DRAFT

AGENDA

Technical Advisory Committee (TAC) Meeting

Thursday, November 9, 2023 at 2:00 P.M.
L.A. Care Health Plan
1055 W. 7th Street, 1st Floor, CR 100, Los Angeles, CA 90017

Members of the committee, 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=mc014b6026f2c58a2cd2851f278837040

To listen to the meeting via teleconference please dial:
Dial: 1-213-306-3065

Meeting number: 2483 925 1787

Event Password: lacare

Teleconference Site

Elaine Batchlor, MD, MPH
Martin Luther King, Jr. Community Hospital 12012 Compton Ave.
4th Floor 4-118
Los Angeles, CA90059

Paul Chung, MD, MS
Kaiser Permanente School of Medicine
98 S. Los Robles Ave.
Pasadena, CA 91101

Muntu Davis, MD, MPH
Los Angeles County Department of Public Health
313 N Figueroa St
Los Angeles, CA 90012

Alex Li, MD
323 E. Wacker Dr.
Chicago, IL 60601

Rishi Manchanda, MD, MPH
Health Begins
2600 W. Olive Ave.
Suite 500
Burbank, CA 91505

Santiago Munoz
UCLA Health
757 Westwood Plaza
Suite 1320
Los Angeles, CA 90095

Elan Shultz
Los Angeles County Department of Mental Health
510 S. Vermont Ave.
Los Angeles , CA 90020

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.

The "chat" will be available during the public comment periods before each item.
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.
Click on the chat icon. It will open two small windows.
Select "Everyone" in the "To:" window,
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.
Type your public comment in the box that says "Enter chat message here".

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When you hit the enter key, your message is sent and everyone can see it.
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 2:00 P.M., November 9, 2023, it will be provided to the members of the committee 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 committee appreciates hearing the input as it considers the business on the Agenda. All public comments submitted will be read for up to 3 minutes during the meeting. The process for public comment is evolving and may change at future meetings. We thank you for your patience.

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

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

	Welcome	Alex Li, *MD* *Chief Health Equity Officer*
1.	Approve today's meeting agenda	Alex Li, *MD*
2.	Public Comment	Alex Li, *MD*
3.	Approve Meeting Minutes • February 9, 2024 Meeting Minutes P.4 • May 11, 2024 Meeting Summary P.14 • August 24, 2023 Meeting Summary P.22	Alex Li, *MD*
4.	Chair and Vice Chair Election	Alex Li, *MD*
5.	Chief Health Equity Officer Update P.31	Alex Li, *MD*
6.	TAC Charter, Approach, Members, Future Items P.91	Committee
7.	Medi-Cal Redetermination Update P.95	Phinney Ahn, *Executive Director, Medi-Cal* Karla Lee Romero, *Director, Medi-Cal Product Management*
8.	Use of Geo-Spatial Resource to Identify and Target L.A. Care Social Service Needs P.121	Jordan Limperis *Data Scientist II,* *Advanced Analytics Lab* Brandon Shelton,

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Senior Director, Advanced Analytics Lab,
Advanced Analytics Lab

9. Follow-Up Health Equity Impact Assessment Tool Update P.136 — Marina Acosta, *MPH*, *Manager, Health Equity, Health Equity*

Adjournment

The next meeting is scheduled on January 11, 2023.
Public comments will be read for up to three minutes.

The order of items appearing on the agenda may change during the meeting.

THE PUBLIC MAY SUBMIT COMMENTS TO THE TECHNICAL ADVISORY COMMITTEE 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 TECHNICAL ADVISORY COMMITTEE CURRENTLY MEETS ON THE THIRD TUESDAY OF THE MEETING MONTH AT 8:30 A.M.
AGENDA and PRINTED MEETING MATERIALS ARE AVAILABLE FOR INSPECTION AT the Reception area off the main lobby at 1055 W 7th Street, Los Angeles, CA, or online at http://www.lacare.org/about-us/public-meetings/board-meetings and by email request to BoardServices@lacare.org

Any documents distributed to a majority of Committee Members regarding any agenda item for an open session after the agenda has been posted will be available for public inspection at https://www.lacare.org/about-us/public-meetings/public-advisory-committee-meetings and can be requested by email to BoardServices@lacare.org. AGENDA and PRINTED MEETING MATERIALS ARE AVAILABLE FOR INSPECTION AT the Reception area off the main lobby at 1055 W 7th Street, Los Angeles, CA.
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.

BOARD OF GOVERNORS
Technical Advisory Committee
Meeting Minutes – February 9, 2023

1055 W. Seventh Street, Los Angeles, CA 90017

Members

Sameer Amin, MD
John Baackes, CEO
Elaine Batchlor, MD, MPH
Paul Chung, MD, MS*
Muntu Davis, MD, MPH*
Hector Flores, MD
Rishi Manchanda, MD, MPH
Santiago Munoz*
Elan Shultz
Stephanie Taylor, PhD*

Management

Katrina Parrish, *Chief Quality and Information Executive, Health Services*
Wendy Schiffer, *Senior Director, Strategic Planning*

** Absent ***Present (Does not count towards Quorum)*

California Governor Newsom issued Executive Orders No. N-25-20 and N-29-20, which among other provisions amend the Ralph M. Brown Act. Members of the public can hear and observe this meeting via teleconference and videoconference, and can share their comments via voicemail, email or text.

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Member Sameer Amin, *MD*, *Chief Medical Officer,* called the meeting to order at 2:05 p.m. without quorum.	
APPROVAL OF MEETING AGENDA	The committee reached a quorum at 2:25 p.m. **The Agenda for today's meeting was approved as submitted.**	**Approved Unanimously. 6 AYES (Amin, Baackes, Batchlor, Flores, Manchanda, Shultz)**
PUBLIC COMMENT	There were no public comments.	
APPROVAL OF MEETING MINUTES	**The September 7, 2022 meeting minutes were approved as submitted.**	**Approved Unanimously. 6 AYES**
CHAIR AND VICE CHAIR ELECTION	Member Hector Flores, *MD*, nominated Member Sameer Amin, *MD*, as Chair. He said that the Chief Medical Officer of L.A. Care brings a unique perspective as the	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	committee Chair. Member Elaine Batchlor*, MD*, agreed with Member Flores. Member Flores presided over the election. There were no other nominations. **Member Sameer Amin, *MD*, was approved as Chair of the Technical Advisory Committee.** Member Baackes nominated Member Flores as the Vice Chair of the committee. No other nominations were made. **Member Hector Flores, *MD*, was approved as Vice Chair of the Technical Advisory Committee.**	**Approved Unanimously. 6 AYES** **Approved Unanimously. 6 AYES**
CHIEF EXECUTIVE OFFICER UPDATE	Member John Baackes, *Chief Executive Officer*, gave the following update: The signature item for 2023 is the redetermination for all 14 million Medi-Cal beneficiaries. Eligibility redetermination has been suspended for three years. Now that the public health emergency is over the redetermination process will resume. It has been announced the redetermination packets will be mailed in April to beneficiaries with effective dates renewing in June. It is anticipated that ineligible determinations will fall into three categories: people that moved and no longer reside in Los Angeles County, people whose income is now above the ceiling of 138%, people who fail to respond to the redetermination package. L.A. Care built this into its budget for this year and next year, because its fiscal year runs from October 1 to September 30. L.A. Care is budgeting based on all of the recommendations from various sources. About 13% of L.A. Care's Medi-Cal membership are expected to lose coverage, but may be eligible for premium subsidies for health coverage through Covered California. L.A. Care's goal is to make sure that everyone who is eligible completes the redetermination process. He thinks this the most critical challenge L.A. Care is facing and L.A. Care is working closely with state representatives and with the Los Angeles County Department of Public Social Services, because that's where the actual redetermination process is housed. L.A. Care will be doing extensive outreach with providers and in the clinic at the hospital levels, and the doctors' offices. L.A. Care will use its community resource centers to assist people completing the paperwork. The community resource centers give L.A. Care an advantage, because qualified enrollment assistors will help people complete the process.	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	L.A. Care enrollment will be impacted by losing members, but it will also gain new members. In January 2024, undocumented residents between ages 26 and 49 will be eligible for Medi-Cal. Just like with the undocumented Medi-Cal beneficiaries age 50 and up, L.A. Care will be trying to match those people to existing primary care doctors they may be already seeing. L.A. Care has a new coding system that will make that facilitation go a lot easier. On January 1, 2020, members who are with L.A. Care through its plan partner arrangement with Kaiser will no longer be enrolled with L.A. Care. L.A. Care factored this into its planning. L.A. Care protested the direct Medi-Cal contract, because Kaiser does not abide by the same rules as all other health plans. About 260,000 members will be leaving L.A. Care through the Kaiser contract. Also, January 1, 2024 is the effective date for re-procurement of the commercial Medi-Cal plans in all California counties. Awards were announced in August. Molina Healthcare would now be the commercial plan in Los Angeles County. Health Net, Blue Shield Promise, and Community Health Plan in San Diego felt that they did not get a fair shot and protested in court in late December. The state announced that they were canceling the entire re-procurement process. They announced that they had reached a settlement agreement with those three plans for coverage beginning in January 2024. Health Net will still be a commercial plan in Los Angeles County, but they are required to seed 50% of their members to Molina, who will work as a subcontractor plan with Health Net, which has always been their relationship. There is no obligation on the part of any enrolled member to remain with any health plan. Enrollees still have freedom of choice and they could all return to Health Net the following month. He noted that the Molina/Health Net arrangement and the Kaiser contract will cause confusion for members. Member Rishi Manchanda, *MD*, asked Member Baackes how L.A. Care will be leveraging the community resource centers to help members with their redeterminations. He asked if they will help get the word out or will they provide assistance with filling out their paperwork. Member Baackes responded that the CRCs will do both. For the latter, he thinks there will be various ways that people will hear about the redeterminations. L.A. Care is telling its members that they can come to resource centers and someone will be there to help them. Member Manchanda asked if L.A. Care will need to hire more staff or use existing capacity. Member Baackes responded that staff will be trained on this new process. There may be staff added so that someone is at the CRC full time focusing on just redeterminations.	

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	Member Manchanda asked for more information on L.A. Care's approach to the Community Health Worker (CHW) benefit. Member Baackes responded that L.A. Care employs CHWs mainly at the community resource centers. This allows CHWs to work with their customer base in the community. L.A. Care also trained CHWs that are now working at Federally Qualified Health Centers. That was a program L.A. Care did a few years ago and it is planned to continue using CHWs.	
CHIEF MEDICAL OFFICER UPDATE	Sameer Amin, MD, *Chief Medical Officer,* gave the following updates: COVID-19 Update The Federal Government announced that on May 11, the Federal Public Health Emergency will end. Additionally, it has been announced that the California Public Health Emergency will end on February 28. The termination of the public health emergencies will impact Medi-Cal redetermination as well as potentially other issues like the cost share for commercially covered individuals for in-home COVID-19 testing. L.A. Care will have more details in the future. L.A. Care may also see a rise of appeals and grievance cases as members and providers adjust to the impact and confusion associated with the conclusion of the public health emergency. Looking at the County and Statewide COVID-19 dashboards, L.A. Care is relieved to see the continued decline in the number of people hospitalized or whose death was associated with COVID-19. The trend began in the second week of January and continues. Local public health colleagues have also expressed a sense of relief. L.A. Care does not currently see any immediate threat from new variants. The Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC) are making a big push towards quality, equity and preventive services. Managed Care Accountability Set will be moving from 15 to 20 measures and there are now penalties if L.A. Care does not achieve the 50th percentile of national benchmark. In order to treat vulnerable communities, L.A. Care will need to solidify its race and ethnicity data so that it treat its members better based on their race and ethnicity. There is a heavy emphasis on addressing the decline in pediatric well visits and vaccinations during the pandemic. He noted that there was a decrease during the pandemic. L.A. Care hopes to see an improvement on its 2022 scores. There are new Long Term Care measures such as Quality Accountability and will be facilitated by Supplemental Payments. It will be managed jointly by DHCS and Los Angeles County Department of	

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	Public Health as these incentives are related to setting workforce staffing ratios at long term care and skilled nursing facilities as well as improving quality of care. National Committee for Quality Assurance and DHCS Audit L.A. Care teams are hard at work in preparation for its DHCS audit. The audit will be done from February to March. Health Services L.A. Care is changing the structure of Health Services to better meet the basic needs of members. It is redesigning departments with clear charters, roles, and responsibilities. He believes this will have a better outcome for members.	
GUN VIOLENCE PREVENTION	*(Member Baackes and Member Manchanda joined the meeting.)* Marina Acosta, *MPH, Manager, Health Equity*, gave a report about L.A. Care's Gun Violence Prevention Summit *(a copy of the full report can be obtained from CO&E.).* • L.A. Care convened a Gun Violence Prevention Summit on December 9, 2022 with the Los Angeles County Office of Violence Prevention, under Los Angeles County Department of Public Health. • Speakers and moderators included: o Deborah Prothrow-Stith, *MD, Dean of College of Medicine, Charles R. Drew University* o Susan Stone, *MD, Senior Medical Director, Utilization and Care Management Services* o Member Baackes o Barbara Ferrer, *MD, Los Angeles County Public Health Director* • The day consisted of two breakout sessions consisting of questions and dialogue among the attendees on how to curb gun violence. • More than 70 registered participants attended. • Attendees came from the fields of: o health care o mental health o public health o academia o advocates o survivors	

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	○ faith-based organizations ○ community-based organizations (CBO) ○ L.A. Care RCAC members • Evaluations we received all rated the event as "Excellent" or "Very Good" • Final overview is being finalized and will be shared with attendees. • Themes from the day include: ○ A number of summit attendees reported personal experiences with gun violence ○ Attendees are working on : - Increasing coordination among key players working to reduce gun violence, - Creating the infrastructure needed to ease re-entry for individuals, - Improving healthcare professionals' preparedness and willingness to assess trauma and its impact on clients, and - Strengthening community-based efforts to reduce person-on-person violence. ○ Barriers: - limited budget and lack of resources - lack of culturally appropriate and compassionate language when engaging with survivors of violence, and limited stakeholder buy-in. ○ Improving System Coordination - engaging with and understanding the different roles that stakeholders are playing, - improving data collection, reporting, and sharing procedures that allow different key players to gather and use input directly from community members, and redesigning funding structures in a manner that requires collaboration. ○ Summit recommendations include: - Continue to include and amplify the voice of survivors. - Training medical professionals on firearm screening. - More non-traditional forms of care in healthcare settings i.e. cooking classes, etc. - Ongoing improvements in community building and cohesion. - Help communities secure long-term funding to showcase best strategies and practices.	

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	- Increase the number of jobs and economic opportunities allowing individuals to re-enter and re-integrate with society successfully. o L.A. Care's has been: - Highlighting as an urgent public health (PH) issue and must be addressed like other PH issues. - Working on a provider training about firearm safety. - Assessments: Reviewing assessments used to ensure gun safety is included. - Adding additional firearm safety resources on our L.A. Care website and communicating these resources. - Potentially adding a Preventive Health Guideline for clinicians on this topic. - Identifying opportunities with new Medi-Cal benefits: Community Health Worker (CHW) benefit can help members receive violence prevention services. - Forging new and ongoing partnership between L.A. Care and OVP to continue to address gun violence prevention. - L.A. Care will continue to urge lawmakers to take further action, and support vigorous research and advocacy to prevent gun violence.	
HOUSING AND HOMELESSNESS INCENTIVE PROGRAM EFFORTS	Karl Calhoun, *Director, Safety Net Programs and Partnerships,* and Alison Klurfield, *Consultant*, presented information about L.A. Care's Housing and Homelessness Incentive Program Efforts *(a copy of the full report can be obtained from Board Services.)* Goals: 1) Ensure managed care plans have the necessary capacity and partnerships to connect their members to needed housing services; 2) Reduce and prevent homelessness Total Funding Available: $1.288 Billion statewide; one-time funding; must be earned by 3/2024; may be spent over a longer timeframe Local Homelessness Plan: Submitted June 30, 2022; updated measures submitted August 12, 2022 Investment Plan: Submitted September 30, 2022 Measurement Period 1 Submission: Due to DHCS on March 10, 2023 HHIP Top Priorities for Investment – January 2023 • Infrastructure: Health Information Exchange, Data Exchange, Workforce • Street Medicine	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Programs to get & keep people housed • Unit Acquisition Strategy • ADL Expansion Strategy HHIP Strategic Housing Investments • L.A. Care is partnering with Health Net to implement HHIP Strategic Housing Investments to meet HHIP metrics and address urgent unmet needs for people experiencing homelessness. • L.A. Care will implement these strategies via investments to the L.A. County Chief Executive Office Homeless Initiative (CEO HI), which is the central coordinating body for L.A. County's efforts. • Depending on CEO HI performance and on future HHIP earnings, L.A. Care also intends to make additional substantial investments for this purpose in 2024. CEO HI Strategic Housing Investments: Unit Acquisition Strategy • Goals: - Increase utilization of tenant-based housing vouchers - Decrease time to lease-up - Decrease effects of discrimination against voucher holders and people experiencing homelessness • Investment funds will support: - Backfill funds that cover non-rent costs of master leasing buildings (e.g. vacancy payments, trash, pest control, damage mitigation) - Program staff - Evaluation The number of units for each funding commitment and expected completion date are estimates. The actual number of units could vary but the total of 1,700 minimum expected units is not impacted by this potential variation. CEO HI Strategic Housing Investments: ADL Expansion Strategy • Goals: - Identify and assess people experiencing homelessness w/ADL assistance needs earlier - Speed appropriate placements into interim and permanent housing	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	- Help people experiencing homelessness w/ADL assistance needs live in less restrictive settings with appropriate supportive services • Investment funds will support program, staff, and evaluation for: - Enhanced Care Assessment Teams - Caregiving in Interim Housing - Enriched Residential Care Member Elan Shultz asked how L.A. Care matches the need of the eligible population. Mr. Calhoun said that it does not meet the need. Ms. Klurfield noted that it depends on the initiative. The enhanced care assessment teams will probably need more funding. Since it is a one-time fund, L.A. Care will spread it out over five years to get a track record and try to figure out the demand. Will look at private funds to expand if necessary.	
ADJOURNMENT	Member Baackes stated that L.A. Care will be announcing a new Chief Health Equity officer soon and noted that the position it is a requirement for the new Department of Health Care Services contract. This position would focus on health disparities and will be outward facing. It will help create a relationship with other organizations. He asked the committee if they wanted it to be an agenda item for a future meeting. The committee agreed to add the topic on the next agenda. Member Manchanda asked if this is related to L.A. Care's goals. Dr. Parrish responded that L.A. Care is working toward Health Equity Accreditation. Dr. Amin stated that it will be added on the agenda for the May 11 meeting. . The meeting was adjourned at 1:20 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: _____
Sameer Amin, MD, *Chairperson*

_____
Date Signed

The following resources were shared with the committee and the public via chat box:

February 9, 2023, 2:24 p.m. from Rishi Manchanda MD, MPH to everyone: A few additional resources and potential leads that may be helpful regarding trainers and training resources. 1) https://doctorsforamerica.org/subcommittee/gun-violence-prevention/

February 9, 2023, 2:24 p.m. from Rishi Manchanda MD MPH to everyone
https://doctorsforamerica.org/wp-content/uploads/2021/05/Public-Service-Announcement-How-to-Talk-with-Patients-about-Gun-Violence.pdf

February 9, 2023, 2:25 p.m. from Rishi Manchanda MD MPH to everyone: https://www.mass.gov/lists/resources-for-talking-to-patients-about-gun-safety#information-for-providers-about-gun-safety-

February 9, 2023, 3:15 p.m. from Rishi Manchanda MD MPH to everyone:
As CHWs, including those based at CRCs, encounter member questions or issues related to tenant protections, this may be a helpful resource
https://t.co/HpsdLcGTTk

February 9, 2023 at 3:15 p.m. from Rishi Manchanda MD MPH to everyone:
https://drive.google.com/file/d/1j4GMj_jpOCTVi9XqaGG2_2LTNqXPWnDz/view

BOARD OF GOVERNORS
Technical Advisory Committee
Meeting Summary – May 11, 2023

1055 W. Seventh Street, Los Angeles, CA 90017

Members

Sameer Amin, MD, *Chair*
John Baackes, CEO*
Elaine Batchlor, MD, MPH
Paul Chung, MD, MS*
Muntu Davis, MD, MPH*
Hector Flores, MD
Rishi Manchanda, MD, MPH
Santiago Munoz
Elan Shultz*
Stephanie Taylor, PhD

Management

Katrina Miller Parrish, *MD, FAAFP, Chief Quality and Information Executive*
Alex Li, *MD, Chief Health Equity Officer*
Terry Brown, *Chief Human Resources Officer*
Felix Aguilar-Henriquez, *MD, Medical Director, Quality*
Wendy Schiffer, *Senior Director, Strategic Planning, Strategy*

** Absent ***Present (Does not count towards Quorum)*

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Member Sameer Amin, *MD*, *Chief Medical Officer,* called the meeting to order at 2:05 p.m. without quorum.	
APPROVAL OF MEETING AGENDA	**The Agenda for today's meeting was not approved.**	
PUBLIC COMMENT	There were no public comments.	
APPROVAL OF MEETING MINUTES	**The February 9, 2023 meeting minutes were not approved.**	
MEMBERSHIP (TAC 100)	**Alex Li, *MD, Chief Health Equity Officer*, was approved as a member of the committee.**	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CHIEF MEDICAL OFFICER UPDATE	Sameer Amin, MD, *Chief Medical Officer,* gave the following updates: He noted that he has been in this post now for almost 7 months and L.A. Care has done a significant amount of work over the last few months. In terms of getting health services reorganized for the challenges of our day and I think some of that is again, the Case Management and Utilization Management over to health services. Some of it is the work that we're doing around building our community health department, which houses social services and behavioral health. Health Services, and making sure that we've done a gap analysis where we need to add resources. He said if they look at what's happened in the course of the past few months, he has done a lot of work in terms of staffing and getting people in positions to really move the organization forward. There are a few areas where he just wanted to call out to everyone here that we're making significant progress. Transitional Care Services He said that Transitional Care Services has been an interesting challenge as the state has come down as part of CalAIM with the requirements that L.A. Care handle transitions of care for its patient population in 2024. That is going to mean that every single patient under its purview. In 2023 the hope is that we are going to handle transitions of care for those who are in the highest risk group. It is a challenge, because even staffing to that consideration is difficult. The real question is, how would L.A. Care go about identifying those members. We have identified that it's not an acute issue that is going to go away. We've attacked this in a number of different ways. First, it had to set up its mission, its feeds, mission discharge, transfer, feeds, such that it is getting the health information that it needs to know when somebody is moving from facility to facility or moving from facility to home. He noted that L.A. Care is a found member of LANEZ. Health information exchanges with, I think, at this point, +80% of our hospital, 70 to 80% of our hospitals and so we're getting the information that we need that people are moving. Beyond that, once they're moving, we are now hiring a whole number of community health workers to make outgoing calls. Contact these members to make sure that they understand their transitions of care plan and we believe that over time that is going to reduce the number of readmissions. He noted that L.A. Care is spending a significant amount of resources and restart and further staffing and expanding our complex case management team so that they can handle these patients once we've identified that. They have an ongoing need. L.A. Care is also working with its enhanced care management providers to make sure that those who need even more resources are	

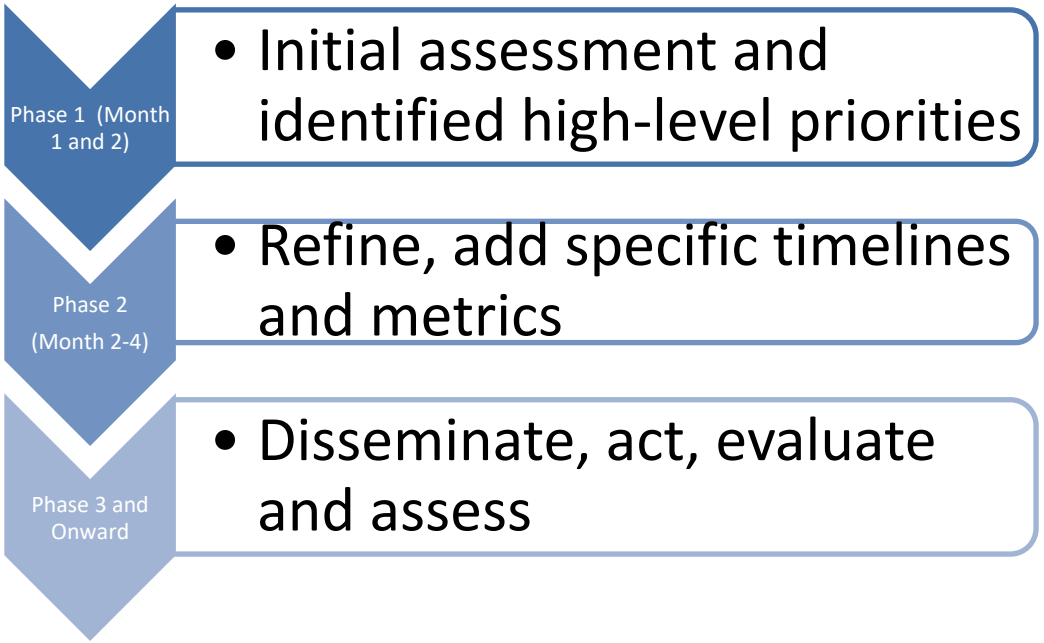
AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	getting them. That's really for the highest of the highest risk patients we're also working with our provider groups to make sure that those who maybe don't have an enhanced care management need or a complex care management need can still get the care management that they deserve within the provider groups themselves and so it is a pretty holistic plan that I'm proud of, that we are rolling out. With the end of the public health emergency, the reduction in the number of beds that each hospital has available to it, as well as nursing shortages. Hospitals are seeing their cost rise and they're seeing L.A. Care take care of its patients. The costs are getting out of control and so we're doing a couple of things to try to help that. John Baackes, *CEO*, has been the founder and pushing forward the California safety net initiative, which is seeking to increase medical reimbursement. That work will hopefully eventually result in an increase in reimbursements to medical providers. L.A. Care is also trying to staff up the inpatient utilization management team as well as its outpatient utilization management team to help with difficult-to-place patients. As a medical provider, we have a lot of difficult place patients and so we are staffing up our teams to help with that process. Member Amin stated that the QI and QI Informatics has been traditionally led by Dr. Miller-Parrish. She is L.A. Care's fantastic clinical leader that's been at this company for quite some time. L.A. Care has treasured her service, but she's made a decision to move on. He noted that L.A. Care will miss her. Dr. Miller-Parrish announced that she will be leaving L.A. Care at the end of the month and will be taking a role in her home state of Virginia. She stated that she leaves the Quality Improvement (QI) Department in good hands. She encouraged the committee to keep their point of contacts in QI and continue their work. *(Member Rishi Manchanda, MD, and Elaine Batchlor, MD, joined the meeting.)*	
HEALTH EQUITY MITIGATION PLAN	Alex Li, *MD, Chief Health Equity Officer,* gave a report about L.A. Care's Health Equity and Disparities, Path, Philosophy and Plan *(a copy of the written report can be obtained from Board Services.).* Part of L.A. Care's DNA • Explicitly calling out and addressing "Health Equity and Disparities" Statement of Principles on Social Justice and Systemic Racism (2020)	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Established an Equity Steering Committee and three sub-committees: Members, Providers, L.A. Care Team (Staff). Inaugural Chief Health Equity Officer (CHEO) -James Kyle, MD (2021-22) • Health Equity Department New Chief Health Equity Officer (Alex Li, MD) began in March 2023 • Develop a Health Equity and Disparities Mitigation plan • Build upon the existing work • Lead where there are gaps • Ensure compliance* Observations Many people have their own definitions of "Health Equity" or specific disparities that they focus on. • Target rich environment and changes will take time. • Work needs to be synergistic and coordinated and not territorial. • Multiple L.A. Care Departments and community partners work on health equity: - E.g. Community Resource Centers, Community Health, Community Benefits, Health Education, Quality Improvement etc. - Health Equity (and CHEO) are written into L.A. Care's DHCS and Covered California contracts. • CHEO for the health plans are not all physician, but best to be familiar with the health plan resources and align with the mission. Philosophy • The How! (Getting things done) - Leverage and partner with existing departments and community based organizations - Lead in areas where additional health equity work needs to be done or be a "Chief Health Coordinator." ➢ Example: Black Infant and Women's Health - Measure impact - Ensure Compliance • The What? (Focus Area)	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN

- More public health and community focused.
- Support and work with L.A. Care service areas and initiatives that impact health equity
- Target programs that are sustainable

- The Who? (Priority Populations and Initiatives)
  - L.A. Care and/or community members
  - Mom and young kids
    - ➢ Birthing individuals/moms, infants and young children (TANF ~1.2M)
      - ▫ Preventive measures and services (e.g. perinatal services, vaccines)
    - ➢ Black women and infants (FY 21-22 ~1,500 births)
  - Homeless/unhoused individuals (~50K)
  - School-aged children and teens (650K)
  - Other key anchor areas and social drivers of poor health
    - ➢ E.g. Gun violence prevention or "Food as Medicine"
  - L.A. Care staff



AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	Health Equity and Disparities Mitigation Plan and Health Equity Zones • Informed by L.A. Care's history of work within and for the safety-net, member needs, our community partnerships, and an internal assessment. - Identified four key health equity zones  	
HEALTH EQUITY ACCREDITATION	Dr. Miller-Parrish gave a presentation about Health Equity Accreditation *(a copy of the written report can be obtained from Board Services.)* Multicultural Health Care (MHC) Distinction • The first NCQA distinction awarded for excellence in serving the needs of a diverse population through cultural assessment and responsiveness, disparity reduction and language services. • MHC distinction is valid for 2 years. - Current certificate expires 03/26/2024 • L.A. Care MHC Distinction Award Longevity: - Medi-Cal: Since 2013 - LACC: Since 2015 - CMC: Since 2017 • As of 2021, L.A. Care scored a 98% for MHC, for all lines of business.	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
	• Health Equity Accreditation incorporates existing Multicultural Health Care Distinction standards and raises the bar to a higher degree of equity. • NCQA awards Health Equity Accreditation to organizations that meet or exceed standards in: - Identifying and reducing disparities - Addressing social risk factors Working toward dismantling the systemic and structural barriers that generate bias or discrimination in health care. Health Equity Accreditation Timeline • L.A. Care Health Equity Accreditation survey will be based on 2023 Standards. • Health Equity Accreditation evidence collection began April 2023. • Health Equity Accreditation survey takes place December 2023 Health Equity Accreditation Requirements • In addition to MHC requirements, HEA adds: • Collection of Sexual Orientation and Gender Identity (SOGI) Data including: - Preferred Pronouns - Sex assigned at birth Note: SOGI information pertains to HE 2D, HE 2E and HE 6B Standards. • New HE 7 Standards Health Equity Accreditation Preparation • Plan Partner Delegation - The Health Equity 7 Standards include L.A. Care Health Plan being responsible for overseeing delegated health equity activities for our plan partners. - Currently, L.A. Care does not directly oversee Health Equity functions for members assigned to the Plan Partners. However, Plan Partners either hold MHC distinction and/or are undergoing their own Health Equity Accreditation with NCQA. Health Equity Accreditation Preparation • L.A. Care uses an outside vendor, *The Mihalik Group* (TMG), to review the business unit document submissions against the 2023 Health Equity NCQA Standards. TMG provides their recommendations on how to meet NCQA requirements, which are	

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	classified as Met, Partially Met or Not Met. If the document was deemed as Not Met, TMG provides the reasoning, as well as their suggestions on how to meet the NCQA requirement. • As of May 2023, there are no gaps to report. Health Equity Accreditation vs Health Equity Plus Health Equity Accreditation (HEA) • Health Equity Accreditation focuses on reducing health care disparities by assessing, respecting and responding to diverse cultural health beliefs, behaviors and needs (e.g., social, cultural, linguistic), when providing health care services. HEA is focused within the health plan. Health Equity Plus Accreditation • Health Equity Plus broadens the view of equitable care within and outside the health plan, by requiring the organization to collaborate with other stakeholders in the healthcare ecosystem including: - Individual patients/members and their families with emphasis on the communities in which members live - Communities - Payers - Clinicians - Local and national policy makers - Community-based organizations - Social services organizations • Voluntary accreditation • Currently assessing readiness with Equity team and Chief Health Equity Officer. *(Member Munoz left the meeting.)*	
ADJOURNMENT	The meeting was adjourned at 3:45 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: _____
Sameer Amin, MD, *Chairperson*
_____
Date Signed

BOARD OF GOVERNORS
Technical Advisory Committee
Meeting Summary – August 24, 2023

1055 W. Seventh Street, Los Angeles, CA 90017

Members

Sameer Amin, MD, *Chair*
John Baackes, CEO*
Elaine Batchlor, MD, MPH
Paul Chung, MD, MS
Muntu Davis, MD, MPH*
Alex Li, MD, *Chief Health Equity Officer*
Rishi Manchanda, MD, MPH***
Santiago Munoz
Elan Shultz***
Stephanie Taylor, PhD***

** Absent ***Present (Does not count towards Quorum)*

Management

Alex Li, *MD, Chief Health Equity Officer*
Terry Brown, *Chief Human Resources Officer*
Felix Aguilar-Henriquez, *MD, Medical Director, Quality*
Wendy Schiffer, *Senior Director, Strategic Planning, Strategy*

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CALL TO ORDER	Chairperson Sameer Amin, *MD*, *Chief Medical Officer,* called the meeting to order at 2:05 p.m. without quorum.	
APPROVAL OF MEETING AGENDA	The Agenda for today's meeting was not approved due to lack of quorum.	
PUBLIC COMMENT	There were no public comments.	
APPROVAL OF MEETING MINUTES	The February 9, 2023 meeting minutes and May 11, 2023 Meeting Summary were not approved due to lack of quorum.	
CHAIR AND VICE CHAIR ELECTION	Member Alex Li, *MD*, *Chief Health Equity Officer,* asked the committee to notify staff if they are interested in running for Chair or Vice Chair of the committee. He stated that Chairperson Amin recommended that Dr. Li assume the Chairperson role for consistency. Dr. Li expressed his willingness to serve as Chairperson. Members can notify staff of any nominations for Chair or Vice-Chair. Member Rishi Manchanda, *MD*, requested that staff send out rules, responsibilities, and time commitments for each Officer role.	

AGENDA ITEM/ PRESENTER	MOTIONS / MAJOR DISCUSSIONS	ACTION TAKEN
CHIEF HEALTH EQUITY UPDATE	Member Li provided a Chief Health Equity Update. Member Li highlighted the official launch of the Health Equity Disparities Mitigation Plan on June 5, 2023. The plan was shared with this Committee and with the Board of Governors. Member Li noted that there was a positive response to the plan at the Board of Governors meeting. He mentioned that people were pleased about the metrics related to health equity zones and that health equity activities are an active part of L.A. Care's mission. Member Li mentioned that he has been in this role for five months and highlighted various initiatives and approaches related to health equity efforts, particularly those presented by Marina Acosta, *Manager, Health Equity*. He encouraged feedback and input from the group to help make these initiatives successful. He shared his excitement about being invited to speak on a panel for health equity at the upcoming meeting of the National Academy of Sciences in October. He expressed the importance of communicating Los Angeles County's efforts in the field of health equity. Member Li discussed a new program initiated by the state, the Health Equity Practice Transformation Program, aimed at addressing health disparities among small and medium-sized practices. He highlighted the challenges related to the rush to enroll practices and the need for more guidance. Member Li expressed his intention to bring the Health Equity Practice Transformation Program for discussion at a future TAC meeting to seek advice and guidance from the group, when more details become available. Member Manchanda acknowledged the progress mentioned regarding the use of zones for strategic priority areas. He said that the concept of "health equity improvement zones" is gaining momentum and is being used to help health plans and systems organize health equity strategies. He requested that this be noted when participating in various forums to reflect the evolving use of zones in healthcare. He emphasized that health equity improvement zones are slightly different from the current definition of strategic priorities and provide an opportunity for bridging work. Member Manchanda expressed his willingness to follow up offline regarding these opportunities and the role of his organization in introducing the terms "health equity improvement zones". He pointed out that the place-based definition of health equity improvement zones is focused on ecosystem-level alignment rather than the current definition of strategic priorities. Member Manchanda also inquired about the practice transformation grants, specifically seeking more details on the requirements given the tight deadline for enrollment by September. He wanted to understand the minimum	

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	requirements. Member Li provided details regarding the requirements for the practice transformation grants. Requirements include: • serving a minimum of 1,000 or more Medi-Cal members, • being a primary care provider, obstetrics (OB), or a behavioral health specialist, • a focus on small to medium-sized practices with a group size of up to 50 providers, • being located in one of the areas listed in the Healthy Places Index, with a focus on areas with the lowest quartile health scores. These criteria are the major eligibility criteria for practice transformation grants. Dr. Aguilar Henriquez mentioned that they are currently in the process of enrolling practices. There is a limited timeframe for this enrollment, and a primary focus is to support the practices in their transformation efforts, with a strong emphasis on health equity. He noted that the practices they are enrolling are diverse and unique, making this initiative special. Member Li stated that there will be a full presentation at a future meeting.	
CHIEF MEDICAL OFFICER UPDATE	Member Amin gave a Chief Medical Officer update. He discussed L.A. Care's material investments aimed at enhancing the health of the population. The update specifically focused on the Utilization Management team, Case Management team, and the departmental structure. About ten months ago, L.A. Care underwent a significant redesign that led to the formation of four major departments within Health Services: • Community Health, • Pharmacy, • Quality Improvement, and Utilization Management, • Case Management and Managed Long-Term Services The restructuring aimed to provide a clear sense of responsibility and accountability for the teams. The organization conducted a foundational assessment to identify resourcing gaps, potential misprioritization, and gaps in non-staff investments. They have increased headcount by over 40% and personnel spend by more than 30%, both in clinical and nonclinical positions. This investment allowed L.A. Care to improve hospital operations and patient care, and facilitate transition of patients who no longer require acute care out of the hospital. Additionally, L.A. Care made significant investments in wraparound care, managed long-term services and support, housing	

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	initiatives, and supports programs. The organization's primary goal is to ensure that their Medi-Cal members receive the right care, at the right time, in the right place, and with the appropriate supportive services. These investments are part of L.A. Care's strategy for clinical and operational excellence and align with their overarching objective of improving patient care. It's worth noting that, like large cruise ships, health plans take time to turn, and L.A. Care is now witnessing the positive impact of these material investments.	
HEALTH EQUITY IMPACT ASSESSMENT TOOL	Marvin Thompson, *Community Benefits Grants Specialist II, Community Benefit Programs,* gave a presentation on then Health Equity Impact Assessment Tool *(a copy of the written report can be obtained from Board Services).* L.A. Care is committed to advancing health equity for our members and their communities. ➢ Health Equity & Disparities Mitigation Plan Zone 4: Serve as a model in supporting an equitable and inclusive work environment, as reflected in our workforce and business practices • *Issue:* In doing this work, it can be difficult to operationalize what we mean by applying an "equity lens" to our work. • Solution: Created a Health Equity Impact Assessment Tool (HEIAT) to: - Provide an opportunity for staff to think through the impact of their projects on diverse member populations. - Systematically and consistently embed these equity questions to enterprise projects - Help provide more equitable care for diverse member population. - Further institutionalize equity efforts. ➢ The tool has 5 questions - *Don't* want teams to be overwhelmed filling this out, but *do* want them to engage in the thought process. ➢ Grading - Each of the 5 questions has a quantitative and free-response section	

Example of question and grading:

Desired Outcomes

-Has the project lead established key outcomes for equitable results to guide the project?

5 Exceeds	4 Above Average	3 Average	2 Slightly Below	1 Well Below

[Please explain your answer here]

Questions:

1. Desired Outcomes
   - Has the project lead established key outcomes for equitable results to guide the project?
     - For example, results shown with data stratification
2. Involve Those Impacted
   - Has information from community members that could be affected by this project and experts been gathered?
3. Benefits/Burden
   - Has your team found quantitative or qualitative evidence of inequality stemming from this project and does its goals aim to address them
4. Advance Opportunity and Minimize Harm
   - Has your team determined the potential impacts of your project? Has your team determined the best way to exacerbate positive outcomes and mitigating negative ones?
5. Evaluation
   - Has a plan been developed to share analysis results with the community this project would affect?

Next Steps:
Introduce the tool to those that oversee L.A. Care IRB process to create parameters and implement this tool as a requirement for larger projects i.e. projects with a budget >$100,000

Member Taylor expressed her appreciation for the presented questions and acknowledged the complexity of constructing questions. She mentioned her professional experience in managing teams that develop questions and noted that while

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	she understood the intent of the questions, there were some aspects that might benefit from minor revisions to ensure clarity. She emphasized that achieving absolute clarity in questions is essential to get the desired results. Member Taylor explained that her intention wasn't to criticize the team's work, but rather to offer fresh perspectives from individuals who approach the questions from a professional standpoint. Ms. Acosta thanked Member Taylor for her input. She acknowledged that the questions were a preliminary draft and that the team was open to making improvements to ensure clarity. She emphasized the shared goal of achieving equity and stated that they welcome feedback on how to create the questions. They aimed to create a tool that wouldn't require a substantial amount of time and effort for assessment, as they wanted it to be easily embraced and allow individuals to reflect on how their programs impact downstream members. Member Manchanda, after expressing his appreciation for the presentation, raised two key questions. He inquired about the strategic alignment between the Health Equity Impact Assessment Tool and the Health Equity Accreditation tools. He would like to understand if the design of the assessment tool intentionally crosswalks with the accreditation tools. He was interested in knowing if the internal assessment's purpose was to identify gaps that could be addressed to move closer to achieving the Quality Accreditation. He asked whether the tool's brief and succinct design intended to function as a screening tool that would lead to a more in-depth follow-up assessment, akin to clinical practice. He wanted to clarify whether the goal was to create a follow-up assessment that delves deeper into each item when gaps are identified. These questions and observations were presented for future discussions. Member Li responded to Member Manchanda's inquiries by explaining that the Health Equity Impact Assessment Tool was not necessarily aligned with Health Equity Accreditation. He mentioned that while they were actively working on achieving accreditation, the tool was designed to go beyond mere checkbox compliance and reach all departments, especially those not required to provide evidence for Health Equity Accreditation. Regarding the nature of the assessment tool, Member Li confirmed that it served as an initial screening step. He noted that the tool aimed to identify gaps and potentially guide the development of additional tools to delve deeper into specific areas. The assessment tool was designed to provide an initial scan of the landscape. He emphasized that the field might evolve, possibly leading to more sophisticated	

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	assessment tools in the future. He asked Members Taylor and Santiago if they are aware of any organizational project assessment tools. Member Taylor acknowledged the extensive availability of health equity assessment tools. She conveyed that the team had put considerable thought into creating the tools. Member Taylor offered to assist with some minor adjustments to enhance the clarity and alignment of the tool to achieve the intended outcomes, without the need for a complete overhaul. The goal was to refine specific areas for a more precise and effective tool.	
HEALTH EQUITY IMPROVEMENT ZONES AND COMMUNITY RESOURCE CENTERS UPDATE	Ms. Acosta gave a presentation about Health Equity Improvement Zones and Community Resource Centers *(a copy of the written report can be obtained from Board Services).* Ms. Acosta provided an update on the Health Equity Improvement Zones and Community Resource Centers. She highlighted that the initiative involves four zones, each addressing specific aspects of disparities, collaboration, data, and regulatory requirements related to health equity. Zone 2 is focused on external collaboration, while Zone 3 pertains to social determinants of health and data linkage. She reported that efforts have been made to create shared agendas with internal and external departments and that meetings have taken place with Community Resource Centers. These efforts have yielded positive outcomes, such as reestablishing connections and the creation of a social determinants of health resource for providers. Ms. Acosta shared upcoming steps, including continued visits to community resource centers, inviting local partners to share priorities, and hiring a field specialist to foster community-based relationships. She mentioned the development of a social determinants of health provider resource sheet with input from both internal and external stakeholders. Ms. Acosta also highlighted a new health equity shirt designed to promote social determinants of health. She invited input on how the initiative can focus on vaccine equity, maternal health, school-aged youth, and high-volume providers within specific areas to move closer to equity. She emphasized the importance of building and maintaining relationships, which are essential for the success of the initiative. Member Manchanda shared several comments and recommendations regarding the presentation. He acknowledged the importance of the ongoing work and expressed his gratitude for the presentation. Member Manchanda discussed his experience with health equity zones, referencing a blog he had written on the topic and the collaboration with Rhode Island and Oregon in creating a public health model called health equity	

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	zones. He highlighted three key considerations for the team as they continue their work: • The importance of geospatial analysis to identify and address inequities, and the need to share this analysis with partners. • The suggestion to tie social determinants resources strategically to health equity goals rather than treating them generically as resources. • The idea of bringing the analysis into the hubs for community sharing and gathering to leverage elder care's role as a convener. Member Manchanda emphasized the need for clear goals and targets when addressing health equity measures and offered to provide more specific feedback and follow up offline. He also shared a link in the chat that explained the rapid improvement model used in the health equity zones work. Member Paul Chung pointed out the importance of asset mapping, particularly differentiating between generic or general-purpose asset mapping and goal-oriented asset mapping. He mentioned that communities have been conducting asset mapping for years, and he questioned whether the discussions with various community-focused groups have addressed asset mapping that has been done by experts who understand neighborhoods and communities. He suggested that these conversations could serve as a starting point for the mapping process. Member Chung raised the question of the end goal of the mapping process, emphasizing the importance of defining the specific objectives related to reducing health inequities and promoting health equity. Member Li stated that they are using the healthy places index as a reference or source. Member Taylor stated that she thinks most universities have been doing this for years and it is really common. She has been doing it for 30 years. It requires special expertise and may not have that capability if that's what he is suggesting. Member Li responded to Member Taylor's comment by acknowledging that they have received a significant amount of qualitative and experiential feedback. This feedback is valuable but is often specific to the areas of expertise or particular regions. For instance, when they target schools, they are specifically working with Title 1 schools. Member Li mentioned that they are attempting to map key indicators related to identifying asset gaps or a target-rich environment in their efforts. This implies that they are focusing on specific criteria and conditions to identify areas of need within the community. Member Taylor expressed some confusion and mentioned that geospatial analysis requires specific expertise. Member Li clarified that their focus is on quality and experiential feedback	

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	rather than geospatial analysis. Member Taylor also referred to using the Healthy Places Index. Both members indicated their willingness to talk offline and collaborate further. Member Li explained that they aim to align resources to address social determinants of health, such as housing, food, and transportation, in response to regulatory requirements. T hey acknowledged that the challenge is to find resources readily available and easily accessible to providers. They provided examples of practical approaches to address these challenges, such as using abbreviated tools and QR codes. Member Li thanked everyone for their feedback, highlighted that this was their first venture in this direction, and that they have had assistance from a creative intern. Member Shultz commented on the current meeting format that his preference is for more data and reports before discussions. He appreciated the previous director's report, which provided an overview of the plan's major initiatives. Member Shultz suggested that lengthy presentations might not be necessary in the future if written presentations are shared in advance, allowing for more interactive discussions during TAC meetings. Member Li acknowledged the value of written presentations sent prior to the meetings, and mentioned that they could streamline the content. They agreed it is important to keep the TAC informed about the plan's direction and activities, and expressed appreciation for Dr. Amin's support in moving towards technical support for health equity efforts and welcomed suggestions for future meeting agendas.	
ADJOURNMENT	The meeting was adjourned at 3:45 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: _____
Sameer Amin, MD, *Chairperson*
_____
Date Signed

October 23, 2023

TO: Board of Governors

FROM: John Baackes, *Chief Executive Officer*

SUBJECT: CEO Report – November 2023

We are into enrollment season for two of our products, Medicare Plus, our Dual Eligible Special Needs Plan, and L.A. Care Covered (LACC), our marketplace option for Covered California. Enrollment for Medicare Plus began on October 15, and will start on November 1 for LACC. We are well poised in both products to offer members quality care and coverage. For Medicare Plus, we have an array of supplemental benefits which are available to eligible members to help them address their social needs, like grocery support, or transportation assistance. LACC has the lowest premium in Los Angeles for 2024, quite a feat in a year where premium hikes were the highest they've been in a long time. For Medi-Cal, we've been preparing for new populations in 2024, and I have attached an article regarding the expansion to undocumented adults, which mentions L.A. Care's preparations.

This month, we wrapped up our successful vaccination clinics held at Community Resource Centers. The clinics provided vaccines as well as basic screenings, and people could choose one or all of the services. Below is a summary of what was provided:

- **1,393** total visits
- **1,061** Flu vaccines
- **347** COVID vaccines (was not available yet for first four events)
- **800** Glucose tests
- **852** Blood Pressure tests

We also provided gift cards, raffles, and food bags at some centers. Each center has partnerships with community-based organizations, making every event tailored to the community. For example, Lynwood held a healthy eating resource fair in partnership with local organizations, while Pomona included mobile eye exams and Wilmington had free dental screenings.

Following is a snapshot of our progress on some of our community- and provider-focused work.

	Since Last CEO Report (9/27/23)	**As of 10/23/23**
Provider Recruitment Program Physicians hired under PRP[1]	1	153
Provider Loan Repayment Program Active grants for medical school loan repayment[2]	-1	109
Medical School Scholarships Grants for medical school scholarships[3]	—	48
Elevating Community Health Home care worker graduates from CCA's IHSS training program	—	6,349

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 October:

L.A. Care Receives National Award for Texting Campaign
L.A. Care is proud to announce that we have received the Activate 2023 Award for Achieving Health Equity for our texting campaigns aimed at improving prenatal and postpartum outcomes. L.A. Care launched the campaign July of last year and it continues today. Members who opt in receive a text once a week for six weeks. For the prenatal campaign, members who opt in receive messages letting them know things like how to contact their physician, how to find a physician, or what to do in an emergency. For the postpartum campaign, members receive messages reminding them that a 24-hour nurse line is available to help them if they have questions about changes in their bodies. The messages also urge them to make a postpartum appointment and to call their physician if they are feeling overwhelmed. Enrollment rates for similar campaigns are typically 10 to 15 percent, while L.A. Care saw an enrollment rate of 28 percent for its prenatal campaign and 33 percent for its postpartum campaign.

L.A. Care Hosted Discussion for "Unidad: Gay and Lesbian Latinos Unidos"
L.A. Care hosted a discussion with the filmmakers of "Unidad: Gay and Lesbian Latinos Unidos" a documentary of the Los Angeles-based Gay & Lesbian Latinos Unidos (GLLU) organization founded in 1981. During the Q&A, the director, executive producer, and a GLLU member discussed why it was important to make the film, the similarities and differences in addressing disparities during the height of the HIV/AIDS pandemic and the most recent COVID pandemic, the lessons health care organizations could take away from the film and more. A recording of the Q&A will be posted on L.A. Care's website.

Speaking Events

October 25 – Modern Healthcare Virtual Social Determinants of Health Symposium; *Managing a Growing List of Vendors to Address the Social Needs of Patients.*

October 25 – California Association of Health Plans Annual Conference; *Improving Primary and Specialty Care in Medi-Cal.*

Attachments
Modern Healthcare

Modern Healthcare

October 17, 2023 05:00 AM 4 HOURS AGO

California healthcare system preps for undocumented immigrant coverage

KARA HARTNETT

Stakeholders throughout the California healthcare system are gearing up to play their parts in the largest Medicaid expansion in the Golden State since the Affordable Care Act broadened program eligibility more than a decade ago.

Starting in January, California will accept Medicaid enrollments from all low-income undocumented immigrants who qualify for benefits, and 700,000 people are projected to sign up. California gradually has been opening Medi-Cal, as Medicaid is known there, to undocumented immigrants since 2016, starting with low-income children and adults younger than 26 or older than 49, and is poised to lift age restrictions next year. The full expansion will cost an estimated $2.1 billion a year.

California Gov. Gavin Newsom (D) says the latest Medi-Cal expansion will save California money over the long term and ease the uncompensated care burden on hospitals. He argues that providing health coverage regardless of immigration status

will enable patients and providers to manage chronic diseases and reduce spending on emergency care by promoting access to lower-cost primary and preventive care.

For the plan to come to fruition, health insurers and providers are getting ready to take on a wave of new patients with unique medical and social needs. Organizations are preparing to build trust and break down language barriers to aid undocumented immigrants in navigating the complex U.S. healthcare system. Health insurers and providers are also gauging network capacity and coordinating with community-based organizations to reach this previously excluded population.

The Medi-Cal expansion could provide a model for states such as Illinois and New York, which have made moves in recent years to expand Medicaid to certain undocumented residents, and are watching the rollout closely.

Submit

“We have been fighting that battle with our budgets with the current governor, and we will continue,” New York state Senate Health Committee Chair Gustavo Rivera (D) said, referring to Gov. Kathy Hochul (D). “We're already spending almost a billion dollars on emergency Medicaid in the state of New York and this would actually save us money. I will be looking closely at how they do it there and I will be fighting to make sure that it happens here in the state of New York.”

Community-based infrastructure

Local organizations and federally qualified health centers have been foundational to expanding provider capacity and enrolling undocumented adults into coverage programs leading up to the latest Medi-Cal expansion, said Laura Sheckler, deputy director of policy and regulatory affairs at the California Primary Care Association.

Many safety-net and community providers have been serving immigrant populations for a long time, and Medi-Cal reimbursements provide revenue that enables them to fill gaps in care, said Dr. Efrain Talamantes, CEO of AltaMed Health Services, a Los Angeles-based network of community health centers.

While undocumented immigrants could only access limited benefits in the past, Medi-Cal covers specialty care, hospital services, physical therapy and social interventions such as housing and nutrition support. People currently enrolled in limited coverage arrangements will automatically be enrolled in Medi-Cal in January. Health insurance companies just starting to bring this population into the fold are leaning on organizations such as AltaMed to manage care and generate long-term savings.

"When we meet with our health plans, they focus on the lives assigned to them which are insured, but now we will be able to see a lot more of our undocumented patients and have discussions about what we can do to partner," Talamantes said. "We know that, at least upfront, there are some unmet needs that we're going to have to bridge

to get these patients stable and start preventing some of the hospital care that is clinically avoidable."

CalOptima, a publicly funded health insurance plan for nearly 1 million low-income residents in suburban Orange County south of Los Angeles, has dedicated $6 million to hire 100 health navigators to work in community-based clinics and federally qualified health centers over the next year to help with enrollment and onboarding. The insurer is expecting an additional 70,000 members from the expansion, CEO Michael Hunn said.

Utilizing community organizations to conduct outreach is "imperative" to overcoming trust barriers, particularly among undocumented immigrants, Hunn said. For example, many potential enrollees may fear deportation if they divulge personal information to a government entity.

"The only point for us is that we want to make sure you have health insurance and that you're medically taken care of," Hunn said. "The way that we can gain the trust of the individual when they're entitled to the benefit but they're afraid to apply is the trust that the community-based organizations provide individuals, because they speak their language. They're in the neighborhood and community where they live."

Health insurance companies are also building up infrastructure and reviewing provider networks to ensure they are prepared to care for patients who don't speak English and to help them navigate the healthcare system. For example, CalOptima has translated forms and documents into languages including Spanish, Vietnamese, Korean, Chinese, Farsi, Punjabi and Arabic, and utilizes interpreters to communicate with members, Hunn said.

L.A. Care Health Plan, which caters to low-income and underserved populations and is the largest health insurer in Los Angeles County, is expanding its onboarding operations and getting workers prepared for nearly 150,000 new Medi-Cal beneficiaries. The company is creating welcome kits and organizing screening efforts to gather information about new members' health needs.

Through Medi-Cal, insurers can connect enrollees to resources such as transportation and medically tailored meals, and initial screenings will help them make those referrals, said Phinney Ahn, executive director of Medi-Cal for L.A. Care Health Plan. "We want to make sure that all of our new members are aware of all of these services they can access," she said.

L.A. Care Health Plan is also tapping into its community resource center network in neighborhoods across the county, which are staffed with multilingual health navigators and community health workers, Ahn said. "There are some individuals who just prefer to work in-person and they may not respond well to our provider directory, and the hardcopy of it, which literally looks like a phone book. That's not going to help them if they're not used to navigating [the healthcare system]," she said.

Access to care

Insurers and primary care providers say they are prepared to take on a wave of new patients. AltaMed is still working on building capacity, but expanding Medi-Cal makes it easier for the safety-net providers by increasing accountability for care to other organizations, Talamantes said.

"This expands the number of stakeholders vested in and caring for our undocumented community," he said. "If you need to refer someone out for specialty care, a lot of times those services haven't been covered by the local county coverage programs. So there have been big gaps in care because they haven't been comprehensive. The opportunity of bringing folks into full-scope Medi-Cal is that they should be able to get that full range of services."

There is a shortage of Spanish-speaking clinicians in California and too few specialists accept Medi-Cal, which creates backlogs and makes it difficult for beneficiaries to obtain care. "Those medical rates are low and getting enough providers in-network is a big challenge," Sheckler said.

At the same time, enrolling undocumented immigrants in Medi-Cal is expected to lighten the load on hospitals as it diverts previously uninsured patients away from costly sites of care such as emergency departments.

"This is about making our hospitals accessible for us when we need them the most and also knowing that we can do a lot more prevention for everyone so that our hospitals are clear for those people who really need them," Talamantes said.

Introduction

Vision 2024

L.A. Care's strategic plan, Vision 2024, outlines our major goals for 2021-2024. Vision 2024 guides us towards continued growth and success using the framework offered by the four strategic directions that remain our guideposts—Operational Excellence, High Quality Network, Member Centric Care, and Health Leader. The Vision 2024 document is 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 fourth quarter of our fiscal year, from July 1 through September 30.**

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

Operational Excellence

Achieve operational excellence by improving health plan functionality.

Goals	Q4: July – September 2023 Highlights
Build out information technology systems that support improved health plan functionality.	• Reprioritized the VOICE Program to focus on enhancing customer experience and adjusting scope based on business need. • Selected a vendor for the cloud-based platform that will enable the Provider Network Management and Provider Data Management teams to perform all provider enrollment and maintenance tasks in an integrated and efficient manner.
Support and sustain a diverse and skilled workforce and plan for future needs.	• Succession planning pilots launched with Legal Services and Products. • Current demographics for all employees: 36.5% Hispanic or Latino, 22.3% Asian, 14.9% Black or African American, 9.9% White, 5.6% Native Hawaiian or other Pacific Islander, 3.0% two or more races, 7.5% non-applicable. Additionally, our employees are 69.6% Female and 30.4% Male. • The second cohort launched and is in process for the Management Certificate Program.
Ensure long-term financial sustainability.	• Our FY 22-23 administrative expenses are tracking lower than the 3+9 forecast but slightly higher than the 9+3, pending year-end close.
Mature L.A. Care's family of product lines, taking an "all products" approach whenever possible.	• Open Enrollment period for L.A. Care Covered is set to launch in October through select channels, with a full-scale rollout by November. • Medicare Plus D-SNP Annual Enrollment Period marketing campaign successfully launched. • L.A. Care established a Physician Advisory Collaborative and a series of provider engagement meetings to be held at Community Resource Centers.

High Quality Network

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

Goals	Q4: July – September 2023 Highlights
Mature and grow our Direct Network.	• Under the guidance of the Direct Network Steering Committee, L.A. Care's Advanced Analytics Lab is consistently improving a multi-metric performance dashboard, embedding it with precise and actionable performance indicators. • Virtual Specialty Care Program passed the one year mark, and in that time, we have received a total of 82 eConsults submitted and four telehealth visits.
Improve our quality across products and providers.	• Two new quality performance reports were shared with the Direct Network: the Practice-level Provider Opportunity Report and the Capitated Claims Report. • Multiple text messaging campaigns launched for preventive screenings and for targeted groups (e.g. parents for well-child visits). • Selected a vendor for the Clinical Data Repository Program to help achieve our NCQA Health Equity Accreditation.
Invest in providers and practices serving our members and the L.A. County safety net.	• Announced eight new scholars who received admission to Charles R. Drew University and UCLA medical schools. • Celebrated another In Home Supportive Services Provider Training graduation with 386 new graduates. • Invested more than two million dollars in 12 clinics to improve patient access and reduce health disparities by addressing workforce shortages as clinics prepare for Medi-Cal expansion in January 2024. In addition, we awarded a grant to implement a simulation center utilizing virtual reality technology to improve staff cultural competency, which enhances patient engagement, treatment adherence, and condition management.

Member Centric Care

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

Goals	Q4: July – September 2023 Highlights
Operate all components of California Advancing and Innovating Medi-Cal (CalAIM) as they are launched.	• On track to further expand our network for Community Supports with the launch of new services on January 1, 2024 (Asthma Remediation and support for members transitioning from Nursing Facilities to their homes or to Assisted Living Facilities). • Increased our Enhanced Care Management provider network by 14 providers, many of which serve the Children and Youth populations.
Establish and implement a strategy for a high-touch care management approach.	• There was a 35% increase in Direct Network cases opened in Care Management in Q4, compared to Q3. • Community Health Workers participated in the “Fight the Flu” campaign to support Care Management members with understanding COVID-19 and the importance of accessing other vaccinations.
Ensure that the services we provide to members promote equity and are free of implicit and explicit bias.	• Hosted an L.A. County Health Equity Officers meeting in August with representatives from Blue Shield/Promise, Cedars Sinai, DHS, DPH, Molina, and UCLA. • Ten of the 16 Member Equity Council goals were completed. • The doula benefit standing order process has been approved and members can now be directly connected to services via the provider directory. L.A. Care has served 32 members to date. • Three new member educational materials were added to the trimester specific pregnancy mailing, distributed to approximately 80 pregnant members monthly. • Added diversity language to the Request for Proposal (RFP) questionnaire to bidders, and the updated language has been included in recent RFP releases. • In August, 206 attendees participated in our second Social Determinants of Health provider training.

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	Q4: July – September 2023 Highlights
Drive improvements to the Affordable Care Act by serving as a model of a successful public option.	• In September, the Los Angeles Times published an opinion piece proposing a public option for California, citing L.A. Care as a successful example.
Optimize members' use of Community Resource Centers and expand our member and community offerings.	• West L.A. and Panorama City Community Resource Centers (CRCs) were completed. • Implemented new hypertension management pilot program with American Heart Association at two CRCs.
Drive change to advance health and social services for our members and the community.	• Introduced the Health Information Exchange (HIE) Participation Measure to incentivize IPAs and hospitals to meaningfully utilize HIEs. • Launched a one-time HIE Adoption incentive for providers to further enhance HIE adoption and support their participation in the California Health and Human Services Agency Data Exchange Framework. • For the Housing and Homelessness Incentive Program (HHIP), we have made significant progress toward our goal of earning full points for HHIP Measurement Period II which ends on October 31.

APPENDIX

Detailed Vision 2024 Progress Report
Fiscal Year Quarter 4
July – September 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.	Reprioritized the VOICE Program to focus on enhancing customer experience and adjusting scope based on business need. IT Leadership is taking a deep-dive in reviewing the program roadmap and overall solution. Development is underway for the post-call survey, starting with the Provider Service Unit. The post-call survey gives the ability to acquire feedback from providers regarding their customer service experience during the call.
Improve efficiency and effectiveness of financial management functions with the implementation of the additional phases of the SAP Enterprise Resource Planning (ERP).	The SAP Analytics Cloud for Reporting Phase 2 is on-track to go live in Q1 FY 23-24. The final two phases of the original SAP strategic project are expected to start in Q3 of FY 23-24 and include Callidus for Broker Commissions and Ariba for Procurement.
Complete the implementation of SyntraNet to support new and updated regulatory requirements, in addition to operational improvements across the enterprise.	Operational leaders in Utilization Management, Enhanced Care Management, and CalAIM Community Health have worked with the new third-party entity project managers to plan and begin execution of high-priority items for configuration within Syntranet. Via multiple workgroups, these leaders, project managers, and UpHealth completed business requirements and implementation schedules for foundational work as well as compliance and efficiency-related enhancements. In order to ensure those priorities are completed by end of the calendar year per the renegotiated Statement of Work, other bodies of work such as Grievance & Appeals and Provider Portal were placed outside of Syntranet's near-term scope. In addition, UpHealth provided comprehensive refresher trainings of core system functionality with designated subject-matter experts from the three business areas.

Build out information technology systems that support improved health plan functionality.	
Tactics	**Update**
Modernize provider data management by defining and creating a roadmap for achieving our target state for our provider data ecosystem.	L.A. Care continued work towards implementing the Provider Target State by: • Selecting a vendor for the cloud-based platform that will enable the Provider Network Management and Provider Data Management teams to perform all provider enrollment and maintenance tasks in an integrated and efficient manner; • Finalizing a licensing agreement with the vendor for suitable configuration of the Network Ops Task Management Platform in accordance with L.A. Care's functional capability requirements, which are specified in the licensing agreement together with a 15-month configuration project plan; and • Finalizing a parallel 15-month project plan for development of the single domain database which will: (1) be interfaced with and continuously updated by the Network Ops Task Management Platform; (2) supply validated and up-to-date network data to all downstream functions and systems; and (3) enable L.A. Care to retire its currently fragmented provider data management systems.
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.	Having completed an RFP process with five select vendors, we are in the final stages of selecting a vendor to the Systems Integrator for the VOICE Program. VOICE will position us well for a "No Wrong Door" strategy.
Develop real-time interoperability capabilities to share data with providers and members.	In accordance with Federal CMS and California mandates, L.A. Care deployed a set of Application Program Interfaces, which provide a data connection for members to access their health information maintained by L.A. Care. Since the service began in May 2023, member adoption has been very low; monitoring of member and third party applications continues. At the request of the Department of Health Care Services (DHCS), in September, L.A. Care posted enhanced information on lacare.org about the risks of sharing health information with third party apps and how members can report any issues.

Support and sustain a diverse and skilled workforce and plan for future needs.	
Tactics	**Update**
Conduct succession planning, particularly at the leadership level.	Succession planning pilots launched with Legal Services and with Products. Success profiles are being created for those identified as potential successors for use in assessing competency levels and potential training/development for those identified.
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. Our employees are: 36.5% Hispanic or Latino, 22.3% Asian, 14.9% Black or African American, 9.9% White, 5.6% Native Hawaiian or other Pacific Islander, 3.0% two or more races, 7.5% non-applicable. Additionally, our employees are 69.6% Female and 30.4% Male.
Improve managed care and Management Services Organization (MSO) acumen among staff.	No new updates this quarter.
Promote retention of staff in an evolving work environment.	The second cohort launched and is in process for the Management Certificate Program. All Leadership Development programs concluded for this fiscal year: 108 leaders completed three or more Leadership Development Courses; 101 have completed one or two offered courses. Next year's programs have been developed and are currently under review.

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.	Our FY 22-23 administrative expenses are tracking lower than the 3+9 forecast but slightly higher than the 9+3, pending year-end close. Savings targets were implemented in the FY 23-24 budget planning and additional efforts will be identified based on the completed competitive analysis.

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 launched a D-SNP plan in 2023. In Q4 FY 22-23, we received approval and executed the 2024 contract with CMS. It will continue to serve the dually eligible Medicare and Medi-Cal population in L.A. County in 2024.
Increase membership across all products by implementing member recruitment and retention strategies.	**Sales** • L.A. Care Covered (LACC): SB-260 (Automatic Health Care Coverage Enrollment) members started with July 2023 effective dates from Medi-Cal members who lost coverage through the Redetermination process. Members are required to effectuate to a Covered California Plan. While the volume of auto-assigned members is almost two times the projections, the opt-in/effectuated rate is lower than projected due mainly due to members declining a premium-based product or those who are confused and want to reapply for Med-Cal. • Medicare Plus D-SNP: Net membership exceeded forecast. Most of the efforts during the Q4 were to prepare and execute the new 2024 growth strategy including multi-channel marketing strategy and refined/targeted broker distribution. • Medi-Cal (MCLA): Planning initiated to provide additional support/resources to build an expanded internal direct enrollment assistance model in coordination with our enrollment assistor community-based organization partners at our Community Resource Centers and direct to the organizations. **Marketing** • LACC: Open Enrollment Period is set to launch in October through select channels, with a full-scale rollout by November. In Q4, we broadened our media efforts to encompass LACC's diverse membership demographics and tailored messaging specifically for Oscar members as Oscar departs the L.A. market. We launched all regulatory and non-regulatory materials as scheduled. • Medicare Plus D-SNP: Annual Enrollment Period marketing campaign successfully launched, utilizing a multi-channel approach. We crafted messaging based on product

Mature L.A. Care's family of product lines, taking an "all products" approach whenever possible.	
Tactics	**Update**
	insights and refreshed creative elements with our distinctive blue and orange brand colors for a compelling and memorable impact. English & Spanish enrollment kits were delivered to brokers. • Medi-Cal (MCLA): In Q4 FY 22-23, we embarked on the next phase of our Plan Partner campaign, an exciting collaboration with Anthem and Blue Shield Promise. This year's strategic approach is built upon the idea of empowering both Plan Partners, enabling them to autonomously oversee and finance digital marketing campaigns that mirror L.A. Care.
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 established a Physician Advisory Collaborative and a series of provider engagement meetings to be held at Community Resource Centers. These sessions aim to achieve two primary objectives: (1) to inform providers about the many resources and services L.A. Care offers to assist with managing member care; (2) to collect valuable feedback from providers, paving the way for enhanced communication, enriched collaboration, and optimized network strategy.

High Quality Network

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

Mature and grow our Direct Network.	
Tactics	**Update**
Insource delegation functions that are currently outsourced, as appropriate and cost effective.	This tactic has been completed.
Improve the operations of all L.A. Care functions necessary to support and scale up the Direct Network.	Under the guidance of the Direct Network Steering Committee, L.A. Care's Advanced Analytics Lab is consistently improving a multi-metric performance dashboard, embedding it with precise and actionable performance indicators. Key stakeholders from Health Services and Network Management within the Steering Committee will employ this dashboard to oversee performance and identify areas for enhancement. Additionally, these stakeholders are crafting

Mature and grow our Direct Network.	
Tactics	**Update**
	an action plan to ensure the dashboard's potential is fully harnessed, streamlining and prioritizing performance improvement initiatives.
Strategically address gaps in the Direct Network to meet all member needs countywide.	L.A. Care consistently oversees network adequacy on a monthly basis, adhering to established regulatory guidelines and standards. The joint efforts of the Network Management and Provider Data Services teams, in collaboration with our regulatory partners, ensure that any gaps in the network are promptly addressed through the submission of Alternative Access Standards requests. Network Adequacy is currently at 100%.
Increase access to virtual care by implementing L.A. Care's Virtual Specialty Care Program (V-SCP).	The pilot V-SCP just passed the one year mark. In Q4 FY 22-23, there were 11 eConsults submitted and no telehealth visits. Since the V-SCP program started last July, we have received a total of 82 eConsults submitted and four telehealth visits. We plan to continue the pilot and will also discuss what our next steps should be.

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.	• Two new quality performance reports were shared with the Direct Network in Q4 FY 22-23, including the Practice-level Provider Opportunity Report (POR) and the Capitated Claims Report. The Practice-level POR contains summaries at both the practice-level and Primary Care Provider (PCP)-level so providers can evaluate their performance relative to the Network. Report distribution began in July, and the report will be distributed on a (near) monthly basis. The Capitated Claims Report measures the volume and timeliness of primary care service claims submitted by non-Fee-for-Service Direct Network PCPs. They are adjudicated against capitation paid to PCPs and compare individual Direct Network PCP performance to the overall Direct Network PCP performance. Report distribution began in September, and will be distributed on a quarterly basis. • In August, Provider Contracts and Relationship Management Account Managers provided reformatted PORs and Quality Improvement resources to the top 18 Direct Network practices. Follow-up meetings with practices will be conducted to provide support in using the reports.

Improve our quality across products and providers.	
Tactics	**Update**
	• The Provider Engagement and Outreach Workgroup reviewed provider feedback from the June Physician Advisory Collaborative meeting including: provide more Quality Improvement and Health Information Exchange program information, provide more support for solo/ small group practices, and increase in-person interactions.
Exceed the DHCS Minimum Performance Level for all measures for Medi-Cal, achieve a four-star quality rating for L.A. Care Covered, and build the infrastructure to achieve a four-star quality rating for our D-SNP.	• L.A. Care Pharmacy staff is partnering with provider groups to conduct medication reviews. • Notified Plan Partners, PPGs, MSOs, and DHS about our supplemental and direct data submission guidance to close Healthcare Effectiveness Data and Information Set (HEDIS) gaps. • Conducted outreach calls to assist members in scheduling annual wellness visits and other needed appointments and tests. • Deployed provider-focused outreach to coordinate the fill of statin medications for members with diabetes or cardiovascular disease. • Text messaging campaigns launched to encourage healthcare visits and remind members about important preventive screenings. • Various social media campaigns deployed in August and September to encourage going to the doctor. #GetBacktoCare
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 have selected a vendor for the Clinical Data Repository Program. More design is needed around the data repositories but we have a solid set of steps in execution to wrap up the Race, Ethnicity, Language, and Sexual Orientation and Gender Identity projects.
Improve clinical performance for children's care.	• A second round of Well-Child Visit reminder calls for children ages 0-30 months launched in late September. • Two text messaging campaigns for children 0-30 months launched in August. The text messages provide health education on preventive care and reminders to complete well-child visits.

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 reporting eight optional clinical quality measures from their electronic health record software in addition to the three required measures. Transform L.A. is promoting the use of Health Information Exchanges (HIE) by encouraging qualified practices to apply for the one-time HIE Incentive program. **Help Me Grow LA:** Practices continued to work on incorporating developmental screening tools into their electronic medical record and to improve their referral processes. One Cohort Two practice successfully added a screening tool and the scoring calculation into their Electronic Medical Record. The practice can send the screener via the patient portal and text messaging to patients prior to their visit. **EQuIP-LA:** Equity & Quality for Independent Practices in L.A. County (EQuIP-LA) is a new practice transformation initiative provided to small/solo practices to support the equitable delivery of health care within independent practices in L.A. County for two years. Three of the four enrolled Direct Network practices are installing or upgrading their electronic health record software programs. 2022 baseline data for the three Healthcare Effectiveness Data and Information Set (HEDIS) measures was sourced from the L.A. Care Provider Opportunity Reports. One practice reported baseline HEDIS data from their Electronic Health Record software.
Provide practice coaching to support patient-centered care.	**Transform L.A.:** The number of Direct Network practices enrolled in Transform L.A. decreased to 20, with 107 providers and 33% of Direct Network members. Two practices enrolled in EQuIP-LA (see below) and one practice's Direct Network primary care contract expired. Eight practices report an average 17% improvement from baseline in Diabetes A1c Poor Control (>9%), 10 practices report an average 19% improvement from baseline in Controlling Blood Pressure. Transform L.A. is continuing to work with 10 practices to improve CIS-10 (Childhood Immunizations) from the 2022 overall baseline of 40.7%. **Help Me Grow LA:** Cohort One practices have increased screenings by 24% over baseline to 39% of patients seen. Cohort Two practices have increased screening by 2% over baseline (0%). Enrollment in the pilot has concluded with six practices participating. 47 of 60 planned early childhood development classes for the community and L.A. Care members have been completed. **EQuIP-LA:** The Equity & Quality for Independent Practices in L.A. County (EQuIP-LA) program launched in late June with the enrollment of four Direct Network practices. The practices have completed initial assessment of their capacity to improve the delivery of patient

Invest in providers and practices serving our members and the L.A. County safety net.	
Tactics	**Update**
	care and health outcomes. The 2022 baseline data for the three HEDIS measures: A1c >9% (Poor Control), Controlling Blood Pressure, and Colorectal Cancer Screening have been submitted to the Improvement Advisor partner. Quality improvement work is underway.
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 153 active providers totaling slightly more than $20.7 million in investment. There are currently 22 vacancies. **Provider Loan Repayment Program:** Of the 173 physicians awarded since 2018, there are currently 109 active loan repayment awards, including 93 new physician awardees and 16 physician award extensions. **Medical School Scholarship Program:** In July, during our annual Elevating the Safety Net celebration, L.A. Care announced eight new scholars who received admission to Charles R. Drew University and UCLA's medical school. With this most recent announcement, L.A. Care has now awarded a total of 48 scholars, 24 at CDU and 24 at UCLA, with full-tuition scholarships. **In-Home Supportive Services Training Program (IHSS) Center for Caregiver Advancement (CCA):** August marked the start of CCA's graduation ceremonies for the Trimester 19 cohort. This cohort had a total of 386 students who completed the L.A. Care training course that is offered through our CCA partners. The trimester 19 cohort has brought the overall total of IHSS Trained Providers to 6,349.
Utilize the Community Health Investment Fund (CHIF) to leverage opportunities for providers to increase quality and access to care.	Community Benefits invested more than two million dollars in 12 clinics to improve patient access and reduce health disparities by addressing workforce shortages as clinics prepare for Medi-Cal expansion in January 2024. In addition, we awarded a grant to implement a simulation center utilizing virtual reality technology to improve staff cultural competency, which enhances patient engagement, treatment adherence, and condition management.

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 has successfully expanded the network of community based organizations and other organizations who are providing Community Supports services to our members. We are currently on track to further expand our network with the launch of three new Community Supports services on January 1, 2024 (Asthma Remediation, Nursing Facility Transition/Diversion to Assisted Living, and Nursing Facility Transition/Diversion to Home). L.A. Care is in the planning process to launch both remaining Community Supports services by July 1, 2024 (Day Habilitation, Post-Hospitalization Short Term Housing). **Enhanced Care Management:** L.A. Care has increased our Enhanced Care Management (ECM) provider network by 14 providers, many of which serve the Children and Youth population of focus. This brings our current ECM network to 72 providers. With input from key stakeholders, we developed a new comprehensive ECM assessment designed to meet the needs of the new Children and Youth populations of focus. L.A. Care is currently preparing to add two new populations in 2024, Birth Equity and Justice Involved. We are engaging with key stakeholders for these populations to utilize their expertise in the development of our Model of Care. We are also engaging with community based providers who serve pregnant/postpartum, and justice involved individuals to be a referral source and potentially join our ECM network. L.A. Care continues to work closely with the other regional Managed Care Plans to align as much as possible on our ECM network and processes.
Ensure CalAIM Population Health Management (PHM) requirements are met.	• Submitted CalAIM PHM Key Performance Indicators in August 2023. • The Initial Health Appointment (IHA) All Plan Letter (APL) 22-030 has been released. The IHA P4P is being updated. Provider and staff training have been updated and will be available on the Learning Management System. • The Annual Cognitive Health Assessment APL 22-025 has been released. Both the P&P and operational procedures have been finalized and implemented for provider training, reports, and payment structure.

Operate all components of California Advancing and Innovating Medi-Cal (CalAIM) as they are launched.	
Tactics	**Update**
Monitor and establish infrastructure for longer-term CalAIM initiatives.	CalAIM's Benefit Standardization includes Long Term Care Carve In, Intermediate Care Facility – Developmental Disabled Carve In, and Pediatric Sub-Acute Carve In. For Coordinated Care Initiative Counties, Long Term Care benefit has been carved in since 2014. DHCS released ICF-DD guidance in August 2023 and business units are in the process of setting up requirements and are on track for January 1, 2024 go-live.

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.	Transitional Care Services under Population Health Management for Care Managers was launched to provide enhanced support to high-risk members admitting to and discharging from inpatient settings. Additionally, there was a 35% increase in Direct Network cases opened in Care Management (CM) in Q4, compared to Q3. CM Community Health Workers (CHWs) continued to conduct field visits with members in CM while addressing member's social needs through CalAIM Community Supports services and other community-based resources. Additionally, CHWs participated in the "Fight the Flu" campaign to support CM members with understanding COVID-19 and the importance of accessing other vaccinations. Finally, the CHWs have worked closely with the Community Resource Center staff to support sponsored drives and events for members and the community at large.
Expand upon our progress with palliative care and add other end-of-life services.	Palliative Care services continue to expand with ongoing educational webinars and partnerships with internal and external stakeholders to increase awareness of the program. In preparation for the Palliative Care expansion to D-SNP in January 2024, training materials have been updated to include this population. Managed Long Term Services and Supports has partnered with Medicare Product team in conducting educational webinars that focus on D-SNP.

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.	L.A. Care hosted a L.A. County Health Equity Officers meeting in August with representatives from Blue Shield/Promise, Cedars Sinai, DHS, DPH, Molina, UCLA. Individuals discussed their organization's health equity priorities, barriers and explored opportunities to work together. This group plans to continue to meet quarterly. Health Equity department visited the Pomona Community Resource Center in August to better understand the community health and social service needs. Ten of the 16 Member Equity Council goals were completed, including: obtaining feedback from the consumer health equity council, provider trainings for social determinants of health, gun violence prevention efforts, COVID vaccination activities, analysis of new health equity questions added to The Clinician and Group Consumer Assessment of Healthcare Providers and Systems survey, creation of health equity assessment tool, release of Advancing Economic Mobility I grant, and collection of required member Sexual Orientation Gender Identity data. Five goals are in progress, in which four will be completed after the fiscal year (Nov. 2023 and Jan. 2024). One measure was not met – HEDIS rates for timeliness of prenatal care for the Black/African American women measure. Community Benefits has deepened its partnership with 12 trusted community based organizations to create pathways to long-term sustainable funding, such as contracts with billable entities and other enduring funding sources through which they can further mitigate the impact of historic injustices the populations they serve have endured. The seventh cycle of grants to improve food security through CalFresh enrollment and benefits maintenance was approved in July for the California Association of Food Banks, with an opportunity for two additional years of support.
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. • 11 Black/African American L.A. Care Covered members with diabetes received eight weeks of Medically Tailored Meals and follow-up support from an L.A. Care Registered Nurse. Enrollment is ongoing in the program. • L.A. Care is making more health reminder calls in languages other than English and Spanish.

Ensure that the services we provide to members promote equity and are free of implicit and explicit bias.	
Tactics	**Update**
	• Cumulatively up to August 2023, 33.4% of outreached members enrolled in the postpartum campaign, and 27.6% of members reported completing their postpartum exam, while 28.1% of Black/ African American outreached members enrolled in the prenatal campaign program. • LACC members are now included in the Prenatal/PPC-1 and Postpartum/PPC-2 texting campaigns. • We continue to expand the doula network. L.A. Care is currently contracted with one doula organization called The Doula Network and working under an Letter of Agreement with Birth Workers of Color Collective as well as two independent doulas. The doula benefit standing order process has been approved and members can now be directly connected to services via the provider directory. L.A. Care has served 32 members to date. All doula services were allocated by The Doula Network organization. • Three new member educational materials were added to the trimester specific pregnancy mailing, distributed to approximately 80 pregnant members monthly. The topics for the new materials are: Pregnancy Vaccines, The Doula Benefit flyer, and Sexually Transmitted Infections. The non-trimester member mailing will include these new materials and is distributed to approximately 800 pregnant members monthly.
Implement initiatives to promote diversity among providers, vendors, and purchased services.	We have added diversity language to the Request for Proposal (RFP) questionnaire to bidders, and the updated language has been included in recent RFP releases. Work is still in progress for including diversity language on the RFP page on the L.A. Care external site and RFP materials such as the RFP Notice, scorecard, and training deck; these efforts are targeted to be completed in Q1 of the fiscal year. The Provider Equity Council would like to expand the definition of “provider” by recognizing the efforts of community-based organizations as well for the Provider Equity Award. The Provider Equity Award will continue to be part of the annual Provider Recognition Awards Ceremony.
Offer providers Diversity, Equity, and Inclusion resources to promote bias-free care.	In August, 206 attendees participated in our second Social Determinants of Health (SDOH) provider training. The purpose of the training was to provide an overview of SDOH Z codes and reasons for collecting this information including improvements in member data capture. L.A. Care is meeting and coordinating with internal departments as well as with our Plan Partners and other local health plans on the finalized DHCS APL, 23-025, Diversity Equity and Inclusion Training Plan.

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.	In September, the Los Angeles Times published an opinion piece proposing a public option for California, citing L.A. Care as a successful example. The authors cited that L.A. Care's low premium costs spurred competition that resulted in premium declines, which did not occur in the rest of the state.
Provide expertise and assistance to other public plans interested in participating in state exchanges.	Inland Empire Health Plan has entered the Covered California marketplace for 2024, serving the Riverside/San Bernardino regions. L.A. Care shared our experience and served as a resource throughout the process.

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.	West L.A. and Panorama City Community Resource Centers completed. Construction continues on South L.A. and Lincoln Heights sites.
Partner with community-based organizations to offer a range of services onsite.	Implemented a new hypertension management pilot program with American Heart Association at two Community Resource Centers.

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.	In addition to the partnerships mentioned in other Vision 2024 updates, the other ongoing collaborations include those with Charles Drew University and Los Angeles Unified School District on vaccine equity.
Support regional Health Information Exchanges (HIE).	L.A. Care actively promotes regional Health Information Exchanges (HIEs) by utilizing federal and state interoperability regulations. We encourage contracted hospitals to participate in the HIE and incentivize IPAs as well as hospitals to meaningfully utilize HIEs through introduction of the HIE Participation Measure. Additionally, L.A. Care closely collaborates with the L.A. County IT/Data Advisory Group and provides funding opportunities to enhance the technical infrastructure of community organizations and foster interoperability through the Incentive Payment Program. We launched a one-time HIE Adoption incentive for providers to further enhance HIE adoption and support their participation in the California Health and Human Services Agency Data Exchange Framework. These adoption incentives will be available from October 2023 – September 2026.
Create a deliberate and tailored strategy to address homelessness among our members.	The Housing Initiatives team has made significant progress on key initiatives. Regarding Housing and Homelessness Incentive Program (HHIP), we have made significant progress toward our goal of earning full points for HHIP Measurement Period II, which ends on October 31. We project our earnings to be a very high percentage of total available funds for this period. With Homeless and Housing Support Services (HHSS) and Street Medicine, we brought on three new key staff who will be instrumental in helping us achieve our long term goals. In HHSS, we have completed certification application processes for seven new HHSS providers and will be onboarding them in Q1 FY 23-24. We have also worked consistently toward completion of a draft contract for Street Medicine services and we anticipate completing that in Q1 FY 23-24 as well.

Final 2023 Legislative Matrix

Last Updated: October 16, 2023

Bills by Issue

2023 Legislation (33)

Bill Number	Status	Position
AB 102	**Enacted**	**Monitor**

Title
Budget Act of 2023.

Description
AB 102, Ting. Budget Act of 2023. The Budget Act of 2023 made appropriations for the support of state government for the 2023–24 fiscal year.This bill would amend the Budget Act of 2023 by amending, adding, and repealing items of appropriation and making other changes.This bill would declare that it is to take effect immediately as a Budget Bill.

Primary Sponsors
Phil Ting

Bill Number	Status	Position
AB 103	**Enacted**	**Monitor**

Title
Budget Acts of 2021 and 2022.

Description
AB 103, Ting. Budget Acts of 2021 and 2022. The Budget Act of 2021 and Budget Act of 2022 made appropriations for the support of state government for the 2021–22 and 2022–23 fiscal years. This bill would amend the Budget Act of 2021 and Budget Act of 2022 by amending and adding items of appropriation and making other changes. The bill would declare that it is to take effect immediately as a Budget Bill.

Primary Sponsors
Phil Ting

Bill Number	Status	Position
AB 112	**Enacted**	**Monitor**

Title
Distressed Hospital Loan Program.

Description
AB 112, Committee on Budget. 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 the Department of Health Care Access and Information to administer the program and would require the department to enter into an interagency agreement with the authority to implement the program. The bill would require the department, in collaboration with the State Department of Health Care Services, the Department of Managed Health Care, and the State Department of Public Health, to develop a methodology to evaluate an at-risk hospital's potential eligibility for state assistance from the program, as specified. The bill would require a hospital or a closed hospital to provide the authority and the department with financial information 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 an application and approval process for loan forgiveness or modification of loan terms, as specified.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. The bill would authorize the Department of Finance to transfer funds from the General Fund to the Distressed Hospital Loan Program Fund between state fiscal years 2022–23 and 2023–24 to implement the bill, as specified. The bill would authorize the department and the authority to require any hospital receiving a loan under the program to provide the department and the authority with an independent financial audit of the hospital's operations for any fiscal year in which a loan is outstanding. The bill would abolish the fund on December 31, 2031, and would require any remaining balance, assets, liabilities, and encumbrances of the fund to revert to the General Fund. By creating a continuously appropriated fund, the ... (click bill link to see more).

Primary Sponsors
House Budget Committee

Bill Number	Status	Position
AB 118	**Enacted**	**Monitor**

Title
Budget Act of 2023: health.

Description
AB 118, Committee on Budget. Budget Act of 2023: health.
(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 requires a health care service plan to provide disclosures regarding the benefits, services, and terms of the plan contract, as specified, to provide the public, subscribers, and enrollees with a full and fair disclosure of the provisions of the plan.This bill would require the department to develop standard templates for the disclosure form and evidence of coverage, to include, among other things, standard definitions, benefit descriptions, and any other information that the director determines, consistent with the goals of providing fair disclosures of the provisions of a health care service plan. The bill would require the department to consult with the Department of Insurance and interested stakeholders in developing the standard templates. The bill would require health care service plans, beginning January 1, 2025, to use the standard templates for any disclosure form or evidence of coverage published or distributed, except as specified. Because a willful violation of these requirements is a crime, the bill would impose a state-mandated local program.This bill would authorize the department to develop standard templates for a schedule of benefits, an explanation of benefits, a cost-sharing summary, or any similar document. The bill would authorize the department to require health care service plans to use the standard templates, except as specified, and would authorize the director to require health care service plans to submit forms the health care service plan created based on the department's templates for the purpose of compliance review. The bill would additionally specify that the department may implement these provisions by issuing and modifying templates and all-plan letters or similar instructions, without taking regulatory action. The bill would also update cross-references in various provisions.
(2) Existing law requires a health care service plan contract or disability insurance policy to cover mental health and substance use disorder treatment, including medically necessary treatment of a mental health or substance use disorder provided by an in-network or out-of-network 988 center or mobile crisis team. Existing law prohibits a health care service plan or insurer from requiring prior authorization for medically necessary treatment of a mental health or substance use disorder provided by a 988 center or mobile crisis team.This bill would instead specify that mental health and substance use disorder trea... (click bill link to see more).

Primary Sponsors
House Budget Committee

Bill Number	Status	Position
AB 119	**Enacted**	**Monitor**

Title
Medi-Cal: managed care organization provider tax.

Description
AB 119, Committee on Budget. Medi-Cal: managed care organization provider tax. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, one of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care plans.Existing law, 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.This bill would repeal those inoperative provisions. The bill would restructure the MCO provider tax, with certain modifications to the above-described provisions, including changes to the taxing tiers and tax amounts, for purposes of the tax periods of April 1, 2023, through December 31, 2023, and the 2024, 2025, and 2026 calendar years. The bill would create the Managed Care Enrollment Fund to replace the Health Care Services Special Fund. Under the bill, moneys deposited into the fund would, upon appropriation, be available to the department for the purpose of funding the following subcomponents to support the Medi-Cal program: (1) the nonfederal share of increased capitation payments to Medi-Cal managed care plans; (2) the nonfederal share of Medi-Cal managed care rates for health care services; and (3) transfers to the Medi-Cal Pro... (click bill link to see more).

Primary Sponsors
House Budget Committee

Bill Number	Status	Position
AB 120	**Enacted**	**Monitor**

Title
Human services.

Description
AB 120, Committee on Budget. Human services. (1) Existing law, the California Community Care Facilities Act, provides for the licensing and regulation of community care facilities, including group home facilities, short-term residential therapeutic programs (STRTPs), and adult residential facilities (ARFs), by the State Department of Social Services. Under existing law, the department similarly regulates residential care facilities for the elderly. A violation of provisions relating to these facilities is a misdemeanor. Existing law requires administrators of these facilities, with specified exemptions, to complete a department-approved certification program, uniformly referred to as administrator certification training programs. Under existing law, these programs require a specified minimum number of hours, depending on the facility type, of classroom instruction that provides training on a uniform core of knowledge in specified areas. Existing law also requires administrator certificates to be renewed every 2 years, conditional upon the certificate holder submitting documentation of a specified number of hours of continuing education, based on the facility type. Existing law permits up to one-half of the required continuing education hours to be satisfied through online courses, and the remainder to be completed in a classroom instructional setting, as prescribed.This bill would revise those provisions by deleting the classroom instruction requirement for initial certification and continuing education purposes, and instead would require instruction that is conducive to learning and allows participants to simultaneously interact with each other as well as with the instructor. The bill would authorize up to one-half of continuing education hours to be satisfied through self-paced courses, rather than online courses. The bill would make various conforming changes.Existing law authorizes the department to license as ARFs, subject to specified conditions, adult residential facilities for persons with special health care needs (ARFPSHNs), which provide 24-hour services to up to 5 adults with developmental disabilities who have special health care and intensive support needs, as defined. Existing law requires the department to ensure that an ARFPSHN meets specified administrative requirements, including requirements related to fingerprinting and criminal records.This bill additionally would require an ARFPSHN to meet the administrator certification requirements of an ARF, including, but not limited to, completing a department-approved administrator certification training program requiring a designated minimum number of hours of instruction conducive to learning, in which participants are able to simultaneously interact wi... (click bill link to see more).

Primary Sponsors
House Budget Committee

Bill Number	Status	Position
AB 129	**Enacted**	**Monitor**

Title
Housing.

Description
AB 129, Committee on Budget. Housing. (1) Existing law establishes the Department of Housing and Community Development (HCD) in the Business, Consumer Services, and Housing Agency for purposes of carrying out state housing policies and programs, and creates in HCD the California Housing Finance Agency.This bill would remove the California Housing Finance Agency from within HCD. This bill would continue the existence of the California Housing Finance Agency in the Business, Consumer Services, and Housing Agency.This bill would also make technical, conforming changes and would delete obsolete references.(2) Existing federal law authorizes the United States Secretary of Agriculture to extend financial assistance through multifamily housing direct loan and grant programs to serve very low, low-, and moderate-income households, including, among other programs, Section 515 Rural Rental Housing Loans, which are mortgages to provide affordable rental housing for very low, low-, and moderate-income families, elderly persons, and persons with disabilities.Existing law establishes a low-income housing tax credit program pursuant to which the California Tax Credit Allocation Committee provides procedures and requirements for the allocation, in modified conformity with federal law, of state insurance, personal income, and corporation tax credit amounts to qualified low-income housing projects that have been allocated, or qualify for, a federal low-income housing tax credit and farmworker housing. Existing law requires not less than 20% of the low-income housing tax credits available annually to be set aside for allocation to rural areas. Existing law defines “rural area” for purposes of the low-income housing tax credit program as an area, which, on January 1 of any calendar year, satisfies any number of certain criteria, including being eligible for financing under the Section 515 program, or successor program, of the United States Department of Agriculture Rural Development. This bill would expand the above-described criteria relating to Section 515 eligibility to instead include eligibility for financing under a multifamily housing program, as specified, or successor program, of the United States Department of Agriculture Rural Development. Existing law also includes in the definition of “rural area” an unincorporated area that adjoins a city having a population of 40,000 or less, provided that the city and its adjoining unincorporated area are not located within a census tract designated as an urbanized area by the United States Census Bureau.This bill would revise the definition of “rural area” to include an unincorporated area that adjoins a city having a population of 40,000 or less, provided that the unincorporated area i... (click bill link to see more).

Primary Sponsors
House Budget Committee

Bill Number	Status	Position
AB 254	**Enacted**	**Monitor**

Title

Confidentiality of Medical Information Act: reproductive or sexual health application information.

Description

AB 254, 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 about a consumer's reproductive or sexual health collected by a reproductive or sexual health digital service, as specified. 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.This bill would incorporate additional changes to Section 56.05 of the Civil Code proposed by AB 1697 to be operative only if this bill and AB 1697 are enacted and this bill is enacted last.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, Dawn Addis, Laura Friedman

Bill Number	Status	Position
AB 317	**Enacted**	**Monitor**

Title
Pharmacist service coverage.

Description
AB 317, 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	Status	Position
AB 352	**Enacted**	**Monitor**

Title
Health information.

Description
AB 352, 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 gender affirming care, abortion and abortion-related services, and contraception, 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 se... (click bill link to see more).

Primary Sponsors
Rebecca Bauer-Kahan

Bill Number	Status	Position
AB 425	**Enacted**	**Monitor**

Title
Medi-Cal: pharmacogenomic testing.

Description
AB 425, 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, commencing on July 1, 2024, 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.The bill would condition implementation of this benefit coverage on receipt of any necessary federal approvals and the availability of federal financial participation. The bill would authorize the department to implement these provisions through all-county letters or similar instructions.The bill would also make related legislative findings.

Primary Sponsors
David Alvarez

Bill Number	Status	Position
AB 531	**Enacted**	**Monitor**

Title
The Behavioral Health Infrastructure Bond Act of 2023.

Description
AB 531, Irwin. The Behavioral Health Infrastructure Bond Act of 2023. Existing law establishes the Multifamily Housing Program administered by the Department of Housing and Community Development. Existing law requires assistance for projects under the program to be provided in the form of deferred payment loans to pay for eligible costs of specified types of development, as provided. Existing law requires that specified funds appropriated to provide housing for individuals and families who are experiencing homelessness or who are at risk of homelessness and who are inherently impacted by or at increased risk for medical diseases or conditions due to the COVID-19 pandemic or other communicable diseases be disbursed in accordance with the Multifamily Housing Program for specified uses.The California Environmental Quality Act (CEQA) requires a lead agency, as defined, to prepare, or cause to be prepared, and certify the completion of, an environmental impact report on a project that it proposes to carry out or approve that may have a significant effect on the environment or to adopt a negative declaration if it finds that the project will not have that effect. CEQA does not apply to the approval of ministerial projects. Existing law, until July 1, 2024, exempts from CEQA a project funded to provide housing for individuals and families who are experiencing homelessness, as described above, if certain requirements are satisfied, including if the project proponent obtains an enforceable commitment to use a skilled and trained workforce for any proposed rehabilitation, construction, or major alterations, as specified.This bill would provide that projects funded by the Behavioral Health Infrastructure Bond Act of 2024 that provide housing for individuals and families who are experiencing homelessness or who are at risk of homelessness and who are inherently impacted by or at increased risk for medical diseases or conditions due to the COVID-19 pandemic or other communicable diseases and are disbursed in accordance with the Multifamily Housing Program, or projects that are disbursed in accordance with the Behavioral Health Continuum Infrastructure Program, are a use by right and subject to the streamlined, ministerial review process. The bill would define use by right for these purposes to mean that the local government's review of the project does not require a conditional use permit, planned unit development permit, or other discretionary local government review or approval that would constitute a project subject to the approval process in CEQA.Because the bill would revise the approval process of specified projects, the bill would impose a state-mandated local program.Existing law authorizes the State Department of Health ... (click bill link to see more).

Primary Sponsors
Jacqui Irwin, Susan Eggman, Richard Roth

Bill Number	Status	Position
AB 557	**Enacted**	**Monitor**

Title
Open meetings: local agencies: teleconferences.

Description
AB 557, 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 the legislative body of 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. Those circumstances are that (1) state or local officials have imposed or recommended measures to promote social distancing, (2) the legislative body is meeting for the purpose of determining whether, as a result of the emergency, meeting in person would present imminent risks to the health or safety of attendees, or (3) the legislative body has previously made that determination. 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 th... (click bill link to see more).

Primary Sponsors
Gregg Hart

Bill Number	Status	Position
AB 614	**Enacted**	**Monitor**

Title
Medi-Cal.

Description
AB 614, 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 require the director, prior to issuing a new request for proposal or entering into new contracts, to provide an opportunity for interested stakeholders to provide input to inform the development of contract provisions.The bill would also make technical changes to some of the provisions described above.

Primary Sponsors
Jim Wood

Bill Number	Status	Position
AB 659	**Enacted**	**Monitor**

Title
Cancer Prevention Act.

Description
AB 659, 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 that pupils in the state are advised to adhere to current immunization guidelines, as recommended by specified health entities, regarding full human papillomavirus (HPV) immunization 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 adhere to current HPV immunization guidelines before admission or advancement to the 8th grade level, as specified. The bill would require that the notification also include a statement containing certain health information. The bill would incorporate that notification into existing provisions relating to notifications by school districts. 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 advised to adhere to current immunization guidelines, as specified, regarding full HPV immunization 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 wil... (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	Status	Position
AB 663	**Enacted**	**Monitor**

Title
Pharmacy: mobile units.

Description
AB 663, 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 instead authorize a county, city and county, or special hospital authority to operate one or more mobile units as an extension of a pharmacy license held by the county, city and county, or special hospital authority, as described above. The bill would require the pharmacist-in-charge to determine the number of mobile units that are appropriate for a particular pharmacy license. The bill would additionally authorize a mobile unit to provide prescription medication within its jurisdiction to city-and-county-operated housing facilities.This bill would exempt from the above-described 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.Existing law requires a city, city and county, or special hospital authority, at least 30 days before commencing operation of a mobile unit, to notify the board of its intention to operate a mobile unit. Existing law further requires that the board be given notice at least 30 days before discontinuing operation of a mobile unit.This bill would instead require a county, city and county, or special hospital authority to notify the board of its intention to operate a mobile unit as soon as possible, and no later than 5 business days after commencing operation of a mobile unit. The bill would a... (click bill link to see more).

Primary Sponsors
Matt Haney

Bill Number	Status	Position
AB 712	**Enacted**	**Support**

Title
CalFresh: hot and prepared foods.

Description
AB 712, 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

Organizational Notes

Last edited by Joanne Campbell at Jun 6, 2023, 3:17 PM
California Association of Food Banks (co-sponsor), GRACE/End Child Poverty CA (co-sponsor)

Bill Number	Status	Position
AB 716	**Enacted**	**Monitor**

Title
Ground medical transportation.

Description
AB 716, Boerner. 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 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 sending to collections a higher amount, would limit the amount an enrollee or insured owes a noncontracting ground ambulance provider to no more than the in-network cost-sharing 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 directly reimburse a noncontracting ground ambulance provider for ground ambulance services the difference between the in-network cost-sharing amount and an amount described, as specified, 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 ... (click bill link to see more).

Primary Sponsors
Tasha Boerner Horvath

Organizational Notes

Last edited by Joanne Campbell at Jul 14, 2023, 6:35 PM
California Association of Health Plans - Oppose

Bill Number
AB 816

Status
Enacted

Position
Monitor

Title
Minors: consent to medical care.

Description
AB 816, 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 at a physician's office, clinic, or health facility, by a licensed physician and surgeon or other health care provider, as specified, whether or not the minor also has the consent of their parent or guardian. The bill would authorize a minor 16 years of age or older to consent to any other medications for opioid use disorder from a licensed narcotic treatment program as replacement narcotic therapy without the consent of the minor's parent or guardian only if, and to the extent, expressly permitted by federal law.

Primary Sponsors
Matt Haney

Bill Number
AB 904

Status
Enacted

Position
Monitor

Title
Health care coverage: doulas.

Description
AB 904, 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. Under the bill, a Medi-Cal managed care plan would satisfy that requirement by providing coverage of doula services so long as doula services are a Medi-Cal covered benefit. The bill would require the Department of Managed Health Care, in consultation with the Department of Insurance, to collect data and submit a report describing the 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 948	**Enacted**	**Monitor**

Title
Prescription drugs.

Description
AB 948, 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 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 requires a health care service plan contract or health insurance policy for a nongrandfathered individual or small group product that maintains a drug formulary grouped into tiers, and that includes a 4th tier, to define each tier of the drug formulary, as specified. Existing law defines Tier 4 to include, among others, drugs that are biologics. Existing law repeals these provisions on January 1, 2024.This bill would delete drugs that are biologics from the definition of Tier 4. The bill would require a health care service plan or a health insurer, if there is a generic equivalent to a brand name drug, to ensure that an enrollee or insured is subject to the lowest cost sharing that would be applied, whether or not both the generic equivalent and the brand name drug are on the formulary. The bill also would delete the January 1, 2024, repeal date of the above 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	**Enacted**	**Monitor**

Title
Dental coverage disclosures.

Description
AB 952, 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, including a specialized health care service plan or specialized health insurer covering dental services, to disclose whether an enrollee's or insured's dental coverage is "State Regulated" through a provider portal, if available, or otherwise upon request, on or after January 1, 2025. The bill would require a plan or insurer to include the statement "State Regulated," if the enrollee's or insured's dental coverage is subject to regulation by the appropriate department, on an electronic or physical identification card, or both if available, for contracts covering dental services issued on or after January 1, 2025. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.This bill would provide that no reimbursement is required by this act for a specified reason.

Primary Sponsors
Jim Wood

Bill Number	Status	Position
AB 988	**Enacted**	**Monitor**

Title
Miles Hall Lifeline and Suicide Prevention Act: veteran and military data reporting.

Description
AB 988, 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	Status	Position
AB 1241	**Enacted**	**Monitor**

Title
Medi-Cal: telehealth.

Description
AB 1241, 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 and follow protocols 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	Status	Position
SB 311	**Enacted**	**Support**

Title
Medi-Cal: Part A buy-in.

Description
SB 311, 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 department, 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 enter into a Medicare Part A buy-in agreement, as defined, for qualified Medicare beneficiaries with the federal Centers for Medicare and Medicaid Services by submitting a state plan amendment. Under the bill, the buy-in agreement would be effective on January 1, 2025, or the date the department communicates to the Department of Finance in writing that systems have been programmed for implementation of these provisions, whichever date is later.The bill would authorize the department to implement these provisions through all-county letters or similar instructions until regulations are adopted. Under the bill, these provisions would be implemented only to the extent that any necessary federal approvals are obtained and that federal financial participation is available and is not otherwise jeopardized.To the extent that the bill would increase duties for counties, 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

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 326	**Enacted**	**Monitor**

Title
The Behavioral Health Services Act.

Description
**SB 326, Eggman. The Behavioral Health Services Act.
(1) 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, funds a system of county mental health plans for the provision of mental health services. 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. Existing law authorizes the Legislature to add provisions to clarify procedures and terms of the MHSA by majority vote.If approved by the voters at the March 5, 2024, statewide primary election, this bill would recast the MHSA by, among other things, renaming it the Behavioral Health Services Act (BHSA), expanding it to include treatment of substance use disorders, changing the county planning process, and expanding services for which counties and the state can use funds. The bill would revise the distribution of MHSA moneys, including allocating up to $36,000,000 to the department for behavioral health workforce funding. The bill would authorize the department to require a county to implement specific evidence-based practices.This bill would require a county, for behavioral health services eligible for reimbursement pursuant to the federal Social Security Act, to submit the claims for reimbursement to the State Department of Health Care Services (the department) under specific circumstances. The bill would require counties to pursue reimbursement through various channels and would authorize the counties to report issues with managed care plans and insurers to the Department of Managed Health Care or the Department of Insurance.The MHSA establishes the Mental Health Services Oversight and Accountability Commission and requires it to adopt regulations for programs and expenditures for innovative programs and prevention and early intervention programs established by the act. Existing law requires counties to develop plans for innovative programs funded under the MHSA.This bill would rename the commission the Behavioral Health Services Oversight and Accountability Commission and would change the composition and duties of the commission, as specified. The bill would delete the provisions relating to innovative programs and instead would require the counties to establish and administer a program to provide housing interventions. The bill would provide that “low rent housing project,” as defined, does not apply to a project that meets specified criteria.This bill would make extensive technical and conforming changes.(2) Existing law, the Bronzan-McCorquodale Act, contains provisions governing the operation and financing of community mental health services for pers... (click bill link to see more).**

Primary Sponsors
Susan Eggman

Bill Number	Status	Position
SB 348	**Enacted**	**Support**

Title
Pupil meals.

Description
SB 348, Skinner. Pupil meals. (1) Existing law establishes a system of public elementary and secondary schools in this state. This system is composed of 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. 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 each school district, county superintendent of schools, and charter school to make available a nutritionally adequate breakfast, as defined, and a nutritionally adequate lunch, as defined, free of charge during each schoolday, as defined, 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. The bill would require each school district, county office of education, or charter school that offers independent study to meet the above meal requirements for any pupil on any schoolday that the pupil is scheduled for educational activities, as provided. The bill would require the State Department of Education to submit a waiver request to the United States Department of Agriculture to allow for one meal to be provided during a schoolday lasting 4 hours or less to be served in a noncongregate manner. The bill would authorize each school district, county superintendent of schools, and charter school to make available either a nutritionally adequate breakfast or a nutritionally adequate lunch, as defined, in a noncongregate manner, as provided, if the State Department of Education receives approval for the federal noncongregate waiver. The bill would require each school district, county superintendent of schools, and charter school to provide pupils with adequate time ... (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	Status	Position
SB 496	**Enacted**	**Monitor**

Title
Biomarker testing.

Description
SB 496, Limón. Biomarker testing. (1) Existing law, the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law 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, 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 medically necessary biomarker testing, as prescribed, 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, 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 or denied 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. 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 the Medi-Cal schedule of benefits to include biomarker testing, as prescribed, for the purposes of diagnosis, treatment, appropriate management, or ... (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	Status	Position
SB 502	**Enacted**	**Monitor**

Title
Medi-Cal: children: mobile optometric office.

Description
SB 502, 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.Existing federal CHIP provisions require federal payment to a state with an approved child health plan for expenditures for health services initiatives (HSI) under the plan for improving the health of children, as specified. As part of limitations on expenditures not used for Medicaid or health insurance assistance, existing federal law, with exceptions, prohibits the amount of payment that may be made for a fiscal year for HSI expenditures and other certain costs from exceeding 10% of the total amount of CHIP expenditures, as specified.Pursuant to existing state 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 California State Board of Optometry.This bill would require the department to file all necessary state plan amendments to exercise the HSI 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. Under the bill, the federal financial particip... (click bill link to see more).

Primary Sponsors
Ben Allen

Bill Number	Status	Position
SB 525	**Enacted**	**Monitor**

Title
Minimum wages: health care workers.

Description
SB 525, Durazo. Minimum wages: 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 establish 5 separate minimum wage schedules for covered health care employees, as defined, depending on the nature of the employer.This bill would require, for any covered health care facility employer, as defined, with 10,000 or more full-time equivalent employees (FTEE), as defined, any covered health care facility employer that is a part of an integrated health care delivery system or a health care system with 10,000 or more FTEEs, a covered health care facility employer that is a dialysis clinic or is a person that owns, controls, or operates a dialysis clinic, or a covered health facility owned, affiliated, or operated by a county with a population of more than 5,000,000 as of January 1, 2023, the minimum wage for covered health care employees to be $23 per hour from June 1, 2024, to May 31, 2025, inclusive, $24 per hour from June 1, 2025, to May 31, 2026, inclusive, and $25 per hour from June 1, 2026, and until as adjusted as specified.This bill would require, for any hospital that is a hospital with a high governmental payor mix, an independent hospital with an elevated governmental payor mix, a rural independent covered health care facility, or a covered health care facility that is owned, affiliated, or operated by a county with a population of less than 250,000 as of January 1, 2023, as those terms are defined, the minimum wage for covered health care employees to be $18 per hour from June 1, 2024, to May 31, 2033, inclusive, and $25 per hour from June 1, 2033, and until as adjusted as specified.This bill would require, for specified clinics that meet certain requirements, the minimum wage for covered health care employees to be $21 per hour from June 1, 2024, to May 31, 2026, inclusive, and $22 per hour from June 1, 2026, to May 31, 2027, inclusive, and $25 from June 1, 2027, and until as adjusted as specified.This bill would require, for all other covered health care facility employers, the minimum wage for covered health care employees to be $21 per hour from June 1, 2024, to May 31, 2026, inclusive, $23 per hour from June 1, 2026, to May 31, 2028, inclusive, and $25 per hour from June 1, 2028, and until as adjusted as specified. This bill would provide that a covered health care facility that is county owned, affiliated, or operated must implement the appropriate minimum... (click bill link to see more).

Primary Sponsors
Maria Durazo

Bill Number	Status	Position
SB 621	**Enacted**	**Monitor**

Title
Health care coverage: biosimilar drugs.

Description
SB 621, 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, but requires a plan or insurer to expeditiously grant a step therapy exception request if specified criteria are met. 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, but that the requirement to try biosimilar, generic, and interchangeable drugs does not prohibit or supersede a step therapy exception request.

Primary Sponsors
Anna Caballero

Bill Number	Status	Position
SB 770	**Enacted**	**Monitor**

Title
Health care: unified health care financing.

Description
SB 770, 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 system.This bill would direct the Secretary of the California Health and Human Services Agency to research, develop, and pursue discussions of a waiver framework in consultation with the federal government with the objective of a health care 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 engage specified stakeholders to provide input on topics related to discussions with the federal government and key design issues, as specified. The bill would require the secretary, no later than January 1, 2025, to provide an interim report to specified committees of the Legislature and propose statutory language to the chairs of those committees authorizing the development and submission of applications to the federal government for waivers necessary to implement a unified health care financing system. The bill would require the secretary, no later than June 1, 2025, to complete drafting the waiver framework, make the draft available to the public on the agency's internet website, and hold a 45-day public comment period thereafter. The bill would require the secretary, no later than November 1, 2025, to provide the Legislature and the Governor with a report that communicates the finalized waiver framework, as specified, and sets forth the specific elements to be included in a formal waiver application to establish a unified health care financing system, as specified. 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
HR 3068	**In House**	**Support**

Title
Equal Health Care for All Act

Primary Sponsors
Adam Schiff

September 2023
Grants & Sponsorships Report
October 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	**Golden Future Expos Inc.**	Golden Future 50+ Senior Expo	9/5/2023	Sponsorship	$ -	$ 15,000	$ 18,500
2	**Alzheimer's Los Angeles**	Making Memories Festival	9/5/2023	Sponsorship	$ -	$ 5,000	$ 5,000
3	**Institute for High Quality Care**	2023 Quality Improvement Summit	9/5/2023	Sponsorship	$ -	$ 5,000	$ 5,000
4	**KJLH**	Taste of Soul	9/5/2023	Sponsorship	$ -	$ 25,000	$ 55,000
5	**Student Health SVCS Support Fund**	Salute to Student Health Awards	9/5/2023	Sponsorship	$ -	$ 5,000	$ 5,000
6	**Project Angel Food**	Angel Awards	9/5/2023	Sponsorship	$ -	$ 20,000	$ 220,000
7	**California Association of Health Plans**	CAHP's 37th Annual Conference	9/12/2023	Sponsorship	$ -	$ 6,000	$ 11,000
8	**AltaMed Foundation**	2nd Annual AltaMed Tardeada	9/12/2023	Sponsorship	$ -	$ 5,000	$ 5,000
9	**KHEIR**	Kheir's 37th Anniversary Fundraising Gala	9/12/2023	Sponsorship	$ -	$ 6,000	$ 6,000
10	**Vision y Compromiso**	Vision y Compromiso Annual Conference	9/13/2023	Sponsorship	$ -	$ 14,600	$ 14,600
11	**California Association for Adult Day Services**	CAADS 2023 Fall Conference	9/25/2023	Sponsorship	$ -	$ 2,000	$ 2,000
12	**Los Angeles Rams Foundation**	Los Angeles Rams x L.A. Care Health Plan Thanksgiving Food Drive + Merchandise Bank	9/27/2023	Sponsorship	$ -	$ 75,000	$ 150,000
13	**Clinica Msgr. Oscar A. Romero**	Clínica Romero 40th Anniversary Gala	9/27/2023	Sponsorship	$ -	$ 10,000	$ 10,000
14	**China Town Service Center**	To recruit and support staff to develop and implement a simulation center utilizing virtual reality technology to provide staff training	9/15/2023	Ad Hoc Grant	$ 175,000	$ -	$ 175,000
15	**LA Family Housing**	To recruit a Mental Health Specialist who will rotate between Permanent Supportive Housing (PSH) sites	9/15/2023	Ad Hoc Grant	$ 100,000	$ -	$ 100,000
16	**Housing Works**	to recruit and support a contractor and contextual training coach to improve workforce development opportunities. Housing Works will update training curriculum and materials	9/27/2023	Ad Hoc Grant	$ 150,000	$ -	$ 150,000
17	**New Economics for Women**	Provide culturally competent, technology-based skills training to, and placement in high-demand jobs in the technology and service sector	9/25/2023	Advancing Economic Mobility Grant	$ 130,000	$ -	$ 130,000
18	**The SoLa Foundation**	To train and place 100 clients aged 16 - 30 years old in high demand, tech career fields through its two workforce development and certification programs	9/25/2023	Advancing Economic Mobility Grant	$ 150,000	$ -	$ 150,000

19	**UNITE-LA, Inc.**	Train and place 175 clients aged 18 - 25 years old in clean technology jobs through the agency's Cleantech Career Academy	9/25/2023	Advancing Economic Mobility Grant	$ 150,000	$ -	$ 150,000
20	**A Step to Freedom**	Strengthen organizational cpaacity to collect, track and manage data in effort to apply for long-term sustainable funding from State and Federal sources.	9/27/2023	Equity and Resilience IV Grant	$125,000	$ -	$ 125,000
21	**California Black Women's Health Project**	Develop increased capacity to secure sustainable public sector contracts and establish an ecommerce website to produce unrestricted funding sources.	9/27/2023	Equity and Resilience IV Grant	$125,000	$ -	$ 125,000
22	**Creative Acts**	To identify 5 long-term mission-aligned funding opportunities, prepare three applicationis and submit at least one to result in long-term sustainable and/or billable funding	9/27/2023	Equity and Resilience IV Grant	$125,000	$ -	$ 125,000
23	**Homies Unidos**	To build organizational capacity to identify and develop a plan to secure long term sustainable funding to serve 2400 gang impacted youth and families.	9/27/2023	Equity and Resilience IV Grant	$75,000	$ -	$ 75,000
24	**Inclusive Action for the City**	Will develop a program participant database that will streamline program management to help IAC track the progress of and manage service delivery to at least 200 participants per year	9/27/2023	Equity and Resilience IV Grant	$125,000	$ -	$ 125,000
25	**Khmer Girls in Action**	To organization will try to bring on another development staff person to support their long-term sustainable funding efforts	9/27/2023	Equity and Resilience IV Grant	$75,000	$ -	$ 75,000
26	**Kutturan Chamoru Foundation**	Pursue funding to increase clients reached through development capacity for KCF leads by increasing knowledge of long term funding opportunities with focused Staff in this area.	9/27/2023	Equity and Resilience IV Grant	$75,000	$ -	$ 75,000
27	**Latino Equity Alliance Latino Equality**	Engage with consultants and/or advisors to identify at least 4 opportunities to support organizational growth through the development of at least 4 new titles, roles, and positions.	9/27/2023	Equity and Resilience IV Grant	$125,000	$ -	$ 125,000
28	**LA Commons**	To support staff in efforts to diversify and establish more long-term sustainable funding	9/27/2023	Equity and Resilience IV Grant	$125,000	$ -	$ 125,000
29	**Southeast Asian Community Alliance**	Build SEACA's development capacity by increasing knowledge of potential funding opportunities and how to prepare for applications for sustainable funding	9/27/2023	Equity and Resilience IV Grant	$75,000	$ -	$ 75,000

30	**SoCal PICRT**	Seek out sustainable funding to support increasing outreach/education services and referrals to 40 NHPI families (160 individuals) impacted by mental/behavioral health disorders, lack of food access, and environmental justice issues	9/27/2023	Equity and Resilience IV Grant	$75,000	$ -	$ 75,000
31	**Stem to the Future**	Conduct outreach and build relationships with key stakeholders and decisionmakers at organizations that could provide long-term funding or cover fee for service costs	9/27/2023	Equity and Resilience IV Grant	$125,000	$ -	$ 125,000
				Total of grants and sponsorships approved in September 2023	**$ 2,105,000**	**$ 193,600**	**$ 2,612,100**

* Per the Community Health Investment Fund (CHIF) grant agreements, the first half of the grant award is released upon receipt of a fully executed agreement. The second half of grant award is released upon expenditure of the first pament and completion of at least half of the entire project's objectives, as detailed in semiannual progress report submissions.

Board of Governors
Technical Advisory Committee
CHARTER

General Information

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

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

Committee Roles

The primary roles of the committee are:

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

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

Field Code Changed

C. The committee

Technical Advisory Committee (TAC) Charter

Committee Responsibilities

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

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

B. Provision of expert advice to the Chief Health Equity Officer~~CMO~~ and L.A. Care Board of Governors concerning L.A. Care Health Plan proposals or activities impacting the provider community.

C. Creation of an annual workplan with periodic status reports to the Board on the implementation of the workplan.

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

Committee Operations and Organizational Interface

Key aspects of committee operations and organizational interface include:

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

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

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

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

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

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

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

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

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Signed: ~~Mario Ramos~~
Secretary, Board of Governors

Date:

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Tick, Tock, Time to Renew!

Unwinding Continuous Coverage for Medi-Cal Beneficiaries - Update

Medi-Cal Product
November 2023

ELEVATING HEALTHCARE IN LOS ANGELES COUNTY SINCE 1997

Agenda

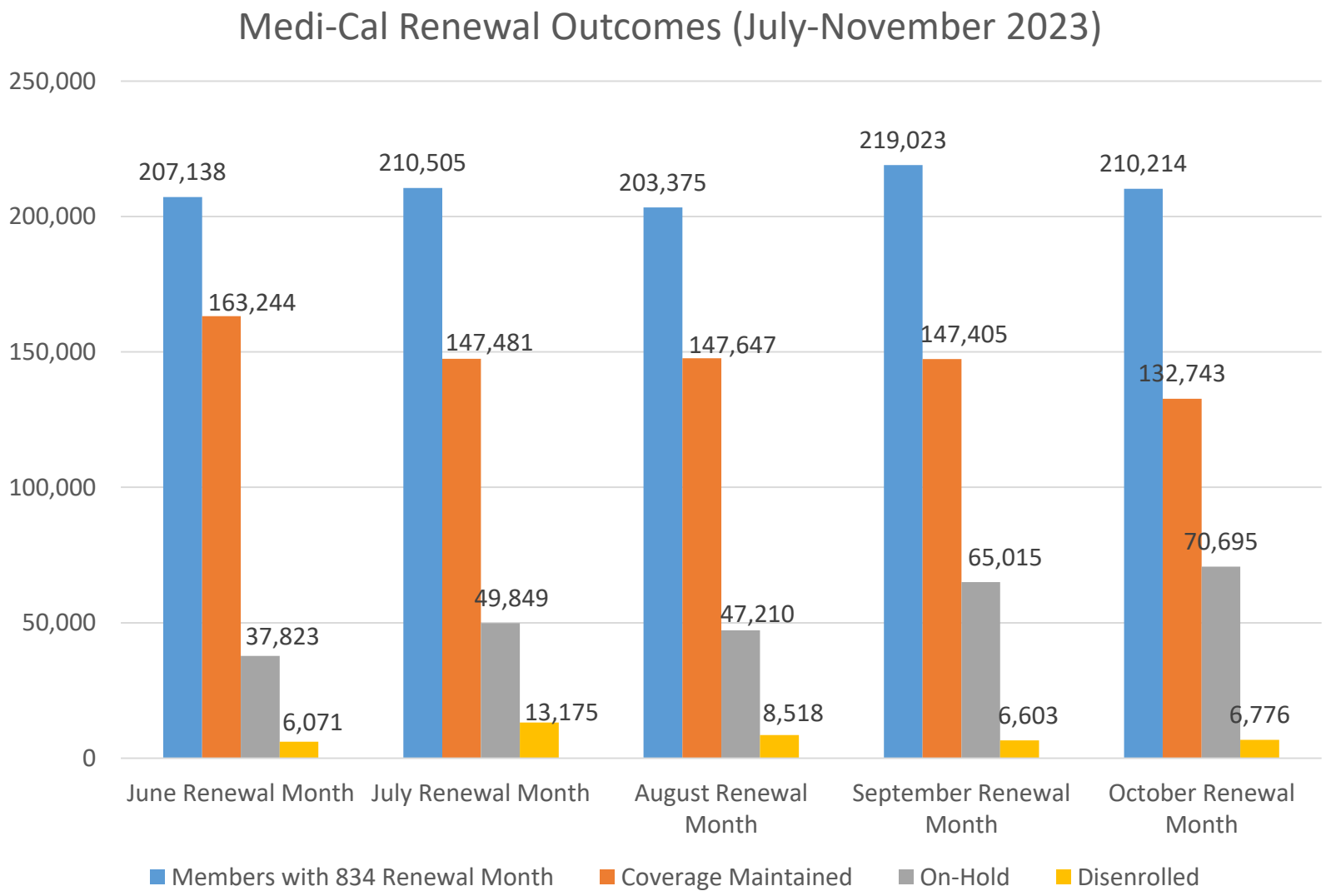
- Medi-Cal redetermination updates
- Current outreach tactics

Redetermination Experience – November 2023

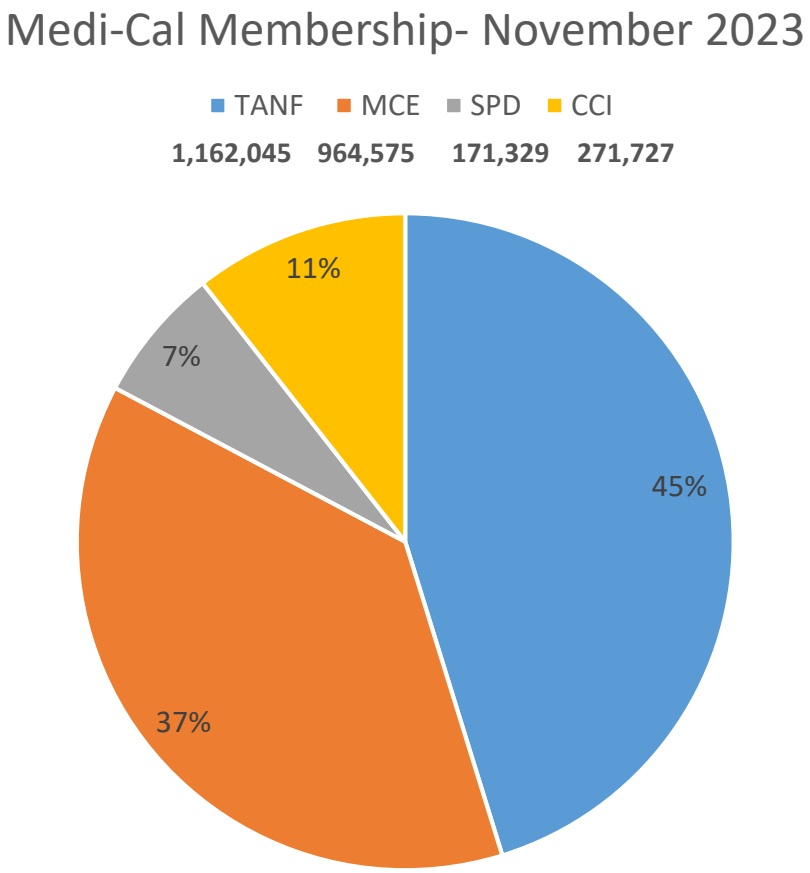
Medi-Cal redeterminations for members with October renewal month

- 11/1/23 - Action taken on fifth cohort of beneficiaries
  - Auto renewal using existing info in DPSS systems started in August
    - Pass = renewed!
    - Fail – Beneficiaries mailed renewal packet in late August
      - ~**126K** L.A. Care members were mailed a packet
      - L.A. Care began a call campaign for these members in late September
      - Monthly data file of members who were mailed a packet shared with groups/IPAs
- If no response to packet/request for info, beneficiary lost coverage effective 11/1 and entered the 90-day cure period (procedural term/on hold)
    - L.A. Care is calling and mailing postcards to these “on hold” members
    - Monthly on-hold data file shared with groups/IPAs
- November 2023 disenrollment and on-hold counts
  - **77.5**K total disenrollments
    - **70.7**K procedural terminations / on-holds
    - **6.8**K disenrollments / no longer eligible

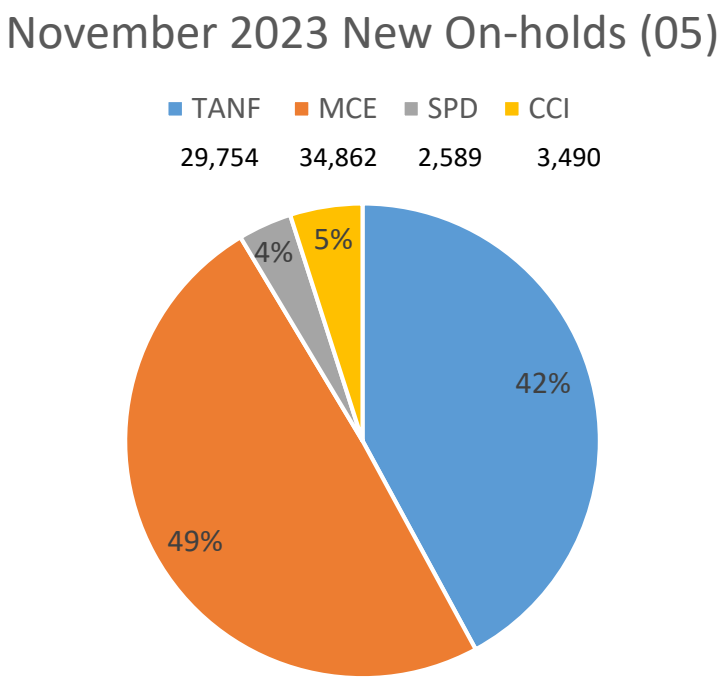
Redetermination Outcomes to Date

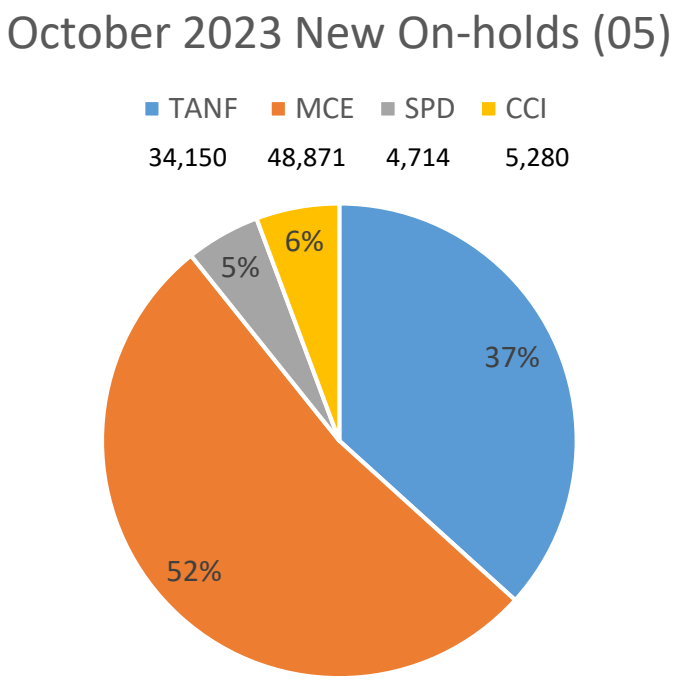


Current Membership

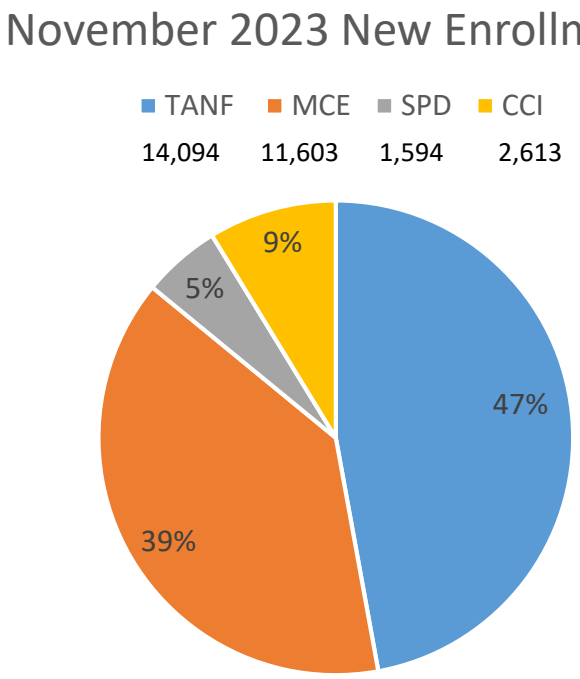


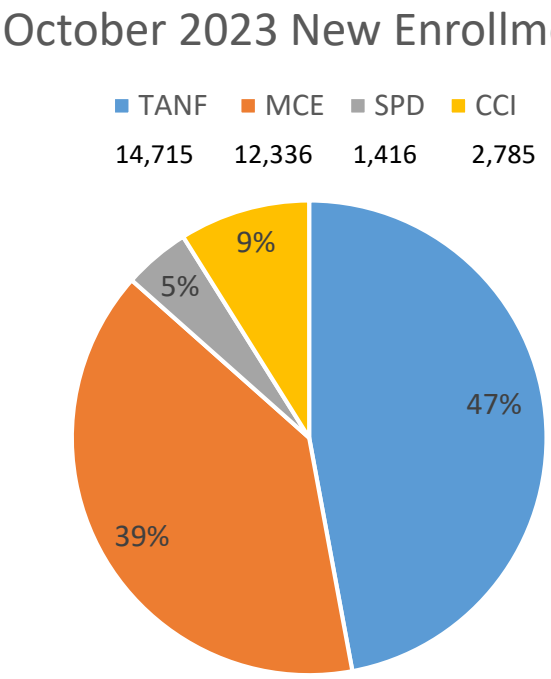
New On-holds (05)- November and October



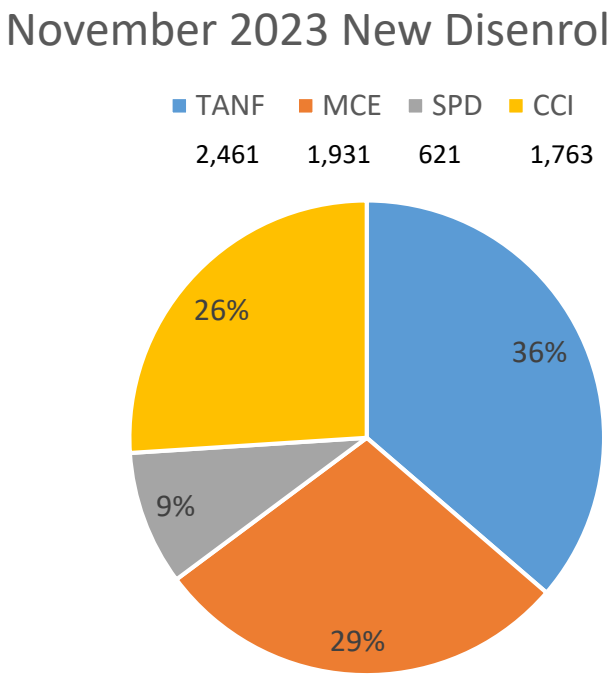


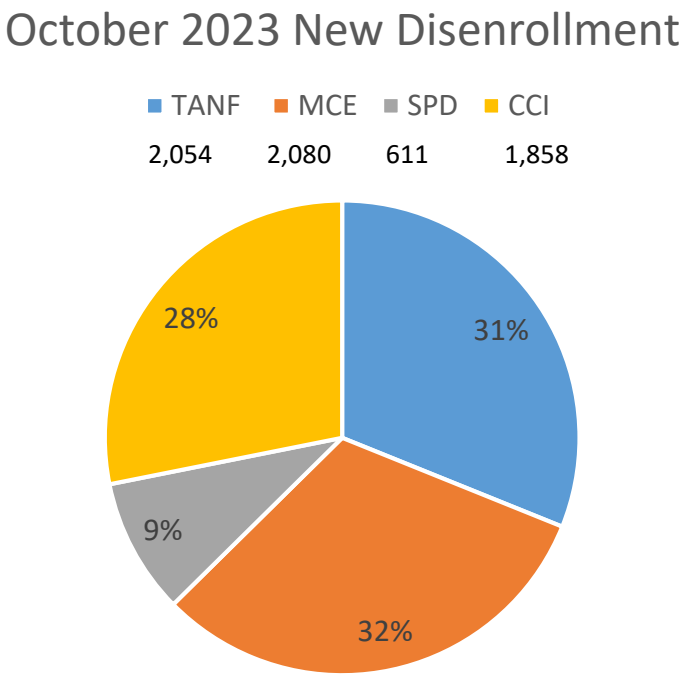
New Enrollment- November and October





New Disenrollment- November and October





The Unwinding Continues

Medi-Cal redeterminations continue to be in flight

- Next cohort of beneficiaries impacted are those with a November 2023 renewal month (6th cohort)
  - Renewal processing for beneficiaries with a November renewal month began in September
  - Paper packets for the **120K** individuals who failed auto renewal were mailed around September 17th
  - L.A. Care conducted target outreach to these individuals
    - Call campaign
    - Data sharing with participating provider groups/IPAs and Plan Partners
  - Disenrollments will occur on December 1st for beneficiaries who do not respond to the county and for those who are determined ineligible

Medi-Cal redetermination will continue annually for all beneficiaries.

Key Messages to Share with Beneficiaries

- **Update your contact information**
  - Make sure the county has your current contact information, if it has changed. This way, the county can contact you about your Medi-Cal. If your information has changed, you can update it online at benefitscal.com or by calling DPSS at 1-866-613-3777.
- **Create or check your online account**
  - You can sign up to receive alerts on your case. Create or log into your BenefitsCal account to get these alerts. You may submit renewals or requested information online.
- **Check your mail**
  - The county will mail you a letter about you Medi-Cal eligibility. You may need to complete a renewal form.
- **Complete your renewal form (if you get one)**
  - If you receive a renewal form in the mail, submit your information by mail, phone, in person, or online so you do not lose your coverage.
- **Watch out for scammers**
  - There is no cost to renew your Medi-Cal!

L.A. Care Redetermination Outreach Tactics

Outreach Strategies	Jan 2023	Feb 2023	March 2023	April 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023
DPSS & Plan Partner Collaboration	X	X	X	X	X	X	X	X	X	X	X	X
Member Engagement	X	X	X	X	X	X	X	X	X	X	X	X
Provider Engagement			X	X	X	X	X	X	X	X	X	X
Traditional Marketing					X	X	X	X	X	X	X	X
Digital Marketing				X	X	X	X	X	X	X	X	X

Phase 1 Strategies and Activities

Provider Engagement

-General Provider Outreach

-Provider Newsletter Article

Member Engagement

-In-person/virtual assistance with Medi-Cal renewals (CRCs & CBOs)

-FAQ for call center reps to answer Qs and direct members to resources

-Medi-Cal renewal page on L.A. Care website

-Annual mailing

-Animations & social media campaign

DPSS & Plan Partner Collaboration

-Secure sharing of member contact info changes daily (established process since August 2017)

-Developing process to include subcontracted plan data onto new standardized template for sharing with DPSS

L.A. Care Redetermination Outreach Tactics

Phase 2 Strategies and Activities in Process

Provider Engagement

- Sharing monthly renewal packet list and on-hold data with Participating Provider Groups
- Redetermination provider webpage on L.A. Care website- Provider webinar training
- Multiple provider toolkits:
  - Key messages and FAQs
  - CRC and CBO renewal assistance flyer
  - Educational animations
  - Provider poster

Member Engagement

- Text campaign
- Robocall campaigns
  -renewal packet and on-hold
- Social media campaigns
  - Animations
- Member newsletters
- Reminder postcards sent to disenrolled members (procedural terms)
- Bus shelters & media ads
- Digital marketing
- Health promoter training
- Flyer for RAC / community members

DPSS, Plan Partner, & State Collaboration

-NFSA in process to allow DPSS to ingest Medi-Cal contact and demographic changes from L.A. Care and L.A. Care Plan Partners on new standardized template

-Receipt of monthly data file from DHCS that includes a list of members who were mailed a renewal packet

-November 3rd, received file with renewal month data for all Medi-Cal members from DHCS

Redetermination Provider Toolkit

Toolkit for LACOE- Cobranded with Health Net*

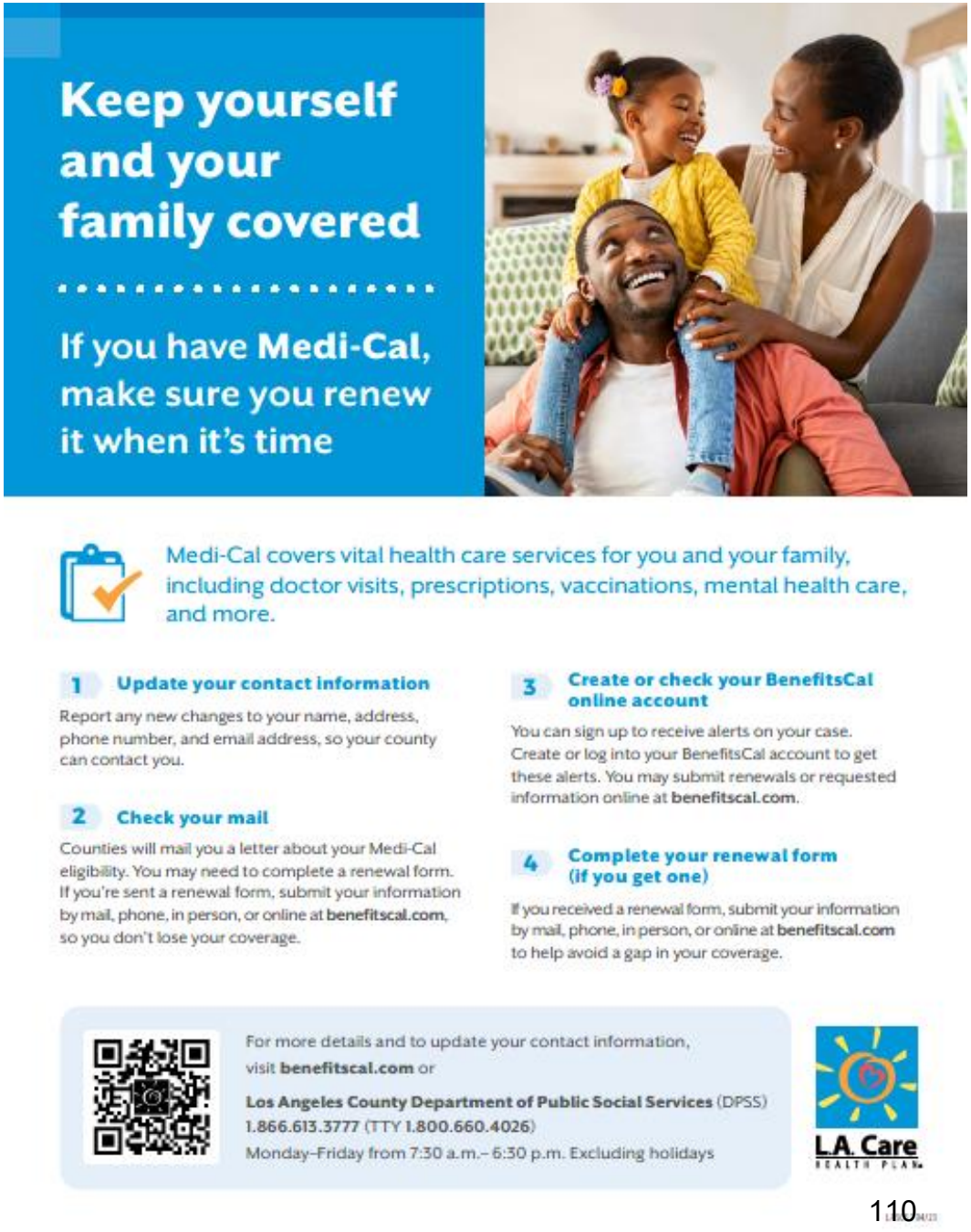
*Toolkit is draft as of 9/11/23

Medi-Cal Redetermination Provider Poster

- 11x16 posters distributed to providers
- Also available in 11 threshold languages on our website

Medi-Cal Redetermination Flyer

- To be distributed to members and the larger community
- ECAC and RCACs
- Also available in 11 threshold languages on our website

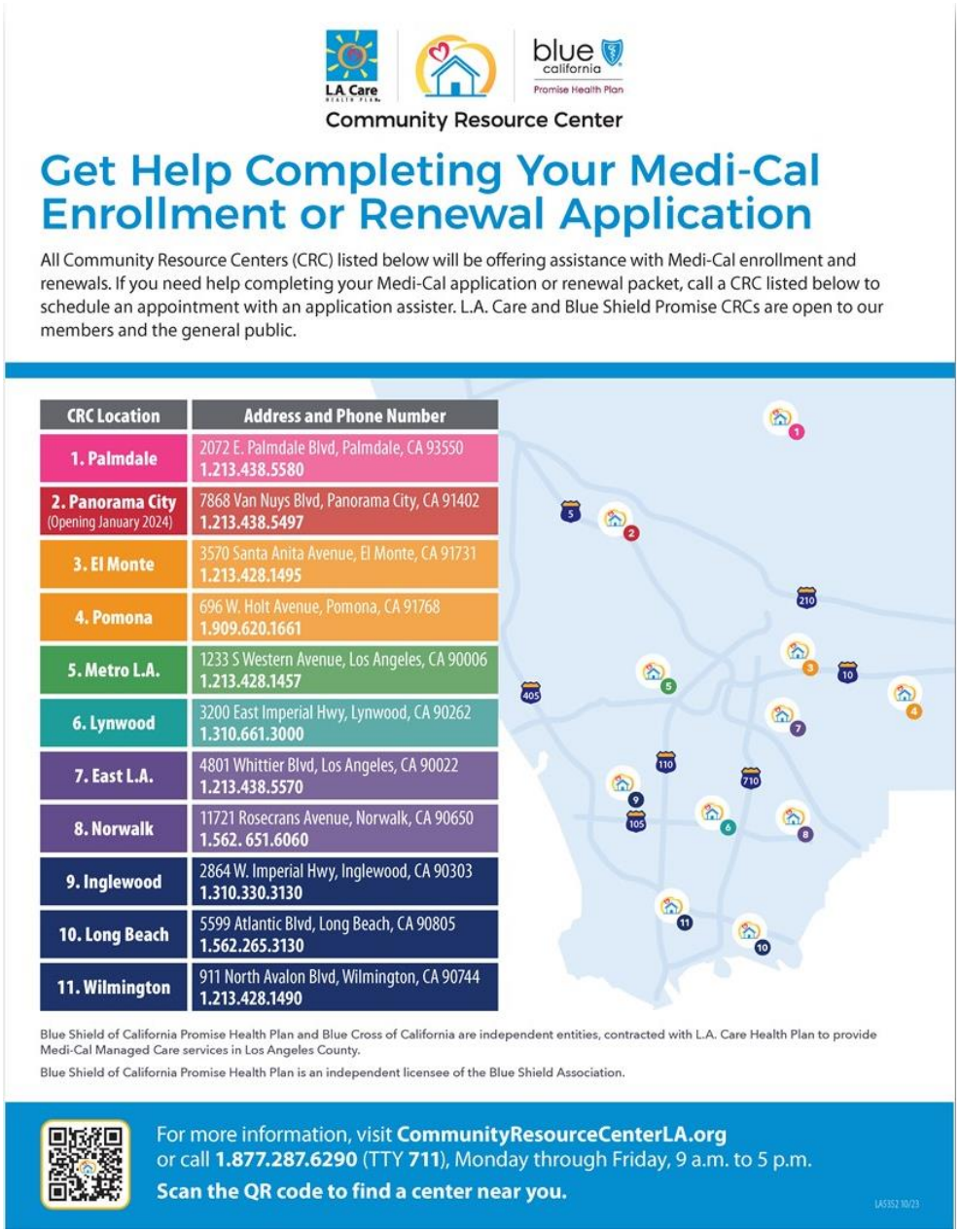


Medi-Cal Redetermination CRC Postcard

- To be distributed at Community Resource Center events (e.g., flu clinics, back to school, food pantries, etc)
- Available in all languages and physical copy available
- Dual language pieces available per request

Medi-Cal Redetermination Assistance at CRCs

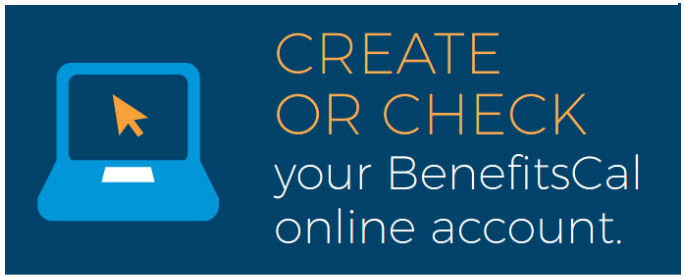
- Community Resource Centers offering telephonic and in person technical assistance with renewal paperwork
- Available to the community



Redetermination- Social Media Graphics

Report any new changes to your name, address, phone number, and email address, so your county can contact you. For more details and to update your contact information, visit benefitscal.com or Los Angeles County Department of Public Social Services (DPSS) 1.866.613.3777 (TTY 1.800.660.4026) Monday–Friday from 7:30 a.m.– 6:30 p.m. Excluding holidays.

L.A. Care HEALTH PLAN



You can sign up to receive alerts on your case. Create or log into your BenefitsCal account to get these alerts. You may submit renewals or requested information online at benefitscal.com.

L.A. Care HEALTH PLAN

Counties will mail you a letter about your Medi-Cal eligibility. You may need to complete a renewal form. If you're sent a renewal form, submit your information by mail, phone, in person, or online at benefitscal.com, so you don't lose your coverage.

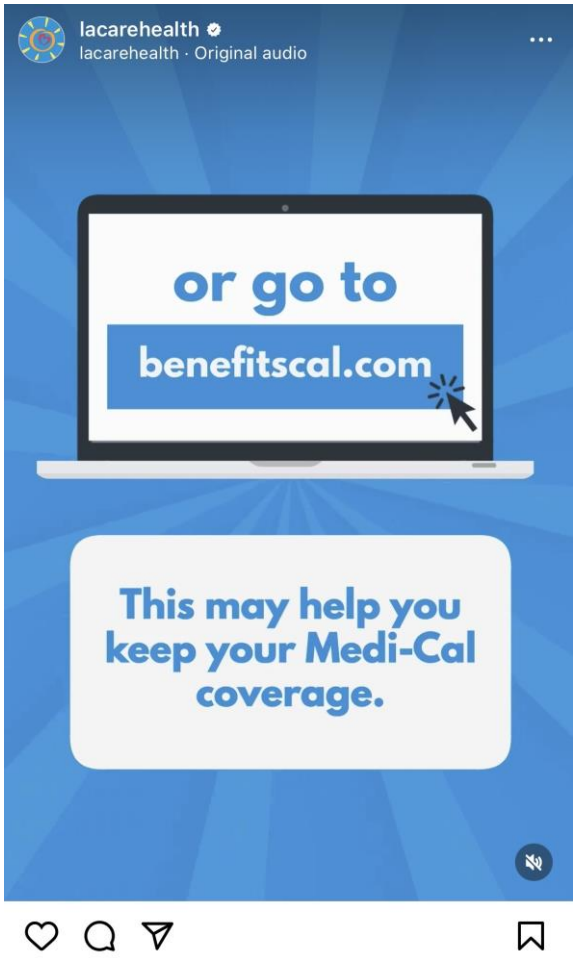
L.A. Care HEALTH PLAN

If you received a renewal form, submit your information by mail, phone, in person, or online at benefitscal.com to help avoid a gap in your coverage.

L.A. Care HEALTH PLAN

Redetermination- Animations

- Animation- “Preparing for Medi-Cal Renewals” https://youtu.be/U-dGAcgQLNs
- Examples of social media posts using DHCS global outreach language



Redetermination Info Page in the Medi-Cal Annual Mailing (Jan 2023)

Medi-Cal Renewal

During the COVID-19 public health emergency (PHE), you have been able to keep your coverage regardless of any changes in your circumstances. However, once the COVID-19 PHE ends, the Los Angeles County Department of Public Social Services (DPSS) will check to see if you still qualify for free or low-cost Medi-Cal.

Keep your Medi-Cal benefits by renewing on time. Here is some important renewal information:

What can I do to prepare for my Medi-Cal renewal?

- If you moved recently, or if any of your contact information, like your phone number or an email address, has changed, report your changes to DPSS to make sure you get important information about your Medi-Cal coverage.
- If you got a new job or your income has changed, be prepared to provide verifications.
- Check your mail – If you receive a renewal packet/form or a notice asking for more information, you may submit the information by mail, phone, in person, or online.
- Check your online BenefitsCal account for alerts – You may submit renewals or requested information online.

Do I need to complete a Medi-Cal renewal?

- DPSS will try and renew your Medi-Cal with information they already have available.
- DPSS will only ask you for more information if they need it to renew your Medi-Cal. It is important that Medi-Cal beneficiaries respond to county requests. This will make sure DPSS has the most current information it needs to renew your Medi-Cal coverage.

What happens after I return my form?

- DPSS will send you a letter to let you know if you still qualify for Medi-Cal coverage. If additional information is needed to renew your coverage, DPSS will send you a letter requesting any missing information.

Here is some important DPSS contact information to help you with your renewal:

1. BenefitsCal website: **benefitscal.com**

   BenefitsCal is a website for LA County residents to apply for and to view benefits online for CalWORKs, CalFresh, General Relief, and Medi-Cal applications

2. DPSS Customer Service Center (CSC) Telephone Numbers

Toll Free	**866-613-3777**
Local numbers	**626-569-1399** **310-258-7400** **818-701-8200**
Hours of Operation	The CSC is available to assist you: • Monday–Friday from 7:30 a.m. – 7:30 p.m. • Saturdays from 8:00 a.m. – 4:30 p.m. • Excluding holidays

If you have questions about your Medi-Cal renewal:

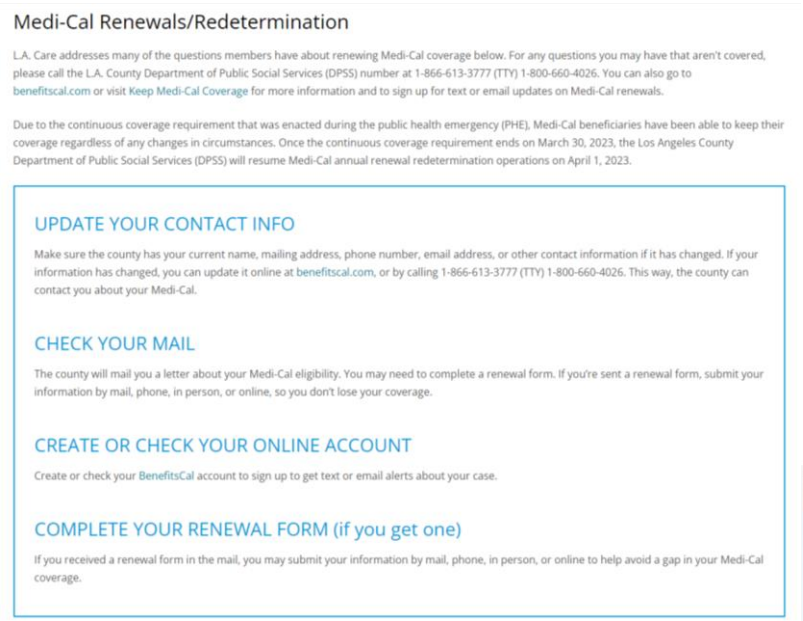
- Contact your Medi-Cal case worker at your local DPSS office at **1-866-613-3777** (**TTY/TDD 1-800-660-4026**) Monday – Friday from 7:30 a.m. – 7:30 p.m. and Saturdays from 8:00 a.m.– 4:30 p.m. (excluding holidays)

I have SSI-Linked Medi-Cal, how do I update my information?

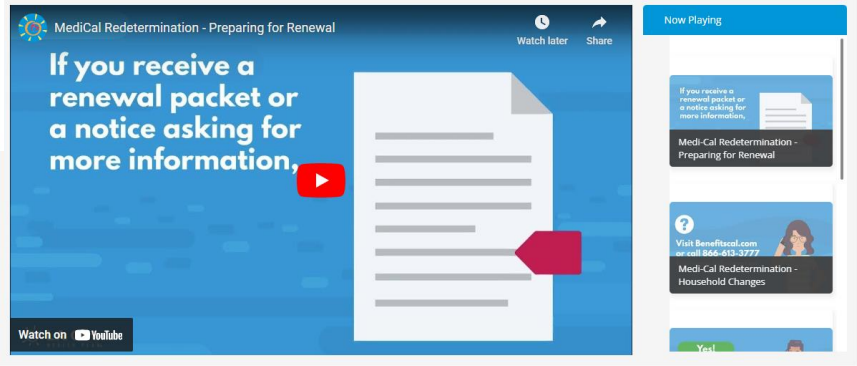
- If you have SSI-Linked Medi-Cal you have to update your information through Social Security. You can report your change by calling **1-800-772-1213** (**TTY 1-800-325-0778**), Monday through Friday, 8:00 a.m. – 7:00 p.m.

Redetermination - Website Highlights

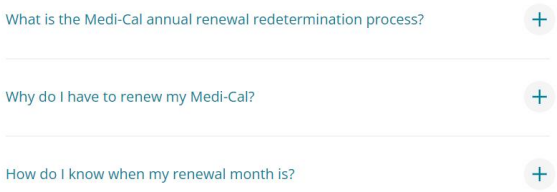
Updated Renewal Webpage, Animation Videos, and FAQs



Updated Medi-Cal Renewal Member Webpage with Key Messaging on Redeterminations



Featured Redetermination Animation Videos and FAQs



Redetermination - On Hold Postcard

Please Remember

Keep your health care benefits...
It's time to renew your Medi-Cal coverage!

To apply for your Medi-Cal renewal, please complete the forms from the L.A. County Department of Public Social Services (DPSS) and return them as soon as possible!

Call the DPSS Customer Service Center at **1.866.613.3777**, Monday through Friday from 7:30 a.m. – 7:30 p.m. and Saturdays from 8:00 a.m. – 4:30 p.m. (TTY users should call **1.800.660.4026**), and speak to your eligibility worker for assistance or go to **benefitscal.com** to complete your renewal forms.

L.A. Care works with three other health plans to provide health care services for members.

L.A. Care Health Plan	blue california Promise Health Plan	Anthem BlueCross	Kaiser Permanente
1.888.839.9909	1.800.605.2556	1.888.285.7801	1.800.464.4000

Disclaimers from Plan Partners

Blue Shield: Blue Shield of California Promise Health Plan is contracted with L.A. Care Health Plan to provide Medi-Cal managed care services in Los Angeles County. L.A. Care and Blue Shield Promise are independent entities. Blue Shield Promise is an independent licensee of the Blue Shield Association.

Anthem: Blue Cross of California is contracted with L.A. Care Health Plan to provide Medi-Cal Managed Care services in Los Angeles County. Anthem Blue Cross is the trade name for Blue Cross of California. Anthem Blue Cross is an independent licensees of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Kaiser: In California, all plans are offered and underwritten by Kaiser Foundation Health Plan, Inc., One Kaiser Plaza, Oakland, CA 94612.

L.A. Care complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

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Redetermination - Marketing Campaign

Phase 3 Strategies and Discussion

- **Additional Outreach for Phase 3**
  - Text campaign to members who are mailed a packet
  - Email outreach campaign
    - We have over 319K MCLA emails on file!
  - High-touch call for SPD members who are mailed a packet and/or who go on-hold
  - Robocall campaign to all HOH members who have an upcoming renewal month
  - Training our internal health promoters and CHWs
  - Mailing a postcard 2 months prior to the member's renewal month
  - Developing education videos for members who speak indigenous languages
- **Discussion**
  - What other outreach strategies should L.A. Care focus our efforts on?

Thank You

Use of Geospatial Resources to Identify and Target L.A. Care Social Service Needs

AAL

November 9, 2023

L.A. Care HEALTH PLAN®

For All of L.A.

Advanced Analytics Lab

Delivering quantifiable business value through analytics

Road Map

1. Why Look at Members Geospatially?
2. Issue: Geographic Coverage of Care
3. Intervention: CRC Clinical Services
4. Discussion: Exposomes and SDOHs

Why Look at Members Geospatially?

How could geography be so intertwined with health outcomes?

***Key Idea:* Disadvantaged Neighborhoods**

Research on health outcomes has firmly established that residents of disadvantaged neighborhoods suffer worse health outcomes than their counterparts in more affluent communities.

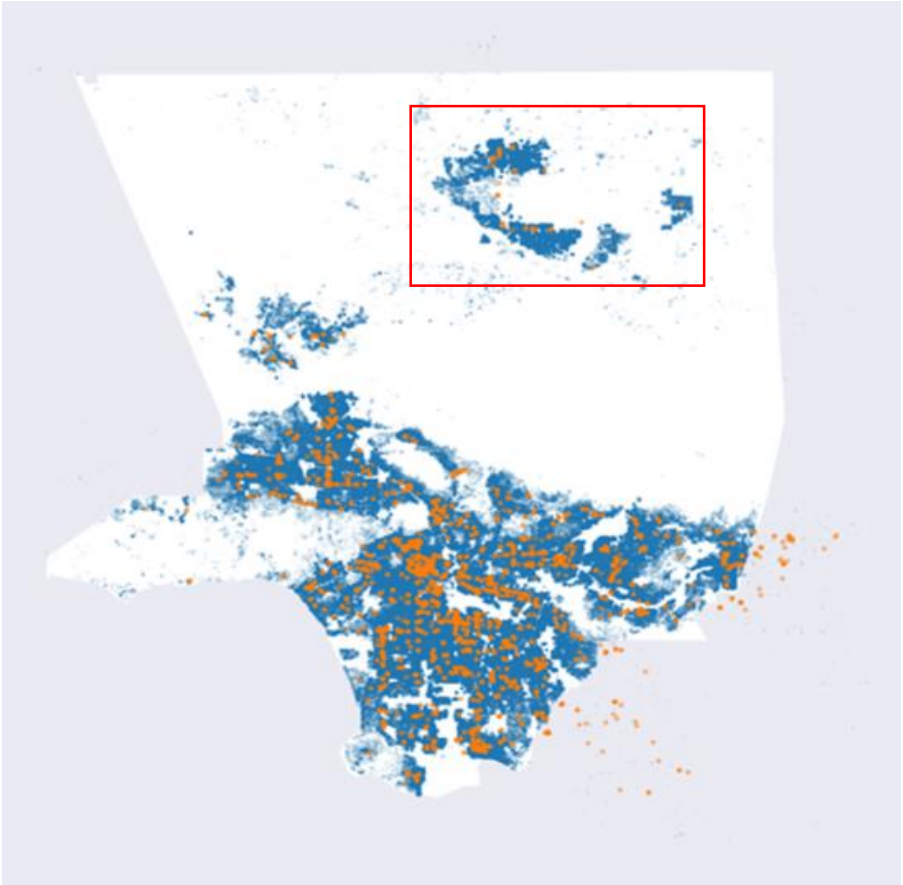
Evidence:

- Poor and minority populations often live in socioeconomically disadvantaged neighborhoods, which directly affects access to food, safety, education, health behaviors and stress [1-5].
- Living in a disadvantaged neighborhood has been linked to higher rates of diabetes, cardiovascular disease, morbidity, and many other diseases [1-5].
- Studies have shown that poor people who live in wealthier neighborhoods have better health outcomes than poor people in disadvantaged neighborhoods [2,5]

Examples:

1. Diabetes education programs will do little to reduce disparities if participants live in an area with substandard housing and lack access to a refrigerator for insulin storage [1].
2. Being in a disadvantaged neighborhood is an equitable re-hospitalization risk as if you were living with Chronic Pulmonary Disease [2] .

Issue: Geographic Coverage of Care



- Certain areas of our networks have much more sparse coverage. As expected, our rural areas, like the Antelope Valley struggle.
  - We see high ED utilization and continued ED utilization in these areas.
  - Overall, we know there is an access to care issue for members
- Below is map of coverage of the LA network. Circled is our Antelope Valley area. The orange dots are the PCPs, the blue dots are the members.

Intervention: CRC Clinical Services

- **Issue**: L.A. Care would like to offer clinical services from L.A. Care Community Resource Centers (CRCs), which have not been historically offered. We are looking to supplement regular member care with basic testing services and preventative care (Vaccines, IHAs, etc.). There are certain areas with limited resources and we want to find where those services would have the greatest impact.

- **Data Source**: HEDIS metrics are a measurement that are used in multiple avenues to measure L.A. Care performance and address key preventative areas of care. We evaluated 2022.

- **Problem Formulation:** Normally HEDIS metrics are reported on a Line-of-Business (LOB) level, so to cater to measurement of each CRC some type of geospatial aggregation must occur.

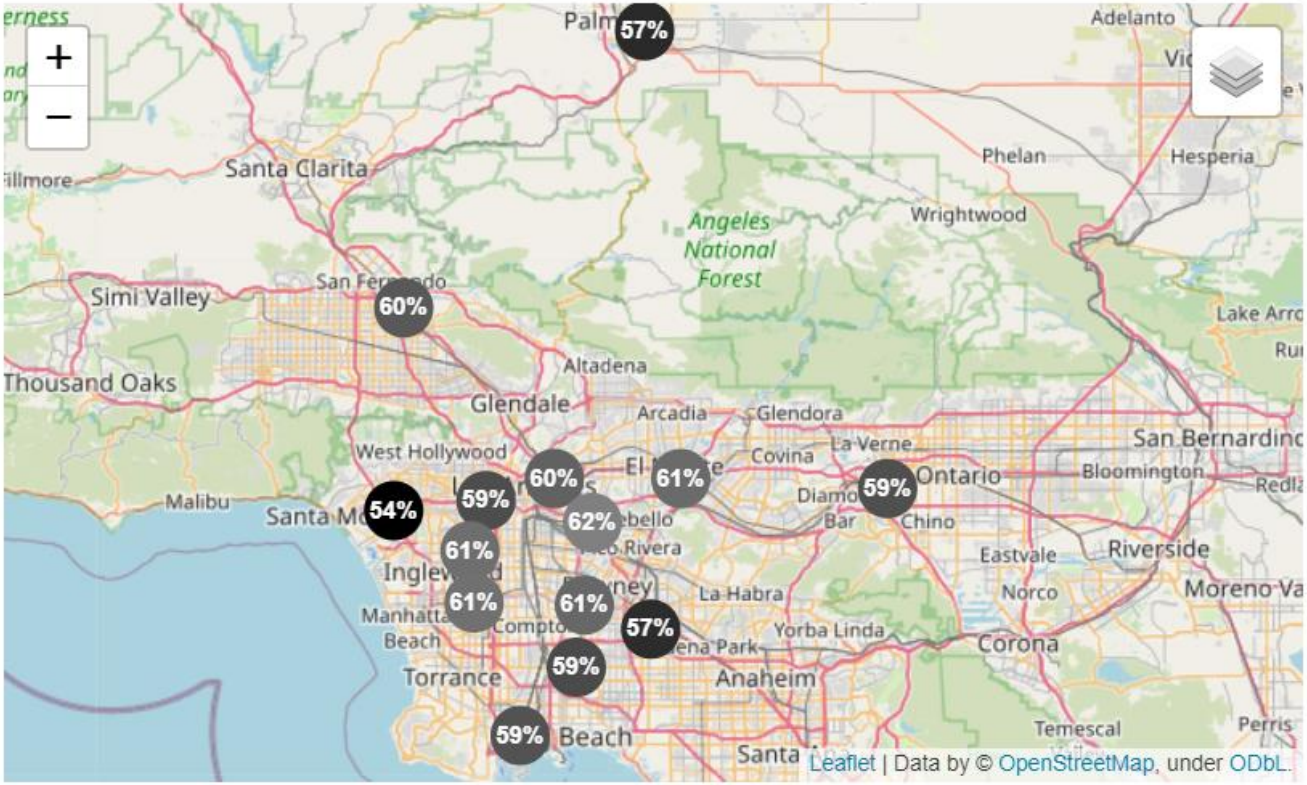
- **Solution:**
  - 5 mile radius around each center
  - Exclude CCI Coordinated Care Initiative members since another health plan might have covered their care (missing data)
  - Exclude 834 file “generic” addresses indicating unknown-location homeless members

Intervention: CRC Clinical Services

CRC	Active Members within 5-mile Radius	Adult Flu Shot (AIS-E)	Adult TDAP Shot (AIS-E)	Adult Zoster Shot (AIS-E)	Adults Access to Preventive / Ambulatory Health Services (AAP)	Colorectal Cancer Screening (COL-E)	Controlling High Blood Pressure (CBP)	Lead Screening in Children (LSC)	PCP Visit Last 1 Year	PCP Visit Last 2 Years
East L.A.	114,612	20.7%	47.5%	18.4%	62.2%	38.2%	36.6%	65.0%	42.2%	59.2%
El Monte	64,380	23.2%	44.4%	17.5%	60.9%	41.7%	36.1%	65.1%	41.3%	58.6%
Inglewood	133,562	15.7%	42.4%	12.8%	61.3%	35.2%	30.4%	53.4%	37.3%	54.7%
Lincoln Heights	138,552	20.1%	44.2%	17.2%	60.3%	37.0%	36.9%	64.7%	40.2%	55.0%
Long Beach	89,373	16.3%	41.7%	14.7%	58.9%	34.4%	23.2%	49.3%	37.4%	54.5%
Lynwood	146,244	16.9%	43.1%	15.3%	60.7%	34.8%	29.8%	56.7%	39.4%	57.4%
Metro L.A.	179,494	17.7%	40.5%	15.8%	59.1%	36.1%	33.6%	60.9%	37.2%	52.2%
Norwalk	63,758	18.4%	41.8%	16.4%	57.1%	33.1%	30.9%	50.6%	35.6%	52.0%
Pacoima	79,207	15.6%	44.7%	13.5%	59.8%	34.3%	35.4%	55.2%	40.7%	58.3%
Palmdale	23,417	14.5%	45.1%	15.4%	56.9%	34.5%	35.7%	50.8%	32.8%	51.6%
Pomona	29,571	16.5%	42.7%	12.5%	59.2%	34.4%	41.8%	43.2%	37.2%	54.0%
South L.A.	175,466	16.4%	42.7%	14.4%	61.1%	36.5%	30.3%	57.3%	37.8%	54.8%
West L.A.	38,940	18.7%	40.7%	18.5%	54.3%	32.4%	22.1%	63.0%	31.8%	45.8%
Wilmington	52,995	18.2%	43.4%	17.8%	59.4%	35.1%	24.5%	47.6%	37.6%	52.7%

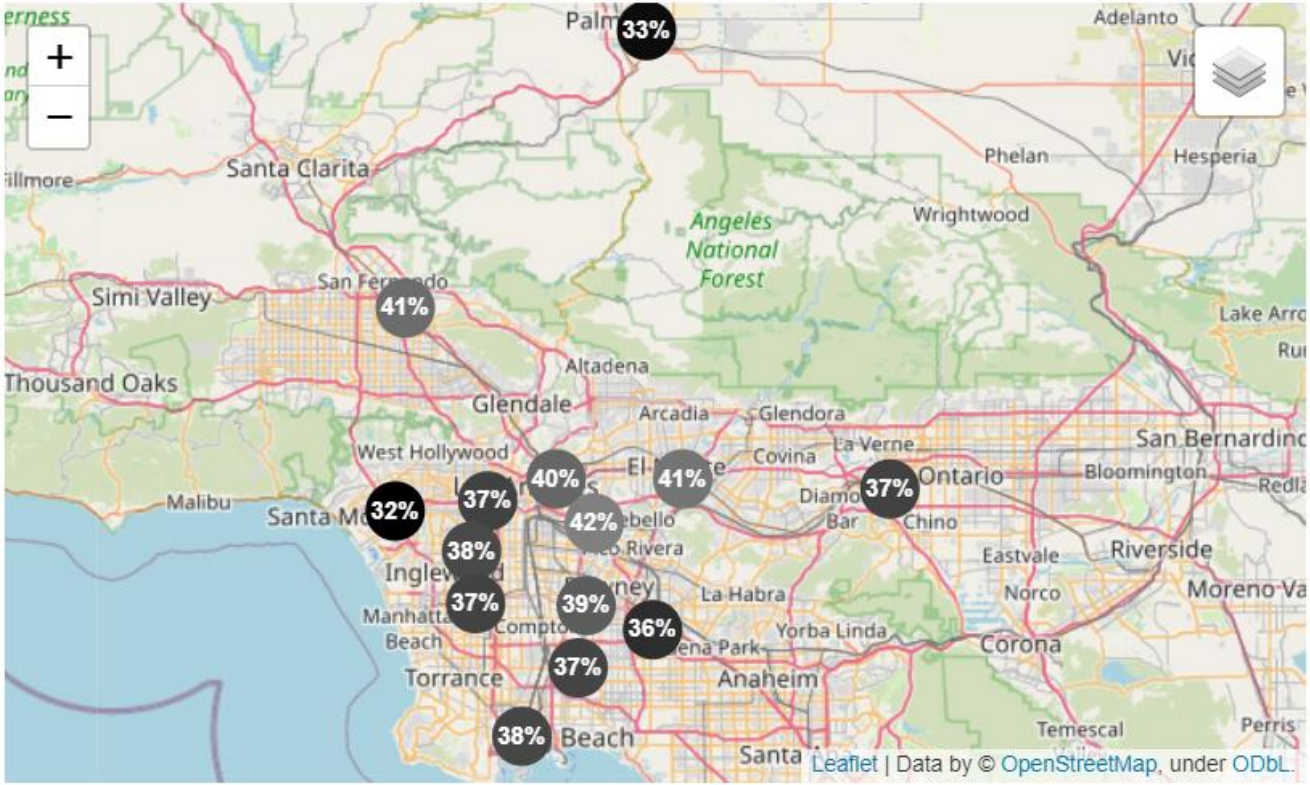
Intervention: CRC Clinical Services

AAP – wide net of doctors visit types



Intervention: CRC Clinical Services

PCP Visits – specifically well care visits, significant drop in Antelope Valley



Intervention: CRC Clinical Services

Discussion:

- How can we better orient or refine this analysis to the needs of the different locations?
  - For example, we could separate out rural areas and increase geographic radius or services that non-clinical staff can perform.
- What type of “non-standard” metrics could we perform geographical aggregation over to better capture clinical need in these areas?
  - We think capturing SDOH transport insecurity would be really powerful, but the question is how to measure it.
- Would changing the geographic aggregations for specific areas prove helpful or hurtful?
  - We are afraid doing custom aggregations for rural sites might obfuscate comparison to other locations

Discussion: Exposomes and SDOH Indexes

- **CMS:** Recently mandated that provider (ACO REACH) reimbursement would be risk adjusted nationally using an Exposome (Area Deprivation Index, ADI), which was a very controversial change. They are looking at doing the same for STARs.
  - **Exposome is** a geographic clustering of a multitude of non-healthcare-specific data that is linked to healthcare outcomes. These indices are broken down to the **Census Tract Level** to effectively capture Social Drivers of Health (SDOHs) and model the **Neighborhood Disadvantage.**
  - There are individualized ways to calculate SDOH's for members, but this abstraction might provide a way to ensure we have this data over near-every member with a strong research backing.
- **Here are some prominent indexes:**
  - **Healthy Places Index (HPI)** – Made specifically for California. We have used this in the past and it has the best documentation and support.
  - **Area Deprivation Index (ADI) –** Modified to the Census Tract Level by the University of Wisconsin
  - **Social Vulnerability Index (SVI) –** Created by the CDC for natural disaster recovery

Discussion: Exposomes and SDOHs

HPI Score (3.0)
Percentile Ranking

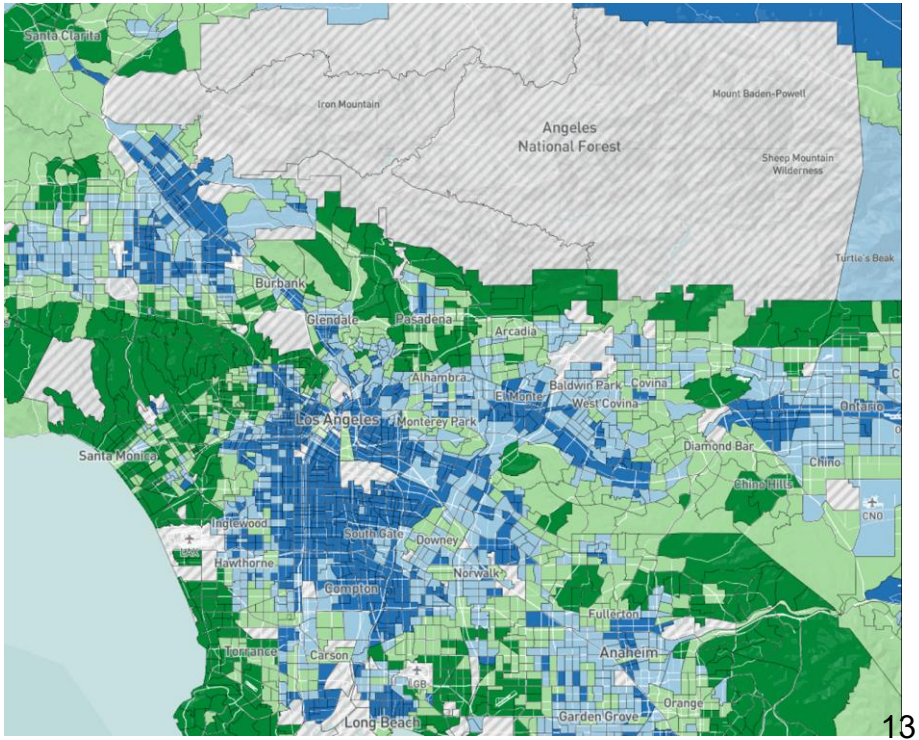
Less → More healthy community conditions

0 25 50 75 100 Excluded

- **Here is a look at HPI over Los Angeles**. They model morbidity against data in the following areas

Economic
Education
Social
Transportation
Neighborhood
Housing
Clean Environment
Healthcare Access

Indicator	Value	Percentile Ranking
Active Commuting	41.0%	96.6
Automobile Access	62.8%	1.2

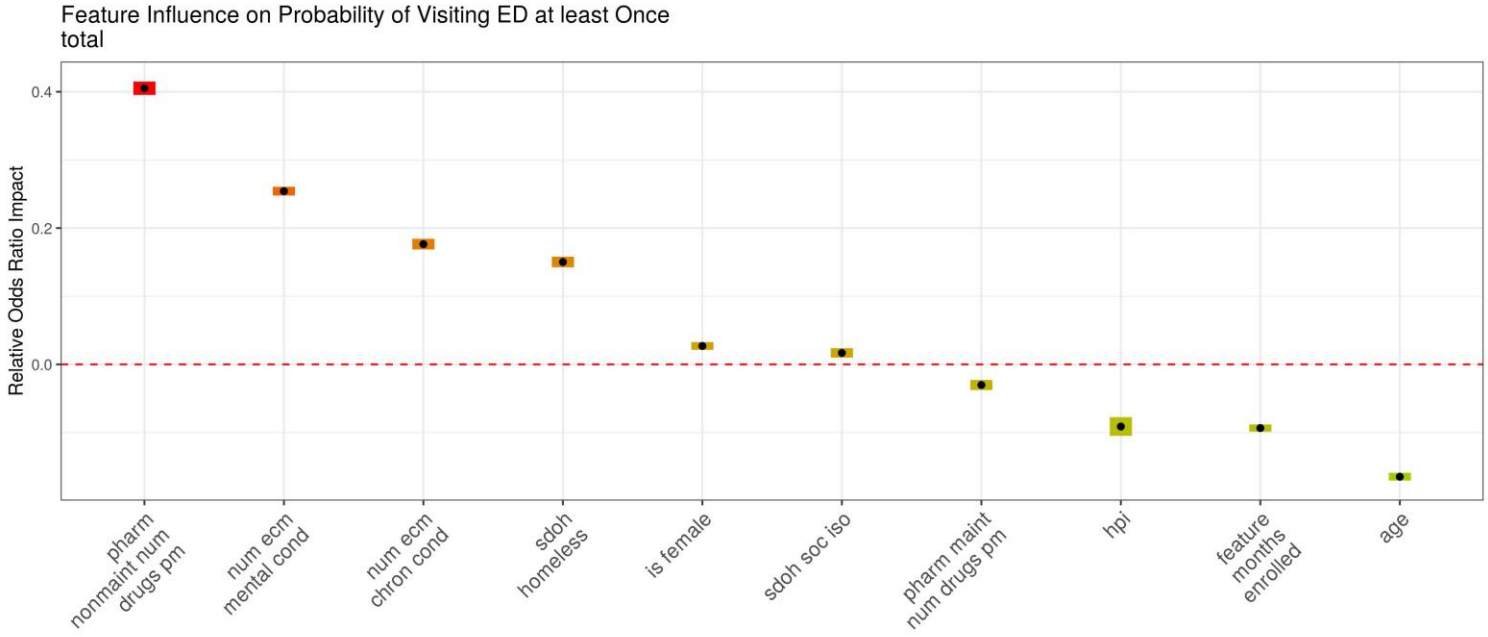


Discussion: Exposomes

- Utilization of HPI specifically:
  - We include HPI in our “Member Profiling Data” which a collection of various data points, like utilization, Optum SDOH metrics, HPI, and demographics to throw into a model to have it select key features.
  - We use this in production for our AAP model that predicts which members for a given year will not satisfy the measure. We are still exploring, but Optum also provides a SVI-based metric and we are exploring its influence on the model as well.

Discussion: Exposomes

- We included HPI in a Bimodal Hurdle model to better capture causal relationships (exclude other influencing factors) and see that it can reduce likelihood of going to the ED (initial ED visit, not repeated ED visits)



Discussion: Exposomes

- Does TAC have any opinions on what indices we should be evaluating?
  - We know that RAND recommended SVI and ADI to CMS
  - We like HPI's transparency and ability to provide breakdowns, which other indices don't use

- Even though we don't have conclusive evidence of the relationship or impact of specific exposome index, we would very much like to begin the process of **validation**
  - What type of targets could we validate these scores against? We can of course use utilization metrics (e.g. ED utilization, IP bed days), but are additional targets necessary
  - What type of targets matter the most for validation of these indices?

- What type of use cases could the board see for a tool like this once validated?
  - For example, could we use HPI's "transportation subcomponent" to include in the heat map for CRCs?

References

1. Link BG, Phelan J. Social conditions as fundamental causes of disease. *J Health Soc Behav.* 1995.
2. Ludwig J, Sanbonmatsu L, Gennetian L, et al. Neighborhoods, obesity, and diabetes — a randomized social experiment. *N Engl J Med.* 2011.
3. Kind AJ, Jencks S, Brock J, et al. Neighborhood socioeconomic disadvantage and 30-day rehospitalization: a retrospective cohort study. *Ann Intern Med.* 2014
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5. Hu J, Kind AJ, Nerenz D. Area deprivation index predicts readmission risk at an urban teaching hospital. *Am J Med Qual.* 2018.
6. Delamater PL, Finley AO, Banerjee S. An analysis of asthma hospitalizations, air pollution, and weather conditions in Los Angeles County, California. Science of the Total Environment. 2012.

Health Equity Impact Assessment Tool

Directions: One of the key aims of our health equity efforts is for us to think thoughtfully about how we structure our programs at L.A. Care with the goal to improve access to services in a more equitable way (Please see: Health Equity Zone 4 in the 2023-25 L.A. Care Health Equity and Disparities Mitigation Plan).

This Health Equity Impact Assessment Tool seeks to help us as an organization assess the effects of your project or program on our members and providers. Please answer the following questions to assess your project and impact on health equity.

Brief Description of the Project

-Describe the project you are working on. What are you planning to do?

[Please provide a brief project overview]

Target Populations and Desired Outcome

-Has the project owner or team identified the target population(s) that this project may impact and established the desired outcomes?

[Please list your target population and outcomes]

Involve Community Members Impacted or Solicit Input from Key Informants

-Have you sought feedback or input from community members or key informants during your planning?

[Please list those community (non-L.A. Care) members or key informants that you have consulted]

Identifying Disparities or Inequities

-Has your team found evidence of disparities or inequities while reviewing or planning for the project?

[Please provide disparities evidence]

Advance Opportunity and Minimize Harm

-Has your team determined any potential adverse impacts of your project during planning where it may be harmful to a specific population or exacerbate any disparities or inequities?

[Please share your response here and if there is any potential adverse impacts identified, then please share how you have mitigated the adverse impacts]

Evaluation

-Has a plan been developed to follow up and track the impact it has on the impacted members and/or providers?

[Please share your plan]

-Please share if you have any plans to share the results of your finding with the members and providers this project would impact.

[Please share your answer here]