00	0.00	(9,981,628.19)
03/21/23	03/22/23	Buy	5,000,000.000	U.S. TREASURY BILL MAT 04/06/23 Cpn 912796YN3	(4,993,044.79)		0.00	0.00	(4,993,044.79)
03/23/23	03/23/23	Buy	40,000,000.000	U.S. TREASURY BILL MAT 04/04/23 Cpn 912796Z93	(39,950,000.00)		0.00	0.00	(39,950,000.00)

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03/23/23	03/24/23	Buy	10,000,000.000	U.S. TREASURY BILL MAT 04/04/23 Cpn	912796Z93	(9,988,694.44)		0.00	0.00	(9,988,694.44)
03/23/23	03/24/23	Buy	20,000,000.000	FHLB DISCOUNT NOTE MAT 03/27/23 Cpn	313384DP1	(19,992,516.67)		0.00	0.00	(19,992,516.67)
03/23/23	03/24/23	Buy	15,000,000.000	FNMA DISCOUNT NOTE MAT 04/10/23 Cpn	313588ED3	(14,968,833.33)		0.00	0.00	(14,968,833.33)
03/21/23	03/27/23	Buy	8,500,000.000	FHLB C 4/27/23 M MAT 03/27/24 Cpn 5.62	3130AVGN6	(8,500,000.00)		0.00	0.00	(8,500,000.00)
03/27/23	03/28/23	Buy	43,000,000.000	FHLMC DISCOUNT NOTE MAT 03/29/23 Cpn	313396DR1	(42,994,744.44)		0.00	0.00	(42,994,744.44)
03/27/23	03/28/23	Buy	50,000,000.000	FHLMC DISCOUNT NOTE MAT 03/29/23 Cpn	313396DR1	(49,993,888.89)		0.00	0.00	(49,993,888.89)
03/27/23	03/28/23	Buy	50,000,000.000	FHLMC DISCOUNT NOTE MAT 03/29/23 Cpn	313396DR1	(49,993,888.89)		0.00	0.00	(49,993,888.89)
03/27/23	03/28/23	Buy	50,000,000.000	FHLMC DISCOUNT NOTE MAT 03/29/23 Cpn	313396DR1	(49,993,888.89)		0.00	0.00	(49,993,888.89)
03/27/23	03/28/23	Buy	50,000,000.000	FHLMC DISCOUNT NOTE MAT 03/29/23 Cpn	313396DR1	(49,993,888.89)		0.00	0.00	(49,993,888.89)
03/27/23	03/28/23	Buy	50,000,000.000	FHLMC DISCOUNT NOTE MAT 03/29/23 Cpn	313396DR1	(49,993,888.89)		0.00	0.00	(49,993,888.89)
03/27/23	03/28/23	Buy	50,000,000.000	FHLMC DISCOUNT NOTE MAT 03/29/23 Cpn	313396DR1	(49,993,888.89)		0.00	0.00	(49,993,888.89)
03/27/23	03/28/23	Buy	50,000,000.000	FHLMC DISCOUNT NOTE MAT 03/29/23 Cpn	313396DR1	(49,993,888.89)		0.00	0.00	(49,993,888.89)
03/28/23	03/29/23	Buy	20,000,000.000	FHLB DISCOUNT NOTE MAT 04/28/23 Cpn	313384EX3	(19,922,666.67)		0.00	0.00	(19,922,666.67)

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03/28/23	03/29/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 04/28/23 Cpn	313384EX3	(49,806,666.67)		0.00	0.00	(49,806,666.67)
03/28/23	03/29/23	Buy	31,000,000.000	FHLB DISCOUNT NOTE MAT 05/02/23 Cpn	313384FB0	(30,866,200.56)		0.00	0.00	(30,866,200.56)
03/28/23	03/29/23	Buy	50,000,000.000	FHLB DISCOUNT NOTE MAT 05/08/23 Cpn	313384FH7	(49,749,444.44)		0.00	0.00	(49,749,444.44)
03/28/23	03/29/23	Buy	43,000,000.000	FHLB DISCOUNT NOTE MAT 05/19/23 Cpn	313384FU8	(42,716,128.33)		0.00	0.00	(42,716,128.33)
03/28/23	03/29/23	Buy	110,000,000.000	FHLMC DISCOUNT NOTE MAT 04/04/23 Cpn	313396DX8	(109,920,250.00)		0.00	0.00	(109,920,250.00)
03/28/23	03/29/23	Buy	300,000,000.000	FHLMC DISCOUNT NOTE MAT 04/05/23 Cpn	313396DY6	(299,746,250.00)		0.00	0.00	(299,746,250.00)
03/28/23	03/29/23	Buy	50,000,000.000	FHLMC DISCOUNT NOTE MAT 04/10/23 Cpn	313396ED1	(49,927,333.33)		0.00	0.00	(49,927,333.33)
03/28/23	03/29/23	Buy	30,000,000.000	FHLMC DISCOUNT NOTE MAT 04/13/23 Cpn	313396EG4	(29,945,500.00)		0.00	0.00	(29,945,500.00)
03/28/23	03/29/23	Buy	50,000,000.000	FHLMC DISCOUNT NOTE MAT 04/13/23 Cpn	313396EG4	(49,909,166.67)		0.00	0.00	(49,909,166.67)
03/29/23	03/29/23	Buy	10,000,000.000	FHLMC DISCOUNT NOTE MAT 05/01/23 Cpn	313396FA6	(9,958,383.33)		0.00	0.00	(9,958,383.33)
03/29/23	03/29/23	Buy	50,000,000.000	FHLMC DISCOUNT NOTE MAT 05/01/23 Cpn	313396FA6	(49,791,916.67)		0.00	0.00	(49,791,916.67)
03/30/23	03/31/23	Buy	1,000,000.000	CASH MGMT BILL MAT 04/17/23 Cpn	912797LM7	(997,831.56)		0.00	0.00	(997,831.56)

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Fixed Income - cont.									
03/30/23	03/31/23	Buy	50,000,000.000	CASH MGMT BILL MAT 04/17/23 Cpn 912797LM7	(49,891,577.78)		0.00	0.00	(49,891,577.78)
			3,769,547,000.000		(3,761,939,354.48)	(15,407.76)	0.00	0.00	(3,761,954,762.24)
03/02/23	03/02/23	Coupon		CANADIAN IMPERIAL BANK YCD MAT 03/02/23 Cpn 3.70 13606KMN3		139,520.83	0.00	0.00	139,520.83
03/08/23	03/08/23	Coupon		NATIXIS NY YCD MAT 03/08/23 Cpn 3.82 63873QWG		143,250.00	0.00	0.00	143,250.00
03/08/23	03/08/23	Coupon		SWEDBANK NY YCD MAT 03/08/23 Cpn 4.74 87019WFR1		118,500.00	0.00	0.00	118,500.00
03/09/23	03/09/23	Coupon		MMAF 2022-B A1 EQP 144A MAT 12/01/23 Cpn 4.92 606940AA2		11,363.34	0.00	0.00	11,363.34
03/10/23	03/10/23	Coupon		CRVNA 2021-P4 A2 CAR MAT 04/10/25 Cpn 0.82 14687KAB2		1,445.79	0.00	0.00	1,445.79
03/10/23	03/10/23	Coupon		CRVNA 2023-P1 A1 CAR 144A MAT 03/11/24 Cpn 5.28 14688EAA7		14,412.73	0.00	0.00	14,412.73
03/13/23	03/13/23	Coupon		SKANDINAV ENSKILDA BK YCD FR MAT 04/12/23 Cpn 5.06 83050PP60		29,516.67	0.00	0.00	29,516.67
03/15/23	03/15/23	Coupon		ALLYA 2022-2 A2 CAR MAT 10/15/25 Cpn 4.62 02008MAB5		14,245.00	0.00	0.00	14,245.00
03/15/23	03/15/23	Coupon		CARMAX 2019-3 A3 CAR MAT 08/15/24 Cpn 2.18 14315PAD7		1,159.65	0.00	0.00	1,159.65
03/15/23	03/15/23	Coupon		CARMX 2021-4 A2A CAR MAT 11/15/24 Cpn 0.24 14317JAB3		122.16	0.00	0.00	122.16

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03/15/23	03/15/23	Coupon		CARMX 2023-1 A1 CAR MAT 02/15/24 Cpn 4.96 14318DAA7		13,340.05	0.00	0.00	13,340.05
03/15/23	03/15/23	Coupon		CNH 2021-C A2 EQP MAT 01/15/25 Cpn 0.33 12598LAB2		617.56	0.00	0.00	617.56
03/15/23	03/15/23	Coupon		FORDL 2023-A A1 LEASE MAT 02/15/24 Cpn 4.96 345287AA4		5,858.40	0.00	0.00	5,858.40
03/15/23	03/15/23	Coupon		FORDO 2022-C A1 CAR MAT 10/15/23 Cpn 3.63 34535AAA8		3,317.06	0.00	0.00	3,317.06
03/15/23	03/15/23	Coupon		GALC 2022-1 A1 EQP 144A MAT 10/16/23 Cpn 4.34 39154TBU1		9,708.42	0.00	0.00	9,708.42
03/15/23	03/15/23	Coupon		HALST 2021-A A3 LEASE 144A MAT 01/16/24 Cpn 0.33 44891TAC0		243.25	0.00	0.00	243.25
03/15/23	03/15/23	Coupon		HALST 2021-A A3 LEASE 144A MAT 01/16/24 Cpn 0.33 44891TAC0		215.68	0.00	0.00	215.68
03/15/23	03/15/23	Coupon		HALST 2021-C A2 CAR LEASE 144A MAT 01/16/24 Cpn 0.24 44933MAB7		131.05	0.00	0.00	131.05
03/15/23	03/15/23	Coupon		HALST 2021-C A2 CAR LEASE 144A MAT 01/16/24 Cpn 0.24 44933MAB7		31.66	0.00	0.00	31.66
03/15/23	03/15/23	Coupon		HAROT 2022-1 A2 CAR MAT 10/15/24 Cpn 1.44 43815BAB6		4,015.70	0.00	0.00	4,015.70
03/15/23	03/15/23	Coupon		HART 2019-B A4 CAR MAT 04/15/25 Cpn 2.00 44891JAD0		6,610.50	0.00	0.00	6,610.50
03/15/23	03/15/23	Coupon		JOHN DEERE 2020-B A3 EQP MAT 11/15/24 Cpn 0.51 47787NAC3		1,003.44	0.00	0.00	1,003.44
03/15/23	03/15/23	Coupon		KUBOTA 2020-1A A3 EQP 144A MAT 03/15/24 Cpn 1.96 50117WAC8		1,160.65	0.00	0.00	1,160.65

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
03/15/23	03/15/23	Coupon		KUBOTA 2020-1A A3 EQP 144A MAT 03/15/24 Cpn 1.96 50117WAC8		278.45	0.00	0.00	278.45
03/15/23	03/15/23	Coupon		KCOT 2022-2A A1 EQP 144A MAT 07/17/23 Cpn 2.60 50117JAA1		845.06	0.00	0.00	845.06
03/15/23	03/15/23	Coupon		MERCEDES 2020-B A4 LEASE MAT 06/15/26 Cpn 0.50 58769EAD0		1,837.46	0.00	0.00	1,837.46
03/15/23	03/15/23	Coupon		NALT 2023-A A1 LEASE MAT 02/15/24 Cpn 4.97 65480VAA1		14,084.53	0.00	0.00	14,084.53
03/15/23	03/15/23	Coupon		NAROT 2022-B A1 CAR MAT 10/16/23 Cpn 3.69 65480JAA8		7,495.25	0.00	0.00	7,495.25
03/15/23	03/15/23	Coupon		CA SAN FRAN PUB UTIL COMM CP MAT 03/15/23 Cpn 4.67 79770TRC4		54,483.33	0.00	0.00	54,483.33
03/15/23	03/15/23	Coupon		SYNCT 2018-2 A CDT MAT 05/15/26 Cpn 3.47 87165LCC3		20,097.08	0.00	0.00	20,097.08
03/15/23	03/15/23	Coupon		TAOT 2022-C A2A CAR MAT 08/15/25 Cpn 4.19 89231CAB3		18,156.67	0.00	0.00	18,156.67
03/15/23	03/15/23	Coupon		TAOT 2023-A A1 CAR MAT 01/15/24 Cpn 4.84 891940AA6		9,596.76	0.00	0.00	9,596.76
03/15/23	03/15/23	Coupon		WOART 2022-B A2A CAR MAT 10/15/25 Cpn 2.77 98163QAB5		8,619.45	0.00	0.00	8,619.45
03/15/23	03/15/23	Coupon		WOART 2023-A A2A CAR MAT 07/15/26 Cpn 5.18 98164JAB0		23,741.67	0.00	0.00	23,741.67
03/15/23	03/15/23	Coupon		WOLS 2022-A A2 LEASE MAT 10/15/24 Cpn 2.63 98163NAB2		2,455.68	0.00	0.00	2,455.68
03/16/23	03/16/23	Coupon		GMCAR 2022-4 A1 CAR MAT 10/16/23 Cpn 3.62 36265QAA4		5,922.99	0.00	0.00	5,922.99

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
03/16/23	03/16/23	Coupon		GMCAR 2023-1 A1 CAR MAT 01/16/24 Cpn 4.89 38013JAA1		20,494.41	0.00	0.00	20,494.41
03/16/23	03/16/23	Coupon		CA SAN JOSE FIN AUTH LEASE RE MAT 03/16/23 Cpn 4.65 79815WDH8		34,244.38	0.00	0.00	34,244.38
03/18/23	03/18/23	Coupon		HONDA 2021-3 A2 CAR MAT 02/20/24 Cpn 0.20 43815EAB0		40.73	0.00	0.00	40.73
03/20/23	03/20/23	Coupon		DLLAD 2023-1A A1 EQP 144A MAT 02/20/24 Cpn 5.01 233258AA0		5,954.78	0.00	0.00	5,954.78
03/20/23	03/20/23	Coupon		EFF 2022-2 A1 FLEET 144A MAT 06/20/23 Cpn 2.76 29374JAA3		790.54	0.00	0.00	790.54
03/20/23	03/20/23	Coupon		EFF 2022-3 A1 FLEET 144A MAT 08/20/23 Cpn 3.61 29374FAA1		6,911.18	0.00	0.00	6,911.18
03/20/23	03/20/23	Coupon		EFF 2022-4 A1 FLEET 144A MAT 11/20/23 Cpn 5.15 29374GAA9		15,358.92	0.00	0.00	15,358.92
03/20/23	03/20/23	Coupon		GMALT 2021-1 A3 LEASE MAT 02/20/24 Cpn 0.26 36261RAC2		446.18	0.00	0.00	446.18
03/20/23	03/20/23	Coupon		GMALT 2021-1 A3 LEASE MAT 02/20/24 Cpn 0.26 36261RAC2		15.12	0.00	0.00	15.12
03/20/23	03/20/23	Coupon		GMALT 2021-2 A LEASE MAT 05/20/25 Cpn 0.41 380144AD7		717.50	0.00	0.00	717.50
03/20/23	03/20/23	Coupon		GMALT 2023-1 A2A LEASE MAT 06/20/25 Cpn 5.27 362541AB0		13,438.50	0.00	0.00	13,438.50
03/20/23	03/20/23	Coupon		HPEFS 2022-3A A1 EQP 144A MAT 10/20/23 Cpn 4.33 403951AA4		2,543.12	0.00	0.00	2,543.12
03/20/23	03/20/23	Coupon		LLOYDS BANK YCD FRN SOFRRAT MAT 04/19/23 Cpn 5.21 53947BJ43		90,762.50	0.00	0.00	90,762.50

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
03/20/23	03/20/23	Coupon		SRT 2021-A A3 LEASE 144A MAT 07/22/24 Cpn 0.51 80286TAC7		1,374.73	0.00	0.00	1,374.73
03/20/23	03/20/23	Coupon		SUMITOMO MITSUI BANKING YCD MAT 03/20/23 Cpn 86565FTC6		27,843.75	0.00	0.00	27,843.75
03/20/23	03/20/23	Coupon		TESLA 2021-B A2 LEASE 144A MAT 09/22/25 Cpn 0.36 88161KAB1		454.21	0.00	0.00	454.21
03/20/23	03/20/23	Coupon		TLOT 2021-B A3 LEASE 144A MAT 10/21/24 Cpn 0.42 89239CAC3		875.00	0.00	0.00	875.00
03/20/23	03/20/23	Coupon		TLOT 2021-B A3 LEASE 144A MAT 10/21/24 Cpn 0.42 89239CAC3		1,281.00	0.00	0.00	1,281.00
03/20/23	03/20/23	Coupon		VALET 2021-1 A2 CAR MAT 10/21/24 Cpn 0.49 92868KAB9		741.54	0.00	0.00	741.54
03/21/23	03/21/23	Coupon		NORDEA BANK NY YCD FRN MAT 04/20/23 Cpn 5.16 65558UXX5		30,100.00	0.00	0.00	30,100.00
03/21/23	03/21/23	Coupon		SVENSKA HANDELSBANKEN NY Y MAT 04/21/23 Cpn 5.16 86959RM31		30,100.00	0.00	0.00	30,100.00
03/22/23	03/22/23	Coupon		DEFT 2022-2 A1 EQP 144A MAT 07/24/23 Cpn 3.06 24702CAA2		1,461.40	0.00	0.00	1,461.40
03/23/23	03/23/23	Coupon		INTL BK RECON & DEVELOP FRN S MAT 09/23/26 Cpn 5.13 459058KK8		15,753.25	0.00	0.00	15,753.25
03/23/23	03/23/23	Coupon		INTL BK RECON & DEVELOP FRN S MAT 09/23/26 Cpn 5.13 459058KK8		50,503.08	0.00	0.00	50,503.08
03/25/23	03/25/23	Coupon		BMW 2021-1 A4 LEASE MAT 07/25/24 Cpn 0.37 05591RAD6		693.75	0.00	0.00	693.75
03/25/23	03/25/23	Coupon		CITIBANK CD FRN SOFRRATE MAT 05/25/23 Cpn 5.29 17330QAG2		29,166.67	0.00	0.00	29,166.67

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
03/25/23	03/25/23	Coupon		FHMS KF36 A MAT 08/25/24 Cpn 5.01 3137FBAR7		29.37	0.00	0.00	29.37
03/25/23	03/25/23	Coupon		FHMS KF38 A MAT 09/25/24 Cpn 5.00 3137FBUC8		1,054.03	0.00	0.00	1,054.03
03/25/23	03/25/23	Coupon		FHMS KI04 A 1MOFRN CMBS MAT 07/25/24 Cpn 5.03 3137FNAV2		328.36	0.00	0.00	328.36
03/25/23	03/25/23	Coupon		FHMS KI06 A 1MOFRN CMBS MAT 03/25/25 Cpn 4.89 3137FVNA6		2,031.69	0.00	0.00	2,031.69
03/25/23	03/25/23	Coupon		FHMS KI07 A SOFRFRN MAT 09/25/26 Cpn 4.70 3137H3KA9		24,219.75	0.00	0.00	24,219.75
03/25/23	03/25/23	Coupon		FHMS KI08 A 1MOFRN CMBS MAT 10/25/26 Cpn 4.73 3137H4RC6		11,687.02	0.00	0.00	11,687.02
03/25/23	03/25/23	Coupon		FHMS Q015 A 1MOFRN CMBS MAT 08/25/24 Cpn 4.76 3137FYUR5		3,052.33	0.00	0.00	3,052.33
03/31/23	03/31/23	Coupon		INTL FINANCE CORP FRN SOFRRA MAT 06/30/23 Cpn 4.94 45950KCW8		111,548.31	0.00	0.00	111,548.31
03/31/23	03/31/23	Coupon		U.S. TREASURY NOTE MAT 03/31/23 Cpn 0.13 91282CBU4		31,250.00	0.00	0.00	31,250.00
						1,254,671.07	0.00	0.00	1,254,671.07
03/01/23	03/01/23	Income	(29,211.060)	ADJ NET INT MAT Cpn USD		(29,211.06)	0.00	0.00	(29,211.06)

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Tr Date	St Date	Transaction Type	Units	Description			Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
Cash - cont.											
03/01/23	03/01/23	Income	279,581.710	STIF INT MAT	Cpn	USD		279,581.71	0.00	0.00	279,581.71
			250,370.650					250,370.65	0.00	0.00	250,370.65
03/09/23	03/09/23	Contributn	420,000,000.000	NM MAT	Cpn	USD	420,000,000.00		0.00	0.00	420,000,000.00
03/10/23	03/10/23	Contributn	1,850,000,000.000	NM MAT	Cpn	USD	1,850,000,000.00		0.00	0.00	1,850,000,000.00
			2,270,000,000.000				2,270,000,000.00		0.00	0.00	2,270,000,000.00
03/03/23	03/06/23	Sell Long	50,000,000.000	U.S. TREASURY BILL MAT 03/07/23	Cpn	912796Y86	49,843,547.64	150,185.00	(9.65)	0.00	49,993,732.64
03/24/23	03/27/23	Sell Long	47,000,000.000	U.S. TREASURY BILL MAT 03/28/23	Cpn	912796Z85	46,897,572.51	97,773.18	1,097.06	0.00	46,995,345.69
			97,000,000.000				96,741,120.15	247,958.18	1,087.41	0.00	96,989,078.33
03/09/23	03/09/23	Pay Princpl	432,328.742	MMAF 2022-B A1 EQP 144A MAT 12/01/23	Cpn 4.92	606940AA2	432,328.74		(0.00)	0.00	432,328.74
03/10/23	03/10/23	Pay Princpl	383,067.503	CRVNA 2021-P4 A2 CAR MAT 04/10/25	Cpn 0.82	14687KAB2	383,067.50		0.00	14.80	383,067.50
03/10/23	03/10/23	Pay Princpl	1,734,134.895	CRVNA 2023-P1 A1 CAR 144A MAT 03/11/24	Cpn 5.28	14688EAA7	1,734,134.89		(0.00)	0.00	1,734,134.89
03/15/23	03/15/23	Pay Princpl	227,137.786	CARMAX 2019-3 A3 CAR MAT 08/15/24	Cpn 2.18	14315PAD7	227,137.79		0.00	(432.14)	227,137.79

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
03/15/23	03/15/23	Pay Princpl	204,482.990	CARMX 2021-4 A2A CAR MAT 11/15/24 Cpn 0.24 14317JAB3	204,482.99		0.00	0.58	204,482.99
03/15/23	03/15/23	Pay Princpl	622,149.046	CARMX 2023-1 A1 CAR MAT 02/15/24 Cpn 4.96 14318DAA7	622,149.05		0.00	0.00	622,149.05
03/15/23	03/15/23	Pay Princpl	362,914.275	CNH 2021-C A2 EQP MAT 01/15/25 Cpn 0.33 12598LAB2	362,914.28		0.00	8.02	362,914.28
03/15/23	03/15/23	Pay Princpl	296,106.909	FORDL 2023-A A1 LEASE MAT 02/15/24 Cpn 4.96 345287AA4	296,106.91		0.00	0.00	296,106.91
03/15/23	03/15/23	Pay Princpl	1,173,904.081	FORDO 2022-C A1 CAR MAT 10/15/23 Cpn 3.63 34535AAA8	1,173,904.08		(0.00)	0.00	1,173,904.08
03/15/23	03/15/23	Pay Princpl	623,406.312	GALC 2022-1 A1 EQP 144A MAT 10/16/23 Cpn 4.34 39154TBU1	623,406.31		(0.00)	0.00	623,406.31
03/15/23	03/15/23	Pay Princpl	570,877.777	HALST 2021-A A3 LEASE 144A MAT 01/16/24 Cpn 0.33 44891TAC0	570,877.78		1,647.06	0.00	570,877.78
03/15/23	03/15/23	Pay Princpl	506,178.296	HALST 2021-A A3 LEASE 144A MAT 01/16/24 Cpn 0.33 44891TAC0	506,178.30		2,097.02	0.00	506,178.30
03/15/23	03/15/23	Pay Princpl	474,159.472	HALST 2021-C A2 CAR LEASE 144A MAT 01/16/24 Cpn 0.24 44933MAB7	474,159.47		0.00	2.84	474,159.47
03/15/23	03/15/23	Pay Princpl	114,549.417	HALST 2021-C A2 CAR LEASE 144A MAT 01/16/24 Cpn 0.24 44933MAB7	114,549.42		292.98	0.00	114,549.42
03/15/23	03/15/23	Pay Princpl	374,814.025	HAROT 2022-1 A2 CAR MAT 10/15/24 Cpn 1.44 43815BAB6	374,814.03		0.00	13.89	374,814.03
03/15/23	03/15/23	Pay Princpl	706,106.663	HART 2019-B A4 CAR MAT 04/15/25 Cpn 2.00 44891JAD0	706,106.66		2,151.42	0.00	706,106.66
03/15/23	03/15/23	Pay Princpl	363,595.213	JOHN DEERE 2020-B A3 EQP MAT 11/15/24 Cpn 0.51 47787NAC3	363,595.21		4,508.39	0.00	363,595.21

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
03/15/23	03/15/23	Pay Princpl	223,321.834	KUBOTA 2020-1A A3 EQP 144A MAT 03/15/24 Cpn 1.96 50117WAC8	223,321.83		0.00	(1,256.48)	223,321.83
03/15/23	03/15/23	Pay Princpl	53,577.211	KUBOTA 2020-1A A3 EQP 144A MAT 03/15/24 Cpn 1.96 50117WAC8	53,577.21		0.00	(278.93)	53,577.21
03/15/23	03/15/23	Pay Princpl	417,565.834	KCOT 2022-2A A1 EQP 144A MAT 07/17/23 Cpn 2.60 50117JAA1	417,565.83		(0.00)	0.00	417,565.83
03/15/23	03/15/23	Pay Princpl	4,409,911.153	MERCEDES 2020-B A4 LEASE MAT 06/15/26 Cpn 0.50 58769EAD0	4,409,911.15		21,697.58	0.00	4,409,911.15
03/15/23	03/15/23	Pay Princpl	542,145.953	NALT 2023-A A1 LEASE MAT 02/15/24 Cpn 4.97 65480VAA1	542,145.95		(0.00)	0.00	542,145.95
03/15/23	03/15/23	Pay Princpl	961,308.309	NAROT 2022-B A1 CAR MAT 10/16/23 Cpn 3.69 65480JAA8	961,308.31		0.00	0.00	961,308.31
03/15/23	03/15/23	Pay Princpl	67,582.590	TAOT 2022-C A2A CAR MAT 08/15/25 Cpn 4.19 89231CAB3	67,582.59		4.45	0.00	67,582.59
03/15/23	03/15/23	Pay Princpl	443,451.161	TAOT 2023-A A1 CAR MAT 01/15/24 Cpn 4.84 891940AA6	443,451.16		(0.00)	0.00	443,451.16
03/15/23	03/15/23	Pay Princpl	307,128.003	WOART 2022-B A2A CAR MAT 10/15/25 Cpn 2.77 98163QAB5	307,128.00		17.48	0.00	307,128.00
03/15/23	03/15/23	Pay Princpl	89,245.116	WOLS 2022-A A2 LEASE MAT 10/15/24 Cpn 2.63 98163NAB2	89,245.12		1.27	0.00	89,245.12
03/16/23	03/16/23	Pay Princpl	971,069.826	GMCAR 2022-4 A1 CAR MAT 10/16/23 Cpn 3.62 36265QAA4	971,069.83		0.00	0.00	971,069.83
03/16/23	03/16/23	Pay Princpl	971,896.160	GMCAR 2023-1 A1 CAR MAT 01/16/24 Cpn 4.89 38013JAA1	971,896.16		(0.00)	0.00	971,896.16
03/18/23	03/18/23	Pay Princpl	185,819.794	HONDA 2021-3 A2 CAR MAT 02/20/24 Cpn 0.20 43815EAB0	185,819.79		0.00	2.57	185,819.79

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
03/20/23	03/20/23	Pay Princpl	199,681.295	DLLAD 2023-1A A1 EQP 144A MAT 02/20/24 Cpn 5.01 233258AA0	199,681.30		0.00	0.00	199,681.30
03/20/23	03/20/23	Pay Princpl	381,349.459	EFF 2022-2 A1 FLEET 144A MAT 06/20/23 Cpn 2.76 29374JAA3	381,349.46		0.00	0.00	381,349.46
03/20/23	03/20/23	Pay Princpl	675,164.172	EFF 2022-3 A1 FLEET 144A MAT 08/20/23 Cpn 3.61 29374FAA1	675,164.17		(0.00)	0.00	675,164.17
03/20/23	03/20/23	Pay Princpl	592,599.654	EFF 2022-4 A1 FLEET 144A MAT 11/20/23 Cpn 5.15 29374GAA9	592,599.65		(0.00)	0.00	592,599.65
03/20/23	03/20/23	Pay Princpl	1,093,349.341	GMALT 2021-1 A3 LEASE MAT 02/20/24 Cpn 0.26 36261RAC2	1,093,349.34		3,991.02	0.00	1,093,349.34
03/20/23	03/20/23	Pay Princpl	37,062.690	GMALT 2021-1 A3 LEASE MAT 02/20/24 Cpn 0.26 36261RAC2	37,062.69		135.29	0.00	37,062.69
03/20/23	03/20/23	Pay Princpl	225,571.140	HPEFS 2022-3A A1 EQP 144A MAT 10/20/23 Cpn 4.33 403951AA4	225,571.14		(0.00)	0.00	225,571.14
03/20/23	03/20/23	Pay Princpl	298,468.399	SRT 2021-A A3 LEASE 144A MAT 07/22/24 Cpn 0.51 80286TAC7	298,468.40		6,016.50	0.00	298,468.40
03/20/23	03/20/23	Pay Princpl	139,712.878	TESLA 2021-B A2 LEASE 144A MAT 09/22/25 Cpn 0.36 88161KAB1	139,712.88		0.00	5.26	139,712.88
03/20/23	03/20/23	Pay Princpl	77,948.665	TLOT 2021-B A3 LEASE 144A MAT 10/21/24 Cpn 0.42 89239CAC3	77,948.67		2,302.81	0.00	77,948.67
03/20/23	03/20/23	Pay Princpl	114,116.845	TLOT 2021-B A3 LEASE 144A MAT 10/21/24 Cpn 0.42 89239CAC3	114,116.85		2,714.77	0.00	114,116.85
03/20/23	03/20/23	Pay Princpl	445,877.450	VALET 2021-1 A2 CAR MAT 10/21/24 Cpn 0.49 92868KAB9	445,877.45		0.00	9.00	445,877.45
03/22/23	03/22/23	Pay Princpl	613,630.656	DEFT 2022-2 A1 EQP 144A MAT 07/24/23 Cpn 3.06 24702CAA2	613,630.66		0.00	0.00	613,630.66

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
03/25/23	03/25/23	Pay Princpl	0.001	FHMS KF36 A MAT 08/25/24 Cpn 5.01 3137FBAR7			0.00	(0.00)	
03/25/23	03/25/23	Pay Princpl	226.564	FHMS KF38 A MAT 09/25/24 Cpn 5.00 3137FBUC8	226.56		0.00	0.09	226.56
03/25/23	03/25/23	Pay Princpl	0.001	FHMS KI08 A 1MOFRN CMBS MAT 10/25/26 Cpn 4.73 3137H4RC6			0.00	(0.00)	
			23,708,695.557		23,708,695.56		47,578.04	(1,910.52)	23,708,695.56
03/02/23	03/02/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 03/02/23 Cpn 912796YB9	49,876,111.11	123,888.89	0.00	0.00	50,000,000.00
03/02/23	03/02/23	Mature Long	7,500,000.000	CANADIAN IMPERIAL BANK YCD MAT 03/02/23 Cpn 3.70 13606KMN3	7,500,000.00		0.00	0.00	7,500,000.00
03/07/23	03/07/23	Mature Long	18,000,000.000	U.S. TREASURY BILL MAT 03/07/23 Cpn 912796Y86	17,973,360.00	26,640.00	0.00	0.00	18,000,000.00
03/07/23	03/07/23	Mature Long	2,000,000.000	U.S. TREASURY BILL MAT 03/07/23 Cpn 912796Y86	1,998,269.44	1,730.56	0.00	0.00	2,000,000.00
03/08/23	03/08/23	Mature Long	7,500,000.000	NATIXIS NY YCD MAT 03/08/23 Cpn 3.82 63873QWG	7,500,000.00		0.00	0.00	7,500,000.00
03/08/23	03/08/23	Mature Long	7,500,000.000	SWEDBANK NY YCD MAT 03/08/23 Cpn 4.74 87019WFR1	7,500,000.00		0.00	0.00	7,500,000.00
03/09/23	03/09/23	Mature Long	25,000,000.000	U.S. TREASURY BILL MAT 03/09/23 Cpn 912796YK9	24,740,187.50	259,812.50	0.00	0.00	25,000,000.00
03/09/23	03/09/23	Mature Long	25,000,000.000	U.S. TREASURY BILL MAT 03/09/23 Cpn 912796YK9	24,915,798.44	84,201.56	0.00	0.00	25,000,000.00
03/13/23	03/13/23	Mature Long	40,000,000.000	FHLB DISCOUNT NOTE MAT 03/13/23 Cpn 313384CZ0	39,985,333.33	14,666.67	0.00	0.00	40,000,000.00

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
03/14/23	03/14/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 03/14/23 Cpn 912796Z69	49,301,013.89	698,986.11	0.00	0.00	50,000,000.00
03/14/23	03/14/23	Mature Long	30,000,000.000	U.S. TREASURY BILL MAT 03/14/23 Cpn 912796Z69	29,921,600.00	78,400.00	0.00	0.00	30,000,000.00
03/14/23	03/14/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 03/14/23 Cpn 912796Z69	49,913,054.17	86,945.83	0.00	0.00	50,000,000.00
03/14/23	03/14/23	Mature Long	10,000,000.000	U.S. TREASURY BILL MAT 03/14/23 Cpn 912796Z69	9,994,994.44	5,005.56	0.00	0.00	10,000,000.00
03/15/23	03/15/23	Mature Long	7,500,000.000	CA SAN FRAN PUB UTIL COMM CP MAT 03/15/23 Cpn 4.67 79770TRC4	7,500,000.00		0.00	0.00	7,500,000.00
03/16/23	03/16/23	Mature Long	14,000,000.000	U.S. TREASURY BILL MAT 03/16/23 Cpn 912796YL7	13,940,901.96	59,098.04	0.00	0.00	14,000,000.00
03/16/23	03/16/23	Mature Long	32,000,000.000	U.S. TREASURY BILL MAT 03/16/23 Cpn 912796YL7	31,933,133.33	66,866.67	0.00	0.00	32,000,000.00
03/16/23	03/16/23	Mature Long	4,000,000.000	U.S. TREASURY BILL MAT 03/16/23 Cpn 912796YL7	3,992,067.56	7,932.44	0.00	0.00	4,000,000.00
03/16/23	03/16/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 03/16/23 Cpn 912796YL7	49,900,844.44	99,155.56	0.00	0.00	50,000,000.00
03/16/23	03/16/23	Mature Long	20,000,000.000	U.S. TREASURY BILL MAT 03/16/23 Cpn 912796YL7	19,977,750.00	22,250.00	0.00	0.00	20,000,000.00
03/16/23	03/16/23	Mature Long	40,000,000.000	U.S. TREASURY BILL MAT 03/16/23 Cpn 912796YL7	39,970,663.33	29,336.67	0.00	0.00	40,000,000.00
03/16/23	03/16/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 03/16/23 Cpn 912796YL7	49,963,329.17	36,670.83	0.00	0.00	50,000,000.00
03/16/23	03/16/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 03/16/23 Cpn 912796YL7	49,963,329.17	36,670.83	0.00	0.00	50,000,000.00

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
03/16/23	03/16/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 03/16/23 Cpn 912796YL7	49,963,329.17	36,670.83	0.00	0.00	50,000,000.00
03/16/23	03/16/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 03/16/23 Cpn 912796YL7	49,963,329.17	36,670.83	0.00	0.00	50,000,000.00
03/16/23	03/16/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 03/16/23 Cpn 912796YL7	49,963,329.17	36,670.83	0.00	0.00	50,000,000.00
03/16/23	03/16/23	Mature Long	40,000,000.000	U.S. TREASURY BILL MAT 03/16/23 Cpn 912796YL7	39,970,666.67	29,333.33	0.00	0.00	40,000,000.00
03/16/23	03/16/23	Mature Long	4,200,000.000	CA SAN JOSE FIN AUTH LEASE RE MAT 03/16/23 Cpn 4.65 79815WDH8	4,200,000.00		0.00	0.00	4,200,000.00
03/20/23	03/20/23	Mature Long	7,500,000.000	SUMITOMO MITSUI BANKING YCD MAT 03/20/23 Cpn 86565FTC6	7,500,000.00		0.00	0.00	7,500,000.00
03/21/23	03/21/23	Mature Long	40,000,000.000	U.S. TREASURY BILL MAT 03/21/23 Cpn 912796Z77	39,941,173.33	58,826.67	0.00	0.00	40,000,000.00
03/21/23	03/21/23	Mature Long	10,000,000.000	U.S. TREASURY BILL MAT 03/21/23 Cpn 912796Z77	9,986,387.50	13,612.50	0.00	0.00	10,000,000.00
03/23/23	03/23/23	Mature Long	30,000,000.000	U.S. TREASURY BILL MAT 03/23/23 Cpn 912796U31	29,953,525.00	46,475.00	0.00	0.00	30,000,000.00
03/23/23	03/23/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 03/23/23 Cpn 912796U31	49,922,541.67	77,458.33	0.00	0.00	50,000,000.00
03/27/23	03/27/23	Mature Long	20,000,000.000	FHLB DISCOUNT NOTE MAT 03/27/23 Cpn 313384DP1	19,992,516.67	7,483.33	0.00	0.00	20,000,000.00
03/28/23	03/28/23	Mature Long	3,000,000.000	U.S. TREASURY BILL MAT 03/28/23 Cpn 912796Z85	2,993,392.05	6,607.95	(0.00)	0.00	3,000,000.00
03/28/23	03/28/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 03/28/23 Cpn 912796Z85	49,889,867.50	110,132.50	0.00	0.00	50,000,000.00

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Tr Date	St Date	Transaction Type	Units	Description		Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
03/28/23	03/28/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 03/28/23 Cpn	912796Z85	49,889,867.50	110,132.50	0.00	0.00	50,000,000.00
03/28/23	03/28/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 03/28/23 Cpn	912796Z85	49,889,867.50	110,132.50	0.00	0.00	50,000,000.00
03/28/23	03/28/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 03/28/23 Cpn	912796Z85	49,889,867.50	110,132.50	0.00	0.00	50,000,000.00
03/28/23	03/28/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 03/28/23 Cpn	912796Z85	49,889,867.50	110,132.50	0.00	0.00	50,000,000.00
03/28/23	03/28/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 03/28/23 Cpn	912796Z85	49,889,867.50	110,132.50	0.00	0.00	50,000,000.00
03/28/23	03/28/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 03/28/23 Cpn	912796Z85	49,889,867.50	110,132.50	0.00	0.00	50,000,000.00
03/28/23	03/28/23	Mature Long	40,000,000.000	U.S. TREASURY BILL MAT 03/28/23 Cpn	912796Z85	39,911,280.00	88,720.00	0.00	0.00	40,000,000.00
03/29/23	03/29/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 03/29/23 Cpn	313384DR7	49,881,777.78	118,222.22	0.00	0.00	50,000,000.00
03/29/23	03/29/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 03/29/23 Cpn	313384DR7	49,881,777.78	118,222.22	0.00	0.00	50,000,000.00
03/29/23	03/29/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 03/29/23 Cpn	313384DR7	49,881,777.78	118,222.22	0.00	0.00	50,000,000.00
03/29/23	03/29/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 03/29/23 Cpn	313384DR7	49,881,777.78	118,222.22	0.00	0.00	50,000,000.00
03/29/23	03/29/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 03/29/23 Cpn	313384DR7	49,881,777.78	118,222.22	0.00	0.00	50,000,000.00
03/29/23	03/29/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 03/29/23 Cpn	313384DR7	49,881,777.78	118,222.22	0.00	0.00	50,000,000.00

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Tr Date	St Date	Transaction Type	Units	Description		Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
03/29/23	03/29/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 03/29/23 Cpn	313384DR7	49,881,777.78	118,222.22	0.00	0.00	50,000,000.00
03/29/23	03/29/23	Mature Long	50,000,000.000	FHLB DISCOUNT NOTE MAT 03/29/23 Cpn	313384DR7	49,881,777.78	118,222.22	0.00	0.00	50,000,000.00
03/29/23	03/29/23	Mature Long	43,000,000.000	FHLMC DISCOUNT NOTE MAT 03/29/23 Cpn	313396DR1	42,994,744.44	5,255.56	0.00	0.00	43,000,000.00
03/29/23	03/29/23	Mature Long	50,000,000.000	FHLMC DISCOUNT NOTE MAT 03/29/23 Cpn	313396DR1	49,993,888.89	6,111.11	0.00	0.00	50,000,000.00
03/29/23	03/29/23	Mature Long	50,000,000.000	FHLMC DISCOUNT NOTE MAT 03/29/23 Cpn	313396DR1	49,993,888.89	6,111.11	0.00	0.00	50,000,000.00
03/29/23	03/29/23	Mature Long	50,000,000.000	FHLMC DISCOUNT NOTE MAT 03/29/23 Cpn	313396DR1	49,993,888.89	6,111.11	0.00	0.00	50,000,000.00
03/29/23	03/29/23	Mature Long	50,000,000.000	FHLMC DISCOUNT NOTE MAT 03/29/23 Cpn	313396DR1	49,993,888.89	6,111.11	0.00	0.00	50,000,000.00
03/29/23	03/29/23	Mature Long	50,000,000.000	FHLMC DISCOUNT NOTE MAT 03/29/23 Cpn	313396DR1	49,993,888.89	6,111.11	0.00	0.00	50,000,000.00
03/29/23	03/29/23	Mature Long	50,000,000.000	FHLMC DISCOUNT NOTE MAT 03/29/23 Cpn	313396DR1	49,993,888.89	6,111.11	0.00	0.00	50,000,000.00
03/29/23	03/29/23	Mature Long	50,000,000.000	FHLMC DISCOUNT NOTE MAT 03/29/23 Cpn	313396DR1	49,993,888.89	6,111.11	0.00	0.00	50,000,000.00
03/30/23	03/30/23	Mature Long	20,000,000.000	U.S. TREASURY BILL MAT 03/30/23 Cpn	912796YM5	19,959,275.56	40,724.44	0.00	0.00	20,000,000.00
03/30/23	03/30/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 03/30/23 Cpn	912796YM5	49,898,188.89	101,811.11	0.00	0.00	50,000,000.00
03/30/23	03/30/23	Mature Long	50,000,000.000	U.S. TREASURY BILL MAT 03/30/23 Cpn	912796YM5	49,898,188.89	101,811.11	0.00	0.00	50,000,000.00

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03/31/23	03/31/23	Mature Long	50,000,000.000	U.S. TREASURY NOTE MAT 03/31/23	Cpn 0.13	91282CBU4	50,000,000.00		0.00	0.00	50,000,000.00
			2,297,700,000.000				2,293,514,126.43	4,185,873.59	(0.00)	0.00	2,297,700,000.00
03/02/23	03/02/23	Withdrawal	(50,000,000.000)	WD MAT	Cpn	USD	(50,000,000.00)		(50,000,000.00)	0.00	(50,000,000.00)
03/06/23	03/06/23	Withdrawal	(50,000,000.000)	WD MAT	Cpn	USD	(50,000,000.00)		(50,000,000.00)	0.00	(50,000,000.00)
03/09/23	03/09/23	Withdrawal	(50,000,000.000)	WD MAT	Cpn	USD	(50,000,000.00)		(50,000,000.00)	0.00	(50,000,000.00)
03/14/23	03/14/23	Withdrawal	(70,000,000.000)	WD MAT	Cpn	USD	(70,000,000.00)		(70,000,000.00)	0.00	(70,000,000.00)
03/16/23	03/16/23	Withdrawal	(425,000,000.000)	WD MAT	Cpn	USD	(425,000,000.00)		(425,000,000.00)	0.00	(425,000,000.00)
03/17/23	03/17/23	Withdrawal	(65,000,000.000)	WD MAT	Cpn	USD	(65,000,000.00)		(65,000,000.00)	0.00	(65,000,000.00)
03/23/23	03/23/23	Withdrawal	(35,000,000.000)	WD MAT	Cpn	USD	(35,000,000.00)		(35,000,000.00)	0.00	(35,000,000.00)
03/24/23	03/24/23	Withdrawal	(30,000,000.000)	WD MAT	Cpn	USD	(30,000,000.00)		(30,000,000.00)	0.00	(30,000,000.00)
03/27/23	03/27/23	Withdrawal	(60,000,000.000)	WD MAT	Cpn	USD	(60,000,000.00)		(60,000,000.00)	0.00	(60,000,000.00)

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Tr Date	St Date	Transaction Type	Units	Description			Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
Cash - cont.											
03/30/23	03/30/23	Withdrawal	(50,000,000.000)	WD MAT	Cpn	USD	(50,000,000.00)		(50,000,000.00)	0.00	(50,000,000.00)
			(885,000,000.000)				(885,000,000.00)		(885,000,000.00)	0.00	(885,000,000.00)

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Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
03/01/23	03/02/23	Buy	670,000.000	U.S. TREASURY NOTE MAT 02/29/28 Cpn 4.00 91282CGP0	(662,043.75)	(145.65)	0.00	0.00	(662,189.40)
03/20/23	03/21/23	Buy	1,180,000.000	U.S. TREASURY NOTE MAT 02/29/28 Cpn 4.00 91282CGP0	(1,201,940.63)	(2,693.48)	0.00	0.00	(1,204,634.11)
03/29/23	03/30/23	Buy	545,000.000	U.S. TREASURY NOTE MAT 02/29/28 Cpn 4.00 91282CGP0	(552,855.66)	(1,777.17)	0.00	0.00	(554,632.83)
			2,395,000.000		(2,416,840.04)	(4,616.30)	0.00	0.00	(2,421,456.34)
03/01/23	03/01/23	Coupon		CA GLENDALE USD GO/ULT TXB MAT 09/01/24 Cpn 1.46 378460YD5		1,821.25	0.00	0.00	1,821.25
03/01/23	03/01/23	Coupon		CA HESPERIA REDEV AGY SUCCE MAT 09/01/23 Cpn 3.13 42806KAS2		12,343.75	0.00	0.00	12,343.75
03/01/23	03/01/23	Coupon		CA SANTA ANA CMNTY REDEV AG MAT 09/01/23 Cpn 3.57 801096AR9		8,025.75	0.00	0.00	8,025.75
03/01/23	03/01/23	Coupon		CA SAN DIEGO REDEV AGY TAB T MAT 09/01/23 Cpn 3.38 79730WAZ3		7,593.75	0.00	0.00	7,593.75
03/01/23	03/01/23	Coupon		CA SAN JOSE-EVERGREEN CCD T MAT 09/01/23 Cpn 3.50 798189RE8		6,825.00	0.00	0.00	6,825.00
03/01/23	03/01/23	Coupon		CA SAN LUIS WESTLANDS WTR DI MAT 09/01/24 Cpn 1.45 798736AW4		2,970.45	0.00	0.00	2,970.45
03/15/23	03/15/23	Coupon		CARMX 2020-1 A3 CAR MAT 12/16/24 Cpn 1.89 14315XAC2		202.37	0.00	0.00	202.37
03/15/23	03/15/23	Coupon		CARMX 2021-2 A3 AUTO MAT 02/17/26 Cpn 0.52 14314QAC8		353.45	0.00	0.00	353.45
03/15/23	03/15/23	Coupon		CARMX 2021-3 A3 CAR MAT 06/15/26 Cpn 0.55 14317DAC4		435.42	0.00	0.00	435.42

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03/15/23	03/15/23	Coupon		CAPITAL ONE 2020-1 A3 CAR MAT 11/15/24 Cpn 1.60 14043MAC5		117.96	0.00	0.00	117.96
03/15/23	03/15/23	Coupon		FORDL 2021-B A3 LEASE MAT 10/15/24 Cpn 0.37 345329AC0		277.50	0.00	0.00	277.50
03/15/23	03/15/23	Coupon		JOHN DEERE 2020-A A3 EQP MAT 08/15/24 Cpn 1.10 47789KAC7		87.09	0.00	0.00	87.09
03/15/23	03/15/23	Coupon		JOHN DEERE 2021-A A3 EQP MAT 09/15/25 Cpn 0.36 47788UAC6		123.74	0.00	0.00	123.74
03/15/23	03/15/23	Coupon		KUBOTA 2021-2A A3 EQP 144A MAT 11/17/25 Cpn 0.56 50117XAE2		443.33	0.00	0.00	443.33
03/15/23	03/15/23	Coupon		MERCEDES 2021-B A3 LEASE MAT 11/15/24 Cpn 0.40 58769KAD6		195.74	0.00	0.00	195.74
03/15/23	03/15/23	Coupon		NY STATE DORM AUTH PERS INC T MAT 03/15/25 Cpn 0.89 64990FD43		3,015.80	0.00	0.00	3,015.80
03/15/23	03/15/23	Coupon		NY STATE DORUM AUTH-PIT TXB MAT 03/15/23 Cpn 2.01 64990FX82		9,040.50	0.00	0.00	9,040.50
03/15/23	03/15/23	Coupon		U.S. TREASURY NOTE MAT 03/15/24 Cpn 0.25 91282CBR1		181.25	0.00	0.00	181.25
03/15/23	03/15/23	Coupon		U.S. TREASURY NOTE MAT 03/15/24 Cpn 0.25 91282CBR1		875.00	0.00	0.00	875.00
03/15/23	03/15/23	Coupon		WORLD OMNI 2021-A A3 LEASE MAT 08/15/24 Cpn 0.42 98163JAC9		236.99	0.00	0.00	236.99
03/16/23	03/16/23	Coupon		GMCAR 2021-2 A3 CAR MAT 04/16/26 Cpn 0.51 380149AC8		80.41	0.00	0.00	80.41
03/20/23	03/20/23	Coupon		GMALT 2021-2 A LEASE MAT 05/20/25 Cpn 0.41 380144AD7		256.25	0.00	0.00	256.25

Account Name: L.A. CARE HEALTH PLAN-LOW DURATION PORT

03/01/2023 through 03/31/2023

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
03/20/23	03/20/23	Coupon		SRT 2021-C A3 LEASE 144A MAT 03/20/25 Cpn 0.50 80286CAC4		186.57	0.00	0.00	186.57
03/20/23	03/20/23	Coupon		TESLA 2021-B A2 LEASE 144A MAT 09/22/25 Cpn 0.36 88161KAB1		59.57	0.00	0.00	59.57
03/20/23	03/20/23	Coupon		VERIZON 2020-B A PHONE MAT 02/20/25 Cpn 0.47 92290BAA9		147.82	0.00	0.00	147.82
03/25/23	03/25/23	Coupon		BMW 2021-1 A4 LEASE MAT 07/25/24 Cpn 0.37 05591RAD6		92.50	0.00	0.00	92.50
03/01/23	03/25/23	Coupon		FHMS K031 A2 MAT 04/25/23 Cpn 3.30 3137B3NX2		1,840.19	0.00	0.00	1,840.19
03/01/23	03/25/23	Coupon		FHMS K033 A2 MAT 07/25/23 Cpn 3.06 3137B4WB8		2,086.28	0.00	0.00	2,086.28
03/01/23	03/25/23	Coupon		FHMS K034 A2 MAT 07/25/23 Cpn 3.53 3137B5JM6		1,346.96	0.00	0.00	1,346.96
03/01/23	03/25/23	Coupon		FHMS K725 AM CMBS MAT 02/25/24 Cpn 3.10 3137BWWE		2,095.20	0.00	0.00	2,095.20
03/01/23	03/25/23	Coupon		FHMS K726 AM CMBS MAT 04/25/24 Cpn 2.99 3137BYPR5		1,417.88	0.00	0.00	1,417.88
03/01/23	03/25/23	Coupon		FHMS KJ28 A1 MAT 02/25/25 Cpn 1.77 3137FREB3		9.45	0.00	0.00	9.45
03/01/23	03/25/23	Coupon		FHMS KJ30 A1 CMBS MAT 01/25/25 Cpn 0.53 3137FUZN7		15.23	0.00	0.00	15.23
03/31/23	03/31/23	Coupon		FHLMC C 12/30/2022 Q MAT 09/30/25 Cpn 4.75 3134GX3A0		14,487.50	0.00	0.00	14,487.50
03/31/23	03/31/23	Coupon		U.S. TREASURY NOTE MAT 09/30/25 Cpn 0.25 91282CAM3		625.00	0.00	0.00	625.00

Account Name: L.A. CARE HEALTH PLAN-LOW DURATION PORT

03/01/2023 through 03/31/2023

Tr Date	St Date	Transaction Type	Units	Description			Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
03/31/23	03/31/23	Coupon		U.S. TREASURY NOTE MAT 03/31/25	Cpn 0.50	912828ZF0		4,215.00	0.00	0.00	4,215.00
03/31/23	03/31/23	Coupon		U.S. TREASURY NOTE MAT 03/31/26	Cpn 0.75	91282CBT7		3,506.25	0.00	0.00	3,506.25
03/31/23	03/31/23	Coupon		U.S. TREASURY NOTE MAT 03/31/26	Cpn 0.75	91282CBT7		3,412.50	0.00	0.00	3,412.50
03/31/23	03/31/23	Coupon		U.S. TREASURY NOTE MAT 03/31/26	Cpn 0.75	91282CBT7		1,762.50	0.00	0.00	1,762.50
03/31/23	03/31/23	Coupon		U.S. TREASURY NOTE MAT 09/30/26	Cpn 0.88	91282CCZ2		6,146.88	0.00	0.00	6,146.88
03/31/23	03/31/23	Coupon		U.S. TREASURY NOTE MAT 09/30/24	Cpn 1.50	912828YH7		6,675.00	0.00	0.00	6,675.00
03/31/23	03/31/23	Coupon		U.S. TREASURY NOTE MAT 03/31/27	Cpn 2.50	91282CEF4		5,625.00	0.00	0.00	5,625.00
03/31/23	03/31/23	Coupon		U.S. TREASURY NOTE MAT 03/31/27	Cpn 2.50	91282CEF4		11,250.00	0.00	0.00	11,250.00
								122,506.03	0.00	0.00	122,506.03
03/01/23	03/01/23	Income	(323.800)	ADJ NET INT MAT	Cpn	USD		(323.80)	0.00	0.00	(323.80)
03/01/23	03/01/23	Income	3,673.300	STIF INT MAT	Cpn	USD		3,673.30	0.00	0.00	3,673.30
			3,349.500					3,349.50	0.00	0.00	3,349.50

Account Name: L.A. CARE HEALTH PLAN-LOW DURATION PORT

03/01/2023 through 03/31/2023

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
03/15/23	03/15/23	Pay Princpl	17,661.570	CARMX 2020-1 A3 CAR MAT 12/16/24 Cpn 1.89 14315XAC2	17,661.57		0.00	(108.28)	17,661.57
03/15/23	03/15/23	Pay Princpl	46,250.203	CARMX 2021-2 A3 AUTO MAT 02/17/26 Cpn 0.52 14314QAC8	46,250.20		0.00	4.90	46,250.20
03/15/23	03/15/23	Pay Princpl	12,215.724	CARMX 2021-3 A3 CAR MAT 06/15/26 Cpn 0.55 14317DAC4	12,215.72		0.00	1.16	12,215.72
03/15/23	03/15/23	Pay Princpl	16,149.762	CAPITAL ONE 2020-1 A3 CAR MAT 11/15/24 Cpn 1.60 14043MAC5	16,149.76		0.00	0.61	16,149.76
03/15/23	03/15/23	Pay Princpl	95,233.947	FORDL 2021-B A3 LEASE MAT 10/15/24 Cpn 0.37 345329AC0	95,233.95		0.00	6.07	95,233.95
03/15/23	03/15/23	Pay Princpl	21,287.459	JOHN DEERE 2020-A A3 EQP MAT 08/15/24 Cpn 1.10 47789KAC7	21,287.46		0.00	0.24	21,287.46
03/15/23	03/15/23	Pay Princpl	23,669.153	JOHN DEERE 2021-A A3 EQP MAT 09/15/25 Cpn 0.36 47788UAC6	23,669.15		0.00	2.17	23,669.15
03/15/23	03/15/23	Pay Princpl	39,669.640	MERCEDES 2021-B A3 LEASE MAT 11/15/24 Cpn 0.40 58769KAD6	39,669.64		0.00	1.16	39,669.64
03/15/23	03/15/23	Pay Princpl	45,660.562	WORLD OMNI 2021-A A3 LEASE MAT 08/15/24 Cpn 0.42 98163JAC9	45,660.56		0.00	1.94	45,660.56
03/16/23	03/16/23	Pay Princpl	10,564.792	GMCAR 2021-2 A3 CAR MAT 04/16/26 Cpn 0.51 380149AC8	10,564.79		0.00	0.45	10,564.79
03/20/23	03/20/23	Pay Princpl	40,479.241	SRT 2021-C A3 LEASE 144A MAT 03/20/25 Cpn 0.50 80286CAC4	40,479.24		0.00	0.81	40,479.24
03/20/23	03/20/23	Pay Princpl	18,323.000	TESLA 2021-B A2 LEASE 144A MAT 09/22/25 Cpn 0.36 88161KAB1	18,323.00		0.00	0.69	18,323.00
03/20/23	03/20/23	Pay Princpl	64,935.668	VERIZON 2020-B A PHONE MAT 02/20/25 Cpn 0.47 92290BAA9	64,935.67		0.00	(31.29)	64,935.67

Account Name: L.A. CARE HEALTH PLAN-LOW DURATION PORT

03/01/2023 through 03/31/2023

Tr Date	St Date	Transaction Type	Units	Description	Proceeds / (Cost)	Accrued Interest (Purch) or Sold	G/L < 1 Yr Amort Cost	G/L > 1 Yr Amort Cost	Total Amount
03/01/23	03/25/23	Pay Princpl	263,459.160	FHMS K031 A2 MAT 04/25/23 Cpn 3.30 3137B3NX2	263,459.16		0.00	(830.44)	263,459.16
03/01/23	03/25/23	Pay Princpl	82,910.980	FHMS K033 A2 MAT 07/25/23 Cpn 3.06 3137B4WB8	82,910.98		0.00	(483.92)	82,910.98
03/01/23	03/25/23	Pay Princpl	25,633.393	FHMS K034 A2 MAT 07/25/23 Cpn 3.53 3137B5JM6	25,633.39		0.00	(228.02)	25,633.39
03/01/23	03/25/23	Pay Princpl	1,308.006	FHMS KJ28 A1 MAT 02/25/25 Cpn 1.77 3137FREB3	1,308.01		0.00	0.01	1,308.01
03/01/23	03/25/23	Pay Princpl	1,107.160	FHMS KJ30 A1 CMBS MAT 01/25/25 Cpn 0.53 3137FUZN7	1,107.16		0.00	0.01	1,107.16
			826,519.420		826,519.41		0.00	(1,661.71)	826,519.41
03/15/23	03/15/23	Mature Long	900,000.000	NY STATE DORUM AUTH-PIT TXB MAT 03/15/23 Cpn 2.01 64990FX82	900,000.00		0.00	0.00	900,000.00

LA CARE

Cash Activity by Transaction Type GAAP Basis

03/31/2023 Accounting Period

Cash Date	Trade/Ex-Date	Settle/Pay Date	Custodian	Cusip	Description	Quantity	Income Amount	Principal Amount	Contributions/ Withdrawals	Total Amount
BUY										
03/02/23	02/28/23	03/02/23	TNT77	91324PEP3	UNITEDHEALTH GROUP INC	5,000,000.00	(12,395.83)	(5,071,350.00)	0.00	(5,083,745.83)
03/08/23	03/08/23	03/08/23	TNT77	665278404	NORTHERN INST GOVT MONEY MKT	871,164.26	0.00	(871,164.26)	0.00	(871,164.26)
03/13/23	03/09/23	03/13/23	TNT77	04636NAF0	ASTRAZENECA FINANCE LLC	5,000,000.00	(6,770.83)	(4,969,000.00)	0.00	(4,975,770.83)
TOTAL BUY						10,871,164.26	(19,166.66)	(10,911,514.26)	0.00	(10,930,680.92)
DIVIDEND										
03/01/23	03/01/23	03/01/23	TNT77	665278404	NORTHERN INST GOVT MONEY MKT	784,277.22	3,757.98	0.00	0.00	3,757.98
TOTAL DIVIDEND						784,277.22	3,757.98	0.00	0.00	3,757.98
INTEREST										
03/01/23	03/01/23	03/01/23	TNT77	010392FY9	ALABAMA POWER CO	7,000,000.00	145,104.17	0.00	0.00	145,104.17
03/01/23	03/01/23	03/01/23	TNT77	20030NBS9	COMCAST CORP	3,500,000.00	55,125.00	0.00	0.00	55,125.00
03/01/23	03/01/23	03/01/23	TNT77	29157TAC0	EMORY UNIVERSITY	4,305,000.00	33,708.15	0.00	0.00	33,708.15
03/02/23	03/02/23	03/02/23	TNT77	14913R2K2	CATERPILLAR FINL SERVICE	5,000,000.00	22,500.00	0.00	0.00	22,500.00
03/03/23	03/03/23	03/03/23	TNT77	57636QAN4	MASTERCARD INC	3,000,000.00	30,000.00	0.00	0.00	30,000.00
03/10/23	03/10/23	03/10/23	TNT77	771196BV3	ROCHE HOLDINGS INC	7,500,000.00	86,775.00	0.00	0.00	86,775.00
03/13/23	03/13/23	03/13/23	TNT77	828807DG9	SIMON PROPERTY GROUP LP	5,000,000.00	50,000.00	0.00	0.00	50,000.00
03/15/23	03/15/23	03/15/23	TNT77	29736RAJ9	ESTEE LAUDER CO INC	1,500,000.00	23,625.00	0.00	0.00	23,625.00
03/15/23	03/15/23	03/15/23	TNT77	74456QCF1	PUBLIC SERVICE ELECTRIC	9,000,000.00	42,750.00	0.00	0.00	42,750.00
03/17/23	03/17/23	03/17/23	TNT77	931142ER0	WALMART INC	5,000,000.00	26,250.00	0.00	0.00	26,250.00
03/19/23	03/19/23	03/19/23	TNT77	30231GBH4	EXXON MOBIL CORPORATION	2,000,000.00	29,920.00	0.00	0.00	29,920.00
03/20/23	03/20/23	03/20/23	TNT77	89236TKJ3	TOYOTA MOTOR CREDIT CORP	3,000,000.00	68,250.00	0.00	0.00	68,250.00
03/24/23	03/24/23	03/24/23	TNT77	254687FN1	WALT DISNEY COMPANY/THE	3,000,000.00	50,250.00	0.00	0.00	50,250.00
03/25/23	03/25/23	03/25/23	TNT77	458140BP4	INTEL CORP	2,500,000.00	42,500.00	0.00	0.00	42,500.00
TOTAL INTEREST						61,305,000.00	706,757.32	0.00	0.00	706,757.32
SELL										
03/02/23	03/01/23	03/02/23	TNT77	17325FAS7	CITIBANK NA	4,300,000.00	17,002.92	4,233,522.00	0.00	4,250,524.92
03/02/23	03/01/23	03/02/23	TNT77	693475AV7	PNC FINANCIAL SERVICES	250,000.00	947.92	245,910.00	0.00	246,857.92
03/08/23	03/08/23	03/08/23	TNT77	665278404	NORTHERN INST GOVT MONEY MKT	784,277.22	0.00	784,277.22	0.00	784,277.22
03/13/23	03/10/23	03/13/23	TNT77	693475AV7	PNC FINANCIAL SERVICES	5,000,000.00	24,305.56	4,914,200.00	0.00	4,938,505.56

LA CARE

Cash Activity by Transaction Type GAAP Basis

03/31/2023 Accounting Period

Cash Date	Trade/Ex-Date	Settle/Pay Date	Custodian	Cusip	Description	Quantity	Income Amount	Principal Amount	Contributions/ Withdrawals	Total Amount
TOTAL SELL						10,334,277.22	42,256.40	10,177,909.22	0.00	10,220,165.62
GRAND TOTAL						83,294,718.70	733,605.04	(733,605.04)	0.00	0.00

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April 17, 2023

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 2023

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 2023.

L.A. Care Health Plan
AFS-006 Authorization and Approval Limits Quarterly Report
January 2023 - March 2023

New POs and Contracts	
Vendor Name	**PO and Contract Total**
County Superintendent of Schools	$ 17,137,115.00
I Color Printing & Mailing Inc	$ 11,260,147.64
Sierra Pacific Constructors, Inc.	$ 3,495,482.00
ePlus Technology, inc.	$ 2,379,558.55
SHI International Corp	$ 1,797,935.30
Q-PERIOR Inc.	$ 1,622,000.00
Charles R. Drew University of Medicine and Science (Grantee)	$ 1,613,387.00
UCLA Foundation, The (Grantee)	$ 1,613,387.00
Center for the Study of Services	$ 1,324,195.00
Verizon Business Network Services Inc	$ 1,062,727.78
Arent Fox LLP	$ 1,000,000.00
Daponde Simpson Rowe PC	$ 800,000.00
Sheppard Mullin Richter & Hampton LLP	$ 700,844.79
Canon Solutions America Inc	$ 618,297.85
MetaSoftTech Solutions LLC	$ 597,600.00
GTT LLC	$ 500,000.00
Advantmed, LLC	$ 488,000.00
A&M Healthcare Industry Group, LLC (a Wholly Owned Subsidiary of A&	$ 465,000.00
SKKN, INC.	$ 459,809.78
Isaacs | Friedberg LLP	$ 400,000.00
Earth Print, Inc.	$ 340,762.99
mPulse Mobile, Inc.	$ 336,602.00
salesforce.com, inc.	$ 332,175.46
mPulse Mobile, Inc.	$ 318,491.00
FanelliPM	$ 290,887.00
Axis Technology, LLC	$ 285,000.00
Amplifi Group, LLC	$ 280,000.00
National Health Foundation	$ 270,284.40
Alison Klurfeld	$ 267,400.00
Training Connection LLC	$ 232,980.56
Burke, Williams & Sorrensen, LLP	$ 200,000.00
Orbach, Huff, Suarez & Henderson LLP	$ 200,000.00
The Berman Law Firm, APC	$ 200,000.00
Moss Adams LLP	$ 186,903.00
Zones, LLC (Wholly Owned by Zones IT Solutions Inc.)	$ 182,971.03
Cynthia ReedCarmona	$ 182,000.00
Qualtrics, LLC	$ 151,998.00
Infosys Limited	$ 148,576.00
Gartner Inc.	$ 148,045.00
Ex Novo, Inc	$ 134,660.04
Aunt Bertha, a Public Benefit Corporation	$ 132,000.00

New POs and Contracts	
Vendor Name	**PO and Contract Total**
Korean Health, Education, Information and Research Center (Grantee)	$ 125,000.00
Valley Community Healthcare (Grantee)	$ 125,000.00
Live Art Plantscapes, Inc.	$ 118,941.00
Bhive Holdings, LLC	$ 111,250.00
Musick, Peeler & Garrett LLP	$ 100,000.00
St. John's Well Child & Family Center (Grantee)	$ 100,000.00
Venice Family Clinic (Grantee)	$ 100,000.00
Via Care Community Health Center (Grantee)	$ 100,000.00
Westside Family Health Center (Grantee)	$ 100,000.00
White Memorial Community Health Center (Grantee)	$ 100,000.00
Wilmington Community Clinic (Grantee)	$ 100,000.00
NAVEX Global, Inc.	$ 91,527.18
Harvard Business School Publishing Corporation	$ 81,795.04
Zipari, Inc.	$ 70,600.00
NAVEX Global, Inc.	$ 70,000.00
HALO BRANDED SOLUTIONS, INC.	$ 66,800.40
Merito Solutions, Inc	$ 59,562.40
SAP America, Inc.	$ 56,989.28
DLT Solutions, LLC.	$ 56,038.45
Informatica LLC	$ 54,432.00
Ollivier Corporation	$ 54,017.10
Sonia P. Guzman	$ 51,500.00
NTT America Solutions, Inc.	$ 51,120.00
Antelope Valley Partners for Health	$ 50,290.00
Health Management Associates Inc.	$ 50,000.00
VideoGuard, LLC	$ 48,000.00
M. Arthur Gensler, Jr. & Associates, Inc	$ 47,787.50
Providence Little Company of Mary Foundation	$ 45,600.00
BrandFuse, inc.	$ 45,379.25
California Hospital Assessment and Reporting Task Force (CHA	$ 45,000.00
God's Pantry	$ 42,950.00
Partners In Care Foundation Inc.	$ 41,880.00
AEGIS.net, Inc.	$ 40,000.00
HRRP Garland LLC	$ 39,528.00
Jennifer Baez	$ 34,320.00
LPS Holdco LLC	$ 33,790.00
FiscalNote, Inc	$ 33,700.00
Office Depot, Inc.	$ 32,090.75
Gloria S. Nuestro	$ 31,200.00
Kinema Fitness, Inc.	$ 30,000.00
RightStar, Inc.	$ 29,120.00
Amazon Capital Services, Inc.	$ 27,185.49
Healthy Cooking LLC	$ 26,400.00
ABF Data Systems, Inc	$ 24,960.00
Mayra Selene Sosa	$ 19,725.00

New POs and Contracts	
Vendor Name	**PO and Contract Total**
Uline, Inc.	$ 17,669.75
Tony Lopez International	$ 17,275.69
Critical Care Training Center	$ 16,800.00
Footage Firm, Inc	$ 15,500.00
Galan Cultural Center Inc.	$ 15,200.00
Voices of Our Youth	$ 13,600.00
Sculpt Fitness Long Beach LLC	$ 12,600.00
JeffersonLarsonSmith, LLC	$ 11,500.00
Lands' End, Inc	$ 10,987.95
Rainbow Services, Ltd.	$ 10,800.00
Rubi Ruiz	$ 10,650.00
AHN Foundation	$ 10,400.00
PhotoShelter, Inc.	$ 9,999.00
Omar Sanchez Barreras	$ 9,800.00
Stella Ilran Han	$ 9,600.00
ISI Telemanagement Solutions, LLC	$ 9,000.00
Michael Moldofsky	$ 8,500.00
Absolute Ops LLC	$ 8,450.00
Angela P. Ahmu	$ 8,320.00
Getty Images (US), Inc.	$ 8,200.00
Homeboy Industries	$ 7,798.00
Lakeshore Equipment Company	$ 6,691.08
GOANIMATE, INC.	$ 6,594.00
Lee Hecht Harrison LLC	$ 5,150.00
Sage Software, Inc.	$ 4,261.50
Digicert, Inc.	$ 4,062.20
Alzheimer's Greater Los Angeles	$ 4,000.00
Blackbaud, Inc.	$ 3,786.00
Majestic Marketing, Inc.	$ 3,086.25
ABMS Solutions, LLC	$ 3,045.00
I.D. Systems & Supplies, Inc.	$ 2,632.99
WW North America Holdings LLC	$ 2,500.00
Public Health Foundation Enterprises, Inc.	$ 2,400.00
Zoll Medical Corp	$ 2,076.00
Blue Ribbon Technologies, LLC	$ 1,560.00
Sovos Compliance, LLC	$ 1,095.48
Fitness International, LLC	$ 1,000.00
RLG Enterprises, Inc	$ 1,000.00
Norm's Refrigeration, LLC.	$ 875.00
Total	**$ 57,219,168.90**

L.A. Care Health Plan
AFS-006 Authorization and Approval Limits Quarterly Report
January 2023 - March 2023

Amended Vendor Contracts

Vendor Name	Current Contract Total	Amendment	New Contract Total	Term Date
Advanced Medical Reviews LLC	$ 299,000.00	$ 150,000.00	$ 449,000.00	12/31/2023
ALTA Language Services, Inc.	$ 51,920.00	Time	$ 51,920.00	5/1/2023
ALTA Language Services, Inc.	$ 51,920.00	$ 15,000.00	$ 66,920.00	9/30/2024
Angie Gomez	$ 13,600.00	$ 3,380.00	$ 16,980.00	6/30/2023
Cognizant Technology Solutions U.S. Corporatior	$ 5,822,277.80	$ 337,081.20	$ 6,159,359.00	5/31/2023
Cognizant TriZetto Software Group, Inc.	$ 75,634,459.22	$ 310,152.00	$ 75,944,611.22	9/30/2027
EVERFI INC.	$ 24,000.00	$ 50,880.00	$ 74,880.00	3/5/2025
FRASCO, Inc	$ 214,000.00	$ 100,000.00	$ 314,000.00	9/30/2023
Healthcare Informatics LLC	$ 67,200.00	$ 19,200.00	$ 86,400.00	6/25/2023
I Color Printing & Mailing Inc	$ 2,295,000.00	$ 1,795,200.00	$ 4,090,200.00	6/30/2025
Imagenet LLC	$ 1,400,000.00	$ 2,701,233.00	$ 4,101,233.00	9/30/2025
Infosys Limited	$ 219,123.36	$ 70,500.00	$ 289,623.36	4/30/2023
Juan Andres lara	$ 10,320.00	$ 7,560.00	$ 17,880.00	8/31/2023
LCG Services LLC	$ 200,000.00	$ 200,000.00	$ 400,000.00	8/14/2024
Milliman Inc	$ 1,299,000.00	$ 300,000.00	$ 1,599,000.00	12/31/2023
Milliman Inc	$ 1,250,000.00	$ 400,000.00	$ 1,650,000.00	12/31/2023
Milliman Inc	$ 50,000.00	$ 25,000.00	$ 75,000.00	2/28/2024
NTT America Solutions, Inc.	$ 2,275,680.00	Time	$ 2,275,680.00	1/25/2027
NTT America Solutions, Inc.	$ 704,325.00	$ 119,406.72	$ 823,731.72	6/27/2025
Oliver Tate Brooks	$ 690,000.00	$ 150,000.00	$ 840,000.00	12/31/2023
OptumInsight, Inc.	$ 550,000.00	Time	$ 550,000.00	4/30/2025
Panhealth Inc.	$ 150,000.00	$ 245,000.00	$ 395,000.00	12/31/2023
Scout Exchange LLC	$ 154,000.00	$ 100,000.00	$ 254,000.00	No Expiration
Scout Exchange LLC	$ 33,964,908.00	$ 14,500,000.00	$ 48,464,908.00	12/31/2023
Solugenix Corporation	$ 6,461,804.00	$ 12,819,718.00	$ 19,281,522.00	6/30/2023
SSI (US) Inc	$ 200,000.00	$ 15,000.00	$ 215,000.00	5/4/2023
Toney HealthCare Consulting, LLC	$ 800,000.00	Time	$ 800,000.00	9/30/2023
Toney HealthCare Consulting, LLC	$ 175,000.00	$ 150,000.00	$ 325,000.00	6/30/2023
Toney HealthCare Consulting, LLC	$ 11,928,571.00	$ 1,232,000.00	$ 13,160,571.00	9/30/2023
Toney HealthCare Consulting, LLC	$ 1,748,800.00	$ 277,200.00	$ 2,026,000.00	9/30/2023
Traliant Holdings, LLC	$ 39,335.00	$ 19,680.00	$ 59,015.00	1/14/2024
UNUM Life Insurance Company of America	$ 50,000.00	Time	$ 50,000.00	12/31/2023
Urban Voices Project	$ 32,240.00	Scope	$ 32,240.00	6/30/2024
Vendor Credentialing Service LLC	$ 38,025.00	Time	$ 38,025.00	3/31/2023
Infosys Limited	$ 34,819.80	$ 16,453.20	$ 51,273.00	1/31/2023
			$ 185,028,972.30	

L.A. Care Health Plan
AFS-007 Authorization and Approval Limits Quarterly Report
January 2023 - March 2023

Vendor Selection - Sole Source

Vendor Name	Contract Total	Paid As Of 4/17/23	Vendor Selection
Alison Klurfeld	$ 267,400.00	$ 84,746.24	Sole Source
National Health Foundation	$ 270,284.00	$ -	Sole Source
Amplifi Group, LLC	$ 280,000.00	$ 89,000.00	Sole Source
Axis Technology, LLC	$ 285,000.00	$ -	Sole Source
GTT LLC	$ 500,000.00	$ -	Sole Source
County Superintendent of Schools	$ 839,497.00	$ -	

DATE: April 26, 2023

TO: Finance & Budget Committee

FROM: Afzal Shah, *Chief Financial Officer*

SUBJECT: AFS-027 Travel Expense Report & AFS-004 Non-Travel Expense Report

L.A. Care's internal policies, AFS-027 Travel Related Expenses and AFS-004 Non-Travel 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.

Expenses covered under the Travel Related Expenses 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

Expenses covered under the Non-Travel Expenses policy:

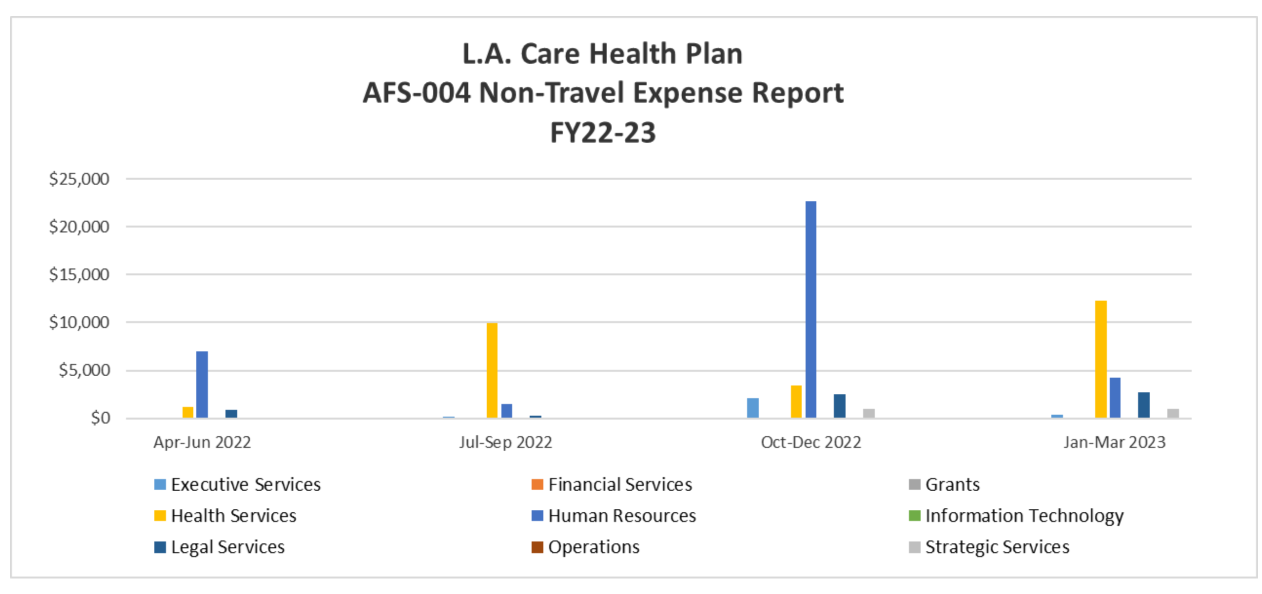
Any lunch, event, or gathering at which stakeholders are in attendance, such as:

- 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, or Orientation Events
- 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 internal policy, presented herein are the travel and non-travel related expenses for the second quarter of Fiscal Year 2022-2023, January through March 2023.



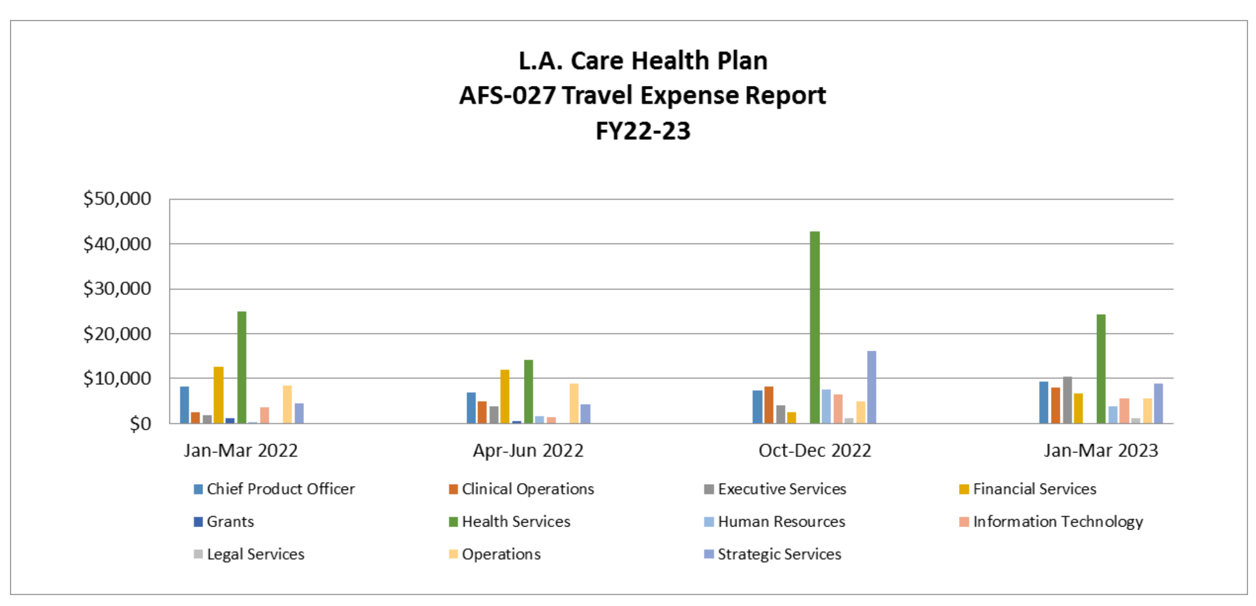
L.A. Care Health Plan
AFS-004 Quarterly Non-Travel Expense Report

Divisions	Apr-Jun 2022	Jul-Sep 2022	Oct-Dec 2022	Jan-Mar 2023	Totals
Chief Product Officer	$0	$0	$0	$0	$0
Compliance	$0	$0	$920	$0	$920
Executive Services	$0	$223	$2,120	$364	$2,707
Financial Services	$0	$0	$0	$0	$0
Grants	$0	$0	$0	$0	$0
Health Services	$1,146	$9,985	$3,450	$12,301	$26,882
Human Resources	$7,008	$1,463	$22,633	$4,275	$35,378
Information Technology	$0	$0	$0	$0	$0
Legal Services	$877	$293	$2,521	$2,677	$6,367
Operations	$0	$0	$0	$0	$0
Strategic Services	$0	$0	$983	$1,016	$1,999
Total Non-Travel Related Expenses	$9,031	$11,964	$32,626	$20,632	$74,253

Notable Non-Travel Expenses January through March 2023 (Q2):

Rough Estimates: for internal use only

- Executive Services expenses are related to refreshments for executive team meeting.
- Health Services expenses are related to in-person CME/CE Psychotherapy for Substance Use Disorder dinner event.
- Human Resources expenses are related to refreshments for New Hire Orientation events and Social Worker Month luncheon.
- Legal Services expenses are related to refreshments for committee meetings.
- Strategic Services expenses are related to refreshments for CHEC New Member Orientation, RCAC Meeting and Training, and ECAC special meeting.



L.A. Care Health Plan
AFS-027 Quarterly Travel Expense Report

Divisions	Jan-Mar 2022	Apr-Jun 2022	Oct-Dec 2022	Jan-Mar 2023	Totals
Chief Product Officer	$8,144	$6,946	$7,427	$9,284	$31,801
Clinical Operations	$2,433	$4,855	$8,228	$8,068	$23,583
Compliance	$0	$0	$16,231	$4,767	$20,998
Executive Services	$1,816	$3,725	$4,019	$10,488	$20,049
Financial Services	$12,749	$11,876	$2,587	$6,801	$34,014
Grants	$1,128	$508	$0	$0	$1,636
Health Services	$24,969	$14,119	$42,699	$24,213	$106,000
Human Resources	$159	$1,724	$7,632	$3,728	$13,243
Information Technology	$3,550	$1,308	$6,434	$5,602	$16,895
Legal Services	$0	$0	$1,226	$1,186	$2,413
Operations	$8,415	$8,878	$4,935	$5,506	$27,734
Strategic Services	$4,604	$4,259	$16,114	$8,968	$33,945
Total Travel Related Expenses	$24,225	$68,229	$117,533	$88,611	$332,310

Notable Conferences and other Travel Expenses January through March 2023 (Q2):

Rough Estimates: for internal use only

- Chief Product Officer expenses are related to attendance of California Primary Care Association (CPCA) Conference, Sales Outreach events and L.A. Care staff mileage reimbursement.
- Clinical Operations expenses are related to L.A. Care Community Health Worker (CHW) staff mileage reimbursement and nursing license renewals.
- Compliance expenses are related to attendance of California Association of Health Plans (CAHP) and National Health Care Anti-Fraud Association (NHCAA) conferences.
- Executive Services expenses are related to attendance of America's Health Insurance Plans (AHIP) Board meeting, LHPC conference, Medi-Cal Ballot Measure Meeting, and American College of Healthcare Executives conference.
- Finance Services expenses are related to actuarial licenses and dues and approved L.A Care staff travel.
- Health Services expenses are related to attendance of California Association of Health Plans (CAHP) Conference, NCQA Health Innovation Summit, American Society of Health-System Pharmacists (ASHP) Conference, College of Healthcare Information Management Executives (CHIME) Fall Forum, continuing education fees, license renewals, and staff expense and mileage reimbursement for clinics.
- Human Resources expenses are related to attendance of Association of Talent Development (ATD) conference and L.A. Care staff mileage reimbursement.

- Information Technology expenses are related to attendance of HLTH 2022 conference and LA Care staff mileage reimbursement for CRC visits.
- Legal Services expenses are related to attendance of California Association of Health Plans (CAHP) conference.
- Operations expenses are related to attendance of National Health Care Anti-Fraud Association (NHCAA) conference, approved L.A. Care staff education and travel, and staff transportation for CRC visits.
- Strategic Services expenses are related to Association of Community Affiliated Plans (ACAP) membership, support fees for CRC workshops and Outreach events, and approved L.A. Care staff transportation for site visits and meetings.

BOARD OF GOVERNORS
Finance & Budget Committee
Meeting Minutes – March 22, 2023

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

Members
Stephanie Booth, MD, *Chairperson*
Al Ballesteros
Hilda Perez **
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*
Linda Greenfeld, *Chief Products Officer*
Alex Li, MD, *Chief Health Equity Officer*
Tom MacDougall, *Chief Technology & Information Officer*
Marie Montgomery, *Chief Financial Officer*
Noah Paley, *Chief of Staff*
Acacia Reed, *Chief Operating Officer*
Afzal Shah, *Deputy 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 1:03 p.m. The meetings were held simultaneously. She welcomed everyone and summarized the process for public comment during this meeting. • For those who provided public comment for this meeting by voice message or in writing, L.A. Care is glad that they provided input today. The Committee will hear their comments and they also have to finish the business on the Agenda today. • For people who have access to the internet, the meeting materials are available at the lacare.org website. If anyone needs information about how to locate the meeting materials, they can reach out to L.A. Care staff. • 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. • Public comment will be made before the Committee starts to discuss an item. If the comment is not for a specific agenda item, it will be read at the general Public Comment. • Chairperson Booth provided information on how to submit a comment in-person, or live and directly using the "chat" feature.	
APPROVE MEETING AGENDA	The Agenda for today's meeting was approved.	**Approved unanimously by roll call. 3 AYES (Booth, Perez, and Vaccaro)**

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
PUBLIC COMMENTS	There were no public comments.	
APPROVE CONSENT AGENDA	• February 22, 2023 meeting minutes • Customer Motivators Contract Amendment **<u>Motion FIN 100.0423</u>** **To authorize staff to amend an existing contract with Customer Motivators to provide member incentive fulfillment services for the period of July 1, 2023 to June 30, 2026, in the amount of $1,999,999 for a new total of $2,999,999 over a 5-year period.** • Center for Caregiver Advancement Contract Amendment **(FIN 101)** **<u>Motion FIN 101.0423</u>** **To authorize a contract renewal in the amount of $11,640,388 with Center for Caregiver Advancement (CCA) to provide education and training for In-Home Supportive Services (IHSS) providers for dual-eligible beneficiaries for the period of May 14, 2023 through May 13, 2026.**	**Approved unanimously by roll call. 3 AYES** **The Committee approved to include FIN 100 and FIN 101 on the Consent Agenda for the April 6, 2023 Board of Governors Meeting**
CHAIRPERSON'S REPORT	There was no Chairperson report.	
CHIEF EXECUTIVE OFFICER'S REPORT	*Board Chairperson Ballesteros joined the meeting.* John Baackes, *Chief Executive Officer*, reported: • L.A. Care is financially stable in 2023, and there will be significant changes in 2024. L.A. Care will focus on adapting and preparing for January 2024. • Cherie Compartore, *Senior Director, Government Affairs*, will report at the Executive Committee meeting on the California State budget gap of over $30 billion that will probably be announced in the May Budget revise, after a year with a surplus over $100 billion. This will impact Medi-Cal funding. Mr. Baackes added that we do not know exactly what the impact will be. The Finance & Budget Committee members should understand what is coming, though currently L.A. Care is in a good financial position. L.A. Care will diligently monitor this situation. • The California Safety Net Coalition (CSNC) is a 501(c)(4) organization that was created to lead the ballot initiative on revising managed care rates to capture more revenue to supplement the Medi-Cal rates. CSNC is led by Jim DeBoo, the former Chief of Staff of	

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Governor Newsom during his first term. Progress is moving quite rapidly and Mr. Baackes is participating in every meeting. • Mr. Baackes reported that it has been widely circulated that former Los Angeles County Supervisor Gloria Molina has terminal cancer and is now in hospice care. The current Supervisors voted to rename Grand Park as Gloria Molina Park. Mr. Baackes expressed that Supervisor Molina is a former L.A. Care Board Member and will be in his thoughts and prayers Committee Chairperson Booth and Board Member Perez also expressed that Supervisor Molina will be in their thoughts and prayers.	
COMMITTEE ITEMS		
Chief Financial Officer's Report	*(Member Roybal joined the meeting.)* Marie Montgomery, *Chief Financial Officer*, announced that this is her last Committee meeting. She invited Afzal Shah, *Deputy Chief Financial Officer*, to provide the financial report. Mr. Shah thanked and expressed his appreciation for Ms. Montgomery's coaching and mentorship the past few months; and he congratulated her on her retirement. He presented the Financial Reports for January 2023 *(a copy of the report is available by contacting Board Services).* <u>Membership</u> January 2023 membership is 2.8 million. This is the first month comparing to the 3+9 forecast. The January 2023 actual membership was used for the 3+9 forecast as it was known during the 3+9 forecast update. The forecast assumes the public health emergency ends in April with redeterminations beginning in July. <u>Consolidated Financial Performance</u> The January 2023 net surplus was $18 million, $27 million favorable to the forecast. From an operating margin standpoint, this was favorable to the forecast by $11 million driven primarily by the incurred claims, which are favorable to the forecast by $13.7 million. Other favorable items include Community Based Adult Services due to such services now being returned to being provided at centers and Pharmacy. Administrative Expense and Non-Operating expense are both favorable to the 3+9 forecast. The results in operating margin and net surplus include $29 million for the Housing and Homelessness Incentive Program/ Incentive Payment Program (HHIP/IPP). This is a matter of timing and all funds will be spent.	`

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	The YTD net surplus was $57 million; $27 million favorable to the forecast. The variances are the same for the month and YTD since is the first month being compared to the 3+9 forecast. <u>Operating Margin</u> • Overall Medical Cost Ratio (MCR) is 94.1% versus forecast of 94.5%. • Medi-Cal MCR is favorable to forecast due lower Fee for Service (FFS) costs. • Cal MediConnect (CMC) MCR is slightly unfavorable to the forecast. This shows the last quarter of the product as it has now been sunset. • Duals Special Needs Plan (D-SNP) MCR is lower than forecast. It is only one month of data. • Commercial MCR is higher than the forecast due to the changes in Risk Adjustment Factor (RAF) score from 0.75 to 0.67. Staff is currently working on solutions to increase the RAF score. • Housing and Homelessness Incentive Program/ Incentive Payment Program (HHIP/IPP) – Staff is expecting that all funds received will be fully invested. It is a matter of timing. <u>Reported vs Paid Claims Trend</u> Prior to fiscal year end, there was some volatility in the paid claims but there is more stability since then. L.A. Care experienced a spike in paid and reported claims in January 2023. The membership continues to grow so the absolute dollars should increase but were favorable to the expectations by the $13.7 million favorable variance mentioned for January 2023. The year-end reserve position is holding up with four months of experience. Staff will continue to monitor. <u>Key Financial Ratios</u> • Medical Care Ratio was 94.1% • The administrative ratio was 4.8%, lower than the forecast of 5.0%. • Working Capital and Tangible Net Equity are ahead of benchmarks. • Cash to claims is below the benchmark. The cash to claims ratio will not fully recover until the In-Home Support Services balances with the Department of Health Care Services (DHCS) is settled. <u>Tangible Net Equity (TNE) and Days of Cash on Hand</u>	

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	January 2023 Fund Balance was $1.1 billion, which represents 538% of TNE. The target of 600% was based on the average of 8 other Local Initiatives and County Organized Health Systems. For January 2023, L.A. Care currently has enough cash to cover operating expenses for 53 days. Board Member Perez asked what is "cash on hand". Mr. Shah responded that it refers to how long L.A. Care will be in good financial position if the State did not pay L.A. Care's revenue, L.A. Care will be able to cover paying its obligations. Most of L.A. Care's competitors who are similar public plans have a higher number, like CalOptima has 230 days of cash on hand, and San Mateo has 254 days. L.A. Care is lower than its peers when it comes to that matrix but L.A. Care has fairly good TNE of 538% ratio. Board Member Perez asked what would be the reason for the State to stop payment. Mr. Baackes responded that the State would have no funds. Committee Chairperson Booth commented that the State sent her and her partner, IOUs. Mr. Baackes added that when he was working in New York, there was a time when New York State paid in scrip, which is like paying in confederate dollars. Mr. Shah added that in 2008 or 2009, there was a delay in State payment. As an organization, L.A. Care has to have enough cash on hand to meet its obligations. Mr. Baackes commented a delay in payment has happened in his tenure. There was a time when Ms. Kent was running the Department of Health Care Services and L.A. Care was asked if it could weather a one month delay. Ms. Montgomery added that the State's delays in payment are typically related to the budget not being passed on time. There was a time when the State budget was passed late in June due to opposition. There was confusion in the wording in the budget; that was when the State took the opportunity to permanently delay payments. As Mr. Baackes mentioned, the State asked L.A. Care if they could pay one month late. Once the delay was implemented, the State made it permanent. There was a year that L.A. Care received 11 payments instead of 12. The State kept the cash flow advantage to themselves through to today. The State is also talking about maybe increasing the 30 days to be more like 45. This gives L.A. Care less cash to hold and more cash for the State to hold. With budget challenges, L.A. Care should be prepared for when the State would have cash flow issues. Although L.A. Care is earning more because of its high return short-term portfolio focus, the State could decide to make changes in how they pay L.A. Care.	

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Board Chairperson Ballesteros asked about the delegated model within the context around cash and delayed payments from the State, is L.A. Care obligated still to pay according to what is in the contract with L.A. Care's delegates. Mr. Shah responded that if the State delays payment, L.A. Care could hold payment to Plan Partners but he thinks L.A. Care could not hold payment to Provider Partners.[1] L.A. Care has an obligation to pay, regardless of the contract. [2]Board Chairperson Ballesteros asked why L.A. Care uses "reported" in Reported vs Paid Claims Trend. Mr. Shah clarified that "paid" is what L.A. Care paid for that month, and "reported" is the paid and change in the reserve. Every month L.A. Care is estimating a reserve for claims for the previous 3 months and prior periods. Any change in the reserve is reflected in the reported financials. <u>**Motion FIN 102.0423**</u> **To accept the Financial Reports for January 2023, as submitted.** Chairperson Booth expressed her appreciation to Ms. Montgomery for the all help she has extended. Board Member Perez thanked Ms. Montgomery for her services and wished her the best on her retirement.	**Approved unanimously by roll call. 5 AYES (Ballesteros, Booth, Perez, Roybal, and Vaccaro)**
• Monthly Investment Transactions Reports	Ms. Montgomery 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 January 31, 2023 was $2 billion. • $1.79 billion managed by Payden & Rygel and New England Asset Management (NEAM) • $74 million in Local Agency Investment Fund • $157 million in Los Angeles County Pooled Investment Fund	
Public Comments on the Closed Session agenda items.	There were no public comments.	

[1] The Provider Network Department confirmed after the meeting that L.A. Care can also hold payments to certain Provider Partners.

APPROVED

AGENDA ITEM/PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
ADJOURN TO CLOSED SESSION	The Joint Powers Authority Finance & Budget Committee meeting adjourned at 1:40 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 1:41 pm. CONTRACT RATES Pursuant to Welfare and Institutions Code Section 14087.38(m) • Plan Partner Rates • Provider Rates • DHCS Rates 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: *March 2025*	
RECONVENE IN OPEN SESSION	The meeting reconvened in open session at 1:52 pm. Ms. Haydel advised the public that no reportable action from the closed session.	
ADJOURNMENT	The meeting adjourned at 1:53 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:

____
Stephanie Booth, MD, *Chairperson*
Date Signed ________________________________

APPROVED

BOARD OF GOVERNORS
Compliance & Quality Committee Meeting
Meeting Minutes – March 16, 2023

L.A. Care Health Plan CR 100, 1055 W. Seventh Street, Los Angeles, CA 90017

Members
Stephanie Booth, *MD, Chairperson*
Al Ballesteros, *MBA*
Hilda Perez
G. Michael Roybal, *MD*

* *Absent*
** *Via Teleconference*

Senior Management
Augustavia J. Haydel, *General Counsel*
Thomas Mapp, *Chief Compliance Officer*
Sameer Amin, *MD, Chief Medical Officer*
Tom McDougall*, Chief Information and Technology Officer*
Katrina Miller Parrish*, MD, FAAFP, Chief Quality and Information Executive*
Michael Sobetzko, *Senior Director, Risk Management and Operations Support, Compliance*
Tara Nelson, *Senior Director, Utilization Management*,
Angie Lageson, *Director, Provider Contracts and Relationship Management*
Demetra Crandall, *Director, Customer Solution Center Appeals and Grievances*
Michael Devine, *Director, Special Investigations Unit*
David Kagan, *Senior Medical Director, Direct Network*

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 2:00 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. There were no members of the public present either in person attending virtually by WebEx or telephone.	
APPROVAL OF MEETING AGENDA	**The Meeting Agenda was approved as submitted.**	**Approved unanimously by roll call. 3 AYES (Ballesteros, Booth, and Roybal)**

APPROVED

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
PUBLIC COMMENT	There was no public comment.	
APPROVAL OF MEETING MINUTES	**The February 16, 2023 meeting minutes were approved as submitted.**	**Approved unanimously by roll call. 3 AYES**
CHAIRPERSON REPORT	Chairperson Booth thanked everyone for attending, all input helps L.A. Care move forward. She asked if lower levels of care can be automatically approved. She also wondered why L.A. Care still uses faxes. She said that they are very old and most people don't use faxes anymore, but she could be wrong. She thinks Medi-Cal is expecting L.A. Care to be the Utilization Management for everyone, including transferring members to lower levels of care. She wonders why L.A. Care can't do discharge planning over a weekend. She has noticed that Skilled Nursing Facilitities are not open to take extra patients. She said that it might be better for members to transfer on weekends, and it may lower cost.	

CHIEF COMPLIANCE OFFICER REPORT	*(Board Member Perez joined the meeting.)*
	Thomas Mapp, *Chief Compliance Officer*, and Compliance Department staff presented the Chief Compliance Officer Report: *(a copy of the written report can be obtained from Board Services)*:.
	The report includes:
	• Final 2023 C&Q Reporting Calendar
	• Issues Inventory
	• Risk Assessment Remediation Status
	Michael Sobetzko, *Senior Director, Risk Management and Operations Support,* reported on the Issues Inventory through the end of February 2023.
	The Issue Inventory continues to be updated and going through a clean-up process:
	• 2022 Issues that are remediated will be part of the Internal Audit follow-up review process.
	• 91 Issues being tracked from 2022 and into 2023
	  - 56 Closed and Remediated
	  - 19 are in process of remediation
	  - 16 Enforcement Actions – handled separately and were part of remediated in prior month	

APPROVED

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

Issue Name	Status	Comments
Transparency in Coverage Phase 2, Self-Service Tool	Going to IRB for approval	Effective January 1, 2023 Transparency in Coverage legislation requires carriers provide a compliant Pricing Tool for L.A. Care Covered and Personal Assistance Services Council members to determine their out-of-pocket costs when seeking care. The L.A. Care time to develop tool may take until October 2023. Will be presented to external vendor project plan by March 2, 2023
Payment Lock-Provider Payments Not Sent	Received plan, lacked dates	A provider escalation relative to a payment not being remitted in December 2022, (9999 payment lock error) resulted in the identification of opportunities to improve the process of reconciling 9999 payment lock errors.

Board Member Roybal asked if transparency coverage is something that L.A. Care is a regulatory obligation to have up and running by January 1. He asked if it includes in-network costs or covers any out of network costs that might be incurred for particular members. Mr. Sobetzko replied that he will provide a response at a later time. Most certainly in-network and it is unclear on the out of network. Board Member Roybal asked how many members were affected. He said that might be part of the solution. Mr. Sobetzko will provide data in response to his request.

Issue Name	Date Reported	Accountable Exec /Accountable Business Unit	Date Closed	Issue found comments

APPROVED

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

Failure to pay provider	November 6, 2022	Provider Network/Claims	February 28, 2023	• A Beacon provider did not receive payment. • Remediation- EPO work with Claims to clear matter.
Requirements for observation of inpatient admission	January 10, 2023	UM	February 28, 2023	• UM to ensure that the new process of checking voicemails every thirty minutes and/or the message detailing the requirements for Observation and inpatient admission has been added. • Remediation- Monitoring measures in place
Untimely Behavioral Health Authorizations	July 14, 2022	UM/Behavioral Health	February 28, 2023	• From 6/28/2022 to 7/29/2022. 153 cases were identified as non-compliant with authorization turnaround times (TAT) for routine requests for autism services for MCLA members. • Remediation- Monitoring measures in place to manage TAT and address outliers.

Board Member Roybal asked if there is a a monthly report generated for patient issues that can be reviewed to see the timeliness on responses to make sure the messages are cleared in an hour. Mr. Sobetzko responded that each call is tracked and not automatically created.

Risk Assessment Remediation Status

Risk ID	Risk Title	BU/Owner	Mitigation Update	Status Internal Audit	
C2	HRA Assessment /	HRA Assessment / Care Managemen	• Existing workflows and monitoring reports will continue for the Disabled and Special Needs Plan.	To be included in IA follow-up plan and	Delayed / Possibly Off-Track with a Path

APPROVED

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS						ACTION TAKEN
		Reassessment Timeliness	t / Even MORE Steven Chang	New workflows are being developed to identify the three new populations requiring annual reassessments (members with Long Term Services and Supports needs, children with special health care needs, and pregnant individuals), in accordance with the latest Department of Health Care Services CalAIM Policy Guide and Frequently Asked Questions. • Integrate and automate multiple monthly reports into Health Reimbursement Arrangment (HRA) dashboard for more efficient monitoring. Pending development resources. • Until efforts to complete a reliable HRA dashboard, the overall monitoring process, including for the new Public Health Managament populations, will remain highly inefficient and subject to user errors.	Part of D-SNP Readiness	to Green	

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AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

C13	Compliance Program Effectivenes s	Compliance Tom Mapp	• Completion of outstanding Compliance Program Effectiveness deliverable – Board Training (December 2022) • Reorganization of Compliance department (February 2023)	Part of Follow-up Assessment from prior CPE	In Process / On Track to Mitigation Strategy

Mr. Mapp stated that Centers for Medicare and Medicaid Services (CMS) requires L.A. Care to do this annually in connection with any CMS contract.

Risk ID	Risk Title	BU/Owner	Mitigation Update	Status Internal Audit
O4	Provider Quality	PQI - Untimely Processing Christine Chueh	• Additional staff; improved collaborative partnership between Provider Quality Review and Appeals & Grievances; and migrating Provider Quality Issues actions and Corrective Action Plans into Jira application for workflow management. 1.26.23 Update: Ongoing Monitoring and reports to ICC. • ICC Update Provided January 25, 2023: • RN and Specialist Bonus Program for case completion running October 2022 – February 2023 • December 2022 Provider Quality Review team closed 528 cases; reduced the untimely aging category from 479 to 343 • Total of 20 Registered Nurses on team now.	To be include in Follow-up assessment in 2023

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AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	O20 | Staffing / Skilled Hires / Time to Hire | HR Terry Brown | • Compliance requested to delay audit until after March 10 • Document requests in preparation | Included in Internal Audit audit 2023	
CHIEF MEDICAL OFFICER REPORT	Sameer Amin, MD, *Chief Medical Officer,* reported: *(a copy of the written report can be obtained from Board Services).* Dr. Amin referred to the written report that is included in the meeting packet.. Dr. Amin reported that a relatively large redesign of Health has been completed as of February 27, and people have moved into new positions. Case Management, Utilization Management, and Managed Long Term Support Services have moved into Health Services. Operational and clinical leadership members are working together. The medical directors for the most part, used to have a reporting structure that was apart from the actual department they're often working with. The new organizational structure allows for operational clinical leadership to be involved very early on in strategy. There is a clinical leader and an operational leader in charge of Case Management; and a clinical leader and operational leader in charge of Utilization Management. The focus has been around improved discharge planning and increasing staff capacity for that work. Positions were added for education auditing, and for clinical decisions being made. In addition, a new department called Community Health was established. It includes Behavioral Health, Social Services, and Community Supports. The initial goals are to pull together L.A. Care's housing initiatives into one holistic program and then further build out the community supports programs. There is a whole menu of items that Dr. Amin would like to get to better support the community and that team is going to be working on what comes next to make sure that they are well built out, but clinically and operationally sound. Dr. Amin reported he has tried to get away from faxes and get these things to be completely digital to be able to pass information back and forth. It has been a struggle and it is not necessarily on the health plan side. If the question is whether or not the provider network, the hospital to Skilled Nursing Facilities can send information using the portal. Faxing is a health care industry standard. L.A. Care is working on establishing a portal.	

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	Chairperson Booth asked if they arrive to L.A. Care as an email. Tara Nelson, *Senior Director, Utilization Management*, said she works on the UM side and is not an IT person so she does not have specifics. Faxes come in and L.A. Care has a fax vendor who then converts them into electronic files which are uploaded to L.A. Care's internal system. By the time they reach UM they are electronic files. Tom McDougall, *Chief Information and Technology Officer,* said that L.A. Care has a cloud vendor to digitize faxes electronically. Post-Discharge Care Dr. Amin reported that L.A. Care often has to step in to make sure that its members are getting the most appropriate care in the best setting. Whether it's moving people to recoup care, or it's moving them to a skilled nursing facility, L.A. Care wants to be part of that discussion as a managed care plan. He thinks L.A. Care's voice is key. L.A. Care has several trusted skilled nursing faciltities and has a red line with their leadership and don't require a prior authorization from those faciltities, because there is an established relationship and they do high quality work. Ms. Nelson stated that L.A. Care has staff working seven days a week and they still have to intake them and process all the fax requests. If they're sent later in the evening, it might not be addressed until the next morning, but we do prioritize those requests to make sure that we're not holding up any hospital discharges. The goal of a managed care plan is to make sure that members are getting the right care at the right place at the right time. L.A. Care teams make its organizational structure to help facilitate internal teams in getting their work done. Dr. Amin added that when additional resources are needed, John Baackes, *Chief Executive Officer*, and the Executive team are providing these resources. In the three months that he has been at L.A. Care he has worked with Mr. Mapp on delegates and clinical oversight provided by Health Services. He feels they are having a very constructive conversation with the Department of Health Services. During the audit they will reaffirm a desire to strengthen oversight for delegates and providers.	
PROVIDER QUALITY REVIEW ANNUAL UPDATE	Christine Chueh, RN, *Senior Manager, Provider Quality, Quality Improvement*, and Rhonda Reyes, *Quality Improvement Program Manager III, Quality Improvement,* provided the Provider Quality Review Annual Update *(a copy of the written report can be obtained from Board Services).* The Quality Improvement (QI) Provider Quality Review (PQR) team manages the Potential Quality of Care Issue (PQI) process, which is a regulatory requirement to identify clinical issues/concerns and ensure high quality patient care is delivered to L.A. Care members. The QI PQR process evaluates an occurrence or occurrences in which there are potential or suspected deviations from accepted standards of clinical care. The QI PQR team conducts the PQI review for L.A. Care's direct lines of business. Plan Partners (PP) are delegated to conduct the QOC (Quality of Care) review for members assigned to them and their network providers. Annual oversight audit and quarterly monitoring of Plan Partners (PP) are done to ensure PP QOC reviews align with L.A. Care Policies & Procedures QI-001. All reviews must be completed within 6	

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AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

	calendar months (L.A. Care P&P Q I-001). The QI PQR team monitors quarterly submission of Critical Incident (CI) Reports required by Cal MediConnect (CMC) delegates (Participating Physician Groups PPG) and Vendors) to appropriately capture critical incidents (abuse, exploitation, neglect, disappearance/missing member, a serious life threatening event, restraints or seclusion, suicide attempt or unexpected death) for the health, safety and welfare of L.A. Care's members.
	
	PQI Data Analysis – Q4 2021 – Q3 2022
	• PQI's processed 3273: 495 (15%) triaged 0 (not a PQI).
	  - Triage zero decrease from previous year 41% triage zero
	  - Provider quality review was conducted on 2,778 cases.
	• PQIs can be identified by any department, yet 98.1% came from Appeals & Grievances (A&G) or Customer Solution Center (CSC).
	• Medi-Cal had the most cases, however, the ratio of cases per thousand members per year (PTMPY) is higher for the CMC product line at 2.09 cases PTMPY.
	• Top issues are consistent with the previous year. Treatment/Diagnosis (28.3%),Delay in Service (17.3%) and Communication/Conduct (13.3%) was the third highest issue followed by Access to Care (12.4%).
	• Delay in Authorization had an increase of 2.5% from previous year and Access to Care increased by 3.3%	

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Issue Code	Issue Description	2021/2022 Rate	Difference
PQ1	DME/Supplies	2.2%	-2.4%
PQ2	Benefit Issue	1.8%	-0.5%
PQ3	**Delay in Service**	**17.3%**	0.0%
PQ4	Denial of Service	2.3%	-0.1%
PQ5	Refusal of Care/Rx	5.6%	-1.9%
PQ6	Refusal of Referral	1.9%	0.3%
PQ7	**Treatment/Diagnosis**	**28.3%**	0.8%
PQ8	Delay in Authorization	7.3%	2.5%
PQ9	**Access to Care**	**12.4%**	**3.3%**
PQ10	Continuity of Care and Coordination of	3.2%	-2.3%
PQ11	**Communication/Conduct**	**13.3%**	0.0%
PQ12	Physical Environment	1.1%	0.5%
PQ13	Medical Record/Documentation	0.6%	-0.4%
PQ14	Transportation	1.9%	1.9%
PQ15	Systems Issue	0.9%	-1.6%

LOB	Member Month	PQI	PTMPY	Difference
MCLA	15,797,625	1,943	0.12	0.1
LACC	1,338,573	283	0.21	0.0
CMC	214,780	448	2.09	-1.4
PASC	604,523	104	0.17	0.1
Total	**17,955,501**	**2,778**	**0.15**	0.0

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Board Member Roybal asked if there is an industry standard for raised issue per member per year. Ms. Reyes will have to answer that question at another time. Katrina Miller Parrish, *MD, FAAFP, Chief Quality and Information Executive* stated that they do have comparisons to Plan Partners coming up and it's one way to look at it. Industry standards are difficult because they are done differently in different places.

- C0 (No Quality of Care or Service Issues) - 12.8% Increase
- C1 (Substantiated service issue causing member dissatisfaction) - 12.8% Increase
- C2 (Borderline Quality of Care issue with potential for adverse health outcome) - 1.7% Increase
  - Clinical review staff has been taking more of a deep dive analysis on each case and a stricter approach when leveling each case.
- C3 (Moderate Quality of Care issue with actual adverse health outcome) – one Case
- C4 (serious and or significant quality of care issue with significant adverse health outcome) – one Case

- PQR team continues to meet quarterly with selected PPG's/Vendors to review any PQI findings and discuss issues or trends.
- The below chart represents PPG membership and number of PQI per thousand member per year (PTMPY) by PPG

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AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• The membership bars highlighted in blue represent the PPG's we have ongoing quarterly monitoring to identify any trends or issues. Board Member Roybal asked asked if this is a rate and if it should matter how many members they have. Ms. Reyes responded that this is a rate; the more members means the rate will be lower. Delegation Oversight • Collection of quarterly reporting from each delegate as well as monitoring of timely closure of potential quality issues (PQI). • Continued issue with Anthem Blue Cross with the number of PQI being captured. - Anthem noted 2,627 (25%) clinical grievances of 10503 grievances during the audit period were reviewed by a medical director. Of those 192 (7%) were referred for PQI review by the medical director. The PQR team will continue to monitor the volume and compare the data with L.A. Care grievances.	

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	Quality Assurance Validation and Report • PQR Inter-Rate Reliability (IRR) - To improve the consistency and accuracy in applying review criteria, in the leveling and final reporting of PQIs, the PQR clinical team conducts quarterly internal inter-rater reliability (IRR) testing, evaluation, and monitoring. o The appropriate determination of PQI severity level continues to be the most discussed area. o The clinical team uses the bi-weekly huddles to review and align decision determination for PQI severity level. • Review Appeals & Grievances (A&G) and Customer Solution Center (CSC) Cases - PQR conducts monthly oversight of CSC and A&G cases (1% or 30 cases each) not referred to PQI during FY 2021-2022. Goal is for 100% compliance - CSC met 100% compliance rate and A&G met 88% compliance rate but continues to improve	

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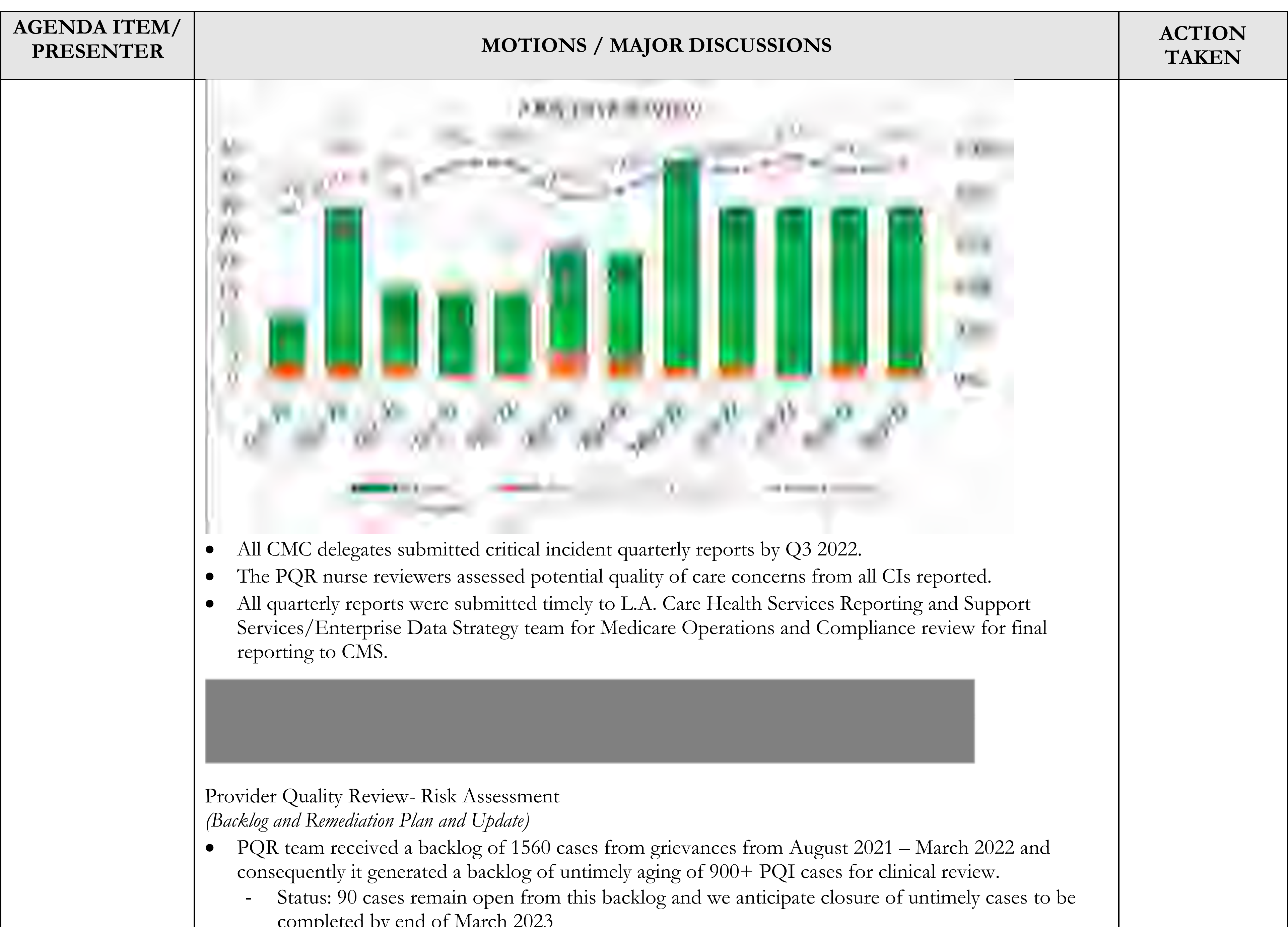
AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	 • All CMC delegates submitted critical incident quarterly reports by Q3 2022. • The PQR nurse reviewers assessed potential quality of care concerns from all CIs reported. • All quarterly reports were submitted timely to L.A. Care Health Services Reporting and Support Services/Enterprise Data Strategy team for Medicare Operations and Compliance review for final reporting to CMS. Provider Quality Review- Risk Assessment *(Backlog and Remediation Plan and Update)* • PQR team received a backlog of 1560 cases from grievances from August 2021 – March 2022 and consequently it generated a backlog of untimely aging of 900+ PQI cases for clinical review. - Status: 90 cases remain open from this backlog and we anticipate closure of untimely cases to be completed by end of March 2023	

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AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• A second backlog of 503 cases was identified on October 6, 2022 - The 503 cases are from Appeals and Grievances (A&G) that contained a PQI date from January 1, 2021-December 31, 2022. - The cause of the backlog was identified on January 1, 2023 as human error of an incorrect selection of delivery method in PCT when submitting the PQI referral. Delivery methods consisted of typing of an incorrect or misspelling of an email address to PQI inbox, sent to member or regular mail to our headquarter address. - During the first week of February, A&G delivered the additional 503 cases to PQR team for review which will become due the first week of August, 2023. - A remediation plan to close these additional cases in a timely manner has been implemented. Designated staff has been assigned to work the additional cases with a goal of completing at least 100 cases or more each month. The designated staff consist of 1 triage RN, 4 clinical review RNs and 3 project specialists. While our goal is to get all cases closed within the timely aging category, there is still a risk that some may fall into the untimely aging category as some of these cases have aged and retrieval of medical records may be difficult. Chairperson Booth asked if all those cases were late to A&G first. Dr. Parrish responded that it was the A&G backlog. The quality of care issues were submitted to her team. Dr. Amin stated that there is a larger discussion about clinical partnership between A&G and the QI team that will be remediated. The immediate problem has been remediated but some additional work will be done by Health Services. Open Aging Report and Forecast by Aging Status • Assumptions: Intake 560/Month, Closed 550 Month • February includes new backlog of 503 additional cases	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Open Aging by PQI Due Date • Currently we have 90 cases considered untimely. (shown in red) • Blue bars represent our current open aging of cases and when they are due which is 6 months from the date PQR team receives the case. • Orange bar represents the additional cases received as part of a second backlog from appeals and grievances. • PQR team average monthly closure rate is about 500-550 cases per month. (shown on next slide)	

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AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	PQI Intake, Output, and Open Aging by Month • Additional staff was hired in July, 2022 resulting in an increased closure rate of PQI cases. • Spot bonus program was implemented to our review team in October 2022 which provided financial incentives to close additional cases. • Staff Paid Time Off contributed to the lower case closure during November 2022 – January 2023 • February intake total includes the 503 from the new backlog.	

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AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

Headcount: 36: including two supervisors and one program manager

As of 02/28/2023	Regular Cases + First Backlog	2nd Backlog
# PQI Cases	2265 including 90 cases in the untimely aging category	468 cases
# Staff Dedicated	2 Triage RNs 14 Clinical Review RNs 8 Project Specialist 2 Coordinators	1 Triage RN 4 Clinical Review RNs 3 Project Specialist
Estimated Monthly Capacity	450 Cases	100 Cases
Estimated Closure of the Backlog	March 31, 2023 for current untimely cases and keep all open cases in timely aging category (Under 6 months)	August 2, 2023
RISK	Pulled staff from our regular workflow to manage the 2nd backlog may create a risk of cases entering untimely aging if our monthly intake exceeds are closed totals.	Concerns with obtaining medical records for aged cases as they may require more time to process

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AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
APPROVE QUALITY IMPROVEMENT DOCUMENTS (COM A.0323) • **2022 Quality Improvement Annual Evaluation**	Bettsy Santana, *Senior Manager, Quality Improvement Initiatives,* presented the 2023 Quality Improvement Program Description. *(A copy of the written reports can be obtained from Board Services).* • The Quality Improvement Program Evaluation provides an overview of quality improvement activities and significant accomplishments during the past year, including but not limited to: - Quality and Safety of Clinical Care - Quality of Service - Member Experience - Access to Care • The evaluation documents activities to achieve work plan goals and establishes the groundwork for future quality improvement activities. - Staff throughout L.A. Care contribute to the activities QI committees regularly meet to oversee the various activities National Committee for Quality Assurance (NCQA) Accreditation • In 2021, NCQA eliminated the Excellent and Commendable status and moved from a numeric rating (1-5) to a "star" rating system (1-5 stars). - Medi-Cal 3.5 Star - Medicare 3.0 Star - LACC no NCQA rating Health Effectiveness Data and Information Set (HEDIS) Performance DHCS Auto Assignment: • Auto-assigned allocation for Medi-Cal members L.A. Care 67% vs 33% for Health Net. It remains unchanged from the prior year. • For MY2021, L.A. Care met the Minimum Performance Level (MPL) on 12 out of the 15 Managed Care Accountability Sets (MCAS) measures. Measures that were below the MPL were Childhood Immunization Status (CIS), Well Child Visits in the First 30 Months of Life (W30) for both the first 15 months and 15 to 30 months. Member Experience CAHPS Performance: • Medi-Cal Adult and Children scores remained low in 2022. For both adults and children in Medi-Cal, all composites and ratings remain below the 25th percentile except for Medicaid Child ratings for Health Plan (50th percentile) and Specialist Seen Most Often (66th percentile). • L.A. Care Covered scores improved from 2021 to 2022 but we are rated one star for Marketplace.	

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AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Cal MediConnect, most scores declined from 2021 to 2022. L.A. Care's opportunities to improve CAHPS performance are most persistent in measures of access Clinical Initiatives • Completed 31 interventions: social media, mailings, automated & live agent calls and text messaging. • Total of 14 Patient Experience Training webinars and 15 trainings for 11 IPAs/clinics provided by the SullivanLuallin Group. Supported PPGs (12) with improving their HEDIS and CAHPS scores. • Provider training webinars (16) conducted. • Collaborated with national, governmental and community-based organizations: The Childhood Lead Poisoning Prevention Program (CLPPP) within Department of Public Health, Los Angeles City Housing Department, and the Los Angeles HPV Vaccine Coalition. The L.A. Care Health Promoters and the Los Angeles LGBT Center. Care Management (CM)/Disease Management (DM): • For the CMC line of business, 2 out of 3 goals for Care Coordination and Quality Improvement Program Effectiveness (CCQIPE) were met; Health Risk Assessment (Core 2.3) reassessment rates exceeded goal at 67.3% and the Health Risk Assessment (Core 2.1) Initial compliance rate exceeded goal at 99.9%. • A total of 2,908 cases were opened by the CM Department for FY 2022. Population Health Management (PHM) Continues to address members' needs across the continuum of care and through transitions of care focusing on: • Using the findings from the annual population health assessment to identify gaps, and enhance existing programs and interventions and develop new initiatives. • Developing and tracking PHM goals. • Meeting National Committee for Quality Assurance (NCQA) and California Advancing and Innovating Medi-Cal (CalAIM) requirements Addressing Disparities • Over fiscal year 2021-2022, L.A. Care strategically prioritized collection of Social Determinants of Health (SDOH) and Sexual Orientation and Gender Identity (SOGI) data. L.A. Care plans to submit for 2024 NCQA Health Equity Accreditation, which includes collection of SOGI data. • LGBTQ+ trainings - L.A. Care hosted two LGBTQ trainings titled, "LGBTQ+ Health Training for Quality Improvement Staff" and "Gender Affirming Care".	

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	• Introduced two new Community Health Investment Fund (CHIF) grants. *(the full written report can be obtained from Board Services.)* Chairperson Booth commented that there is substantial information about what L.A. Care tried to do and she wonders if there is more explanation in terms of what the outcomes were in the thick packet that was distributed. It does not indicate if they want to do the interventions again. Ms. Santana replied that there is a time lag in getting the information. For example text messaging was deployed in April 2022 and L.A. Care is now just getting the results. Board Member Ballesteros noted that she referenced some of the trainings and collection of data being done for the LGBTQ community and said it would be nice, in the future, to get a sense of what is covered in those topics and how L.A. Care approaches educating the provider base on those issues. One of the things they are speaking about on the HIV Commission is the fact that many individuals could benefit from increased education about STDs and HIV and resources to remain HIV negative but, the commission is unsure about what is happening in the private sector. They are looking at the increased rates of STDs and are concerned that it could possibly lead to increased cases of HIV. In terms of the trainings and how they work to collect some of these disparities, it is interesting to know how providers are being educated about routine screenings and testings. For positive tests, they receive regular reports about people in care, with about 30% non-compliant. The patients do not appear to be seeing doctors routinely. Patients are identified as positive, but are not meeting standards of care. Ms. Santana responded that L.A. Care did some work with providers on gender affirming care and how to work with language.	
• **2023 Quality Improvement Program Description**	Ms. Santana presented the 2023 Program Description Revisions. General Revisions Strategic Priorities (2022-2024), Goals, and Objectives Program Structure QI Program Goals and Objections Organizational Structure, QI Program Leadership and Resources Positions were added, removed if they no longer exist, or modified as appropriate. Committee Structure Added Quality Improvement Health Equity Committee Scope of the Program Staff has continued to add language to address providing *equitable* care and services	

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AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

	References to Cal MediConnect were removed and replaced with Dual-Special Needs Plan (D-SNP) line of business.
	
	Quality of Equitable Care
	• Update to the QI conceptual frame from the Triple Aim to the Quadruple Aim
	• The Healthcare Effectiveness Data and Information Set (HEDIS) measures (31) will be prioritized, by Line of Business, for interventions and/or monitored in 2023.
	• Added the Dual Eligible Special Needs Plans (D-SNPs) line of business and Stars related programs and reporting requirements e.g. the Model of Care.
	• Medi-Cal removed the Individual Health Education Behavioral Assessment (IHEBA) requirement and the Initial Health Assessment name will be changed to the Initial Health Appointment. The 120-day timeframe will remain however a primary care visit within the timeframe can be used as a proxy for compliance with the new IHA requirements.
	
	Quality of Equitable Care
	
	Transitional Care Program
	L.A. Care's Transitional Care Program (TCP) now includes Covered California direct lines of business.
	
	Elevating the Safety Net Initiative
	• In 2018, L.A. Care launched the Elevating the Safety Net (ESN) initiative with an approved five-year investment of up to $155 million to address the physician shortage looming in Los Angeles County.
	
	CalAIM Incentive Payment Program
	• The Department of Health Care Services (DHCS) provided CalAIM Incentive Payment Program (IPP) funding to L.A. Care for Enhanced Care Management (ECM) and Community Supports (CS), to drive delivery system investments in provider capacity and delivery system infrastructure.
	
	Incentives
	• Starting in 2023, L.A. Care will launch a L.A. Care Medicare Plus (Dual-Special Needs Plan) D-SNP VIIP Program for its Medicare providers and members.
	
	Background & 2023 Goals
	The QI Work Plan tracks goals and activities geared toward quality improvement for the organization. It is a fluid document and revised on an ongoing basis throughout the year.
	• For goals not met, the QI Department:
	  - Reviews the findings
	  - Completes a barrier analysis	

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AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	- Develops a plan to address the barriers - Prioritizes interventions - Implements the interventions - Evaluates the effectiveness of interventions General updates • Added an Equity Tab- to track equity activities • Labeled the Quality Transformation Initiative measures (4) • Labeled the Department of Managed Care Services Equity measures • Changed the Consumer Assessment of Healthcare Providers and Systems (CAHPS) rates to reflect our unadjusted rates • Five more measures on the Managed Care Accountability Set (MCAS) now have to meet the minimum performance level (MPL) Total Measures for 2023: • Service: 71 • HEDIS: 30 • CAHPS: 33 • Equity: 9 • Reporting only Measures: 31 • Priority 3 HEDIS Measures: 37 New Measures Medi-Cal MCAS Measures: • Topical Fluoride Varnish • Number of Out-patient ED Visits per 1,000 Long Stay Resident Days • Skilled Nursing Facility Healthcare-Associated Infections Requiring Hospitalization • Potentially Preventable 30-day Post-Discharge Readmission D-SNP: • Diabetes: Eye Exam for Patients With Diabetes L.A. Care Covered: • No changes from prior year *(Few new measures, but several measures moved from the reportable section to the high priority section of the work plan.)*	

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AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	<u>Motion</u> **Approve the following documents:** • **2022 Quality Improvement Annual Report and Evaluation – All lines of business** • **2023 Quality Improvement Program and Work Plan – All Lines of Business**	**Approved unanimously by roll call.** **4 AYES (Ballesteros, Booth, Perez, and Roybal)**
ADJOURN TO CLOSED SESSION	The Joint Powers Authority Compliance & Quality Committee meeting was adjourned at 3:35 pm. Augustavia J. Haydel, Esq., *General Counsel*, announced the following items to be discussed in closed session. The JPA Compliance and Quality Committee meeting adjourned and the Compliance and Quality Committee adjourned to closed session at 3:36 P.M. PEER REVIEW Welfare & Institutions Code Section 14087.38(o) CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION Significant exposure to litigation pursuant to Section 54956.9(d)(2) of Ralph M. Brown Act: Four potential cases CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION CONFERENCE WITH LEGAL COUNSEL—EXISTING LITIGATION Pursuant to Section 54956.9(d)(1) of the Ralph M. Brown Act • Department of Managed Health Care Enforcement Matter Numbers: 18-799, 20-063, 21-428, 21-509, 21-680 • Department of Health Care Services, Office of Administrative Hearings and Appeals, In the matter of: L.A. Care Health Care Plan Appeal No. MCP22-0322-559-MF	
RECONVENE IN OPEN SESSION	The Committee reconvened in open session at 4:20 p.m. There was no report from closed session.	

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AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
ADJOURNMENT	The meeting was adjourned at 4:23 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:

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Stephanie Booth, MD, *Chairperson*
Date Signed: ______________________

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